AGING & INDEPENDENCE SERVICES
COUNTY OF SAN DIEGO ■ HEALTH AND HUMAN SERVICES AGENCY
LONG TERM CARE INTEGRATION PROJECT

ADMINISTRATIVE ACTION PLAN FOR HEALTHY SAN DIEGO PLUS (HSD+)
FINAL DRAFT

JUNE 10, 2004

ADMINISTRATIVE ACTION PLAN EXECUTIVE SUMMARY

This plan for "Healthy San Diego Plus" (HSD+), together with the other two strategies, represents consensus from five years of planning activity on the part of hundreds of "stakeholders" in San Diego. These consumers, caregivers, providers, and advocates have dedicated some 15,000 hours to plan for an improved system of care for San Diego's elderly and disabled persons. This plan proposes a fully integrated, voluntary, service delivery model, with a capitated payment from Medi-Cal, and from Medicare for the "dually eligible." HSD+ plans to build on the "medical home" approach provided by Healthy San Diego (HSD) currently for moms and children, extended to include the broader array of services that becomes possible when Medi-Cal and Medicare funding is pooled.

Integrated care is differentiated from managed care by its ability to provide whatever service an individual needs and chooses to maintain health and function. Managed care can provide only "covered benefits". The aged and disabled populations need considerable support with chronic care management, which will be provided routinely and systematically, based on need and consumer choice, in this strategy. Budget neutrality will be achieved by substituting home and community services for unnecessary hospital, emergency room, and nursing home utilization. Pre-implementation activities focus on: 1) assuring HSD+ feasibility; 2) expanding HSD infrastructure and governance for new populations and services; 3) working with the State to gain waivers/variances needed; 4) fleshing out the detail that will provide for the minimum qualifications required in a process similar to HSD's Request for Statement of Qualifications.

Potential provider network contractors will be offered technical assistance to gain understanding regarding the "building blocks" of integrated care, including care management, network development, quality assurance, and information systems integration. Community-based organizations providing aging and support services will also be supported to actively participate in HSD+. Once potential contractors are approved locally, they will be able to negotiate with the State Department of Health Services and the Center for Medicare and Medicaid Services for a three party contract. The County of San Diego will assume no financial risk, but proposes to contract with the State to support oversight and quality initiatives in HSD+.

On-going stakeholder participation for accountability and oversight of quality will also build upon the HSD structure within the Joint Consumer and Professional Committee. The Committee and its Sub-Committees will be expanded with aging and disability stakeholders for the purpose of representing the interests of the new population and program. Once contracts are in place, characteristics of the HSD+ initial phase of implementation (July 2006) include voluntary enrollment of those 65 years and older who have Medi-Cal or Medi-Cal and Medicare coverage into one of the contracted, integrated provider networks delivering coordinated health and social services. Based on other national integration models, the first three years' experience will provide the basis for expanding, modifying, or improving the new system. It is anticipated that up to 10,000 aged and disabled persons will choose to enroll in HSD+ in the first three years. The Board will be asked to approve initial implementation before July 2006.

INTRODUCTION

Today, more than ever, there is a need for options that will serve to improve our San Diego health care system. The state is in a budget and health care crisis and needs solutions. San Diego is poised to develop a complementary set of strategies that will serve to improve the care of aged, blind, and disabled (ABD) populations. The strategies were inspired by the Board of Supervisors' desire to have an array of options that would accomplish the goal of integrating community based long-term care and social supports with the local medical care systems.

Implicit in this charge was the fact that many components of the current health and social care system for these populations need improvement and that no one strategy is the obvious choice for reaching this goal. To be successful there needs to be broad based community recognition of the advantages of better coordination of Medicare and Medicaid benefits. To this end, stakeholders have proposed the three strategies described below. While each one represents a different level of integration of social and medical supports, they are intended to be complementary and to build upon each other.

Healthy San Diego Plus (HSD+) will be a fully integrated service delivery model, with a capitated payment from both Medi-Cal, and Medicare for the "dually eligible." HSD+ plans to build on the "medical home" approach provided by HSD for moms and children extended to include the broader array of value-added services that become possible when Medi-Cal and Medicare are integrated. The ABD populations need considerable support with long-term care and chronic care management. HSD+ is expected to be the most comprehensive of the three options to be tested and is expected to be most effective in creatively meeting the needs of the ABD beneficiaries.

The HSD+ model can take full advantage of the ability to improve the consumer benefits by pooling Medicare and Medicaid funding, minimizing administrative barriers, eliminating cost shifting incentives, and offering care coordination support to consumers to help them better use community-based social and medical care. It is the option that responds to the Olmstead Decision to use public resources for care chosen by the consumer. It is the option that allows the flexibility to create individualized care plans that support enrollees and caregivers in the community by avoiding unnecessary hospital, emergency room, and nursing home use.

Development of the HSD+ model has been supported by the California Department of Health Services Office of Long Term Care. The State favors this approach because it insures that Federal Medicare dollars are used effectively with Medi-Cal dollars to reduce unnecessary institutionalizations and to broaden the array of home and community-based supports available to ABD recipients within a budget neutral framework. These populations tend to be disproportionately expensive. While ABDs represent 25% of Medi-Cal eligibles, they are responsible for 67% of Medi-Cal expenditures. This is due to multiple chronic illnesses and functional dependencies that can benefit from integrated care. The attached Administrative Action Plan was prepared in response to the latest round of funding for planning the detail of HSD+.

The second service delivery model is the Physician Strategy, which is a "managed fee-for-service" model. In this model, traditional medical benefits are better linked to community information and assistance services to help improve care coordination support for consumers, their families, and primary care physicians. This strategy is motivated by two key concerns. There is a general wariness of managed care by San Diego physicians, based on past experience with the traditional managed care models. At the same time, there is a need to improve the geriatric and chronic care management support for primary care physicians. While these challenges are expected to be a major focus of the HSD+ strategy, the need to allay these concerns is community-wide and needs to be addressed as much as possible for those who are not willing or able to participate in HSD+. It is also important that progress is made in fee-for-service

environments so that there is broad community support for creating better links between acute and long-term care.

The underlying goal of this managed fee-for-service model is similar to that of HSD+; quality, consumer-centered health and social services through improved chronic care management, but without the capitation risk. The special challenge of this strategy is finding the interventions that are effective and the resources to support those interventions permanently. Development of a plan to implement the specifics of the Physician Strategy is currently being supported by the California Endowment. The Physician Strategy implementation plan will be available for stakeholder review in approximately 12 months. The phase-in plan for both HSD+ and the Physician Strategy is to begin enrollment on July 1, 2006.

The third component to be implemented is the Network of Care, which though not a service delivery model, has the potential to serve as the central data and communication system for the two service delivery model strategies outlined above. The Network of Care strategy builds upon an investment made by the County of San Diego to provide web-based access to a site loaded with local health and social service resources, information on assistive devices, pharmaceuticals, health literature, a legislative link, a community meeting planner, and a personal, password-protected medical record (www.networkofcare.org). The goal is to perform formalized testing to assess the adequacy of the database and function for physicians, consumers, caregivers, and Call Center users. This information will then be used to build a continuous quality improvement mechanism into the system. Development of the Network of Care Strategy will be supported by a grant from the Administration on Aging and the Centers for Medicare and Medicaid Services.

Together these strategies provide San Diego with a multifaceted approach to long-term care integration that will help put San Diego in a leadership position in California's redesign of the Medi-Cal Program. The approach will also serve as an investment in San Diego's home and community-base care system and choric care management expertise that will benefit all San Diego's aged and disabled citizens. This attached Administrative Action Plan for developing the HSD+ is based on the work of the last five years of LTCIP stakeholders, expert consultants, Dr. Mark Meiners and Mercer Government Human Services. The Draft AAP should be considered a living, working document, as it will be revised and modified many times based on on-going analysis, feedback, and experience. To provide input: e-mail evalyn.greb@sdcounty.ca.gov.

1. OVERVIEW: SAN DIEGO LONG TERM CARE INTEGRATION AND THE CHRONIC CARE MODEL

The County of San Diego, in partnership with the State Office of Long Term Care, the Centers for Medicare & Medicaid Services, local stakeholders, and national consultants, has developed a vision for improved care of elderly and disabled persons. The program developed in response to this vision will be referred to as Healthy San Diego Plus (HSD+) within this document. The purpose of HSD+ is to deliver and coordinate all Medicare and Medicaid covered benefits for eligible San Diegans through a chronic care model using contracted organizations with extensive integrated provider networks. Phase I will begin enrolling elderly Medi-Cal or Medi-Cal/Medicare beneficiaries with a goal of 10,000 enrollees within three years. San Diego's existing systems and "safety net" will be kept in place during this start-up phase. San Diego is home to approximately 95,000 Medi-Cal eligible persons in the Aged, Blind, and Disabled aid categories, 62,000 of whom are also eligible for Medicare.

The chronic care model is a shift from the fragmented systems that provide health and social services today to a single continuum of care, funded by budget-neutral Medicare and Medicaid capitated rates, wherein the consumer is an integral member of the care planning team. The goal is improved outcomes leading to improved quality of life. To that end, stakeholders have been involved in the planning process from the very beginning and include health and social service providers, consumers, caregivers,

government officials, and many invited experts (see Appendix I for list of organizations represented on the Planning Committee). San Diego's planning activity summary over the last five years is available on the LTCIP web site at www.sdcounty.ca.gov/cnty/cntydepts/health/ais/ltc/.

Over 15,000 hours of stakeholder time have been devoted to the planning of San Diego's LTCIP to-date. Education on successful integration models in the nation has provided a broad understanding of the complexity of the issues. Consensus building in topic-related workgroups has produced recommendations, based on Guiding Principles, which are reflected in this proposal. Agreement to explore expansion of San Diego's Medi-Cal managed care program (Healthy San Diego) as a service delivery model raised issues, such as mandatory enrollment, dismantling the existing system before a new one had proven successful, and the balance between the social and the medical models.

This Administrative Action Plan builds on the efforts of other integrated care initiatives from around the country that have resolved similar concerns. For example, LTCIP stakeholder response to the recently-implemented Massachusetts Senior Care Options (MassSCO) program was that its design could resolve many of these challenges. Today, stakeholders have the opportunity and responsibility to provide input on this Administrative Action Plan so that San Diego can take the next important steps toward implementation of better care systems for its citizens. While identified activities and timelines may change as movement is made toward implementation, the vision of a fully integrated acute and long term care system remains strong among our stakeholders.

1.1 Goals of the Pilot Program (AB 1040 or CA W&I Codes 14139.11)

The authorizing legislation for this initiative is exhibited in Appendix II.

1.2 Chronic Care Integration Values: Characteristics of an Integrated Chronic Care System

Values for a chronic care system are also exhibited in Appendix II.

Major Milestones	Target Dates
• Present and discuss draft AAP with LTCIP Planning Committee	4/14/04
• Update County Board of Supervisors	5/01/04
• Submit County-approved AAP to California Department of Health Services, Office of Long Term Care	6/30/04
• Presentation of San Diego LTCIP concept paper to CMS	9/30/04
• Submit Medicare (and Medicaid, if applicable) waiver request(s)	1/05
• Waiver(s) approved (Medicare and Medicaid, if applicable)	7/05
• State contract awards determined (signed)	2/06
• Begin pre-enrollment activities	3/06-5/06
• Enrollment of members with contractors (effective 7/1/06)	5/06-6/06
• Phase I implementation begins (65+ in greater metro SD)	7/06
• Phase I evaluation complete	7/07
• Phase II planning begins	7/07
• Phase II implementation begins (65+ in entire County)	7/08
• Phase I and Phase II evaluation complete	7/09
• Phase III planning begins	7/09
• Phase III implementation begins (ages 21+ in entire County)	7/10
• Phase I, Phase II, and Phase III evaluation complete	7/11
• Phase IV planning begins	7/11
• Phase IV implementation begins	7/12

2. AGENCY, ADMINISTRATIVE & GOVERNANCE STRUCTURE

2.1 Lead Agency, Required Resources for Implementation, & Capitation

Healthcare is a local issue. San Diego proposes to expand its unique Medi-Cal managed care program, Healthy San Diego (HSD). The goal will be to incorporate health and supportive services for the aged and disabled population using both Medicare and Medicaid funding. This document refers to the proposed expansion as Healthy San Diego Plus (HSD+). For the sake of clarity, HSD will be described first and then the expansion for HSD+ will be discussed.

HSD is unique among all California Medi-Cal managed care plans. HSD planning included stakeholder input over a period of 5 years, with a decision early in the process to eliminate consideration of the "Two Plan" model as a possibility for San Diego County. The Board of Supervisors was not interested in pursuing the County Organized Health System (COHS) model. Stakeholders sought a plan that would create a system that both consumers and providers supported. State legislation (Welfare and Institutions Code 14089.05) was procured to authorize the HSD structure and provide for continuing local stakeholder input after implementation in January 1997, today, and in the future. The HSD structure has four components:

1.) The Operating Agency comprised of County program staff;
2.) The Governing Body, comprised of consumer and professional representatives;
3.) The Health Plans which contract directly with the state Department of Health Services (DHS); and
4.) The State Department of Health Services, which holds contracts with the County and Health Plans.

The Operating Agency is a division of the Health and Human Services Agency of the County of San Diego, governed by the local Board of Supervisors. It is responsible for the oversight of the Medi-Cal Managed Care Program, HSD, in San Diego. This Operating Agency also has a contract with the state to provide and be reimbursed for certain counseling and enrollment activities as well as support activities for the Governing Body. The Operating Agency staff is referred to locally as HSD staff.

The Governing Body is known as the HSD Joint Professional and Consumer Committee. The HSD program statute referenced above sets forth the required membership and representation on this Committee. This Committee is a separate entity from the Operating Agency, which provides staff support for the Governing Body and its sub-committees. The Governing Body conducts its official business in a public meeting once a month. The Governing Body is advisory to the Director of the Health and Human Services Agency on all matters relating to Medi-Cal Managed Care in San Diego.

The Health Plans are the third part of the HSD Program structure. HSD statute allows qualifying health plans in San Diego to contract directly with the State Department of Health Services (DHS) for a capitated rate that is negotiated confidentially by the California Medical Assistance Commission. It should be noted that HSD, as a program, has an excellent reputation locally and in the state, with HEDIS (Health Plan Employer Data and Information Set) and CAHPS (Consumer Assessment of Health Plans Study) audits scored well above average. Individuals reported higher satisfaction and better access to specialty care in HSD than fee-for-service and reported having a medical home for the first time.

HSD+ will require changes within each of the four HSD components. The Operating Agency will add support staff with expertise in aging and long-term care issues and for the purpose of planning and implementing program details. Once the implementation plan is approved at the local, state, and federal levels, these additional staff will be required to develop the Request for Statement of Qualifications (RFSQ), Operational Plan, Enrollment Plan, Policies and Procedures, and implementation staffing.

Options counseling and enrollment are currently handled by the HSD staff, and that staff will be augmented for HSD+ to help the new aged and disabled members make a good choice of contracted, integrated provider network and provide education on how best to use the system of care, including how

to appeal a decision or file a complaint. The enrollment function for HSD+ will include outreach and education in naturally occurring senior gathering places as well as to the existing networks providing services to the aged and disabled populations. HSD+ will seek an on-going contract amendment to the existing contract with DHS for enrollment counseling and administrative support activities like HSD has for the current program. This amended contract with the state will provide for the additional staff to be recruited and trained for outreach and enrollment activities six months prior to HSD+ implementation. This Options Counseling is different from that provided by the Health Insurance Counseling and Advocacy Program (HICAP) in that the state pays for this counseling separately. Under HSD currently, counseling is strictly limited to providing information on all the different contractors available so that the enrollee can make an informed choice. Education on how to use the new system is also provided and will be an important feature under HSD+.

The Governing Body envisioned for HSD+ is the current HSD Joint Consumer and Professional Committee, expanded to represent the interests of acute and long term care providers and consumers. The relationship of HSD+ Operating Agency staff to the governance structure is to provide support for such things as monitoring local quality standards and developing provider contracts. A revised organization chart for the HSD program is included in Appendix III. This Administrative Action Plan specifies key activities and timelines for the expansion of the Operating Agency to support LTCIP.

Health Plans or contracting integrated provider networks will enter into a new business line in San Diego for HSD+. They will receive a capitated rate from the state and federal government to provide the full continuum of care described in this document, either directly or through sub-contract, and they will be responsible for managing the capitated dollars. The Operating Agency will qualify potential contractors based on the RSFQ criteria. Those who are qualified will respond to the DHS Request for Application. Qualifications will include subcontracting requirements with home and community-based care providers. DHS will select contractors in conjunction with the Center for Medicare and Medicaid Services (CMS) and a three party contract will be signed between/among the qualified applicant, DHS, and CMS. The Medicare and Medi-Cal capitation will be pooled at the contracting integrated provider network level. During the first phase of implementation, proposed rates will be based on actuarially sound analysis with rate cells based on the care setting and functional/cognitive level of the enrollee. Integrated provider network contractors will be responsible for provision of all services on an at-risk basis.

The fourth component of the HSD structure, the State Department of Health Services will expand its role with HSD+ at the local and federal level. DHS will work with CMS to procure any waivers/plan amendments needed at the state level. DHS will work with CMS on the rate-setting activity. DHS will approve all local policies and procedures for HSD+. DHS will select and contract with local integrated provider networks and CMS for the purpose of implementing HSD+. DHS will expand the contract with the HSD Operating Agency for the purpose of implementing HSD+.

The lead or operating agency will plan to meet with the state early in the pre-implementation phase to determine which activities need to be completed by each entity to prepare for implementation. Initially, the state may need to take responsibility for some local activities, such as quality improvement and facility review, until HSD+ gains the expertise to assume these functions.

Resources required to move from the planning of HSD+ to implementation have been estimated based on the experience of HSD implementation. The first pre-implementation year will focus on local, state and federal approvals of the HSD+ Program. This will require three full-time staff, some actuarial analysis, and expert consultant(s) contract(s). Resources for the first year are estimated at $550,000.

Once the HSD+ Program has been approved at all levels, three additional staff will be required to write the RSFQ, develop the Operational Plan and the Enrollment Plan, write policies and procedures, develop

outreach and educational material, develop the integrated data system plan, and other required business activities. Estimated resources required for this pre-implementation year are $700,000. San Diego will look to the state for support, and perhaps matching funds, to approach foundations for these resources.

2.2 Management

Executive leadership for system management will be provided for the Operating Agency by the Board of Supervisors, delegated to the Health and Human Services Agency Director. Service management leadership will be the responsibility of the contracted integrated provider networks with quality oversight provided by the governing body. Minimum requirements for management that is responsible for the provision of acute and long term care services for the aged and disabled will be established at the local level through the RFSQ process. Examples of some of those requirements are included in the Quality Management and Improvement Plan (see Section 6).

2.3 & 2.4 Governing Board & Relationships

Governance will build upon the existing HSD system and administrative infrastructure. The current governance structure for HSD, the Joint Professional and Consumer Advisory Committee meets the membership requirements of AB 1040 and the State Office of Long Term Care. The Joint Committee membership has already been augmented to better reflect the HSD+ target population (AARP, disability advocate, consumer, and nursing facility representatives). The committee already maintains a membership that represents different types of healthcare services and providers, for example, Dental Society, mental health service consumers, Center for Health Education and Advocacy, and others. The Joint Committee's monthly meetings provide for the surfacing of quality issues, which allow for problem resolution and system improvement.

Recommendations for system improvement are generated locally, approved by the Joint Committee, submitted to the Health and Human Services Agency Director and subject to approval by DHS. Joint Committee meetings are public and covered by the Brown Act for public noticing and public decision-making. All persons who have participated in the LTCIP planning process for HSD+ will be invited to audit the expanded Joint Committee, and are eligible to make public comment. Sub-committees include the enrollment and quality sub-committees, which will be expanded to include LTCIP issues and stakeholders. LTCIP issues and recommendations will be identified locally and forwarded to the state, in the same manner as is currently done for HSD.

2.5 Capitation, Contracts, Enrollment

The goal is to develop a reimbursement and payment methodology that maximizes consumer-centered care and assures fair provider compensation in order to improve access and quality. To that end, local LTCIP staff will work collaboratively with contracted integrated provider networks, Office of Long Term Care, the Center for Long Term Care Integration, and the Rate Setting and Managed Care Divisions of the State Department of Health Services, and the Center for Medicare and Medicaid Services to build an appropriate set of assumptions and risk adjustment methodologies for a capitated reimbursement to the contracted integrated provider networks by Medi-Cal and Medicare. Replicating a MassSco model would allow for start-up with rate cells based on enrollee setting and level of function. This would allow for budget neutrality, while avoiding the problem of adverse selection under a single capitated rate to the contractors.

For purposes of this document, budget neutrality means that through the duration of the waiver period (typically 5 years) no more will be spent on County residents under the proposed program than it would under its current FFS arrangement. The County recognizes that there are investments that will need to be made by both the County and its health plan partners. These initial higher costs in the first years of the program start up are expected to be offset in future years by efficiencies achieved from prevention of

unnecessary hospital, emergency room and nursing home utilization and improved health of the enrolled members so that they can remain in the community longer.

Based on stakeholder input within the planning process over the last five years, San Diego plans to begin with a voluntary, senior-only enrollment, including disabled seniors, to gain experience in providing integrated care. While the stakeholder vision includes enrollment of all those who choose an integrated system, including the younger disabled, implementation for a limited group will allow for the quality assurance and improvement starting with a smaller scope. The evaluation process envisioned for this initiative will provide direction for the next phases in program refinement, expansion, and replication. Evaluation will include consideration of additional expertise and services needed for the younger disabled and of the pros and cons of mandatory enrollment to help San Diego to be prepared to respond should the state decide to implement this option.

San Diego wants to be prepared to implement high quality, consumer-centered, integrated care as envisioned within the local planning process. This includes the vision of taking advantage of the flexibility provided by capitation to move resources to community-based care from acute utilization. (The Texas StarPlus integration model in 2001-02 increased community-based service usage by 30%, funded by a 13% reduction in hospital admissions and a 38% reduction in emergency room use). Enrollment with contractors will be based on active enrollee choice to this voluntary program.

A minimum of two contracted integrated provider networks must be available in all areas covered by HSD+ to provide choice to consumers. Qualified integrated provider networks shall have the option to renew and/or expand their current HSD contract to include HSD+ or not. Integrated provider networks may also have the option to delegate any administrative functions or services. Covered benefits include the entire list in Appendix IV.

New integrated provider network entrants shall have the opportunity to participate in the RFSQ process for HSD+, in which the local Operating Agency will pre-qualify an integrated provider network to be able to contract with DHS. The development of the RFSQ will be a key activity during pre-implementation and will be based upon the RFSQ used for the current Medi-Cal managed care contractors in San Diego. During that process, reporting requirements will be defined in conjunction with state and federal standards. Also during that process, the phase-in of risk will be defined, as well as stop loss protection for the contractors.

2.6 Functional Integration

HSD expansion to integrate acute and LTC services for the aged and disabled populations includes local Operating Agency (HSD+) development of designation criteria that local integrated provider networks would agree to meet or exceed before being able to contract with the state. Once approved locally, the plan could apply to the state to be an HSD+ provider for a consolidated rate(s) for integrated, at-risk service delivery, meeting state and federal requirements for quality and cost under Medicare and Medicaid. Integrated provider network entities must meet Medicare or Medicaid health plan requirements, including solvency requirements, and must be Knox-Keene licensed within two years of the start-up contract date for HSD+. The state will also contract with the Operating Agency (HSD+) for enrollment, education and the administrative duties required to monitor the quality and integrity of the local program.

The HSD+ contractors will be required to sub-contract for "complex care management" from the County of San Diego Aging & Independence Services and/or community-based organizations based on qualifications that will be set forth in the RFSQ. The goal is to engage the local aging and social service network to work along with the primary and acute providers in the chronic care management of HSD+ enrollees. Care managers will be required members of the team developing and authorizing "complex

care plans", and will be able to act as consumer advocates with no conflict of interest regarding setting or services for an individual. Additionally, it will be these care managers who assign enrollees to a "rate cell" based on functional level during start-up phases. The Operating Agency will randomly sample these assignments as a guarantee to the state that the potential of contractor "gaming" is closely supervised. The state and federal officials will be invited to audit this process as desired.

"Complex care management" need will be determined by the screening/assessment tool that scores the functional rating of an enrollee at a nursing facility level of care. With the designation of "complex care", a sub-contracted care manager will be added to the primary care physician (PCP) from the aging network (in a later phase, also the disability network). Along with the PCP, enrollee, family, caregiver, and other involved professionals, this community care manager will take a lead role on the Primary Care Team (PCT). The PCT is responsible for developing the Care Plan to support the enrollee at the most stable level, avoiding acute service utilization whenever possible and appropriate. The community care manager will take responsibility for implementation of the Care Plan services if the enrollee does not desire that role.

With the support of the state Department of Health Services, San Diego proposes to begin implementation with a model in which any integrated provider network that meets the following qualifications may apply with the Operating Agency to be qualified to contract with the Center for Medicare and Medicaid Services and the state Department of Health Services for HSD+. Integrated provider Networks must:

1. Have the capability and willingness to perform all the functions detailed in the contract;
2. Be able to establish and maintain an organized, integrated provider network that can offer, directly or by contract, all acute, long term care, and mental health and substance abuse services to enrollees and meet Medicare and Medicaid requirements for access and availability standards. In order to establish and maintain this integrated provider network, the contractor must:
    - **a.** Be able to establish an organizational structure and delivery system that meets the contractor responsibilities described in the RFSQ for San Diego and the contract;
    - **b.** Demonstrate its ability to provide covered services for HSD+ members within that service area;
    - **c.** Sub-contract for care management with the local Area Agency on Aging (Aging & Independence Services) and/or one or more community based organizations to serve each area the contractor proposes to cover; and
    - **d.** Be able to meet the financial solvency requirements for Medicare Advantage Plans under the new Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 or Medicaid managed care organizations or Programs of All Inclusive Care for the Elderly (PACE).
    - **e.** Satisfy all of the conditions and qualifications set forth in the Request for Statement of Qualifications (RFSQ) in San Diego and the contract for HSD+.

Major Milestones	**Target Dates**
• Meet with State staff to determine State vs. County activities	8/04
• Expand membership in the Joint Committee	1/05-1/06
• Present and discuss draft of RFSQ for comment from HPs and LTCIP Planning Committee	6/05
• Finalize and release RFSQ	9/05
• RFSQ responses due	11/05
• RFSQ evaluations complete	1/06
• RFSQ responses and recommendations forwarded to State	1/06
• Perform readiness reviews of contractors	2/06-4/06
• Expand county/state contract (to include enrollee education &	3/06

administration)	
• Add additional staff	1/06-12/06
• Systems modifications and/or development	1/06-12/06
• Training of existing and new staff	1/06-12/06

3. POPULATION, SCOPE OF SERVICES, SERVICE DELIVERY SYSTEM

3.1 Target Population

At full implementation, it is envisioned that HSD+ will be available to all elderly and disabled San Diegans. For the start-up phase, San Diego proposes to enroll 65 years old+, Medi-Cal or Medi-Cal and Medicare beneficiaries on a voluntary basis until a stable environment is attained or 15,000 eligibles are enrolled. Stability will be measured both by the contractor "maturity" with the new system as well as the level of customer satisfaction and improved outcome measures. While this may take three years, it will involve continuous quality improvement evaluation methods designed to implement ongoing program monitoring to help identify problems, and develop and test solutions so that progress can be accomplished on a more frequent and regular basis.

Other phases will be planned concurrently to continue extending enrollment to the elderly and then the younger disabled, with the ensuing time used to create suitable criteria for serving the younger population and their special needs. While the plan is to start slowly for the purpose of insuring quality, the attractiveness of the program may lead to a quickened pace of enrollment in the community. At start-up, it is proposed that persons with a share-of-cost not be enrolled, but this will be re-examined during the federal negotiation process. It is preferred to include many of the share-of-cost eligibles who are at or below 200% of the federal poverty level.

3.2 Scope of Services

The list of covered benefits includes all Medicare and all Medi-Cal state plan services for enrollees who are eligible to both programs. For aged and disabled persons on Medi-Cal only, all Medi-Cal state plan services will be covered benefits. Additionally, value added or home and community-based services will be provided under the HSD+ contracts. An important distinction between integrated care and managed care is that integrated care may purchase whatever the primary care team decides the enrollee needs. Under managed care, only covered benefits may be reimbursed. Thus, integrated care is described as being more flexible and creative, having the ability to purchase caregiver support services, mobile services for the homebound, services to prevent diseases from inactivity, access services, and whatever else maintains health independence for the enrollee. The complete list of covered benefits is exhibited in Appendix IV. It should be noted that Medicare and Medi-Cal-covered mental health and substance abuse services will be included for the 65+ year old enrollees during the first phase. Service utilization will be closely monitored at the request of stakeholders to assess the potential for offering HSD+ to the younger mentally ill population in a future phase.

It is anticipated that this full list will be available at start-up to meet the individual needs of each enrollee from the beginning of the program. As additional populations are phased-in, the desired list of covered benefits may be expanded, but will meet the criteria for budget neutrality. The contracting integrated provider networks will be responsible for service authorization, delivery, quality, and reimbursement from the capitated rate negotiated with CMS and DHS. No non-Medi-Cal or non-Medicare services will be provided other than those authorized in lieu of state plan services or Medicare services, which will be monitored for budget neutrality.

Services from other traditional funding sources, such as Older Americans Act, Veterans, and Public Health, will be coordinated through Memoranda of Understanding between HSD+ contractors and other

community contractors, and included by the care manager as a referred services in the Care Plan of complex care enrollees. In San Diego, this will include:

- Housing Department and Commission
- Older Americans Act (OAA)
- Veteran's Administration services
- Department of Health Services public health services (non-Medi-Cal)
  - Refugee health services
  - Rural health services
  - Contagious disease programs
  - Immunization programs, etc.
- Department of Social Services
  - Adult Protective Services, Title 19 block grant
  - Assistance dog special allowance
  - Habilitation services
- Department of Rehabilitation Services
  - California assistive technology system: I & R
  - Client assistance program
  - Deaf access assistance
  - Elderly visually impaired
  - Independent Living Centers (AB 204)
  - Interpreter for hearing impaired
  - Orientation center for the blind
  - Rehabilitation counseling, training & placement
- Department of Development Disabilities
  - Regional Center services
  - Development center
- Department of Mental Health Services
  - County mental health services
  - Mental health managed care services
  - State psychiatric hospitals
  - Traumatic brain injury project
- Department of Alcohol & Drug Programs
  - Alcohol & substance abuse treatment

Memoranda of Understanding (MOUs) are currently in place between the HSD contractors and 11 different community services. These MOUs provide for formal referral and feedback between HSD and other providers so that care can be tracked across services and continuous quality improvement mechanisms can track where members may be failing to follow through on referrals or when the referring provider fails to get feedback. Existing HSD MOUs will need to add reference to HSD+ enrollees or extended to community providers on the list above who frequently receive referrals to provide service to aged and disabled HSD+ enrollees. HSD+ contractors who are new and do not serve the TANF population will need to comply with and submit signed MOUs with all appropriate providers of referred services as described in the RFSQ requirements. The local requirements will then be included in the contract between the local provider, the state, and the federal government.

3.3 Service Delivery System

San Diego's vision is a service delivery system that responds to the need of the "whole person" for health, social, and supportive services through one system of care. The delivery system change will be supported and complemented by clinical change on the part of providers and behavioral change on the part of consumers. A clinical change example for the physician might be to assess the need for treatment within

a chronic care model rather than symptom treatment. A behavioral change example is the consumer who begins to take responsibility for his/her diabetic condition and changes his/her diet and exercise plans to lose weight. The new system's ability to provide services that are flexible and individualized to consumer need allows outcomes to be the focus for continuous quality improvement.

The service delivery system minimum criteria will be defined within the Request for Statement of Qualifications. For the greatest majority of elderly and disabled persons moving from fee-for-service to chronic care management, HSD+ will

1) Improve system efficiency with "no wrong door" entry, a single assessment and care planning tool and a centralized consumer database;
2) Improve service quality by evaluating outcome indicators built into the data system for the purpose of continuous quality improvement;
3) Enhance consumer access via the "no wrong door" point of entry housed within the Aging and Independence Services Call Center, which provides Information and Assistance as well as Intake. Contracting integrated provider networks will agree to access criteria to all specialty and diversity enhancing services within the contracting process;
4) Substitute lower cost, long-term services in the home and community for higher cost institutional based services, as the contracted integrated provider networks will assume risk for the cost of all Medicare and Medicaid services in exchange for a capitated rate. This fiscal arrangement will be enhanced with the community-based care manager assisting in the development of a care plan to stabilize the individual at home with supportive services whenever possible, appropriate, and the consumer's choice.
5) Offer the incentive to provide appropriate, high quality chronic care on a budget neutral basis using quality indicators monitored by all stakeholders, and require continuous quality improvement policies and procedures as detailed in the RFSQ. The incentive for budget neutrality is fiscal solvency of an organization that contracts for a capitated rate.
6) Coordinate non-covered services by the care managers through on-going referral and monitoring. Non-covered service referral will be tracked in the care plan document. For providers with frequent referrals, an MOU will be developed to formalize the policy and procedure that ensures each care plan service is delivered as desired to the individual.

3.4 Network Development and Coordination

Given the contracting model described in Section 2.1, network development for service delivery will be the responsibility of contracting integrated provider networks. The Request for Statement of Qualifications (RFSQ) will mandate the set of requirements for the number of types of providers based on the number of types of enrollees in each network. This will include specialty providers of health and social services across the acute and long term care continuum.

Within the RFSQ process, integrated provider network contractors will be asked to demonstrate the qualifications and commitment of providers in the network to care for people with chronic illness, including functional and cognitive impairments. Applicants will explain how the system assures/promotes continuity of care and how unnecessary or premature institutionalization will be prevented. In the application for designation as a potential contractor, integrated provider networks shall identify whether they are traditional Medi-Cal providers and provide a listing of:

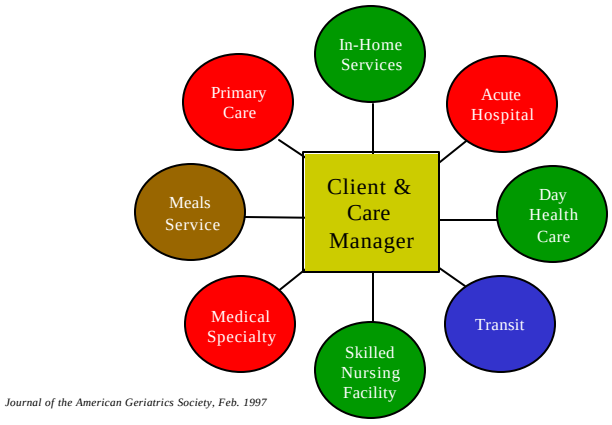
- Primary Care Providers and Specialists, locations, phone numbers
- Hospitals and nursing homes, locations, phone numbers
- Pharmacies, locations, phone numbers
- Optometry and locations
- Labs and locations
- In-home professional service providers

- Home and community-based care providers.

Integrated provider network applicants will be required to provide names of the contracting organizations and will indicate which are already Medi-Cal and/or Medicare certified. The list of services provided in Appendix IV will be required to be addressed within the application process. The applicant will list those who will be under contract for which services and will list services to be procured on an ad hoc basis. Applicants will also need to describe how the various system elements will be integrated into an effective network. Network services will be coordinated with those provided outside the network through the formal process and procedure outlined in Memoranda of Understanding, as described in 3.2 Scope of Services.

Coordination of benefit components will be the responsibility of the care manager. Contract language between/among CMS, DHS, and integrated provider networks will require that care managers are sub-contractors from the County of San Diego or community-based care management organizations. Minimum requirements for education, experience, and certification/licensure will also be addressed in the contract language. Care managers will work in tandem with the consumer/caregiver as the hub to the constellation of services needed (See graphic at end of section).

As the care manager works with the consumer across settings and through health and social crises, continuity of care is a primary responsibility. Guiding Principles include consumer right to choice and consumer-directed care. The capitation of Medicare and Medicaid resources into one pool will allow the care manager flexibility to develop individualized care plans in conjunction with the client and caregiver that enhance options for home and community-based care. The requirement for contracting with a care manager outside the integrated provider network also insures that expertise in referring to available community resources is a part of the care planning process.



Journal of the American Geriatrics Society, Feb. 1997

3.5 Medicare

Current HSD contractors who also have a Medicare product include Blue Cross, HealthNet, Kaiser, and Universal Care. Additionally, the Senior Care Action Network in Long Beach has a Social Health Maintenance Organization that is interested in exploring expansion to San Diego County for the purpose of contracting for HSD+. Also, Evercare remains interested in contracting for a pilot in San Diego County and has been successful in having a bill introduced as AB 2822 on February 20, 2004 that would

authorize such a pilot. Integrated provider network meetings for the purpose of LTCIP have included representatives of all these organizations since August of 2003. San Diego desires dual capitation from Medicare and Medi-Cal for the purpose of aligning incentives to move high acuity utilization resources to lower cost community services that help stabilize chronic conditions and improve the quality of life for individual enrollees by preventing unnecessary emergency room visits, hospitalizations, and nursing home stays.

3.6 Access and Transportation

Service areas will be phased in with increases in enrollment numbers and will need to be carefully planned as one of the activities to be completed within the Administrative Action Plan for the purpose of the RFSQ process. The plan will include transportation availability assessment in each phase-in service area. Transportation, which assures access to care, will be handled the same as all other covered benefits within the contracting process. Access through appropriate language and culture must also be described through the RFSQ process. A 24-hour, seven day/week hotline with clinical response will be required to guarantee access to clinical counseling, triage, and after hour service authorization.

3.7 Off-Plan Coordination

As described in Section 3.2 Scope of Services, MOUs will be required with frequently used off-plan service providers to assure continuity for consumers and providers to manage chronic care issues. For providers who already have an MOU with HSD, that MOU may be modified to include HSD+. Non-traditional services are readily available from community-based organizations and product companies since San Diego has purchased goods and services from vendors for over 20 years within the Medicaid Waiver programs. During the RFSQ process, integrated provider networks will be required to demonstrate how they will obtain these services. Care managers will team with the consumer and caregiver to manage chronic care issues across residential settings, including assisted living, residential care, HUD housing, and other congregate living arrangements for aged and disabled persons.

3.8 Consumer Interface

When a potential enrollee contacts or is contacted by the Call Center for intake, the worker will provide information and education on resources available to meet individualized needs. If the potential enrollee then asks to be enrolled in HSD+, an Options Counseling session will be scheduled to explain integrated provider network choices, consumer rights and responsibilities, how to use an integrated provider network most effectively, basic orientation about available services, and the complaint and appeal process. When the potential enrollee signs the application, it will be forwarded to the DHS Medi-Cal enrollment database, MACSTAR. This system matches the person with the provider selected and forwards the information to the contractor who then notifies the enrollee.

The enrollee will be assessed for risk of institutionalization by the integrated provider network. If the enrollee is evaluated as being at risk of institutionalization or having "complex care needs", the care manager will develop a care plan with the Primary Care Team and enrollee within two weeks. If the enrollee is not evaluated as having complex care needs, the enrollee will be informed of the primary care physician assignment and a contact person for any questions regarding obtaining services or any facts related to changes in condition that might necessitate more/different levels of care.

The graphic display in Section 3.4 above depicts the consumer at the hub of care planning activity in conjunction with the care manager. This model is intended to provide the consumer with the opportunity to discuss choices available for the care plan package with the care manager and then develop a plan that reflects the wishes and desires of the consumer and caregivers for setting, services, and products. As consumer-centered continuity of care is a guiding principle, every effort will be made for new enrollees to maintain current providers. Especially important is the relationship between a consumer and a personal care service provider. San Diego has developed a Public Authority that is the employer of

record for individual providers reimbursed under the In-Home Supportive Services Program. Contract language with integrated provider networks will require that a sub-contract with the Public Authority is in place at start-up and throughout the life of the contract to insure continuity of personal care services providers. Integrated provider networks may also contract with other entities for this service.

One of the great assets of the HSD+ model is that an integrated provider network will be required to obtain consumer input for the development of the care plan. If clients ask for a certain vendor for a continuing service, it is expected that the integrated provider network would be able to contract with that vendor if minimum requirements could be satisfied. During the RFSQ process, integrated provider networks will also be required to show how the organization meets Medicare or Medicaid standards for network adequacy, travel time, locations, after hours care, monitoring and continuity of care.

3.9 Special Populations, Cultural Competence

Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and respond appropriately to issues of race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation and occupation. The goal of culturally competent services is to provide the highest quality of care to every enrollee, mindful of diversity in every population.

San Diego has a widely diverse population among its aged and disabled residents, which means that HSD+ must be responsive to the growing and unique needs of many subpopulations and cultures. San Diego's population is 60% White, 24% Hispanic, 9% Asian, 6% Black, and 1% Native American. The county has 18 Native American Tribal reservations, more than any other single county in the country. Between 1995 and 2020, San Diego's Hispanic populations will more than double, comprising one-third of the total population. Approximately 19% of the county's population is immigrants who come from other countries and speak 68 different languages. While interpreter services will be the answer to communication for many who only communicate in languages other than English, there are several "threshold" languages, to which integrated provider networks must respond with appropriately diverse staff and policies. Those threshold languages in San Diego are English, Spanish, Arabic and Vietnamese. Also, San Diego is home to approximately 33,000 gay, lesbian, bi-sexual, and transgender seniors (8% of senior population) who will need providers accepting of diverse sexual orientation and familiar with appropriate resources.

Contracts will be offered to traditional providers in the community, thus enabling providers who serve special populations and/or who have contractual obligations to serve specific members or residents to continue to do so. Integrated provider networks will be required to show how they plan to communicate and understand the culture of persons who speak the threshold languages. The Operating Agency will also need to provide for ethnically sensitive options counseling and orientation as well as appeal and complaint process. Additionally, as outlined in Section 2.1 Lead Agency, staff with expertise in aging, chronic care management, and home and community-based services will be added within the expansion for the HSD+ support structure.

Understanding of access to care issues for diverse groups will be an educational goal. Access does not include just proximity, transportation, or reimbursement. For HSD+, it will also include physical access for those in wheelchairs, interpreter services for the deaf and blind, and culturally appropriate staffing to meet enrollee needs. For persons over the age of 65, outreach and screenings must be provided in naturally occurring senior gathering places such as senior centers. Home visits must be available for those who are homebound or bedbound at any age. San Diego stakeholders have identified several special populations that will require additional planning before phase-in. These include persons with developmental disabilities and persons with mental health or substance abuse service needs. In

California, specialty systems have been carved out for these two populations, which adds to the complexity of phase-in.

3.10 Demonstration of Stakeholder Support

The San Diego LTCIP has about 600 individuals and/or agencies on the mailing list, which receive monthly communication regarding LTCIP activities and meetings. Individual consumers names are not published. The reader will see the very broad representation across health, social services, consumer and caregiver advocacy groups, public officials, and other interested parties. Participation by many of these representatives is well-documented on the LTCIP web site in meeting notes and sign-in sheets from five years of regular Planning Committee and Workgroup meetings. Letters of support from representatives of population subgroups and out-of-network providers will be easily obtained when the final service delivery model is clarified through the activity of the Administrative Action Plan. See Appendix I for the list of organizations represented within the Planning Committee.

Major Milestones	**Target Dates**
• Complete Population Worksheet	10/04
• Complete Scope of Services form	10/04
• Establish budget neutrality criteria as it relates to scope of	12/04
• Establish integrated provider network requirements	4/05
• Develop policy regarding non-Medi-Cal and non-Medicare services	6/05
• Define "complex care needs"	6/05
• Finalize call center consumer interface protocol	1/06-4/06
• Update/expand MOUs with other community providers	1/06-6/06
• Define standard content of enrollee transition materials	2/06

4. CARE MANAGEMENT AND INTEGRATION

San Diego's vision includes access to care management for all enrollees. Based on the initial assessment, enrollees may be determined to have complex care needs or not. If not, the goal will be to provide the enrollee with a number to call (integrated provider network call center) to get any question answered and/or to discuss the need for urgent care. For those not in the "complex care need" category, contractors will need to develop a system for periodic telephone assessment of change in status that might indicate the need for reassessment of complex care need or referral to solve new problems.

For enrollees assessed with complex care needs based on the formal assessment tool and protocol, care management is considered the hub of integration activity. Together with the client and caregiver, the care manager will work in team with the primary care physician to develop a plan of care based on the multi-dimensional assessment of need and consumer preference and choice. The contracting integrated provider networks will sub-contract for complex care management with the County's Aging & Independence Services and/or with a community-based organization providing geriatric care management (and disability expertise in later phases). Individual care managers must be "certified" by a national care management certification agency, such as the Commission for Case Management Certification, to meet the minimum requirements to perform complex care management. Contracting integrated provider networks will need to show how they will meet the care management standards required within the RFSQ.

The standards will encompass the recommendations from the LTCIP Care Management Workgroup, as presented to the Planning Committee in 2001. These include:

#1. Integrated care management model

- Integrated care management teams will include the physician, ancillary health and social service professionals involved in the individual's care, and the consumer, family, and caregivers.
- Integrated care management encompasses medical, social and supportive services.
- Tiered levels of care management will be based on severity of consumer need for frequency of contact, credentials/expertise, and caseload ratio.

#2: Single point of entry (referred to in this document as "no wrong door" entry)

- Access to services will be provided through a single point of entry with streamlined, non-duplicative application and eligibility, coordinated with Medi-Cal and Social Security, etc.
- Those not eligible to LTCIP will get access/advocacy to existing community services.
- A baseline risk assessment will be performed at enrollment.
- There will be a single case management database for each consumer with secured, confidential access to care management team and providers.

#3: Standardized Tools

- Standardized Risk and Assessment Tools will have "triggers", based on medical and social domains, which indicate the need for further assessment/intervention.
- Standardized tools will be used to document baseline consumer information, and to periodically update with consumer status.
- Assessment information will be the basis for Care Plan development.

#4: Integrated Care Plan

- Integrates medical and social services to be referred/authorized
- Identifies primary care manager
- Is prescriptive to all involved in consumer's care

#5: Establish care management quality assurance measures

- Contract language to include specific and detailed standards.
- Contract monitoring to assess care management quality on periodic basis.
- Quality Improvement Committee to provide oversight, improve policies and procedures as necessary.

#6: Develop MOUs with non-integrated (funding) providers

- Develop Memoranda of Understanding (MOUs) to improve service coordination with those providers whose funding is not integrated during Implementation Phase 1, including the Regional Center for Services to the Developmentally Disabled, County Mental Health Services, Public Health, and other community providers, as needed.

The stakeholder vision in San Diego includes a modest but critical shift: the development of a close working relationship between the physician, the care manager, and health and social service providers for an individual. Communication will be the key to this shift. Periodic interchange between providers on the team will be essential. As a member of the primary care team (PCT), the role of the care manager is to:

1. Participate in initial and ongoing assessments of the health and functional status of enrollees, including determining appropriateness for institutional care, developing community-based care plans and service packages necessary to improve/maintain enrollee health and functional status;
2. Arrange and, with the agreement of the PCT, coordinate and authorize the provision of appropriate community long term care and social support services according to the agreed upon Care Plan located in the Central Client Database (such as assistance with the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), housing, home-delivered meals, and transportation) and, under specific conditions or circumstances established by the contractor, authorize a range and amount of community-based services;
3. Monitor the appropriate provision, costs, and functional outcomes of community long term care

services, according to the service plan as deemed appropriate by the PCT; and
4. Track enrollee transfers across settings (for example, hospital to home or nursing home to adult day health) and adjust the plan as deemed appropriate by the PCT; and
5. Maintain accurate and current information in the Care Plan regarding home and community based services for the PCT.

The integrated provider network contractor may also enter into a subcontracting relationship with community-based organizations for functions beyond the care management roles above, including but not limited to:
1. Providing community-based services, such as homemaker, chore, and respite services;
2. Arranging and coordinating the completion of a standardized assessment tool, such as the MDS-HC, which will be required for rate cell assignment determination; and
3. Conducting risk-assessment and care-planning activities regarding non-medical service needs of enrollees without complex care needs.

Chronic disease self-management is a goal of HSD+. As such, the Community Education Workgroup of the current LTCIP has just been initiated to address four specific areas of development to insure that contractors and consumers are engaged in this activity. The four areas of development are: curriculum, media/informational materials, implementation, and evaluation. The link with the web-based data system, Network of Care, will become the warehouse of information to support chronic disease self-management. The County of San Diego sponsors and updates the web site and encourages contractors and members to access the information and communication capabilities it offers. Required quality improvement initiatives in chronic care management are described more fully in Section 6. Quality Management and Improvement Plan.

The "no wrong door" entry will lead potential HSD+ enrollees directly to the Call Center at Aging & Independence Services. Call Center staff is professional level social workers who have excellent electronic support skills in both dealing with volume and having resource information readily available. If the staff assesses that a person is eligible for HSD+, the individual will be referred to an enrollment counseling session by County staff. At this session, the individual will receive education on how best to use HSD+, how to choose an integrated provider network, contractor and enrollee rights and responsibilities, and the appeal process. When the individual completes the enrollment application, it will be forwarded to the Medi-Cal enrollment database, where it will be verified and notice will be sent to the contracting integrated provider network.

The integrated provider network must contact the individual and complete the standardized assessment in the enrollee's own setting within two weeks. If the enrollee is assessed as having complex care needs, a care manager will be assigned and will contact the enrollee immediately to develop the Plan of Care in conjunction with the enrollee and the PCT. The care manager will record the enrollee choice for quality of life, including setting and services. Emphasis must be on the needs of the individual and use of flexible funding with the capitated rate to develop a Plan of Care that corresponds to the desire of the consumer for quality of life. For enrollees with a conservator or assigned power of attorney, requirements within the RFSQ will outline policies and procedures for inclusion in HSD+. For those enrollees not assessed as having complex care needs, the primary care physician (PCP) assumes the role of care manager for the purpose of referring for/authorizing services, including non-medical services that are needed.

The integrated provider network contractor must ensure effective linkages of clinical and management information systems among all providers in the network, including clinical subcontractors (that is, acute, specialty, behavioral health, and long term care providers). (See Section 7 for more detail on requirements for information systems.) Integrated provider networks are responsible for assuring, monitoring and

reporting on the accountability of PCPs and PCTs for integration and coordination of services, which includes, but is not limited to:

- **a.** An Individualized Plan of Care for each enrollee, developed by the PCP or, if applicable, the PCT, including the schedule of periodic review and modification of this treatment plan by the PCP or PCT;
- **b.** Written protocols for generating or receiving referrals and for recording and tracking the results of referrals;
- **c.** Written protocols for providing or arranging for second opinions, whether in or out of network;
- **d.** Written protocols for sharing clinical and Individualized Plan of Care information, including management of medications;
- **e.** Written protocols for determining conditions and circumstances under which specialty services will be provided appropriately and without undue delay to enrollees who do not have established complex care needs (for example, geriatric support and specialty physician services);
- **f.** Written protocols for tracking and coordination of enrollee transfers across settings and ensuring continued provision of necessary services; and
- **g.** Written protocols for obtaining and sharing individual medical and care planning information among the enrollee's caregivers in the integrated provider network, and with CMS and DHS for quality management and program evaluation purposes.

Each integrated provider network contractor must maintain current enrollee information in a database that is available to their own 24/7 call center for clinical triage and after hour services. Outreach will occur via the existing aging, health, and social service network announcements and publications. The Aging & Independence Services Call Center's "800" number will be provided in these outreach activities, which will be organized by HSD+ County staff, and sensitive to the diversity of the population in San Diego.

Major Milestones	**Target Dates**
• Define minimum care management and integration standards for RFSQ	1/05
• Develop minimum contract requirements for contractors' 24/7 call center for clinical triage and after hour services	1/05
• Expand Quality Improvement Committee to include LTCI issues and representation	2/05
• Define minimum contents of Integrated Care Plan	3/05
• Define frequency requirements of contact based on consumer need (by care manager and rest of care management team)	4/05
• Determine standards for Contractor evaluations of care managers	5/05
• Define contents and accessibility of case management database	5/05
• Develop web-based data system to support chronic disease self-management	5/06

5. FINANCING, COST CONTAINMENT, COST NEUTRALITY

5.1 Capitation Rate

San Diego proposes incremental phase-in of a fully integrated Medicaid and Medicare model. The state and federal officials of these programs will be approached, as soon as this Administrative Action Plan is completed, to discuss the development of a dual capitation rate for Healthy San Diego Plus (HSD+) contractors. Because the San Diego program will be a new start-up and will be voluntary in its early phase(s) of implementation it is recommended that the reimbursement approach include:

- Multiple Medi-Cal capitation rate cohorts similar to the Mass SCO model,

- A risk sharing and/or stop-loss mechanism(s) similar to those offered by Mass SCO and the Arizona program, and
- Dual funding from Medi-Cal and Medicare to the contractors.

Initial implementation must be planned for a small number of enrollees. In order to succeed with small numbers of enrollees, San Diego plans to initiate the program with five to ten rate cells based on setting and functional status. The Center for Long Term Care Integration has provided significant analysis of the expenditure data for San Diego. This information, together with actuarial trending and new legislative impacts, will be considered in the development of capitated rates in conjunction with the state and federal rate-setting staff.

The plan is to bring all Medicare and Medicaid services into the capitated rate with incentives for contractors to substitute home and community-based care services for acute and institutional care whenever possible and appropriate. In the case of the Medi-Cal Personal Care Services Program, this will include "maintenance of effort" on the part of the County of San Diego, to keep up resources currently committed by percentage. The relatively small enrollment numbers during start-up will allow for the changes to respond to problems identified during the process. The goal is to develop a program of improved care that is desired and chosen by all the elderly and disabled in San Diego for optimum chronic care management. At the point at which the critical mass of enrollment allows the development of a single capitated rate across the population, new policies and procedures will be forwarded to the state and federal officials for approval of implementation of a single capitated rate.

5.2 Risk Management

The County of San Diego will not assume risk. The Center for Medicare and Medicaid Services (CMS) and the California Department of Health Services (DHS) Medi-Cal program will contract directly with contractors pre-qualified for the HSD+ program implementation. During the planning process, local organizations interested in potentially contracting for HSD+ expressed great concern about the very low level of per capita Medi-Cal expenditures for the aged and disabled who represent 25% of the Medi-Cal population but expend 67% of the Medi-Cal budget. Therefore, risk sharing and/or stop loss mechanisms need to be identified as HSD+ works toward implementation.

Two successful models of integration have been examined to provide insights. The Arizona Long Term Care Service Program is fully integrated for Medicaid services and features mandatory enrollment into managed care plans. However, Arizona has a mature program with all contractors serving more than one thousand enrolled members, which provides them with a sufficient enrollment base to spread financial risk. Arizona utilizes a single capitation rate per contractor, which varies by geographic region. The capitation rate development takes into account historical member placement (i.e., in-home and community based versus institutionalized members). The rate development also accounts for the percent of members who are dually eligible for both Medicaid and Medicare. Through this single capitation rate the State provides a financial incentive for the contractors to further develop options and network capacity for non-institutional care. Arizona also includes some stop-loss protection for their contractors via State-sponsored reinsurance and reconciliation mechanisms. Medicare funding is not a formal integrated component of the Arizona model.

The Massachusetts Senior Care Options (MassSCO) program is a brand new fully integrated long-term care program that features voluntary enrollment for Medicaid eligible members age 65 and over and a coordinated dual funding stream to the contractors from Medicaid and Medicare, where applicable. The State utilizes six different capitation rate categories, which vary depending on the individual member's placement (community versus institutional), nursing home certifiable status, and level of institutional placement. These rating groups are further varied by geography and dual eligibility status, bringing the total number of different Medicaid capitation rates to 24. The program also provides a State-sponsored aggregate risk-sharing mechanism via risk corridors.

Medicare funding for the dual eligible members is based on conversion factors applied to the base Medicare Advantage rates by geographic region for Part A and Part B. These conversion factors/rates also vary by gender, five different age cohorts, and again by nursing home certifiable status, and institutional placement. The dual funding streams afford the contractors the greatest potential to fully integrate services and coordinate care for their members.

The more complicated and varied capitation approach employed by the MassSCO program provides the necessary mechanism to match reimbursement to risk for a voluntary start-up program, which will have limited enrollment for the immediate future. The HSD+ rate setting approach will seek actuarial assistance to take advantage of the risk adjustment strategies used by these and other states to best meet the needs and expectations of our consumer-centered care goals and the budget neutrality expectations of County, State, and Federal payers.

5.3 Financial Analysis and Plans

Much work has been accomplished in preparation for a final rate-setting analysis. The Center for Long Term Care Integration worked closely with the local Data/Finance Workgroup, which provided recommendations regarding covered services and phase-in based on the analysis of past Medicaid expenditures. That work was further developed by three expert contractors during Fiscal Year 2002-03 with grant support from the State Office of Long Term Care. Currently, San Diego has contracts with two experts at the national forefront of long term care integration program and rate development: Dr. Mark Meiners and Mercer Human Services Consulting. These consultants bring the extra value of having assisted in the development of the program and rates being used for the MassSCO, seen locally as the model that most closely reflects the San Diego vision for acute and long term care integration.

HSD+ contracts are envisioned to be three-party contracts between/among CMS, DHS, and HSD+ providers. The providers will bear risk and may or may not choose to pass risk to sub-contractors. See Appendix IV for list of covered benefits. Activities to proceed to the implementation phase are included with each major section of this Administrative Action Plan. Federal and state auditing requirements will be addressed within the three-party contracting process. The Operating Agency will require state funds to plan, support, and oversee HSD+ and will work with the state to determine the scope and budget necessary to expand the current HSD Operating Agency.

5.4 Cost Neutrality

Cost neutrality will be established during the rate-setting negotiations with CMS and DHS within the capitated rates set by cohort for the start-up phase and later for the single rate across all cohorts. In order to account for non-state plan services, the contracts will include these services as covered benefits along with language that requires the provision of these services in lieu of state plan services. Additionally, contractors will be required to perform on-going cost benefit analysis to account for budget neutrality. After completion of the Administrative Action Plan, San Diego will begin the pre-implementation activities toward start-up. A cost neutrality worksheet will be completed during that phase.

The California Center for Long Term Care Integration analyzed San Diego's Medi-Cal and Medicare expenditure data for the calendar years 1996 through 2000. One of the reports exhibited the "High Cost Users" by diagnostic conditions. During a presentation of this report to the stakeholders, it was noted by a disability community advocate that almost all of the high cost conditions were preventable given good care management. HSD+ plans to identify these high-risk individuals at enrollment and prevent unnecessary exacerbation of conditions that have a negative impact on the quality of life and result in much higher costs than preventive and stabilizing home and community-based care.

Major Milestones	**Target Dates**

• Contract/plan in place for actuarial support	9/1/04
• Initial planning discussion with CMS	10/04
• Review detailed reimbursement approach with LTCIP Planning Committee and potential contractors (HPs)	12/04
• Complete cost analysis for budget neutrality	1/05
• Perform a gap analysis of system(s) requirements, related to reimbursement approach, against current system(s) capabilities (including local and State systems)	2/05
• Present reimbursement approach to the State DHS for approval	2/05
• State approval of reimbursement approach	3/05
• Develop applicable RFSQ language regarding Contractor fiscal solvency, budget neutrality, and reimbursement approach	4/05
• Begin capitation rate development process	4/05
• Final capitation rates developed	12/05

6. QUALITY MANAGEMENT AND IMPROVEMENT PLAN

The stakeholder group has identified many reasons to consider building upon a capitated model like HSD+. Research points to the following opportunities in well-developed Medicaid managed care plans, which are not systematically provided under a fee-for-service model:

- Availability of a health professional 24/7 in the contractor call center
- Participation of an increased number of Primary Care Physicians (PCP)
- Participation of an increased number of specialists
- Initial health assessment with enrollment screens for needed services
- Members linked to a system of providers for a "medical home"
- The medical home model has greatly reduced emergency room use (50% in Texas StarPlus)
- Members have higher rates of preventive services and screening
- Members have pharmacy management
- The contractor must meet cultural and diversity requirements
- Disease management and care coordination are required
- Physicians must meet minimum credentialing requirements
- Member satisfaction is measured annually.

HSD+ plans to take advantage of these opportunities for improved care by including these requirements in the Request for Statement of Qualifications (RFSQ) for providers. The contractor will be required to demonstrate how utilization of services will be reviewed and managed on a day-to-day operational basis. The RFSQ will require a description of policies and procedures in place for utilization review and management. The contractor must also describe its current computer capacity, hardware and software, and its plans to coordinate with the state and Operating Agency systems. The contractor must describe its ability to supply computerized data, if necessary, to CMS and DHS via computer disks or tape, and produce any required reports described in the RFSQ. The contractor must indicate the technical qualifications of staff operating the computer system(s) and generating reports as well as the flexibility of the computer system to modify reports or produce other reports, as may be required by CMS or DHS. External surveys required by Medicare and Medi-Cal managed care organizations will be required of contractors, including HEDIS and CAHPS reporting.

6.2 Complaints and Appeals (Grievances)

The contractor has the first responsibility for resolving conflicts and dealing with complaints and grievances. During the enrollee option counseling and education, the process for making a complaint or filing for an appeal will be explained in detail and provided in writing. HSD currently works very closely

with the Center for Health Education and Advocacy (the Center). This is an external local agency and is staffed with attorneys and individuals who speak a total of 8 different languages. Individuals who have complaints about HSD service or system problems are encouraged to call the Center for Health Education and Advocacy if unhappy with the results of complaints to the contractor. Complaints or grievances not resolved at the local level will go to the State and/or CMS process.

An enrollee complaint is an enrollee's informal expression of dissatisfaction with any aspect of his or her care. An enrollee complaint is different from an appeal, which is described below. An enrollee may file an enrollee complaint at any time by calling or writing the contractor. The contractor must inform enrollees of the postal address or toll-free telephone number where an enrollee complaint may be filed. The contractor must have a system in place for addressing enrollee complaints. The system must meet the standards required by Medicare and Medi-Cal for timely acknowledgement and response. The contractor must have written process compliant with the service decision/appeals process in the RFSQ.

If the enrollee disagrees with the contractor's decision regarding the provision of a service, the enrollee may file an internal appeal by writing, faxing, or calling the contractor within 60 calendar days of the receipt of the written denial notice. An enrollee must first exhaust the contractor's internal appeal process before the enrollee can proceed with an external appeal. The contractor must make an internal appeal decision within appropriate timeframes. The internal appeal decision must be made by a physician who was not involved in the initial decision and who has appropriate expertise in the field of medicine for the services at issue. The contractor must notify the enrollee of its internal appeal decision in writing.

If, on internal appeal, the contractor does not decide fully in the enrollee's favor within the relevant time frame, the contractor will automatically forward the case file to the CMS Independent Review Entity for a new and impartial review. If the contractor or the enrollee disagrees with the CMS Independent Review Entity's decision, further levels of appeal may be available. The contractor must cooperate with any requests for information or participation from such further Appeal entities. If, on internal appeal, the contractor does not decide fully in the enrollee's favor, the enrollee may also request an external review by the state Medi-Cal Office. This process will be described in the RFSQ, and taken as a whole, this procedure will comply with and mirror the Medi-Cal and Medicare process and will be clearly and specifically described in integrated provider network contracts and enrollee education materials.

6.3, 6.4, 6.5 Monitoring Outcomes/Evaluation, Quality Improvement, Evaluation Criteria and Target Areas for Quality Assurance

San Diego's vision for an improved system of care for the elderly and disabled will depend on a quality management and improvement system that can focus on outcomes. The contractor must operate an ongoing quality management program that includes quality assessment and performance improvement, in accordance with federal and State requirements. Contractors will be expected to review for under-utilization as well as over-utilization with the highly vulnerable population in HSD+. The contractor must also participate in annual external quality reviews conducted by an External Quality Review Organization.

For the purposes of quality management and rating-category determination, the contractor must accept, process, and report to CMS and the State uniform individual enrollee data, based upon an initial and on-going assessment that includes ICD-9 diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0), and any other data elements deemed necessary by CMS and the State and included in the RFSQ. The contractor's continuous quality improvement program must:

1. Recognize that opportunities for improvement are unlimited;
2. Be data driven;
3. Seek and incorporate enrollee input;
4. Seek and incorporate input from all employees of the Contractor and its subcontractors; and

5. Require measurement of effectiveness, continuing development, and implementation of improvements as appropriate.

The contractor must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. A Quality Management Director will be required to oversee all quality management and performance-improvement activities. The quality management director must have competency/expertise in geriatric (and eventually disability) models of care. A Medical Director will be required to have geriatric expertise and experience in community and institutional long term care and will be responsible for establishing medical protocols and practice guidelines to support the quality improvement initiatives described below.

A qualified geriatrician will be required to be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support a geriatric model of practice. A qualified behavioral health clinician, with expertise in geriatric services, will be responsible for establishing behavioral health protocols and providing specialized support to PCPs and PCTs. Quality improvement initiatives will be formally and specifically described in the RFSQ. These will include, but will not be limited to:

1. Initiative to Reduce Preventable Hospital Admissions

The contractor must develop/adopt written protocols, or adopt nationally recognized protocol, to minimize unnecessary or inappropriate hospital admissions and a reporting system to record all preventable hospital admissions. Protocols must include at least the following:

a. Monitoring and risk-assessment mechanisms, which operate on a continuous basis, to identify enrollees "at-risk" for at least the following conditions or profiles: pneumonia, dehydration, injuries from falls, skin breakdown, loss of caregivers, and history of poor compliance with treatment programs;

b. Processes that link the initial and ongoing assessments to the timely provision of appropriate preventive care and other treatment interventions to at-risk enrollees. Such processes must emphasize continuity of care, coordination of services, and be in accordance with accepted clinical practice. The contractor must perform outcome analyses to evaluate the effectiveness of the protocols;

c. Formal linkages among the PCP, PCT, and providers (specialty, long term care, and behavioral health) through the centralized enrollee record, that must be used to provide timely information to the contractor's integrated provider network, in order to implement early interventions for enrollees to prevent unnecessary hospitalizations.

2. Discharge Planning Initiative

The contractor must develop/adopt written protocols and a reporting system to record discharge activities to ensure that enrollees who are admitted to an institution receive the following:

a. Interdisciplinary discharge planning and implementation processes that begin at the point of admission to the hospital or nursing facility;

b. Involvement of the care manager, the providers of home and community-based services, and the enrollee in determining which discharge setting is appropriate; and

c. Care planning and arranging for services that will be needed upon discharge.

3. Preventive Immunization

The contractor must develop/adopt written protocols to provide pneumococcal vaccine and timely annual influenza immunizations and a reporting system to record all immunizations given. The protocols must include the following components:

a. Development and distribution of contractor and PCP/PCT practice guidelines and measurement of PCP/PCT compliance with the guidelines;

b. Educational outreach to enrollees about appropriate preventive immunization schedules; and

c. Prompt access to immunizations for ambulatory, homebound, and institutionalized enrollees.

4. Screening for Early Identification of Cancer

The contractor must develop/adopt written protocols to provide cancer screening services, and the provision of appropriate follow-up services. The contractor must develop a reporting system to record all tests given, positive findings, and actions taken to provide appropriate follow-up care. The protocols must include the following components:

a. Written practice guidelines developed in accordance with accepted clinical practice, provided to all PCP/PCTs, with compliance measured at least annually;

b. Education outreach to both enrollees and caregivers about preventive cancer-screening services;

c. Fecal occult-blood test annually; and

d. Mammography services: annually for women aged 65-69 and as medically appropriate for women aged 70-79.

5. Disease Management

The contractor must develop/adopt written protocols to manage the care for enrollees identified with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and depression and a reporting system that produces clinical indicator data. The protocols must include the following:

a. Written practice guidelines, in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards;

b. Measurement and distribution of reports relating to contractor and PCP/PCT compliance with practice guidelines;

c. Educational programming for Enrollees and significant caregivers that emphasizes self-care and maximum independence;

d. Formal educational processes for clinical providers in the best practices of managing the disease; and

e. Evaluation of effectiveness of each program by measuring outcomes of care.

6. Management of Dementia

The contractor must develop/adopt written protocols to manage the care for enrollees identified with dementia and a reporting system that produces clinical indicator data. The protocols must include the following:

a. Written practice guidelines in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards, with evaluation of the effectiveness of these protocols on outcomes of care;

b. Measurement and distribution of reports relating to compliance with practice guidelines;

c. Educational programming for significant caregivers that emphasizes community-based care and support systems for caregivers; and

d. Formal educational process for clinical providers in the best practices of managing dementia.

7. Appropriate Nursing Facility Institutionalization

The contractor must develop/adopt appropriate written protocols for nursing facility admissions and report institutional utilization data. The protocols must include the following activities:

a. Identify medical conditions and patient profiles that differentiate between enrollees at risk of being institutionalized and those who require institutional care;

b. Develop monitoring and risk-assessment mechanisms that assist the PCP or PCT to identify enrollees at risk of institutionalization;

c. Implement care management processes that link initial and ongoing assessments to the timely provision of appropriate preventive care and treatment interventions to at-risk enrollees. Such protocols must emphasize continuity of care and coordination of services. The protocols must be based upon an evaluation of the outcomes and costs of care;

d. Implement processes to ensure the timely provision of nursing facility services when necessary;

e. Identify and formalize the linkages present between the PCPs, PCTs, and the long term care providers of home- and community-based services, and how these linkages encourage and support maintaining enrollees in their communities as long as appropriate; and

f. For individuals who can safely and adequately be cared for in the community, implement a discharge planning program that begins at the point of admission to any institution, to ensure the earliest appropriate discharge to community LTC.

The contractor must administer an annual survey to all enrollees and report the results to CMS and DHS on the anniversary of the individual's enrollment date. As part of its measurement, the contractor must conduct one survey or focus group with each of the following groups, as selected in consultation with CMS and DHS:

1. Non-English speaking enrollees to assess their experience with the contractor's ability to accommodate their needs;

2. Persons with physical disabilities to assess their experience with the contractor's ability to meet their needs;

3. Enrollees from a minority ethnic group served by the contractor to assess their experience with the contractor's ability to provide culturally sensitive care and support to family members and significant caregivers; and

4. Family members and significant caregivers of enrollees to assess the contractor's ability to support family members and significant others.

The contractor will also be required to conduct an evaluation of the effectiveness of health promotion and wellness activities on each anniversary of the start date of the contract, specifying the costs, benefits, and lessons learned. The contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for providers. The contractor must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including end-of-life issues and advance directives.

Major Milestones	**Target Dates**
• Define Contractor QM requirements for RFSQ	11/04
• Define complaint and appeals protocol	1/05
• Define County's method/process to monitor the Quality Management requirements	2/05
• Develop policies and standards of utilization review and management for inclusion in RFSQ	3/05
• Define required Contractor reports and reporting standards for RFSQ	4/05
• Determine standards for Contractor provider credentialing process and provider profiling for RFSQ	5/05
• Draft materials that will be provided in writing to the consumer about the complaint and appeals process	1/06

7. INTEGRATED INFORMATION SYSTEMS

San Diego's vision includes an information technology (IT) system that supports the integration of care across the continuum of providers of health, social, and supportive services. It will be web-based and compliant with federal law for privacy, security, and confidentiality. A single customer file will support the vision to eliminate duplication and fragmentation, and to support coordination between all providers of an individual. Potential contractors will be required to describe the IT system to be used for day-to-day management of operations and long term planning to insure the health of the organization. Data will be required to be collected and retrieved on an individual patient basis and in the aggregate. Minimum criteria for IT system capacity and compatibility will be established in the RFSQ process. The State and County IT systems will need to be able to interface with contractors' IT systems. Contractor IT requirements may also include new types of system capacity, such as support for care management

activity. Web-based capacity will allow for pre-arranged access to the enrollees care plan by out-of-plan and emergency providers.

The Operating Agency will develop a plan during pre-implementation that includes a longer term vision for a web-based data system that serves both enrollees and providers to the best possible extent. The Network of Care component mentioned in the Executive Summary will be examined as a potential vehicle to be the over-arching information and communication system. The Operating Agency currently has two data support programs that will be expanded for the aged and disabled population for the purpose of HSD+. These are the Panorama View and Geo-Access Programs.

Panorama View is a Medi-Cal Encounter Database that allows HSD staff to access statewide data regarding eligibility, utilization and quality of services. This database is the only data source available for much of this information and is an invaluable tool for monitoring service utilization and quality of care measures in the Medi-Cal program, both for fee-for-service and managed care providers. This program allows staff to look at a variety of encounter data elements such as access for well-child visits and lead screenings for example, to determine if there are disparities in access to care and to assess the success of local programs in providing access to quality health care. The data in Panorama is state data collected by a contractor, MEDSTAT. San Diego has only been granted a license to access what the state wants and/or requires, and does not determine what those elements are other than to suggest elements thought to be important. San Diego has mentioned to MEDSTAT staff that data relating to the ABD population was something of great interest to many people. It may be possible to have indicators more useful for the elderly and disabled population added to the system.

GeoAccess is an online provider directory that allows HSD staff to assist consumers in identifying which plan their Primary Care Provider (PCP) belongs to and/or to select a provider within their geographic region if they do not have one for both the Medi-Cal and Healthy Families programs. Plans can update this database monthly with changes in their integrated provider networks. The plan is to expand this system for the purpose of implementing HSD+.

Major Milestones	**Target Dates**
• Define minimum criteria for IT system capacity and compatibility for RFSQ	1/05-5/05
• Perform a gap analysis of system(s) requirements against current system(s) capabilities (including local and State systems)	2/05
• Plan with stakeholders to expand Panorama View & GeoAccess capabilities to meet the needs of HSD+	3/05-5/05
• Define contents and accessibility of case management database	5/05
• Expand & modify Panorama View and GeoAccess using previous planning & discussion process with stakeholders	6/05-12/05
• Systems modifications and/or development	1/06-12/06
• Develop web-based data system to support chronic disease self-management	5/06
• Continue to find ways to improve system integration and capacities	On-going

8. PHASE-IN STRATEGY

The rationale for starting with a limited and voluntary enrollment schedule with elderly-only is to allow time for contractors to build expertise, an adequate network of providers, and infrastructure in order to gain maturity with this new approach to caring for the aged and disabled individuals in San Diego. It is the intent of the Operating Agency to set up evaluation criteria with baseline data and benchmarks in

order to measure the success of phases and to be able to justify moving to the next phase. The evaluation plan criteria will be developed prior to implementation of Phase I. Goals and performance criteria for each phase will be established and continuously modified with implementation. From initial implementation, all services in Appendix IV will be HSD+ covered benefits.

Phase I enrollment will be scheduled for a specific geographic area of the county and will be open, voluntary monthly enrollment of Medi-Cal or Medicare/Medi-Cal beneficiaries who are age 65 and older.
Phase II enrollment, after application of the evaluative process described above, is expected to open voluntary enrollment in the remainder of the county for the same population.
Phase III enrollment, continuing with the evaluative process, is expected to be the enrollment of those who are over the age of 21 and are elderly or disabled and are beneficiaries of the Medi-Cal program or Medicare and Medi-Cal.
Phase IV enrollment, continuing with the evaluative process, will explore enrollment for those who are beneficiaries of Medi-Cal or Medicare and Medi-Cal, are over the age of 21 years and are elderly or disabled, based on the experience of the earlier phases.

The timelines listed below are the outside dates for implementation. It is the desire of stakeholders to proceed with due diligence. If experience in the early phases lead to a decision to proceed toward full implementation more quickly, then the time between phases will be shortened.

Major Milestones	**Target Dates**
• Define evaluation plan criteria for baseline data and benchmarks for Phase I	1/06-5/06
• Enrollment of members with contractors (effective 7/1/06)	5/06-6/06
• Phase I implementation begins (65+ in greater metro SD)	7/06
• Phase I evaluation complete	7/07
• Modify Phase I evaluation plan criteria for Phase II	7/07-12/07
• Phase II planning begins	7/07
• Phase II implementation begins (65+ in entire County)	7/08
• Phase I and Phase II evaluation complete	7/09
• Modify Phase I and II evaluation plan criteria for Phase III	7/07-12/09
• Phase III planning begins	7/09
• Phase III implementation begins (ages 21+ in entire County)	7/10
• Phase I, Phase II, and Phase III evaluation complete	7/11
• Modify Phase I, II and III evaluation plan criteria for Phase IV	7/11-12/11
• Phase IV planning begins	7/11
• Phase IV implementation begins	7/12

9. MAJOR KNOWN CHALLENGES

A. Lack of interest and/or participation by Contractors (Health Plans). Contractors are the core of the integrated full-risk delivery model. If Contractors are unwilling to participate in this voluntary program, the program cannot be implemented.

— Potential causes for lack of interest/participation
  - Lack of health plan involvement in the design/development of the program
  - Perceived poor overall design or too many questions remain unanswered
  - Too much perceived financial risk (lack of financial protection)
  - Perception of excessive administrative requirements
  - Concern regarding insufficient member enrollment

— How to mitigate lack of interest/participation

- Continue to seek and facilitate input from the potential contractors
- Continue to work with potential contractors on specific program design issues
- Design adequate reinsurance, risk corridors and/or other stop-loss mechanisms
- Market the LTCIP to existing Healthy San Diego Contractors as a mechanism to add cash-flow to their existing operations that can help to cover a portion of their existing administrative overhead
- Attempt to find the best possible balance between administrative requirements and appropriate program and other quality controls
- Educate potential contractors of efforts that will be made to encourage member choice (enrollment)

B. Lack of member choice (enrollment) after implementation. This is a potential risk because San Diego is planning to initially implement the program as "voluntary" from a member enrollment perspective. If this risk is not adequately dealt with early in the implementation planning process it will likely impact/drive the level of interest of potential contractors (discussed above). Potential contractors know that insufficient enrollment will impact their ability to cover their administrative costs and impact the adequacy of the reimbursement rates and the overall reimbursement methodology.

— Potential causes for low member choice (enrollment)
- Pervasive negative perception of the "managed care" aspect of the full-risk integrated contracting approach
- Real or perceived concern regarding the sufficiency of Contractors' networks
- Lack of available relevant and effective information regarding the program design including performance standards and other quality care protections

— How to mitigate the risk of low member choice (enrollment)
- Continue to educate members and advocates of the benefits expected through an integrated care (managed care) approach
- Publish integrated provider network and other standards that contractors will be held to under contract
- Produce effective educational enrollment materials and ensure an adequate system of distribution is utilized to encourage enrollment choice.

C. Inability to resolve issues with CMS regarding Medicaid/Medicare waivers in a timely manner. This will impact the County's ability to design and implement the type of program desired in a timely manner. This will either result in a delayed implementation altogether or implementation of a revised program design.

— Potential causes for untimely resolution of CMS waiver questions and issues
- Delays at the State level
- Lack of sufficient understanding of specific waiver submission requirements
- Inability to provide CMS specific data, information, and/or answers to their questions
- Insufficient time to work through issues

— How to mitigate risk of untimely resolution of CMS waiver issues
- Early communication with the State and CMS to identify necessary data and design concepts to provide the necessary data and information with the first waiver submission
- Study other waiver submissions with similar provisions from other states
- Adequate data analysis
- Maintain close communications with CMS and the State throughout the waiver process.

D. Actual or perceived insufficient funding. This risk is a concern because all parties have to believe the program can be adequately funded, or it will be difficult to achieve the necessary buy-in by all parties, which will result in some of the risks discussed above.

— Potential causes of actual or perceived insufficient funding
  - Current low Medi-Cal FFS rates
  - Discussion of the "Budget Neutrality" requirement caveat
  - Insufficient data to address the funding concern

— How to mitigate risk of actual or perceived insufficient funding
  - Build capitation reimbursement considering current unmet needs and quality improvement expectations, not just based upon historical FFS utilization and rates
  - Design adequate reinsurance, risk corridors, and/or other stop-loss mechanisms
  - Continue to educate stakeholders regarding how an appropriate shift in services through improved coordination of care and care delivery options can save money, thereby funding a "Budget Neutral" program design
  - Show how expected Medicare funding via capitation compares favorably to historical Medicare FFS expenses for the target member population.

E. Insufficient provider support. This will hinder contractor interest, adequacy of integrated provider networks and member/advocate confidence. It is important to realize up front that it will not be possible to achieve universal support from all types of providers. However, as long as enough providers are supportive to start with, implementation can proceed.

— Potential causes of insufficient provider support
  - Concerns regarding managed care red tape (procedures)
  - Concern about adequacy of funding and anticipated rates to be paid by contractors
  - General lack of information

— How to mitigate the risk of insufficient provider support
  - Continue to engage the providers in the design and implementation planning process (separate meetings with key provider types may be necessary)
  - Educate providers and build controls into contracts to address and minimize their concerns

F. Insufficient administrative funding resources for pre-implementation activities. It will be necessary to obtain sufficient funding to continue the planning and pre-implementation efforts related to a full-risk integrated long-term care program. Despite the notable progress to date, the County will continue to need funding for staff and/or professional and outside service firms to assist in the development of program design, waiver requests, data analysis, and policy development (as part of the RFSQ). Without adequate pre-implementation administrative funding, the LTCIP will quickly lose momentum and the timeline for actual implementation will be considerably lengthened.

— Potential causes for insufficient funding related to pre-implementation activities
  - Lack of support at the State and/or County level
  - Constricted State and County budgets

— How to mitigate risk of insufficient funding
  - Adequately educate State and County policymakers of the benefits of the LTCIP and the potential Medi-Cal costs of aging baby boomers in the current system
  - Seek funding from a variety of sources including federal, State, and County appropriations and/or grants as well as non-governmental grant funding

G. Diversion of attention to other opportunities that may present themselves. Specifically, local health care providers and/or health plans may roll out pilot programs or alternatives to the LTCIP initiatives presented in the AAP. County representatives will have to consider whether any such

proposals are positive (in that they may be a means to early implementation of some form of integrated long-term care) or negative (in that attention would have to be at least partially diverted from implementation efforts towards the full-risk LTCIP currently envisioned, thereby delaying startup).

- Potential causes of providers/health plans proposing pilots and/or other alternatives
  - Lack of support for the LTCIP as currently envisioned
  - New grant funding programs being sponsored at the federal or State level
- How to mitigate risk of unwanted proposals
  - Continue to engage potential Contractors during the pre-implementation activities related to the LTCIP
  - Perform a quick, yet thorough assessment of any such proposal to gain a complete understanding of whether it would likely help or hinder the County's efforts to implement a county-wide LTCIP

Planning Committee Organizational Representation **Appendix I**

AGENCY

1. AARP Health Issues
2. ACCESS Center
3. Adult Protective Services, Inc
4. Age Concerns
5. Aging & Independence Services (AIS) -LTCIP
6. Aging Assistance
7. AIS Advisory Council
8. AIS Senior Team
9. AIS/APS
10. AIS/MSSP
11. Alpine Special Treatment Center
12. Altam Associates, Inc.
13. Alzheimer's Association
14. AmeriChoice
15. ARC North County
16. ARC-San Diego
17. Area Board XIII on Developmental Disabilities
18. Assembly Committee on Aging & LTC
19. At Your Home Services for Aging & Disabilities and Family Care
20. Aurora Behavioral Health
21. Bair Financial
22. Bayside Community Center
23. Blue Cross of California
24. Borseth Chiropractic Center, Inc.
25. Brighton Health Facilities
26. CA Association of Health Facilities
27. CA Department of Adult & Aging Services
28. CA Dept. Health Services/OLTC
29. CA Dept. of Mental Health
30. CA Health & Human Services Agency
31. California Commission on Aging
32. California Endowment
33. California Healthcare Alliance
34. Californians for Disability Rights
35. CaLMA
36. Care Access
37. Care Rite Vocational Services
38. Care View Medical
39. Casa de Oro, Adult Day Health Care Center
40. Catholic Charities
41. Center for Elders Independence
42. Center for Healthy Aging
43. Center for Long Term Care Integration
44. Center on Aging, SDSU
45. Challenge Center
46. Chicano Federation
47. Children's Convalescent Hospital
48. Christine Kehoe's Office
49. Clairemont Friendship Sr. Center, Inc.
50. Cloisters of Mission Hills
51. Coastal Senior Consulting
52. Commission on Aging
53. Community Catalysts California
54. Community Health Group (CHG)
55. Community Health Improvement Partners
56. Community Interface Services
57. Community Options
58. Community Research Foundation
59. Consumer Center for Health Ed & Advocacy (CCHEA)
60. Continental Rehabilitation Hospital
61. Contra Costa County LTCI
62. Contra Costa Health Plan
63. Council of Community Clinics
64. Council on Minority Aging
65. Country Hills Health Care Center
66. County Adult/Older Adult Mental Health Services
67. County Medical Society
68. County Mental Health Board
69. County of San Diego IHSS Public Authority
70. County of San Diego, HHSA
71. County of SD-Board of Supervisors
72. Creative Support Alternatives
73. Cypress Court Senior Living
74. Dartmouth Medical School/Psychiatric Research Center
75. DAWCAS
76. Deaf Community Services of San Diego
77. Department of Public Health Office of Policy & Planning
78. Department of Rehabilitation
79. Desert HomeCare
80. Developmental Services Continuum, Inc. - HireWorks
81. Dignified Living Choices, Inc.
82. District 72
83. Downtown, Inc.
84. Dr. Yang's Family Care
85. DSC Inc.

86. Easter Seals So. Cal.
87. Edgemoor Hospital, AIS, HHSA
88. Education Extraordinaire
89. ElderHelp of San Diego
90. Exceptional Family Resource Center
91. Evercare
92. FAST
93. Firstat Nursing Services
94. Friendship Development Services
95. Garden Park Villas
96. GE Financial
97. Generations Health Care
98. George G Glenner/Alzheimers Center
99. GeriNet Medical Associates
100. Golden Care Workforce Institute
101. Golden Hill Health Careers Academy
102. Grace Care Management
103. Grice, Lund & Tarkington
104. Grossmont/Sharp Senior Resource Center
105. Guardian Angel Program of San Diego
106. Health Net
107. Health Policy Source, Inc.
108. Healthcare Association of San Diego & Imperial Counties
109. Healthcare Financial Solutions
110. HealthCare Quality Review
111. HHSA - AIS PA/PG
112. HHSA - Healthy San Diego
113. HHSA - North Region
114. HHSA - South Region
115. HHSA CAO
116. HICAP
117. Home of Guiding Hands
118. Housing & Community Development
119. Howell Associates
120. IHC Board of Directors
121. IHSS Advisory Committee
122. InCare Health Services
123. Independence for Life Choices, Inc.
124. Indian Health
125. Internal Medicine & Associates
126. Internext Homecare
127. IP
128. Jewish Family Service
129. JG Solutions
130. Kaiser Permanente
131. Kennon S. Shea & Associates
132. Kindred Hospital
133. La Jolla Nurses Homecare
134. La Mesa Police Department
135. LA PAI Office
136. Law Offices of James Boyd
137. Legislative Analyst Office (LAO)
138. Lenora's Assisted Living Services, Inc.
139. LightBridge Hospice
140. LivHome
141. Los Angeles County Area Agency on Aging
142. LTC Ombudsman Program
143. Managed Health Care
144. Managed Medical Services - Mobile Physician Services
145. Maric College
146. Marin County LTC
147. MassHealth Senior Care Options
148. Meals-on-Wheels Greater S.D., Inc.
149. Medical Care Program Administration
150. Medi-Cal Field Office
151. Medical Office Management
152. Mental Health Association
153. Mental Health Systems, Inc.
154. Mercer
155. Mesa Valley Grove Senior Health Plan Adult Day Health Care
156. Milliman USA
157. Mithras Group
158. Mobile Cardiology Services
159. Mobile Physician Services
160. Mount Miguel Covenant Village
161. Mountain Shadows
162. NAMI San Diego
163. NASW Region E
164. National Multiple Sclerosis Society
165. National Sr. Citizens Law Ctr.
166. NCSL
167. Neighborhood House Association
168. Nevada County HAS
169. North Coast Home Health Products
170. Nursing Home Admin
171. Nursing/Case Management
172. Office of AIDs Coordination
173. Office of Public Health
174. Office of Senator Ducheny
175. OSHPD
176. P.R.I.D.E., Inc.

177. Pacific Health Policy Group
178. Pacificare Health Services
179. Palomar Pomerado Health
180. Paradise Valley Hospital
181. Paradise Valley Senior Health
182. Partnership with Industry
183. Pfizer
184. PPH Behavioral Health Services
185. Promising Futures, Inc.
186. Protection & Advocacy, Inc. (PAI)
187. PulmoCare Respitory Services
188. RAND Corporation
189. Rawlings Consulting Services
190. Redwood Elderlink
191. Rehab HabilitationServices
192. RTI International
193. S.D. Community College District
194. Sacramento Co. Department of Medical Systems
195. Safety Alert
196. Salvation Army
197. San Diego Association of Nonprofits
198. San Diego Center for the Blind
199. San Diego Central Jail
200. San Diego City Council
201. San Diego Dental Society
202. San Diego Hospice & Palliative Care
203. San Diego Housing Commission
204. San Diego Job Corps Center
205. San Diego Mental Health Board
206. San Diego Park & Rec Disabled Services
207. San Diego Parkinson's Disease Assn.
208. San Diego PAS Co-op
209. San Diego Psychiatric Society
210. San Diego Regional Center
211. San Diego State University - Geronotlogy
212. San Diego-Imperial Counties Labor Council
213. San Mateo County HAS Aging & Adult Services
214. San Ysidro Urban Council, Inc.
215. SCAN (SHMO)
216. Scripps Behavioral Health
217. Scripps Continuing Care
218. Scripps Mercy Hospital
219. SD Health Services Advisory Board
220. SD Imperial County Regional Home Care Council/Accent Care
221. SD Mental Health Board
222. SD Park & Rec Disabled Services
223. SD Regional Center
224. SDSU - College of Health & Human Services
225. SDSU School of Public Health
226. SecureHorizons
227. Seeds
228. SEIU Local 2028
229. Senate Comm. on HHS
230. Senator, Dede Alpert
231. Senior Care Management Inc.
232. Senior Community Centers of SD
233. Service Employees Intl. Union Local 2028
234. Shared Solutions
235. Sharp Healthcare
236. Sharp Health Plan
237. Sharp La Mesa Senior Health Center
238. Sharp Mesa Vista
239. Sharp Senior Health Center -downtown
240. Sharp-Grossmont
241. Silverado Senior Living
242. Social Security Administration
243. Social Work Service 122, VA Medical Center
244. Sonoma County Transition Planning for LTCI
245. Souare Consulting
246. South County Meals-On-Wheels
247. Southern Caregiver Resource Center
248. Southern Health Services
249. Southern Indian Health Council, Inc.
250. St. Madeleine Sophie's Center
251. St. Paul Senior Homes & Service
252. Staff Builders
253. State Department of Finance
254. State Dept. of Social Services
255. Stein Educational Services
256. Telecare Corp.
257. Telecare Cresta Loma
258. TERI, Inc.
259. The Access Center of San Diego, Inc .
260. The Arc of San Diego
261. The Broadway Home-RCFE
262. The Call Doctor Company
263. The Fromm Group/Chicano Fed Dev.
264. The Pennant Alliance
265. Toward Maximum Indep., Inc.
266. UCSD Department of Family & Preventive Medicine
267. UCSD Dept. of Psychiatry
268. UCSD Extension

269. UCSD- Geriatric Medicine
270. UCSD Medical School/Geropsych
271. UCSD School of Medicine
272. UCSD Senior Behavioral Health
273. UCSD Shiley Eye Center - UCSD
274. UCSD/ CHIP Mental Health Workgroup
275. UCSD/ St. Vincent De Paul Village
276. United Behavioral Health
277. United Cerebral Palsy
278. United Domestic Workers of America/AFSCME
279. United Way Information & Referral
280. Universal Health Care
281. University Community Med Center
282. University of Maryland, Center on Aging
283. University of Southern California
284. Unlimited Options
285. Unyeway Inc.
286. UPAC
287. USD School of Nursing
288. VA Gero Psychiatry, UCSD
289. VA Medical Center
290. VA San Diego Healthcare System
291. Verilet-Health Care Info. Technology
292. Volunteers of America, Elderly & Disabled Division
293. West HealthCare

AB 1040 and Chronic Care Integration Values **Appendix II**

Goals of the pilot program (AB-1040 - 14139.11):

(a) Provide a continuum of social and health services that fosters independence and self-reliance, maintains individual dignity, and allows consumers of long-term care services to remain an integral part of their family and community life.

(b) If out-of-home placement is necessary, to ensure that it is at the appropriate level of care, and to prevent unnecessary utilization of acute care hospitals.

(c) If family caregivers are involved in the long-term care of an individual, to support caregiving arrangements that maximize the family's ongoing relationship with, and care for, that individual.

(d) Deliver long-term care services in the least restrictive environment appropriate for the consumer.

(e) Encourage as much self-direction as possible by consumers, given their capability and interest, and involve them and their family members as partners in the development and implementation of the pilot project.

(f) Identify performance outcomes that will be used to evaluate the appropriateness and quality of the services provided, as well as the efficacy and cost effectiveness of each pilot project, including, but not limited to, the use of acute and out-of-home care, consumer satisfaction, the health status of consumers, and the degree of independent living maintained among those served.

(g) Test a variety of models intended to serve different geographic areas, with differing populations and service availability.

(h) Achieve greater efficiencies through consolidated screening and reporting requirements.

(i) Allow each pilot project site to use existing funding sources in a manner that it determines will meet local need and that is cost-effective.

(j) Allow the pilot project sites to determine other services that may be necessary to meet the needs of eligible beneficiaries.

(k) Identify ways to expand funding options for the pilot program to include Medicare and other funding sources.

Chronic Care Integration Values – Characteristics of an Integrated Chronic Care System

1) A comprehensive continuum of (a) home and community-based services (HCBS), (b) care delivered in residential and institutional settings, and (c) medical services (e.g., acute, primary, and ancillary).
2) Phase-in plan that reaches full integration in five years.
3) Services that are consumer-responsive and user-friendly.
4) Community standards for service delivery and quality assurance / quality improvement.
5) An emphasis on prevention of unnecessary illness and accidents, deterioration of chronic health conditions, and premature institutionalization.
6) Services are delivered in a manner that is sensitive to clients' linguistic, religious, and cultural backgrounds as well as individual differences and preferences.
7) Appropriate types and amounts of care management for all who truly need it.
8) Cost neutrality after the startup phase.

9) Operations that balance standardization and efficiency with flexibility and personalization.

10) Ability to maintain people in the least restrictive appropriate environment.

11) Establishment of standards for acceptable personal risk.

12) Elimination of duplicative administrative, operational, and reporting requirements.

13) Considers quality of life in addition to, and perhaps more than, quality of care

14) A contracted, integrated provider network that extends far beyond traditional managed care to include community-based services such as personal care, homemaker/chore service, transportation, home-delivered meals, respite care, adult day health, personal emergency response system, home modifications, and residential and institutional services including skilled nursing facility care.

15) Care management structure that integrates medical care with all of the above-listed community-based supportive services, and more.

16) A team approach to individual care, involving professionals, paraprofessionals, front-line care workers, members, and informal caregivers including family members.

17) A mechanism for identifying member needs in all dimensions (physical and psychosocial) and matching the minimal effective "dose" of service to those needs.

18) A mechanism for encouraging consumer choice, involvement in care planning, and direction in arranging for services.

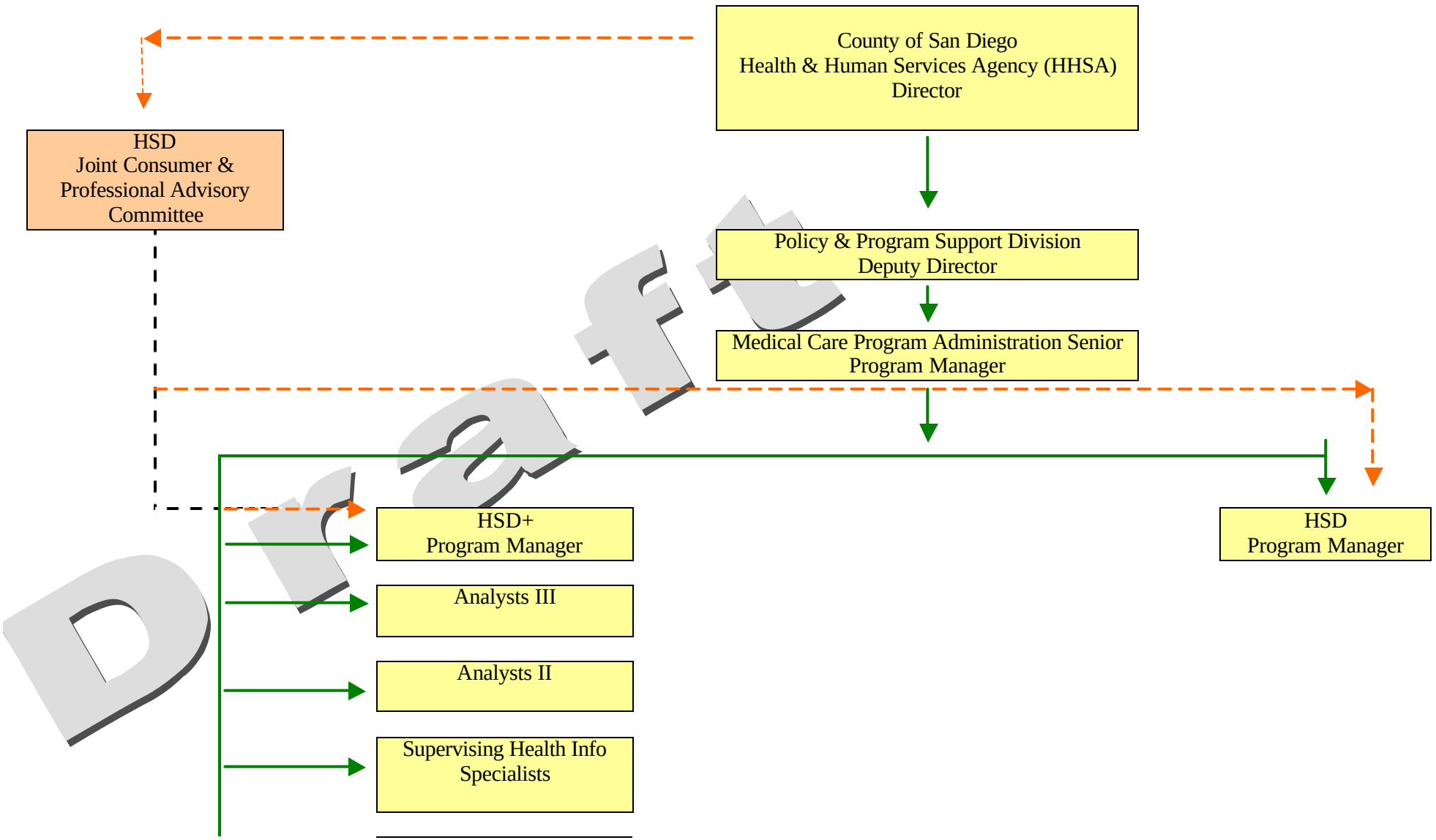
19) Chronic care protocols appropriate for people with multiple chronic conditions as well as more traditional evidence-based, single-condition protocols.

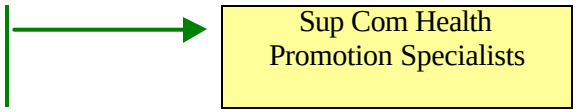
20) A governance system incorporates participation by consumers and consumer advocates and is open to public comment and scrutiny.

21) A system of communication that enables all players to have immediate access to information about the member's condition, care and treatment plan, preferences, and other relevant items. This system will also enable front-line caregivers, such as personal care attendants, to provide input on changes in members' condition.

22) A system of accountability and continuous quality improvement that rewards providers for excellence in meeting the goals of the chronic care model.

Healthy San Diego Plus (HSD+) Organization Chart **Appendix III**





Covered Benefits **Appendix IV**

State plan services.
This table lists the state plan services currently provided by Medi-Cal. The state plan includes certain amounts of each type of service. If the chronic care program wishes to provide more than the normal amounts, you will need to justify to the state how much extra service you wish to provide, to whom, under what circumstances, and also identify a source of funding or savings to provide the extra amounts.
Description of each column.

- *Direct*: Checkmark here if the service will be provided by health plan staff.
- *Network*: Check if service will be contracted to network provider.
- *Ad Hoc*: Check if service will be provided fee-for-service or on an ad hoc basis if needed.
- *Phase:* Provide number of phase in which this service will be integrated.
- *Justify extended state plan service:* Describe changes to the normal state plan service (including how much extra, to whom, under what circumstances it will be provided beyond state plan levels. (You will be required to identify a source of funding or savings to pay for these extended services).

State Plan Services	Direct	Network	Ad Hoc/ FFS	Phase	Justify extended state plan service
Acupuncture		X		All	
Acute care services: medical and psychiatric inpatient, outpatient & ER		X		All	
Adult day health care (ADHC)		X		All	
Audiology		X		All	
Case management			X	All	
Chiropractor		X		All	
Clinic services		X		All	
Dental services		X		All	
Diagnostic services (lab, x-ray, etc.)		X		All	
Durable medical equipment		X		All	
EPSDT & pediatric services		N/A			
Hearing aids		X		All	
Hemodialysis (chronic)		X		All	
Home health agency services		X		All	
Hospice		X		All	
Hospital inpatient transitional care		X		All	
Hospital outpatient services and organized outpatient clinic services		X		All	
Intermediate care facility (ICF)		X		All	
ICF-DD - habilitative		X		Phase III+	
ICF-DD - nursing		X		Phase III+	
Local education agency (LEA) services		X		Phase III+	

Medical and surgical services furnished by a dentist		X		All	
Medical supplies, prescribed		X		All	
Medical transportation - emergency		X		All	
State Plan Services	**Direct**	**Network**	**Ad Hoc/ FFS**	**Phase**	**Justify extended state plan service**
Medical transportation - non-emergency		X		All	
Non-physician medical practitioner (nurse practitioner, etc.)		X		All	
Occupational therapy		X		All	
Optometry services		X		All	
Other Medi-Cal covered outpatient services (e.g. heroin detox)		X		All	
Personal care services		X		All	
Pharmaceutical services		X		All	
Physical therapy		X		All	
Physician services		X		All	
Podiatry		X		All	
Pregnancy related services		X		Phase III+	
Prosthetic & orthotic devices related services		X		All	
Psychiatric & psychological services (limited)		X		All	
Rehabilitative mental health services		X		All	
Rural health clinic services (including FQHC)		X		Phase II+	
Sign language interpreter services		X		All	
Skilled nursing facility (SNF)		X		All	
Special tuberculosis related services		X		All	
Speech therapy services		X		All	
Subacute facility care		X		All	
Substance abuse treatment Services		X		All	
Transitional care nursing facility		X		All	