June 1, 2011

Kevin Morrill, Chief of OMCP
Department of Health Care Services
Office of Medi-Cal Procurement
MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Morrill,

Together, L.A. Care Health Plan and Health Net of California are pleased to submit our response to the request for information on pilots for beneficiaries dually eligible for Medi-Cal and Medicare. In developing our response, we have collaborated to leverage and expand our considerable and collective experience in the California marketplace, and in the largest dual eligible county in the country.

We applaud the Department of Health Care Services' (DHCS) efforts to find viable and effective means to improve the delivery system for California's dual eligible beneficiaries in an integrated, cost-effective, efficient, and quality-driven manner. We have explored a number of approaches to delivering coordinated and cost effective care to dual eligibles and would welcome direct discussion of these alternative enhancements to our proposed model with the Department.

We look forward to assisting California achieve optimal value and care for the dual-eligible beneficiaries in the State and hope our responses are helpful as you shape the RFP to meet your stated objectives. If you have any questions or require additional information, please feel free to contact either of us.

Sincerely,

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Diana Dooley, *Secretary CA Health and Human Services Agency*

State of California
Health and Human Services Agency
Department of Health Care Services

Response to

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

Submitted by

Health Net of California, Inc.
21650 Oxnard Street
Woodland Hills, California 91367

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555 W 5th Street, 29th Floor
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Part 1 - Questions for Potential Contracted Entities Only (limit 15 pages)

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

Introduction

In response to the recent California Department of Health Care Services (DHCS) Request for Information (RFI) soliciting input for models to better serve beneficiaries who are eligible for both Medi-Cal and Medicare (duals or dual eligibles), we propose to utilize an existing organized approach and unique competitive partnership already serving a largely similar population to pilot an integrated care program in Los Angeles County.

The Two-Plan model, which has operated in Los Angeles County for more than a decade, presents a natural platform upon which to build an integrated managed care program for dual eligibles. A joint proposal that brings together the existing expertise and local, State, and federal relationships of L.A. Care and Health Net could maximize the strengths of the health care delivery system components of each plan. L.A. Care and Health Net are uniquely positioned to provide a comprehensive and fully integrated LA County-specific solution that leverages existing organized systems, structures, and experience.

The Two-Plan model in Los Angeles County has the following infrastructure and elements positioning it to successfully facilitate an integrated care program for duals:

- The transition of Medi-Cal-only Seniors and People with Disabilities (SPD) into the Two-Plan model offers an opportunity for coordinating the beneficiary's care over the long term as they transition from Medi-Cal-only to dual eligible status. Both L.A. Care and Health Net have significant experience in managing the care of duals and other large populations, such as the SPD Medi-Cal only beneficiaries, who have a similar incidence of comorbidity within similar clinical conditions. It is estimated that 30% of Medi-Cal-only SPD's transition to dual eligibility within 24 months of enrollment in Medi-Cal. Already having SPDs enrolled in our plans provides us with significant experience in managing this population. The SPD's engagement with managed care and the care management it provides will garner cost savings for the State as they covert to dual eligible status.
- Due to the significant involvement by L.A. Care and Health Net in Los Angeles' very large Medi-Cal SPD and dual eligible market, risk selection is much less likely to occur, thus ensuring the integrity of the State's rate setting process and its potential for predictable savings.

- Enrollment and oversight infrastructure is already in place through DHCS.
- Beneficiary choice is preserved through the option of choosing either the Local Initiative (L.A. Care Health Plan) or the Commercial Health Plan option (Health Net) with minimal disruption to beneficiaries and providers.
- Managed care can achieve actual savings for the dual eligibles program as opposed to merely shifting expenditures. Even when low unit costs are considered, the managed Medi-Cal program in Los Angeles is very efficient when compared nationally and to Los Angeles' Medicare performance.
- Both L.A. Care and Health Net are existing Medicare Advantage organizations each with a Medicare contract and each operating Special Needs Plans for duals (MA-SNP for duals). The MA-SNP for duals offers a foundation to create an integrated care program with one set of comprehensive benefits. Further, Medicare covered benefits would continue to be paid at contracted rates consistent with Medicare.

A program that builds on the success of the Two-Plan model in coordinating care in a high quality and cost-effective manner for duals in Los Angeles County can integrate the long term care (LTC) components of the Medi-Cal Fee-For-Service (FFS) program through a new partnership between DHCS and the health plans in the Two-Plan model.

The Two-Plan model can provide a streamlined continuum of care that is easy for beneficiaries and caregivers to navigate and ensure timely access to care management and coordination services. While there are opportunities to bend the cost-curve of health services consumed by this population throughout the spectrum of care, the greatest opportunity lies in the area of LTC costs. Through care coordination and the use of proven interventions, there is an opportunity to:

- Allow beneficiaries to remain in their homes for as long as medically possible and assist them to return to their homes after an acute episode of care;
- Expand the existing infrastructure to an improved, more comprehensive and coordinated system of care for vulnerable populations, while preserving beneficiary choice of care providers;
- Slow the Medicare and Medi-Cal expenditure growth rate with efficiencies and provide a complimentary system of care in the most-appropriate care settings to prevent unnecessary and/or long-term admissions to nursing facilities;
- Utilize an intense care management effort, manage hospital care and mitigate unnecessary access and use of skilled nursing facilities, while optimizing an organized network for home health care support;
- Increase access to primary care services and ensuring high standards of quality of care across the care continuum.

Programmatic Model

Currently, the well established Two-Plan model operates effectively in Los Angeles County, suggesting that a pilot in this county is feasible. There are approximately 364,000 duals in Los Angeles County. The population for this pilot would include those in the aged, blind, and disabled

eligibility categories. It is estimated that there are less than 45,000 duals in Los Angeles County currently enrolled in MA-SNPs for dual eligibles.

Clearly, the more robust the network offered under managed care, the greater the potential to enroll dual eligibles in larger numbers. This must be considered in light of the State's budgetary constraints and political reality. L.A. Care and Health Net are open to implementing the pilot either on a voluntary basis throughout Los Angeles and/or in specific geographic regions via a passive enrollment process with an active opt out option. The selected model would be dependent on how widely and rapidly DHCS wishes to implement the pilot. Even with a fully voluntary approach, there may be supplemental care coordination options that can be applied countywide.

Consistent with the final rule adopted by CMS on April 15, 2011 requiring that MA-SNP for duals have a State Medicaid contract, existing MA-SNPs for duals without a Medi-Cal contract would be evaluated by each respective Two-Plan model health plan to enter into a subcontracting relationship for the pilot. MA-SNP for duals without a Medi-Cal contract would be evaluated based on their delivery system and their ability to meet the new requirements of this pilot and would only be able to contract with one or the other of the Two-Plan model plans. Those existing MA-SNP for duals with a Medi-Cal contract could continue to operate and market their product within existing CMS and DHCS guidelines.

In addition, those Medi-Cal beneficiaries already enrolled in either of the Two-Plan model health plans' Medi-Cal managed care program and/or MA-SNP for duals would remain with their current health plan. Those without a Two-Plan model health plan affiliation would be given the choice to enroll in either plan and the plan chosen would be responsible for providing the beneficiary with:

- One ID Card and a single point of accountability for the delivery, coordination, and management of comprehensive benefits: primary, acute, behavioral, prescription drug, and LTC;
- Single and coordinated care team with comprehensive individualized care planning;
- Non-traditional benefits that help beneficiaries avoid long term care until it is medically necessary;
- Policies that ensure patient-centered health care decisions based on each members' needs and preferences; and
- Administrative simplicity including one process for submitting appeals, marketing, and enrollment material as currently modeled in Two-Plan counties

The MA-SNPs for duals that will continue to operate within Los Angeles County and are not part of the pilot would not be part of the passive enrollment process. Beneficiaries would need to make an affirmative decision to opt-out of the pilot to enroll with these MA-SNPs for duals.

Network Composition, High Performing Medical Groups and Centers of Excellence

Both Health Net and L.A. Care have ***comprehensive*** networks that include approximately 34 medical groups and IPAs encompassing nearly 3,000 primary care physicians and 7,000 specialists in LA County alone. Many of these medical groups and IPAs are recognized as having advanced

infrastructure for progressive care management and include some of the most prominent and innovative groups serving commercial and Medicare populations today.

Several of these groups already participate in one or both of the MA-SNP for duals networks of L.A. Care and Health Net. We view them as important provider partners and our proposal aims to include them as care providers in the pilot. Both health plans have experience in contracting with large provider groups and licensed health plans, and are in the process of evaluating their respective networks for potential additions to an already comprehensive system. Some of these discussions have already been initiated and are showing good progress.

Other currently subcontracted Medi-Cal health plans will be evaluated for their added value and may be approached to extend their contractual relationships with L.A. Care and Health Net to the duals population.

Both Health Net and L.A. Care currently contract with the PACE program operator in Los Angeles County, making it and the adult day health centers important potential partners.

Our proposed "all inclusive" network approach would ensure that providers who demonstrate having the infrastructure to manage this population could participate in the network under one or both of the two health plans. This would be in addition to the existing comprehensive provider network already contracted by L.A. Care and Health Net.

The Los Angeles County Department of Health Services (DHS) operates tertiary medical centers, a community hospital and numerous ambulatory care sites in partnership with two highly respected medical schools (USC and UCLA). Additionally, Rancho Los Amigos National Rehabilitation Center, regularly recognized as a leader in rehabilitative care, is operated by DHS. However, patients with Medicare coverage make up less than 7% of DHS's patients. This public resource offers the opportunity to develop centers of excellence for the duals as part of this pilot in the areas of rehabilitation, gerontology and other specialized medical offerings. Some of this work has already begun with L.A. Care and DHS through the planning process associated with the SPD transition to Medi-Cal managed care.

Managed Health Network (MHN), is Health Net's behavioral health division. MHN coordinates case management for those members with a behavioral health diagnosis only (e.g., major depression, paranoid, bi-polar, schizophrenia, or drug/alcohol disorders). L.A. Care contracts with CompCare for behavioral health services, which has similar capabilities. As such, our enterprise brings clinical expertise to the discussion of managing behavior health issues. In addition, we recognize that there is a vast and well-developed infrastructure within the counties to address behavioral health issues 'on the streets', providing important services to support the community.

Both L.A. Care and Health Net utilize the County's comprehensive behavioral health network with similar providers for segments of their respective membership. The array of County systems is important to the backbone of support and we would expect to leverage the current County systems as an integral and coordinated part of the care delivery network. Mental health professionals are important contributors to Interdisciplinary Care Teams and would be reimbursed accordingly.

An interdisciplinary model of care is critical to improving health care quality, ensuring appropriate use of services in the ideal facility, improving clinical outcomes, and reducing the cost of care. Therefore, it follows that long-term care providers and facilities would be integral to that interdisciplinary model of care. While we have contracts with a network of service providers for LTC, we would add to this network as needed to ensure an appropriate level of care is provided. The opportunity to realize cost savings is seen not through intensified unit-cost discussions, as we understand their current rate structure is very low, but through the coordination and inclusiveness into an integrated delivery model.

In addition, the coordination of services would enable those who wish to and are medically able to live at home, as opposed to living in institutions. They should receive community based services to help fulfill this objective, such as Adult Day Care, In-Home Supportive Services, and potential referrals to Independent Living Centers.

Assessment and Care Management

The main focus of the care coordination and management model of the pilot would be to produce measurable reductions in: 1) preventable hospitalizations and 2) long term nursing home stays. As such we could follow the care management approach as we do under current SNP plan requirements. Some of the mechanisms we would expect to leverage to achieve this include:

- Coordination of services
- Health risk assessment and stratification to identify the most vulnerable and focus interventions
- Case management, including care coordination, decision support, and member advocacy
- Individualized care plans with member and/or family involvement, when possible
- Team-based care through an interdisciplinary care team
- Management of transitions of care
- Utilization of evidence-based clinical guidelines

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.***

Both L.A. Care and Health Net have significant experience in managing the care of duals and other large populations, such as the SPD Medi-Cal only beneficiaries, who have a similar incidence of comorbidity within similar clinical conditions. It is estimated that 30% of Medi-Cal only SPDs transition to dual eligibility within 24 months of enrollment in Medi-Cal.

Also, Health Net has its established behavioral health division, Managed Health Network (MHN) and L.A. Care is contracted with CompCare for behavioral health services. Both health plans would utilize an existing County-based infrastructure as well.

The proposed model would meet the needs of the duals by:

- Determining the needs of members through evidence based risk stratification and assessment tools designed for seniors and people with disabilities
- Using best practices from successful dual eligible programs nationwide to tailor the model of care to the population
- Leverage the plans' existing relationships with community-based organizations and agencies that serve duals (such as the Alzheimer's Association, senior centers, Area Agency on Aging, Regional Centers, Independent Living Centers, and County Department of Mental Health); and use them as stakeholders in the care design process; incorporate the services they provide into the model of care; coordinate and collaborate with agencies that serve duals
- Build information systems to share health information among mental and behavioral health providers and physical health providers, to foster better integration of these services

We would suggest that for those already in LTC, we explore various options for care management and financing, such as a risk sharing methodology, with DHCS. Special arrangements should be structured for those in LTC to facilitate alternatives to long term care in a nursing home setting through support services to the beneficiary that allow them to stay in their home. Once a beneficiary is institutionalized in LTC, it is likely that they may no longer have a home to return to and the ability to influence that shift is minimal.

Further, as stated in the RFI, patients meeting the eligibility requirements for PACE will be able to select the pilot option.

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

An integrated model would change:

a) **Behavior** through the implementation of evidence-based self-management and goal setting health education curricula including *"Living Well with a Disability,"* a health education workshop developed by the University of Montana and launched in L.A County by L.A. Care in 2009, and *"Healthier Living"* based on the Stanford University/Kate Lorig self-management curriculum for people with chronic conditions that L.A. Care has offered for the last two years.

   Member incentives can be offered to reward health-promoting behaviors such as follow up after hospitalization, or keeping doctor's appointments (critical to the monitoring and management of some chronic diseases).

There is much research that shows that behavior change is most likely and lasting when people have actively participated in the decision making process. The active engagement of the beneficiary and his/her key family members in goal setting and establishing care plans with Care/Case Managers is fundamental to influencing change. We detail this further below.

b) **Use of services** by minimizing carve outs, integrating mental and behavioral health, incorporating long-term care and long term services and supports, using community resources for housing, meals, and other social needs, and implementing readmission reduction programs. All these items could result in changing use patterns - shifting from inpatient-based and SNF-based care to home and community-based care.

When provided effective care management in appropriate settings, members are more satisfied with their care, quality improves, and utilization declines**.** Care plan goals and associated interventions required to achieve the goals will be successful when developed by an Interdisciplinary Care Team and with valuable inputs provided by the member, or in the event of incapacitation, their representative family members. Documentation developed from effective engagement, is collectively agreed upon, and that is easy to understand will include:

- Interventions provided for the member to achieve specific goals
- Program referrals (internal and external)
- Skills training interventions structured with incremental time frames as appropriate to achieve educational and self-management goals
- Discharge interventions established to target optimal health condition and prevent re-admissions
- Development and communication of self-management plan to the member and/or his family
- Intervention prioritization based on the urgency of the problem or issue, and what is important to the member and/or family/representative
- Follow up and communication schedules with the member and/or representative based on the member's acuity level and clinical judgment of the Care/Case Manager.

Care/Case Managers continually monitor the quality of care, services, cost and products delivered to the member to determine if the goals are being met or if new problems have developed. Through ongoing assessment, using the systematic assessment tools and risk profiles, Care/Case Managers determine whether the goals continue to be appropriate and realistic, and what interventions may be implemented to achieve positive outcomes. As part of the monitoring process, the Care/Case Manager contacts the member or authorized representative and provider(s) at established timeframes based on specific interventions and/or the Care/Case Manager's clinical judgment.

Care/Case Managers monitor care plans and progress towards meeting goals. As such, they evaluate modification needs. If progress is not being made toward meeting the goals, the case manager would reassess the case to identify barriers.

In addition to assisting members and their families in managing their goals, we also understand that the industry is wrought with fraud and abuse issues. Managed care systems and structures minimize fraud, waste and abuse (FWA) in the delivery of medical care, and we believe that there is an opportunity to

develop and deploy a more effective control and engagement strategy to address FWA in the full scope of care to the dual eligible population.

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?***

Shifting from a fragmented FFS system towards a patient-centered medical home model provided in managed care, is a key and valuable approach to providing comprehensive, high-quality, affordable care. Medical homes have demonstrated better access to health care, increased satisfaction with care, and improved health outcomes and quality.

On the medical side, most medical groups and IPAs in California are accustomed to and familiar with the medical management capabilities and strategies utilized by managed care organizations, such as care/case management, discharge planning and coordination, hospital intensivist review, skilled nursing facility care management and discharge planning, home health care coordination, etc. The opportunity exists to enhance these strategies to bring additional services under the umbrella of care, minimize carve outs, reduce the fragmented delivery of care, and reduce the byproducts of fragmented care, such as unnecessary hospital readmissions, physician-hopping, and prescription-seeking.

Skilled Nursing Facilities and In Home Supportive Services will need to be coordinated within the body of the care delivery model, and both L.A. Care and Health Net will need to build the necessary internal capability and expertise to develop the necessary provider networks in this area as well as the SNF and home health care management expertise.

In addition, since a significant portion of the dual eligible population have serious behavioral health conditions and needs, it will be necessary to integrate an extensive behavioral health support capacity. Utilizing Health Net's experience developed specifically and uniquely for the military beneficiary community behavioral health needs under the TRICARE Program, we will consider extending the use of the MHN developed behavioral health network and the use of other TRICARE behavioral support tools (the Family Life Counseling system, telephonic coaching and counseling, internet based support, etc.) in order to meet the significant needs of the dual eligible population, in addition to county-based behavioral health care.

By developing appropriate and effective performance measurement and incentive programs for physicians, we would hope and expect primary care physicians (PCP) to enhance their referrals for necessary in-home care and homemaker services, as well as deliver the quality of care that will be measured and reported, consistent with the clinical measures relevant to best serving the dual-eligible population.

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

In this pilot, we would suggest that the Medicare covered benefits would be provided under each of the Two-Plan model health plan's respective MA-SNP for duals and that each health plan would continue to be Medicare Advantage organizations each with a Medicare contract. Payments for Medicare covered services would continue to flow directly to plans from CMS.

The assumption of additional Medi-Cal benefits by the health plans, including those associated with home-based care and LTC, would be funded through an enhanced, blended Medi-Cal payment. The health plans would then blend the received Medicare and Medi-Cal funds to expand flexibility in coverage, ensure a continuum of care, and minimize coverage gaps. A shared savings model would be developed splitting savings over expected costs had the beneficiary remained in the FFS program and had not been transitioned into the pilot between the State and the health plan, effectively aligning incentives to help beneficiaries avoid institutions.

There are several advantages for allowing the Medicare funds to continue to be issued from CMS direct to the health plans:

- Contracts with our broad network of provider partners have been based on Medicare rates. Hospitals will object to any possibility that payment rates will encroach downward from the Federal rates.
- Health plans receive rate payments that are risk adjusted and dependent on a judicious and thorough process established by Medicare. Changing that structure and payment source would jeopardize the revenue streams that help fund appropriate levels of care.
- Medicare has broad and strict fraud, waste, and abuse provisions which are directly tied to payment structures and with significant consequences. In order to best achieve California's stated objectives, we believe it is better to keep Federal funding and hold tight to those regulations.

As previously discussed, a significant share of the savings from this pilot would be derived from the health plans' ability to delay beneficiaries' need for long term care. However, one must recognize that a significant portion of long term care cannot be completely avoided and some may not be delayed by interventions designed to allow the beneficiary to remain in their home. The vast majority of costs associated with duals in the LTC eligibility category are directly related to nursing home care and it is not likely that health plans would be able to effectively transition those members who have already been institutionalized from that setting.

Therefore, during a transitional period of the program, we propose that DHCS consider a "risk-sharing model" for the skilled nursing facility component of the dual eligible costs. Since health plans generally are less experience in managing the skilled nursing facility (SNF) component of expense, it is recommended that the proposal offer a mutually agreed upon[1] benchmark target for skilled nursing facility cost savings (utilizing prior expense experience and trend) and that the State would experience skilled nursing facility costs at a targeted level no greater than current experience. The SNF portion of care would be subject to risk corridors. A risk sharing methodology would

[1] Mutually agreed upon between the State and the Health Plans

allow the State to capture the savings from the efficiencies of managed care while insulating the plans from the potential of insufficient funding for a type of service which is currently less understood. The proposal would create an incentive for plans to contain costs for shared upside to the cost savings, but while enabling a reasonable period to transition this membership.

We also propose that once an enrollee in the pilot meets the criteria described in Title 22 regulations for nursing facility level of care and that member has been in long term care for 6 months that they should be automatically disenrolled from the pilot and enrolled into FFS.

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?

Both Health Net and L.A. Care have ***comprehensive*** networks that include medical groups and IPA's that are recognized as having advanced infrastructure for progressive care management. Combined, our Medicare and Medi-Cal provider networks include all significant provider groups in Los Angeles County. In addition, both L.A. Care and Health Net have subcontracted arrangements that include other major Knox-Keene licensed health plans, including Kaiser, Anthem Blue Cross, Care1st, and Molina Healthcare. We bring an inclusive and collaborative model which we can build to even greater effectiveness, while minimizing beneficiary disruption.

We understand that some specific high performing provider partners (Heritage and Health Care Partners) have expressed extremely strong interest in offering individual proposals in support of the dual eligible population. It would be imperative, therefore, to submit a proposal that would be inclusive of at least these two health care delivery partners within the scope of the L.A. Care and Health Net delivery systems.

Stakeholder support will be garnered from several Regional Centers and other community based organizations that are already engaged with the health plans. We would engage the many local and statewide stakeholder agencies with which we have strong relationships and bring them into a stakeholder process similar to what DHCS used for the launch of the 1115 waiver. This stakeholder process would include consumer representation. In addition, L.A. Care has 11 Regional Community Advisory Committees throughout the County, comprised of health plan members and member advocates, that serve as conduits for input on health plan operations and program design. Members of these committees today include seniors, people with disabilities, and parents and caregivers of children and adults with disabilities.

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

- What percent of Medi-Cal members, by County, enter the program while in a nursing home- (i.e., spend down their resources and then qualify).

- The current funding sources and amounts for each of the programs being brought under the umbrella of care. What are the services that DHCS is seeking to integrate, and how much is currently paid for them?
- Historical claims and/or utilization data consistent with the benefits to be covered for the population expected to be covered under the integrated plan. Data should be sufficiently split into member type classifications:
    a. Younger physically disabled,
    b. Older and chronically ill,
    c. Persons with intellectual and developmental disabilities, and
    d. Persons with serious mental illness.
    e. Hospital admits/1000, ALOS readmission rates, ER rates
    f. Dx codes for ER visits and inpatients stays
    g. Pharmacy – PMPM costs, top 50 drugs prescribed, generic percent vs brand usage, average number of prescriptions per person
    h. Population data similar to the data plans received on FFS SPDs (every claim paid by both Medicare and Medi-Cal FFS for the most recent 12 months, deidentified)
    i. Details on the channel on where the services were provided
- Proposed payment and risk adjustment basis.
    a. Payment for services covered by Medicare to come directly from Medicare
    b. Payment for services covered by the State to come directly from the State
- Expected program for enrollment of members
    a. Who is eligible for each of these categories, on a county-by-county basis?
    b. Distribution of duals by zip code
    c. Demographic data (population and member-specific):
        i. Languages written and spoken
        ii. Ages
- All member and claim level detail data consistent with *Covered Benefits* as defined in the RFI document from DHCS released April 29, 2011. More specifically, given that there are multiple funding sources today:
    A. FFS Data from DHCS:
        a. Member-level claims data that is paid by the State (all claims information, both for services that may be carved out to Managed Care plans as well as services that the State has risk for, including but not limited to long term support and services (LTSS))
        b. Data for the Dual Eligibles for the last 3 years, CY 2008, CY 2009 and CY 2010.
        c. The following beneficiary data:
            i. Beneficiary's age
            ii. Paid date
            iii. Provider number
            iv. Adjustment indicator - Identifies the record as an adjustment
            v. Aid Codes
            vi. Encrypted beneficiary ID
            vii. California Children's Services/Genetically Handicapped Person's Program (CCS/GHPP) indicator

viii. Claim type code
ix. Emergency service indicator
x. Inpatient days
xi. Main Segment ID Number - uniquely identifies each claim line
xii. Origin of point of service code
xiii. Paid amount
xiv. Primary diagnosis code
xv. Procedure code
xvi. Procedure indicator - identifies the type of code used in the procedure code filed
xvii. Provider specialty code
xviii. Ingredient Code Logarithmic Numbers (HICL) - Code for grouping of similar drugs regardless of maker
xix. Vendor code

B. Member-level claims data that is paid by Medicare
C. Medicare HCC data and other Risk Score Methodology and data for the membership included in the historical data

- Provider level data
  a. List of high volume providers along with their claim costs
  b. Provider information detail with requested fields as outlined below
     i. Provider number
     ii. Provider legal name
     iii. Provider type
     iv. Provider specialty
     v. Provider address (Attention, street, city, state, zip)
     vi. Provider ID

- Supplemental information which would include
  a. Member and claim level pharmacy data be provided at the NDC code level including member classification described above.
  b. Cost and utilization of services that are currently carved out of Managed Medi-Cal at the eligible member level. These would include the long-term supports and services (LTSS) benefits to be covered under the integrated plan such as:
     i. Institutional long-term care
     ii. Home and community-based services
     iii. Personal care services, adult day care, home modifications, and DME
     iv. Others

     This data should be provided at the member level or summarized by the member type classifications.
  c. Any differences in the qualification requirements between the historical data and the proposed benefits.
- SNF - percent of beneficiaries that convert to long term care in a year, percent that max out their Medicare SNF benefit, admits/1000 and average length of stay for shorter-term SNF stays

- Number of IHSS hours approved for each patient

8. What questions would need to be answered prior to responding to a future RFP?

- Could we have a complete description of the benefits to be provided under the integrated plan? (Detailed benefit descriptions must include any and all prior authorization and/or special qualification requirements as well as any benefit limits.)
- What are the potential differences in the bid process with CMS for the Medicare funded portion of the benefit?
- Will the benefit years for this program differ or coincide with the CMS calendar for bidding, enrollment, and benefit accumulations?
- Would member enrollment for beneficiaries be voluntary or mandated, and would it include Managed Care for both Medi-Cal and Medicare?
- How does the State budget deficit impact the future funding for this program?
- How will rates be set – will the rates be included in the RFP?
- Will the State consider a risk sharing (both upside and downside risk) as part of the proposal response?
- When you file your waiver, will it be possible to modify the care requirements to be more adaptable and flexible to meet the needs of this population?
- What quality measures would be implemented? Would there be additional HEDIS measures from what we currently report?
- Would there be a different member satisfaction survey than the one currently being used?
- If building upon the Two-Plan model, what would determine auto-assignment? Would it be the current Medi-Cal algorithm or something different?
- What would be the baseline default rate used? Would it be the current default rates assigned to the current Medi-Cal membership for that county, or would there be an even-split in the initial year(s) of the program?

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

We believe the adequacy of the timeline is dependent of the type of model that is selected for implementation. However, should DHCS announce pilot counties in March 2012, we believe that at minimum, the nine months proposed in the timeline will be needed to create an appropriate model.

Part 2 - Questions for Interested Parties (including potential Contracted Entities Only): (limit 10 pages)

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

We believe it would be best to passively enroll but there could be some criteria to opt-out, such as for the PACE program. Therefore, we suggest a voluntary passive enrollment process with an active opt out option.

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

- IHSS-like services, such as personal attendant care
- Home and community based waiver programs that provide nursing services that allow people to remain in their homes
- Long-term care (SNF and ICF)
- Adult Day Health Care
- Social work support for housing assistance

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

Behavioral health should be fully integrated. The plan should be capitated for the services, and should demonstrate a sufficient provider network to meet the needs of dual eligibles and a system in place to ensure coordination of services between mental and physical health providers to include the electronic exchange of information and participation in joint care management.

4. If you are 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?

N/A

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

- Minimal carve outs
- One plan, one ID card, one benefit package (everything provided by the plan)
- Social work team to address social needs that have impact on health outcomes such as housing, meals and isolation
- Full integration of mental and behavioral health services. Integrate caregivers and IHSS workers into care plans
- Dental

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

We would build on our current outreach and education efforts related to the 1115 waiver/SPD enrollment which include:

- One-on-one and group educational sessions with providers including physicians, hospitals, medical groups and IPAs, office staff, and ancillary providers. To include currently contracted providers and those serving the dual eligibles through the FFS system.
- Presentations at CBOs and advocacy organizations serving dual eligibles
- On-site health plan support at all seven Regional Centers by the L.A. Care Regional Center Liaison
- Customized education for administrators of residential facilities (group homes) for people with developmental disabilities (These individuals are critical to the success of a coordinated care system as they make the decisions about how to seek healthcare for the people living in their facilities)
- Stakeholder meetings to ensure input from consumers and advocates
- Contract with a reputable CBO to do additional consumer and stakeholder outreach
- Host webinars and community forums

7. What questions would you want a potential contractor to address in response to a RFP?

We would want potential contractors to respond to all questions in Part 1 of this RFI.

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 would be held to the standards and regulations contained in their existing contracts with DHCS for Medi-Cal services and CMS for Medicare services.

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

N/A

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

- Disenrollment policies for members who are abusive or threatening.
- Extent of the plan LTC coverage – do people stay enrolled for the duration of their LTC stay or are they disenrolled back to FFS at some point?
- Appropriate outcome measures for a dual eligible population.

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

The pilot could be evaluated at least two years following implementation in the following categories:

- Health care costs compared to FFS experience.
- Delay or decrease in long term care enrollment/utilization.
- Avoidable inpatient admissions and length of stay.
- Avoidable emergency room visits.
- Comorbidity for selected clinical outcome measures (diabetes, COPD, asthma, CHF).
- Quality indicators (satisfaction, patient experience, quality of life indicators, etc).
- Utilization of appropriate services
- Health outcomes and status
- Member retention in pilot

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?***

The vast majority of costs associated with duals in the LTC eligibility category are directly related to nursing home care and it is not likely that health plans would be able to effectively transition those members who have already been institutionalized from that setting.

Therefore, during a transitional period of the program, it is recommended that the proposal include proposing a "risk- sharing model" for the skilled nursing facility component of the dual eligible costs. Since health plans generally are less experience in managing the skilled nursing facility (SNF) component of expense, it is recommended that the proposal offer a mutually-agreed-upon[2] benchmark target for skilled nursing facility cost savings (utilizing prior expense experience and trend) and that the State would experience skilled nursing facility costs at a targeted level no greater than current experience. The SNF portion of care would be subject to risk corridors. A risk sharing methodology would allow the State to capture the savings from the efficiencies of Managed Care while insulating the plans from the potential of insufficient funding for a type of service which is currently less understood. The proposal would create an incentive for plans to contain costs for shared upside to the cost savings, but while enabling a reasonable period to transition this membership.

[2] Mutually agreed upon between the State and the Health Plans