Department of Health Care Services

California's Dual Eligible Demonstration Request for Solutions

California Department of Health Care Services

Released: January 27, 2012

Applicable Dates:

Applicants' Teleconference: 2 pm to 4 pm February 6, 2012

Applications Due: February 24, 2012

Announcement of Selected Sites: Anticipated Mid to Late March

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Request for Solutions

January 27, 2012

Overview

Purpose

The California Department of Health Care Services (DHCS), Medi-Cal Managed Care Division, in partnership with the Centers for Medicare and Medicaid Services (CMS), invites qualified entities to submit a proposal to provide comprehensive health care services to individuals eligible for Medicare and Medi-Cal in California, known as dual eligibles. These proposals are being requested under California's Dual Eligibles Demonstration Project (Demonstration).

In coordination with the Federal Government, the State is planning the Demonstration for launch in 2013 to examine the benefits of coordinated care models. By enrolling a portion of dual eligibles into coordinated care delivery models, this three-year Demonstration (2013 to 2015) aims to test how aligning financial incentives around beneficiaries can drive streamlined, beneficiary-centered care delivery and can rebalance the current health care system away from avoidable institutionalized services and toward enhanced provision of home- and community-based services.

The purpose of this Request for Solutions (RFS) is to identify Applicants with the requisite qualifications and resources best suited to provide seamless access to the full continuum of medical care and social supports and services dual eligibles need to maintain good health and a high quality of life in the setting of their choice.

Applicants should note this Demonstration is pending stakeholder review and federal approval. The sites selected through this RFS process may be included in the Demonstration Proposal. DHCS will release the Proposal for public comment in March 2012 and submit to Centers for Medicare and Medicaid Services (CMS) later in Spring 2012. The Proposal will outline specific programmatic design elements and technical parameters. The Demonstration approach is subject to change until the Proposal is finalized and approved, which is anticipated to occur May 2012. All Demonstration sites and programs will be rigorously evaluated as to their ability to improve quality and reduce costs. Finally, sites must pass a rigorous Readiness Review prior to enrollment of any

beneficiary. Every site will be subject to a Readiness Review across all areas included in the RFS, including but not limited to network adequacy, stakeholder involvement, and consumer protections.

Authority

In 2010, the Federal Coordinated Health Care Office was established by section 2602 of the Patient Protection and Affordable Care Act (ACA). The ACA charges the Federal Coordinated Health Care Office (renamed the Medicare-Medicaid Coordination Office or MMCO) with more effectively integrating Medicare and Medicaid benefits, and with improving the coordination between the federal and state governments for individuals eligible for both Medicare and Medicaid benefits (dual eligibles).

In 2010, the California Legislature enacted Senate Bill 208 (Steinberg), authorizing DHCS to implement a coordinated care Demonstration in up to four counties. The legislation specifies that the Demonstration include at least one county that provides Medicaid services via a Two-Plan Model, and at least one county that provides Medicaid under a County Organized Health System (COHS). In 2011, California was one of 15 states selected by CMS to receive a $1 million design contract through the Center for Medicare and Medicaid Innovation at the CMS to develop new ways to meet the often complex and costly needs of dual eligibles.

On July 8, 2011, CMS issued a State Medicaid Director letter providing guidance on financial alignment models that CMS seeks to test with States (See Appendix B for links to relevant CMS documents). Under the capitated financial alignment Demonstration, CMS will test a new capitated payment model using a three-way contract among States, CMS, and health plans beginning in 2013. The State intends to work with CMS under this authority in developing a Demonstration Proposal to test the capitated model in the selected counties. Implementation of the Demonstration is contingent upon State submission of a Demonstration Proposal, and CMS review to determine the State's ability to meet certain standards and conditions.

This RFS is not intended to suggest that CMS has approved this Demonstration, as the State has not submitted a Demonstration Proposal to CMS.

Background

California has approximately 1.2 million people enrolled in both Medicare and Medi-Cal, according to the latest data. Many individuals in this heterogeneous group are among the state's highest-need users of health care services. Dual eligibles tend to be older, poorer, and sicker than most Medicare and Medi-Cal enrollees. In California, 71 percent of dual eligibles are 65 and older and most have multiple, co-occurring chronic conditions.

Additionally, many have high levels of inability to perform activities of daily living, such as walking and bathing.

The Demonstration offers perhaps no better opportunity to test innovative service delivery and payment models. Today's system is riddled with perverse incentives that encourage Medicare and Medi-Cal to shift costs to one another — with beneficiaries caught in the middle. While Medicare is the primary payer for dual eligibles, the Medi-Cal program plays a significant role in covering their out-of-pocket expenditures and pays for most long-term care services. Yet, Medicare and Medi-Cal often work at cross-purposes because they have different payment rules and cover different services. For beneficiaries, this means no single entity is responsible for ensuring they receive necessary care and services – both medical and social – to remain in their homes and communities for as long as possible. Far too many people have no options other than institutional care. This removes people from their homes and needlessly increases costs. Furthermore, beneficiaries must navigate two separate, complex systems on their own, which often results in poorly coordinated and inefficient care.

While roughly 175,000 of California's 1.2 million dual eligibles are enrolled in organized delivery systems, the remaining 80-plus percent receive services through the fragmented fee-for-service (FFS) system. With rare exceptions, none of these systems offers a full continuum of medical, behavioral, social, and long-term care services. There is a critical need for new organized systems of care that provide beneficiaries with more tailored and supportive benefits in the setting of their choice.

The Demonstration will support the creation of such organized systems of care that are responsive to beneficiaries' needs and overcome existing fragmentation and inefficiencies created by current categorical funding and service structures. This RFS reflects DHCS' aim to rebalance care away from institutional settings and into the home and community when possible. It promotes the development of coordinated care models that provide seamless access to the full continuum of services dual eligibles need to maintain good health and a high quality of life in their homes and communities for as long as possible. The criteria reflect rounds of input provided by a wide array of consumers and stakeholders during numerous conversations and public meetings over the past six months, including comments on the Dual Eligible Framework documents released earlier this year (Please See Appendices D, E and F).

In determining the counties in which to establish the Demonstration, SB 208 requires DHCS to consider the following factors:

- Local support for integrating medical care, long-term care, and home- and community-based services networks.
- A local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development,

implementation, and continued operation of the pilot project.

Additionally, DHCS will evaluate submitted Applications to determine which proposals best meet the required and desired qualifications for this Demonstration. This may include review of CMS data, and, as appropriate, discussion with CMS. Successful Applicants may be included in the DHCS Demonstration Proposal to CMS. A determination by DHCS that an Applicant is qualified and selected for inclusion in the Demonstration Proposal, however, confers no rights or expectations that the Applicant will receive a contract. Announcement of the selected sites is expected in mid to late March 2012.

Please note that while submissions to this RFS will be used to select the initial sites, DHCS may also use the submissions to assess the ability of additional Applicants to implement this project, should additional Demonstration sites be authorized.

Demonstration Goals

Health care services are useful only to the extent they lead to positive health outcomes and increased quality of life. By rebalancing the health care delivery system to provide coordinated and beneficiary-centered care, California can generate greater value – that is improved beneficiary health outcomes achieved for each dollar invested.

The goals established for this Demonstration by SB 208 are as follows:

1. Coordinating benefits and access to care, improving continuity of care and services.

2. Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

3. Increasing availability and access to home- and community-based alternatives.

In addition, DHCS proposes the following goals, based on CMS guidance and stakeholder input. These goals may be modified based on further stakeholder input. The Demonstration should:

1. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.

2. Improve health processes and satisfaction with care.

3. Improve coordination of and timely access to care.

4. Optimize the use of Medicare, Medi-Cal and other State/County resources.

Demonstration Model Summary

This Demonstration will involve models through which one entity is coordinating care for the total needs of a person, including medical, behavioral, social, and long-term care services. This design could take a number of different forms, depending on local circumstances. There is an expectation that all Medicare and Medi-Cal services will be coordinated and that the care experience will be seamless for the beneficiary. Additionally, sites are expected to demonstrate the ability to improve quality and contain costs.

Key Attributes

Demonstration Population: All full benefit dual eligibles in the selected Demonstration areas will be eligible for enrollment. Full benefit dual eligibles have Medicare Parts A, B, and D coverage, and Medi-Cal coverage for Medicare premiums, co-insurance, copayments, and deductibles, as well as additional services that are covered by Medi-Cal that Medicare does not cover (QMB+ individuals, SLMB+ individuals, and other full benefit dual eligibles).

No beneficiaries will be excluded from the Demonstration based on specific diagnostic categories.

The Demonstration will apply to the following populations as described here:

Share of Cost Beneficiaries: Under federal law, the majority of beneficiaries in long-term care facilities are assumed to have met their share of cost each month. DHCS intends to include these beneficiaries in the Demonstration. The Demonstration Proposal will provide more details regarding Share of Cost beneficiaries.

Children: In counties or zip codes with a California Children's Services (CCS) pilot, children will not be enrolled in the Demonstration.

PACE Enrollees: In Demonstration areas where the Program of All-Inclusive Care for the Elderly **(**PACE) is available, PACE enrollees will be carved out of the Demonstration. Beneficiaries meeting the eligibility requirements for PACE will be able to select PACE, the Demonstration plan, or may opt-out of both.

AIDS Healthcare Foundation (AHF) enrollees: Similar to PACE, AHF will remain a separate program, and existing enrollees will not be included in the Demonstration.

Developmentally Disabled Beneficiaries: Demonstration sites shall be responsible for the provision of all medical services and long-term supports and services for enrolled developmentally disabled beneficiaries. However, home- and community-based waiver services[1] provided through the Department of Developmental Services for the developmentally disabled population will remain as currently available and carved out of the Demonstration. The Demonstration will not affect eligibility for regional center benefits among dual eligibles.

Enrollment: The Demonstration shall use an opt-out or "passive" enrollment process in which eligible beneficiaries would be enrolled automatically into Demonstration sites for coverage of both Medicare and Medicaid benefits unless they voluntarily choose to opt out. DHCS believes passive enrollment is necessary to ensure beneficiaries receive access to a robust network of providers and quality care management systems. The state will work with an independent enrollment broker, community groups, and others to inform beneficiaries of their choices. Under passive enrollment, beneficiaries will receive notification of their choice to opt out of the Demonstration and subsequently receive notification of their choice of Demonstration plans, unless they are in a COHS county, where there is only one option.

DHCS will seek permission from the Federal government to implement an enrollment lock-in, in which beneficiaries who initially enroll in a managed care health plan under the Demonstration must remain enrolled with that health plan for at least six months. Under this Proposal to CMS, after the six months, beneficiaries would be able to switch to another Demonstration site, Medicare Advantage, Medicare fee-for-service, or PACE. The department, with stakeholder input, may exempt specific categories of dual eligibles from these enrollment requirements.

DHCS is committed to a phased enrollment process starting January 1, 2013 and will work with health plans, stakeholders, beneficiaries, and the Federal government on the design of this process. There is a need to carefully coordinate demonstration enrollment with the standard Medicare enrollment process, and that will require thoughtful consideration. DHCS is examining alternatives that would minimize beneficiary disruption and confusion. Building on and improving the transition of Seniors and Persons with Disabilities (SPDs) into organized care, DHCS intends to design and implement a seamless transition with no disruptions in care.

[1] Home- and Community-Based Waiver Services for the Developmentally Disabled include: Homemaker, Chore Services, Home Health Aide Services, Respite Care, Habilitation, Pre-Vocational Services, Supported Employment, Environmental Accessibility Adaptations, Skilled Nursing, Specialized Medical Equipment and Supplies, Transportation, Personal Emergency Response Services, Family Training, Adult Residential Care, Supported Living Services, Vehicle Adaptations, Communication Aides, Crisis Intervention, Nutritional Consultation, Behavioral Intervention, and Specialized Therapeutic Services.

Geographic Coverage: SB 208 allows pilot projects to be established in up to four counties. The legislation specifies that the Demonstration include at least one county that provides Medi-Cal services via a Two-Plan Model, and at least one COHS county. To be considered for the Demonstration, potential sites must be capable of covering the entire county's population of dual eligibles. Certain exceptions may be allowed in rural zip codes of large counties, as currently allowed by Medi-Cal managed care contracts.

Integrated Financing: Under the capitated financial alignment Demonstration, CMS will utilize a new capitated payment model using a three-way contract among States, CMS, and health plans beginning in 2013. Participating sites will receive a capitation rate that will reflect the integrated delivery of the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees. No Part C or D premiums will be charged to beneficiaries. Rates for participating sites will be developed based on the baseline spending in both programs and anticipated savings that will result from improved care quality realized through the integrated care delivery and care management. The rate will provide will provide upfront savings to both Medicare and Medicaid. (See Appendix C for links to more information, including a new CMS document, "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans.")

Benefits: Demonstration sites shall be responsible for providing enrollees access to the full range of services currently covered by Medicare Parts C and D. Sites also will be responsible for providing access to all State Plan benefits and services covered by Medi-Cal. Also included will be provision of long-term care supports and services (LTSS), which include State Plan benefits of In-Home Supportive Services (IHSS), Community-Based Adult Services Center services (CBAS Center, formerly called Adult Day Health Care Services), long-term custodial care in Nursing Facilities, and the Multi-Purposes Senior Services Program. Other home- and community-based services under the 1915 (c) Section of Social Security Act waivers also will be included, pending federal approval[2]. Sites must demonstrate adequate capacity to provide seamless access and coordination of services, based on the needs and preferences of the enrollees, across the full continuum of services from medical care to LTSS.

Additionally, Demonstration sites shall be responsible for providing enrollees seamless access the full range mental health and substance use services currently covered by Medicare and Medi-Cal. For beneficiaries receiving care from the County Specialty Mental Health Plan, close coordination with County agencies will be necessary. Medi-Cal and Medicare medical necessity standards are not to be restricted by health plans, ensuring that individuals have access to any benefits they would have had access to absent the Demonstration.

[2] To the extent the federal resource in Money Follows Person continues to exist, a one- time resource to re-establish household will be available to plans who successfully transition eligible beneficiaries (with at least 90 days prior stay in long-term nursing facilities) back into the community.

Pharmacy Benefits: Demonstration Sites will be required to offer Medicare Part D coverage and meet all Medicare Part D requirements. They will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call Letters for contract year (CY) 2013 in February and April 2012, respectively.[3] Beneficiaries would not be subject to any Part D premiums but would continue to be subject to standard low-income subsidy copayment levels. Plans could elect to buy down Part D co-payment levels. Sites will be required to cover medically necessary drugs covered by Medi-Cal and not covered by Part D. See CMS "Plan Guidance" document referenced earlier for more details on Part D requirements and timeline.

IHSS: In the first year of the Demonstration, IHSS benefits will be authorized under the same process used under current state law. The Demonstration site will contract with the County social service agency. Sites must work with Counties to develop processes that allow information sharing on the care needs of the clients. In the subsequent years, the Demonstration site can suggest expanding its role. DHCS is developing further guidance on how IHSS and LTSS would be integrated over a three-year period and expects to release it in the near future.

Mental Health and Substance Use Benefits: Demonstration sites are required to develop integrated delivery of behavioral health services for all enrollees. This includes screening to identify existing unmet needs and linking individuals to services. Additionally, the findings from the statewide behavioral needs assessment DHCS commissioned to be completed in 2012 should be incorporated into the design (See: http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx).

For the most seriously affected individuals, sites should develop a plan, with local input, to achieve full integration of mental health and substance use services by January 1, 2015 (i.e. inclusion of behavioral health services into the integrated capitated payment). The integration plans should build on the model of care set forth in Sections 5801, 5802, and 5806 of the California Welfare and Institutions Code. Applicants shall contract with providers experienced in delivering that model of care within their networks directly or through contracts with the county mental health agency, which currently funds these programs.

[3] Through the annual Call Letter process, CMS provides operational and policy guidance necessary for prescription drug plans and Medicare Advantage (MA) plans to successfully bid in June in order to offer benefits for the following contract year. The Call Letter is issued together with the advance and final payment notices used to provide information on the annual MA capitation rates, risk and other factors used to adjust such rates, and changes to Part D benefit parameters. A draft Call Letter is issued in mid-February, and a final Call Letter is issued in early April, 60 days prior to the statutory deadline for bid submission for the following contract year. Additional information about the MA and Part D programs is provided on http://www.cms.gov/PrescriptionDrugCovContra/ and http://www.cms.gov/HealthPlansGenInfo/.

Proposals with more detailed descriptions of processes for shared accountability, coordination and eventual integration will be scored higher. During the readiness review process, demonstration sites will have to show they have formal partnership agreements and/or contracts with Counties that demonstrate a plan to move toward integrated financing and service delivery by 2015. These plans shall demonstrate shared accountability based on agreed-upon performance measures and financial arrangements, such as incentive payments or shared savings structures. DHCS and CMS will provide technical assistance and support to develop these locally tailored solutions. Proposal variation is expected, depending on each county's level of readiness. (See Appendix G for technical assistance on coordination and integration.)

Person-Centered Care Coordination. All sites will be required to offer person-centered care coordination as an essential benefit. Coordination is important for all services across the care continuum, including home-and community-based services and behavioral health services. Care coordination standards will be developed with stakeholder input. Recognizing that enrolled beneficiaries require varying levels of care coordination, if any, Demonstration sites will be required to plan and implement care management systems capable of assessing and responding to these different levels of need. Care management can range from simple service coordination to enhanced, ongoing care management to beneficiaries with complex medical, behavioral health, and/or long-term care needs to achieve optimal health outcomes and independent living in the community.

A standardized LTSS assessment process will be developed with stakeholder input. Demonstration sites will be expected to use this assessment process once it is completion.

Supplementary Benefits: Demonstration sites are strongly encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services beyond those available today in most Medicare Part C benefit plans. Until rates are developed, it is not possible to know the extent of a health plan's ability to offer supplemental benefits.

A key part of this Demonstration is bringing together social services and medical services. Thus, Demonstration sites are required to have plans to contract, utilize, and pay for community-based services that are not necessarily a plan benefit but can help beneficiaries remain in their homes and communities. These community resources include, but are not limited to, Meals-on-Wheels, housing services (Residential Care Facilities, Continuing Care Retirement Communities), and services offered at Independent Living Centers, Senior Centers, Area Agencies on Aging and Aging and Disability Resource Connections. Recognizing that the loss of housing during a short-term institutionalization can be an obstacle to returning to the community, DHCS intends to work with CMS and plans to explore housing as a supplemental benefit.

Technology: Coordinated care will increasingly depend on the effective use of eCare technology, such as telehealth-enabled critical and specialist care, home technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living, and safety technologies. Demonstration sites are encouraged to include such technologies in their models. Technology, however, shall not supplant in-person delivery of essential, core activities of a person-centered care coordination program.

Beneficiary Notification: A consistent set of required beneficiary notifications shall apply. Enrollee materials shall be integrated to the extent possible and must be accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency. Communication in alternate formats will be required. CMS and DHCS will approve all outreach and marketing materials in advance, subject to single set of rules to be developed. DHCS will consider consumer/advocate input when developing notification materials from the State. The forthcoming Demonstration Proposal and MOUs shall include more detailed information on beneficiary notification.

Appeals: For the Demonstration, it is intended that there be a uniform appeals process across Medicare and Med-Cal. The forthcoming Demonstration Proposal and MOU shall include more detailed information related to the integrated appeals process.

Network Adequacy: DHCS intends to follow Medicare standards for network adequacy for medical services and prescription drugs and Medi-Cal standards for network adequacy for LTSS. The latter standards will be developed with stakeholder input prior to the readiness review process. For areas of overlap, where services are covered under both Medicaid and Medicare, the appropriate network adequacy standard will be determined via MOU negotiation and memorialized in three-way contracts with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The forthcoming Demonstration Proposal and MOU shall include more detailed network requirements related to accessibility, appropriateness and timely access. Each Demonstration site's network adequacy will be subject to confirmation through readiness reviews before any beneficiary is enrolled. Demonstration sites also will have to use the Facility Site Review Tool DHCS developed to assess accessibility of providers' facilities. (See http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf)

Monitoring and Evaluation: All sites will be required to participate in an evaluation process organized by DHCS and CMS. All sites will be required to participate in quality assurance and improvement initiatives. CMS and DHCS shall work together to develop

applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process to ensure strong, consistent, quality oversight and monitoring. Quality requirements will be integrated, and include a unified minimum core set of reporting measures, to evaluate quality improvement of sites during Demonstration period. An external evaluator will be contracted to measure quality and cost impacts to both Medicare and Medicaid in this Demonstration. Detailed reporting on numerous process and outcome measures will be required.

Quality Incentives: Participating sites will not be eligible for Medicare star bonuses. Plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the Demonstration). Sites will be able to earn back the capitation revenue if they meet quality objectives.

Medical Loss Ratio: The Demonstration sites will be required to follow existing state law requiring a minimum Medical Loss Ratio in the large group market of 85 percent. DHCS will carefully monitor the impact of the 85 percent for potential adverse impact on beneficiary health. Participating plans will be required to report on costs to ensure transparency and facilitate evaluation.

Learning and Diffusion: Demonstration sites should be able and willing to participate in ongoing meetings to share challenges and best practices.

Ongoing Stakeholder Involvement: Meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required. Integrating entities, at a minimum, should develop a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

Timeline

The following is a process planning timeline for California's Dual Eligibles Demonstration project authorized by SB 208 (Steinberg, 2010).

Activity	Approximate Timeframe	Activity
Release of draft site selection criteria	Late December	Previously, the goal had been to release final site selection criteria by year's end. Given the complexity of the issues, the goal is to now release draft criteria for comment.
Comment period on criteria and incorporation of comments	Comment period closes at 5 pm January 9, 2012.	DHCS will compile site selection criteria comments, and DHCS will make any changes as needed. Public meeting held in Sacramento early January on the criteria.
Release of final site selection criteria and beginning of selection process	January 27, 2012 February 6, 2012	Final set of site selection criteria released. A second public meeting held on LTSS in Sacramento. Applicant conference held.
Applications due	February 24, 2012	Site Applications are due, likely with sites having a two- to three-week window for completion.
Announcement of sites selected for Demonstrations under SB 208	Mid to Late March	DHCS will announce sites selected to participate in the Demonstration, as authorized under SB 208.
DHCS releases draft Demonstration Proposal for 30-day state comment period	Mid to Late March	The site selection criteria are not the same as California's Demonstration Proposal. The Proposal will outline operations of the Demonstration and will be subject to a 30-day comment period. Town Hall meetings held in Sacrament and each county selected.
DHCS closes state comment period and updates draft duals Demonstration Proposal	Mid to Late April	DHCS will have incorporated comments on the Proposal, as needed. Public presentation discussing changes made during the comment period.
Submission of draft Demonstration Proposal to CMS and beginning of 30-day Federal comment period	Late April or Early May	DHCS will submit the Duals Proposal to CMS, which will have a formal 30-day public comment period.

Application and Submission Information

Applicants' Conference

The proposed Applicants' teleconference will be held on February 6, 2012 from 2 pm to 4 pm. During this time, DHCS staff and contractors will review the final RFS and answer questions from potential Applicants in an open, public forum. Questions will be taken from the public at-large following Applicants' questions. DHCS will document significant questions and responses from the conference, which may include answers to other questions, received following the release of this document, and will make questions and responses available.

Technical Assistance and Data Availability

DHCS and Harbage Consulting, the state's contractor for the Duals Project, will continue to be available to provide technical support to all potential Applications. Requests can be submitted through the email address Duals@dhcs.ca.gov.

DHCS recognizes that some Applicants may be interested in receiving Medicare and Medicaid data to inform the development of their Application. DHCS will continue to discuss data needs with all Applicants, when appropriate to the particular care model or infrastructure activity.

Application Content

Applicants are encouraged to suggest improvements to the Demonstration model that enhance the quality, effectiveness and efficiencies of the Demonstration. The Applicant should identify, and inform DHCS of any functions or services not identified in the RFS that the Applicant believes is desired or required to provide all functions necessary to implement and operate the Demonstration.

Application submissions will be reviewed in their totality. DHCS will select sites in up to four counties based on their assessment of which Applications best meet the selection criteria described below. The final decision is at the sole discretion of DHCS.

DHCS may elect to enter into discussions with one or more potential sites should discussions or negotiations with one or more sites not progress within anticipated timeframes or for any other reason within the sole discretion of DHCS.
During the Application process, all potential sites are encouraged to offer their best method of how to provide the State's desired outcomes that meet federal requirements and make use of their best individual business practices and/or to take advantage of other technological or business solutions not identified by the State. DHCS reserves the right to

accept Applications as submitted. DHCS reserves the right to reject a part or all of an Application. DHCS also reserves the right to reject all Applications.

Applicants may be asked to enter into negotiations with DHCS to discuss and provide further information on any business practices and/or technological or business solutions proposed by the Applicant or the State, changes in proposed service levels, and/or improvements to the submitted Application, including the service levels described in this Application. DHCS will conduct an analytical review and evaluation of each Application with the selection criteria described in this RFS. DHCS is the sole judge of proposed methods for achieving desired contractual outcomes.

Sites may subcontract with other entities to provide services under this contract (e.g., contracted provider network, pharmacy benefits management, etc.) in support of the goal of integrated delivery. Such subcontract arrangements should be described in the application. It will not be acceptable for any incentive arrangements to include any payment or other inducement to withhold, limit or reduce medically necessary services to enrollees. Previous performance in Medicare and Medicaid of the subcontracted entities will be considered. Any and all subcontracts entered into by the Contractor for the purpose of meeting the requirements of this contract are the responsibility of the Contractor. DHCS will hold the Contractor responsible for assuring that subcontractors meet all the requirements of the negotiated contract for services pursuant to the RFS.

Application Submission

Each Application must include all contents required in this document and conform to the following specifications. Failure to follow these specifications will result in disqualification.

- Use 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides).
- Font size must be no smaller than 12-point.
- The Project Narrative must be double-spaced.
- All pages of the Project Narrative must be numbered in the lower right hand corner with the name of the submitting entity in the left lower corner.

Applications must not be more than 100 pages in length, which includes the executive summary and Project Narrative. Supporting attachments are limited to 100 pages, excluding the SNP model of care. The application should be prepared as a single PDF document. A total of seven printed and bound copies should be submitted, as well as an electronic version on a CD.

In addition, an electronic version of the Application must be submitted in large format in font size no smaller than 14-point and double-spaced prepared as a PDF file. Applications should be compliant with Section 508 of the Rehabilitation Act of 1973 (www.section508.gov). Page restrictions do not apply to this version of the Application.

NOTE: All responses and attachments will be public. DHCS will consider advance requests that demonstrate compelling reasons to keep proprietary information in the Application confidential.

All Applications are due by Friday, February 24, 2012. Applications received after 5pm Pacific Time on Feb. 24, 2012 will not be considered.

Applications shall be delivered to the DHCS Procurement Office at the following address. Email Applications will not be accepted.

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

Selection of Demonstration Sites

Applications will be evaluated by the state using a four-stage process.

1. **Mandatory Qualification Requirements.** Applicants must certify they meet the Qualification Requirements described below. Failure to do so will result in Applications being disqualified.

2. **Criteria for Additional Consideration.** Applications will be given additional consideration to the extent they meet the following quality, experience, and implementation criteria. Applications should include information necessary to determine the extent to which these criteria are met. Additional consideration will be given to entities based on:

    a. Record providing Medicare benefits to dual eligibles; with longer experience offering a D-SNP without significant sanction or significant corrective action plans considered beneficial. Evidence of Medicare sanctions and corrective action plans will count negatively.

    b. Most recent three years of HEDIS results, with higher results and a demonstrable trend toward increasing success considered beneficial.

    c. National Committee for Quality Assurance (NCQA), with level of accreditation for Medi-Cal managed care plans considered beneficial.

    d. NCQA SNP approval or demonstration of significant progress toward certification or accreditation.

    e. Length of Medi-Cal Contract, with longer periods of experience considered beneficial.

    f. Inclusion of additional benefits beyond the minimum Medicare and Medi-Cal benefits is strongly encouraged, for example: dental, vision and substance use services.

    g. Letters of agreement to work in good faith on this project from County officials will be considered beneficial. (Submit these letters as attachments. They will not count against the page limit.) These could include the County agency head with operational responsibility for:
        - Agencies that oversee the range of LTSS services, including transportation, Area Agencies on Aging, Independent Living Centers, Aging and Disability Resource Centers, caregiver resources, home modifications and affordable housing;
        - Behavioral Health (both Mental Health and Substance Use, if those are overseen by separate County entities); and,

- Health (the County agency with the most direct responsibility for the County public medical center(s), if any).

h. Existence of a draft Agreement or Contract with the County IHSS Agency will be beneficial toward demonstrating significant steps in the development of a formal agreement between the Demonstration site and County IHSS agency. (Submit these as attachments. They will not count against the page limit.)

i. Existence of a draft Agreement or Contract with the County Mental Health Department will be beneficial toward demonstrating significant steps in the development of a formal agreement between the Demonstration site and County Mental Health Department. (Submit these as attachments. They will not count against the page limit.)

j. Plans to contract with providers groups with a strong track record of providing innovative and high value care to dual eligibles.

3. **Project Narrative.** Applications will be reviewed based on the following criteria:

   a. Does the Application fully respond to all items in the Project Narrative? Are examples provided?

   b. How well does the Application meet the site selection criteria defined by SB 208:
      i. Local support for integrating medical care, long-term care, and home- and community-based services networks.
      ii. A local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the pilot project.

   c. How well does the Application provide concrete evidence that it will further the goals of the Demonstration?

   d. Does the Application reflect an organization with the structural capacity to complete and sustain the Demonstration?

   e. Does the Application demonstrate sufficient progress to date to meet a January 1, 2013 initial enrollment date?

4. **Interviews as Needed.** DHCS may choose to conduct oral interviews with the most promising Applicants. DHCS may, at its discretion, choose not to conduct oral interviews. The purpose of the interview is to assess and/or confirm the ability of the Applicant to meet the goals of the Demonstration, commitment to local partnerships and stakeholder engagement, and the capabilities and strengths of the Applicant's management team.

Mandatory Qualification Requirements

All Applicants must certify the following.

1. **Knox-Keene License**

   Applicants must have a current unrestricted Knox-Keene License showing authority to operate in the State in order to participate in this RFS. Applicants must provide a copy of a current Knox-Keene License and has no adverse actions with regard to enforcement, or quality management. COHS plans would not need to seek separate Medi-Cal Knox-Keene licensure for purposes of participating in the Demonstration. COHS plans are exempt from Knox-Keene licensure for Medi-Cal pursuant to Welfare and Institutions Code Section 14087.95.

2. **Financial Condition**

   Existing Knox-Keene Licensed Applicants must be in good financial standing with DMHC. Applicants must submit a letter from DMHC demonstrating that the Applicant is in good standing with DMHC. DHCS reserves the right to request additional information in the event DMHC does not provide a qualified letter of good standing.

3. **Current Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)**

   There must be experience operating a D-SNP in each Demonstration county. Criteria for D-SNP experience will vary by type of county. All Applicants must provide responses to all SNP Model of Care Elements and Standards, as modified to reflect the Dual Demonstration Application (See Appendix C).

   a. Two-Plan Model Counties
      At least one of the Applicants must have experience in the last three years operating a D-SNP in that county. The other Applicant must certify that it will work in good faith to meet all the D-SNP requirements in that county the next year.

   b. County-Organized Health System (COHS) Counties
      The Applicant must have experience in the last three years operating a D-SNP.

   c. Geographic Managed Care Counties
      At least one of the Applicants must have experience in the last three years operating a D-SNP in that county. All other County Applicants that do not have a D-SNP must certify that it will work in good faith to meet all the D-SNP requirements in that County in the next year.

4. **Current Medi-Cal Managed Care Plan**

Applicants must have a current contract with DHCS to operate a Medi-Cal Managed Care contract in the same county in California as the proposed dual eligible site.

a. Two-Plan Model Counties

   For Applicants in Two-Plan Model Counties, Applications will only be considered if both plans submit an individual Application.

   Note: DHCS encourages cooperation and collaboration between local plans. Applications that demonstrate such collaboration will receive additional consideration.

b. County-Organized Health System (COHS) Counties

   For Demonstration site Applications in COHS Counties, only the current COHS may apply.

c. Geographic Managed Care Counties

   For Demonstration site Applications in Geographic Managed Care Counties, at least two entities with a current Medi-Cal managed care contract must apply for the Applications to be considered.

   Note: DHCS encourages cooperation and collaboration between local plans. Applications that demonstrate such collaboration will receive additional consideration.

5. Subcontracting

Applicants must work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.

6. Countywide Coverage

Successful Applications will demonstrate ability to cover a county's entire population of dual eligibles; either on their own or through partnerships of agreed upon geographic divisions with other Applicants. To be considered, Applicants must certify they will coordinate with relevant entities to ensure coverage of the entire county's population of duals. (Certain exceptions will be allowed in rural areas of large counties, as currently allowed by Medi-Cal managed care contracts.)

7. **Business Integrity**

Applicants must demonstrate business integrity by:

a. Listing all sanctions, penalties and corrective action plans issued by Medicare or a state of California government entity taken in the last five years, including information about the reason for the corrective action plan

and the resolution. An action taken does not necessarily result in disqualification. (Include this list in an attachment. It will not count against the page limit.)

b. Certifying that they are not under sanction by Centers for Medicare and Medicaid Services within California.
c. Certifying that it will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.

8. High Quality

Applicants must demonstrate a capability of providing for the health and safety of dual eligible beneficiaries. Applicants must list the most recent three years of all the following (Include this list as an attachment. This will not count against the pate limit):

a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.
b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.

9. NCQA Accreditation

Applicants shall certify that they will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of their participation in the Demonstration.

10. Encounter Data

Applicants must certify that they will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.

11. Americans with Disabilities Act and Alternate Format

Applicants must certify that they shall fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, and shall develop a plan to encourage its contracted providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review. More specific requirements will be included in future state guidance.

12. Stakeholder Involvement

Applicants must demonstrate a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the project. As such, Applicants must certify that 3 of the following 5 are true:

- The Applicant has at least one dual eligible individual on the board of directors of its parent entity or company.
- The Applicant has created an advisory board of dually eligible consumers reporting to the board of directors (or will do so as part of the Readiness Review).
- The Applicant has provided five letters of support from the community, with sources including individual dual eligible consumers, advocates for seniors and persons with disabilities, organizations representing LTSS, such as community-based organizations, and/or individual health care providers.
- The Applicant sought and accepted community-level stakeholder input into the development of the Application, with specific examples provided of how the plan was developed or changed in response to community comment.
- The Applicant has conduct a program of stakeholder involvement (with the Applicant providing a narrative of all activities designed to obtain community input.)

13. Attestation

DHCS may refuse to enter into a contract with a Applicant if any person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant, has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare. Applicant shall certify that it has no such relationships with such a person.

14. Corporations

Corporations must certify they are in good standing and qualified to conduct business in California.

15. Limited Liability Companies and Limited Partnerships

Limited Liability Companies and Limited Partnerships must certify that they are in "active" standing and qualified to conduct business in California.

16. Nonprofit Organizations

Non-profit organizations must certify their eligibility to claim nonprofit status.

17. Past Business Practice

Applicants must certify they have a past record of sound business integrity and a history of being responsive to past contractual obligations.

18. Work plan and Deliverables Certification

The Applicant must certify that they are willing to comply with future Demonstration requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. In addition, the Applicant certifies that it will provide

operational plans for achieving those requirements as part of the Readiness Review.

Project Narrative

In the Project Narrative section, Applicants will describe how they would implement the Duals Demonstration, and ultimately, meet the objectives of this project under the model specified in this RFS. The required sections are listed below. The bullet points below each sub-section are intended to provide a description of the type of information that is required. The Application must be organized by these headings.

Complete each section inquiry clearly and completely. Responses should be concise and to the point. Examples should be provided. When responding, repeat each section heading and then respond directly; the Application must include all of the headings listed below. Do not refer to other source documentation in lieu of responding to inquiries.

If you are unable to answer an inquiry, indicate why you cannot. Additionally, if you are unwilling to disclose the particular information requested, indicate your reasons. If there is additional relevant information or documentation that you feel would aid DHCS in the selection process, provide that information separately when appropriate as an attachment.

DHCS reserves the right to request additional information and/or clarification from Applicants and to utilize responses as an indication of the Applicant's internal processes and procedures.

Section: Executive Summary

The Applicant must provide a two-page executive summary of the Demonstration project. This should serve as a succinct description of the proposed project, including the goals of the project, the proposed geographic coverage area, number of projected dual eligibles to be enrolled, and list of strategic partnerships that will be developed to carry out the project. Write the executive summary so that it is clear, accurate, concise, and without reference to other parts of the Application.

Section 1: Program Design

Section 1.1: Program Vision and Goals

The Application must:

Question 1.1.1 Describe the experience serving dually eligible beneficiaries, both under Medi-Cal and through Medicare Advantage Special Needs Plan contracts, if any.

Question 1.1.2 Explain why this program is a strategic match for the Applicant's overall mission.

Question 1.1.3 Explain how the program meets the goals of the Duals Demonstration.

Section 1.2: Comprehensive Program Description

The Application must:

Question 1.2.1 Describe the overall design of the proposed program, including the number of enrollees, proposed partners, geographic coverage area and how you will provide the integrated benefit package described above along with any supplemental benefits you intend to offer. (You may mention items briefly here and reference later sections where you provide more detailed descriptions.)

Question 1.2.2 Describe how you will manage the program within an integrated financing model, (i.e. services are not treated as “Medicare” or “Medicaid” paid services.)

Question 1.2.3 Describe how the program is evidence-based.

Question 1.2.4 Explain how the program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify risk factors.

Question 1.2.5 Explain whether/how the program could include a component that qualifies under the federal Health Home Plans SPA.

Question 1.2.6 Identify the primary challenges to successful implementation of the program and explain how these anticipated risks will be mitigated.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

The Applicant must:

Question 2.1.1 Describe how would you propose to provide seamless coordination between medical care and LTSS to keep people living in their homes and communities for as long as possible.

Question 2.1.2 Describe potential contracting relationships with current LTSS providers and how you would develop a reimbursement arrangement.

Question 2.1.3 Describe how you would use Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.

Question 2.1.4 Describe any experience working with the broad network of LTSS providers, ranging from home- and community-based service providers to institutional settings.

Question 2.1.5 Describe your plans for delivering integrated care to individuals living in institutional settings. Institutional settings are appropriate setting for some individuals, but for those able and wanting to leave, how might you transition them into the community? What processes, assurances do you have in place to ensure proper care?

Section 2.2: IHSS

The Applicant must:

Question 2.2.1 Certify the intent to develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1. The contract shall stipulate that:

- IHSS consumers retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select who else participates in their care planning.
- County IHSS social workers will use the Uniform Assessment tool and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams.
- Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.
- County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.
- IHSS providers will continue to be paid through State Controller's CMIPS program.
- A process for working with the County IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.

Question 2.2.2 With consideration of the LTSS Framework in Appendix E that emphasizes consumer choice, and in consideration of the approach taken in Year 1 as described above, please describe the interaction with the IHSS program through the evolution of the Demonstration in Years 2 and 3. Specifically address:

- A proposed care coordination model with IHSS, including the referral, assessment, and care coordination process.
- A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease.
- A plan for coordinating emergency systems for personal attendant coverage.

Section 2.3: Social Support Coordination

Applicants must:

Question 2.3.1 Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

Question 2.3.2 Describe how you will assess and assist beneficiaries in connecting to community social programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community.

Question 2.3.3 Describe how you would partner with the local Area Agency on Aging (AAA), Aging and Disability Resource Connection (ADRC), and/or Independent Living Center (ILC).

Question 2.3.4 Describe how you would partner with housing providers, such as senior housing, residential care facilities, assisted living facilities, and continuing care retirement communities, to arrange for housing or to provide services in the housing facilities for beneficiaries.

Section 3: Coordination and Integration of Mental Health and Substance Use Services

The Applicant must:

Question 3.1 Describe how you will provide seamless and coordinated access to the full array of mental health and substance use benefits covered by Medicare and Medi-Cal, including how you will:

- Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for substance use.
- Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for mental illness.

Question 3.2 Explain how your program would work with a dedicated Mental Health Director, and /or psychiatrist quality assurance (preferably with training in geriatric psychiatry).

Question 3.3 Explain how your program supports co-location of services and/or multidisciplinary, team-based care coordination.

Question 3.4 Describe how you will include consumers and advocates on local advisory committees to oversee the care coordination partnership and progress toward integration.

Section 3.1: County Partnerships

Applicants must:

Question 3.1.1 Describe in detail how your model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders. In preparing the response, keep in mind that your system of care may evolve over time, relying more heavily on the County in Year 1 of the Demonstration. (See Appendix G for technical assistance on coordinating and integrating mental health and substance use services for the seriously affected.)

Question 3.1.2 Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.

- Describe how you will work with County partners to establish standardized criteria for identifying beneficiaries to target for care coordination.
- Describe how you will overcome barriers to exchange information across systems for purposes of care coordination and monitoring.

Section 4: Person-Centered Care Coordination

The Applicant must:

Question 4.1 Describe how care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among dual eligibles, including those who can self-direct care and also those with dementia and Alzheimer's disease.

Question 4.2 Attach the model of care coordination for dual eligibles as outlined in Appendix C. This will not count against any page limit.

Question 4.3 Describe the extent to which providers in your network currently participate in care coordination and what steps you will take to train/incentivize/monitor providers who are not experienced in participating in care teams and care coordination.

Section 5: Consumer Protections

Applicant must:

Question 5.1 Certify that your organization will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.

Section 5.1: Consumer Choice

Applicant must:

Question 5.1.1 Describe how beneficiaries will be able to choose their primary provider, specialists and participants on their care team, as needed.

Question 5.1.2 Describe how beneficiaries will be able to self-direct their care and will be provided the necessary support to do so in an effective manner, including whether to participate in care coordination services.

Section 5.2: Access

Applicant must:

Question 5.2.1 Certify that during the readiness review process you will demonstrate compliance with rigorous standards for accessibility established by DHCS.

Question 5.2.2 Discuss how your program will be accessible, while considering: physical accessibility, community accessibility, document/information accessibility, and doctor/provider accessibility.

Question 5.2.3 Describe how you communicate information about the accessibility levels of providers in your network to beneficiaries.

Section 5.3: Education and Outreach

Applicants must:

Question 5.3.1 Describe how you will ensure effective communication in a range of formats with beneficiaries.

Question 5.3.2 Explain how your organization currently meets the linguistic and cultural needs to communicate with consumers/beneficiaries in their own language, and any pending improvements in that capability.

Question 5.3.3 Certify that you will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review:

- A detailed operational plan for beneficiary outreach and communication.
- An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.
- An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.

Section 5.4: Stakeholder Input

The Application must:

Question 5.4.1 Discuss the local stakeholder engagement plan and timeline during 2012 project development/implementation phase, including any stakeholder meetings that have been held during development of the Application.

Question 5.4.2 Discuss the stakeholder engagement plan throughout the three-year Demonstration.

Question 5.4.3 Identify and describe the method for meaningfully involving external stakeholders in the development and ongoing operations of the program. Meaningfully means that integrating entities, at a minimum, should develop a process for gathering and incorporating ongoing feedback from

external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

Section 5.5: Enrollment Process

The Applicant must:

Question 5.5.1 Explain how you envision enrollment starting in 2013 and being phased in over the course of the year.

Question 5.5.2 Describe how your organization will apply lessons learned from the enrollment of SPDs into Medi-Cal managed care.

Question 5.5.3 Describe what your organization needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot programs begin enrollment.

Section 5.6: Appeals and Grievances

Applicants must:

Question 5.6.1 Certify that your organization will be in compliance with the appeals and grievances processes for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

Section 6: Organizational Capacity

The Applicant must:

Question 6.1 Describe the guiding principles of the organization and record of performance in delivery services to dual eligibles that demonstrate an understanding of the needs of the community or population.

Question 6.2 Provide a current organizational chart with names of key leaders.

Question 6.3 Describe how the proposed key staff members have relevant skills and leadership ability to successfully carry out the project.

Question 6.4 Provide a resume of the Duals Demonstration Project Manager.

Question 6.5 Describe the governance, organizational and structural functions that will be in place to implement, monitor, and operate the Demonstration.

Section 6.1: Operational Plan

The Applicant must:

Question 6.1.1 Provide a preliminary operational plan that includes a draft work plan showing how it plans to implement in 2013 and ramp up in the first year.

Question 6.1.2 Provide roles and responsibilities of key partners.

Question 6.1.3 Provide a timeline of major milestones and dates for successfully executing the operational plan.

Question 6.1.4 Certify that the Applicant will report monthly on the progress made toward implementation of the timeline. These reports will be posted publicly.

Section 7: Network Adequacy

The Applicants must:

Question 7.1 Describe how your organization will ensure that your provider network is adequate for your specific enrollees.

Question 7.2 Describe the methodologies you plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers.

Question 7.3 Describe how your organization would encourage providers who currently do not accept Medi-Cal to participate in the Demonstration project.

Question 7.4 Describe how you will work with providers to ensure accessibility for beneficiaries with various disabilities.

Question 7.5 Describe your plan to engage with providers and encourage them to join your care network, to the extent those providers are working with the Demonstration population and are not in the network.

Question 7.6 Describe proposed subcontract arrangements (e.g., contracted provider network, pharmacy benefits management, etc.) in support of the goal of integrated delivery.

Question 7.7 Certify that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by sub-contractual relationships of the Applicant.

Question 7.8 Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Question 7.9 Certify that the Plan will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.

Section 7.1: Technology

The Applicant must:

Question 7.1.1 Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the federal "meaningful use" health information technology (HIT) standards.

Question 7.1.2 Describe how your organization intends to utilize care technology in the duals Demonstration for beneficiaries at very high-risk of nursing home admission (such as telehealth, remote health vitals and activity monitoring, care management technologies, medication compliance monitoring, etc.)

Question 7.1.3 Describe how technologies will be utilized to meet information exchange and device protocol interoperability standards (if applicable).

Section 8: Monitoring and Evaluation

The evaluation will examine the quality and cost impacts on specific vital Medicare and Medicaid services, including the integration on IHSS and other home- and community-based LTSS. Therefore, the Applicant must:

Question 8.1 Describe your organization's capacity for tracking and reporting on:

- Enrollee satisfaction, self-reported health status, and access to care,
- Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied)
- Condition-specific quality measures, and
- Risk-adjusted mortality rates.

Question 8.2 Describe your organization's capacity for reporting beneficiary outcomes by demographic characteristics (specifically age, English proficiency, disability, ethnicity, race, gender, and sexual identity)

Question 8.3 Certify that you will work to meet all DHCS evaluation and monitoring requirements, once made available.

Section 9: Budget

The Applicant must, pending further rate development:

Question 9.1 Describe any infrastructure support that could help facilitate integration of LTSS and behavioral health services (i.e. information exchange, capital investments and training to increase accessibility of network providers, technical assistance, etc).

Appendix List

Appendix A – Background on Federal and State Programs
Appendix B – Links to CMS Documents on the Duals Demonstration (CMS July 2011 State Medicaid Director's Letter: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees and Demonstration Proposal Instructions)
Appendix C – SNP Model of Care Elements and Standards (Modified for the Duals Demonstration)
Appendix D – Framework for Understanding Consumer Protections
Appendix E – Framework for Understanding Long-Term Supports and Services
Appendix F – Framework for Understanding Behavioral Health
Appendix G – Technical Assistance on Coordinating and Integrating Behavioral Mental health and substance use services

Appendix A – Background on Relevant Federal and State Programs

Under this initiative, participating sites will be required to provide, either directly or through subcontracts, seamless and integrated access to all medically necessary Medicare and Medi-Cal-covered services. DHCS and the participating sites will ensure that beneficiaries have access to an adequate network of medical and supportive services. Below are brief descriptions of the programs/benefits that will be impacted by the Demonstration.

Federal Background

Medicare is the federal health insurance program for people age 65 and older and people younger than 65 who have been disabled for 24 months and meet other eligibility criteria. Broadly, Medicare's benefits include services from inpatient and outpatient hospitals, hospice, and limited skilled nursing facility and home health coverage (Part A); medically necessary outpatient services, including physicians' fees (Part B); and prescription drugs (Part D).

Medicare Advantage and Special Needs Plans: Medicare Part C consists of managed care plans, known as Medicare Advantage (MA) plans. These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the original Medicare program. Starting in 2003 CMS established specialized Medicare Advantage Coordinated care Plans for Special Needs Populations, or "SNPs." There are three types of SNPs: chronic, dual, and institutional. Dual Eligible SNPs, or "D-SNPs" enroll beneficiaries entitled to both Medicare and Medicaid, and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs must offer Part D prescription drug coverage. D-SNPs are able to coordinate services at the plan level; however, they are not able to integrate funding or home and community-based services.

All D-SNPS must meet CMS standards as executed by the National Committee for Quality Assurance and, starting in 2013, must have a State Medi-Cal contract to operate. In California, 36 D-SNPs are currently in operation, with enrollment of about 156,000 individuals in at least 16 counties.

State Background

Medi-Cal, California's Medicaid program, provides health care to 7.5 million low-income individuals and families in the state. Medi-Cal is available through fee-for-service and managed care models. Medi-Cal managed care is available in 30 counties, and currently serves about 60 percent of the total Medi-Cal population.

Managed Care: California has three delivery models of managed care: County Organized Health Systems (COHS) currently serve about 885,000 beneficiaries through six health plans in 14 counties. In the COHS model counties, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the County, and

everyone is in the same managed care plan. Two-Plan Models serve about three million beneficiaries in 14 counties. In most Two-Plan model counties there is a “Local Initiative” (LI) and a “commercial plan” (CP). DHCS contracts with both plans. Local stakeholders are able to give input when the LI is created, and it is designed to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. Geographic Managed Care (GMC) models serve about 450,000 beneficiaries in two counties: Sacramento and San Diego. In GMC counties, DHCS contracts with several commercial plans.

In November 2010, California obtained federal approval authorizing expansion of mandatory enrollment into Medi-Cal managed care plans in 16 counties of over 600,000 low-income seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only (not Medicare). Enrollment has been phased in over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month are being enrolled. Prior to this, enrollment was mandatory for children and families in 16 counties and for SPDs in 14 counties.

Dual eligibles have remained exempt from mandatory enrollment in Medi-Cal managed care, though currently some voluntarily enroll in managed care. For dual eligible beneficiaries, Medicare generally is the primary payer for benefits covered by both programs. Medi-Cal is then available for any remaining beneficiary cost sharing. Medicaid may also provide additional benefits that are not (or are no longer) covered by Medicare. For example, Medicare covers Skilled Nursing Facility (SNF) services when a dual eligible beneficiary requires skilled nursing care following a qualifying hospital stay. During this time, Medicaid benefits may be available for amounts that are not paid by Medicare. Once the beneficiary no longer meets the conditions of a Medicare skilled level of care benefit, Medicaid may cover additional nursing facility services, including custodial nursing facility care. In California, most state General Fund dollars spent on dual eligibles are for long-term services and supports. In 2007, dual eligibles accounted for 75% of the $4.2 billion spent by Medi-Cal on long-term care.

Long-Term Services and Supports (LTSS) include home- and community-based services (HCBS) and long-term custodial care in nursing facilities. California home and community base services include In-Home Supportive Services (IHSS), Community-Based Adult Services Center (CBAS Center, formerly called Adult Day Health Care Services), and a number of specific HCBS waiver programs. The latter include: Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled Services waivers, Assisted Living waiver, In Home Operation waivers, and AIDS waivers. Currently, all LTSS are provided on a fee-for-services basis and carved-out of the two-plan or geographic managed care counties. The COHS benefits include custodial care in nursing facilities.

In-Home Supportive Services: California’s In-Home Supportive Services (IHSS) program serves approximately 450,000 Californians. Approximately 82% of IHSS recipients are SSI/SSP beneficiaries. A cornerstone of the state’s long term care services, the IHSS program allows beneficiaries (consumers) to select providers to deliver a range of assistances with activities of daily living, including housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments,

and protective supervision for the mentally impaired. IHSS consumers control the selection, management and supervision of their providers, who are usually family members (72%). Legislative statute requires each County to establish a public authority or similar entity to be the employer of record for the care provider; currently 56 counties have a Public Authority. The local social service agency in each county evaluates consumers to determine the number of authorized IHSS hours required and, annually, performs a recertification of those hours. Providers' time sheets, signed by consumers, are submitted to the state and entered into a payroll system that generates a payment to the provider. On average IHSS recipients receive 82 hours of services each month. Up to 283 hours of service may be authorized per month. IHSS is a Medicaid program, funded by Federal, State, and County sources.

Community-Based Adult Services: The new Community-Based Adult Services (CBAS) will become operational on March 1, 2012. Based on the Adult Day Health Care (ADHC) model, CBAS has a higher eligibility standard for beneficiary participation and is designed to be available primarily through managed care plans in July, 2012. The CBAS program and standards of participation for both providers and beneficiaries were developed during the settlement process in the Darling v. Douglas lawsuit. Plaintiffs representing ADHC clients worked closely with DHCS to create a program that will meet with needs of the most vulnerable ADHC clients. Almost 82% of the ADHC clients are dual eligible and a large percentage of the CBAS clients will also be dually eligible. Under the settlement agreement, CBAS will be available as a benefit only through managed care beginning no sooner than July 1, 2012. DHCS will continue to set the daily rate for CBAS services and Plans will contract at CBAS centers at those rates. If beneficiaries want to use a CBAS service, they must join managed care plans to access the centers. In counties where managed care is not available or for those CBAS clients who do not qualify for managed care, CBAS will be available through FFS. In areas where CBAS centers are not available, managed care plans will be expected to provide beneficiaries the constellation of services encompassed by the CBAS centers that will help the beneficiary maintain independence and avoid institutionalization.

Multipurpose Senior Service Program: Local Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care. Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement.

Skilled Nursing Facilities (SNFs): SNFs provide nursing care and/or skilled rehabilitation services, and other related health services to facility residents. SNFs may be part of a nursing home or hospital. In general, Medicare funds short-term SNF placement after a hospitalization, and Medi-Cal funds long-term SNF placement, known as custodial care. Medicare does not cover custodial care if it is the only type of service needed from a SNF.

Long-term SNF placement is usually excluded from Medi-Cal managed care, and is paid via fee-for-service.

Behavioral Health services include mental health and substance use services. Medi-Cal beneficiaries with severe mental illness or substance use receive services organized and managed by County specialty systems. Counties use realignment funds (composed of ½ cent sales tax and vehicle license fees); Mental Health Services Act (1% income tax on millionaires); and a fixed annual allocation of state general funds (until 2013), based on historical Medi-Cal billings, to incur California's mental health "certified public expenditure" (CPE) and draw down matching federal dollars. Funding for specialty mental health services is capped for adults, but not for children age 21 and younger.

California's Specialty Mental Health System: Through a Section 1915 (B) freedom of choice waiver, all individuals who meet specified medical necessity criteria[4] are mandatorily enrolled in the state's 57 County Mental Health Plans. This waiver program is referred to as the Specialty Mental Health System and serves an estimated 445,000 individuals. About 27 percent of the 240,000 adults served are dual eligibles. These County Mental Health Plans are responsible for managing all specialty mental health services (inpatient psychiatric and outpatient services). County Mental Health Plans select and credential their provider network, negotiate rates, authorize services, and pay for qualifying services. The portion of services provided directly by the County's own providers versus contracted private providers varies between counties. The services provided under the Specialty Mental Health Services waiver for eligible adult beneficiaries include: 1) Psychiatric inpatient hospital services, 2) targeted case management services, and 3) rehabilitation services, including medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services.

Non-Specialty Mental Health Services: DHCS is responsible for all mental health care needs for Medi-Cal beneficiaries not meeting the criteria for specialty services and for all pharmaceutical costs. In such cases, Medi-Cal fee for service or Medi-Cal managed care plans cover the services. In fee-for-service, these services are subject to a limit of two visits per month and available for diagnoses that the SMHS waiver does not cover; mental health impairments not considered significant; and/or impairments that general physical health care practitioners can treat and do not require the services of a licensed mental health care practitioner. Medi-Cal managed care plans must have appropriate mechanisms to coordinate with County Mental Health Plans. DHCS requires them to negotiate in good faith and execute a memorandum of understanding (MOU) with their local County mental health plan.

[4] Medi-Cal beneficiaries receive specialty mental health services if they meet all of the following medical necessity criteria:

1) Diagnosis – one or more of 18 specified Diagnostic and Statistical Manual of Mental Disorders
2) Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won't progress appropriately
3) Intervention: services must address the impairment, be expected to significantly improve the condition, and a physical health care based treatment would not work.

Substance use services “Drug Medi-Cal” is California’s substance use benefit for Medi-Cal beneficiaries. Drug Medi-Cal Benefits include methadone maintenance, day care rehabilitation, outpatient individual and group counseling, and perinatal residential services. Substance use benefits are not a required benefit for managed care Medi-Cal. There is no “rehabilitation option” for Drug Medi-Cal so it does not cover case management or services outside a clinical setting. Currently, much of Drug Medi-Cal spending on dual eligibles goes toward the methadone maintenance program. Until 2011, the State Department of Drug and Alcohol Programs (DAP) reimbursed providers directly for Drug Medi-Cal services. Starting in FY 2011-2012, however, counties assumed this responsibility under realignment. California spent about $131 million on Drug Med-Cal services in 2010-2011.

Program of All-Inclusive Care for the Elderly (PACE) is a privately operated comprehensive model of care that integrates Medicare and Medi-Cal financing to provide all needed preventive, primary, acute and long-term supports and services for older adults who are determined eligible for nursing home level of care. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model allows eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment. California has five PACE programs, serving a largely dual-eligible population.

Appendix B – Relevant CMS Documents

July 2011 CMS State Medicaid Director Letter

On July 8, 2011, CMS issued a State Medicaid Director letter described in-depth the Financial Models to Support State Efforts to Integrate Care for Medicare- Medicaid Enrollees. The letter is available at this link:
http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

CMS Demonstration Proposal Instructions

To participate in the financial alignment model, CMS will require that States demonstrate their ability to meet or exceed certain standards and conditions. In order for CMS to determine whether these criteria have been met, each State must submit a Proposal that describes the proposed approach for the selected model(s). CMS has developed instructions for developing the Demonstration Proposal available at this link:
http://www.cms.gov/medicare-medicaid-coordination/downloads/financialalignmentdemonstrationproposalinstructions.pdf

CMS Plan Guidance

January 25, 2012 CMS released a document offering guidance to organizations interested in offering capitated financial alignment Demonstration Plans. The document is available at this link:
http://dhcsinternetauthoring/provgovpart/Documents/Duals/Final_CMS_Plan_Guidance.pdf

Appendix C – SNP Model of Care Elements and Standards (Modified for the Duals Demonstration)

Note: Applicants should provide a current SNP model of care, revised to reflect the Duals Demonstration. The NCQA questions for the SNP model of care are included below.

1. **Description of the Dual-specific Target Population.**

2. **Measurable Goals**

   These goals must be stated in measurable terms that indicate how the plan will know whether the goals have been achieved. The care management goals should include at a minimum:

   - Improving access to essential services such as medical, mental health, LTSS and social services;
   - Improving access to affordable care;
   - Improving coordination of care through an identified point of contact;
   - Improving seamless transitions of care across health care settings, providers and HCBS;
   - Improving access to preventive health services;
   - Improving access to HCBS;
   - Assuring appropriate utilization of services; and
   - Improving beneficiary health outcomes (specify Medicare Advantage Organization (MAO) selected health outcome measures).

   2b. Describe the goals as measurable outcomes and indicate how you will know when goals are met.

   2c. Discuss actions that will be taken if goals are not met in the expected time frame.

3. **Staff Structure and Care Management Roles**

   3a. Identify the specific employed or contracted staff to perform administrative functions (at a minimum identify staff who process enrollments, verify eligibility, process claims).

   3b. Identify the specific employed or contracted staff to perform administrative and clinical oversight functions (at a minimum verifies licensing and competency,

reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines).

4. Interdisciplinary Care Team (ICT)

The description must include at a minimum:

• How the Plan will determine the composition of the ICT;

• How the beneficiary will participate in the ICT, as feasible;

• How the ICT will operate and communicate; and

• How the activities of the ICT will be documented and maintained.

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols.

The description must include at a minimum:

- Facilities pertinent to the care of the targeted special needs population (e.g., inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging, etc.);
- Medical specialists (e.g., cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists, etc.);
- Behavioral and mental health specialists (e.g., drug counselors, clinical psychologists, etc.);
- Nursing professionals (registered nurses, nurse practitioners, nurse managers, nurse educators, etc.);
- Allied health professionals (pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc.);
- Home- and community-based services providers (e.g. CBAS, MSSP)
- Long-term care providers (e.g. skilled nursing facilities, residential care facilities)
- How the plan determines that their facilities and providers are actively licensed and competent;
- Who determines the services beneficiaries will receive (e.g., who serves as the entry point, how is the beneficiary connected to the appropriate service provider, etc.);

- How the provider network coordinates with the ICT and the beneficiary to deliver specialized services;

- How the plan assures that specialized services are delivered to the beneficiary in a timely and quality way;

- How reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan;

- How services are delivered across care settings and providers; and

- How the plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.

1. Model of Care (MOC) Training for Personnel and Provider Network

The description must include at a minimum:

- Plan for initial and annual MOC training, including training strategies and content (at a minimum includes at least one of the following: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing).

- Method for assuring and documenting completion of training by the employed and contracted personnel (at a minimum include attendee lists, and at least one of the following: results of testing, web-based attendance confirmation, electronic training record).

- Identified personnel responsible for oversight of the MOC training.

- Actions to take when the required MOC training has not been completed (at a minimum includes: contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion)

7. Health Risk Assessment (HRA)

The description must include at a minimum:

- The HRA tool used to identify the specialized needs of its beneficiaries (at a minimum includes: medical, psychosocial, functional and cognitive needs, LTSS needs, medical and mental health history).

- When and how the initial HRA and annual reassessment are conducted for each beneficiary.

- The personnel who review, analyze, and stratify health care needs.

- The communication mechanism to notify the ICT, provider network, beneficiaries, etc. about the HRA and stratification results.

8. Individualized Care Plan

The description must include at a minimum:

- Which personnel develop the individualized plan of care (POC) and how the beneficiary is involved in its development, as feasible.

- The essential elements incorporated in the POC (at a minimum includes: results of health risk assessments, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits, services beneficiaries with disabilities, services for those near the end-of-life)

- The personnel who review the care plan and how frequently the POC is reviewed and revised (at a minimum: POC is developed by the ICT, beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified)

- How the POC is documented and where the documentation is maintained (at a minimum includes: accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality)

- How the POC and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers.

9. Communication Network

The description must include at a minimum:

- The structure for a communication network (at a minimum includes at least one of the following: web-based network, audio conferencing, face-to-face meetings)

- How the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies.

- How to preserve aspects of communication as evidence of care (at a minimum includes at least one of the following: recordings, written minutes, newsletters, interactive websites).

- The personnel having oversight responsibility for monitoring and evaluating communication effectiveness.

10. **Care Management for the Most Vulnerable Subpopulations**

The description must include at a minimum:

- How the MAO identifies its most vulnerable beneficiaries.
- The add-on services and benefits the MAO delivers to its most vulnerable beneficiaries.

11. Performance and Health Outcome Measurement

The description must include at a minimum:

- How the MAO will collect, analyze, report, and evaluate the MOC (at a minimum include: specific data sources, specific performance and outcome measures).
- Who will collect, analyze, report, and act on to evaluate the MOC (at a minimum includes: internal quality specialists, contracted consultants).
- How the MAO will use the analyzed results of the performance measures to improve the MOC (at a minimum includes: internal committee, other structured mechanism).
- How the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the MOC (at a minimum includes: electronic or print copies of its evaluation process).
- The personnel having oversight responsibility for monitoring and evaluating the MOC effectiveness (at a minimum includes: quality assurance specialists, consultants with quality experience)
- How the MAO will communicate improvements in the MOC to stakeholders (at a minimum includes: webpage for announcements, printed newsletters, bulletins, announcements)

Appendix D – Framework for Understanding Consumer Protections

The process to develop California's duals Demonstration criteria should be more than a listening process. It must be an open dialogue that fosters an exchange of information between the state and others. This interactive process should inform the ultimate design. These concepts have been drafted to set the stage for a conversation around consumer protections.

1) Beneficiary control and choice. The Demonstration should consider the need for beneficiaries to self-direct their care and be able to hire, fire and manage their personal care worker. Choice begins with the decision to opt out of the Demonstration.

2) Beneficiary-centered models. The coordinated care delivery Demonstration at every level should focus on the beneficiary. Provider networks, care coordination and assessment tools should be built around the beneficiary. The beneficiary experience should be at the heart of the metrics for monitoring and evaluation.

3) Comprehensive benefit design. Coordinated care models have the potential to provide access to all necessary supports and services beneficiaries need and want. Financial incentives can then be aligned around keeping people in their homes and communities. Coordinated care models have the potential to increase the availability of and access to valued home and community based services.

4) Responsive appeals process. The Demonstration should include an appeals process that is comprehensive of both Medicare and Medi-Cal benefits.

5) Transition rights to avoid care disruptions. Care continuity is a critical issue when proposing new delivery models. The Demonstration should develop policies and procedures to ensure smooth care transitions.

6) Meaningful notice. Patients should be informed about enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information should be delivered in a format and language accessible to enrollees. Lessons from the SPD process under the 1115 waiver must be learned and addressed here.

7) Oversight and monitoring. These critical elements should be coordinated and complementary between DHCS and CMS. Agency authority should be clear and systems should be developed to respond quickly to problems. Clear authority and operational capacity should exist to address problems identified through oversight.

8) Appropriate and accessible. Coordinated care delivery models in the duals Demonstration should be culturally and linguistically appropriate, as well as physically accessible to all enrollees.

9) Phased approach. The Demonstration should be phased in before expanding to all dual eligibles.

Appendix E – Framework for Understanding Long-Term Care Coordination

The process of developing California's duals Demonstration criteria should be more than a listening process. It must be an open dialogue that fosters an exchange of information between the state and others. This interactive process should inform the ultimate design. These concepts have been drafted to set the stage for a conversation around coordination of long-term care and supportive services.

1) Consumer Choice. Building on the current system, the Demonstration should consider the need for consumers to self-direct their care and e able to determine where they receive care. Home- and community-based services (HCBS) provide a health care benefit to the consumer by allowing them to stay in their home.

- At each step in the care delivery system, there should be clear thought about how that step affects the ability of the consumer to stay in their home and community. By improving preventative care and maintaining HCBS, the consumer is able to stay at home and use less acute care services.
- All entities in the system should have the incentives and resources needed to promote hospital discharge into their homes and communities, when possible, so beneficiaries can better maintain a high quality of life.
- Consumers should be allowed to choose their health care provider. Family matters.

2) Care Coordination. Care coordination and consistently implemented policies will reduce administrative costs and increase quality of care.

3) Access to services. For consumers at risk of institutionalization, the Demonstration should offer a structure for them to access HCBS meeting their needs and maintaining a high quality of life in the community.

4) Consumers as part of their coordinated care team. The Demonstration should consider how the consumer is included in an organized delivery system that meets his or her unique social and medical needs.

- Improved understanding of the different needs of each population is needed.
- HCBS reforms should aim to improve care coordination, health care services delivery and access, consumers' quality of life, and rebalancing of institutional care in favor of HCBS.

5) Oversight and monitoring. The Demonstration has the potential to realign the current health care system's poorly aligned incentives around beneficiaries' needs.

- The new system can stop the County-State-Federal cost shifting.
- The state must aggressively monitor the Demonstration site for quality and access.

6) Workforce training. This Demonstration has the potential to improve care and curb unnecessary costs by offering home workers basic training in areas such as dietary needs, wound care, and care management.

- The Demonstration should consider an investment to have the right workforce at the right place at the right time.
- There is an opportunity to create different levels of care within HCBS with tiered levels of training and certification designed to ensure beneficiaries receive the appropriate level of care. Program design should consider that some workers will not want any training.
- Consumer privacy should be considered in developing these different workforce levels, including consumer control on who speaks to medical providers on consumers' behalf (if at all) and consumer control on who provides even the most basic care.

Appendix F – Framework for Understanding Mental Health and Substance Use

California's dual eligible population includes many individuals who need mental health services. This includes people with short-term needs and those with chronic needs who qualify for Medicare and Medi-Cal due to a psychiatric disability. Substance abuse frequently co-occurs among these individuals. Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services in a seamlessly coordinated manner. The following concepts have been drafted to set the stage for future conversations around the coordination of mental health and substance use services within California's Duals Demonstration.

1) There is no one-size-fits-all approach to coordinating mental health and substance use services.

- The appropriate model depends on patient needs, on-site capacity, the funding environment, community resources, and local partnerships.

2) Care management should be broadly defined and aimed toward recovery.

- Reimbursement structures should consider supporting care management and service provision based on a recovery trajectory and not a narrow medical model.
- Care management should consider employing team-based approaches, and where possible, alternative options for consultations, such as telemedicine and an e-referrals.

3) Adequate screening and links to services for mental illness and substance use disorders within primary care can facilitate treatment of these conditions before they become severe and disabling.

- Coverage of full array of federally allowable mental health and substance use benefits will be important for care coordination.
- Plans should include traditional mental health and substance use providers in their networks.

4) Person-centered health homes that emphasize communication, coordination, shared records and active outreach can improve care for beneficiaries with mental illness and substance use disorders.

- Ideally behavioral health and medical services would be co-located. The primary health home should be clearly designated so there is clear responsibility for leading care coordination. For those with severe mental illness, that health home often will be located with a community mental health provider.
- Data sharing/privacy guidelines and data management tools should facilitate sharing of essential treatment-related information while protecting confidentiality.

5) Financing arrangements should be developed with a focus on aligning incentives to deliver the right care where and when people want and need it.

- Care coordination has the potential to rebalance service delivery away from the hospital and emergency department and instead to community-based services, resulting in improved health outcomes and lower costs.
- Coordinated models should reduce the administrative overhead required for claims processing.

Appendix G – Technical Assistance Regarding Coordinating and Integrating Mental Health and Substance Use Services

This table provides technical assistance for coordinating and integrating mental health and substance use services for beneficiaries with serious and persistent conditions. DHCS expects to see solutions that reflect unique local circumstances and vary by county in their structure and timing of integration. The following table draws on practices from other states and reflects a continuum of options, starting on the left with coordination partnerships between health plans and county specialty mental health service and substance use providers and moves toward full integration of financing and service delivery.

This attachment is intended only as technical assistance concepts for integration.

For more information and resources, please see:

- 1115 Waiver Behavioral Health Integration Technical Workgroup web page, http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupBHI.aspx
- Center for Health Care Strategies Inc. web page on behavioral health, http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16219

	Coordination Partnership	Full Integration
Overview	Dual eligibles with Serious Mental Illness (SMI) continue receiving specialty Medi-Cal mental health services through the county. Counties and health plans enter formal agreements that include incentives for care coordination and performance measures for tracking shared accountability. This agreement could initially focus on a subset of high-cost, high-user beneficiaries for intensive case management. Counties and health plans "rise and fall" together based on achievement of established performance measures and possible savings from enhanced targeted case management and reductions in unnecessary medical care utilization.	Health plans receive capitated payments to cover all benefits, including specialty mental health services. Dual eligibles who meet medical necessity criteria for Medi-Cal specialty services are identified, and the health plan subcontracts to the county mental health plan to be the specialty provider network and/or the behavioral health organization responsible for organizing and managing all those enrollees' behavioral health needs on either a capitated or fee-for-service basis.
Financing	Mental health services for SMI are carved out of capitated payment to health plans. **Incentive Payments:** Health plans and Counties could enter a formal agreement for care coordination. An incentive pool could be arranged to award bonus payments for meeting set performance measures tied to activities that promote integration and/or outcomes that indicate successful coordination and eventually good health outcomes. The incentive payments could be factored into the plan's capitated payment.	All mental health and substance use benefits are included in the capitated payments to health plans. **IGTs**: Counties could provide an inter-governmental transfer (IGT) to the State or appropriate government entity for the portion of the capitated rate related to mental health services for dual eligibles with SMI. The IGT could be based on an analysis of the amount of funding the county would have expended through certified public expenditures (CPEs) for enrolled duals. DHCS could include

	Shared Savings: Health plans and Counties could agree to an arrangement that establishes mechanisms for local shared savings (between the plan and county) that result from lower medical costs due to enhanced targeted case management.	those funds within the capitated rate paid to the plan. The plan could contract back with the county mental health agency for service delivery.
Roles	Health Plans would be responsible for medical and LTSS benefits for all enrollees and also mental health services for those not meeting the medical necessity criteria for county specialty services. County mental health agencies maintain primary responsibility for mental health services and substance use services, as reflected in current law. Formal agreements between the counties and plans would establish incentives for care coordination and shared accountability for dual eligibles with SMI. Substance use services could follow similar arrangements and be delivered by the plan or county.	Health plans are responsible for ensuring enrolled ALL dual eligibles receive appropriate access to all Medicare and Medi-Cal required benefits. The plan subcontracts with the county mental health agency for inpatient psychiatry and outpatient specialty mental health services on a FFS or capitated basis. If subcontracting is done through capitation, the county bears the risk for Medi-Cal specialty mental health services (but the health plan is ultimately responsible as the state contractor). Under a FFS model, the plan maintains financial risk. The plan and counties could establish agreed-upon strategies for managing utilization. Substance use services could follow similar arrangements and be delivered by the plan or county.
Measures	Performance measures provide a foundation for awarding incentives and tracking shared accountability. Measures could be phased to reflect evolution of integration and unique to local context • Year 1: Measures reflect process improvements and evidence of collaboration and coordinated care, such as common member assessments, screening, stratification, jointly developed care plans, and real-time notification of hospital and ED admissions. • Year 2: Measures evolve to capture intermediate outcomes, such as reduced emergency department use and inpatient admissions. • Year 3: Measures include health outcomes achieved and/or actual calculation of savings. Measures and benchmarks should correspond to state and national evaluation frameworks to allow for comparisons. Another approach could be using evidence from other states/entities to develop benchmark savings targets based on pre-determined utilization changes. Incentive funds would be awarded if those targets are achieved.	
Data Exchange	Clear data sharing/privacy guidelines need to be established to facilitate information exchange across systems, such as exchange of pharmacy data to inform care management. Detailed plans for overcoming this barrier will be necessary. Processes for sharing information electronically will need to be established eventually. This exchange could be phased-in and correspond to the performance measures indicating progress toward integration.	