HERITAGE PROVIDER NETWORK

Dual RFI Response Summary

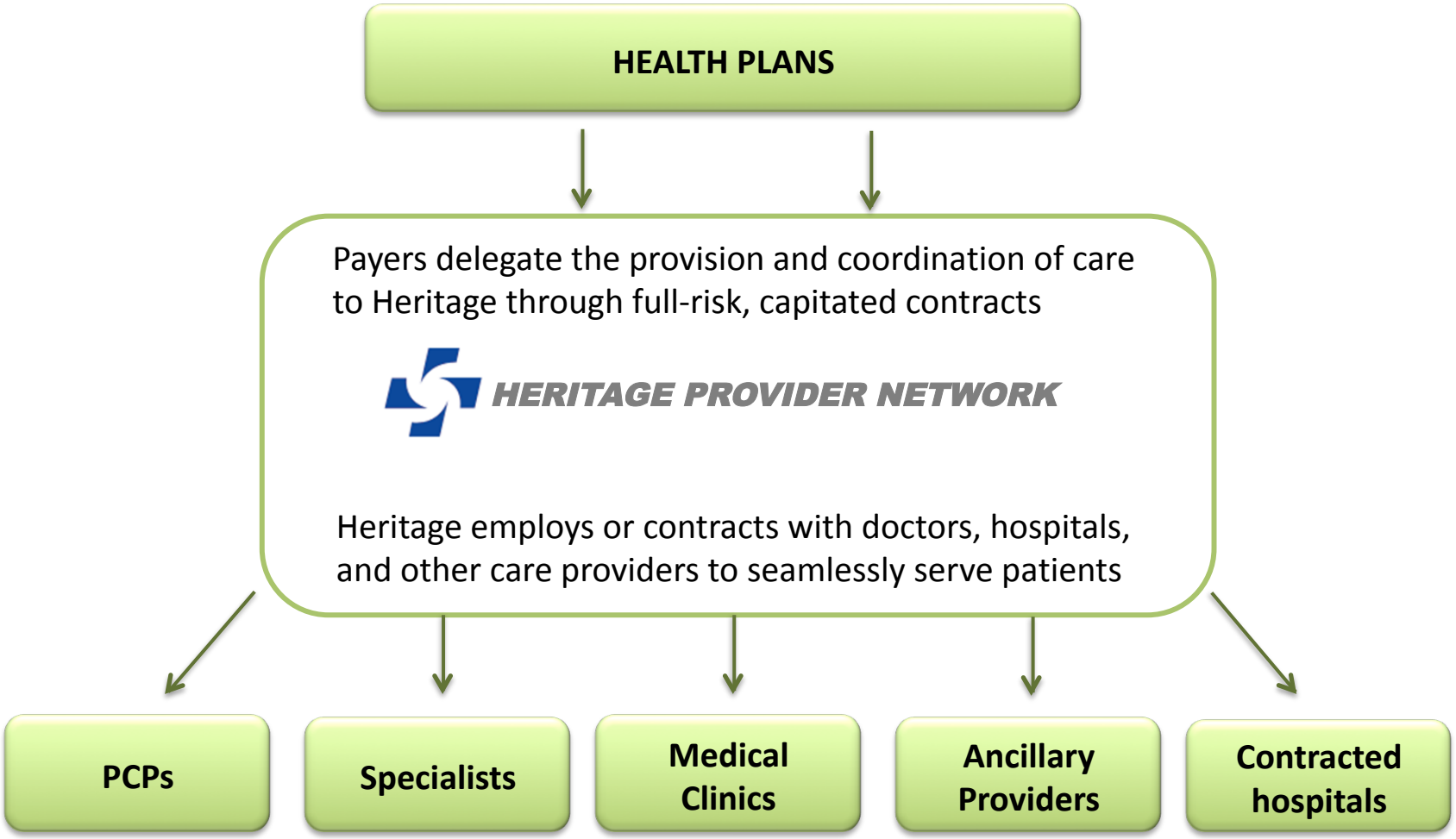
Improving Care through Integrated Medicare and Medi-Cal Delivery Models

Stakeholder Meeting August 30, 2011

Organization Background

- Founded by Dr. Richard Merkin, MD in 1974, HPN has been operating as a coordinated care provider organization for over 35 years
- Provides high-quality, cost-effective care to patients from a wide range of socioeconomic, ethnic, and cultural groups and with different levels of health status
- HPN is the one of the largest healthcare delivery networks in Southern California and has the largest geographic scope of any integrated physician organization in the State
- One of a few medical groups with a limited Knox-Keene license, which allows HPN to assume full-capitated risk for all patient services, except pharmacy services
- Currently offers 16 medical management and patient care programs that provide services from across the care continuum
- Awarded “Elite” status four years running by CAPG’s Standards of Excellence (SOE).
- NCQA certified in credentialing and re-credentialing

How We Work


HEALTH PLANS
Payers delegate the provision and coordination of care to Heritage through full-risk, capitated contracts
HERITAGE PROVIDER NETWORK
Heritage employs or contracts with doctors, hospitals, and other care providers to seamlessly serve patients
PCPs
Specialists
Medical Clinics
Ancillary Providers
Contracted hospitals

Existing Problems this Proposal Addresses

- Providing Better Care Coordination:

Dual eligibles often do not have a single entity coordinating their care. HPN will usean interdisciplinary team of clinicians and allied professionals with specialized-expertise providing care through the life continuum to increase coordination of care.

- Identifying High-Risk Members:
  - Using a proprietary algorithmic program, HPN is able to identify high-risk members for case management and disease management programs. Participants in these programs are assigned a nurse case manager.
- Reducing Costs:
  - HPN will lower the costs of providing care to dual eligibles by reducinghospital readmissions, assuming full risk for professional and institutional costs,educating members, and coordinating care.
- Guaranteeing Savings:
  - HPN will guarantee savings to the State by bearing full-risk and providing better coordinated care for dual beneficiaries.

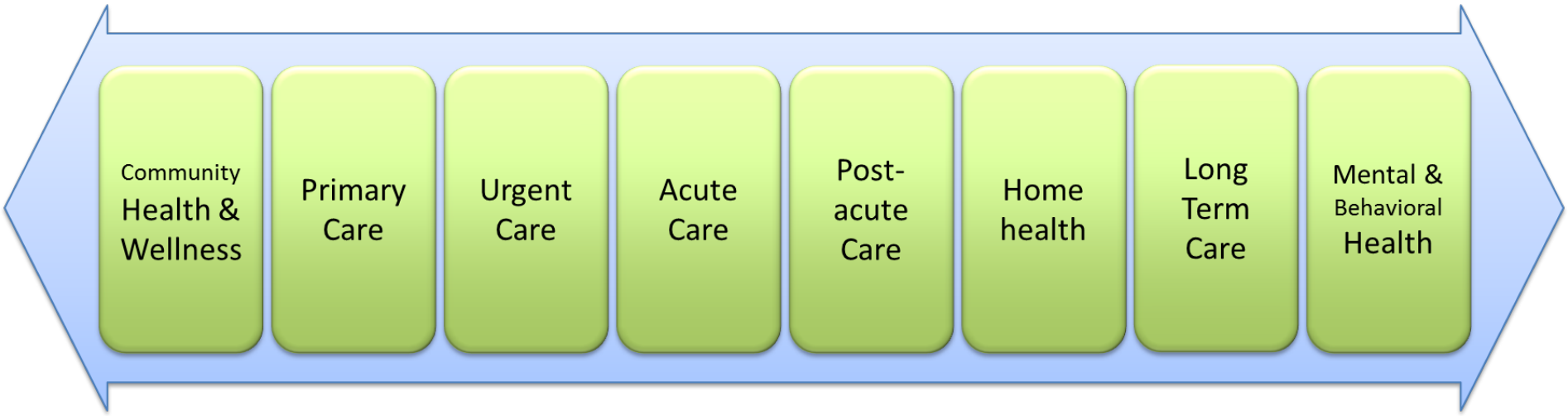
Overview: Proposed Integrated Care Plan

- Scalable Service Areas:
  - HPN has established provider groups and networks in eight counties in Southern California (Kern, Los Angeles, Orange, Riverside, San Bernardino, San Luis Obispo, Tulare, and Ventura) providing an opportunity for a scalable pilot.

- Population to be served:
  - There are 1.1 million dual eligibles in California, of which about 700,000 live in counties with established HPN networks.
- Provider Network:
  - HPN contracts with approximately 2,300 primary care physicians, 30,000 specialist physicians, and over 100 hospitals. In addition, HPN and its affliates employ hundredsof physicians at their own primary care and multi-specialty group clinics.
- Financial Structure:
  - As a limited licensed Knox-Keene Health Care Service Plan, HPN is proposing a capitated, full-risk pilot in which HPN will assume full risk for all professional and institutional costs of the participating beneficiaries.

Key Points: Proposed Integrated Care Model

- HPN employs an integrated delivery system model that coordinates health services, including preventive, emergency, acute, chronic, behavioral, rehabilitative, long-term, and palliative care.



Key Points: Proposed Integrated Care Model

- The HPN model includes expert, timely recognition and management of medical and behavioral health care needs through:
  - Member-centered care
  - The coordination of care through a central point of contact,electronic health records,and individualized care management plans
  - Aninterdisciplinary team (IDT) consisting of primary care physicians, nurses,pharmacists,social service workers, and ancillary health care providers with expertiseproviding care through the life continuum
  - Preventative health services
  - Seamless service delivery that meets the expressed needs of the member as they transition from one level of care to another
  - Reducing unwarranted hospitalizations through management of planned or unplanned hospital admissions
  - Implementation of clinical guidelines promoting best practices
  - Continuous quality improvement processes

Specific Care Integration Challenges

Mental & Behavioral Health Care:

- HPN works closely with its Behavioral Health partners to ensure members are provided services that meet their mental and behavioral health needs.
- Services include:
  - Screening services designed to proactively detect behavioral health diagnoses
  - Coordination of medical and behavioral care through a central point of contact who serves as the member's case manager
  - Preventative health services
  - Psychiatric consultation liaison services (designed to provide psychiatric consults to inpatient medical patients prior and post procedure)
  - Collaborative practice by interdependent professionals, including physicians, licensedpsychiatric assistants, licensed therapists, and licensed clinical social workers
  - Inpatient intensive case management

Specific Care Integration Challenges

Long Term Care:

- HPN employs an integrated delivery system model that coordinates services including long-term and palliative care with end of life planning.
- Examples of programs HPN offers include:
  - Palliative Care Programs: Programs include a team of specialized physicians and nurses who educate and explain all treatment options to members.
  - Hospice: Programs are designed to serve the special needs of members with critical conditions as they experience the reality of a progressive, life-limiting disease.
  - Home Health Services: Recognizing many seniors are unable to visit a doctor, HPN's Physician Home Care teams of doctors, nurse practitioners, and physician assistants provide in-home care to seniors.
  - Skilled Nursing Facilities: This model supports the provision of institutional long-termcare through a team of Skilled Nursing Facility physicians (SNFists), nurse casemanagers, and other team members identified through the health risk assessment ofthe member.

Measures for Success

- Possible monitoring metrics to use to evaluate the success of the pilots:
  - Measuring member and caregiver satisfaction through regular PatientSatifaction SurveysTracking changes in health care utilization, cost of care, and network
  - adequacyAssessing care coordination and transition opportunities
  - Monitoring the development of individual care plans and the application
  - ofevidence-based practice guidelinesReviewing grievances and appeals for issues related to quality of care, access,timeliness of care, and staff attitude
  - Determining the financial solvency of the participating pilot organization and whether it has the financial resources to provide sufficient and continued services
  - Savings to the State and Federal Government

- HPN proposes evaluating the pilot's success by comparing performance metrics of the pilot population to their same metric information prior to the pilot.

- HPN agrees to regular reporting on the metrics determined by the State as often as designated by the State.

Information Needed from CMS and the State

- Claims data
- Pharmacy data
- Lab data
- Utilization management data