Part 1: Questions for Potential Contracted Entities Only

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

a. Geographical location:

IEHP's existing DHCS's approved service areas including Riverside and San Bernardino counties, except for some extreme rural areas with the following zip codes – 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93558, 93562, and 93592.

b. Approximate size of target enrollment for first year:

There are approximately 100,000 Full Dual individuals in Riverside and San Bernardino counties. Our target enrollment is unknown at this time because DHCS has not specified how the department will transition the Full Duals into the managed care system and how many plans will participate in this pilot program in our service areas. For example, what is the phase-in period for the transition? Will the Full Duals have an option to opt out? How many health plans will DHCS approve for the Inland Empire?

Also, IEHP may consider at least two options. One option is to provide services to all Full Duals. Another option is to provide services to a segment of the Full Dual population that excludes individuals who are institutionalized in any long-term care (LTC) facilities. We are reviewing the options and will be ready when the RFP is released.

Currently, IEHP provides Medicaid and Medicare benefits to about 5,000 full duals in our Medicare Advantage Special Needs Plan product.

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

IEHP has a mixed model provider network that includes IPAs and directly contracted physicians. Most of our providers are the Traditional and Safety Net providers and contracted IPAs/medical groups. Our current network consists of 700 PCPs, 1,800 Specialists, 600 pharmacies, and 27 major hospitals in the Inland Empire. IEHP's internal Behavioral Health department directly contracts with over 200 providers who see our members in the Medicare Advantage Special Needs Plan (Full Dual), Healthy Families and Healthy Kids products. Our existing network size meets and/or exceeds the requirements of DMHC, DHCS, and MRMIB. We expect that our network size and composition will increase to meet the needs of the pilot program's members and our network will have to satisfy the requirements set by DMHC and DHCS.

Currently, we do not have a LTSS provider network. In order to provide home and community-based services including non-Medicaid long term supports and services

(LTSS), IEHP may choose to contract directly with the LTSS providers, or partner with existing managed care plan(s) and/or an organized care system that already has a strong LTSS provider network. In the Inland Empire area, there are few existing organized health systems that IEHP could form a partnership with and deliver necessary services to the Full Duals.

d. Specific plan for integrating home and community-based services, including non-Medicaid long term supports and services:

As mentioned above, we do not have a LTSS provider network in place yet. In order to provide the home and community-based services including non-Medicaid long term support and services (LTSS), IEHP may choose to contract directly with the LTSS providers, or partner with existing managed care plan(s) and/or an organized care system that already has a strong LTSS provider network. In the Inland Empire, there are few existing organized health systems that IEHP could form a partnership with to deliver necessary services to the Full Duals.

Regardless of the contracting model that we plan to use, our existing multi-disciplinary Care Team (including a physician, nurse, social worker, behavioral health specialist, health educator, member service representative, etc.) will work closely with contracted entities to fully integrate medical and behavioral services with home and community-based services including non-Medicaid long term support and services. Currently, we are partnering with many local social service agencies such as Inland Regional Center, behavioral health departments, disabilities community agencies, etc. to connect our members with other program benefits that are covered by Medi-Cal and Medicare but not by IEHP.

e. Assessment and care planning approach:

Currently, IEHP has implemented a Model of Care program for the Full Duals enrolled in our Medicare SNP product. This newly created program involves multi-disciplinary team including a physician, nurse, social worker, behavioral health specialist, health educator, member service representative, etc. This team conducts health assessments, develops an individualized care plan for each member, and provides proactive care coordination and management services as needed. In addition, we also provide a health assessment and an individualized care plan for the Medi-Cal Seniors and People with Disabilities who will mandatorily enroll with IEHP starting June 1, 2011. Finally, IEHP is partnering with many key social and health services agencies such as Inland Regional Centers, county behavioral health clinics, CCS, etc. to coordinate the program's carve-out benefits to our members.

These two new assessments and care planning approaches were approved by CMS and DHCS in 2011; we expect that these care management and coordination modules will be modified to reflect new requirements determined by DHCS and CMS under the Full Dual pilot program. The pilot program requirements are not yet defined.

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

Same as above.

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

IEHP currently receives capitated payments from DHCS, MRMIB, and CMS for the program covered benefits. For 15 years, IEHP has been consistently meeting the financial stability requirements established by DMHC. We project that our total revenue for FY 11-12 will be about $941 million.

IEHP believes that in order for the Full Dual pilot program to succeed, DHCS and CMS need to reimburse health plans with sound actuarial payments that fully reflect the risk of the population served.

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

Currently, IEHP serves about 25,000 people with disabilities (with conditions listed above) who voluntarily chose IEHP. As a result of the Senior and People with Disabilities mandatory enrollment, we expect to serve a total of 60,000 members in this category. Under DHCS's program requirements, IEHP has demonstrated the plan's readiness in providing medical services and coordinating behavioral benefits for this population.

Furthermore, for our Medicare SNP members, IEHP is currently providing most of Medicare and Medi-Cal's medical and behavioral health benefits, except for LTSS, home and community-based services. The Full Duals receive both Medicare and Medi-Cal benefits with IEHP. IEHP coordinates the benefits between the two programs and pays the providers for the covered benefits accordingly. Our Care Team (including a physician, nurse, social worker, behavioral health specialist, health educator, member service representative, etc.) provides health assessments, proactive care coordination and care management services as needed.

In addition, IEHP partners with many key social and health services agencies such as Inland Regional Centers, county behavioral health clinics, CCS, etc. to coordinate the program carve-out benefits to our Members.

In order to provide a full spectrum of Medicare and Medi-Cal benefits including the LTSS, IEHP will integrate our existing model with a new LTSS provider network and its care management module.

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

Our Model of Care not only provides extensive care management services through one-on-one with each individual member, but also promotes the ability to live more independently. This module involves a multi-disciplinary team that includes a physician, nurse, social worker, behavioral health specialist, health educator, member service representative, etc. The team provides multiple relevant care resources and tools to help members change their behavior and live independently. Also, our care transition program provides immediate and necessary coaching and follow-up services to the newly discharged members. This approach is to prevent avoidable re-hospitalization.

Furthermore, our Wellness Programs are designed to help our members change their negative health behaviors and live a healthy lifestyle. We have over 20 programs such as Diabetes Self-management, Hypertension, Living Well Disabilities, Audio Health Library, etc. These programs offer convenient options such as a classroom approach and/or home self-education approach. This allows us to reach out to members who have specific learning styles.

In summary, IEHP has a program and structure in place that helps members change their behavior, promote independent living, and navigate the healthcare system. We expect that our program will reflect all the new services identified in the pilot program.

4. How would an integrated model change provider behavior or service use in order to produce cost-savings that could be used to enhance care and services? For example, how would your model improve access to HCBS and decrease reliance on institutional care?

We believe that by improving access to medical care and HCBS services we will be able to decrease the system's reliance on institutional care. Currently, Medicare and Medi-Cal provides many benefits – both medical and HCBS – but in a fragmented way. It is common that same services are duplicated in different care settings. Furthermore, some care services rendered may not be medically necessary and the services may not even improve the individual's health. Managed care will provide a coordinated healthcare system that can address some parts of the issues outlined above. Through appropriate provider credentialing process and medical review process, we can ensure that members receive appropriate care when needed.

In addition, managed care can improve access to care. Currently, few providers accept patients who have a public-sponsored health insurance due to program's low reimbursement. As a result of medical access issues, these individuals will turn to the more expensive care settings such as hospitals. Managed care plans have historically brought more providers to offer medical care and treat this population. Managed care plans will likely improve access to the HCBS providers, so the Full Duals can get most of their services at this setting, instead of at institutionalized care facilities. We will develop our network development plan accordingly after further research and consultation with the

LTSS and HCBS providers.

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

IEHP has several payment methodologies with providers to allow contract flexibility for the providers and also help us achieve our program goals. For example, some providers (mostly primary care physicians) prefer the capitation model, and other providers (specialists, hospitals, etc.) prefer the per diem model. For our IPAs, we pay a capitation for delegated services including primary and specialty. We also use a Pay-for-Performance (P4P) program as an incentive program to encourage our providers to conduct key preventive care services such as annual physical exams, immunizations, breast cancer screenings, etc. The program has been improving many of our HEDIS measures.

Through future discussions with the potential LTSS providers, we will work to determine what payment mechanism will work for both entities. Our payment mechanism not only reimburses the providers for the services rendered, but also promotes access to care – medical and HCBS services – and to decrease reliance on institutional care.

6. Do you have support for implementing a duals pilot among local providers and stakeholders? If so, please describe. If not, how would you go about developing such support? How would you propose to include consumer participation in the governance of your model?

IEHP has not discussed the pilot program with local providers and stakeholders yet. However, we are committed to work with local providers and key stakeholders to develop and implement this pilot program. As we receive direction from DHCS, we will inititate collaboration with these relevant entities.

As a public entity, IEHP has a Governing Board that includes 4 County Board Supervisors and 3 Community Representatives. Our monthly Governing Board meeting is open to the public. We do not anticipate any change to this Governing Board's structure. Furthermore, we currently have a Public Policy Participation Committee (a Member Advisory Committee) that is composed of 30 active IEHP Members. In addition, we have a Person with Disabilities Workgroup (a Member Advisory Committee) that is composed of 20 active IEHP Members who have a disabilitiy. Both advisory committees meet quarterly. We expect a new Member Advisory Committee to be created for this pilot program.

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

Full data (both Medicare and Medi-Cal) on the most recent 3 years for:

- All similar data provided through the SPD Mandatory Enrollment initiative such as pharmacy, medical utilization with diagnosis code by beneficiary, etc.
- All data for the behavioral health and LTSS service utilization by beneficiary
- List of current active behavioral health and LTSS providers with total program payments by year and their full contact information (NPI, address, phone, etc.)

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

- Will DHCS offer seed funding to the health plans to support the start-up costs (staffing, IT system investment, contracting, etc.)?

- Currently, health plans are working with both DHCS and CMS for Medi-Cal and Medicare, respectively. What will happen for the following aspects, but not limited to:
  - ✓ The annual Medicare bidding process?
  - ✓ All Medicare regulations – development, submission, review, and monitoring?
  - ✓ Medicare pays the plan accordingly to the HCC score of each enrolled member. Will this process change?
  - ✓ Medicare Star Rating

- Will DHCS plan to consolidate and/or streamline the regulatory requirements of Medi-Cal and Medicare?

- How does DHCS plan to reimburse the health plans for enrolled members?

- What size of the target enrollment is DHCS anticipating in the 1st, 2nd, and 3rd year?

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

Yes.