

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

*Part 1: Questions for Potential Contracted Entities*

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;*
  - 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.*

a. *Geographical location*

SCAN is very interested in partnering with the Department to serve California's dual eligible population of all ages. Any program designed to serve dual eligibles should focus on providing high quality and coordinated Medicare and Medi-Cal services in a manner that improves health status and outcomes for this vulnerable population, but does so in a way that maximizes the use of resources available under the Medicare and Medi-Cal programs.

SCAN would be open to participating in a pilot program in most geographic regions of California. However, our preference would be to build on the existing SCAN infrastructure and provider networks in counties where we currently operate. These are Contra Costa, Los Angeles, Kern, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara and Ventura counties.

Again, while our exact level of participation would certainly depend on the model, SCAN's participation could take any of a number of forms; that is, a single county, a subsection of a county or several counties, including non-adjacent counties.

b. *Approximate size of target enrollment for first year*

The size of SCAN's target enrollment in the first year would depend on the structure of the pilot program and geographic location. However, SCAN envisions adapting its operations to serve a target population beginning with approximately 10,000 to 25,000 beneficiaries and the potential to grow to approximately 50,000 or more beneficiaries by 2014.

c. *General description of provider network, including behavioral health and LTSS*

Under a pilot program, SCAN would bring to the Department a network or networks capable of providing physician, hospital and other services necessary to provide seamless, coordinated care services to the dual eligibles participating in the pilot program. SCAN would do this on a full-risk basis for all Medicare and Medi-Cal covered services, including professional and hospital, pharmacy, home and community-based and long-term care services.

Because of the complex needs of a dual eligible population, SCAN maintains that a critical feature of any pilot program should be the establishment of a patient-centered care delivery

model with a designated primary care provider for each participating dual eligible beneficiary. Members should be able to designate their primary care provider with a physician or clinic of their choice. The patient-centered care delivery model must focus on care improvement and enhancement through a dedicated primary care provider, an interdisciplinary team, member (and caregiver/family) education, physician education and support, and use of information technology to communicate and support the provision of care. Entities contracting in the pilot program should be able to demonstrate how their dual eligible beneficiaries will be served by a patient-centered care delivery model in the Request for Proposals (RFP) for the program.

Given the complexity of the health care needs of the dual eligible population, SCAN would maintain that any pilot program require a contracting entity to include at least the following types of providers in their network:

- Hospitals
- University Medical Centers
- Pharmacies
- Durable medical equipment and other ancillary providers and services
- Home and community-based care providers and services
- Skilled nursing facilities and other long-term care providers and services
- End-of-Life, palliative care and hospice services
- Home Health Agencies
- Regional Centers (for services for the developmentally disabled)

Also, importantly, given the prevalence of mental/cognitive diseases and conditions among dual eligibles, contractors participating in the pilot program should also demonstrate how they will manage these conditions in a medical home environment. This will require additional behavioral health services that coordinate with the patient's primary care medical home and serve as an active participant of the multi-disciplinary team. The behavioral health interdisciplinary team should be comprised of a pharmacist, licensed behavioral health providers such as Licensed Clinical Social Workers (LCSW), Marriage/Family Therapists (MFT) or psychologists, registered nurses, social workers and care coordinators. For behavioral health services that are not delivered at the patient's primary care location, alternative treatment sites must meet the beneficiary's medical, psychological and functional status needs and preferences and may include a medical office where medical and psychiatric care are co-located, or in the member's home (includes a nursing home, assisted living facility, private residence or telephonically).

SCAN is proud of its longstanding experience providing long term services and supports to nursing facility certified individuals. This experience has allowed SCAN to develop the networks and infrastructure to provide the necessary long term care services and supports to its member population. These services include, but are not limited to, adult day health care, adult day care, attendant care, home-delivered meals, home health care, personal care, homemaker, respite care services and others. Under a pilot program, SCAN would leverage our experience and knowledge to serve the pilot program target population. Because of the importance of providing coordinated acute and long term care services for the target population, entities interested in participating in the pilot program should be required to describe and demonstrate how they will provide such services.

*d. Specific plan for integrating home and community-based services*

Among California's managed care plans, SCAN has unique experience integrating home and community-based services and medical care management in its care model. Under a pilot

program, SCAN would envision a comprehensive plan for integrating these services based on the assessed needs of the individual. The pilot programs should build on providing comprehensive, multidisciplinary care management services that includes the use of social workers, nurses, and gerontologists with specific expertise in the social and behavioral needs of dual eligible beneficiaries. The pilot programs should also include access to the full range of necessary home and community-based services as outlined above to implement a beneficiary's individual care plan to support them in the community as much as possible.

e. Assessment and care planning approach

Individual assessment and care planning are central to integrating the range of services required by dual eligibles. Given the medical and behavioral complexity of the dual eligible beneficiaries, the successful contracting entity must be able to implement specific assessment tools toward the care of patients who are at greatest risk for worsening conditions and hospital utilization. SCAN's current ability to meet the diverse needs of its high-need members cost-effectively relies heavily on its risk stratification tools used in conjunction with the expertise of its multidisciplinary care teams.

SCAN uses individual assessment tools and techniques to stratify members based on their specific needs and/or risk. These tools and techniques are best practices that have been found successful in identifying and/or predicting risk for chronic conditions and disabilities. A successful risk stratification tool should incorporate past medical claims data, pharmacy data and some laboratory results, CMS diagnosis information (to better understand new members who do not yet have claims history), and information from beneficiary-completed surveys including disability level (i.e., limitations in activities of daily living).

Once beneficiaries are flagged as eligible for disease management or case management program, care teams work with beneficiaries to understand their needs and selectively target the type and level of services called for. Like SCAN, entities participating in the pilot program should have a care planning process that incorporates:

- Input from the patient regarding personal health goals, preferences regarding care, understanding of health status, language and cultural preferences.
- Assessment tools to identify patient needs, goals, readiness/motivation for change and track changes in the patient's health status on an ongoing and regular basis.
- Review of the patient's encounter and utilization data, pharmacy utilization data, assessment questions across multiple domains (i.e., chronic illness, medication, cognitive, social-psychological, spiritual, self-management skills, community resource needs, preventive services, and access to care).
- Data from assessment informs the care plan and interventions designed specific to the patient.

A plan of care should then be developed and executed in collaboration with the patient's primary care provider (PCP) and the patient (and their caregiver, if appropriate). This may involve specific risk stratification to identify members for medical management programs, and assessment tools to identify patient needs and goals. The focus of this treatment plan is to care for the entire patient, including health goals and cultural preferences, communication, coordination and access.

*f. Care management approach, including following a beneficiary across settings*

SCAN's capacity to coordinate care across settings begins with the flexibility of our provision of a patient-centered care delivery model. SCAN's care teams are highly-trained to address the complex needs of the chronically-ill population, and each of our specific programs are coordinated with the others to ensure successful care transitions between all levels of care and providers in the integrated care delivery system. SCAN would recommend that any pilot program include use of a model based on:

- Use of a personal health record to communicate information to primary and specialist physicians;
- Reconciliation of pre- and post-hospital medications;
- Knowledge of warning signs and symptoms; and
- Understanding appropriate follow-up care post-discharge

Highly-trained care teams can be used to address the complex needs of the chronically-ill population, with each program coordinated to ensure successful care transitions between all levels of care and providers in the integrated care delivery system. Care management programs should work with patients to ensure care plan adherence, timely access to PCPs, preventive health referrals, improved self-management of chronic conditions, and medication reconciliation. Disease management programs specific to the needs of the dual eligible population focus on the disease state, including process and management, recognizing disease-specific symptoms and actions to take, when to call a doctor or to seek emergency care, medication management, nutrition, self-management and healthy behaviors, and advance care planning.

Given the need for strong coordination and successful transitions between providers, there are several disease management programs that should be considered for inclusion in the pilot program(s) such as:

- Home Care Programs
- Complex Care and Disease Management including:
  - Congestive Heart Failure (CHF)
  - Diabetes
  - Chronic Pulmonary Disease (COPD)
  - Chronic Kidney Disease (CKD)
  - Depression
- Behavioral health care coordination, including dementia care
- Medication therapy management
- Nursing facility management
- Inpatient complex care management

Entities interested in participating in the pilot programs should be required to describe their experience and expertise in these and other relevant program areas.

*g. Financial Structure*

Given the complexity of the dual eligible population and the attendant cost of care, it is remarkable that approximately 90 percent of the dual population remains in fee-for-service. SCAN believes that dual eligible beneficiaries can be much better served by contracting entities that accept risk for the pilot population. Being at risk encourages successful contracting entities to deliver the right care at the right time, thus preventing unnecessary emergency room utilization, re-hospitalizations and other costly episodes of care. SCAN envisions that the state

will establish a capitated rate that would afford the state and federal government a guaranteed rate of savings versus historical fee-for-service costs for this population and care management costs would be included in the medical cost calculation. In addition, the Department may want to consider a number of innovative rate structures that provide incentives for quality outcomes and cost efficiency. These could include, but would not necessarily have to be limited to, bonuses for reaching specific quality benchmarks or savings.

- 2. How would the model above meet the needs of all dual eligible, 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 eligible, please describe that approach.*

As the fourth-largest not-for-profit Medicare Advantage plan in the United States, SCAN serves a diverse population of both elderly and non-elderly Medicare beneficiaries, including dual eligibles. SCAN's focus on the support and care management of high-need beneficiaries is at the heart of our mission and organizational strategy. We have a long and proud history serving seniors and persons living with disabilities and chronic illnesses and conditions in a comprehensive manner that emphasizes independence and the provision of care in the setting of the consumer's choice. Approximately 17% of our current membership is nursing home certified based on functional and cognitive need. SCAN's ability to serve its current population in lower-cost settings is demonstrated by the fact that less than one percent of our membership lives in institutional settings. SCAN strongly believes this experience will allow it to serve a greater population of dual eligible beneficiaries using many of the same intensive care management strategies.

SCAN's current model of care will meet the needs of California's dual eligible population, including younger beneficiaries with disabilities, because of its existing patient-centered care delivery model and strong focus on coordinated care, supportive services and emphasis on home and community-based services rather than institutional care. SCAN believes that the pilots should adopt this same care model and require contracting entities to provide comprehensive management of high risk patients. Patients classified as high risk should be triaged into specialized health care programs that emphasize the improvement of care transitions and reducing preventable hospital readmissions. SCAN would suggest that the model being used by the Department to mandatorily enroll seniors and persons with disabilities (SPD) in Medi-Cal managed care represents a strong foundation to providing care for younger beneficiaries with disabilities, including those with developmental disabilities. As demonstrated in the SPD enrollment, a great deal of time has been spent by the Department and stakeholders to review contracting requirements, patient assessment, network adequacy assessments and facility site tools. Other critical factors have been community education, sensitivity training for plans and providers, and involving the beneficiary in the management of their care by providing appropriate, easy-to-understand information in formats that include Braille, large-print, and audio.

Dual eligible patients with serious mental illness should be primarily treated in collaborative care sites using appropriate protocols and evidence-based guidelines tailored to meet the individual patient needs. SCAN's experience shows that alternative models of care are necessary in the treatment of members with both medical and behavioral health care needs. As such, SCAN strongly believes that appropriately trained and educated providers will be critical elements for the coordination and collaboration in case management programs or any necessary inpatient behavioral treatment services.

SCAN supports the provision of behavioral health care in a site co-located with medical care. When this model is inappropriate or undesirable for a beneficiary, alternatives such as in-home treatment can be available. Home-based care may include a private residence, nursing home, or assisted living facility. Home-based behavioral health care may be most appropriate for particularly frail or functionally-disabled beneficiaries who have difficulty in tolerating transportation or long office visits. In some cases, follow-up care may be appropriate by telephone if it suits the beneficiary's needs or preference. Regardless of the location of behavioral health treatment, the interdisciplinary team should work to include physician involvement, psychiatrist consultation (when needed), family conferences with beneficiary consent, comprehensive documentation of the care plan and progress toward treatment goals, review of medications for medical and psychiatric conditions, family counseling/coaching, integration with medical care management, attention to cultural and linguistic needs and preferences, and resolution of any barriers to care. Service provision in alternative sites must provide for electronic transfer of case information to secure sites.

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?*

SCAN has successfully used a comprehensive, patient-centered care delivery model of care for over 30 years. This model spans the continuum of a beneficiary's health status at each stage and provides the right care at the right time. SCAN has demonstrated in published research that this integrated model is responsible for fewer hospital and emergency room visits, lower hospital readmission rates, lower overall medical costs and a greater likelihood that beneficiaries in long-term care facilities will return to the community within 90 days.

SCAN currently uses approaches such as motivational interviewing, coaching for self-management, caregiver support, and behavioral health coordination to help the patient maximize their ability to live independently and with better health outcomes. For healthier populations, SCAN emphasizes preventive strategies and includes education and coaching to enhance a patient's self-management skills specific to their diagnosis or condition. The pilots should provide a range of management programs specifically designed to enhance the beneficiary's behavior and appropriate use of services using:

- Care management programs that include behavioral health care coordination, dementia case management, in-person and/or telephonic case management services, medication therapy management, skilled nursing facility case management and inpatient complex care management.
- Collaboration with other community and state agencies such as state Regional Centers for the care of individuals with developmental disabilities to avoid duplication of case coordination activity, coordinate benefits and assure access in a timely manner.
- Care transitions including reconciliation of medication regimens across care settings, physician follow-up after hospital discharge, and teaching home caregivers about warning signs and care plans.
- Disease management programs specific to the needs of the individual patient such as diabetes, behavioral health, congestive heart failure and chronic obstructive pulmonary disease.
  - Whenever possible, a disease management program should provide an educational pathway or protocol focused on the disease state, including disease process and management, recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, medication management, nutrition, self-management and healthy behaviors.

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?*

SCAN currently has a fully integrated and at-risk capitation model of care through its contract with the state of California. In SCAN's experience, aligned incentives shared with provider groups provide a higher level of quality of care for beneficiaries. Structuring provider payment for patient care on a performance-based reimbursement system such as the 5-Star System developed by CMS is one example of aligning financial incentives with quality improvement.

The contracting entity, in partner with the providers, must analyze the appropriate data to understand and meet the needs of the dual eligible population. These interventions may include CME training based on best practices for the population and development of supporting infrastructure. Plan and providers should work together on carrying out a coordinated model of care to ensure that patients receive the appropriate care at the appropriate time.

SCAN's unique experience of delivering home and community-based care for over 30 years leads to lower rates of institutionalization and greater beneficiary satisfaction. In spite of serving a predominantly frail elderly population, SCAN has maintained an extremely low level of institutionalization because of its focus on HCBS services and allowing beneficiaries to maintain their independence and control over where and how they live.

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

SCAN is uniquely qualified to integrate Medicare and Medi-Cal funds as well as the medical and long-term care responsibilities. For most of its history, SCAN operated under Medicare's Social HMO demonstration, incorporating a HCBS benefit together with a comprehensive program of assessment and care management. For the enrollees who were dually eligible, SCAN blended Medicare and Medi-Cal funding to provide a fully integrated array of Medicare, Medi-Cal, and HCBS benefits. SCAN offers the scale and operational sophistication of a large Medicare plan together with the mission and care coordination resources of a specialized plan focused on care management.

Based on our history as a specialized program integrating management of medical and LTC needs, SCAN believes that the pilots must be prepared to devote significant resources to beneficiary assessment and care management.

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?*

SCAN is a community-based plan with longstanding ties to local providers and community organizations in Southern California. Indeed, SCAN was formed by a group of citizen activists in the 1970s to provide innovative services for the senior community in Southern California. From that seed has grown the fourth largest not-for-profit Medicare Advantage plan in the United States. Despite our size, SCAN continues to engage at the local level, operating a number of community-oriented programs such as health literacy presentations for enrollees and their

families, and free wellness screenings at local health fairs. We have established member/advocate groups to evaluate our programs and provide valuable feedback on ways to improve our care delivery.

The pilot should allow for a robust local stakeholder advisory committee comprised primarily of representatives for the dual eligible population being served, the contracting entity's leaders, medical group leaders, clinical experts, advocates from entities representing the dual eligible population and local health community leaders. The role of this advisory board will be to comment on the model of care and share perspectives on how to better serve the needs of this population. These advisory board meetings should be open to attendance by the contracting entity's enrollees and their caregivers and would be held in accessible sites based on a published meeting schedule. Advisory board recommendations should be reviewed by the contracting entity and viewed as an opportunity for quality improvement. The RFP should allow for interested bidders to provide greater detail on how to incorporate local stakeholder input into the design and implementation of the dual eligible pilot.

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

Ideally, the Department should be prepared to provide rate data and information when the Request for Proposal is issued. If this is not possible, the Department should provide interested parties as much information as possible regarding the rate methodology, what will be included in the rate, as well as the timeline for rate development. It would also be helpful for the Department to provide greater detail on how the funds from Medicare and Medi-Cal are going to be blended and distributed to the entities participating in the pilot program.

Entities chosen as part of the pilot should have access to the same data currently being provided to Medi-Cal Managed Care plans accepting the mandatory senior and persons with disabilities population. This data includes:

- Demographic data;
- Fee-for-service utilization for auto-enrolled members, including but not limited to, pharmacy, hospital and provider claims;
- Medi-Cal long-term care service claims history;
- Medicare Part A, B and D claims;
- HCC scores;
- Safety-net provider data; and
- Eligibility history of dual eligibles.

*8. What questions do you need answered prior to responding to a future RFP?*

- Will Medicare risk enrollment be mandatory, voluntary or mandatory with an opt-out?
- If Medicare enrollment is voluntary, will Medicaid-only enrollment be mandatory for individuals who remain in Medicare FFS?
- Will plans be fully at risk for residential or institutional placements for an indefinite length-of-stay? Will this include spend-down residents?
- Will the state's existing Medicaid managed care network adequacy requirements differ for long-term care provider contracting?
- Will membership be locked in for 12 months?



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

Yes.

*Part 2: Questions for Interested Parties (including potential contracted entities):*

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

To facilitate optimal participation in the coordinated care model and pilot location, participants should be auto-enrolled, with the ability to opt-out of the program if they choose.

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

The long-term supports and services must address the needs of beneficiaries across the continuum of care and emphasize patient-centeredness, hands-on care coordination, linkages between primary care and other clinical, behavioral, and supportive services with an emphasis on home and community-based services rather than institutional care. The services that allow for the greatest degree of patient independence must include, at a minimum:

- Attendant care
- Home-delivered meals
- Home health services
- Home/domestic assistance
- Personal care
- Respite care
- Home modifications
- Support in navigating health care and community resources (e.g., assistance with scheduling appointments, arranging for prescriptions, transportation, or durable medical equipment)

SCAN would suggest that the pilots be granted flexibility to provide any necessary services to the dual eligible population and not be held to the benefit limitations and requirements for services as outlined in the Department's Medi-Cal Provider Manual. In addition, the pilot program rates and contracts must embrace the innovative nature of this coordinated care, and the contracting entities participating in the pilot should not be penalized in their subsequent rates for providing needed services that are not currently covered under the Medi-Cal benefit structure.

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

Each of the pilot's contracting entities should be prepared to manage the chronically mentally ill patients in a patient-centered care delivery model with benefits and services that allow patients to live and participate in their community. The successful contracting entities will accomplish this by:

- Providing behavioral health services that coordinate with the patient's established primary care provider and serve as part of the multi-disciplinary team;
- Providing services using appropriate protocols and evidence-based guidelines tailored to meet the needs of the individual patient;
- Providing consultative and support services to the patient's established primary care provider and other providers, the care team and network care management staff to identify mental health risk and/or needs; and
- Providing appropriately trained personnel to provide consultation, coordination and collaboration assistance for beneficiaries who are included in case management programs or who require inpatient behavioral health treatment services.

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?*

While SCAN is not a provider of long-term supports and services, our patient-centered care delivery model includes long-term supports and services in the continuum of care that a beneficiary will require throughout their life. We contract with a number of these providers and work with them to ensure seamless transition for individuals that require this care. We would anticipate continuing to do this if SCAN is chosen as a contracting entity for the pilot.

SCAN is a current contractor with the Department, but would suggest that the pilots include a regulatory streamlining process to eliminate conflicting or duplicative administrative and reporting requirements across the Medicare and Medi-Cal programs. Specifics on this process could include aspects of communication, facility inspection, appeals, etc. and would need to be developed in cooperation with the pilot entities, DHCS, and CMS. This is very important in order to ensure that there is seamless coordination of services between Medicare and Medi-Cal covered services for pilot participants, to facilitate and clarify service provisions for providers and to enhance the efficiency of the operation of the pilot program.

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

SCAN believes that a patient-centered care delivery model of care include hands-on care coordination, linkages between primary care and other clinical, behavioral, and supportive services and an emphasis on home and community-based services rather than institutional care. These services would include:

- Individual care plans for all patients with an established primary care provider and using a multi-disciplinary team to address both medical management and social supports.
- Predictive modeling and risk stratification techniques to focus resources on care of patients who are at greatest risk for worsening conditions and hospital utilization.
- Specialized health care programs to improve care coordination, chronic and acute care management, care transitions and reduce preventable hospital readmissions for high-risk patients. The integrated plan must have the capacity to support providers in the development of these programs and to provide intensive care management wrap-around services.
- Provision of home and community-based services, such as in-home personal care and homemaking assistance to support patients in community settings.
- Behavioral health services to meet the complex needs of dual eligible patients.
- Provider group development and support to assure best practices for dual eligible patients.

6. *What education and outreach (for providers, beneficiaries, and stakeholders) do you consider to be essential to a model of integrated care for dual eligibles?*

Providers: SCAN believes that providers must be evaluated at the beginning of the pilot to assess the strength, adequacy and quality of the network. For providers that require additional education, the contracting entity should coach these providers to implement best practice methodologies. Obviously, providers will need education, infrastructure support (e.g.,

continuing medical education, technical assistance, etc.) and wrap-around care management services in order to best manage this population.

Beneficiaries: SCAN strongly supports an active and aggressive education effort prior to the implementation and enrollment of the dual eligible population in the pilot. In addition to materials about the program in a culturally and linguistically-appropriate manner, SCAN considers community engagement to be critical to the successful transition of this population to a more organized delivery system. This community engagement could include local meetings with key organizations serving the target population including clinics, places of worship, regional centers, respite centers, area agencies on aging, etc.

Stakeholders: SCAN maintains a strong working relationship with local and statewide advocacy groups that serve or represent the interests of the dual eligible population. These entities should be allowed to review the materials prior to their release to the target population to ensure they are consistent and in an easy-to-read format. On-site education would occur with local stakeholders to ensure they were sufficiently comfortable with the pilot in order to help beneficiaries successfully transition into the pilot.

*7. What questions would you want a potential contractor to address in response to a Request for Proposals?*

As a potential contractor, SCAN believes that the RFP should require all potential contractors to demonstrate a comprehensive and patient-centered approach to improving the health outcomes for this population in an efficient and effective manner. Potential contractors must provide details on how this care will be provided at the right time and right place. One of the most important factors to the success of this pilot is the productive engagement of the individual beneficiary and their caregiver/family.

*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?*

SCAN supports the extensive stakeholder involvement in the mandatory enrollment in managed care for seniors and persons with disabilities. If chosen as a pilot participant, SCAN would expect to be held to the same standards and contractual terms. These expectations, goals and metrics must be established prior to implementation pilot and remain consistent throughout the term of the pilot.

SCAN also believes that a specifically-developed standard contract tailored to the pilot demonstration be provided to the contracting entities prior to implementation that clearly outlines the coordinated roles for Medicare and Medi-Cal services and requirements.

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

SCAN would work with local providers and beneficiaries to ensure the success of the pilot in our areas of the state. We would certainly like to be a contractor under the pilot program.

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

Under the current system, a number of barriers and challenges exist to hinder the delivery of quality care to dual eligibles. These include conflicting requirements between Medicare and Medicaid pertaining to:

- Appeals procedures (different rights regarding grievance and appeals)
- Auditing (different standards and schedule)
- Benefits (different criteria for “medical necessity” as well as conflicts in the handling of mid-year benefit changes, non-covered benefits, and the establishment of standards and guidelines.
- Billing/payment systems (fee schedules and payment rules differ with different timelines for claims payment)
- Contract administration (different timelines for contract approval as well as different rules governing assessment and services to accommodate cultural and linguistic delivery)
- Contract bid schedules (timing of state and federal bid processes vary)
- Eligibility (two forms of eligibility verification exist)
- Enrollment (the programs use two different enrollment forms, and the failure to qualify for one program automatically disenrolls a member from the duals program; different submission cut-off timeframes exist)
- Enrollment dates for eligibility must be coordinated between the programs so beneficiaries are not at risk of being found ineligible for one program and maintaining eligibility in another.
- Financial reporting (different reporting requirements)
- Provider networks (differing standards for assessing network adequacy, as well as differing timeframes on network regulations)
- Quality measures (differences exist in quality reporting processes, separate HEDIS audits are conducted, and different HEDIS reporting requirements are used between the programs)

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

The pilots should provide a web-enabled dashboard of performance metrics with real-time data to CMS and DHCS to allow for continuous monitoring of all outcome metrics. Reports could provide real time utilization, quality measures, bed days and enrollment. Evaluation metrics should reflect the diversity of the dual eligible population and be appropriate to the care being provided across the continuum of care. The core measures would address:

- Patient experience in ambulatory settings, continuity of care, and LTC (home and institutional). At a minimum, these would include CAHPS and HOS surveys adapted to a dual eligible population.
- Preventive care measures appropriate for the dual eligible population.
- Process and clinical outcome measures for a defined set of chronic conditions.
- Behavioral health measures specific to the dual eligible population.
- Utilization reporting including hospital, SNF and ER admission, length of stay, and bed days. The evaluation should also monitor 30-day readmission rates, out-patient surgery utilization and preventable hospitalizations.
- Number and length of nursing home stays.
- Other pharmacy measures will be adherence rates, generic utilization, inappropriate use in the elderly/disabled and formulary compliance.
- Patient and family satisfaction will be measured in the surveys listed above in addition to the appeals, grievances and disenrollment rates.

Obviously, there should be a robust quantitative and qualitative external evaluation of these pilots in order to demonstrate improved quality of health, health outcomes and an overall reduction in cost. The selected pilots should be allowed to work with the external evaluator prior to implementation in order to finalize goals and data collection requirements.

12. *What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of this project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?*

SCAN currently accepts risk for providing care to medically fragile populations in California and would require an appropriate capitated rate to provide a comprehensive set of services for this medically complex population. Providing appropriate care and access to services requires that the reimbursement rate reflect the intensity and quality of services for individuals with extensive medical conditions. The rates developed for the pilots must be transparent and accurately reflect the historical cost of institutional and non-institutional care required by the dual population. They should be actuarially sound, and each participating plan/pilot must have adequate time to review the rates and if necessary, request modifications. The successful contracting entities, with an adequate capitated rate, should be expected to align incentives with contracting providers and make value-based purchasing decisions that improve the quality of care for the dual eligible population.