

SHASTA COMMUNITY HEALTH CENTER
Response to RFI on Pilots for Beneficiaries Dually Eligible
For Medi-Cal and Medicare
June 1, 2011

Part 1: Questions for potential contracted entities only (15 pages)

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

A. geographic location

This project will focus on Shasta County, California.

B. approximate size of target enrollment for first year

Shasta Community Health Center serves 3100 (39%) of the dual eligibles in Shasta County. This will be the focus of our program for the first year. During the program development process that takes place prior to December 2012, we will develop a process to recruit additional members of this population.

C. general description of provider network including behavioral health and LTSS

Shasta Community Health Center is one of the primary providers of behavioral health services in Shasta County. Our program follows an “integrated behavioral health – primary care model”.

We have provider staff of 5 and work closely with the county Mental Health agency to serve the at risk population. We also have a strong working relation with the Far Northern Regional Center and are the major provider of care for the Developmentally Disabled population in the region.

D. specific plan for integrating home and community –based services

All efforts to integrate and community care will be based on expanding the relationships we currently have with care providers in the areas of adult day health care, home health agencies, county public health services, and a variety of social service agencies that we work with in the community. A case management component will be the essential mechanism to make this happen.

E. assessment and care planning approach

We will be using a “Primary Care Case Management or PCCM model” for this project following the overarching Patient Centered Health Medical home delivery model. This will be done as an expansion to our current approach to providing integrated direct care that includes medical, dental, mental health, and specialty consultation.

F. Care management approach including following a beneficiary across settings.

Based on the Patient centered health home model case management would coordinate the essential services with outpatient support services, such as adult day health care or group services for targeted mental health sub populations. We currently maintain a call service that would allow patients to contact a case manager 24 hours a day to address critical needs and reduce the use of hospital emergency rooms for non emergency problems.

G. Financial structure, e.g. ability to take risk for this population.

The financial structure of the primary care case management health home model would be somewhat of a hybrid of current models with limited risk and an emphasis on the rural community based environment that we operate in. This would require a low risk sharing structure to demonstrate new risk arrangements that can be assessed as part of the project outcomes. The ability to manage care and prevent health conditions from escalating while

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avoiding unnecessary emergency room visits or hospitalization will be measured in cost saving to the community. There are no data on the actual savings from this type of preventive care and the pilot project will seek models to measure these outcomes.

2. How would the model above meet the needs of all dual eligible's, i.e. seniors, younger beneficiaries with disabilities, people diagnosed with Alzheimer's disease and other dementias, people who live in nursing facilities etc. if you could propose to serve a smaller segment than the full range of dual eligibles, please describe that approach.

Services for all of the care needs of the dual eligible population are available in our community but further collaboration through a patient centered health home model emphasizing case management will be necessary. Most of our dual eligible patients are under 64 years of age and we see 90% of the patients under the care of the far northern regional center. We currently provide home visits to Developmentally Disabled adult care facilities. Care for Alzheimer's patients and other disabled seniors is provided by Golden Umbrella and North Valley Catholic Social Services which would become part of our network linked through the Patient centered health home and case management services. Our approach would be to enroll patients that we have contact with through our current patient panels and the other organizations within our network that also currently serve the target population. There is currently a model of care in the region that emphasizes caring for patients in the target population within their own homes with assistance from a network of cooperative providers.

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?

a) The case management component provided by our anticipated model will help patients link their care providers more closely. Often small items in the process can cause difficulties. A problem getting a ride or a waiting list for a service can be helped with the intervention of a case manager. Early identification of changes in health or behavior can also be identified by a case manager which can lead to valuable intervention and reduce the risk of an inpatient hospital stay. The patient centered health home will enhance coordination of services among network organizations and for out-of-network referrals.

b) While we anticipated possibly greater use of outpatient services in the beginning stages of the pilot project, the long term outcome of the care network developed around the patient centered health home. We expect that the long term result will be a reduction in acute care services and skilled nursing services for this population and less use of the hospital emergency department by this population. The capacity for case management that links primary care, ancillary services, and outpatient social services has the potential to evaluate health status, correct an individual's health care program in a variety of settings, and make adjustments and corrections in an expeditious manner rather than having a family member make determinations about various medical and environmental issues with which they have little experience.

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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?

Case management is the key to any Patient Centered Health Home model for this population. The interaction of the care team(provider, case manager, family care giver, and other ancillary services and support systems in the health care decision process will decrease the use of unnecessary higher cost services by having a broader picture of the patient's needs and environment support system. The involvement of the larger support system also facilitates preventive care and diagnostic tests in a more timely manner which will further translate to cost savings and reduced emergency department and inpatient care.

The primary care team with an active case manager will improve access to HBCS by determining the best use of community resources to meet the medical and social service needs of the patient. Family involvement in the decision making process is essential to the optimal use of community resources such as home care or low impact institutions leading to lower cost by full use of appropriate resources without over prescribing higher levels of care when unnecessary.

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

The payment system has to fund cost effective alternatives to the utilization of inappropriate and more expensive hospital and emergency department use. The patients we will enroll in the beginning are currently our patients and with better resources we can manage their care more effectively. Support (reimbursement) for case management at a level that will meet the needs of this complicated patient population is a key to the success of this effort.

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 support? How would you propose to include consumer participation in the governance of your model?

The advantage of a rural area is that we know the community stakeholders and have strong working relationships. Through our local consortium the Health Alliance of Northern California we are involved in a number of patient centered health home projects. Moving forward with a pilot project for dual eligibles would include formalizing relationships with many of our current partners to focus on the specific needs of the target population. This would be undertaken during the initial development and refinement of the program model that would take place during the year prior to the implementation of the pilot project.

Shasta Community Health Center currently has a consumer majority on the Board of Directors. For the terms of our by-laws a consumer is a board member that receives care or has a dependent family member that receives care at one of our health centers. For a pilot project of this magnitude we would

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develop an advisory body with both institutional-I stakeholders and consumer representatives. This body would provide feedback on the efficacy of services, patient satisfaction and areas where improvement is warranted. The advisory body would be recruited in the early stages of developing the program model.

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

There are a number of data items that are not readily available to us at this time:

- Specific Medicare data on the utilization of services by dual eligibles.
- Annual cost breakdown by age & diagnosis.
- Patient specific data on cost to help identify those with highest cost and service mix.

Further data needs will be identified as a response to the RFP is developed. The main issue is the DHCS provides or arranges access to data without delay and that any consent or waiver issues are addressed as part of the RFP not later in the process.

8. What questions would you need to be answered prior to responding to an RFP?

- Does the rural geographic area that we propose (Shasta County) lend itself to the pilot project as envisioned by DHCS?
- Will a service area with no existing managed care meet the criteria for this pilot project?
- Is DCHS serious about providing the financial support necessary to provide a patient centered health home model of case management?
- At a point when reimbursement for many outpatient support services (e.g. Adult Day Health Services) are threatened, is it reasonable that paying more for these services to keep patient out of the hospital will be embraced at a future budgetary level?
- A final product must have financial incentives that benefit providers at all levels as well as patients.

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

The key to the timing of this project is having a clear understanding of the available funds and program expectations. It is important that potential applicants have a clear understanding of the parameters as DHCS sees them. Responses will be based on our needs assessment and a number of assumptions that are likely to change during the process. It is critical that DHCS and other state agencies respond to data requests in a timely manner. It will also be necessary to retain consultants, which takes time in itself. To have community buy-in active involvement from local stakeholders is also essential and adds its own time constraints.

SHASTA COMMUNITY HEALTH CENTER
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Part 2: Questions for interested parties (including potential contracted entities: Please limit to 10 pages)

1. What is the best enrollment model for this program? Since we are beginning with SCHC's existing dual eligible populations, we would propose reaching out to them via our normal mechanisms of mail, phone calls and in person assistance.
2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model? Services such as In-Home Support Services and community resources such as Golden Umbrella Adult Day Health services and programs, along with Shasta Senior Nutrition, Mercy Hospice are critical in keeping people safely in their homes.
3. How should behavioral health services be included in the integrated model? Shasta CHC already uses an integrated behavioral health model but would expand those models to include group sessions around certain chronic diseases including patient self-management groups.
4. If you are a provider of long-term supports and services, how would you propose participating in an integrated 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?
5. Which services do you consider to be essential to a model of integrated care for duals? Integrated primary care case management inclusive of chronic disease management and integrated primary care and behavioral health.
6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation? Providers will be brought into the process and system through normal communication channels of meetings and other communiqués since these services will be limited to SCHC and its employed physicians and physician extenders. SCHC proposes to begin sending a newsletter with a cover letter by the CEO introducing patients to these new services as the very start. Brochures will be available within the clinic and support staff will get some basic training.
7. What questions would you want a potential contractor to address in response to a request for proposals?
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?
9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

SHASTA COMMUNITY HEALTH CENTER
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10. What concerns would need to be addressed prior to implementation?

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

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?