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Re: Request for Information (RFI) on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Part 1: Questions for Potential Contracted Entities Only (Please limit to 15 pages)

1. Describe the model you would develop to deliver the components described above, including at least:
   a. Geographical location; SynerMed through its Risk Bearing Entities of Independent Practice Associations and Medical Groups have substantial Medi-Cal operations in Fresno (20,272), Kings (2,381), Los Angeles (284,737), Madera (2,710), Riverside (31,486), Sacramento (25,148), San Bernardino (32,733) and San Diego (49,336) which represents over 57% of all Duals in the State of California
   b. Approximate size of target enrollment for first year; We currently have 15,000 MAPD members under management of which 6,000 are Duals that have voluntarily chosen our network via an available Special Needs Medicare Advantage Plan. The first year of the pilot we believe we could add an additional 15,000 Duals to our current provider network. In fact, we anticipate adding 5,000 Duals as the SPD population is added over the course of the next twelve months and through organic membership growth.
   c. General description of provider network, including behavioral health and LTSS; We have over 5,000 primary care providers and 10,000 providers total covering all the required sub specialty services in each market we operate. Our RBOs are Angeles IPA, Community Family Care IPA, Employee Health Systems, Multicultural IPA and Mid County Physicians. These provider groups work with Anthem Blue Cross, Care 1st, HealthNet and Molina statewide. We also have

relationships with the quasi private public health plans including Inland Empire Health Plan and LA Care.

d. Specific plan for integrating home and community-based services, including non-Medicaid long term supports and services; James Mason worked at SCAN Health Plan before running SynerMed and he has direct experience in developing provider networks to support the integration of home and community based services to keep patients healthy and safe in their home rather than in an institutional setting. Our programs and processes include the integration of social workers into our clinical team, we work with care givers, we use a uniform assessment tool and we use our advanced analytics to track and monitor the quality care metrics of this population.

e. Assessment and care planning approach; All MAPD, MA-SNP and SPD members are assigned a case manager who does an initial assessment. This assessment plan is then shared with the primary care provider to help coordinate care. If necessary home based, hospital based or nursing home based assessments will be completed. Together the team develops a care plan to address the patients need. We measure performance on an ongoing basis including claims review, monthly reports on utilization and sentinel events and program quality reports.

f. Care management approach, including following a beneficiary across settings; (See part e).

g. Financial structure, e.g. ability to take risk for this population. All our RBOs have the ability to take risk and are taking risk for over 600,000 members in the state of California

2. How would be model above meet the needs of all dual eligible, i.e., seniors, younger beneficiaries with disabilities, person with serious mental illness, people with intellectual and development 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. These populations will have unique challenges. We already manage 4,000 SPD members most of which are younger beneficiaries and many have unmet mental health needs. We have developed models of care around the resources available in the community and in some cases developed resources to address the issues of mental health. Mental Health services have but cut significantly and a lot of this pathology has leaked into the medical side mostly through the Emergency Room. To respond, specifically in Sacramento County we developed a mental health integration program in partnership with Anthem Blue Cross. In Los Angeles County we are working with Special Needs Plans that have specific mental health designation to support care coordination. In general we will coordinate with the Regional centers and county clinics as well.

3. How much 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? The integrated approach will improve access to care, reduce costs, improve quality and improve the member experience. That has been our experience for over 15 years.
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? Our proprietary analytics allows our providers that operate in our virtual patient centered medical homes to manage their population more effectively than in a non-integrated approach. In essence our tools allow the physician to focus her attention on the 200 members that require care of the 2,000 members assigned. This is the power of the integrated care coordination approach.
5. How would your specific use of blended Medicare and Medi-Cal funds support the objectives outlined in the proposal above? The additional funds will be used to address the gaps in care that exist in the Fee for Service system.
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? Yes, all our contracted providers are committed to supporting these programs. SynerMed and its RBOs are unique since we are comprised of independent traditional safety net providers. These are the providers that care for 70% of the Medicaid population. These providers offer the highest value at the lowest costs to provide for these members as compared to County, FQHCs or Academic settings.
7. What data would you need in advance of preparing a response to a future Request for Proposals? We would like to see claim history (Physician, Hospital, IHSS and RX) for the population.
8. What questions would need to be answered prior to responding to a future RFP?
9. Service area, Implementation Schedule, Provider Network Adequacy Requirements, copy of model contract, access standards and guidelines, member enrollment processes, Lock-in, member disenrollment, Benefits and Services, member rights and responsibilities, grievance and appeals, marketing and outreach guidelines, system and technical requirements, claims management, reimbursement, financial solvency, fraud and abuse, Dispute resolution, TPL reporting, and reporting guidelines.
   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): (please limit to 10 pages)

1. What is the best enrollment model for this program? Through existing managed care models (GMC, Two-Plan or COHS) with MA SNPs. In markets that these models do not exist the State should consider a PCCM model with existing RBO that have the care coordination capabilities to manage this population.
2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model? Proper funding, Membership lock in for a year, membership default assignment if they do not choose a plan during open enrollment.
3. How should behavioral health services be included in the integrated model? Mental Health dollars should be re-alligned to support the needs of a patient centered medical home
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 subcontractor for the contracted entities? Our providers will want Medicare rates as the basis of their reimbursement and 100% of Medicare rates should be the default fee schedule for non-contracted providers including hospitals.
5. Which services do you consider to be essential to a model of integrated care of duals? Patient Centered Medical Home aka primary care gatekeeper model. A Risk Bearing Accountable Care model with physician led provider groups directing the care. Organizations that can identify and manage their CHF patients, COPD patients, ESRD patients. Organizations that coordinate care with Urgent Care facilities and incorporate hospitalists and SNFists. Organizations that have integrated high risk programs, mental health and palliative programs.
6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?
7. What questions would you want a potential contractor to address in response to a Request for Proposals? Similar to previous RFPs for Medi-Cal and Medicare.
8. Which requirements should DHCS hold contractors to for this population? Very similar to the requirements as set forth by Medi-Cal and Medicare. Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries? Same as above.
9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area? Either as a direct contractor as a PCCM or as a provider we are prepared to help coordinate the care for this population.
10. What concerns would need to be addressed prior to implementation?

11. How should the success of these pilots be evaluated, and over what timeframe? One year and three year look back. Evaluate based on the triple aim of the accountable care act. Reduce costs, improve quality and improve customer satisfaction.
12. What potential financial arrangement 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? Financial risk aligned with the the triple aim makes healthcare more accountable and a physician level. Instead of being motivated to do more to get paid more the physicians are motivated to provide the care that is needed when it is needed.

Please feel free to contact us if you have any additional questions. Thank you in advance for your time and consideration.

Sincerely,

James Mason, President & CEO
SynerMed