Applicant Name: Santa Clara Family Health Plan Date: February 20, 2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt. Attachment 6	X	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter) Attachment 1	X	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	X	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	N/A	
4	Applicant has a current Medi-Cal contract with DHCS.	X	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	X	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	X	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.	NO	There have not been any sanctions or penalties
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	X	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	X	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. Attachment 2	X	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	NO	SCFHP does not have a SNP Plan currently. See Medi-Cal HEDIS above.
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	X	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	X	

Signature: _____

Applicant Name: Santa Clara Family Health Plan Date: February 20, 2012

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	X	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement. Attachment 3	X	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	X	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.		
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	X	
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	X	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	X	

Signature: _____

Applicant Name: Santa Clara Family Health Plan Date: February 20, 2012

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	3	2007, 2008, 2009
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	No	
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	X	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	No	SCFHP is working toward NCQA Accreditation
5	Has the Plan received NCQA certification for its D-SNP Product?	No	
6	How long has the Plan had a Medi-Cal contract?	15 years	February 1997
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	Dental, vision, hearing screening/test, delivery of meals and accupuncture
8	Did the Plan submit letters from County officials describing their intent to work together in good faith on the Demonstration Project? From which agencies? Attachment 4	X	
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	The Plan is in talks with IHSS regarding this.
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health? Attachment 5	Yes	
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligibles? Which groups?	Yes	When SCFHP's Medicare contract ended, only one hospital ended its relationship, Regional Medical Center. SCFHP will negotiate a new contract with them for the Demonstration.

Signature: _____

Applicant Name: Santa Clara Family Health Plan Date: February 20, 2012

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
2.2.1	Applicant will develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1, which stipulates the criteria in the RFS.	X	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	X	
5.1	Applicant will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.	X	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	X	
5.3.3	Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review. o A detailed operational plan for beneficiary outreach and communication. o An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. o An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.	X	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	X	
6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	X	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	X	
7.8	Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	X	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	X	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	X	

Signature: _____

Executive Summary

The dual demonstration project is a strategic partnership Santa Clara Family Health Plan (SCFHP) is interested in entering with California State Government and the Federal Government. SCFHP currently serves 136,000 Medi-Cal, Healthy Families, Healthy Kids and Healthy Workers lives in Santa Clara County. Three years ago, SCFHP had a Dual Special Needs Plan. Unfortunately, due to a mistake by our actuaries we were compelled to exit the Medicare Dual Special Needs plan on December 31, 2009.

At the end of SCFHP's contract with Medicare in 2009, enrollment was, 4276 dual eligible members. SCFHP as of February 1, 2012, is managing care for 6,308 dual eligible members. That translates to more than 2,000 additional dual eligibles that have chosen to enroll with SCFHP in the past three years, not being required to enroll and with no marketing efforts on our part. For these dual members, we currently coordinate care, case manage, coordinate claims payment and coordinate services that Medicare does not cover, such as transportation.

We request for this demonstration, our service area be Santa Clara County in its entirety. We estimate, Santa Clara County has 45,000 dual eligibles and we would anticipate that approximately 27,000 of those will enroll with us or be auto-assigned to us from Health Care Options. Since exiting our Medicare contract in 2009, only one provider hospital contract has been cancelled as they would not accept Medi-Cal payment rates. We will re-contract with this provider with a specific Medicare contract and rates, which we believe they will execute. Once that is achieved, we will have all hospitals in the County under contract. SCFHP's vision for this project is to integrate the social, medical and environmental influences a member has in their every day lives and create a holistic single source approach. We envision a true partnership with these organizations to create a fully integrated care model treating their physical and mental needs. We want the member to think of SCFHP as the health plan that will coordinate their community resources. SCFHP already has in place a Memorandum of Understanding (MOU) with United Way 211, which puts members in touch with community resources such as meals on wheels, housing/rent

payment help, legal and immigration services, mental health services and care giver services. We actively promote United Way 211 to our members. There is a link on our website and our partnership is very strong.

SCFHP also has an MOU in place with the Santa Clara County Public Health Department. We currently work together to coordinate services for our members in the following areas: County Mental Health for all benefits/services not carved out, California Children's Services, CHDP (well child exams, testing, reporting), HIV case management and referral, Public Health Department Immunization Branch that SCFHP set up open clinics with in 2011 and hopes to expand the service in 2012, Mother Child Adolescent Health which helps our young mothers receive the prenatal care they need, STD case management and reporting, TB testing and reporting, and Women Infant Children services.

SCFHP has begun our 2012/2013 budget process. In July we are planning to increase our nursing staff to meet the demands of case management and disease management services , and to recruit social

workers to help facilitate the social and environmental needs of the dual elgibles.

One model that SCFHP will explore in depth for this demonstration, is the model we have begun to create with our new CBAS contracts/partnerships. These providers have a unique relationship with the member and have been working with the member in some cases for many years. Our goal is not to take the entire care model (medical, social and environmental care) and implement it ourselves but to work with the current providers who are already administering the care. We will contract with providers such as long term care and mental health, IHSS care givers and others to care manage the members they already serve and report back to us their care management services and we will pay them for this service. This process will help the member and the facility transition to a managed care environment. The key issue behind this relationship will be for SCFHP to be paid appropriately for these services. The most obvious change is in mental health. We contract with the Mental Health Department and we have contracts with community providers. However, if we want to contract with larger

community providers who are currently paid under the Short-Doyle program then we will need to contract and pay at the Short-Doyle rates or at a rate method that is similar. Key to this issue is providers are reimbursed using tobacco tax money and health plans are not. If we are not compensated in an equivalent manner then these facilities and members will be left without a provider, as we will not be able to reimburse providers at the current rates.

Section 1: Program Design

Section 1.1: Program Vision and Goals

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

Santa Clara Family Health Plan (SCFHP) is a fully licensed health care service plan, which began operations in February 1997, as a Medi-Cal Managed Care Plan. It has served Medi-Cal managed care enrollees, including dual eligibles, in Santa Clara County for 15 years. Enrollment in SCFHP has continued to grow with the majority of the Medi-Cal Managed Care members in Santa Clara County selecting SCFHP to be their managed care plan, rather than the commercial plan.

In 2007, SCFHP received a Medicare Advantage contract for an MA-PD Dual-Eligible Special Needs Plan and served approximately 4,300 members. SCFHP voluntary terminated its contract with CMS effective January 1, 2010 and in doing so agreed not to apply for a new contract for a period of two years. Approximately 80% of the dual eligible Medicare Advantage members were also in SCFHP's Medi-Cal plan. SCFHP successfully coordinated benefits for both the Medicare and Medi-Cal population.

DHCS began transitioning specific populations into managed care settings. In 2008, the Agnews Developmental Center institutionalized members were transitioned into Medi-Cal Managed Care and in 2011 Lanterman Regional Center members were also transitioned into Managed Care Plans. In order to better serve these newly transitioned members, SCFHP developed a network of care providers, on-site case management and a pharmacy management plan for this group of members. Also in 2011, Seniors and Persons with Disabilities (SPD) were transitioned into Managed Care and as a result, SCFHP currently manages the care of 9,800 SPD members. SCFHP had been managing

the care of SPDs who had voluntarily enrolled in the Plan prior to June 2011. Managing the care for this population included conducting health risk assessments (HRA) to identify the specialized needs of these beneficiaries, developing care plans using the information from the HRA and care management.

SCFHP also manages three other lines of business, Healthy Families, Healthy Kids and Healthy Workers and is dedicated to improving the health and well-being of the residents of our county. SCFHP will continue to realize its vision of serving new enrollees, consistent with its mission and its core values.

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

SCFHP's mission is to provide high quality, comprehensive health coverage for those Santa Clara County residents who do not have access to, or are not able to purchase health care at an affordable price. The Dual Demonstration Plan allows SCFHP to offer a full range of coordinated medical, behavioral social and long-term care seamlessly to the dual-eligible population. The Demonstration Plan allows for a more

comprehensive integration of care for members than has existed in the past.

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

SCFHP's extensive history and experience in providing care to Medi-Cal beneficiaries, which currently includes serving more than 6,000 dual members, provides a unique opportunity to expand its offering of high quality healthcare services to a larger dual eligible population. SCFHP will leverage this experience to successfully market the Dual Eligible Demonstration to approximately 45,000 potential dual eligible's in the Santa Clara County service area.

Key components of the mission are the commitment to continuous quality improvement, clear communication to prospective and current members, and ardent pursuit of our established goals, many of which parallel those goals and standards promoted by CMS and DHCS.

SCFHP's benefit plans strive to:

- Foster member independence;

- Improve member health status, and improve or delay functional declines;
- Provide members and families with greater flexibility in meeting health and long-term care needs in accordance with medical necessity, their preferences and their circumstances;
- Enhance member satisfaction;
- Reduce Medicare and Medi-Cal expenditures for covered services.

SCFHP will continue to coordinate the benefits and access to care for its members. It will allow members to have one plan to work with for all of the needs, allowing for improved health processes, satisfaction with care, and coordination of care between Medicare and Medi-Cal benefits. As total integration occurs, the care experience will be seamless for beneficiaries and allow them case management that coordinates not only the medical, but also the behavioral, social, and long term care needs of the member. Thus allowing SCFHP to addresses the unique needs of the dual eligible beneficiary by combining benefit design and clinical management programs. The service delivery model enhances primary and preventive care by directly involving the Plan's care management

team with the delivery of Medicare and Medi-Cal benefits in the care of dual eligible members. SCFHP works closely with Medi-Cal service providers and care managers to ensure coordination of care of Plan and Medi-Cal services so that members obtain services they are eligible to receive, regardless of payer. Administrative processes between the Health Plan and Medi-Cal (for example Appeals and Grievances) will also be coordinated and streamlined, whenever possible.

Section 1.2: Comprehensive Program Description

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

Santa Clara Family Health Plan's vision for the Dual Demonstration project is to integrate the social, medical and environmental services a member needs in their every day lives and create a holistic single source approach. We want the member to think of Santa Clara Family Health Plan as their health plan and their community resource for their environmental and social needs. Santa Clara County (our service area)

has approximately 45,000 dual eligibles. Of these 45,000 dual eligibles in the County, we would expect that approximately 27,000 will enroll with us or be auto-assigned to us from Health Care Options. Our goals will be to develop individualized care plans that take into account the different needs of the many populations involved in the RFS and to have the technology throughout the community for all members to have their care plans accessible via the web for any provider the members seeks care from has access.

Santa Clara Family Health Plan will coordinate all the usual Medi-Cal and Medicare covered services. In addition to these services we will include: transportation, meals, physician home visits, in home monitoring, mobile lab, respite care, substance abuse care, care for the developmental disabled and other services that if chosen, we will seek provider community involvement.

SCFHP already has in place a Memorandum of Understanding (MOU) with United Way 211, which puts members in touch with community resources such as meals on wheels, housing/rent payment help, legal and

immigration services, mental health services and care giver services. We actively promote United Way 211 to our members. There is a link on our website and our partnership is very strong.

SCFHP has an MOU in place with the Santa Clara County Public Health Department. We currently work together to coordinate services for our members in the following areas: County Mental Health for all benefits/services not carved out, California Children's Services, CHDP (well child exams, testing, reporting), HIV case management and referral, Public Health Department Immunization Branch which SCFHP set up open clinics with in 2011 and hopes to expand the service 2012, Mother Child Adolescent Health which helps our young mothers receive the prenatal care they need, STD case management and reporting, TB testing and reporting, and Women Infant Children services.

Santa Clara Family Health Plan and On Lok Lifeways, a PACE program, are in discussion to explore sub-contracting for non-PACE services that would benefit Santa Clara County dual beneficiaries. Santa Clara Family Health Plan and On Lok Lifeways will work together

during the planning process to determine how the assessment and referral process for PACE eligible dual beneficiaries who are interested in enrollment in PACE.

PACE is a fully integrated, comprehensive provider of a full continuum of care that includes both medical and long-term supports and services (LTSS) in a seamless, coordinated manner to the dual eligible population meeting the nursing facility level of care. On Lok Lifeways, the national prototype for PACE, has provided PACE services to Santa Clara County residents since 2009 and is committed to PACE expansion throughout the county. PACE's comprehensive, all-inclusive services has been proven effective in keeping high risk individuals out of institutional care and reducing costs while improving the patient's satisfaction with their health care services.

On Lok is committed to participating in Santa Clara Family Health Plan's Dual Demonstration project. Federal statute and regulations require PACE organizations to operate under a three-way agreement between the CMS and the state Medicaid agency to receive capitated

payments from Medicare and Medi-Cal directly from these payor sources. In addition, recent California legislation (SB 208) mandates that PACE is available to eligible beneficiaries as a direct enrollment option and individuals will be informed of this ability to select PACE.

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

The Dual Eligible Demonstration Program covers certain benefits not covered by Medicare. Health plans will receive two monthly premiums: a Medicare Advantage Premium from the Centers for Medicare and Medicaid Services (CMS), and a payment from Medi-Cal. The Dual Eligible program will be a cost-containment mechanism for the Medi-Cal dually eligible population by combining two programs and offering a single seamless benefit program to reduce overall cost of care for a medically complex, high need population. The goal of the combined reimbursement for the dual demonstration is to keep the member in the current setting and offer a single, coordinated and integrated approach to care. We will work with our providers and community resources to

achieve a single "blended rate". For example, if the member has IHSS, goes to CBAS three times a week, is in custodial care or skilled nursing we will develop a provider reimbursement plan that takes into account the medical home of the members choosing. We will develop a reimbursement package for providers to keep members at their current level of care. The basis will be fee-for-service rates; however, in addition we will need to reimburse providers for case management, reporting of members care, transportation, meals, physician home visits, in-home monitoring, mobile lab and respite care. If we do not include these as a bundled service, pay case rates, or consider a new alternative way to pay in discussion with our provider partners then we will not be successful in keeping the members medical, social and environmental needs intact. Therefore, SCFHP will collaborate with it's provider community to develop an integrated care plan that includes capitated and non-capitated medical, LTSS, IHSS and community support services to achieve this integrated model.

1.2.3 Describe how the program is evidence-based.

Santa Clara Family Health Plan's Disease Management programs emphasize prevention of exacerbations and complications by utilizing evidence-based practice guidelines, providing education and coaching on member self-management strategies while supporting the physician's plan of care. The can be accomplished in a variety of ways including telephonic outreach, face to face nurse evaluations with the member and care giver, with all outcomes being reported to the member's providers, PCP and specialists.

Since many members with selected diagnosis for case management often have other co-morbid conditions such as CHF, depression, diabetes and hypertension, dementia, the disease management nurse will address those issues through evidence based care guidelines keeping in mind the social and environmental factors. The members and caregivers will be given education materials and action plans to complete, and may be provided with tools such as scales and weight charts (CHF) and spacers (COPD), to promote self-management.

Santa Clara Family Health Plan employs an evidenced based philosophy in its review and requires contracted providers to adhere to evidence

based criteria through its provider contract and Provider Manual. Santa Clara Family Health Plan's Medical Director maintains open communication and dialogue with contracted providers in the discussion of evidenced based medicine documents and guidelines. Santa Clara Family Health Plan utilizes evidenced based protocols as approved by the Plan's Utilization Management Committee

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

Underserved Health Disparities

Santa Clara Family Health Plan expects that there may be access to care issues, homelessness, chronic physical conditions that have not been treated, lack of public transportation and other publicly funded support systems and other issues that we will need to address to support the quality of care initiatives. This population may also have a higher rate of developmental disabilities or mental illness that we will need to manage in addition to their medical care.

Higher rate of racial and cultural disparity

Santa Clara Family Health Plan ensures that members receive care from all staff and providers that is effective, understandable and respectful in a manner compatible with their cultural health beliefs and practices and preferred languages. A written program and work plan with clear goals, policies, operational plans and management accountability and oversight is included as a component of the Quality Improvement Program Work Plan and Annual Evaluation.

Higher number of co-morbidities

Santa Clara Family Health Plan will review the HRA, medical, behavioral and pharmacy claims data and Health Outcomes Survey (HOS) results to categorize and prioritize the types of health care issues our enrolled members are experiencing and develop quality of care initiatives directly related to our findings. The initiatives will address social, behavioral approaches and other environmental issues important in the successful health care management of these members.

Lower level of education

Santa Clara Family Health Plan will focus on the development of a quality improvement program that encompasses the individual member's level of education, reading level and learning approach in order to optimize their understanding of their plan of care and other programs. An individualized approach to meet each member's unique needs will be included in their plan of care and a driving force with its implementation.

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

The Health Home program enacted under ACA requires that a health plan set up an inter-disciplinary and inter-professional team in order to take care of the "whole person". This "whole person" concept drives to the core of how Santa Clara Family Health Plan views this dual demonstration of treating the medical, social and environmental needs of every member. We envision reporting to the State how we coordinate: medical care, preventative care, mental health, enhanced care management, care coordination between providers, disease management,

family, and community and social support. We will work with the provider community to create individual care plans that are specifically designed for this population and not take a one size fits all approach. These care plans will be on an electronic platform in order for any provider the member seeks out for care to view the member's entire history. Our goal will be to track, trend and report all this data to the State in an electronic format so we can receive the 90% Federal Match Rate.

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

The primary challenge to the dual demonstration project will be the seamless integration of the medical, social and environmental services for the dual eligibles. SCFHP has established relationships with many community providers and will establish inter-disciplinary care teams that involve these providers. These teams will be able to treat the member's full spectrum of needs, with the combined goal to improve utilization patterns, reduce emergency room visits, have fewer hospital and nursing homes admissions and days, and reduce overall medical costs.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

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

SCFHP will draw on its Agnews transition experience, when Agnews' members were transitioned from an Institutional setting to a home setting. The SCFHP Care Managers have experience in the coordination of benefits and facilitation of access to community-based resources and will assist the beneficiaries and their families in the coordination of services and benefits. The care team will work together on problem solving and SCFHP will utilize its experience with the local home and community based service providers in Santa Clara County to obtain the needed services that will keep a member in their home/community for as long as possible.

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

The goal of reimbursement for the LTSS providers is to keep the member in the current setting; shifting focus of care from high-cost

hospitals and nursing homes to cost-effective community- and home-based services.

If the member has IHSS, goes to CBAS three times a week, is in custodial care or skilled nursing we will develop a provider reimbursement plan that takes into account the medical home of the members choosing. If the member currently receives CBAS three times per week paying Medicare rates or Medi-Cal rates for services each insurance covers is not sufficient. It is clear from the example that a new approach needs to be achieved; therefore, we will develop a reimbursement package for providers to keep members at their current level of care.

The basis will be fee-for-service rates, however, in addition, we will need to reimburse providers for case management, reporting of members care, transportation, meals, physician home visits, in home monitoring, mobile lab and respite care. If we do not include these as a bundled service, pay case rates, or consider a new alternative way to pay our provider partners, then we will not be successful in keeping the members medical, social and environmental needs intact. We are in discussions

and working together with the LTSS providers to develop a reimbursement strategy to allow for more cost predictability integrating both the Medicare and Medi-Cal rates to allow for coordination of benefits/services. This will achieve a single, coordinated and integrated approach to care.

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

SCFHP will utilize the Health Risk Assessment (HRA) Screening to identify new enrollees in need of medical care and LTSS. Currently, SCFHP has one HRA tool for this purpose. Each care managed member will be categorized into pre-determined classification levels to assure appropriate interventions in accordance with each member's health care needs. Case classification and reclassification will occur, as new information becomes available, but at least annually. The care manager will formulate interventions according to classification level criteria using the information obtained through the assessment process,

interviews with the member, the member's family, the PCP and/or other providers, and administrative data.

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

SCFHP case management services has more than 14 years' experience working with the local home and community-based service providers in Santa Clara County. SCFHP Medi-Cal members who qualified for Skilled Nursing Facilities, but chose to stay in their home were referred by SCFHP case managers to multiple home and community-based service providers for additional support services. In addition, for the past 14 years, SCFHP has experience working with the local nursing facilities and assisted living facilities. Our contracted Network covers the entire County. SCFHP has established good working relationships with the contracted and most non-contracted facilities. In 2008, SCFHP worked with the Department of Disability Services and the San Andreas Regional Center to transition care of 132 former residents of the Agnews Developmental Center. All members had extremely complex and

medically fragile health conditions. SCFHP successfully built a provider network of medical and behavioral health care for members transitioned to community care homes within Santa Clara County. SCFHP case management continues to support the membership in sixty-one (61) community care homes/group homes to ensure they are adequately cared for in our community. At the end of 2011, SCFHP went beyond the relationship of merely referring members to Adult Day Health Care Centers. SCFHP began meeting with the members/caregivers and Adult Day Health Care Center providers to transition over 250 members that potentially could lose the benefit of these services. SCFHP case management worked with the local PACE program, IHSS, and others to plan for each members's preferences.

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

SCFHP plans to contract with a group/network of providers who specialize in caring for individuals in both institutional and assisted

living settings. With their expertise involved in the care team, there is ability to implement an evidence-based transition of care or diverting of care from the institutional setting. This process will involve complex care coordination across all settings and care team members.

Section 2.2: IHSS

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

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

SCFHP certifies to the intent to develop a contract with the County to administer IHSS services.

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

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

Once year one of the Program is developed and agreed upon, SCFHP will incorporate into its ICT model and use the HRA in developing care plans and include the IHSS worker in our care teams when appropriate and/or as needed. This will include Dementia and Alzheimer's disease assessments.

SCFHP will establish an on-call rotation schedule and publish the number in order to coordinate "emergent" and/or "urgent" requirements for personal attendant coverage.

SCFHP will incentivize the IHSS worker through the agreement carved out in year one and include them in any provider and model of care trainings.

Section 2.3: Social Support Coordination

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

SCFHP certifies that we will provide an operational plan for connecting beneficiaries – our members, to needed and appropriate social supports.

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

As the primary contact and liaison between the member, the Plan and the network of participating and community based providers, the Care Manager will discuss strategies with the member, family/significant other, as appropriate, to produce positive outcomes for the member. All communication with the members' caregivers, family, or significant others will meet SCFHP HIPAA Guidelines.

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

SCFHP will partner with local Aging and Disability Resource Connection and Independent Living Centers. SCFHP will encourage the local agencies and Health Plans to participate in a Health Care Collaborative. The Collaborative will serve as a venue to share best practices as well as serve as an advisory council for some of the beneficiary issues the Health Plans encounter.

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

Again, SCFHP will invite local housing providers, especially senior housing, residential care facilities and assisted living facilities to participate on a Health Care Collaborative. Together with other community agencies, SCFHP will work for a seamless and integrated coordination of services for the Dual Members.

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

3.1 Describe how you will provide seamless and coordinated access to the full array of mental health and substance use benefits covered by Medicare and Medi-Cal, including how you will:
*** Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for substance use.**
*** Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for mental illness.**

SCFHP's care management team has responsibility to screen, identify, and manage mental health and/or substance abuse problems in members, independently or as part of the team.

SCFHP used an HRA as a comprehensive assessment of the member's medical, psychosocial, functional and cognition status. The results of the HRA identifies the needs of the members and enables stratification of identified risk.

Based on the HRA results, those members identified at being possible at risk, undergo a more intensive assessment conducted telephonically. This assessment provides a thorough review of 14 key domains, representing the vast majority of problem areas that most dramatically

impact the quality of life of dual eligible individuals, which include mental health/substance abuse.

Our goals in case management are to reduce unneeded and expensive medical care; and decrease member and family confusion by increasing a member's control of his/her medical care. The focal point of complex care management is the care plan, which details how care should be coordinated across multiple providers, including PCP's, specialists, nurses, social workers, mental health workers, etc. The Case Manager is responsible for developing, executing and modifying the care plan.

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

SCFHP will utilize a dedicated Mental Health Program Director to be the subject expert. This position will not only work internally within the Health Plan to educate the departments on coordination of covered benefits but also oversee the coordination of care for the members. The Program Director will be a liaison between the Community and the Health Plan. Medi-Cal regulations, provider contracts, and member

benefits will be part of the Program Director's responsibility. The position will participate on local committees, educate providers on screening and proper referrals and oversee the regulatory compliance of the Mental Health Program.

The Mental Health Program Director will also assist in growing a mental health network of community based providers. The key challenge with this is that community providers are paid at the Short-Doyle rates or rate methods that are similar. If the health plan is not compensated in an equivalent manner then contracting may be difficult.

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

SCFHP has an established relationship with FQHC's in Santa Clara County. In addition, the Health Plan has been supportive in their efforts to become certified medical homes. Santa Clara County already has mental health services and substance abuse services located at some FQHC's. SCFHP will model the coordination and integration of mental

health services that is currently implemented in FQHC's and broaden the co-location of services to other medical homes.

The Care Management Team, consisting of both clinical and social care managers, work together to coordinate both physical and Mental health care needs utilizing all available benefits, providers and community services required to address the problems identified through the assessment process. The SCFHP network provides available resources and providers to meet the needs and goals including:

- Member compliance in meeting scheduled appointments
- Medication monitoring
- Assistance with pharmacy issues
- Coordination with the social service system including assistance with application for SSI/SSD
- Identification and coordination of community support services which includes subsidized meal service
- Assistance with HRA application for supportive housing
- Transportation assistance
- Crises intervention

- Support to the member and their family members with support group education in understanding their issues.

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

SCFHP encourages the participation of consumers and advocates on the Health Plan's Consumers Advisory Committee. It will also be beneficial for a staff member of the Health Plan to participate on local Mental Health advisory committees. The Health Plan is a partner in this community and Mental Health and other local committee participation is essential in integration.

Section 3.2: County Partnerships

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

SCFHP currently coordinates services for our members with the County Mental Health for all benefits/services not carved out. Dual eligibles with Serious Mental Illness (SMI) continue receiving specialty Medi-Cal mental health services through the county. Counties and health plans enter formal agreements that include incentives for care coordination and performance measures for tracking shared accountability. This agreement could initially focus on a subset of high-cost, high-user beneficiaries for intensive case management.

With continued support from Santa County Mental Health Department, SCFHP will integrate the mental health benefits for Members as seamlessly as possible. With the challenges of different data systems, it will first be critical to begin the process of the systems connections in Year 1 of the Demonstration. As the technical aspects are being worked on, SCFHP will have a staff member/liaison at the SCCMHD to assist the severely affected members and SCCMHD staff. We believe this model of embedding Health Plan staff, in Year 1 of the Demonstration will greatly increase the communication and overall success of members receiving seamless and integrated mental health services.

In addition to Health Plan staff embedded in the day to day operations of SCCMHD, a clinical and technical workgroup will be established in Year 1 of the Demonstration. The clinical workgroup will consist of providers at County Mental Health, Health Plan clinical staff, community advocates, and members/member's representatives. The workgroup will meet to discuss how beneficiaries will be identified for care coordination. SCFHP will seek input for stakeholders on their experiences and establish standard criteria that are acceptable to the majority of stakeholders. The technical workgroup will be an internal workgroup. Both SCFHP and SCCMHD will work together on strategies to overcome barriers to the exchange of vital information. SCFHP is committed to technical and infrastructure resources in the area of informatics.

3.2.2 Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.
*** Describe how you will work with County partners to establish standardized criteria for identifying beneficiaries to target for care coordination.**

*** Describe how you will overcome barriers to exchange information across systems for purposes of care coordination and monitoring.**

For the past fourteen years, SCFHP and Santa Clara County Mental Health Department have participated in an MOU. That MOU outlines our annual plan to provide coordinated services for members with seriously and persistent mental illness and those requiring substance abuse services. The portions of the MOU, such as shared accountability, reporting requirements, care coordination and quality assurances will be a foundation of a contractual agreement by 2015.

Section 4: Person-Centered Care Coordination

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

Navigating both Medicare and Medicaid programs with different program rules and financing incentives is complex for beneficiaries and providers and complicates care coordination. To help mitigate these issues, the Plan's approach focuses on enhanced assessment, increased

member monitoring and care coordination, personalized attention and improved access to expanded primary and preventive services for members.

Santa Clara Family Health Plan has many means of identifying those members most at risk. All members will be assessed upon enrollment, and depending on needs, members will be further assessed using a comprehensive, multi-dimensional tool at least annually to determine their needs and establish a responsive care plan. In addition, data mining, including claims data and service utilization, will be conducted to identify those members who may be at risk. In addition, referrals from physicians, members, caregivers, community agencies, pharmacies and other interested parties are accepted.

Those members identified to be at risk are contacted by phone and if they agree, are given a comprehensive assessment of their physical, mental and social health. Based on the level of care needed, the member is assigned a Case Manager. A care plan is then developed with input from the member, member's primary care physician, other health providers, social support service providers and families to provide a

responsive care plan including intensive primary and preventive services to members.

Santa Clara Family Health Plan provides benefits and services that original Medicare does not cover, such as improved access to primary and preventive care including vision services, dental services and transportation services. The members benefit from a coordinated approach to their care. Given that Medicare and Medicaid have different rules and benefit structures, providing care to the dual member can be confusing for both providers and members. SCFHP will provide:

- Education and information to members and providers as to what benefits the members are eligible for in both programs
- Work with the member to retain Medicaid eligibility
- Coordinate payment of Medicare and Medicaid claims
- Streamline appeals and grievance procedures through education
- Act as an advocate for the member
- Work with the local Medicaid offices and care management professionals to foster the collaborative care approach

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

Please see the Dual eligible Model of Care (MOC).

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

SCFHP currently has a large network of providers that participate in care coordination. Within the Networks at Kaiser and Palo Alto Medical Foundation, there are strong Medical Home models. SCFHP has supported our largest Network, which includes the FQHC's to become certified Medical Homes. All Providers within the Network are currently working towards improved data collection. Individually, Providers work with SCFHP staff in Medical Management, Member Services and Provider Services to coordinate care for their members. During the SPD implementation, SCFHP took the opportunity to train some providers on basic case management. This was well received by providers. In order to outreach to all Network providers we will develop a web based tool in addition to providing on site training. The Contracting Committee will review the potential for incentivizing

providers who actively participate on care teams and care coordination. Monitoring of providers can be accomplished by implementation of medical management data software that will track data by individual provider and individual member. SCFHP will also monitor gaps in care. By identifying gaps in care, SCFHP can call the care team into further action of health related services.

Section 5: Consumer Protections

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

SCFHP certifies it will comply with all consumer protections described in the forthcoming Demonstration proposal and Federal/State MOU.

Section 5.1: Consumer Choice

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

The Dual Eligible beneficiary can select any family, friends and/or professionals to participate fully in any discussions or decisions regarding treatment or services. This includes being an active participant in their care team. Beneficiaries are able to communicate their choices directly to the SCFHP case manager.

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

SCFHP Case Management policy states: "based on the goals of person-centered planning, an on-going problem solving process is established to help beneficiaries plan for the future through identification of barriers and opportunities and establish action steps to create opportunities for increased control over their own lives. The Dual Eligible beneficiary can select any family, friends and/or professionals to participate fully in any discussions or decisions regarding treatment or services. The member will receive all necessary information regarding treatment and services so that they can make an informed choice.

SCFHP's Case Management Program will be a single, coordinated and integrated approach to care using designated case managers. The case managers will work with members, physicians and other providers to assist the member in the coordination of all services. Beneficiaries will be given the choice to accept the care coordination services. If they accept the beneficiary participates as a member of their care team. Case managers, primary providers and specialists are supportive and their role is to assist the coordination of services and benefits of the individual. The beneficiaries and the team will receive all necessary information regarding treatment and services so that they can make an informed choice. The care team works together on problem solving processes and goal setting. If at any time the beneficiary wishes to discontinue case management services they may. They are able to request case management services again at any time as well.

Section 5.2: Access

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

Santa Clara Family Health Plan certifies it will comply with accessibility standards as established by DHCS.

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

Enrolled beneficiaries will continue to have access to Medicare services not included in the Medicare Advantage benefit package from Medicare FFS providers using their red, white and blue Medicare Benefit Card. This will also apply to Medi-Cal covered benefits not included in the Medi-Cal managed care benefit package, by approved Medi-Cal FFS providers using their Medi-Cal Benefit Card.

The SCFHP Care Managers have experience in the coordination of benefits and facilitation of access to community-based resources. The Plan's case management abilities, along with an interfacing claims database allows for identification of potential and real issues in coordination of benefits and early intervention to prevent access to care and service issues for members. For example, Medical Adult and Social

Day Care services could be recommended and coordinated by the care managers for qualified members requiring socialization when covered by FFS Medi-Cal. Referrals to community resources, such as senior centers, and entitlement programs are a major component of the Care Managers activities. In addition, the Case Managers or Community Resource Coordinator will have knowledge of relevant community-based programs, such as Alzheimer's socialization programs and will be able to suggest and help coordinate these services for enrollees.

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

SCFHP will use the Evidence of Coverage (EOC), which will be distributed to all members to inform its enrollees. SCFHP currently distributes a newsletter and places notices on its website and contracted providers are required to distribute plan prepared communications to their patients.

Section 5.3: Education and Outreach

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

SCFHP informs its members about their rights and responsibilities through their enrollment package, welcome call, newsletter, website, and orientation. All members are advised that they can contact the Member Services Department during normal business hours to request interpretation and translation services. Appointments with interpreters can be scheduled for any day/any time; however, 48-hours advance notice is preferred. Translated written materials are available in the Health Plan's threshold languages.

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

All SCFHP members are informed of their member's right to an interpreter, free of charge, and they are discouraged from relying on friends and family members to interpret for them.

SCFHP members have access to interpreter services 24 hours a day, at all points of key contacts. Interpreter services include but are not limited to

- American Sign Language Interpreter
- Telephone interpreter
- Face-to-face interpreter
- Bilingual Health Plan staff, bilingual providers and office staff.

In addition to interpreter services, SCFHP provides member "informing" written materials in the Health Plan's threshold languages. All standard translations receive three tiers of translation and review to ensure cultural and linguistic accuracy. The first tier is the initial translation; the second tier, performed by a different vendor, is proofreading and editing; and the third tier is layout and review by SCFHP staff.

On a monthly basis, SCFHP receives utilization reports from Interpretation and Translation agencies. The reports are analyzed by the cultural and linguistic staff for quality issues and any trends in over and under utilization and to identify additional needs.

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

*** A detailed operational plan for beneficiary outreach and communication.**

SCFHP certifies to comply. During regular business hours, bilingual Member Services Representatives (MSR's) are available to assist members in the Plan's three threshold languages in person or by telephone. A TDD line is available for hearing-impaired members, as well as the California Relay Service is available in Spanish and English. Additionally, MSRs are trained to assist provider offices and members in the scheduling of telephonic or face-to-face interpreter services through the Plan's contracted vendors.

If MSRs do not speak a member's language, contracted telephone interpreter services, available immediately, 24 hours a day, in 120 languages, will be used.

For face-to-face interviews with non-English speaking members, any SCFHP staff member may request face-to-face interpreter services by contacting Member Services to schedule an appointment through the SCFHP contracted interpreter service, or they may utilize the contracted 24-hour telephone interpreter service.

After regular business hours, the Member Services toll-free number provides an "After Hours" message in the Plan's three threshold languages. The message informs the caller of the regular business hours of the Health Plan, and instructs the caller to contact his/her doctor directly in the case of an urgent medical need and/or call the 24-hour nurse advice line (telephone number provided). Callers can also leave a message and are informed that their call will be returned on the next business day.

*** An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.**

SCFHP informs members about the availability of interpreter services at no charge through a welcome call and letter, Evidence of Coverage, member newsletter, and website. Written communication materials are available in the Health Plan's threshold languages and in alternative formats such as Braille, large print, CD, DVD and oral interpretation. Information about interpreter services given to members includes:

- right not to use family subscribers, friends or minors as interpreters

- right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers
- right to receive subscriber materials in the plan's threshold languages
- right to receive subscriber materials in alternative formats (Braille, large print, CD, DVD and oral translations)
- right to file a complaint or grievance if linguistic needs are not met
- An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.

SCFHP informs new direct-contracted providers in an orientation session about the procedures for accessing three types of interpreter services: telephonic, face-to-face and sign language. The provider is also provided with resources for working with interpreters. In the provider networks where interpreter services are delegated, any communication of information to providers concerning these services is also delegated.

SCFHP also informs providers about interpreter services through: the Provider Manual, Provider newsletters, SCFHP website, and other communications. Information about interpreter services given to providers includes:

- The phone numbers, access codes and other required information needed to request interpreter services.
- Instructions on how to document each member's preferred language in the patient chart as well as dated requests for— and refusals of— interpreter services.
- Informing providers that they must not require or suggest that non-English speaking or hearing-impaired members provide their own interpreters unless the member requests it after being informed that he/she has a right to free interpreter services and about the risks of relying on family and friends to interpret.

Section 5.4: Stakeholder Input

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

SCFHP participated in an open forum with Anthem Blue Cross, the other Santa Clara County two-plan model plan, on Tuesday, February 21, 2012. The meeting was held to receive thoughts and comments from community stakeholders regarding the Dual Eligible Demonstration Plan. Some of the stakeholders who attended the meeting included, dual eligible members, caregivers, advocates, long-term support services representatives, and IHSS representatives. The forum allowed for both plans to discuss the goals of the Demonstration and get feedback on the project. It also permitted the Plan's to share how the Demonstration project matches the goals and mission of each plan.

5.4.2 Discuss the stakeholder engagement plan throughout the three-year demonstration

Stakeholder involvement in the three-year demonstration will occur through:

- stakeholder involvement in the Consumer Affairs Committee (CAC),
- joint operations meetings with contracted community-support services,

- provider and member surveys and
- an annual community forum.

5.4.3 Identify and describe the method for meaningfully involving external stakeholders in the development and ongoing operations of the program. Meaningfully means that integrating entities, at a minimum, should develop a process for gathering and incorporating ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

As new products within the current book of business or new groups of people have been moved into Managed Care, SCFHP has assured that a group a representative be placed on the Consumer Affairs Committee (CAC). A recent example of this was with the transition of the SPD population into Managed Care; SCFHP added an SPD member and a United Way representative to the committee to assist in monitoring and problem-solving issues of the SPD membership. The CAC is a standing committee of the Governing Board and is required by Ordinance to have a sufficient number of members to provide community involvement and appropriate representation of the interests of enrolled Plan members. The CAC is responsible for participating in establishing public policy of

the health plan. Two members on the Governing Board are also represented on the committee.

Section 5.5: Enrollment Process

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

SCFHP will request a waiver to allow all of its current dual eligible members to be "passively enrolled into the program, so they won't have to "actively" re-enroll, which will decrease confusion for the beneficiaries, unless they voluntarily "opt-out". DHCS is seeking permission for a six month "lock-in" for beneficiaries initially enrolling into a plan. For all other potential enrollees, it is our understanding that participation in the Medi-Cal Dual Eligible Program and enrollment in a health plan's Dual Eligible Program is voluntary for all eligible persons. SCFHP will actively "market" its program and the benefits to those in the community that are eligible for this program.

To be eligible to enroll in the Program individuals must be:

Full benefit dual eligibles having Medicare Parts A, B, and D coverage, and Medi-Cal coverage for Medicare premiums, co-

insurance, co-payments, and deductibles, as well as additional services that are covered by Medi-Cal that Medicare does not cover (QMB+ individuals, SLMB+ individuals, and other full benefit dual eligibles).

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

Santa Clara Family Health Plan learned the following from the SPD population:

- Data received on the Membership did not represent the entire health status of the SPD member. Some enrollees did not have chronic illnesses, but many had psycho-social issues that would put them at risk for future health concerns.
- Some of the enrollees with data about high risk health concerns were very well connected with family and services.
- Even though many of our Providers continued to see their Medi-Cal FFS members that were now Managed Care members, they (the Providers) were very confused with their role in basic case

management of the member now. Providers needed more information from both Medi-Cal FFS and from Managed Care Plans.

- Our telephonic nurse case management model, needed to be revised. SCFHP looked to the community for the other case managers already involved with the SPD members, and utilized the expertise to coordinate services. For example, the County Mental Health department, the public health nurses at Valley Medical Center, Case Managers at the dialysis centers, etc. Regional Center, IHSS, ADHC, and MSSP Case Managers/workers are essential in the care plan process with the SPD member.
- SCFHP learned that the SPD population not only have physical barriers to accessing care, but have significant cognitive barriers to accessing care. Managed Care protocols can be difficult for everyone. For persons with disabilities, there are challenges that need to addressed, and just not left to see if they will appeal, or request at a later date. SCFHP learned that if a prior authorization request was made, even if it was not a covered benefit, we needed to communicate with the requesting provider, to see if there was something else the

member needed. Often there was another covered benefit, but the member was not able to verbalize it to the Provider, and the Provider did not exactly know the benefit for the Member.

- Social Services resources needed to be reassessed. We learned from the SPD members that we could not case manage their medical care, if they only focused on being evicted from their home. Member Services could not assist them to get to their medical appointments, if they had not fed their children in three days. SCFHP worked with United Way, to get the quickest, most up to date resource tool for every SCFHP staff member desktop. We were trained by United Way staff on how to access the community resources available.
- A good lesson was the implementation of HRA outreach calls upon enrollment to the Health Plan. Not only was this a positive lesson to identify the care needs of the high risk members, but it was also an introduction of our Health Plan to the member. SCFHP has over fifty percent success rate for reaching SPD member by phone. Besides completing the HRA, the Member Services team introduces them selves and takes care of any issues the member may have at the time.

The member can be transferred immediately to a nurse case manager or the pharmacy manager for any clinical issues.

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

SCFHP needs DHCS to confirm plans will be able to "market" to beneficiaries per CMS Medicare Advantage rules and regulations, as opposed to being auto-assigned via "auto generation" to the next plan "up".

Section 5.6: Appeals and Grievances

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

Santa Clara Family Health Plan certifies that it will comply with the appeals and grievance processes for both beneficiaries and providers as outlined in the forthcoming proposal and Federal/State MOU. Santa Clara Family Health Plan has a grievance and appeals process in place now for its membership that follows DHCS/MRMIB/DMHC required

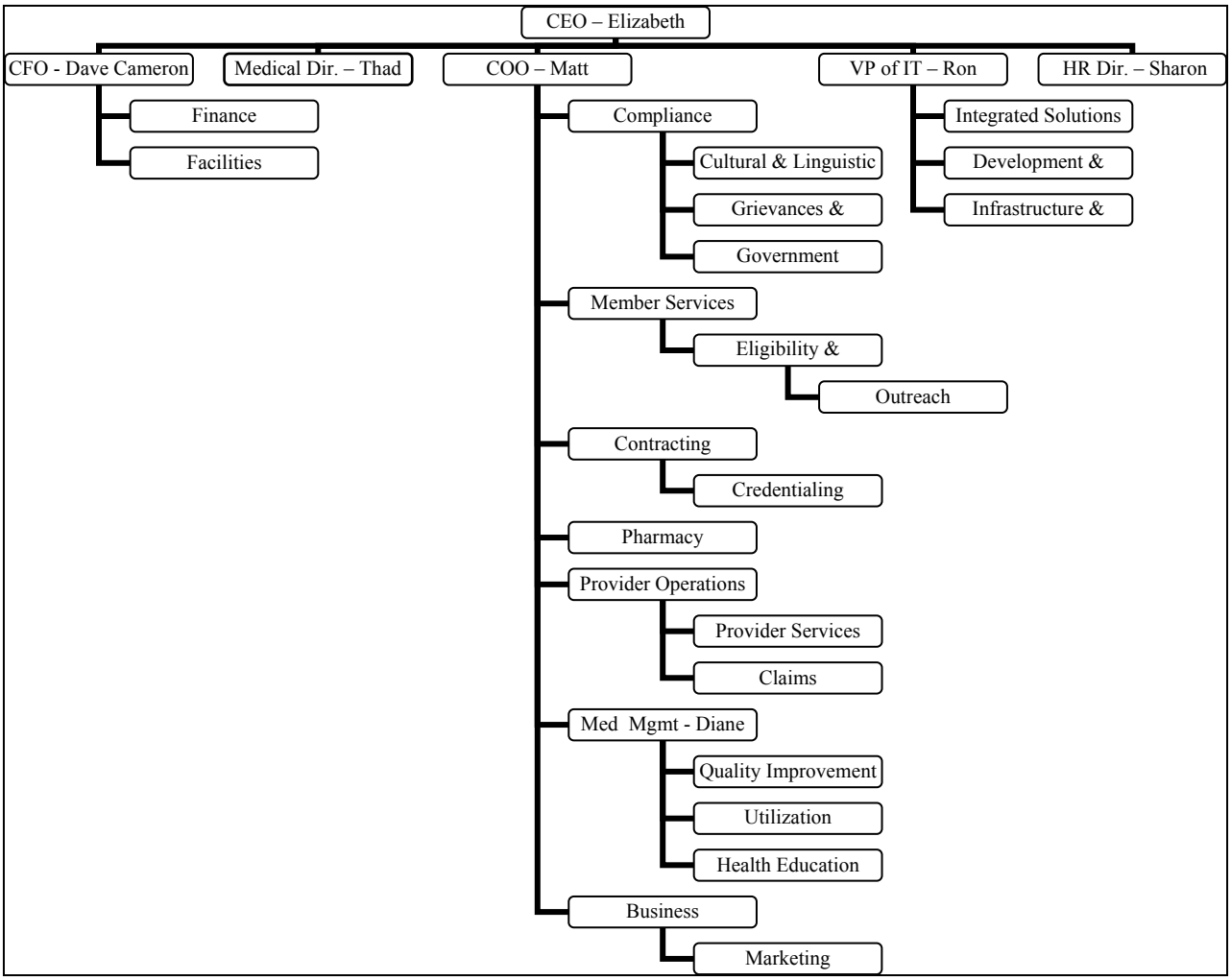
guidelines. SCFHP is also familiar with CMS' grievance and appeals guidelines from when it operated its MA-PD dual SNP.

Section 6: Organizational Capacity

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

The guiding principle of SCFHP is the "Spirit of Care" in all circumstances, irrespective of any changes within the Plan. SCFHP has fifteen years of successful experience with the Medi-Cal Program and extensive experience with managing the comprehensive care needs of the Dual Eligible members and former institutional members transitioned from the Agnews Developmental Center and Lanterman Regional Center. SCFHP's approach to integrating care for Dual Eligibles will build upon and directly connect the Plan's previous and ongoing efforts to integrate care for these members.

6.2 Provide a current organizational chart with names of key leaders. Please also see Attachment #10.



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

Elizabeth Darrow, Chief Executive Officer, has over 15 years of health related experience with an emphasis on Medicare Advantage Dual SNPs Programs. She will monitor the Demonstration to ensure that the goals and objectives are met.

Matt Woodruff, Chief Operations Officer, has over 16 years of health related experience, including Medicare Advantage Dual SNPs Programs. He will be responsible for the oversight of the program and will be involved in all aspects of the planning process.

Dave Cameron, Chief Financial Officer, has over 20 years of financial experience working in the health care industry. He will be responsible for the overall financial management of the Demonstration.

Ron Schmidt, Chief Information Officer, has worked in healthcare for over 25 years. He and his staff will be responsible for receiving data and overseeing the analysis of the Medicare/Medi-Cal data files.

Dr. Narciso Thad Padua, MD., Medical Director, will be responsible for ensuring the availability, quality and delivery of health care services to the Demonstration's members by medical oversight of all mechanisms and activities of Utilization Management, Quality Improvement, Pharmacy, and Health Education.

Diane Brown, RN, Director of Medical Management, has over 24 years experience in health care services, including Medicare Advantage Dual SNPs Programs. She and her staff will be responsible for case management, concurrent review, quality outcomes, health education, utilization management and ensuring the availability, quality, and delivery of these health care services.

6.4 Provide a resume of the Duals Demonstration Project Manager

Matthew Woodruff will be the Dual Demonstration Project Manager. His resume, which includes 16 years of experience in government programs, is included as Attachment # 7

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

SCFHP has the infrastructure to implement, monitor and operate the Demonstration.

The Eligibility, Claims, and IT Departments will serve as a basis for current an ongoing data capacity and analysis.

The Compliance Department will be responsible for ensuring that appropriate staff are knowledgeable of, and comply with, all requirements of the Demonstration and will conduct periodic audits to ensure compliance.

The Medical Services Department will monitor and evaluate the quality and utilization of services using standardized measures. Case Managers will be involved in monitoring and improving care coordination.

SCFHP's Governing Board will review and monitor the financial and operational activities of the Demonstration.

Section 6.2: Operational Plan

6.2.1 Provide a preliminary operational plan that includes a draft work plan showing how it plans to implement in 2013 and ramp up in the first year. Attachment # 8

6.2.2 Provide roles and responsibilities of key partners.

The success of the demonstration plan is dependent upon key partnerships that are established. SCFHP will utilize current partnerships and is in the process of exploring new ones.

Medical Care will be provided building on SCFHP's current provider network of PCPs, Specialists and Hospitals and community resources. SCFHP will expand its network and contract with the one hospital in Santa Clara County that it does not have a contract with as well as add additional PCPs, specialists, and Long Term Care facilities.

Mental Health Care will initially be provided through SCFHP's existing relationship (MOU) with Santa Clara County Mental Health Department (SCCMHD). Over the first year of the Demonstration, SCFHP will build its mental health network through expanding its contracts with community providers.

Medical and Social Support Services (e.g long term support services, transportation, housing, meals, etc.) will be built through the collaborative efforts of SCFHP and agencies that will include: Santa Clara County Public Health Department, San Andreas Regional Center, United Way, Catholic Charities, Community Health Partnership, PACE (On-Lok), Council on Aging. SCFHP has an existing agreement with the United Way and is finalizing agreements with the San Andreas Regional Center, and the Department of Public Health. Letters of

support and interest to collaborate have been received from the Santa Clara County Health and Hospital System, Catholic Charities and Community Health Partnership. SCFHP will continue to evaluate the needs of its membership and pursue other non-traditional contracting relationships as need.

6.2.3 Provide a timeline of major milestones and dates for successfully executing the operational plan

SCFHP has submitted a timeline of major milestones and dates for successfully executing the operational plan as Attachment # 9.

6.2.4 Certify that the applicant will report monthly on the progress made toward implementation of the timeline. These reports will be posted publicly.

SCFHP certifies that it will report monthly on the progress made toward the implementation of the timeline.

Section 7: Network Adequacy

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

SCFHP has a process for formally collecting, analyzing and reviewing the annual assessment of its provider network, which includes the following:

- Medicare- HSD tables for providers based on zip codes will be reviewed and evaluated to determine any potential deficiency
- Medical management reports monthly on out of network services utilized; this helps determine any deficiencies within the provider network
- Quarterly reports to DHCS for providers based on county and service type will be reviewed and evaluated to determine any potential deficiency
- SCFHP uses its credentialing database to collect data in order to assess the size of its network. SCFHP also uses its provider database to determine which PCP panels are open and closed.
- SCFHP will also monitor accessibility and compliance with standards through the following activities:
    - Conducting random telephone audits for appointment scheduling

- Monitoring of member complaints and grievances for problems with appointment scheduling and access during and after office hours

- Analysis of community patterns of care

- SCFHP utilizes GeoNetwork from GeoAccess to perform its network analysis of distance between provider offices and members. GeoNetwork is used to calculate the distance between its members relative to network providers. These distance calculations are combined with provider, member and other data to provide comprehensive and detailed analyses of SCFHP's networks.

SCFHP may also incorporate additional features to assess its network annually, when applicable/available such as:

- Annual review of member satisfaction with questions pertaining to members' perception of choice in selecting personal physician (per CAHPS).

- Monitoring projected membership growth against the current network.

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

SCFHP pays its contracted hospitals a mutually agreed upon per diem amount; contracted providers receive Medicare FFS rates or Medi-Cal FFS rates.

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

SCFHP currently contracts with 99% of the providers within the contracted service area and all but one regional hospital. We will actively seek a contract with the one outstanding hospital once we receive approval of our application to participate in the Dual Eligible Demonstration Program.

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

SCFHP currently serves more than 6,000 dual members that our provider network currently serves. The Provider Relations staff will

orient and service providers using materials that explain the integrated benefits and program. The Provider CSR's will be able to clearly identify members in the SCFHP Demonstration program when assisting providers with inquiries.

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

SCFHP currently serves more than 6,000 dual members that our provider network currently serves. The Provider Relations staff will orient and service providers using materials that explain the integrated benefits and program. The Provider CSR's will be able to clearly identify members in the SCFHP Medicaid Advantage program when assisting providers with inquiries.

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

The Care Management program will be a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates

options and services to meet the individual's health care needs through communication and available resources to promote quality, cost-effective outcomes. The chronically impaired member may access a wide range of services from acute care to social services, mental health, home care or sub-acute care. The Care Management program will integrate these wide-range services and develop a plan and manage the member across settings so that care for needs are assessed independently and an individualized care plan is developed in conjunction with the care manager, member, informal caregiver, PCP and community supports. Some contracts are already in place for the long term services and support providers, however additional contracting will be pursued to provide the benefit. SCFHP's current PBM will continue to operate the pharmacy benefit for this population and is familiar with both Medi-Cal and Medicare requirements.

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

SCFHP certifies that the goal of integrated delivery of benefits for those enrolled beneficiaries will not be weakened by sub-contracted relationships. Due to the strong relationship SCFHP has developed and maintained over the years with its contracted and sub contracted providers, the providers will welcome the integration of benefits and care that will allow their patients to receive most, if not all, of their care from one plan and a familiar network of providers. Thus allowing the providers to streamline their claims submission to one plan and receive payment from one plan.

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

SCFHP certifies that it meets the Medicare standards for medical services and prescription drugs, in addition to the Medi-Cal network standards to meet the needs of the enrollees within the approved service area for SCFHP.

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

SCFHP certifies it meets all Medicare Part D requirements through its contract and partnership with MedImpact. MedImpact will assist in submitting formularies and PDE data when requested.

Section 7.2: Technology

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

SCFHP is implementing a web-based provider portal that allows providers access to their patient's medical and pharmacy history and profiles. All pharmacy, encounter and FFS data will be placed within the portal to develop a comprehensive electronic medical record for each member. The electronic medical record and portal deploy all HIPAA safeguards. A member-specific portal will also be rolled out later this year (2012), so that members also have electronic access to their medical profiles. Protections will be in place for authorized viewing of the information. SCFHP is considering using this portal to incorporate the

members Individual Care Plan to allow provider, Inter-disciplinary Care Team, members/member's family/representative's access to actively use the care plan in the management of the member. This decision will be made following input from those that will participate in the inter-disciplinary care team to allow for the fullest functionality of the ICP.

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

SCFHP utilizes a risk assessment methodology for the SPD population that uses health information provided by the member, medical utilization data and prescription utilization data. We will take this model but change it from telephonic use to face to face Health Risks Assessments for consumers at risk of being put into an institution. Many times these beneficiaries also have care givers. We will involve the care giver and providers in all assessments. For our members that live at home and are high risk, Santa Clara Family Health Plan is planning as a potential benefit, a system that incorporates home monitoring, medication dispensing and telehealth solutions for remote monitoring. We have

started conversations with Philips Home monitoring and we will continue those conversations if we are chosen for this demonstration. The telehealth system will remotely be able to provide improved access and management of chronic conditions such as diabetes, obesity, and hypertension. It also provides improved prevention and access to care, enables responsive real-time services, and increased significant cost savings.

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

The web-based provider and member portal for SCFHP has the ability to send and receive data in HIPAA compliant formats. We already know that our new diabetic glucose and blood pressure monitoring vendor can send the data to our web portal. A member needs to connect to the internet and the modem installed by the vendor will send the data to the SCFHP provider, member portal and to the vendor's portal. We will be able to monitor and report this data.

Section 8: Monitoring and Evaluation

8.1 Describe your organization's capacity for tracking and reporting on:
*** Enrollee satisfaction, self-reported health status, and access to care,**

SCFHP has been asked by our Governing Board to be certified in Member Services Excellence. As part of this process we are currently surveying a random sample of our members who call SCFHP with questions every month. These members are queried on a variety of topics including but not limited to: SCFHP team professionalism and knowledge, access to their providers, and many other questions. Currently, SCFHP tracks and trends provider access and will be reporting timely access in our networks to the State on March 31, 2012. SCFHP uses a telephonic Health Risk Assessment (HRA) tool for new members. This HRA is self-reported information that is put into our system and members are placed into case management depending on how they self report. Within the HRA, there are key questions where the member's answer could trigger immediate Member Services action. In these instances, the member is warm transferred immediately to a case

management nurse who works with the member on their immediate needs and follow up care.

*** Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied)**

As of January 1, 2012, SCFHP is compliant with the HIPAA 5010 format of 837, encounter data file format.

*** Condition-specific quality measures.**

Currently SCFHP tracks specific conditions: High Risk OB, Obesity in Children, Diabetes, Asthma in Children, Hypertension, CHF, COPD, ESRD. All of these measures are being tracked, trended and providers receive necessary information on their members with these disease states. SCFHP Medical Services Department reviews the members on these reports monthly (weekly if inpatient) in order to ascertain if these members are using the services they need and receiving appropriate care.

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

SCFHP has a robust report portal. Currently, we can report beneficiary outcomes by: provider, IPA, or group; ethnicity, race, gender, language preference, disabled (aid code), disease states, and case management.

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

SCFHP certifies it will comply with all DHCS evaluation and monitoring requirements.

Section 9: Budget

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

Currently, Santa Clara Family Health Plan is implementing provider and member web portals. This portal is fully HIPAA compliant and can send and receive HIPAA compliant transactions. We hope to have this portal fully implemented by August 2012. This portal will allow our providers to speak directly to other providers and for our members to have web access to their entire medical history through the portal or on their phone. This will enable providers to treat the member's full

spectrum of needs. Santa Clara Family Health Plan if selected for this demonstration expects to hire case managers, disease management nurses and social workers. This core group's goal will be to keep the member in the level of care they currently receive. Santa Clara Family Health Plan also wants to work with current behavioral health community providers to train our care management team on helping to diagnose the early onset of behavioral health traits and subsequently jointly manage the member's care with the behavioral health provider.

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: 916-445-7401
Email: reuren@dmhc.ca.gov

February 22, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Steven Mihara
Sr. Financial Analyst
Santa Clara Family Health Plan
210 East Hacienda Avenue
Campbell, CA 95008

Re: Letter of Standing – Santa Clara County Health Authority

Dear Mr. Mihara:

On February 21, 2012, you requested a letter regarding Santa Clara County Health Authority's ("SCCHA") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] SCCHA makes this request to satisfy requirements for a Request for Solutions ("RFS") issued by the California Department of Health Care Services, for the Dual Eligibles Demonstration Project.

The Department of Managed Health Care ("DMHC") confirms that, as of today's date, SCCHA is licensed, and permitted to operate in the State of California, as a Knox-Keene health care service plan.

A review of the Enforcement Action Database shows that there are currently zero enforcement actions involving SCCHA. The plan is not currently under supervision, a corrective action plan or special monitoring by the Office of Enforcement. The Office of Enforcement does not comment on past, pending, or anticipated Enforcement actions against any plan that might potentially impact its licensing with the State.

The Division of Financial Oversight ("DFO") has reviewed SCCHA and SCCHA is currently in compliance with the Department's financial solvency requirements, including Tangible Net Equity ("TNE") and financial viability.

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for SCCHA was issued on October 5, 2007. The Routine Medical Survey did not identify any deficiencies. The next Routine Medical Survey is scheduled to begin in February 2014.

[1] California Health and Safety Code Sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at Title 28 California Code of Regulations.

Please contact me with any questions or concerns.

Sincerely,

Richard Euren
Health Program Manager II, Licensing Division
Office of Health Plan Oversight

cc: Kathleen McCarthy, Santa Clara Family Health Plan
Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Kelly Gaspar, Division of Licensing
Evan Lo, Division of Financial Oversight

Measure Rate Count	Measure Code	Measure	LOB	Total Eligibles***	Pos
1	ASM	ASM (ASTHMA)	HK		
		5-9 YEARS OLD	HK		
		10-17 YEARS OLD	HK		
		18-56 YEARS OLD	HK		
2	CAP	COHORT 1 (Ages 12 - 24 months)	HK		
		COHORT 2 (Ages 25 months - 6 yrs)	HK		
		COHORT 3 (Ages 7 - 11 yrs)	HK		
		COHORT 4 (Ages 12 - 18 yrs)	HK		
		All COHORTS	HK		
3	CHL	CHLAMYDIA SCREENING IN WOMEN			
		COHORT 1 (Ages 16-20 yrs)	HK		
4	CWP	APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	HK		
5	IHA	120-DAYS INITIAL HEALTH ASSESSMENT	HK		
6	ADV	ANNUAL DENTAL VISIT			
		Age 2-3	HK		
		Age 4-6	HK		
		Age 7-10	HK		
		Age 11-14	HK		
		Age 15-18	HK		

7	MPT	Mental Health Utilization (ANY MH SERVICES)	HK		

8		Emergency Dept visits per Member Month			
		Age <1			
		Member Months			
		ED Visits			
		Visits/1,000 Member Months			
		Age 1-9			
		Member Months			
		ED Visits			
		Visits/1,000 Member Months			
		Age 10-19			
		Member Months			
		ED Visits			
		Visits/1,000 Member Months			

* Minimum Performance Level
** High Performance Level
*** For MPT, AMB, ORX, IPA and FSP, the numbers recorded in the Total Eligibles column are the hits per 10(

Neg	2010 Final Rate	2009 Final Rate	2008 Final Rate	2007 Final Rate	2006 Final Rate	2005 Final Rate
		100%	93.33%	97.6%	88.4%	57.3%
		100%	85.7%	100.0%	92.9%	60.5%
		100%	100.0%	94.7%	75.0%	55.2%
		NA	N/A	100.0%	100.0%	33.3%
		97.62%	100.00%	96.72%	100.00%	100.00%
		80.00%	86.19%	84.92%	87.51%	84.84%
		82.65%	85.18%	85.48%	85.16%	84.23%
		79.01%	79.18%	79.93%	78.75%	77.78%
		80.40%	82.80%	83.12%	82.41%	81.35%
		46.70%	45.61%	N/A	N/A	N/A
			40.98%	N/A	N/A	N/A
			51.70%	50.11%	45.7%	45.1%
			0%	0%	0.0%	0.0%
		47.34%				
		79.26%				
		82.40%				
		75.18%				
		68.60%				

0		#DIV/0!	1.02	2.15	N/A	N/A

		562				
		15				
		23.09				
		43,916				
		536				
		11.95				
		77,202				
		783				
		8.89				

00 Member Months.

Comment
NCQA changed the medication in numerator in 2009.
NCQA changed the medication in numerator in 2009.
NCQA changed the medication in numerator in 2009.
NCQA changed the medication in numerator in 2009.
New Measure for QI Internal Study in 2009

2011-2010-2009 SANTA CLARA FAMILY HEALTH PLAN (SCFHP) HYBRID HEDIS MEASURE RATES

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
CIS	CHILDHOOD IMMUNIZATION STATUS (COMBO 10)	HF	25.89%	NA	NA
CIS	CHILDHOOD IMMUNIZATION STATUS (COMBO 10)	HK	11.36%	NA	NA
CIS	CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	MC	79.40%	75.78%	75.00%
CIS	CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	HF	74.47%	61.92%	71.15%
CIS	CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	HK	72.73%	53.13%	49.12%
IMA	IMMUNIZATIONS FOR ADOLESCENTS (IMA)	HF	60.42%	NA	NA
	IMMUNIZATIONS FOR ADOLESCENTS (IMA)	HK	66.44%	NA	NA
W15	WELL CHILD VISITS IN THE 1st 15 MONTHS OF LIFE	HF	56.84%	45.05%	46.67%
W15	WELL CHILD VISITS IN THE 1st 15 MONTHS OF LIFE	HK	64.71%	38.46%	43.48%
W34	WELL CHILD VISITS 3-6 YEARS OLD	MC	73.61%	70.78%	73.15%
W34	WELL CHILD VISITS 3-6 YEARS OLD	HF	75.23%	75.06%	76.16%
W34	WELL CHILD VISITS 3-6 YEARS OLD	HK	74.31%	65.75%	75.93%
AWC	ADOLESCENT WELL-CARE VISITS	MC	41.20%	40.95%	42.23%
AWC	ADOLESCENT WELL-CARE VISITS	HF	51.16%	50.00%	47.45%
AWC	ADOLESCENT WELL-CARE VISITS	HK	43.52%	42.47%	42.59%
PPC	PRENATAL AND POSTPARTUM CARE	MC			
PPC	- PRENATAL VISIT	MC	83.56%	84.81%	83.18%
PPC	- POSTPARTUM VISIT	MC	62.73%	65.99%	66.36%
CCS	CERVICAL CANCER SCREENING	MC	74.36%	72.54%	74.41%
LSC	LEAD SCREENING IN CHILDREN	HF	63.48%	69.21%	70.51%
CDC	COMPREHENSIVE DIABETES CARE				
CDC	- HbA1c Testing	MC	84.38%	86.43%	85.66%
CDC	- Poor HbA1c Control (>9.0%)	MC	34.73%	24.43%	38.73%
CDC	- Good HbA1c Control (<8.0%)	MC	56.41%	52.04%	52.14%
CDC	- Eye Exam	MC	51.52%	54.52%	59.03%
CDC	- LDL-C Screening	MC	78.32%	78.96%	78.21%
CDC	- LDL:-C Level <100 mg/dL	MC	51.28%	45.02%	42.09%
CDC	- Medical Attention for Nephropathy	MC	76.22%	79.41%	77.65%
CDC	- Blood Pressure Controlled <130/80 mm Hg (NR)	MC	46.15%	33.94%	35.38%
CDC	- Blood Pressure Controlled <140/90 mm Hg	MC	62.70%	61.31%	61.82%
WCC	Weight Assessment & Counseling Children/Adolescents				
	BMI Percentile	MC	60.88%	44.67%	NA
	Counseling for Nutrition	MC	61.81%	58.50%	NA
	Counseling for Physical Activity	MC	40.05%	33.56%	NA
CDC	COMPREHENSIVE DIABETES CARE				
CDC	- HbA1c Testing	HG	NA	NA	90.14%
CDC	- Poor HbA1c Control (>9.0%)	HG	NA	NA	33.10%
CDC	- Good HbA1c Control (<8.0%)	HG	NA	NA	53.52%
CDC	- Eye Exam	HG	NA	NA	63.15%
CDC	- LDL-C Screening	HG	NA	NA	79.58%

2011-2010-2009 SANTA CLARA FAMILY HEALTH PLAN (SCFHP) HYBRID HEDIS MEASURE RATES

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
CDC	- LDL:-C Level <100 mg/dL	HG	NA	NA	45.07%
CDC	- Medical Attention for Nephropathy	HG	NA	NA	88.50%
CDC	- Blood Pressure Controlled <130/80 mm Hg (NR)	HG	NA	NA	36.38%
CDC	- Blood Pressure Controlled <140/90 mm Hg	HG	NA	NA	60.56%
COL	Colorectal Cancer Screening	HG	NA	NA	43.90%
CBP	Controlling Blood Pressure	HG	NA	NA	51.81%
ABA	Adult BMI Assessment	HG	NA	NA	21.06%
MRP	Medication Reconciliation Post Discharge	HG	NA	NA	28.78%
CMC	Cholesterol Management for Patients with Cardivascular Conditions	HG			
	Numerator 1 - LDL-C Screening	HG	NA	NA	85.00%
	Numerator 2 - LDL-C Level <100mg/dl	HG	NA	NA	45.00%
COA	Care of Older Adults	HG			
	Advance Planning	HG	NA	NA	18.98%
	Rx Review	HG	NA	NA	74.31%
	Functional Status	HG	NA	NA	36.81%
	Pain Screening	HG	NA	NA	71.06%

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
AAB	INAPPROPRIATE TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS (INVERTED RATE)	MC	31.41%	30.43%	25.13%
URI	Appropriate treatment for Children with Upper Respiratory Infection	MC	94.79%	94.55%	92.60%
	Appropriate treatment for Children with Upper Respiratory Infection	HF	91.06%	91.89%	NA
	Appropriate treatment for Children with Upper Respiratory Infection	HK	95.53%	95.86%	NA
ASM	USE OF APPROPRIATE MEDICATION FOR PEOPLE WITH ASTHMA*				
	COHORT 1: Ages 5-11 yrs	HF	93.48%	91.46%	
	COHORT 2: Ages 12-50	HF	94.74%	86.96%	
	Total	HF	93.96%	89.84%	
*Change in age-group reporting for 2010	USE OF APPROPRIATE MEDICATION FOR PEOPLE WITH ASTHMA				
	COHORT 1: Ages 5-11 yrs	HK	96.77%	92.86%	
	COHORT 2: Ages 12-50	HK	95.00%	94.12%	
	Total	HK	96.08%	93.33%	
BCS	BREAST CANCER SCREENING				
	42-69 YEARS OLD COHORT	MC	55.44%	52.18%	55.23%
LBP	USE OF IMAGING STUDIES FOR LOW BACK PAIN (new for 2010)	MC	82.30%	84.13%	NA
CHL	CHLAMYDIA SCREENING IN WOMEN	HF	42.63%	55.91%	51.45%
	CHLAMYDIA SCREENING IN WOMEN	HK	NA	49.40%	46.70%
CWP	APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	HF	23.84%	26.70%	24.22%
		HK	36.42%	45.24%	46.70%
ADV	ANNUAL DENTAL VISITS				
	Age <2	HK		5.56%	NA
	Age 2-3	HK	43.22%	48.46%	47.34%
	Age 4-6	HK	81.22%	82.11%	79.26%
	Age 7- 10	HK	83.74%	84.18%	82.40%
	Age 11-14	HK	78.13%	78.49%	75.18%
	Age 15-18	HK	70.88%	72.06%	68.60%
	Age 19-21	HK	50.00%	68.42%	NA
CAP	CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS				
	12-24 Months	MC	96.68%	91.99%	97.17%
	25 months - 6 years	MC	88.56%	83.01%	86.73%
	7-11 years	MC	89.17%	82.47%	85.87%
	12-19 years	MC	83.41%	75.49%	81.75%
	12-24 Months	HF	99.52%	99.58%	98.73%
	25 months - 6 years	HF	91.18%	87.63%	88.97%
	7-11 years	HF	92.53%	87.20%	91.36%
	12-19 years	HF	87.43%	85.06%	86.83%
				84.96% MRMIB	
	12-24 Months	HK	100.00%	97.92%	97.62%
	25 months - 6 years	HK	86.83%	75.96%	80.00%
	7-11 years	HK	85.94%	81.62%	82.65%
	12-19 years	HK	79.46%	77.39%	79.01%

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
AMB	AMBULATORY CARE (**Per 1000 MM**)			Visits/1000 MM	
	OUTPATIENT VISITS	MC			
	* Cohort 1: Age <1	MC	335.55	268.18	
	* Cohort 2: Ages 1-9	MC	189.34	193.51	
	* Cohort 3: Ages 10-19	MC	140.33	144.25	
	* Cohort 4: Ages 20-44	MC	296.69	283.29	
	* Cohort 5: Ages 45-64	MC	337.64	328.41	
	* Cohort 6: Ages 65-74	MC	232.37	175.3	
	* Cohort 7: Ages 75-84	MC	242.06	166.86	
	* Cohort 8: Ages 85 & Over	MC	242.79	160.42	
	* All age cohorts combined	MC	218.82	212.36	
	EMERGENCY DEPT VISITS:	MC			
	* Cohort 1: Age <1	MC	56.15	36.87	
	* Cohort 2: Ages 1-9	MC	28.20	35.56	
	* Cohort 3: Ages 10-19	MC	18.99	22.52	
	* Cohort 4: Ages 20-44	MC	40.78	43.12	
	* Cohort 5: Ages 45-64	MC	26.40	27.11	
	* Cohort 6: Ages 65-74	MC	8.37	5.96	
	* Cohort 7: Ages 75-84	MC	10.25	6.59	
	* Cohort 8: Ages 85 & Over	MC	10.99	6.9	
	* All age cohorts combined	MC	28.56	31.72	
AMB	AMBULATORY SURGERY PROCEDURES:	MC		Per 1000MM	
	* Cohort 1: Age <1	MC	NA	1.01	
	* Cohort 2: Ages 1-9	MC	NA	2.22	
	* Cohort 3: Ages 10-19	MC	NA	2.99	
	* Cohort 4: Ages 20-44	MC	NA	10.62	
	* Cohort 5: Ages 45-64	MC	NA	15.62	
	* Cohort 6: Ages 65-74	MC	NA	10.47	
	* Cohort 7: Ages 75-84	MC	NA	8.99	
	* Cohort 8: Ages 85 & Over	MC	NA	6.16	
	* All age cohorts combined	MC	NA	5.37	
AMB	OBSERVATION ROOM STAYS:	MC		Per 1000MM	
	* Cohort 1: Age <1	MC	NA	0.02	
	* Cohort 2: Ages 1-9	MC	NA	0.01	
	* Cohort 3: Ages 10-19	MC	NA	0.02	
	* Cohort 4: Ages 20-44	MC	NA	0.13	
	* Cohort 5: Ages 45-64	MC	NA	0.3	
	* Cohort 6: Ages 65-74	MC	NA	0.08	
	* Cohort 7: Ages 75-84	MC	NA	0.05	
	* Cohort 8: Ages 85 & Over	MC	NA	0	
	* All age cohorts combined	MC	NA	0.06	
AMB	OUTPATIENT VISITS	HF			
	* Cohort 1: Age <1	HF	578.86	378.53	
	* Cohort 2: Ages 1-9	HF	210.82	200	
	* Cohort 3: Ages 10-19	HF	136.14	141.25	
	* All age cohorts combined	HF	175.57	173.70	
	EMERGENCY DEPT VISITS:	HF			
	* Cohort 1: Age <1	HF	39.22	15.41	
	* Cohort 2: Ages 1-9	HF	15.16	17.40	
	* Cohort 3: Ages 10-19	HF	9.01	11.53	
	* All age cohorts combined	HF	12.22	14.57	

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
AMB	AMBULATORY SURGERY PROCEDURES:	HF		Per 1000MM	
	* Cohort 1: Age <1	HF		1.54	
	* Cohort 2: Ages 1-9	HF		1.68	
	* Cohort 3: Ages 10-19	HF		1.69	
	* All age cohorts combined	HF		1.65	
	OBSERVATION ROOM STAYS:	HF		Per 1000MM	
	* Cohort 1: Age <1	HF		0.00	
	* Cohort 2: Ages 1-9	HF		0.01	
	* Cohort 3: Ages 10-19	HF		0.00	
	* All age cohorts combined	HF		0.01	
AMB	OUTPATIENT VISITS	HK			
	* Cohort 1: Age <1	HK	477.19	287.50	
	* Cohort 2: Ages 1-9	HK	123.57	149.56	
	* Cohort 3: Ages 10-19	HK	70.18	93.75	
	* All age cohorts combined	HK	86.72	112.69	
	EMERGENCY DEPT VISITS:	HK			
	* Cohort 1: Age <1	HK	14.04	8.33	
	* Cohort 2: Ages 1-9	HK	12.18	13.24	
	* Cohort 3: Ages 10-19	HK	8.17	8.26	
	* All age cohorts combined	HK	9.33	9.88	
AMB	AMBULATORY SURGERY PROCEDURES:	HK		Per 1000MM	
	* Cohort 1: Age <1	HK		2.08	
	* Cohort 2: Ages 1-9	HK		1.25	
	* Cohort 3: Ages 10-19	HK		0.71	
	* All age cohorts combined	HK		0.89	
	OBSERVATION ROOM STAYS:	HK		Per 1000MM	
	* Cohort 1: Age <1	HK		0.00	
	* Cohort 2: Ages 1-9	HK		0.00	
	* Cohort 3: Ages 10-19	HK		0.00	
	* All age cohorts combined	HK		0.00	
GSO	Glaucoma Screening in Older Adults	HG	NA	NA	39.83%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	HG	NA	NA	NA*
PCE	Pharmacotherapy Management of COPD Exacerbation	HG			
	Systemic Corticosteroid	HG	NA	NA	63.33%
	Bronchodilator	HG	NA	NA	70.00%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	HG	NA	NA	NA*
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	HG	NA	NA	NA*
OMW	Osteoporosis Management in Women Who Had a Fracture	HG	NA	NA	NA*
AMM	Antidepressant Medication Management	HG			
	Effective Acute Phase Treatment	HG	NA	NA	NA*
	Effective Continuation Phase Treatment	HG	NA	NA	NA*
FUH	Follow-Up After Hospitalization for Mental Illness	HG			
	30-Day Follow-Up	HG	NA	NA	NA*

Measure Code	Measure	LOB	2011 Rate	2010 Rate	2009 Rate
	7-Day Follow-Up	HG	NA	NA	NA*
MPM	Annual Monitoring for Patients on Persistent Medications	HG			
	ACE Inhibitors or ARBs	HG	NA	NA	72.75%
	Digoxin	HG	NA	NA	NA*
	Diuretics	HG	NA	NA	72.76%
	Anticonvulsants	HG	NA	NA	18.46%
	Total	HG	NA	NA	67.63%
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly	HG			
	Falls + Tricyclic Antidepressants or Antipsychotics	HG	NA	NA	NA*
	Dementia + Tricyclic Antidepressants or Anticholinergic Agents	HG	NA	NA	NA*
	Chronic Renal Failure +Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	HG	NA	NA	NA*
	Total	HG	NA	NA	NA*
DAE	Use of High-Risk Medications in the Elderly	HG			
	One Prescription	HG	NA	NA	30.42%
	At Least Two Prescriptions	HG	NA	NA	10.05%
AAP	Adults' Access to Preventive/Ambulatory Health Services	HG			
	20-44 Years	HG	NA	NA	88.21%
	45-64 Years	HG	NA	NA	95.86%
	65+ Years	HG	NA	NA	95.45%
LET	Initiation and Engagement of AOD Dependence Treatment	HG			
	Initiation of AOD Treatment: 13-17 Years	HG	NA	NA	NA*
	Engagement of AOD Treatment: 13-17 Years	HG	NA	NA	NA*
	Initiation of AOD Treatment: 18+ Years	HG	NA	NA	28.77%
	Engagement of AOD Treatment: 18+ Years	HG	NA	NA	0.00%
	Initiation of AOD Treatment: Total	HG	NA		28.77%
	Engagement of AOD Treatment: Total	HG	NA	NA	0.00%
CAT	Call Answer Timeliness	HG	NA	NA	49.05%
CAB	Call Abandonment	HG	NA	NA	14.86%
	NA* = Denominator fewer than 30				

Measure	LOB	MC MPL HF Ave	2010 Final Rate	2009 RATE
PRENATAL AND POSTPARTUM CARE				
- PRENATAL VISIT	MC	78.5%	**84.8%**	**83.2%**
- POSTPARTUM VISIT	MC	57.9%	**66.0%**	**66.4%**
CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	MC	62.4%	**75.8%**	75.0%
CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	HF	**77.7%**	**61.9%**	71.2%
CHILDHOOD IMMUNIZATION STATUS (COMBO 3)	HK		**53.1%**	49.1%
Six WELL CHILD VISITS IN THE 1st 15 MONTHS OF LIFE	HF	**58.1%**	**45.1%**	46.7%
Six WELL CHILD VISITS IN THE 1st 15 MONTHS OF LIFE	HK		**38.5%**	43.5%
WELL CHILD VISITS 3-6 YEARS OLD	MC	80.3%	**70.8%**	73.2%
WELL CHILD VISITS 3-6 YEARS OLD	HF	**76.8%**	**75.1%**	76.2%
WELL CHILD VISITS 3-6 YEARS OLD	HK		**65.8%**	75.9%
LEAD SCREENING IN CHILDREN	HF	**61.7%**	**69.2%**	70.5%
Weight Assessment & Counseling Children/Adolescents				
BMI Percentile	MC		**44.7%**	
Counseling for Nutrition	MC		**58.5%**	
Counseling for Physical Activity	MC		**33.6%**	

2008 RATE	2007 RATE
84.4%	**79.9%**
61.9%	**58.3%**
78.5%	79.6%
78.9%	79.4%
59.3%	54.6%
56.8%	42.6%
70.0%	42.9%
73.2%	73.8%
75.2%	78.7%
73.8%	68.1%

Measure Code	Measure	LOB	Sample Size	Admin Positives	Review Positives	Combined Positives

2010 Final Rate	MMCD 2010 Required MPL	MMCD 2010 Required HPL**	2009 RATE	2008 RATE	2007 RATE	2006 RATE	2005 RATE

Catholic Charities
of Santa Clara County

Behavioral Health Services
210 N. Fourth Street, Suite 100
San Jose, CA 95112-5569
Tel: 408.295.5288
Fax: 408.292.0295
www.catholiccharitiesscc.org

February 22, 2012

Mr. Brian Quacchia and Mr. Steve Sodergren
Department of Health Care Services
Office of Medi-Cal Procurement
MS 4200
1501 Capitol Avenue, Suite 71.3041
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Quacchia and Mr. Sodergren:

Catholic Charities of Santa Clara County is a CARF-accredited, behavioral health provider that is a subcontractor for Santa Clara County Mental Health Department to provide behavioral health services to dual eligible Medi-Cal beneficiaries in this county. We understand that the Office of Medi-Cal Procurement is soliciting health care providers for the dual eligible project and that Santa Clara Family Health Plan (SCFHP) is an applicant. As a county mental health provider for services to dual eligibles, we support the application of SCFHP for providing services to the target population.

We have been a contract behavioral health provider with the SCFHP since it's inception in Santa Clara County. Our working relationship on behalf of the non-SED children who need our services has been a good partnership. The plan providers and Quality Improvement staff are responsive to requests for additional service when we can demonstrate that the individual child and his/her family need more help. Our current relationship with the Plan regarding the FIRST FIVE children has been beneficial for clients, us and the Plan. As cooperative partners, we agreed at the time to be part of the Medicare Advantage plan when SCFHP was working on that service model.

As a local provider serving older adults and disabled persons in need of behavioral and physical health care, we support the efforts of the applicant organization to establish care services that are person-centered in order to help the beneficiaries achieve important health care goals.

Sincerely,

Katherine M. Mason, MSW
Director, Behavioral Health Services

SAN ANDREAS REGIONAL CENTER

SANTA CLARA COUNTY

300 Orchard City Drive
Suite 170
Campbell, CA 95008

P.O. Box 50002
San Jose, CA
95150-0002
Tel: 1(408) 374-9960
Fax: 1(408) 376-0586

SOUTH SANTA CLARA AND SAN BENITO COUNTY

7855 Wren Avenue
Suite A
Gilroy, CA 95020
Tel: 1(408) 846-8805
Fax: 1(408) 846-5140

MONTEREY COUNTY

344 Salinas Street
Suite 207
Salinas, CA 93901
Tel: 1(831) 759-7500
Fax: 1(831) 424-3007

SANTA CRUZ COUNTY

1110 Main Street
Suite 8
Watsonville, CA 95076
Tel: 1(831) 728-1781
Toll Free
within Santa Cruz County
1(831) 688-7633
Fax: 1(831) 728-5514

www.sarc.org

Member of the Association of Regional Center Agencies

February 21, 2012

Department of Health Care Services
Office of Medi-Cal Procurement

To Whom It May Concern:

It is our pleasure to write a letter of support for Santa Clara Family Health Plan's (SCFHP) application to become a Dual Eligible Demonstration Plan in Santa Clara County.

San Andreas Regional Center's mission is to provide service, advocacy, respect and choice for individuals with developmental disabilities. As defined by the Lanterman Act and based on an individual's needs and generic resources, we provide a variety of consumer services which include adult work services, behavior intervention services, early intervention, living skills training, in-home skilled nursing services, respite care, supported living arrangements, and therapeutic services. Santa Clara Family Health Plan is very familiar with these same needs for their vulnerable population. We work closely and collaboratively with them and their Medi-Cal population.

In conclusion, we fully support the efforts of Santa Clara Family Health Plan to integrate the medical and social needs of their members. They recognize the importance of their members having access to valuable community resources. With this much-anticipated Dual Eligible Demonstration program being developed, it will allow SCFHP to serve many more of those not currently able to participate in one of their great plans. SCFHP not only understands the importance of this program to their members and others, but they have ability to integrate care in a seam-less manner by integrating the benefits from both Medicare and Medi-Cal. The San Andreas Regional Center looks forward to continuing its work with Santa Clara Family Health Plan.

Sincerely,

Debora A Salazar

Debora A. Salazar RN, BSN, MA
Health Services Coordinator
San Andreas Regional Center

COMMUNITY HEALTH PARTNERSHIP

February 23, 2012

Department of Health Care Services
Office of Medi-Cal Procurement

To Whom It May Concern:

It is my pleasure to support Santa Clara Family Health Plan's (SCFHP) application to become a Dual Eligible Demonstration Plan in Santa Clara County.

The Community Health Partnership (CHP) has had a productive working relationship with SCFHP for many years and this application signifies one more opportunity to jointly embrace 2014! The Community Health Partnership is a member organization that represents our local community health centers and clinics throughout the county. Our mission is to assure access to healthcare for all in Santa Clara County, including seniors and those with Special Needs.

Now, more than ever, identifying critical needs and aligning resources to achieve the best solutions is important. Services for seniors includes information and assistance, health insurance counseling and advocacy program, meals, legal advice and representation for housing, care management for those without assistance, "care call" in case of falls, and a senior employment program. Santa Clara Family Health Plan is also very familiar with the need to integrate the medical and social needs of their vulnerable population.

In conclusion, we fully support the efforts of Santa Clara Family Health Plan. They recognize the importance of their members (our patients) having access to valuable community resources. With this much-anticipated Dual Eligible Demonstration program being developed, it will allow SCFHP to serve many more of those not currently able to participate in one of their great plans. SCFHP not only understands the importance of this program to their members and others, but they have ability to integrate care in a seamless manner by integrating the benefits from both Medicare and Medi-Cal.

On behalf of our Board of Directors of The Community Health Partnership, I look forward to working more closely with Santa Clara Family Health Plan with this new integrated program. Please feel free to contact me directly for more information at (408) 579-6000 or Dolores@chpscc.org.

Sincerely,

Dolores Alvarado, CEO
Community Health Partnership

Asian Americans for Community Involvement • Foothill Health Center • Gardner Family Health Network
Indian Health Center of Santa Clara Valley • Mar Monte Community Clinic MayView Community Health Centers
North East Medical Services • Planned Parenthood Mar Monte • Ravenswood Family Health Center • RotaCare Bay Area, Inc.
School Health Clinics of Santa Clara County • Santa Clara Valley Health & Hospital System
COMMUNITY HEALTH PARTNERSHIP, INC., *a consortium of community health centers*
100 N. Winchester Blvd., Suite 250, Santa Clara, CA 95050
www.chpscc.org • thepartnership@chpscc.org • Phone (408) 556-6605 • Fax (408) 556-6617

MARINER
Health Care

February 24, 2012

Department of Health Care Services

Office of Medi-Cal Procurement

To Whom It May Concern:

It is our pleasure to write a letter of support for Santa Clara Family Health Plan's (SCFHP) application to become a Dual Eligible Demonstration Plan in Santa Clara County.

Mariner Health Care's mission is to provide compassionate and comprehensive care in a pleasant and comfortable environment. We have a network of 18 skilled nursing facilities in southern and northern California. We offer 24 hour care for short term rehabilitation services to quality long term restorative nursing care. With the concern of the quality of life for each of our residents, we support them with nursing care, social workers, rehabilitation services, nutritional services, activities, and long term supportive care. Santa Clara Family Health Plan is very familiar with the needs for their frail and elderly population. We work closely with them and their Medi-Cal population.

At Mariner Health Care, we fully support the efforts of Santa Clara Family Health Plan to integrate the medical and social needs of their members. They recognize the importance of their members having access to valuable community resources. With this much-anticipated Dual Eligible Demonstration program being developed, it will allow SCFHP to serve many more of those not currently able to participate in one of their great plans. SCFHP not only understands the importance of this program to their members and others, but they have ability to integrate care in a seam-less manner by integrating the benefits from both Medicare and Medi-Cal.

Sincerely,

Don Patterson
Director of Business Development
Mariner Healthcare

February 23, 2012

To Whom It May Concern:

It is my pleasure to write a letter of support for Santa Clara Family Health Plan's (SCFHP) application to become a Dual Eligible Demonstration Plan in Santa Clara County.

I fully support the efforts of Santa Clara Family Health Plan to integrate the medical and social needs of their members. They recognize the importance of their members having access to both medical and valuable community resources. With this much anticipated Dual Eligible Demonstration program, it will allow SCFHP to serve many more of those individuals not currently able to participate in one of their great plans. SCFHP not only understands the importance of this program to their members and others, but they have the ability and experience to integrate care in a seamless manner by integrating the benefits from both Medicare and Medi-Cal. I look forward to continuing my association with Santa Clara Family Health Plan in this important endeavor.

Sincerely,

Daljeet Rai, M.D.
General Family Practitioner

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Santa Clara Valley Health & Hospital System
Administration
2325 Enborg Lane, Suite 220
San Jose, California 95128
Phone: (408) 885-4030
Fax: (408) 885-4051

February 22, 2012

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

Dear Friends,

On behalf of the County of Santa Clara I am writing this letter of support for Santa Clara Family Health Plan's (SCFHP) application to become a Dual Eligible Demonstration Plan in Santa Clara County.

In 2010, Santa Clara County had nearly 200,000 residents aged 65 and older and nearly 160,000 residents earning less than the federal poverty level. The County's aged population is growing and with increasing numbers of people impacted by the economic downturn, the population of Dual Eligible residents is likely to increase. The County, through the Santa Clara Valley Health & Hospital System (SCVHHS) and Social Services Department operates as the safety net provider for medical, mental, social and support services. In 2010, SCVHHS alone provided care to more than 85,000 patients covered by Medi-Cal and almost 20,000 covered by Medicare. The Dual Eligible population receives a significant portion of its care through the County's Health & Hospital System; thus, the interest to continue being a provider for this population.

Going forward, it is the intention of the SCVHHS to participate in the Dual Eligible Demonstration. The County is interested in exploring relationships to provide integrated, high quality care to our In-Home Support Services population. We look forward to collaborating further with SCFHP and finding solutions that do not increase County costs. Identifying critical needs and aligning resources to achieve the best solutions is important. We believe it is possible to develop good solutions for the Dual Eligible population with SCFHP as we previously collaborated on the Medicare Advantage Special Needs Plan.

In conclusion, we support SCFHP's application to become a Dual Eligible Demonstration Plan. The County of Santa Clara looks forward to working with SCFHP on this new integrated program.

Sincerely,

René G. Santiago
Deputy County Executive & Director, SCVHHS

MASTER AGREEMENT
BETWEEN
SANTA CLARA SCCMHD HEALTH AUTHORITY, dba,
SANTA CLARA FAMILY HEALTH PLAN
AND
SANTA CLARA COUNTY MENTAL HEALTH DEPARTMENT

MEDI-CAL MENTAL HEALTH SERVICES

THIS MASTER AGREEMENT (hereinafter referred to as the "Agreement") is entered into by SANTA CLARA COUNTY HEALTH AUTHORITY, dba SANTA CLARA FAMILY HEALTH PLAN ("SCFHP"), a public agency, and the SANTA CLARA COUNTY MENTAL HEALTH DEPARTMENT ("SCCMHD")

RECITALS

WHEREAS, SCFHP is a licensed health care service plan, which contracts with the State Department of Health Care Services ("DHCS") to provide covered health care services to Medi-Cal beneficiaries who enroll in, or are assigned to, SCFHP.

WHEREAS, the SCCMHD provides mental health services to Medi-Cal enrollees with physicians and counselors who are duly licensed by the State of California to practice medicine and counseling services and provide access to mental health services at offices located throughout Santa Clara County.

WHEREAS, under contracts between DHCS and the SCCMHD, the SCCMHD is a designated provider of Carve-Out Mental Health Services provided to SCFHP Medi-Cal Members; SCFHP and the SCCMHD agree to cooperate with each other and enter into Memoranda of Understanding (MOUs) to coordinate care and facilitate the exchange of medical records and other personally identifiable information about SCFHP Medi-Cal Members receiving Carve-Out Mental Health Services from the SCCMHD.

NOW THEREFORE, in consideration of the premises set forth above, and the mutual agreements contained herein, and in exchange for other valuable consideration, the receipt and adequacy of which is hereby acknowledged, SCFHP and the SCCMHD agree as follows:

SECTION 1 – DEFINITIONS

The following terms, as used in this Agreement, have the meanings set forth below:

1.1 "Carve-Out Service" means a health care service which an SCFHP Member is entitled to receive under the Medi-Cal Program, but which SCFHP is not responsible to provide or arrange and pay for. Rather, DHCS has contracted directly with the SCCMHD, to provide these Carve-Out Services, and DHCS pays the SCCMHD directly for providing these services to their respective beneficiaries. Carve-Out Services are therefore services for which special arrangements must be made, through this Master Agreement, for the exchange of health care information among the Plan, the SCCMHD and the Member's Primary Care Physician (PCP), to ensure coordination of care. Carve out services that DHCS has contracted with the SCCMHD to provide to Medi-Cal Members include Inpatient and Outpatient Mental Health Services.

1.2 "Covered Entity" or "CE" has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

1.3 "Covered Services" means those medical or ancillary health services that: are considered covered benefits under SCFHP's contract with DHCS; are included in the premium that DHCS pays SCFHP; and that are SCFHP's obligation to arrange and pay for under that DHCS contract.

1.4 "Data Aggregation" has the meaning given to such term under the Privacy Rule including, but not limited to, 45 CFR Section 164.501.

1.5 "Designated Record Set" has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

1.6 "Health Care Operations" has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

1.7 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as may from time to time be amended.

1.8 "Member" means a Medi-Cal beneficiary who has selected SCFHP as his or her prepaid health plan under the State's Two Plan Model Medi-Cal managed care program and who is entitled to receive Carve-Out Services from the SCCMHD.

1.9 "PHI" or "Protected Health Information" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual, or to which there is a reasonable basis to believe the

information can be used to identify the individual, and has the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

1.10 "Privacy Rule" means the HIPAA Regulation that is codified at 45 CFR Parts 160 and 164.

SECTION 2 - RELATIONSHIP OF PARTIES

2.1 Basic Relationship

SCFHP and SCCMHD are separate and independent entities. The relationship between SCFHP and SCCMHD is purely contractual. Neither SCFHP nor SCCMHD, nor the employees, servants, agents or representatives of either are considered the employee, servant, agent or representative of the other. As independent contracting parties, SCFHP and SCCMHD maintain separate and independent management, and each has full, unrestricted authority and responsibility regarding its organization and structure. The SCCMHD and its officials, employees and agents are not responsible for the obligations of SCFHP. The parties to this Agreement do not intend to, nor do they have the power to, confer on any person or entity any rights or remedies against the SCCMHD or any officials, employees or agents of the SCCMHD.

2.2 Assignment and Delegation

This Agreement is one for the personal services of SCCMHD and may not be assigned by SCCMHD. Any attempt by SCCMHD to assign this Agreement without the prior written consent of SCFHP is void. By executing this Agreement, SCFHP is hereby consenting to any delegation expressly provided for under this Agreement. SCCMHD is responsible for assuring performance by its contractors or subcontractors and a breach or default by a contractor or subcontractor may be treated by SCFHP as a breach or default by SCCMHD for purposes of the Termination and Default Section or the Sanctions Section hereof.

2.3 Regulatory Compliance

a. SCFHP and SCCMHD agree, and SCCMHD must require its subcontractors to agree, that each must comply with all applicable requirements of municipal, county, state and federal authorities, all applicable municipal and county ordinances and regulations, and all applicable state and federal statutes and regulations now or hereafter in force and effect to the extent that they directly or indirectly bear upon the subject matters of this Agreement. These include, without limitation of the foregoing, applicable requirements under the Knox Keene Act, Medi-Cal law, and any state fair employment practices or similar laws declaring discrimination in employment based upon race, color, creed, religion, sex, sexual preference or national origin as illegal and, if applicable.

b. SCCMHD agrees, and will require its contractors to agree, that they will not employ, contract with or retain an existing employment or contractual relationship with anyone who is excluded from participation in any federal program, including but not limited to exclusion under Section 1128 or 1128A of the Social Security Act.

c. Any provision required by law to be in this Agreement is binding on the parties as if set forth herein in full. The parties may amend the Agreement to expressly include that provision, within a reasonable period of time after the omission or change in law is discovered. If the provision materially affects the obligations of either party, the parties agree to negotiate in good faith to reach agreement on a change in duties or payment rates, accordingly.

SECTION 3 - DUTIES OF THE PARTIES

3.1 MOU; Rights and Duties of Each Party under the MOU

(a) The rights and duties of each party with respect to the sharing of PHI relating to Carve-Out Mental Health Services are set forth in the Memoranda of Understanding that are attached as Exhibit 1 of this Agreement.

(b) Any reference to this Agreement is hereinafter deemed to include the MOU, unless otherwise expressly indicated.

3.2 Nature of this Agreement

This Agreement, and the MOU attached hereto, are contracts for administrative services, not for health care services. This Agreement is not intended, nor should it be construed, to be a provider services agreement. Nor is it intended, nor should it be construed to amend, modify or supersede the terms of SCFHP's Provider Service Agreement with Valley Health Plan (VHP) or any provider services subcontract between the County and any SCFHP capitated provider, including VHP.

SECTION 4 – TERM AND TERMINATION

4.1 Term

This Agreement shall be effective on July 1, 2011 and has a term of three (3) years, unless sooner terminated in accordance with the terms and conditions of this Agreement.

4.2 Termination

a. This Agreement may be terminated with or without cause on sixty (60) days prior written notice by either party. If this Agreement is terminated, then the MOU incorporated by reference terminates simultaneously, unless otherwise mutually agreed to in writing by the parties.

b. If this Master Agreement, or MOU incorporated into this Agreement terminates for any reason, the SCCMHD will assist SCFHP with the timely transition of all administrative records to SCFHP, and the timely transfer of a copy of Member medical records to Member's PCP, if requested by the Member or the PCP, with due attention to confidentiality and applicable law.

SECTION 5 – FISCAL RELATIONSHIPS

This Agreement, through the MOU incorporated herein by reference, requires and facilitates the sharing of PHI, to the extent permitted by law, among the SCCMHD, SCFHP and the Member's PCP regarding Carve-Out Mental Health Services and the Members receiving them. This exchange of information benefits both parties, and this mutual benefit, and the other mutual promises made in this Agreement, are the principal consideration for this Agreement. No financial compensation will be made by or to either party for the information exchange or other administrative services required by this Agreement.

SECTION 6 – INSURANCE AND INDEMNIFICATION

6.1 Insurance

The parties must each maintain policies of general liability, errors and omissions, workers compensation and, if applicable, professional liability insurance in amounts consistent with industry standards, including but not limited to coverage of liabilities arising out of the inappropriate disclosure of PHI. With the consent of the other party, or if required by the County Board of Supervisors,, a program of self-insurance may be substituted for one or more of the policies specified in this Section. SCFHP and SCCMHD agree to promptly notify each other of any claims or demands which arise or for which indemnification is sought.

6.2 Mutual Indemnification for Agreements between Public Entities

In lieu of and notwithstanding the pro rata risk allocation which might otherwise be imposed between the parties pursuant to Government Code Section 895.6, the parties agree that all losses or liabilities incurred by a party will not be shared pro rata, but instead the SCCMHD and SCFHP agree that, pursuant to Government Code Section 895.4, each of the parties will fully indemnify and hold each of the other parties, their officers, board members, employees and agents, harmless from any claim, expense or cost, damage or liability imposed for injury (as defined by Government Code Section 810.8) occurring by reason of the negligent acts or omissions or willful misconduct of the indemnifying party, its officers, board members, employees or agents, under or in connection with or arising out of any work, authority or jurisdiction delegated to such party under this Agreement. No party, nor any officer, board member, employee or agent thereof will be responsible for any damage or liability occurring by reason of the negligent acts or omissions or willful misconduct of other parties hereto, their officers, board members, employees or agents, under or in connection with or arising out of

any work, authority or jurisdiction delegated to such other parties under this Agreement. However a finding of liability may be based on the doctrines of equitable indemnity, comparative negligence, contribution or other common law basis for liability.

SECTION 7 – GENERAL PROVISIONS

7.1 Entire Agreement; Modification

This Agreement constitutes the entire understanding of the parties on this subject matter and supersedes any and all written or oral agreements, representations, or understandings on the same subject matter. The recitals, schedules, exhibits and amendments are integral parts of this Agreement and are incorporated herein by reference. No modifications, discharges, amendments, or alterations are effective unless signed by both parties and approved by County Counsel (if required), except as otherwise provided in this section or in the Notice section (Section 7.6) hereof. Furthermore, neither this Agreement, nor any modifications, discharges, amendments or alterations thereof are considered executed by, or binding upon, SCFHP unless and until signed by the CEO or other authorized officer of SCFHP.

If, however, state or federal laws or regulations change, and affect any provisions of this Agreement, this Agreement is deemed amended to conform with those changes in the laws or regulations effective the date the laws or regulations become effective.

7.2 Invalid Provisions

It is understood that any provision of this Agreement that is in violation of any state or federal laws or regulations is null and void. The provision will be renegotiated by the parties, deemed stricken from this Agreement, or deemed amended to conform to the law or regulation pursuant to the terms of this Agreement. The invalidity or nonenforceability of any terms or provisions hereof may in no way affect the validity or enforceability of any other terms or provisions.

7.3 Governing Law

This Agreement is governed by and construed in accordance with the laws of the State of California and applicable federal law.

7.4 Non-waiver

No covenant, condition, or undertaking contained in this Agreement may be waived, except by the written agreement of the parties or as set forth in this paragraph. Forbearance or indulgence in any other form by either party in regard to any covenant, condition, or undertaking to be kept or performed by the other party does not constitute a waiver thereof, and until complete satisfaction or performance of all covenants, conditions, and undertakings have been satisfied, the other party is entitled to invoke any remedy available under this Agreement, despite any forbearance or indulgence, except as otherwise provided in the limitation on actions section of the Arbitration Exhibit of this Agreement, attached hereto and incorporated herein by this reference.

7.5 Notice

Any notice, request, demand or other communication required or permitted hereunder will be given in writing by certified mail, facsimile or other method of delivery providing proof of delivery or attempted delivery, communication charges prepaid, to the party to be notified. All communications will be deemed given upon delivery or attempted delivery to the address specified herein, as from time to time amended. The addresses for the parties and copied entity for the purposes of communication are:

To SCFHP:	To SCCMHD:
Chief Operations Officer SCFHP 210 E. Hacienda Ave. Campbell, CA 95008	Director of Mental Health Nancy Pena, PhD. 828 S Bascom Ave., Suite 200 San Jose, CA 95128

Either party may at any time change or amend its address for notification purposes, by mailing a notice as required hereinabove, stating the change and setting forth the new address. The new address becomes effective on the date specified in the notice, or if no date is specified, on the tenth (10^{th}) day following the date the notice is received.

7.6 Confidentiality of Medical Records and Other Protected Health Information

a) The Parties must adhere to all applicable state and federal laws and regulations governing the confidentiality, maintenance and retention of protected health information. Such laws include but are not limited to Health Insurance Portability and Accountability Act (HIPAA) and its related regulations, the Health Information Technology for Economic and Clinical Health Act (HITECH), the Confidentiality of Medical Information Act and the Laterman-Petris Short Act.
b) With an enrollee's written permission or as otherwise permitted by law, the identification of a patient, clinic, or other pertinent information will be shared between SCCMHD and SCFHP.

7.7 Duplicate Originals

This Agreement is executed in several counterparts, each of which is deemed an original; however, all constitute one and the same Agreement.

7.8 Approvals

Where agreement, approval, acceptance, or consent by either party is required by any provision of this Agreement, the action may not be unreasonably delayed or withheld.

7.9 Review by Counsel

The parties respectively acknowledge that they have had the opportunity to consult with and have been represented by counsel of their choice throughout the negotiations that preceded the execution of this Agreement. The parties respectively acknowledge that they have read this Agreement and have had its contents fully explained by counsel. The parties further respectively acknowledge that they have mutually

participated in the preparation of this Agreement and that no provision herein may be construed against any party hereto by virtue of the activities of that party or its attorneys.

7.10 Provider Education and Training

SCFHP will work with SCCMHD to schedule and conduct bi-annual meetings which will include SCFHP, SCCMHD, and SCCMHD sub-contractors.

SCFHP and SCCMHD will work collaboratively to develop the meeting agendas, lead the meetings, and provide follow-up to all providers.

7.11 Conflict of Interest

In accepting this Agreement, SCFHP covenants that it presently has no interest, and will not require any interest, direct or indirect, financial or otherwise, which would conflict in any manner or degree with the execution of the terms of this Agreement.

SCFHP further covenants that it will not employ any contractor or person having such an interest during the term of this Agreement.

IN WITNESS WHEREOF, this Agreement has been duly executed by the authorized representative(s) of SCFHP and SCCMHD on the date(s) written below:

SCFHP:

Elizabeth Darrow, CEO — Date: 12/9/11

SCCMHD

TAX ID#: 94-6000533

Nancy Pena, Ph.D., Director
Mental Health Department — Date 12/7/11

APPROVED AS TO FORM AND LEGALITY:

Greta Hansen,
Deputy County Counsel — Date: 11/16/11

APPROVED:

Emily Harrison,
Deputy County Executive — Date: 11/23/11

Exhibits and Attachments to this Agreement:

Exhibit 1 MOU
Exhibit 2 Arbitration

EXHIBIT 1
MEMORANDUM OF UNDERSTANDING

Between
Santa Clara Family Health Plan (SCFHP)
And
Santa Clara County Mental Health Department (SCCMHD)
Medi-Cal

Category	Santa Clara County Mental Health Department (SCCMHD)	Santa Clara Family Health Plan (SCFHP)
Liaison	SCCMHD liaison will coordinate activities with SCFHP. SCCMHD liaison will coordinate with SCFHP quarterly meetings to resolve issues regarding appropriate and continuous care for members. At the discretion of SCCMHD, their liaison may represent SCCMHD in the dispute resolution process. SCCMHD liaison will be responsible for communicating suggestions for MOU changes to SCFHP. SCCMHD will provide the SCFHP with all applicable phone numbers necessary to conduct business and coordinate care with CMHD. .	SCFHP liaison will coordinate activities with the SCCMHD. SCFHP liaison will coordinate with the SCCMHD quarterly meetings to resolve issues regarding appropriate and continuous care for members. At the discretion of SCFHP, their liaison may represent SCFHP in the dispute resolution process. SCFHP liaison will be responsible for communicating suggestions for MOU changes to SCCMHD, and when applicable SCFHP Contracting Department. SCFHP will provide the SCCMHD with the phone numbers of its member services, provider services, and support programs. SCFHP will communicate MOU changes to the State Department of Health Care Services (DHCS) and SCFHP providers.
Covered Services	Under the Short-Doyle Medi-Cal Fee-for-Service Program, SCCMHD is responsible for arranging and paying for, those inpatient and outpatient mental health services, including psychotropic drugs necessary for treatment, that are covered services under that program and a Carve-Out Service under SCFHP's DHCS contract.. Annually a copy of the Short-Doyle Medi-Cal Fee-for-Service Mental Health Provider Manual will be provided to SCFHP.	Under its Agreement with the State Department of Health Care Services, SCFHP is responsible for arranging and paying for, those inpatient and outpatient health care services for SCFHP Medi-Cal members that are covered services under that Agreement. All limits, exclusions and Carve –Out Services provided for under that Agreement with DHCS apply to covered services provided to SCFHP Medi-Cal Members. Annually a copy of SCFHP Medi-Cal EOC will be provided to the SCCMHD. As needed or requested, SCFHP will provide training to the CMHD on the SCFHP web site and Provider Manual.

EXHIBIT 1
MEMORANDUM OF UNDERSTANDING

Category	Santa Clara County Mental Health Department (SCCMHD)	Santa Clara Family Health Plan (SCFHP)
Referrals	The SCCMHD will accept referrals from the following: 1. Self referral 2. SCFHP enrollee's PCP referral	SCFHP Medi-Cal enrollees may initiate mental health services from the CMHD by one of the following methods: 1. Self referral to SCCMHD 2. PCP referral directly to SCCMHD SCFHP is not responsible for providing referrals or authorizations for enrollees to receive Carve-Out Mental Health Services from SCCMHD.
Payment of Services	SCCMHD is responsible for payment to its county clinics, facilities, provider offices and sub-contractors.	SCFHP is not responsible for payment for mental health services provided by SCCMHD clinics, facilities, provider offices or sub-contractors.

EXHIBIT 2
MEMORANDUM OF UNDERSTANDING – SCFHP and SCCMHD
ARBITRATION OF CONTRACTED DISPUTES

Any claim, dispute, or controversy between the parties (any or all of which shall hereinafter be referred to as "Dispute") that arises out of, or relates to, the interpretation, performance or breach of this agreement shall, in lieu of court action, be submitted to mandatory, binding arbitration upon written demand by either party in accordance with the terms and procedures set forth below.

A. Pre-demand Requirements

Within one (1) year of the date a Dispute arises between the parties, the party alleging the Dispute shall notify the other party in writing of the facts giving rise to the problem or Dispute, the matter or matters at issues, the provision(s) of the agreement that are involved, the alleged breach(es) of the Agreement and the amount involved. The parties shall meet and confer in a good faith effort to resolve the Dispute informally, before a demand for arbitration is made. The notice of Dispute and negotiation shall be conditions precedent to the filing of any arbitration demand by either party. Except as may be otherwise discoverable, all negotiations and any documents and/or communications exchanged pursuant to the negotiations shall be privileged settlement communications under State law. Notwithstanding the above, if the parties have already attempted to settle their Dispute through an administrative hearing, the parties may mutually consent in writing to waive the informal meeting (but not the notice of dispute) and proceed to the demand for arbitration.

B. Time Limitations

Demand for arbitration shall be made within twelve (12) months after the notice of dispute is sent, but in no event after the date when institution of legal or equitable proceedings based upon that matter would be barred by any applicable statue of limitations. If demand for arbitration is not made within the twelve (12) month period specified herein, and/or if the pre-demand requirements are not met, the party alleging the dispute shall be deemed to have waived the claim or cause of action and shall be barred from demanding arbitration or pursuing any other remedy, at law or in equity, pertaining to the dispute or to the facts and/or issues giving rise to or relating to the Dispute.

C. Form of Demand

Notice in writing of the demand for arbitration shall be served by mail, in accordance with the terms of the Notice Section of this Agreement, upon the party against whom arbitration is sought. The demand shall set forth with specificity the: facts giving rise to the problem or Dispute, the matter or matters at issue, the provision(s) of the agreement that are involved, the alleged breach(es) of the Agreement, and the amount involved.

D. Type of Arbitration

Except as otherwise provided in this Exhibit 2, the arbitration shall be conducted in accordance with the commercial arbitration rules of the American Health Lawyers Association ("AHLA"), pursuant to the Uniform Arbitration Act as adopted in the State of California, or the State equivalent (either of which is hereinafter referred to as the UAA). If there is a conflict between AHLA rules and the UAA, the UAA shall apply. If there is a conflict between AHLA or UAA and this Exhibit 2, this Exhibit 2 shall govern.

E. Selection of Arbitrators

Within thirty (30) days after service of the demand for arbitration, the party seeking arbitration shall file the required number of copies of the following items with the AHLA and shall copy the non-initiating party by certified mail: This Exhibit 2 and any other relevant portions of this

Agreement, the demand for arbitration, with the details specified in Section C of this Exhibit, any other information specifically required to be filed by AHLA rules, and the appropriate administrative fees as provided in the AHLA administrative fee schedule. The submission shall request that the AHLA submit to the parties a list of at least three (3) disinterested arbitrators who have a law degree, and expertise and experience in managed health care. The prospective arbitrators shall have no prior dealings, transactions, or affiliations with either of the parties. The parties shall jointly select one (1) of the proposed arbitrators. If no agreement is reached as to the selection of the arbitrator, the parties may request that the AHLA recommend at least three (3) additional arbitrators with the above stated qualifications. If the parties cannot agree on one (1) arbitrator from among the second group proposed by the AHLA, the AHLA shall appoint one (1) of the three (3) to serve as the arbitrator.

F. Evidence; Discovery

1. The arbitrator shall be the sole judge of the admissibility, relevance and materiality of the evidence offered by the parties. The parties to the arbitration are entitled to be heard, to present evidence, and to cross-examine witnesses appearing at the hearing. All evidence must be taken in the presence of the arbitrator and of the parties, except where any party is absent, in default or has waived the right to be present.

2. Discovery may be taken by the parties in the arbitration, to the extent that it is not unduly burdensome, oppressive, annoying, or used to harass the other party (ies). The arbitrator may impose limitations on discovery for those reasons. Discovery may include, but is not limited to, depositions, interrogatories, and requests for production. Discovery shall be conducted in accordance with the procedures to be established by the arbitrator. Upon a party's request, the arbitrator may issue a protective order as a condition of taking, or as a limit on, discovery. The arbitrator shall have the power to impose terms, conditions, consequences, liabilities, sanctions, and penalties to enforce the duty to make discovery, to produce evidence or information, including books and records, and to produce persons to testify at a deposition or at a hearing. In accordance with a procedure to be established by the arbitrator, each party shall submit a list of witnesses it intends to call, designating which witnesses it intends to call as expert witnesses, and a list of all exhibits and demonstrative evidence to be used at the hearing. However, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

G. Burden of Proof and Burden of Persuasion

The Burden of Proof and Burden of Persuasion shall be on the party who institutes arbitration.

H. Location of Hearing

The arbitration hearing shall be held at a time and place designated by the arbitrator in the county of Santa Clara, State of California.

I. Closed Hearings

The arbitration hearings shall be closed to all persons except the arbitrator, the parties, their attorneys, and their witnesses. The arbitration shall be a confidential proceeding in accordance with AHLA rules.

J. Arbitration Costs

The arbitrator shall fix his/her own compensation together with the time and manner of payment. Compensation, and all filling fees and costs charged by AHLA, shall be borne equally by the parties.

K. Limitation on Relief Awardable

Except as provided in paragraph O below, the arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by State law, except that punitive

or exemplary damages may not be awarded and no multiple of actual damages pursuant to ant statue or regulation may be awarded. Pre-award and post-award interest may be awarded at a rate of eight percent (8%) per year or at the prime rate of interest in effect at the time and place of the award, whichever is less, unless otherwise required by law. The arbitrator shall not have the power to commit errors of law or legal reasoning. The award may be vacated or corrected by a court of law if there us such an error, notwithstanding any provision to the contrary herein. Each party shall bear an equal share of the cost of arbitration, except that the expenses of witnesses shall be born by the party producing the witnesses. Each party shall pay its own attorney's fees.

L. Decision of the Arbitrator and Entry of Judgment

The decision of the arbitrator shall be issued by the arbitrator within forty-five (45) days of the conclusion of the arbitration hearing. The decision and award shall be in writing and include the arbitrator's factual findings and the legal reasons on which the decision is based. Except as otherwise required by law, neither the AHLA, nor the arbitrator, nor either party may publically disclose, report or disseminate the decision and/or award. The decision of the arbitrator shall be final and binding upon, and enforceable as to, the parties. Judgment on the arbitration award may be entered in a court having jurisdiction over the matter.

M. Payment of Award; Performance of Obligations

The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of entry of judgment on the award or take an appeal, to the extent that appeals of binding arbitration are permitted under the AHLA procedures and the Uniform Arbitration Act as adopted in the State of California or the State equivalent. .

N. Continuation of Performance

Both parties shall continue performance of their contract obligations while arbitration is pending.

O. Provision Relief

Notwithstanding the above, if either party wishes to obtain injunctive relief or a temporary restraining order (TRO), that party may initiate an action for relief in a court of law and the decision of the court of law with respect to the unjunctive relief or TRO shall be subject to appeal only through the courts of law.

P. Effect of Arbitration Claims

The parties shall be collaterally stopped from re-litigating issues determined in any final award or judgment issued by an arbitrator. If a dispute subsequently arises between the parties in which the claim or cause of action asserted raises or involves issues previously arbitrated and decided by the arbitrator, the prior decision of the arbitrator on those issues shall be final and binding on the parties in the subsequent arbitration.

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF CORPORATIONS

NONTRANSFERABLE

HEALTH CARE SERVICE PLAN

LICENSE

Licensee: File No. 933-0351

Santa Clara County Health Authority
d/b/a: Santa Clara Family Health Plan
4050 Moorpark Avenue
Santa Clara, California 95117

IS HEREBY LICENSED AS A HEALTH CARE SERVICE PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975, AS AMENDED, AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A HEALTH CARE SERVICE PLAN, AND OFFER SUCH SERVICES TO MEDI-CAL BENEFICIARIES WITHIN THE STATE OF CALIFORNIA, COUNTY OF SANTA CLARA, SUBJECT TO THE PROVISIONS OF SAID ACT, THE RULES OF THE COMMISSIONER OF CORPORATIONS ADOPTED PURSUANT THERETO, AND ANY UNDERTAKINGS PROVIDED BY THE APPLICANT, UNTIL SUCH TIME AS THIS LICENSE IS SUSPENDED, REVOKED, OR MODIFIED BY ORDER OF THE COMMISSIONER, OR IS SURRENDERED. THIS LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

Dated: December 20, 1996
Los Angeles, California

(SEAL)

KEITH PAUL BISHOP
Commissioner of Corporations

By _____ FOR:
Warren L. Barnes
Supervising Counsel

Matthew E. Woodruff

Experience

Chief Operations Officer
Santa Clara Family Health Plan 7/10 - Present

As COO I am responsible for the ongoing operations of SCFHP programs to ensure health plan goals and objectives are met including operations of the following areas: Compliance, Member Services, Eligibility, Claims, Provider Services, Contracting, Credentialing, Delegation Oversight, Health Education, Cultural and Linguistic Services, Outreach, Marketing, Quality Management, Medical Management and Pharmacy.

1. Provide direction and oversight of the major operational areas, policies, objectives and initiatives of the Health Plan.
2. Actively participate in the establishment of strategic plans for the Health Plan: under direction from the CEO and in coordination with Senior Staff, develop short and long-range plans designed to meet corporate objectives.
3. Actively participate in Governing Board activities including, planning, reporting, presenting and training.
4. Guide direct reports in the development of work plans necessary to meet corporate, divisional and individual goals.
5. Assist each of the COO's direct reports toward the achievement of their respective corporate, divisional and individual goals and objectives: provide leadership, mentor, supervise and evaluate results.
6. Work with all Senior Staff to ensure smoothly functioning communications and integrate operations and functions across the Plan.
7. Under direction from the CEO, establish and support operating policies intended to mitigate risk; identify and recommend to the CEO any changes needed.
8. Ensure optimization and compliance with established standards and regulations.
9. Coordinate the activities of major consultants to achieve specific objectives.
10. Maintain positive corporate relationships within the external community.
11. Achieve economies of scale through establishing and sharing resources with major providers as is appropriate.

Senior Consultant
Gorman Health Group 6/09 – 7/10

- Interim General Manager, national MA-PD
- Implemented sales and marketing department, interviewed and recommended hiring employees, created media plan, sales plan and broker strategy for an MA-PD in Miami Florida
- Created sales and marketing training program for MA-PD for use by MA-PD employees and brokers
- Filed twelve Service Area Expansions and two new Service Areas (101 Counties) for National MA-PD

President
MLW Consulting 2/09 – 7/10

- Lead a team of three, created and prepared, CMS corrective action plans for a National MA-PD's biennial CMS Audit
- Wrote Service Area Expansion for health plan in Louisiana
- Developed Operational Gap Analysis for an MA-PD plan in Los Angeles County. Operational areas analyzed were: contracting, provider services, sales, marketing, utilization management, member services,

Matthew E. Woodruff

- Analyzed current operations for an MA-PD and developed three year Business Plan concentrating on enrollment, sales, marketing and contracting
- Conducted a full review of sales and marketing compliance, that included, policies, procedures, broker oversight and internal marketing representative oversight and marketplace strategy for an MA-PD plan in the Midwest

Chief Operating Officer

Molina Medicaid, St. Louis, Missouri 9/08 – 1/09

- Had overall responsibilities for Contracting, Provider Relations, Enrollment, Reconciliation, Claims, Contracting, Member Services, Appeals and Grievances, Retention, Training, Configuration
- Oversight of implementation of IT migration. Chaired migration committee from Amysis to QNXT
- Implemented statewide provider contracting strategy
- Successfully negotiated with two largest providers in the State (had never been contracted before)
- Worked with Healthcare Analytics to ensure contracting rates were sustainable
- Contracts that could not be sustained were re-negotiated or terminated
- Re-designed provider relations department and expectations and committed to providers timely resolution
- Worked with outreach department to identify grass roots providers. Set up meetings with identified providers to discuss their concerns and issues and bring these to resolution
- Worked with PBM transition ESI to RxAmerica. Enabled four entities, Missouri, Molina corporate, ESI and RxAmerica to meet regularly, finalize transition and resolve transition issues
- Met with the State of Missouri about 2010 Medicaid bid and RFP
- Conducted and had oversight of mandatory State training for all employees. Topics included: Medicare, Customer Service, State payment, State regulations, Cultural Competency, HR

Chief Operating Officer

Molina Medicare, Long Beach, CA 10/07 – 8/08

- Had overall responsibilities for Enrollment, Reconciliation, Claims, Contracting, Member Services, Appeals and Grievances, Retention, Training, HR (liaison Medicare employees), IT, Configuration
- Directed and instituted Molina Medicare Compliance project. December 2007 through May 2008, Molina was threatened to be shut down by CMS due to lack of compliance. As lead successfully filed the Molina Part C and D CAPs to go from nearly shut down by CMS, to only one outstanding CAP under Part C by April 2008
- Successfully filed and operationally implemented 2008 Service Area Expansions in Ohio and New Mexico
- Oversight of implementation of IT migration. Worked with IT and Configuration to move Molina from multiple platforms to one single platform
- Created the first Medicare Member Services Department (previously combined with the Utah Medicaid member services)
- Centralized all A&G processing in Utah (previously disbursed over three States)
- Reorganized Enrollment and Reconciliation Departments to come into compliance with CMS regulations
- Created and Implemented first comprehensive sales training to Molina sales representatives
- Created and distributed first companywide Medicare reporting package
- Created Molina's first sales and marketing direct mail campaign
- Worked with Configuration to Re-Configure the 2008 benefits according to Medicare Criteria
- Successfully set up a dental, hearing and vision network in Texas, six weeks prior to start of 2008 benefit year
- Developed Molina's first national broker oversight policy and procedure
- Created a Member Retention Calling Program, and capturing data in SalesForce
- Created or reviewed first company-wide Medicare departmental trainings
- Contracted national vendors for 2009 benefits and implemented operationally
- Participated on the IT Steering Committee as a voting Member

Matthew E. Woodruff

Vice President, Interim Management, Product Development, Sales
Gorman Health Group, California, Washington DC 4/04 – 10/07

- Interim Chief Operating Officer for Medicare Advantage Organization
- Interim Compliance Officer for Medicare Advantage Organization
- Interim Vice President Sales, Marketing and Product Development for a Medicare Advantage Organization
- Created National Online Broker Training for Medicare Compliance Regulations
- Created and delivered live face-to-face broker training for the sale of Medicare Advantage plans in six States
- Worked with actuaries to create benefit plans for MA-PDs, MA only and RPPOs
- Created stand alone benefit plans for transportation, dental, and vision for MA-PDs
- Worked with contracted providers in Minnesota to create a strategy to operationalize Service Area Expansions
- Created outreach campaign to Medical Groups for MA PPO; increased provider contracting
- Lead onsite Gorman Health Group team, in writing, designing, and implementing an MA-PD SNP for a client in seven states
- Lead an onsite team in writing, designing, and implementing a Medicare Advantage PPO application in Montana
- Project director that implemented new MA-PD SNP in Michigan
- Wrote, designed, and operationally implemented Medicare Advantage PPO application in Wisconsin
- Wrote and designed three SNP applications in Maryland, Arizona, and Pennsylvania
- Directed Health Plan team in the writing of a Medicare Advantage Service Area Expansion in Massachusetts
- Developed operational implementation and trainings for MA-PD; departments included: sales, marketing, appeals and grievances, customer service, enrollment

Director, Government Programs
Universal Care, Signal Hill, CA 10/02 - 4/04

- Increased total revenue – 541% in 2003
- Responsible for quarterly Medicare Sales and Marketing reporting initiatives to Board of Directors
- Wrote, designed, and implemented 2004 Provider-Specific Medicare Plans
- Developed operational implementation for 2003 Medicare Advantage HMO
- Wrote and designed 2004 Ventura County and San Diego County Service Area Expansion
- Designed and launched new Medicare Advantage community based marketing campaign for Medicare Advantage HMO
- Created outreach campaign to Medical Groups for Medicare Advantage HMO
- Designed and implemented training for new telemarketing/retention representatives for sales support
- Implemented broker campaign to generate sales leads and enrollments
- Responsible for new hire training of internal Marketing and Sales Representatives
- Cross trained Medi-Cal and Healthy Families representatives on Medicare and Medicare representatives on Medi-Cal and Healthy Families
- Designed and launched new internal Medicare intranet site for reference materials and reporting
- Implemented and trained the following departments in MA regulations and operations: Sales and Marketing, Appeals and Grievances, Claims, Contracting, Enrollment, Compliance, Administration
- Guided Universal Care through first year Centers for Medicare/Medicaid Services (CMS) site visit with no sanctions and few findings

Matthew E. Woodruff

Director, Product Development, Marketing and Sales, Government Programs
Health Net Inc., Phoenix, AZ 11/01 - 8/02

- Designed and implemented Medicare+Choice PPO Demonstration, award received, 7/1/02
- Designed and implemented a new Medicare Supplement Product, award received, 8/1/02
- Implemented new telemarketing unit for sales support
- Supervised and motivated four telemarketers, eight retention specialists, six account executives, an events coordinator and two project managers
- Developed benefit implementation for Medicare HMO and PPO
- Oversight of implementation for new Medicare website
- Created new marketing campaigns for three Medicare product lines
- Created Benefit Rider for Alternative Medicine
- Broker Liaison
- Conducted focused reviews in specific risk areas including: Sales and Marketing, Enrollment/Disenrollment, Claims, and Contracts
- Member of Information Technologies steering committee
- Member of Benefits Committee
- Member of Medicare Finance Committee

Manager, National Medicare Compliance
Health Net Inc., Rancho Cordova, CA 6/00 - 11/01

- Served as lead contact with corporate body for five Health Net Corporation Subsidiaries in six states: California, Arizona, Florida, New York, Connecticut, Pennsylvania
- Researched and responded to Compliance Officer's daily questions
- Supervised five Managers (areas included Fraud and Abuse, Quality, Sales and Marketing, Claims/IT, Beneficiary Services)
- Audited subsidiaries for compliance with Federal Monitoring Review Guide, Mock CMS Reviews
- Conducted focused reviews in specific risk areas: Sales and Marketing, Enrollment/Disenrollment, Membership, Claims, Contracts, Appeals and Grievance
- Wrote Health Net Corporations (HNI) National Monitoring Policy and Procedures
- Assisted in developing, interviewing and writing HNI's National Compliance Risk Assessment for all lines of business
- Assisted in developing National Marketing Lead Region concept for HNI
- Conducted Fraud and Abuse Investigations in operational areas: Sales and Marketing and Appeals and Grievances
- Conducted National Fraud and Abuse Training for Medicare operations departments in Arizona and California
- Functioned as main contact with CMS Region IX

Managed Care Operations Specialist
Centers for Medicare and Medicaid Services, (formerly HCFA) San Francisco, CA 7/98 - 6/00

- Audited Medicare+Choice Organizations (MCOs) for compliance with the 1997 Balanced Budget Act M+C Regulations
- Served as liaison for five Medicare+Choice Organizations; provided technical assistance to M+COs in the implementation of Medicare programs including the HCFA monitoring guide; Operational Policy Letters (OPLs) 100, 106, 113, 114, 118 and coverage issues on Balanced Budget Refinement Act implementation on new Medicare coverage
- Reviewed for denial or approval M+COs marketing material for compliance with the HCFA National Marketing Guidelines
- Resolved beneficiary casework from M+COs, Social Security Administration, Congressional offices, worked with DOI on Medicare appeals, grievances, and allegations of fraud
- Coordinated beneficiary outreach for Division of Health Plans and Providers with the Division of Beneficiary Services for Region IX

Matthew E. Woodruff

- Interpreted policy for OPLs for the National Marketing Guidelines as a member of the HCFA National Marketing Workgroup
- Conducted oversight reviews of KPMG/Barents for the National Marketing Outsourcing Pilot
- Developed material for the Competitive Pricing Demonstration (CPD) in Phoenix, Arizona (Received the HCFA Commissioner's "Citation for Excellence" award for work on the CPD)
- Provided outreach to providers for the first Medicare Private Fee-For-Service contract
- Effectively used the Internet for market conduct reviews and activities in Los Angeles, CA and Phoenix, AZ

Education

St. Mary's College of California

- B.A.; Psychology: emphasis Social Work
- Minor; Religious Studies

							Legend:	On time	G
								On Alert	Y
								At Risk	R
								Completed	C

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	SERVICE AREA								
	Santa Clara County in its entirity for the service area								
	ORGANIZATION								
	a) Identify any management contracts that will be required to implement the Dual Eligible Program	Executive / Legal	Matt Woodruff						
	b) Identify all entities that will be involved in the administration of Dual Eligible Demonstration , including management contractors. Briefly describe the roles of each entity.	Executive / Legal	Matt Woodruff						
	STAFFING								
	a) Identify by title and job description any new staff positions to be added to enable the Plan to satisfy the requirements of the Dual Eligible Demonstration Program. If you are not proposing to add new staff, determine how existing staff will administer this new product line.	Executive / Legal							
	b) Identify individuals that will have lead responsibility for administering Dual Eligible Demonstration including at minimum the medical director, and those responsible for utilization management, case managers, finance, marketing, management information systems and regulatory compliance and quality improvement.	Executive / Legal							

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	IMPLEMENTATION SCHEDULE								
	Provide an implementation schedule outlining the major steps the Plan will take to prepare its organization for participation in Dual Eligible Demonstration . The implementation schedule must include, the following components and the proposed target date for completion of each component. a. Network development and subcontracting, as applicable b. Premium proposal submission c. Secure CMS connectivity d. Complete MIS changes to meet reporting requirements (financial data, encounter data /HEDIS, networks, complaints, etc) e. Staff hiring, if applicable, and training. f. Provider manual updates and training. g. Development of Dual Eligible Demonstration marketing and other member materials including: • Provider directory • Member handbook(s) • Enrollment/disenrollment forms • Membership/ID cards • Marketing materials (brochures, advertising, radio/TV scripts) • Prior authorization/ concurrent review forms • Notices necessary to implement Dual Eligible Demonstration Grievance System requirements (complaint & appeal process, appeal actions and access to state fair hearings • Integrated /Summary of Benefits h. Dual Eligible Demonstration Model Contract execution								
	NETWORK DEVELOPMENT & SUBCONTRACTING								
	a) If Plan is proposing to use its existing contracted provider network to provide Dual Eligible Demonstration the following Medi-Cal covered services, private duty nursing, and dental non-emergency transportation, complete the network. Also, provide a copy of the proposed notice to providers informing them about their obligation under their existing contract to provide services to Dual Eligible Demonstration members.								
	b) If Plan is proposing to enter into any new contracts with providers for any of the following Medi-Cal covered services, private duty nursing, dental, and non-emergency transportation, and provide the following: • a copy of the contract(s) for DHCS review and approval. • Determine any new subcontract arrangements (eg, contracted provider network, pharmacy benefits management, etc) in support of the goal of integrated delivery.								
	c) Identify any new management contracts the Plan proposes to implement in relation to the Dual Eligible Demonstration program. Submit any new contracts to the DHCSfor review and approval.								
	d) Develop plan on how SCFHP will monitor and maintain networks to ensure adequate access and availability of Dual Eligible Demonstration covered services for the enrolled population • How will you work with providers to ensure accessibility for beneficiaries with various disabilities.								
	Determine the methodologies you plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers, including non-traditional providers.								

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	Work with providers to ensure SCFHP meets Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.								

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	ABILITY TO IDENTIFY CHANGES IN MEMBER'S ELIGIBILITY STATUS								
	The Plan must report tany change in status of its enrollees which may impact the enrollee's eligibility for Medi-Cal or Dual Eligible Demonstration within 5 business days of knowledge of such a change including a change in their Medicare Advantage enrollment status. Describe the mechanism the Plan will use to monitor any change in status of its enrollees in order to meet this operational requirement. State the type of data that will be reviewed and the periodicity of the reviews.							6/30/09	
	LTSS INTEGRATION & IHSS AND SUPPORT COORDINATION								
	Describe how the Plan will permit its Dual Eligible Demonstration enrollees to exercise their right to obtain family planning and reproductive health services from either the Contractor, if Family Planning and Reproductive Health Services are provided by the Contractor, or from any appropriate Medi-Calenrolled non-participating family planning provider, without a referral from the Enrollee's PCP or without approval by the Plan, as defined in Appendix C of the Dual Eligible Demonstration Contract. How will the Plan notify its enrollees, staff and network providers of these policies?	Medical Management							
	Create a plan to provide seamless coordination between medical care and LTSS to keep people living in their homes and communities for as long as possible. Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS Begin working with SCFHP Community partners to achieve this.								
	Specifically address: • A proposed care coordination model with IHSSs, including the referral, assessment, and care coordination process. • A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease.								
	how you will assess and assist beneficiaries connecting to community social programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community.								
	Determine the local Area Agency on Aging (AAA), Aging and Disability Resource Connection (ADRC), and/or Independent Living Center (ILC) you will partner with and begin outreach. Determine how you will partner with housing providers, such as senior housing, residential care facilities, assisted living facilities, and continuity care retirement communities, to arrange for housing or to provide services in the housing facilities for beneficiaries, begin contacting.								

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	1. support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders 2. plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015. 3. care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among dual eligibles, including those who can self-direct care and also those with dementia and Alzheimer's disease								
	Describe how the Plan will coordinate the delivery of Medicare/Dual Eligible Demonstration covered services with other services available to the member on a Medi-Cal fee for service basis, and with other community and social services available in the Plan's service area.								
	MARKETING								
	Describe the approaches that the Plan will use to market Dual Eligible Demonstration to dual eligibles consistent with the Dual Eligible Demonstration Marketing Guidelines in Appendix D of the Dual Eligible Demonstration Contract. Describe the training that will be conducted for marketing staff. Describe how the Plan will monitor the activities of its marketing staff.	Marketing							

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	MEDICARE & MEDI-CAL INTEGRATION								
	Dual Eligible Demonstration integrates Medicare and Medi-Calcovered services through one health plan. Describe how you will operationalize Dual Eligible Demonstration within your organization to make the program appear as one benefit to the enrollee. In particular, describe the Plan's plan for issuing member identification cards (i.e., will enrollees use a single health plan card for both Medicare and Medi-Calcovered services) and how the Plan's member services department will interact with Dual Eligible Demonstration members on issues related to both Medicare and Medicaid.								
	plans for delivering integrated care to individuals living in institutional settings. Institutional settings are appropriate setting for some individuals, but for those able and wanting to leave, how might you transition them into the community? What processes, assurances do you have in place to ensure proper care?								
	1. support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders 2. plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015. 3. care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among dual eligibles, including those who can self-direct care and also those with dementia and Alzheimer's disease								
	MEMBER MATERIALS AND EDUCATION & OUTREACH								
	Describe in detail your member services program including: ▪ how staff will be trained on the member rights and responsibilities ▪ educational materials to be provided ▪ ratio of member services representatives to members ▪ hours of operation ▪ language translation services ▪ the establishment of a 1 800 number for members ▪ how the plan will address the needs of persons with visual, hearing, speech, physical or developmental disabilities.							6/30/09	
	ORGANIZATION DETERMINATIONS, ACTIONS & GRIEVANCE SYSTEMS								
	a) Explain the Plan's grievance system procedures and how they will be available to Dual Eligible Demonstration enrollees, including the processes and procedures that the Plan will implement to comply with requirements for organization determinations, action appeals, complaints and complaint appeals, as defined in Section 14 and Appendix F of the Dual Eligible Demonstration Contract.	A & G							
	b) Create a work flow of the Plan's Dual Eligible Demonstration grievance system procedures.	A & G							

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	c) Plan must submit the forms and notices it intends to use to inform members of organization determinations and enrollee complaint appeals, action appeals and grievance rights as part of the Medi Calqualification application.	A & G							
	d) Develop staff training for integrated A&G process for the dual eligible program								

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	FAIR HEARINGS								
	a) Discuss the process and the procedures that the Plan will implement to ensure that Medi-Calmembers are afforded the opportunity to request a fair hearing regarding a denial, termination, suspension or reduction of a service determined by the Plan to be a benefit or a benefit other than those solely covered by Medicare.	A & G							
	b) Discuss the process and procedures for offering “aid continuing” of disputed services pending a fair hearing. The Plan must submit the notices it intends to use.								
	QUALITY MANAGEMENT								
	a) Describe the Plan’s quality assessment and improvement program. Include a description of the structure of the quality program, process of evaluation, and the outcomes of those assessments.	Quality							
	b) Describe Plans quality assessment and improvement program integrates information from clinical and administrative functions such as complaints/grievances/appeals, medical /utilization management, provider relations, etc. to identify problems and implement appropriate corrective actions as needed.	Quality							
	c) Plans not currently operational in NYS for other than Medicare must submit HEDIS or QARR results from other states in which it operates. If the Plan does not collect HEDIS or CAHPS data in other states, describe the process used to measure, benchmark and improve quality and consumer satisfaction performance.	Quality							
	TEHNOLOGY & OPERATIONAL DATA REPORTING								
	a) Describe the SCFHP’s plan for collecting and reporting operational data pursuant to Dual Eligible Demonstration program for Medicare and Medi-Cal reporting requirements as defined (financial, networks, complaints, encounter, quality data, etc.)								
	b) How will the Plan verify the accuracy of data reported by its providers? Discuss any data validation activities the Plan performs including medical record audits.								
	c) Determine how SCFHP will maintain encounter data received from providers and have the ability to report on it and use it as needed								
	a) Develop a plan to utilize technology in providing quality care, including efforts of providers in your network to achieve the federal “meaningful use” health information technology (HIT) standards. b) Develop plan to utilize care technology in the duals Demonstration for beneficiaries at very high-risk of nursing home admission (such as telehealth, remote health vitals and activity monitoring, care management technologies, medication compliance monitoring, etc.)								
	ADA COMPLIANCE								
	Plans are required to comply with Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for program accessibility. Plans shall review their current compliance activities and provide the DHCS with the completed checklist found in Attachment IV.	Compliance							
	PART D - PRESCRIPTION BENEFITS								

Sort #	Task Name	Functional Area Responsibility	Person Responsible	Policy / Document Reference	Priority	Dependencies	Comments	Due Date	Status
	Work with PBM to ensure SCFHP meets all Medicare Part D requirements • benefits, • network adequacy, • Develop and submit formularies and track exceptions • prescription drug event data (PDE)								

Sort #	Task Name	Response Required	Person Responsible	Comment		

Sort #	Task Name	Response Required	Person Responsible	Comment		

Sort #	Task Name	Response Required	Person Responsible	Comment		

Sort #	Task Name	Response Required	Person Responsible	Comment		

Sort #	Task Name	Response Required	Person Responsible	Comment		

Sort #	Task Name	Response Required	Person Responsible	Comment		

Last Name	First Name	Title	MA Project Role	Phone Number	Email

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**Dual Eligible Demonstration Plan (Medicare & Medi-Cal) Planning Project Timeline**																																	
2	**Task /Deliverable**	**March**		**April**				**May**					**June**				**July**				**August**					**September**				**October**				
3	"X" is suggested completion date	**3/19**	**3/26**	**4/2**	**4/9**	**4/16**	**4/23**	**4/30**	**5/7**	**5/14**	**5/21**	**5/28**	**6/4**	**6/11**	**6/18**	**6/25**	**7/2**	**7/9**	**7/16**	**7/23**	**7/30**	**8/6**	**8/13**	**8/20**	**8/27**	**9/3**	**9/10**	**9/17**	**9/24**	**10/1**	**10/8**	**10/15**	**10/22**	**10/29**
4	**Financial Profomas**																																	
5	Operational costs projections						**X**																											
6	Start-up investment requirements						**X**																											
7	Incremental medical cost savings analysis						**X**																											
8	MLR and profitability projection scenarios		**X**																															
9	Membership-patient thresholds		**X**																															
10	Medicare Revenue Projections		**X**																															
11																																		
12	**Market Research and Analysis**																																	
13	Market Overview		**X**																															
14	**Development and implementation roadmap**					**X**																												
15																																		
16	**Product and Operational Design**																																	
17	Supplemental benefits and contracting requirements														**X**																			
18	Potential product benefit design: a. Base benefits for pricing b. Price point in relation to MA portfolio															**X**																		
19	Out-of-network coverage.															**X**																		
20	Actuarial pricing of design options														**X**																			
21																																		

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22	**Important CMS Dates**																																	
23	Last date for submission of a Notice of Intent to Apply			X																														
24	Last date for CMS to receive HPMS User ID conectivity forms			X																														
25	Release 2013 Formulary Submission Module in HPMS							X																										
26	Release 2013 Medication Therapy Management Module (MTMP) in HPMS						X																											
27	CY 2013 Out-of-Pocket Cost (OOPC) estimates for each plan and an OOPC model will be made available to plan sponsors in SAS to download from the CMS website that will assist plans in meeting meaningful difference and total beneficiary cost requirements prior to bid submission.			X																														
28	2013 MTMP submission deadline								X																									
29	Release of the 2013 Plan Benefit Package (PBP) online training module			X																														
30	Release of the 2013 Plan Creation Module, PBP, and Bid Pricing Tool (BPT) software in HPMS.			X																														
31	Part D Formulary crosswalk must be submited for organizations that have already submitted a non-demonstration plan formulary for 2013 and intend to use the same formulary for demonstrations plans									X																								
32	Release of the 2013 Bid Upload Functionality in HPMS								X																									
33	**Submission of proposed plan benefit package (including all Medicare and Medi-Cal benefits)**												X																					
34	2013 Formulary Submissions due from all sponsors offering Part D (11:59 p.m. EDT). Transition Attestations due to CMS (Part D sponsors only)					X																												
35	Final ANOC/EOC, LIS rider, EOB, formularies, transition notice, provider directory, and pharmacy directory models for 2013 will be available for all organizations.																												X					

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36	Release of the 2013 Actuarial Certification Module in HPMS												**X**																					
37	Deadline for submission of CY 2013 bids for all MA plans, MA-PD plans, PDPs, cost-based plans offering a Part D benefit, 800 series EGWP and direct contract EGWP applicants and renewing organizations; deadline for cost-based plans wishing to appear in the 2012 Medicare Options Compare to submit PBPs (11:59 p.m. PDT). Voluntary Non-Renewal. Deadline for MA , MA PD's, PDPs and Cost-Based organizations to submit a contract non-renewal, service area reduction, or Plan Benefit Package (PBP) level non-renewal notice to CMS for CY 2013.												**X**																					
38	**Demonstration plan selection completed (Target Date)**																				**X**													
39	CMS and State conduct readiness reviews for selected plans (Late July - September)																				**X**	**X**	**X**	**X**	**X**	**X**	**X**							

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40	**Organization & Experience**																																	
41	Core Competencies															**X**																		
42	Capabilities gap assessment															**X**																		
43	State Licensure							**X**																										
44	Compliance Plan																									**X**								
45	Training Program																													**X**				
46	Develop Medicare Specific P&Ps																																	
47	Key Management & Staff															**X**																		
48	Staffing requirements, including the organization charts.																				**X**													
49	Job descriptions																				**X**													
50	Budgets (staffing only)																				**X**													
51	Provider Participation Contracts & Agreements CMS language																			**X**														
52	Contract Reimbursement Strategy								**X**																									
53	Network Adequacy Assessment							**X**																										
54	Pay-for-performance strategy and measures								**X**																									
55	Medicare Non-Required Provider Types:																																	
56	FQHC						**X**																											
57	Nurse Practitioners						**X**																											
58	Rural Health Clinics						**X**																											
59	Religious Non-Medical Institutions						**X**																											
60	Care Management																																	
61	Health information system to collect, analyze, and report accurate and complete data																			**X**														

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62	**Quality Improvement Program**																																	
63	Describe the purpose of the quality improvement program in relation to the target population																			X														
64	Describe how the MAO identifies and monitors the most vulnerable members of the population (i.e., frail, disabled, near the end-of-life, multiple or complex chronic conditions, or developing ESRD after enrollment) and the quality improvement activities designed for these individuals																			X														
65	Outline the components of the overall quality improvement program including the MAO's internal activities and the following CMS required activities:																			X														
66	MAO-determined Internal Quality Improvement Activities																			X														
67	Chronic Care Improvement Program (CCIP)																			X														
68	Quality Improvement Projects (QIP)																			X														
69	SNP-specific Care Management Measurement																			X														
70	HEDIS and Structure & Process Measures (NCQA)																																	
71	Health Outcomes Survey - HOS (NCQA)																																	
72	Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey																																	
73	Part C Reporting Elements																																	
74	Part D Medication Therapy Management Reporting																																	
75	Communication on Quality Improvement Program with Providers/Stakeholders																					X												
76	Quality assurance policies and procedures, including medication therapy management and drug and/or utilization management. Identify the conditions for which MTM programs are available, inform beneficiaries that these programs may have limited eligibility criteria, make clear that these programs are not considered a benefit, and remind beneficiaries to contact customer service for additional information.																					X												
77																																		

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78	**Model Of Care**																																	
79	Identify the SNP-specific target population	**X**																																
80	Measurable Goals: Plan Information systems support the collection and evaluation of attainment of goals and the targets	**X**																																
81	Ability to measure of the effectiveness of the SNP model of care, indices of quality, and beneficiary health outcomes	**X**																																
82	Staff Structure and Care Management Roles	**X**																																
83	Administrative and Clinical Oversight	**X**																																
84	Administrative Functions	**X**																																
85	Clinical Staff	**X**																																
86	Collaborative Care Support Team	**X**																																
87	Manager of Utilization Management	**X**																																
88	Manager of Quality Management	**X**																																
89	Quality Management Analyst	**X**																																
90	Behavioral Health Team	**X**																																
91	Pharmacy Team	**X**																																
92	Interdisciplinary Care Team	**X**																																
93	Provider Network Having Special Expertise	**X**																																
94	Provider and Interdisciplinary Care Team															**X**																		
95	Evidence Based Guidelines															**X**																		
96	Model of Care Training for Personnel and Providers															**X**																		
97																																		

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2	**Task /Deliverable**	**March**		**April**				**May**					**June**				**July**				**August**					**September**				**October**				
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98	Health Risk Assessment and Stratification															X																	
99	Individualized Care Plan (ICP)															X																	
100	Care Plan Elements															X																	
101	Level One: Low Acuity (Self‐Care Management with Support).															X																	
102	Level Two: Moderate Acuity															X																	
103	Level Three: Complex/High Acuity															X																	
104	Communication Network															X																	
105	Care Management for the Most Vulnerable Subpopulations															X																	
106	Identification of the most vulnerable beneficiaries															X																	
107	Add‐On services and Benefits for Vulnerable Beneficiaries	X																															
108	Performance and Health Outcome Measurement																																
109	Marketing strategy																																
110	Priority of marketing activities																																
111	Staffing requirements, including the organization charts.	X																															
112	Job descriptions												X																				
113	Budgets (staffing only)												X																				
114	Sales and Sales Oversight Program															X																	
115																																	
116																																	
117																																	
118																																	
119																																	
120																																	

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1																		**20**
2	**Task /Deliverable**	**November**				**December**				**January**					**February**			
3	"X" is suggested completion date	**11/5**	**11/12**	**11/19**	**11/26**	**12/3**	**12/10**	**12/17**	**12/24**	**12/31**	**1/7**	**1/14**	**1/21**	**1/28**	**2/4**	**2/11**	**2/18**	**2/25**
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5	Operational costs projections																	
6	Start-up investment requirements																	
7	Incremental medical cost savings analysis																	
8	MLR and profitability projection scenarios																	
9	Membership-patient thresholds																	
10	Medicare Revenue Projections																	
11																		
12	**Market Research and Analysis**																	
13	Market Overview																	
14	**Development and implementation roadmap**																	
15																		
16	**Product and Operational Design**																	
17	Supplemental benefits and contracting requirements																	
18	Potential product benefit design: a. Base benefits for pricing b. Price point in relation to MA portfolio																	
19	Out-of-network coverage.																	
20	Actuarial pricing of design options																	
21																		

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2	**Task /Deliverable**	**November**				**December**				**January**					**February**			
3	"X" is suggested completion date	**11/5**	**11/12**	**11/19**	**11/26**	**12/3**	**12/10**	**12/17**	**12/24**	**12/31**	**1/7**	**1/14**	**1/21**	**1/28**	**2/4**	**2/11**	**2/18**	**2/25**
22	**Important CMS Dates**																	
23	Last date for submission of a Notice of Intent to Apply																	
24	Last date for CMS to receive HPMS User ID conectivity forms																	
25	Release 2013 Formulary Submission Module in HPMS																	
26	Release 2013 Medication Therapy Management Module (MTMP) in HPMS																	
27	CY 2013 Out-of-Pocket Cost (OOPC) estimates for each plan and an OOPC model will be made available to plan sponsors in SAS to download from the CMS website that will assist plans in meeting meaningful difference and total beneficiary cost requirements prior to bid submission.																	
28	2013 MTMP submission deadline																	
29	Release of the 2013 Plan Benefit Package (PBP) online training module																	
30	Release of the 2013 Plan Creation Module, PBP, and Bid Pricing Tool (BPT) software in HPMS.																	
31	Part D Formulary crosswalk must be submited for organizations that have already submitted a non-demonstration plan formulary for 2013 and intend to use the same formulary for demonstrations plans																	
32	Release of the 2013 Bid Upload Functionality in HPMS																	
33	**Submission of proposed plan benefit package (including all Medicare and Medi-Cal benefits)**																	
34	2013 Formulary Submissions due from all sponsors offering Part D (11:59 p.m. EDT). Transition Attestations due to CMS (Part D sponsors only)																	
35	Final ANOC/EOC, LIS rider, EOB, formularies, transition notice, provider directory, and pharmacy directory models for 2013 will be available for all organizations.																	

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36	Release of the 2013 Actuarial Certification Module in HPMS																	
37	Deadline for submission of CY 2013 bids for all MA plans, MA-PD plans, PDPs, cost-based plans offering a Part D benefit, 800 series EGWP and direct contract EGWP applicants and renewing organizations; deadline for cost-based plans wishing to appear in the 2012 Medicare Options Compare to submit PBPs (11:59 p.m. PDT). Voluntary Non-Renewal. Deadline for MA , MA PD's, PDPs and Cost-Based organizations to submit a contract non-renewal, service area reduction, or Plan Benefit Package (PBP) level non-renewal notice to CMS for CY 2013.																	
38	**Demonstration plan selection completed (Target Date)**																	
39	CMS and State conduct readiness reviews for selected plans (Late July - September)																	

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40	**Organization & Experience**																	
41	Core Competencies																	
42	Capabilities gap assessment																	
43	State Licensure																	
44	Compliance Plan																	
45	Training Program																	
46	Develop Medicare Specific P&Ps		**X**															
47	Key Management & Staff																	
48	Staffing requirements, including the organization charts.																	
49	Job descriptions																	
50	Budgets (staffing only)																	
51	Provider Participation Contracts & Agreements CMS language																	
52	Contract Reimbursement Strategy																	
53	Network Adequacy Assessment																	
54	Pay-for-performance strategy and measures																	
55	Medicare Non-Required Provider Types:																	
56	FQHC																	
57	Nurse Practitioners																	
58	Rural Health Clinics																	
59	Religious Non-Medical Institutions																	
60	Care Management																	
61	Health information system to collect, analyze, and report accurate and complete data																	

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62	**Quality Improvement Program**																	
63	Describe the purpose of the quality improvement program in relation to the target population																	
64	Describe how the MAO identifies and monitors the most vulnerable members of the population (i.e., frail, disabled, near the end-of-life, multiple or complex chronic conditions, or developing ESRD after enrollment) and the quality improvement activities designed for these individuals																	
65	Outline the components of the overall quality improvement program including the MAO's internal activities and the following CMS required activities:																	
66	MAO-determined Internal Quality Improvement Activities																	
67	Chronic Care Improvement Program (CCIP)																	
68	Quality Improvement Projects (QIP)																	
69	SNP-specific Care Management Measurement																	
70	HEDIS and Structure & Process Measures (NCQA)																	
71	Health Outcomes Survey - HOS (NCQA)																	
72	Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey																	
73	Part C Reporting Elements																	
74	Part D Medication Therapy Management Reporting																	
75	Communication on Quality Improvement Program with Providers/Stakeholders																	
76	Quality assurance policies and procedures, including medication therapy management and drug and/or utilization management. Identify the conditions for which MTM programs are available, inform beneficiaries that these programs may have limited eligibility criteria, make clear that these programs are not considered a benefit, and remind beneficiaries to contact customer service for additional information.																	
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78	**Model Of Care**																	
79	Identify the SNP-specific target population																	
80	Measurable Goals: Plan Information systems support the collection and evaluation of attainment of goals and the targets																	
81	Ability to measure of the effectiveness of the SNP model of care, indices of quality, and beneficiary health outcomes																	
82	Staff Structure and Care Management Roles																	
83	Administrative and Clinical Oversight																	
84	Administrative Functions																	
85	Clinical Staff																	
86	Collaborative Care Support Team																	
87	Manager of Utilization Management																	
88	Manager of Quality Management																	
89	Quality Management Analyst																	
90	Behavioral Health Team																	
91	Pharmacy Team																	
92	Interdisciplinary Care Team																	
93	Provider Network Having Special Expertise																	
94	Provider and Interdisciplinary Care Team																	
95	Evidence Based Guidelines																	
96	Model of Care Training for Personnel and Providers																	
97																		

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98	Health Risk Assessment and Stratification																	
99	Individualized Care Plan (ICP)																	
100	Care Plan Elements																	
101	Level One: Low Acuity (Self‐Care Management with Support).																	
102	Level Two: Moderate Acuity																	
103	Level Three: Complex/High Acuity																	
104	Communication Network																	
105	Care Management for the Most Vulnerable Subpopulations																	
106	Identification of the most vulnerable beneficiaries																	
107	Add‐On services and Benefits for Vulnerable Beneficiaries																	
108	Performance and Health Outcome Measurement				**X**													
109	Marketing strategy								**X**									
110	Priority of marketing activities								**X**									
111	Staffing requirements, including the organization charts.																	
112	Job descriptions																	
113	Budgets (staffing only)																	
114	Sales and Sales Oversight Program																	
115																		
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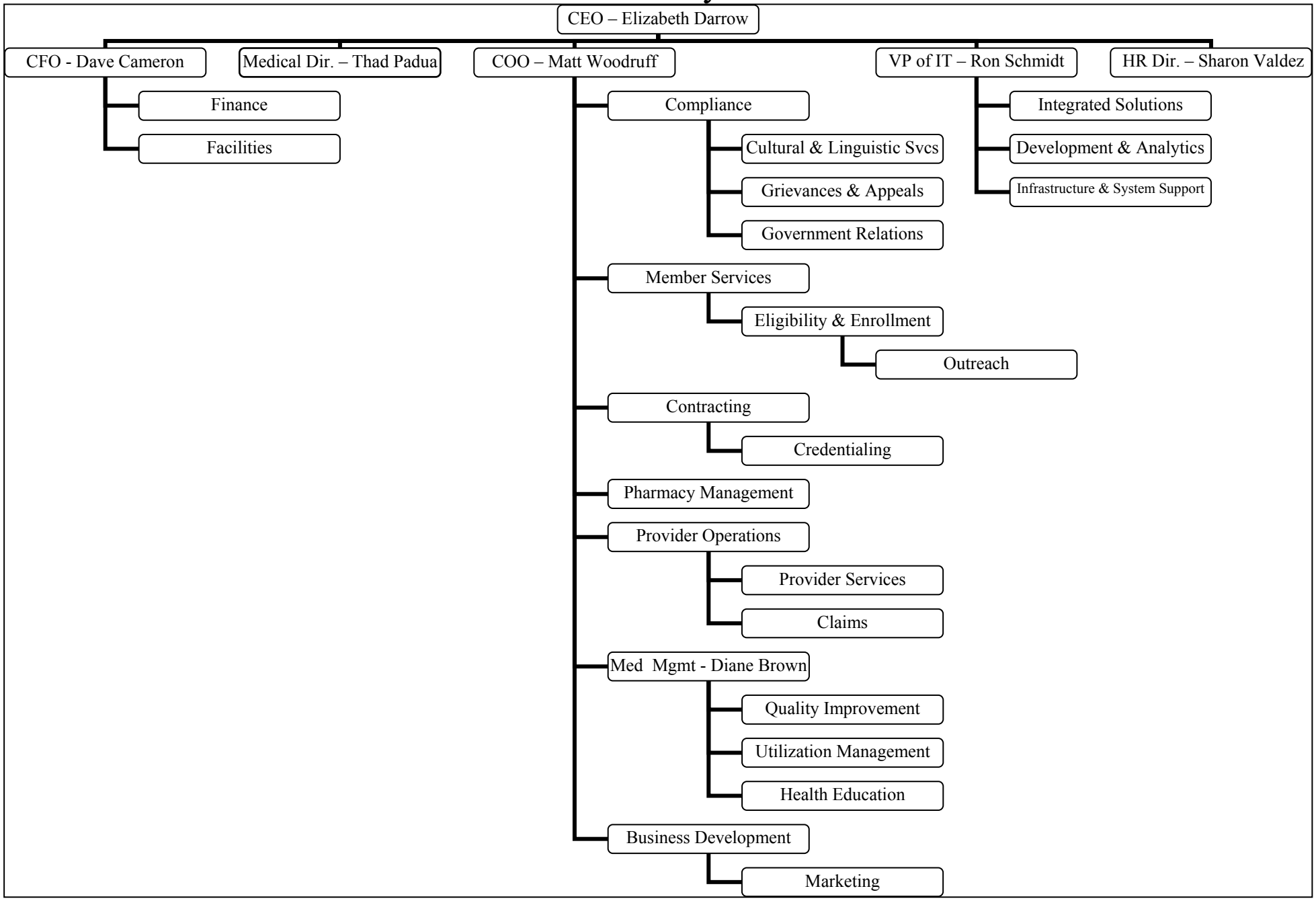
Santa Clara Family Health Plan



6-9-11

Santa Clara
Family Health Plan

The Spirit of Care

DUAL ELIGIBLE DEMONSTRATION PROJECT

MODEL OF CARE

2012

Model of Care Overview

The Santa Clara County Health Authority, operating business as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. SCFHP has subsequently contracted with the California Managed Risk Medical Insurance Board (MRMIB) to serve enrollees in the Healthy Families Program. In 1998, SCFHP began servicing members of the Healthy Family program and in 2001; SCFHP commenced providing health care to children enrolled in the Healthy Kids Program. SCFHP is dedicated to improving the health and well-being of the residents of our region. SCFHP will continue to realize its vision of serving new enrollees, consistent with its mission and its core values. Our mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with select providers, SCFHP acts as a bridge between the health care system and those who need coverage.

Santa Clara Family Health Plan is a fully integrated health plan specializing in serving full-benefit, aged, disabled and dual-eligible members categorized by CMS and will be applying to become a Special Needs Plan (D-SNP).

Santa Clara Family Health Plan offers a full range of coordinated medical, behavioral health and community-based services including acute and chronic care, preventive care, rehabilitation and supportive long-term and home care, as defined by Medicare and Medi-Cal.

Santa Clara Family Health Plan's Model of Care is designed specifically to meet the needs of this ethnically diverse population – a membership consisting largely of beneficiaries who are poor, aged, frail, disabled, chronically ill or near end of life. The average profile of a Santa Clara dual eligible member is a 58-year-old female with three prescription medications. The majority of members have low literacy, less than 40% of the member population speaks English and more than 25 languages are represented across Santa Clara Family Health Plan's membership.

The Santa Clara Family Health Plan Model of Care is being developed to be an intensive care management model ("high-touch") focused on the delivery and coordination of both medical and community service benefits. The Model includes intensive member telephonic and in-person and in-home communication activities, including interpretation services, and is supported by a multi-disciplinary staff, which focuses on the integration of psycho-social, medical, pharmacy and behavioral health services and proactively communicates with the member and caregiver.

Santa Clara Family Health Plan has a clear and well described Mission (outlined below) which informs and guides the goals, the model of care, and the delivery of care to Santa Clara Family Health Plan members.

> Santa Clara Family Health Plan is dedicated to improving the health and well-being of the residents of Santa Clara County. Our mission is to provide high quality, comprehensive health care coverage to those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with select providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, dental and vision coverage via our health insurance programs: Medi-Cal, Healthy Families, Healthy Kids and Healthy Workers. (Medi-Cal and Healthy Families are public insurance programs; Healthy Kids and Healthy Workers are locally funded insurance programs).
>
> Our organization is honored to have been selected by our community as the only health plan provider able to offer a complete range of programs for all uninsured children living in Santa Clara County. The eligibility requirements are quite simple: any child under the age of 19 in a family whose total income does not exceed 300 % of the federal poverty level and who has no access to employer-provided health insurance is eligible to be enrolled in one of our health programs, regardless of the child's immigration status. Depending on age, family income and citizenship status, the child may be eligible for Medi-Cal, Healthy Families, or Healthy Kids (a program which Santa Clara Family Health Plan has developed, and which we alone offer the community). In fact, our Healthy Kids plan was the first of its kind in the country, and now serves as a model for many other communities.

One of SCFHP's core values is our belief that as a publicly funded, local health plan we have a unique responsibility to work toward improving the health status of the community in which we are based. SCFHP will continually advocate promoting community health by incorporating a comprehensive approach to health care and wellness. It is essential that SCFHP have a comprehensive Quality Improvement Program (QIP) that systematically monitors and continually improves the quality of health care to our beneficiaries, provides culturally and linguistically appropriate services, identifies over and under utilization and substandard care, assures member satisfaction and safety, and takes corrective action when indicated.

Santa Clara Family Health Plan's Model of Care addresses the unique needs of the dual eligible beneficiary and combines benefit design, the creation of a provider network, and clinical management programs. The service delivery model enhances

primary and preventive care by directly involving the Plan's care management team with the delivery of Medicare and Medi-Cal benefits in the care of dual eligible members. SCFHP works closely with Medi-Cal service providers and care managers to ensure coordination of care of Plan and Medi-Cal services so that members obtain services they are eligible to receive, regardless of payer. Administrative processes between Health Plan and Medi-Cal (for example Appeals and Grievances) will also be coordinated and streamlined, whenever possible.

Model of Care Elements

There are 11 Model of Care Elements that are subscribed to by Santa Clara Family Health Plan's each of which is described below.

1. Target Population: Dual Eligible Beneficiaries- a Vulnerable Population

Santa Clara Family Health Plans targets the dual eligible population. Dual eligible beneficiaries are among the sickest, poorest, and highest cost individuals covered by Medi-Cal and Medicare. Nationally, in 2007, 57% of these low income individuals have incomes less than $10,000; 52% had difficulty with at least one instrumental activity of daily living (such as shopping, using the phone or managing money), and 44% had difficulty with at least one activity of daily living (such as dressing, bathing, or eating). The prevalence of many serious health conditions, such as cognitive or mental impairments, depression, and diabetes is significantly higher for duals than for non-duals.[1]

Santa Clara Family Health Plan expects the dual eligible population living in the service area to reflect this national data and to have significant medical, behavioral health and social service needs. Thus, the targeted beneficiaries considered to have "special needs" are those:

- Who are dually eligible for Medicare and Medi-Cal living with limited access to public transportation and other support services;
- Experiencing a higher rate of racial and cultural disparity;
- With a higher number of co-morbidities, and
- Limited by a lower level of education.

Navigating both Medicare and Medi-Cal programs with different program rules and financing incentives is complex for beneficiaries and providers and complicates care coordination. To help mitigate these issues, the Plan's approach focuses on enhanced assessment, increased member monitoring and care coordination, personalized

[1] Kaiser Family Foundation analysis of the Centers for Medicare and Medi-Cal Services Medicare Current Beneficiary Survey, 2007 Access to Care file.

attention and improved access to expanded primary and preventive services for members.

Santa Clara Family Health Plan has many means of identifying those members most at risk. All members will be assessed upon enrollment, and depending on needs, members will be further assessed using a comprehensive, multi-dimensional tool at least annually to determine their needs and establish a responsive care plan. In addition, data mining, including claims data and service utilization, will be conducted to identify those members who may be at risk. In addition, referrals from physicians, members, caregivers, community agencies, pharmacies and other interested parties are accepted.

Those members identified to be at risk are contacted by phone and if they agree, are given a comprehensive assessment of their physical, mental and social health. Based on the level of care needed, the member is assigned a Case Manager. A care plan is then developed with input from the member, member's primary care physician, other health providers, social support service providers and families to provide a responsive care plan including intensive primary and preventive services to members.

Santa Clara Family Health Plan provides benefits and services that original Medicare does not cover, such as improved access to primary and preventive care such as vision services, dental services and transportation services. The members benefit from a coordinated approach to their care. Given that Medicare and Medi-Cal have different rules and benefit structures, providing care to the dual member can be confusing for both providers and members. SCFHP will provide:

- Education and information to members and providers as to what benefits the members are eligible for in both programs
- Work with the member to retain Medi-Cal eligibility
- Coordinate payment of Medicare and Medi-Cal claims
- Streamline appeals and grievance procedures through education
- Act as an advocate for the member
- Work with the local Medi-Cal offices, community support service agencies and care management professionals to foster the collaborative care approach

2. Measureable Goals

Santa Clara Family Health Plan (SCFHP) model of care was developed in order to coordinate services and benefits to members receiving both Medicare and Medi-Cal and to address their physical, mental and social needs. SCFHP monitors various data sets to ensure members receive adequate, timely, appropriate care. Inpatient and outpatient

care, including referral management is reviewed for under/over utilization of services. The Plan also measures performance and assesses health outcomes measurements to evaluate the effectiveness of the Model of Care. We will achieve this through a variety of reports designed to measure the Model of Care goals.:

Specific Goals

The specific goals of SCFHP's Model of care include:

1. To ensure the provision of high quality medical, psychosocial, and health support services in the appropriate setting
2. To encourage access to care for the member
3. To improve care coordination through a single point of contact
4. To monitor services and improve seamless transitions of care across all health care settings
5. To promote and improve access to preventative health services and wellness programs;
6. To assure appropriate provision of resources and services needed;
7. To support optimum member health outcomes, including residence in the community whenever possible

Measurable Outcomes

SCFHP supports ongoing activities to identify and evaluate health outcomes and other goals, recognizing that goal achievement and maintenance requires continuous effort. However, goals are periodically reassessed as part of the QI program review cycle to evaluate rate of progression toward goals, barriers, relevance to the current clinical environment and other pertinent observations. Local, regional and national benchmarks are used to assist with goal setting and to assess optimal goal achievement.

SCFHP's goals are established for indicators of care and service, such as:

- HEDIS metrics
- satisfaction surveys
- admission/readmission rates
- timely completion of member risk assessments
- appropriate use of medications
- access and availability metrics

SCFHP has established both organization-wide and discipline-specific indicators to monitor and evaluate achievement toward the overall goals of the company and of specific departments. Indicators have been established to monitor activity associated with the implementation of the Model of Care include, but are not limited to, those represented in the table below.

Table 1: Measurable Goals/Indicators - Samples

Specific Goal	Indicator	Measurable Goal
1	Geriatric Depression Screening (GDS)	90% members receive GDS
2	Provider Access	Goal: 90% of established standards: • Within 48 hours of a request for an urgent care no prior authorization required • Within 96 hours of a request for an urgent appointment for services requiring prior authorization • Within ten (10) business days for non-urgent primary care appointments, • Within fifteen (15) business days for an appointment with a specialist, • Within ten (10) business days for an appointment with non-physician mental health care providers, and • Within fifteen (15) business days for a non-urgent appointment for ancillary services for diagnosis or treatment of injury, illness, or other health condition.
3	Interdisciplinary Care Plan (ICP)	60% Documentation of ICP: • Non-complex – within 120 days • · Complex – within 60 days
4	Post-Discharge Contact	100% members receive contact post discharge within 3 days
5	Pneumococcal/Influenza vaccination	85% members receive: • Influenza – annually • Pneumococcal – any time
6	Medication Review	100% medication review of all hospital discharges
7	Medication Management for chronic care diseases	Compliance with medication therapies

While these provide a snapshot for understanding progress toward the goal-driven outcomes of care and service initiatives for the population, there are also day-to-day evaluations and cycles of improvement within SCFHP, which allow prompt improvements in care for individuals and contribute to refinement in population interventions.

Preventable admissions, readmissions, ER visits for non-emergent conditions, failures in managing transitions, and members' inability to get medications, or inability to get to appointments because of transportation problems are situations, which SCFHP evaluates through measurement and goal setting, but also in real time. These indicators are tracked, described, and analyzed to assess the causes and process failures.

Using exception analysis in addition to more standard interventions allows SCFHP to move steadily towards its goals.

On a regular basis, progress towards individual goals is evaluated. This is accomplished through a number of forums, including:

- Updated Individualized Care Plan (ICP) Reviews
- Weekly Clinical/Grand Rounds Review
- Weekly Transition of Care Reviews

Progress toward population goals relies on data from a variety of sources, including:

- Claims data
- Standardized functional status and other health risk assessments
- PCP assessments
- Pharmacy data
- Surveys of members and providers
- Logs and forums for member and provider inputs

In addition, the effectiveness of the model of care and accomplishment of clinical goals related to the model is assessed through:

- Annual Quality Improvement Program Evaluation
- Quarterly Quality Indicator Reviews
- CAHPS, HEDIS, HOS
- Utilization/cost/total medical expense trend
- Reports from external reviewers (American Association of Retired People (AARP) Study, External Quality Review Organization)

SCFHP assesses the quality and efficacy of care through the monitoring, measurement and analysis of satisfaction as well. Indicators for quality of care satisfaction issues include:

- Complaints/grievances
- Appeals
- Sentinel events
- Provider issues (depth and breadth of network, access/availability)
- Disenrollment data
- Satisfaction surveys

Data to be collected will include claims, utilization, and authorization data and will be analyzed to establish baseline performance in 2011 except for those measures for which baseline data already exists (HEDIS, CAHPS, HOS, etc.); the results are utilized to establish improvement performance goals for the future. Additionally the results are to be evaluated for opportunities for continuous processes improvement relating to the Model of Care. The Director of Medical Management has overall responsibility for Model of Care effectiveness. The Director of Medical Management will prepare an Annual Evaluation of the Model of Care in collaboration with the Plan's Medical Director who, in collaboration with Plan staff and providers, will evaluate the results for effectiveness and identified areas of improvement.

Actions Taken if Goals Are Not Met

The Evaluation will be presented to the Provider Advisory Council (PAC) and Credentialing Committee and the Quality Improvement Committee. Performance measurements presented and discussed during Quality Improvement Committee meetings and are documented and preserved as evidence of care effectiveness in meeting minute notes.

These committees review the findings and recommend specific interventions, including resource redeployment, the appropriateness of the goal given population appropriate external benchmark, and prioritization of goal achievement within the context of the overall QI program. Subsequent recommendations for improvement will be implemented through the Quality Improvement process and include:

- Intensifying communications with providers and members
- Revision of care plans
- Increased stratification and/or searches for clusters not meeting the goals
- Advocacy with other care entities including institutions, and caregivers

Goals not achieved will be reviewed against established benchmarks with focus placed on addressing the challenges/barriers to achieving the goals. Progressive disciplinary action will be taken as necessary. Areas of improvement to the Model of Care are communicated during the Quality Improvement Committee meetings and to all stakeholders via policy and procedure changes. Improvements that are made that directly impact the member will be communicated either telephonically, online/website, or in writing.

3. Staff Structure and Care Management Roles

A. Administrative and Clinical Oversight

SCFHP has responsibility under its contracts with DHCS, MRMIB, and DMHC to provide, monitor, and evaluate the effectiveness of health care services delivered throughout SCFHP's care delivery system.

The SCFHP Governing Board maintains ultimate authority and responsibility for the operation of SCFHP and for the quality of patient care for all its members. The SCFHP Governing Board is responsible for overseeing the quality of care and service provided in the Program. All administrative and clinical functions are ultimately overseen by the Santa Clara Family Health Plan Board of Directors, its Governing Body. Through Santa Clara Family Health Plan's Medical Management Department, led by the Medical Officer and the Director of Medical Management, the plan will monitor Dual Eligible MOC implementation and evaluate MOC effectiveness.

Chief Executive Officer (CEO)

The CEO, who is employed by and reports directly to the SCFHP Governing Board, ensures that SCFHP maintains a meaningful and effective QIP including allocating adequate staff and resources to achieve the Board's objectives. The CEO has overall responsibility to ensure that a continuous QI process is implemented for all systems within SCFHP. The CEO is also responsible for all aspects of the administration of SCFHP and for establishing and meeting goals and objectives approved by SCFHP Governing Board.

Chief Operations Officer (COO)

The COO reports directly to the Chief Executive Officer (CEO) and is responsible for the ongoing operations of SCFHP programs to ensure health plan goals and objectives are met. This position has responsibility for operations for the Divisions of Claims, Provider Network Administration, Member Services, Eligibility, Compliance, Contracting, Credentialing, Pharmacy, Project Management and Medical Management.

Medical Director

The Medical Director acts as an advisor to the QIC and any subcommittees/standing committees as convened. The Medical Director is responsible for the direction and management of all clinically related QI activities in conjunction with the QIC.

Director of Medical Management

The Director of Medical Management reports to the COO and is responsible for the ongoing operations of SCFHP medical management program to ensure health plan goals and objectives are met. This position has responsibility for operations of the Utilization Management, Quality Management, and Health Education Departments.

The Medical Director and the Director of Medical Management has overall responsibility of the Quality Improvement operations of the program, while delegating authority to the associated Directors and Managers within the structure for day-to-day activities. The Director of Medical Management reports directly to the Chief Operations Officer. The Medical Director along with all departments within the organization has responsibility for the implementation and success of the Quality Improvement Program. The Medical Director reports to the Chief Executive Officer. The Medical Director reports quality activities to the SCFHP Board of Directors Quality Improvement Committee and Subsidiary Boards.

Health information is maintained through a HIPAA compliant system. All Utilization Management and Case Management functions are centralized in an electronic information system. Working closely with QI and IT staff, Santa Clara Family Health Plan performs healthcare information management functions so the Plan can review encounter data for appropriateness and timeliness of services, review pharmacy claims, analyze utilization data for appropriateness, and maintain and share other reports related to beneficiary care. On a quarterly basis, the Utilization Management Committee (UMC) reviews the Model of Care Program, which includes analysis and reporting of performance and health data and as part of the Quality Improvement Program (QIP) presents this information to the Quality Council.

B. Administrative Functions

Santa Clara Family Health Plan performs administrative functions comprised of qualified professionals with extensive experience in Medi-Cal (Medi-Cal) and Medicare Advantage plan operations. These operations include marketing and sales, enrollment/disenrollment, eligibility verification, claims processing, member services, provider services, data collection and reporting, delegated entity oversight functions, quality improvement oversight services, member and provider appeals and grievances, member and provider satisfaction surveys, and other administrative services.

Through the sales and marketing functions, the Plan will provide for administrative coordination of Medicare and Medi-Cal benefits by producing and giving prospective members information about benefits they are eligible to receive from both programs. These materials are available in the enrollment packages used in the sales process.

The enrollment and eligibility functions key to identifying changes in member's Medi-Cal eligibility are managed through the Enrollment Department. This area is responsible for maintaining accurate member information including current Medi-Cal eligibility information from the State of California to ensure proper enrollment into the Special Needs Plan. The Enrollment Department is staffed with eligibility coordinators who ensure that the transmissions from the State are accurate. They further are responsible for developing and filing enrollment and eligibility reports used in the enrollment process.

The Claims Department is responsible for the adjudication of Medicare and Medi-Cal claims for which the organization would be contractually responsible. Crossover is the transfer of processed claim data from Medicare operations to Medi-Cal (or state) agencies. The CMS Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. The plan follows all current CMS and state guidelines in the accurate exchange of eligibility and claims files, so the correct Medicare claims are flagged for crossover payment processing.

Member Services is trained and knowledgeable on benefits members are eligible to receive from both programs. They provide members clear explanations of benefits and of any communications; they receive regarding claims or cost sharing from Medicare, Medi-Cal or providers. They also provide members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medi-Cal program.

Clinical Staff

Santa Clara Family Health Plan provides management of the clinical operations and health services functions of the Dual Eligible Medi-Cal population including medical director, case management, utilization management, quality management, pharmacy management and behavioral health care.

Medical Director

The Medical Director acts as an advisor to the QIC and any subcommittees/standing committees as convened. The Medical Director is responsible for the direction and management of all clinically related QI activities in conjunction with the QIC. The Medical Director is also responsible for directing Medical Services activities related to

the dual eligible Special Needs Plan with the focus on the management and improvement of health for the frail and disabled adults and members with chronic disease in the population. This position oversees utilization and quality management activities including support of collaborative relationships with physicians and hospitals to achieve mutually acceptable business goals. The Medical Director:

- Ensures that an effective QIP is established, supported and maintained in conjunction with the QIC and SCFHP.
- Provides clinical direction for all QIP functions
- In conjunction with the QI Manager, provides information to assist the QIC and SCFHP Governing Board with their decision making process regarding matters of quality of care, peer review, credentialing, recredentialing, health education, behavioral health care and clinical and medical procedures.
- In conjunction with the Sr. Manager of Contracting and Credentialing, provides oversight, direction, and pre-approval for all providers presented to the Credentialing Committee.
- Recommends Committee chairs and members to the appropriate senior management for review and approval.
- Has sole responsibility for the determination of denials of care for medical necessity.
- Participates in the behavioral health aspects and internal clinical quality improvement process of the QIP.
- Reports all healthcare delivery systems issues to the QIC on all clinically related issues and to the CEO on administrative issues.
- Provide medical expertise and collaboration for all Case Management, Disease Management, Quality, Pharmacy, and Medical Review initiatives.
- Support collaborative relationships with physicians and hospitals.
- Evaluate and modify medical decision-making policies and review criteria as appropriate.
- Participate in Health Services strategic planning in evaluating utilization, quality, national and local trends, and identify interventions to optimize the utilization of resources and the delivery of high quality health care services.
- Participate in multi-disciplinary meetings and recommends treatment alternatives designed to keep patients healthy or resolve on-going clinical issues.
- Participate in the Appeals and Grievance process to assure timely, accurate responses to members and providers.
- Work to assure productive relationships with all customers, employers, members, and providers to assure that members receive appropriate health care in the most appropriate setting with the best value in health care.

Director of Medical Management

The Director of Medical Management reports to the COO and is responsible for the ongoing operations of SCFHP medical management program to ensure health plan goals and objectives are met. This position has responsibility for operations of the Utilization Management, Quality Management, Case Management and Health Education Departments. This role oversees the case management staff that will perform a major role in the day-to-day management of Dual Eligible plan members and the assignment of integrated care teams (ICT) for each member.

- Provides leadership and directs medical management utilization activities, disease management and Quality Management and Quality Improvement programs in accordance with regulatory, corporate, State and accreditation requirements to maintain compliance with government programs, including CMS, Medi-Cal, and other accrediting bodies for which there is a business need.
- Collaborates with the Medical Director and Department Managers to identify trends in utilization of medical services, practice patterns, and adequacy of benefit/payment components.
- Provides expertise and vision with planning and establishing goals and objectives to improve quality and cost-effectiveness of care and services for members.
- Participates in the review and assessment of provider contracts and provider networks to facilitate implementation of recommendations that would improve utilization and health care quality.
- Recommends Committee chairs and members to the SCFHP Governing Board for review and approval.
- Provides regular written updates to the SCFHP Governing Board on program management and committee activities as requested by the CEO, COO, or Medical Director.

Case Management

The Director of Medical Management oversees Case Management and is responsible for the required reporting for the state, as well as the individual and departmental performance in managing a member's care. This position also ensures that appropriate and cost effective services are authorized and provided. The Manager also ensures and provides oversight to Case Managers for the development, implementation, outcomes and continuous improvement of a written care plan that reflects the agreed upon placement and services that include medical, medically related social, and behavioral health services.

Case Management Team

The Case Management team consists of Certified Case Managers, Licensed Clinical Social Workers, and Case Coordinators. The team ensures that appropriate and cost effective services are authorized in order to promote independence in the most integrated and least restrictive environment. With the involvement of the member and/or member's representative, the Case Manager is responsible for the development, implementation, outcomes and continuous improvement of a written care plan that reflects the agreed upon placement and services that include medical, medically related social, and behavioral health services to individuals eligible for SCFHP's Special Needs Plan.

Certified Case Managers

The roles of the Certified Case Manager (CCM) are designated by complexity of the needs of the Dual Eligible Member and perform initial and ongoing oversight of all Dual Eligible members. Functions of the CTM include the following:

- Performs the initial health risk assessment within 45 days of enrollment and ensures reassessments are completed per established guidelines as outlined by CMS (annual reassessments) and applicable State Medi-Cal program.
- Provides adequate information and training to assist the member, family, additional supports in making informed decisions and choices regarding appropriate service placement to meet the member's needs in the most integrated setting.
- In coordination with the member, member's representative/guardian, additional supports, and Primary Care Physician (PCP), provide a continuum of service options that will support the expectations and agreements established through the care planning process for SCFHP SNP members stratified to risk Level 1 & 2.
- In collaboration with the member, member's representative/guardian, the Care Manager or Complex Care Manager and the appropriate integrated care team members develop an interactive care plan, which outlines goals for the members care and the associated benefits/services provided to meet the goals.
- Provide the member and/or member's representative/guardian with flexible, innovative, and creative service delivery options.
- Integrate access and referrals to SCFHP services available through the community.
- Work collaboratively with SCFHP staff, physicians, discharge planners, utilization management, providers, community agency staff, other professionals/paraprofessionals involved in the care of the member, and with the family to assure provision of high quality cost effective services.

- Educate and help the member, member's representative/guardian to identify their role in interacting with the service system.
- Educate the member, member's representative/guardian on how to report unplanned gaps. Develop written contingency or back-up plan for those members receiving critical services in their own home:
  - Attendant Care
  - Personal Care
  - Homemaker and/or
  - In-home Respite
- With support of the Care Planning system, responsible for the documentation of progress and event changes to the member's plan of care.
- Provides communication to the care team regarding any changes in the members' health status and communicates updates to the care plan as needed.
- Obtain commitment from servicing provider(s), and authorize services as appropriate.
- Provides necessary information to providers about any changes in members functioning to assist the provider in planning, delivering, and monitoring services.
- Monitors performance of the plan of care with the interdisciplinary care team on an as needed basis and ensures that data is collected against key performance indicators for the program.
- Interacts at least monthly with the interdisciplinary care team to track progress made toward the goals of the member's care plan.

Licensed Clinical Social Worker (To be hired in new budget year 7/2012)

- Provide psychosocial assessments of members and families to identify emotional, social, and environmental strengths and problems related to their diagnosis, illness, treatment, and/or life situation.
- Formulate, develop, and implement a comprehensive psychosocial care plan utilizing appropriate clinical social work treatments and interventions.
- Screen, identify, and manage mental health and/or substance abuse problems in members, independently or as part of the team.
- Maintain a working knowledge of relevant medical/legal issues that impact on member care, e.g., advance directives, elder abuse.
- Provide education to members and families around issues related to adaptation to the patient's diagnosis, illness, treatment and/or life situation.
- Participate in the interdisciplinary care teams and provide leadership in representing clinical social work perspective/liaison with member and family.

- Maintain strong working knowledge of and liaison with community agencies, organizations and resources to access and provide for member care needs.
- Arrange, procure, and coordinate member pre and post hospital needs, or other care levels such as skilled nursing facility, rehabilitative care or to home.

Pharmacist and Pharmacy Team

SCFHP Pharmacists are an integral part of the Model of Care and the Interdisciplinary Care Team. SCFHP has an internal pharmacy director and two pharmacy coordinators. The core functions of Pharmacists are to assure member access to appropriate medications, ensure safety, increase adherence, provide education and optimize medication therapy.

SCFHP clinical pharmacists target those members most in need of pharmacy management, including:

- Recently hospitalized members
- Members on multiple medications or with multiple prescribers
- Members on anticoagulants and other high risk drugs
- Members referred by NCMs, PCPs or other team members for medication reviews
- Members in Chronic Care Improvement Programs (CCIP) with congestive heart failure and/or chronic obstructive pulmonary disease

SCFHP Pharmacists participate in weekly clinical rounds to ensure that medication management is integrated into ICPs. In addition, a SCFHP Pharmacist proactively alerts community pharmacists and PCPs when members initiate high risk medications or meet criteria for inclusion in CCIPs; performs medication reviews on members identified as having a potential issue related to appropriateness, safety, or adherence; and shares updated information on drugs and regimens with the appropriate prescriber.

Information related to medication management including medication profiles are documented by SCFHP Pharmacists in the Centralized Enrollee Record (CER) and are available to all members of the Interdisciplinary Care Team (ICT) to promote coordination of care.

MedImpact, Santa Clara Family Health Plan's pharmacy benefit manager, provides the pharmacy benefit program for SCFHP members. MedImpact in conjunction with SCFHP's pharmacy team members' work with the plan's PCPs, specialists and the member's complex case manager. This team provides support in ensuring that the member is on the appropriate medications for their conditions. For members in the Medication Therapy Management Program, a pharmacist acts as a consultant in support of the ICT and provides support in educating staff, member and the member's

representative on the medications utilized and any untoward reactions that could be expected. Appropriate actions are made a part of the interdisciplinary care plan and monitored toward the goal of the actions by the pharmacists and the Case or Complex Case Manager. The major components of Santa Clara Family Health Plan's MTM program includes: Identification of eligible members, targeted drug related problem review, integration of case management with pharmacy management, and collaboration, coordination and communication within the interdisciplinary team and the patient/caregiver.

Health Educator

The SCFHP Health Educator reports to the Director Medical Management. The Health Educator is certified in the three evidence-based educational and wellness programs which include Stanford Chronic Disease Model™ (self-management program), Healthy Eating™, and Matter of Balance™ and has experience working with the geriatric population.

Responsibilities of the Health Educator include:

- Develop and disseminate member health education materials
- Develop and implement caregiver trainings
- Develop and implement the three evidence-based educational programs which include Stanford Chronic Disease Model™, Healthy Eating™, and Matter of Balance™
- Assist in the development and implementation of educational programming for NCMs, CRCs

4. Interdisciplinary Care Team

Santa Clara Family Health Plan will use an interdisciplinary care team (ICT) in the development of care plans and management of care for dual eligible members. The Interdisciplinary Care Team assures timely and appropriate delivery of services, providers' use of clinical practice guidelines developed by professional associations, timely follow-up to avoid lapses in services or health care when there is transition across settings or providers, and conducts chart and/or pharmacy reviews.

Specifically, the Interdisciplinary Care Team:

- Analyzes and incorporates the results of the initial and annual health risk assessment into the care plan
- Collaborates to develop and update an individualized care plan for each beneficiary

- Manages the medical, cognitive, psychosocial, and functional needs of beneficiaries through the initial and annual health assessments
- Communicates to coordinate care plan with all key stakeholders including the provider, beneficiary, family, and health plan, as needed
- Maintains a web based meeting interface
- Maintains a mechanism for resolution of beneficiary complaints and grievance

All meetings are documented and record care changes and decisions as well as team meeting participants, including beneficiary and caregiver involvement when it occurs. Each Plan member will be reviewed on a prescribed basis, or sooner, if there is a change in health status or condition that warrants care team discussion and intervention.

Facilitation of Beneficiary Participation

The ICT coordinates the care of SCFHP members through a comprehensive, integrated and individualized care planning process. The PCP is the focal point of clinical decision making with the participation of the member or his/her legal designee. The member's participation is facilitated by the ICT through home visits, face-to-face meetings, or telephonic communication in the members preferred language. The care planning process integrates the member's goals with the recommendations and insights of all necessary practitioners (e.g., specialists, pharmacists, therapists), and community service providers to establish a continuum of health-related services appropriate to both the needs and the residential setting of the member. The core product of the ICT is the Individual Care Plan (ICP).

The ICP uses the information from the SCFHP health risk assessment and other tools, member goals, medical, behavioral health and social service needs of the individual. Assessments of the member's health status, activities of daily living, instrumental activities of daily living, mental/emotional functioning, safety/environmental status, home situation, and formal and informal support systems all contribute to SCFHP's understanding of the member and the elements needed for a complete care plan. The ICP is implemented by the ICT, which integrates medical, behavioral health, community long term and social supports and other support services toward meeting the needs of each member. The ICP is reviewed periodically and is revised with the members changing conditions and needs.

Participation by all ICT members is integral to the success of the Model of Care. Plan members are invited to participate by their Case Manager when their care plan is being reviewed. Members can attend by telephone. If the member is not able or willing to participate, then Plan members are informed upon receipt of their care plan of the

opportunity to discuss the care plan and submit concerns to their Case Manager or PCP.

The composition and frequency of the member's ICT is based on the member's health needs.

The Case Manager assesses each member's health needs within 45 days of enrollment and at least annually thereafter and upon a change in a member's condition or receipt of a referral. The health risk assessment is used to determine the member's level of need. The level of need may change and can be precipitated by a change in the member's care needs including hospitalizations, a community referral, or data mining. The Level of Need determines the ICT's role, composition and frequency of review by the ICT.

SCFHP is committed to active and collaborative involvement with provider, community organizations and public entities in fostering improved care and services for the cognitive impaired under the age of 65 years and economically disadvantaged with ongoing relationships with external organizations. Santa Clara Family Health Plan will initiate discussions with essential community based agencies and organizations to approach for involvement on the ICT, as indicated by the member's needs.

5. Provider Network Having Special Expertise and Use of Clinical Practice Guidelines

SCFHP contracts with a full network of Board Certified physicians, institutional and ancillary providers as required by CMS. SCFHP is committed to developing and maintaining a comprehensive provider network that meets the medical needs of Plan members. Whenever available, it is a priority to contract with board certified providers. An online provider directory and hard copy directory is available.

SCFHP Provider Network is comprised of a combination of clinical professionals with expertise in dealing with older populations as well as facilities (in addition to hospitals) that care for this high risk populations. These providers also meet the health care needs of our targeted dual eligible membership as this population has the same broad healthcare needs as any Medi-Cal population. The providers all serve Medi-Cal members therefore provide full access to SNP members. In our service area, SCFHP specifically contracts with FQHC provider organizations that have specialized expertise in providing healthcare services to Medi-Cal members. As a Medi-Cal plan SCFHP, offers pharmacy benefits and SCFHP Pharmacists coordinate closely with SCFHP's healthcare providers and SCFHP's Utilization Management and Case Management clinical staff to ensure seamless delivery of care involving both medical care and pharmacy services. SCFHP contracts with behavioral health specialists, physical therapists, occupational and speech therapists, laboratories, and radiology providers for our service area. Qualified nursing personnel are available internally through SCFHP's

Utilization Management and Case Management Departments as well as in each physician office and qualified institution. All providers contracted with SCFHP must meet SCFHP's credentialing criteria and are credentialed according to SCFHP's Credentialing Policies and Procedures. On a quarterly basis as part of the internal auditing and monitoring program, the Plan network is reviewed for adequacy and gaps in the types of specialty care needed to provide services to our members.

As part of SCFHP's quality and credentialing review of its provider network the Plan monitors access to care through specified appointment and after-hours provider surveys as well as on-going monitoring. Providers are re-credentialing every 3 years according to the Plan's credentialing policies and procedures. The Plans credentialing policies and procedures are CMS and NCQA compliant. Delegation oversight of those entities for which credentialing has been delegated occurs at least annually. Access to care and quality of care is also monitored through member complaints, quality of care referrals, grievances, appeals, CAHPS and disenrollment data.

As a coordinated care plan, SCFHP enables delivery of care to members across various care delivery settings and providers through its Utilization Management and Case Management Programs and protocols. Members are encouraged to coordinate all care though their PCP. The PCP makes referrals to other providers as deemed appropriate in their clinical judgment. The Utilization Management and Case Management Departments work with all providers through its referral and authorization system to assist in coordination of the member's care outside the PCP office. SCFHP utilizes Milliman criteria and CMS guidelines in evaluating provider requests for services. Additionally, SCFHP employs an evidenced based philosophy in its review and requires contracted providers to adhere to evidence based criteria through its provider contract and Provider Manual. The SCFHP Medical Director maintains open communication and dialogue with contracted providers in the discussion of evidenced based medicine documents and guidelines.

Providers are required to support and collaborate in the Model of Care and the member's care plan. Case managers and network providers coordinate with the ICT telephonically and by means of the SCFHP Online System as well as by means of Member Services. As needed, they collaborate with the Interdisciplinary Care Team and in the assessment, diagnosis and treatment of the members and in the development and updating of the care plans. The PCP and other providers are involved in the development of the initial and subsequent care plans. Pharmacotherapy consultation in collaboration with the PCP and care team is provided by specialists and SCFHP pharmacists.

Reports are generated monthly, quarterly and annually to members of the ICT depending on the acuity of the member. Audits (scheduled and ad hoc), are conducted

to confirm accuracy and effectiveness of the services and plan of care, and to ensure the completeness of the beneficiary record.

The Medical Director, Director Medical Management, Case Manager, and Provider Relations are also an integral part of the coordination of care and work towards ensuring that specialized services are delivered in a timely and quality way. They too have access to selected databases and reports in order to oversee and monitor coordination of care with the Network Providers.

Physicians provide hospital based emergency and urgently needed services as well as inpatient acute and chronic services at hospitals and long-term care facilities.

Member Services assists the member regarding benefit questions, provider inquiries and clarification of services. Additionally, they assist to facilitate intake of grievances or complaints and appropriate delivery of the complaints for resolution so the member receives timely and satisfactory outcomes.

6. Model of Care Training for Personnel and Provider Network

Model of Care Training Strategies and Content

Model of Care training is a part of the overall training of SCFHP staff and providers, which includes:

- administrative/regulatory curriculum including HIPAA compliance
- extensive clinical curriculum focused on communication protocols, use of SCFHP adopted clinical documentation tools; guidelines and measures of care standards
- QI policies and procedures relevant to either.

Training tools, techniques and strategies for SCFHP staff and providers includes face-to-face interaction, mentoring, manuals, newsletters, web-based communications and portals, like SCFHP provider manual. Training is updated to include changes to policies, nationally and regionally adopted, criteria, guidelines and protocols as they occur.

<u>Staff Training</u>

All clinical and client services staff are required to complete a SCFHP corporate and departmental training program upon hire and as needed. Training is administered using multiple modalities – face-to-face, written materials, feedback assessments, and web-based trainings. Mentoring is an important component of training. All new employees are partnered with an experienced employee. Development and training needs of staff are identified and provided on an ongoing basis.

The administrative/regulatory curriculum includes:

- Orientation to personnel policies and administrative procedures
- Training in mandated policies including HIPPA, work place discrimination
- Overview of the corporate structure, including process for review and approval of Policies and Procedures

The Model of Care training constitutes a major portion of the curriculum including composition, operations, and communication procedures of the ICT; practical training with the individualized care plans, the SCFHP Report Library (UM and other analytics), and other electronic tools and communication modes used to expedite care.

The clinical curriculum includes:

- Overview of the SCFHP Model of Care.
- Effective use of the individualized care plans and authorization application
- Completion of the nursing assessment, fall risk assessment, geriatric depression scale and other clinical measurement tools
- The development of an Individual Care Plan for each member
- Coordination and Communication with providers, community care service providers, and other members of the ICT
- Overview of Clinical and Quality Policies and Procedures including those most pertinent to implementation of the Model of Care.

Provider Training

Provider training has several aspects and components:

- Training related to clinical and service issues for the practitioner
- Training related to administrative and policy issues for the practitioner
- Training of the office staff who support the practitioner

Providers are trained on the Model of Care at least annually with additional training occurring when needed. New providers are trained in the Model of Care upon joining the SCFHP Network. Updates and reinforcement are also provided during nurse case manager and provider interactions, on a monthly basis to providers via a report supplemented with information on his/her patients, new/updated clinical/administrative policies and guidelines and care management issues. In addition, there is a quarterly provider newsletter and a dedicated section in the Provider Manual about the Model of Care, which is available on the SCFHP web portal.

Assuring and Documenting Training

Documentation of Staff Training

All clinical and client services staff are required to complete a SCFHP corporate and departmental training program upon hire. Training includes the content areas as described above, and is documented by the following:

- Attendance records maintained in department files for in-person training
- Electronic records maintained for courses taken through SCFHP University
- Testing of knowledge acquisition maintained in department or Human Resources files

Documentation of Provider Training

Attendance records are maintained in department files for onsite provider training. During ICT meetings, the Nurse Case Manager ensures that training and knowledge transfer occurs. If there is evidence of lack of knowledge transfer, the Directors of Medical Management and Medical Director as appropriate will assess and remediate. In addition, providers are encouraged to participate in educational forums (web-based, meetings, conferences) related to serving the needs of dual-eligible members.

Oversight of Training

Oversight of staff training is the responsibility of the Director of Medical Management.

Oversight of provider training is the responsibility of the Director of Medical Management, Medical Director and Director of Pharmacy in collaboration with the Director of Provider Relations.

Actions if Training is not Complete or is Unsuccessful

Staff

Completion of training and demonstration of competency is critical and mandatory for all SCFHP staff. If competency has not been established, the mentoring process is revised, remediation is provided and skills and competence are reassessed. Staff is not allowed to function within their scope of practice until skills and competence is demonstrated. Competence is a requirement of continued employment.

Providers

If significant quality or service issues arise in the practice indicating a lack of contractual obligation to work within the Model of Care, the SCFHP Medical Director is responsible for addressing quality or service issues and determining appropriate action. Actions

include, but are not limited to, discussion with the provider to address concerns followed by increased monitoring of provider activity, formal written review of the issue which is shared with the PAC through a peer review process followed by increased monitoring of provider activity, and if necessary termination from the provider network.

7. Health Risk Assessment

Santa Clara Family Health Plan conducts an initial health risk assessment (HRA) for each member within 60 days of enrollment. The HRA is mailed with a self-addressed stamped envelope to all members with the Welcome Kit. An initial call is made to the member to discuss the HRA. If there was, no response an additional or second call is placed to the member. If the member still does not respond. Within 90 days of the initial mailing, a query is run to identify all non-respondents. A second HRA is then generated and sent to the non-respondent with a business reply envelope provided. The HRA is a comprehensive assessment of the member's medical, psychosocial, functional and cognition status. The results of the HRA identify the needs of the members and enables stratification of identified risk.

Based on the HRA results, those members identified at being possible at risk, undergo a more intensive assessment conducted telephonically. This assessment provides a thorough review of 14 key domains, representing the vast majority of problem areas that most dramatically impact the quality of life of dual eligible individuals.

These domains are:

- Functional mobility
- Nutrition management
- Medication management
- Continence management
- Mental health/well being
- Sensory capabilities
- Personal and Legal issues
- Financial status
- Environmental issues (household/safety issues)
- Health maintenance (including medical conditions and issues)
- Personal care (including activities of daily living such as dressing, bathing, eating, walking, transferring, toileting)
- Home management (including instrumental activities of daily living such as shopping, meal preparation, housework, and money management)

- Socialization
- Caregiver issues/support network

As a result of this assessment, members are classified into three levels:

Level One- Supported Self-Care Case Management

If the member is determined not to require any specific care management at the time of the initial HRA, the member is placed into Level I. The ICT is identified, and a care plan is developed. Follow up actions are determined. For example, if the member is a smoker, smoking cessation classes may be coordinated.

Level Two- Disease/Episodic Case Management

If it is determined that the member has moderate needs, the member is placed into Level 2. The ICT is assigned and the care plan is developed and implemented. Based upon the outcome of these assessments, all members have interdisciplinary care plans developed collaboratively to identify the member's needs and develop tasks required to meet the goals of the plan of care. The assigned Case Manager will conduct quarterly meetings with the Interdisciplinary Care Team until the member no longer requires that specific type of care or intervention; the member will be continually monitored for risk by the appropriate Case Manager.

Level Three- Complex Case Management

If it is determined that the member has complex, high acuity needs the member is placed into Level 3. The ICT is assigned and the care plan is developed and implemented. Based upon the outcome of these assessments, all members have interdisciplinary care plans developed collaboratively to identify the member's needs and develop tasks required to meet the goals of the plan of care. The assigned Case Manager will conduct quarterly meetings with the Interdisciplinary Care Team until the member no longer requires that specific type of care or intervention; the member will be continually monitored for risk by the appropriate Case Manager.

After the initial stratification and placement into either Level 1, 2 or 3, members will be assessed on an ongoing bases and their placement into a level will be modified as indicated.

Communication of the Health Risk Assessment

The Interdisciplinary Care Team (ICT) consisting of the PCP, SCFHP and CRC coordinates all care for members. Pharmacy and behavioral health specialists are available to the ICT at all times. At the discretion of the PCP, other professionals and

support disciplines are invited to participate in evaluating and planning services critical to meeting the member's care needs. Throughout this process, nurse care manager (NCM) authorizes the services identified in the evolving ICP and arranges for their implementation and monitoring. The member's ICP is available to ICT and provider services on a need-to-know basis to provide the best care and services. SCFHP NCM support communication needs of the ICP by reviewing care plans, arranging in person or telephonic meetings, and ensuring that all ICT participants have needed information. Ongoing communication through follow-up phone calls is monitored and home visits are made as appropriate. PCP, NCM, CRC meetings may be telephonic or face-to-face, as circumstances dictate.

Once approved by the PCP, the plan is reviewed with the member, or the member's designated representative and the member's caregivers and agreed upon by all parties. The ICP is documented and maintained in the secure electronic Centralized Enrollee Record, and provided to the member. To ensure the members' understanding of the ICP, the majority of face-to-face and telephonic member communication occurs in the member's preferred language.

A re-assessment will also be conducted when there is a significant change in the member's health, an unplanned hospitalization or a member, provider, or community service referral. All Santa Clara Family Health Plan Dual Eligible members are re-assessed at least within one year of the last assessment or sooner if there is a change in health status, hospitalization or other trigger.

The results of the assessments will be shared with the PCP, Case Manager, ICT and other health care providers as appropriate. The risk assessment is used by the Case Manager to determine the care plan for the member, and contained in the SCFHP Online System. The risk assessment is used by all the members of the ICT including the member. A member care plan report is provided to the member, PCP and all the members of the ICT. The member care plan report contains the synthesis of the risk assessment.

8. Individualized Care Plan (ICP)

Care Plan Development

An Individualized Care Plan is developed for each beneficiary by the Case Manager and reviewed by the respective Interdisciplinary Care Team. Whenever feasible, the beneficiaries and their caregivers are involved, and the member's health care preferences are incorporated. At least annually, the care plan is reviewed and revised as needed based on the annual re-assessment and feedback from the member, the member's caregiver, PCP, ICT and other providers and community resources personnel. When there is a change in health status or by request from the member, the

member's caregiver, PCP, ICT and other providers and community resources personnel, the ICP is modified more frequently. The care plan is communicated to the beneficiary, caregiver, and providers. The care plan is accessible to all providers as needed either electronically or paper and records are maintained per HIPAA and health information professional standards.

Generally, the goals of care plan are to:

- Promote quality, safe and cost-effective care
- Promote utilization of available resources to achieve clinical and financial outcomes
- Ensure access to and coordination of services regardless of payer
- Work collaboratively with member/family, member's physicians, health plan and others to develop and implement a member-centered plan that meets the individual's needs/goals
- Work collaboratively with member to develop his/her Advance Directives

Care Plan Elements

Each Care plan has a special emphasis on preventative care and care coordination interventions tailored to one or more of the key domains earmarked to support continued independence and promote optimal health. The Care Plan includes the following essential elements:

- Problems/Concerns – category and status- as a result of the health risk assessment
- Goals
- Action Steps
- Service (formal and informal) and Benefit Suggestions
- Member/Family Preferences for Care

Level One: Supported Self Care Case Management

The goal for Level 1 is to help the member continue to manage their health and improve health outcomes. The care plan for members identified as having no assessed care management need includes a mailing with targeted health and wellness educational materials, member newsletters, community resource guide, and information on how to contact the Case Manager, member service representative, or pharmacy area with questions or for help. All members are reminded to contact the Plan if there is any question about the coordination of benefit and services between Medicare and Medi-

Cal. The individualized care plan for each member includes measurable goals and objectives, specific services and benefits to be provided, and measurable outcomes.

The Level 1 care plan is reviewed annually by the Medical Director and approved by the UMC to ensure that the needs of the members who have a general level of need are met. Annual member mailings are conducted to inform members of benefit changes. All care plans and interventions with the members are documented in the member's electronic case management file and are available to the ICT, the member and the member's physician in accordance with HIPAA guidelines. The care plan is maintained in the SCFHP Online System case management module.

Level 2: Disease/Episodic Case Management

The goal for Level 2 is to help the member maintain their optimal level of wellness through medical and social supports. The Case Manager reviews diagnosis and other existing information combined with clinical judgment and critical thinking as part of the plan development process. Factors the Case Manager considers include, but are not limited to:

- Likely course of the natural progression of member's health
- Most common medical and psychosocial problems faced by members with the disease
- Common medical complications
- Extent of member's support system and his/her ability to self-manage
- Other psycho-social factors that impact the member's ability to maintain the treatment plan
- Utilization data and HCC score, if available

The care plan is developed by the Case Manager, reviewed by the ICT at least quarterly, including the beneficiary whenever feasible and other pertinent specialists required by the beneficiary's health or psychosocial needs. The plan is revised upon review as a change in health status is identified. The Case Manager is responsible for communicating to the beneficiary, ICT, PCP and other pertinent network providers any changes, revisions or updates to the plan of care in writing and/or telephonically. All care plans and interventions with the members are documented in the member's electronic case management file and are available to the ICT, the member and the member's physician in accordance with HIPAA guidelines. The care plan is maintained in the SCFHP Online System case management module.

Level 3: Complex Case Management

The goal for Level 3 is to enhance complex members' clinical outcomes; reduce unneeded and expensive medical care; and decrease member and family confusion by increasing a member's control of his/her medical care. The focal point of complex care management is the care plan, which details how care should be coordinated across multiple providers, including PCP's, specialists, nurses, social workers, mental health workers, etc. The Case Manager is responsible for developing, executing and modifying the care plan.

Key components of the Case Management Plan for the most vulnerable population include:

- Care Plan is developed by the Case Manager and ICT with input from the member and caregiver, and supported by clinical guidelines.
- Case Manager oversees delivery of the care, with support from the care providers
- The Case Manager communicates with the member's PCP in the form of regular updates and also provides a status report to the PCP prior to a scheduled visit
- The Case Manager continues to provide the member and family with educational material and support, and follows up with the member and family to answer questions and help solve problems
- The Care Plan is regularly reviewed and additional steps are identified.
- The Medical Director with the ICT reviews the care plan weekly and anticipates issues that may arise. If the issues warrant physician-to-physician communication, the Medical Director will arrange for the communication to take place.
- There is constant, focused clinical attention and coordination of care.

This is a collaborative process of assessing, planning, facilitating and advocating for options and services to meet a member's health needs through active and frequent communication and coordination with the member, member's family/caregiver, the member's physician(s), and community resources to promote quality, cost-effective outcomes. Essential services include discharge planning, condition-specific assessments, coordination with the treating physician to assure adherence to the treatment plan, proactive contingency planning and crisis intervention.

The Case Manager works with the member and their family/caregiver to understand their goals for case management. This ensures a clear understanding of how the member and family would define success for the case management intervention. For complex members, upon completion of the assessment, the Case Manager establishes the member's case management plan based on the issues the member is experiencing.

All Care Plans and interventions with the members are documented in the member's electronic case management file and are available to the ICT, the member and the member's physician in accordance with HIPAA guidelines.

9. Communication Network

A key component to the successful implementation of a members care plan is ensuring all stakeholders understand and implement the care plan. Santa Clara Family Health Plan coordinates the delivery of services and benefits through integrated systems of communication among plan personnel, providers, beneficiaries and family members. Communication of member information complies with HIPAA and privacy laws.

SCFHP employs a variety of communication methods to coordinate communication among plan constituents. Provider communication is coordinated between providers, members and SCFHP through regular face to face meetings in provider offices, office administrator group trainings and orientation meetings, periodic fax updates regarding updated plan information and/or policy changes, distribution and periodic update of the Provider Manual, periodic updates of provider agreements relative to regulatory or policy changes, plan specific web-based interface, through the SCFHP Online System, between plan and providers regarding member medical management progress, prescription drugs, claims and eligibility and posting of pertinent information and documents on Plan's web site. Providers are provided copies of all referral and authorization determinations relative to members in their care. All medical determinations, including basis for determination relative to evidence of care, are documented in the system. Providers are also engaged in the ICT including the member's PCP and, as appropriate, specialist providers. Such interface is typically managed through conference calls and/or PCP collaboration letter. A combination of face-to-face meetings and conference calls are employed to hold scheduled Quality meetings, which engage providers, QI, UM, and other health services personnel.

Member communication is coordinated between providers and the Plan through utilization management and pharmacy services management outreach programs including but not limited to MTM and other defined health services programs as well as standard referral and authorization determinations. Member communication is also enhanced through expansion of the ICT process for the dual members. Member Services conducts regular outreach contact with members and providers as new member orientation and assists in the facilitation of new member's first PCP office visit appointments.

Santa Clara Family Health Plan's web site connects all stakeholder's relative to plan information, benefits, SCFHP's pharmacy formulary, provider network director, and

Evidence of Care which describe the plan's model of care and general policies and procedures with regard to regulatory compliance, member protections, plan rules, etc.

Designated representatives from the departments that support provider and member communication work in collaboration to monitor and assess the effectiveness of the various styles used in providing information. Representatives include but are not limited to Member Services, Claims, Provider Relations, Marketing, Utilization Management and Case Management, and Quality Improvement with involvement from Compliance to ensure communication meets regulatory requirements and guidelines.

Other plan communication methods include:

- Interdisciplinary care team meetings held regularly to ensure that all providers know the care plan and can discuss any changes in the member's needs or services. All meetings are documented in the member's file. Meetings can also be conducted on an ad hoc basis, if the need arises. Care team members and family members are able to attend via audio-conference.
- E-mails, faxes, telephonic , face to face and/or written correspondence to team members and family caregivers to troubleshoot or problem solve an issue
- Member complaint, appeals and grievance system established so members have a formalized mechanism to file complaints and grievances. This system is communicated in the members EOC, on the plan website, and through member services. The concerns received are reviewed on a monthly basis and reported to the QIC. Corrective actions are taken as needed.
- Member and provider toll free call-lines for questions and problem resolution
- Family and member feedback on satisfaction survey
- Electronic and hard copy newsletters and bulletins to members, providers and employees.

10. Care Management for the Most Vulnerable Subpopulations

Dual Eligible members are among the sickest and poorest individuals covered by Medi-Cal and Medicare. SCFHP expects the dual eligible living in our service area to reflect national data and to have significant medical, behavioral health and social service needs. Within these needy dual populations, there are vulnerable subpopulations that require additional services. These include frail members having multiple, complex and/or chronic conditions, the disabled (both under 65 and over 65), those with ESRD, and beneficiaries near the end of life. Vulnerable beneficiaries are identified through discharge referrals, UM process, pharmacy referral, provider referrals, member self-referral, HRA and/or claims.

The needs of the most vulnerable are addressed in terms of goals, staff structure and roles, interdisciplinary care team, provider network, health risk assessment,

individualized care planning, communication network, and performance and health outcome measurement through the case management process, utilization management process and the ICT care meetings. Case Management roadmaps are developed for those with CHF, diabetes, end stage renal disease, developmental disabled and behavioral health and those with multiple chronic conditions and those near end of life. Case managers work collaboratively with all members of the health care team, including discharge planners at the affiliated hospitals and community services that may be available.

SCFHP's collaborative case management model utilizes an integrated social/medical approach to ensure that appropriate care and services are provided to the members with chronic and/or complex conditions, disabilities and/ or identified psychosocial needs. The goals of the case management program are to:

- Deliver coordinated services and benefits that meet the needs of the dual-eligible population
- Effectively identify, asses, measure and address member needs using a multidisciplinary approach
- Improve member health status through care coordination, education and assistance as indicated
- Facilitate access to appropriate provider and services for member
- Ensure that members receive appropriate preventive health services such as screenings and immunizations
- Promote continuity of care when transitioning from one care setting to another

Members of the Plan receive many additional benefits and supports that are not available in traditional FFS Medicare. These benefits and supports are designed and targeted to address the unique needs of dual eligible individuals intended to improve outcomes and quality of life. The add-on services and benefits for vulnerable beneficiaries include transportation, vision, dental services and a scale program for those members with CHF, home monitoring.

11. Performance and Health Outcome Measurement

SCFHP monitors various data sets to ensure members receive adequate, timely, appropriate care. SCFHP measures performance and assesses health outcomes measurements that will evaluate the effectiveness of the Model of Care. Data is collected and analyzed by the Medical Economics team working in collaboration with the Case Management team. Results are analyzed and evaluated to determine where opportunities for improvement relating to the Model of Care exist. Results and recommendations for change and/or improvement in the Model of Care will be provided to the Quality Committee. Discussion is documented in committee meeting minutes and

preserved in a secured electronic file and a hard copy binder maintained by the Quality Improvement Department.

The Director of Medical Management has overall responsibility for Model of Care effectiveness. The Medical Director will collaborate with the Director of Medical Management in monitoring the Model of Care effectiveness. The Director of Medical Management will prepare an Annual Evaluation of the Model of Care in collaboration with the Plan's Medical Director who, in collaboration with Plan staff and providers, evaluates the results for effectiveness and identified areas of improvement. The Evaluation is presented to the Provider Advisory Council and Credentialing Committee and the Quality Committee.

Areas of improvement to the Model of Care will be communicated during the Quality Committee meetings and to all stakeholders via policy and procedure changes. Improvements that are made that directly impact the member will be communicated either telephonically, online/website, or in writing through newsletters and the Annual Quality Improvement Program Evaluation Summary.