Anthem.

February 24, 2012

Brian Quacchia
Steve Sodegren
Department of Health Care Services
Office of Medi-Cal Procurement
MS Code 4200
Sacramento, CA 95899-7413

Re: California's Dual Eligible Demonstration Request for Solutions (RFS) –Alameda County RFS Application

Dear Mr. Quacchia and Mr. Sodegren:

Blue Cross of California Partnership Plan, Inc. ("Anthem") is pleased to support the California Department of Health Care Services (DHCS) Dual Eligible Demonstration through our proposed solution for Alameda County. This solution reflects our deep commitment to the Demonstration population and program, and builds upon our unique combination of capabilities, partnerships and experience.

For the purposes of our submission to DHCS' Request for Solutions, we use "Anthem" to mean Blue Cross of California Partnership Plan, Inc. and Blue Cross of California d/b/a Anthem Blue Cross. Blue Cross of California Partnership Plan, Inc. is the legal entity that holds the Medi-Cal contract with DHCS.

Your point of contact for our proposal is Steve Melody, Regional Vice President of State Sponsored Business in California. His contact information is:

Steve Melody
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State Sponsored Business
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We look forward to working with the State of California and DHCS to develop a strong program to meet the unique needs of dual eligible members. Thank you for your consideration of our proposed solution.

Kevin Hayden
President, State Sponsored Business
Anthem Blue Cross

Date 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

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.	✓	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	✓	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.		See Mandatory Requirement 3b
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.	✓	
4	Applicant has a current Medi-Cal contract with DHCS.	✓	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	✓	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	✓	
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.	✓	See attachments. In addition to sanctions, penalties and related corrective action plans for the Applicant, Blue Cross of California. Partnership Plan, Inc we have also included a listing of sanctions imposed in the last five years for Blue Cross of California (dba Anthem Blue Cross) and Anthem Blue Cross Life and Health Insurance Company which hold our Medicare Advantage contracts with the Centers for Medicare and Medicaid Services (CMS). CareMore has not had any sanctions or penalties in the last

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
			five years.
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	✓	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	✓	
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.	✓	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	✓	While CareMore is not the Applicant, we have included CareMore's MA-SNP quality performance HEDIS and CAHPS scores for California since as noted in our RFS application response since our solution is based on CareMore's model.
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	✓	
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.	✓	
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.	✓	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	✓	Since the Alameda and Santa Clara Counties are contiguous counties, we have included

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
			documentation for both counties in each application.
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.	✓	
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.		Not applicable
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.		Not applicable
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	✓	
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.	✓	

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	**0**	While the Applicant (Blue Cross of California Partnership Plan, Inc) does not have experience operating a D-SNP, CareMore has five years of experience operating D-SNP plans.
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	**No**	The Applicant (Blue Cross of California Partnership Plan, Inc) did not receive significant sanctions or significant corrective action plans. See information provided under Mandatory 7A for details on sanctions, penalties and related corrective actions.
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	**Yes**	The Applicant's (Blue Cross of California Partnership Plan, Inc) three-year trends for Medicaid HEDIS for Alameda and Santa Clara Counties indicate a demonstrable trend toward increasing success. See Mandatory Requirement 8a for details.
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	**Yes**	See attachment. Our assumption is the reference to "Plan" refers to the Applicant.
5	Has the Plan received NCQA certification for its D-SNP Product?	**N/A**	Since the Applicant (Blue Cross of California Partnership Plan, Inc) is not a D-SNP, this additional consideration is not applicable. However, we have included information for CareMore's D-SNP certification. Please see attached documentation.
6	How long has the Plan had a Medi-Cal contract?	**18 years**	Our first Medi-Cal contract was for Sacramento County in April 1994 (almost 18 years ago). We obtained our Medi-

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

			Cal contracts for Alameda and Santa Clara Counties in September 1996.
7	Does the plan propose adding supplemental benefits? If so, which ones?	**Yes**	See attachment for a detailed list of proposed supplemental benefits.
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?	**No**	Given the short time from the release of the RFS and the submission due date as well as the timeframe needed by county officials to review and approve these letters, we were unable to obtain the letters of good faith. We are confident that given our current, active discussions with County officials that a letter of good faith will be received from the County. Understanding the overall budgetary impact of the Duals Demonstration, County administrators are very interested in reaching an agreement. They are also careful to ensure that any agreement entered into is a collective one that includes the County Board of Supervisors and not just the decision of one individual.
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	**No**	While executed agreements or contracts with the County IHSS have not yet been obtained, we have included our draft agreements which will be shared with County IHHS agencies in the near term. For the reasons noted above under Additional Consideration #8, we are confident that we can reach an agreement with the County IHHS Agency.
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	**Yes**	We currently have a comprehensive, executed agreement with the County agency responsible for mental health in Santa Clara County. We also have an

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

			executed agreement for a resolution dispute process with the County agency responsible for mental health in Alameda County. We will build on our existing agreement with the County mental health agency in Alameda to be a more comprehensive agreement similar to our agreement for Santa Clara County. As such, we have attached the agreements for both counties for you reference in each of our applications. Also, for both Counties we will any incorporate any needed elements required for the Duals Demonstration.
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**	See attachment for list of provider groups. Because Alameda and Santa Clara Counties are contiguous, we have included provider groups for both of these counties in each of our applications.

Signature: 2/24/12

Applicant Name: **Blue Cross of California Partnership Plan, Inc** Date: **2/24/12**

#	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.	**Yes**	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	**Yes**	
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.	**Yes**	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	**Yes**	
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.	**Yes**	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	**Yes**	
6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	**Yes**	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	**Yes**	
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.	**Yes**	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	**Yes**	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	**Yes**	

Signature: 2/24/12

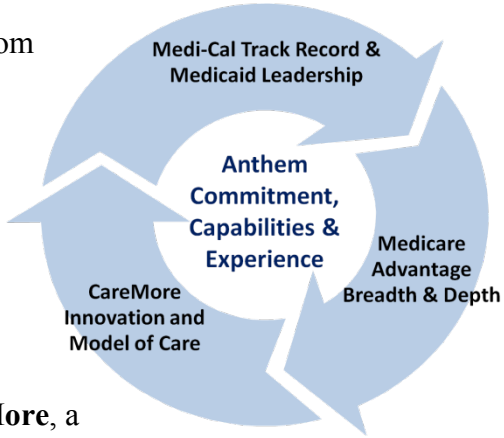
Table of Contents

Executive Summary *1*
Section 1: Program Design *3*
Section 2: Coordination and Integration of LTSS Functions *19*
Section 3: Coordination and Integration of Mental Health and Substance Use Services *35*
Section 4: Person-Centered Care Coordination *45*
Section 5: Consumer Protections *48*
Section 6: Organizational Capacity *67*
Section 7: Network Adequacy *83*
Section 8: Monitoring and Evaluation *94*
Section 9: Budget *99*

EXECUTIVE SUMMARY

Anthem Blue Cross (Anthem) is pleased to support the California Department of Health Care Services (DHCS) Duals Demonstration through our proposed solution for Santa Clara County. This solution reflects our deep commitment to the Demonstration population and program, and builds upon our unique combination of capabilities, partnerships and experience, including:

- A distinguished track record of **Medi-Cal** contributions and leadership, including 18 years of dedicated service to DHCS and our members, which today number over 750,000.
- Leading **Medicaid** capabilities and proven experience from WellPoint plans across ten states serving nearly two million members.
- Broad and deep **Medicare Advantage** expertise, locally within Santa Clara County and across the nation.
- The existing innovations and future expansion of **CareMore**, a new member of the WellPoint family of companies, acquired expressly for the purpose of applying and fostering industry-leading integrated care delivery and population management, with holistic and intensive support for high-risk, high-cost individuals.



Our solution is based upon CareMore's differentiated approach and proven results in caring for vulnerable populations, while driving savings and efficiency.

Goals of our Solution: Our goal is to assess and address the individualized health, psychosocial, and social support needs of our members through an integrated care coordination model that improves health outcomes, access, and satisfaction. CareMore's model

> ***CareMore, through its unique approach to caring for the elderly, is routinely achieving patient outcomes that other providers can only dream about: a hospitalization rate 24 percent below average; hospital stays 38 percent shorter; an amputation rate among diabetics 60 percent lower than average. Perhaps most remarkable of all, these improved outcomes have come without increased total cost.***
> **- "The Quiet Revolution," *Atlantic Monthly*, November 2011**

of care is high-touch and member-centric, offering comprehensive care delivery and case management across the continuum of care and linking members and caregivers with needed services to help members remain in their homes and communities. Through the use of sophisticated health information technology, including an integrated electronic medical record, our solution offers improved data sharing and efficiency. We are confident that the CareMore model provides an unmatched foundation for our Demonstration solution, and is a test-bed of leading practices and innovation that can be evaluated for application across the country.

Coverage Area and Membership Projections: Our solution covers Santa Clara County in its entirety. We have a strong provider network and infrastructure in the county today through our Medi-Cal plan and CareMore's Medicare Advantage Special Needs Plan (SNP). The care and support needs of dual eligible members will require additional providers, including certain safety net providers and specialists. We will execute an aggressive outreach and contracting plan to fill out our target provider network in advance of the readiness review. Based on early assumptions, we estimate that approximately 30,000 - 45,000 dual eligibles in Santa Clara County will be enrolled in the Demonstration. We project Anthem enrollment in the range of 15,000 - 22,500.

Strategic Partnerships: We are expanding upon our partnerships in collaboration with the Santa Clara Family Health Plan, county agencies and community-based organizations, to ensure members receive improved coordination and access to a full continuum of health care services, mental health and substance use services, and long term services and supports, including home and community-based services. We applaud DHCS' emphasis on collaboration and stakeholder involvement, and are committed to playing a leading role in translating this concept into reality.

Anthem is honored to be considered to participate in this bold evolution to a more effective, integrated, and efficient member-centric delivery system in California.

SECTION 1: PROGRAM DESIGN

Section 1.1: Program Vision and Goals

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

We have partnered with DHCS in serving the needs of the Medi-Cal population in Santa Clara County since 1996. As part of our current operations, we have processes in place for dual eligible members enrolled in our Medi-Cal plan, such as: 1) identifying members who need Medi-Cal wraparound services; 2) administering Medi-Cal benefits and services to avoid gaps in care; and 3) adhering to service accessibility and availability requirements for emergent, urgent, and routine service requests. Our locally-based Community Resource Coordinators (CRCs) work collaboratively with county agencies such as the County of Santa Clara Department of Aging and Adult Services, Santa Clara Valley Health and Hospital System (Mental Health Department, Department of Alcohol and Drug Services, and Public Health Department), and community-based organizations (CBOs) to ensure that members are aware of and can access their benefits under the Medicare and Medi-Cal programs. We currently serve over 16,000 dual eligible members in our Medi-Cal plan.

We have experience in providing care management for Seniors and Persons with Disabilities (SPDs), many of whom have similar needs to dual eligible members. We currently serve about 75,000 SPD members in California. We also have experience in providing care to low-income, indigent adults under the County Medical Services Program (CMSP). CMSP provides health coverage for adults who do not qualify for Medi-Cal but are medically needy. We operate in 34 primarily rural California counties as the operations back office for CMSP members. We have been a provider under CMSP since 2005, and serve over 50,000 members.

We will leverage CareMore's experience in providing Medicare benefits to over 10,000 dual eligible members under CareMore's Medicare Advantage Special Needs Plans (SNPs). CareMore operates Medicare Advantage SNPs in multiple counties in California, including several Chronic Care SNPs (C-SNPs) and an Institutional SNP (I-SNP) in Santa Clara County. Dual eligible members are also enrolled in CareMore's End Stage Renal Disease C-SNP, and comprise approximately 25% of the membership in CareMore's I-SNPs. CareMore also serves dual eligible members in dual eligible SNPs in Los Angeles and Orange Counties.

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

Our mission is to **"improve the lives of the people we serve and the health of our communities."** This mission is an integral and influential part of our day-to-day culture and it is evidenced by the extraordinary passion our associates display in assisting our members achieve optimal health and well-being. We believe so strongly in our mission that we have tied every employee's annual bonus to the health improvement of our members. We created our Member Health Index, which tracks when we are making a difference in the most important metric of all – our members' health. Our index tracks 40 different health measures across our more than 33 million members. It is that passion that drives us to work in partnership with DHCS to make a difference in the lives of Californians. The Duals Demonstration provides us with an opportunity to extend the proven experience and passion we have in caring for Medi-Cal members to the most vulnerable subset of that population: dual eligible members. We recognize the need for a high-touch, quality-driven, coordinated model of care for dual eligible members. CareMore's existing Medicare Advantage SNP infrastructure allows us to deliver a model of care that will meet the complex needs of this membership. CareMore provides focused and innovative health

care approaches to address the complex needs of members who are aging and members with disabilities. As stated in The Atlantic article, "The Quiet Health-Care Revolution", CareMore's underlying philosophy towards health care delivery is simple: a patient is one unified human being, not a collection of disconnected symptoms. See **Attachment 13** for the full article. This philosophy is foundational to our program for the Duals Demonstration, as we will develop and implement an innovative, integrated health care delivery model that addresses our members' physical health, behavioral health and social needs in totality.

We are also uniquely positioned to develop this comprehensive system of care for dual eligible members in Santa Clara County because we are a strong local presence. CareMore currently operates two CareMore Care Centers (CCCs) in the county and offers extensive services for members in CCC neighborhoods. CCCs are physical locations that house a full team of health care professionals and offer personalized health planning and preventive care services. CCCs also offer: state-of-the-art examination tables that maximize comfort and accessibility to the patient while allowing optimum functionality for the providers; wheelchair scales with hold bars at the scales; low glare materials on all countertops, floors, furnishings, walls and windows; static resistant carpet to reduce interference with hearing aids and other devices and for the ease of wheelchair-bound members; comfortable seating with "tip" resistant chairs; and lightweight inside doors. CCCs, along with our locally-based Medi-Cal staff, provide a county-based infrastructure that will meet the needs of dual eligible members residing in Santa Clara County.

We also bring innovation to Santa Clara County. In August of 2011, we announced the launch of an Accountable Care Organization (ACO) with Individual Practice Association Medical Group of Santa Clara County (SCCIPA) to provide coordinated, seamless medical care to our preferred provider organization (PPO) members. The ACO is the first of its kind in

Northern California and demonstrates Anthem's commitment to improving health care quality and collaboration, while reducing overall costs. We will leverage innovative best practices for the Demonstration and will continue to offer forward-thinking strategies to DHCS.

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

Our long-term vision is to positively transform health care delivery for dual eligible members throughout California with an immediate focus in the County of Santa Clara.

Our vision is supported by several key goals of the Demonstration; these goals include:

1. ***Holistic patient care which incorporates physical, functional, psychological and social support***
2. ***Reduction in confusion and service variability through assignment of a care team***
3. ***Elimination of waste which results from duplication of services and exacerbations of conditions***
4. ***Overt recognition of barriers to patient compliance and active engagement in reduction of those barriers***
5. ***Use of physician clinical personnel to provide increased access and support***
6. ***Bringing care to the patient's locale when appropriate, including home wireless monitoring***

Over the course of the three-year Demonstration period, we will achieve:

- Coordinated care across settings and services, integrating a member's physical, behavioral, long term services and supports (LTSS), and pharmacy needs, with a whole-person, member-centric focus
- Development of home and community-based services (HCBS) through offering supplemental benefits and developing strategic and collaborative partnerships with county agencies and CBOs
- Expansion of the CareMore patient-centered medical home and health home model that will provide integrated primary care, behavioral health care and LTSS, improving member health outcomes and preventing medically unnecessary care
- Development of a care system that allows and encourages members to self-direct their care and provides support to help them do so

- Implementation of intensive care management for at-risk enrollees and development of comprehensive plans of care in collaboration with members and providers
- Access to a comprehensive network of providers and specialists, including, but not limited to, geriatricians, psychiatrists, neurologists, and other, non-physician support including NPs, podiatrists, nutritionists, psychologists, and others
- Development of innovative quality programs to support health care initiatives
- Focused ongoing development of data analytics and performance reporting to support data-driven clinical decision making and interventions
- Increased meaningful use of health information technology to support integrated care

We know that health plans must demonstrate value with measurable results that improve member access, quality of care, and member satisfaction, while also controlling and reducing costs. Unlike traditional managed care organization, we also measure things like time needed to heal diabetic wounds, development of pressure sores, and other measurements that help improve the overall quality of care and healing time for our members. We are committed to fulfilling the goals of the Duals Demonstration and we believe that we are the best choice for the program.

Anthem Member Story: Helping a member find hope and a home.

One of our members, a truck driver, had his leg amputated following an accident. Unable to drive, he lost his job and became homeless. When we called, we found him in despair: his leg was horribly infected and with no money for transportation, he couldn't visit his doctor. He told our care manager that if he had to be homeless, she would read about his suicide the next day in the newspaper.

Understanding the urgency, our care manager coordinated transportation to get to the doctor. Our care manager then found him a place to stay at a local church shelter.

We helped him get continued medical and mental health services and kept in touch during weekly calls. Finally, an out-of-state family member offered him a home.

Section 1.2: Comprehensive Program Description

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

We will develop and implement CareMore's innovative and highly successful model of care that provides each member with a health home and seamless care coordination, provides access to home and community-based services and supports, provides avenues for increased consumer and caregiver involvement, and aligns incentives and payments for providers to achieve quality outcomes. As part of this program, we will work in collaboration with DHCS and CMS to transition the current fragmented health care delivery system for dual eligible members into a single, comprehensive, and integrated model of care, while achieving appropriate cost savings. Based on early assumptions, we estimate that approximately 30,000 – 45,000 dual eligible members in Santa Clara County will be enrolled in the Demonstration. We project Anthem enrollment in the range of 15,000 – 22,500.

We will provide coverage in the entire county, and will address any network and service gaps through an extensive network adequacy evaluation process for the Duals Demonstration. Please see **Question 7.1** for additional detail on our process to ensure network adequacy. As part of this process, we will work with the Santa Clara Family Health Plan, county agencies and CBOs, such as the Health Trust (Meals on Wheels), Asian Americans for Community Involvement, Catholic Charities, City of Santa Clara Council on Aging, San Andreas Regional Center, Silicon Valley Independent Living Center, Wellness Community of Silicon Valley, City of San Jose Senior Citizens Commission and others, that serve dual eligible members to ensure that gaps are appropriately addressed. For a list of our partners, please see **Question 6.1.2**.

As part of our proposal, we will offer supplemental health benefits, such as vision care, dental care, non-emergency transportation, and fitness programs. To promote continued residency at home and maximum independence for members, we anticipate offering supplemental HCBS, such as Personal Emergency Response Systems (PERS), adaptive technology, respite care, nutritional services and additional hours of In-Home Supportive Services (IHSS) when these hours can prevent admission or readmission to a nursing home. We will explore wrap-around supports that promote access to quality housing and board and care facilities, and medical respite services for members with serious and persistent mental illness who are leaving inpatient medical settings. We will also evaluate offering benefits that are best practices in our current programs, such as 24 hour physician on-call. This program provides 24/7 telephone access to experienced physicians who can authorize services for members with urgent healthcare issues, providing a comprehensive after-hours care program for every member.

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

We will build a program that cuts across traditional Medicare–Medicaid (Medi-Cal) service boundaries so that the two programs' services are integrated and delivered in the best overall coordinated way – with good health outcomes, high consumer satisfaction, and overall cost-effectiveness and savings through the use of appropriate incentives to reduce avoidable hospital stays (saving Medicare funds) and reduce avoidable long-term nursing-home stays (saving Medi-Cal funds). We believe that the integration of payment/benefit packages will allow for innovations in care delivery that have not previously been possible. For example, we can envision health care personnel attending to patients in their homes who have the responsibility for coordinating medical, functional, psychological and social care. We can envision taking

medical services to mental health facilities to eliminate need for these patients to obtain care in multiple locations. We are only at the front end of innovation with this population. Our program will be developed with the understanding that services traditionally paid for by one program – either Medicare or Medi-Cal – could be substituted for services from the other program if this maximizes the quality, efficiency and satisfaction of care provided. For example, an assigned nurse practitioner could deliver primary care services directly in a member's home or residence. This, in combination with Medi-Cal personal care (e.g., IHSS), may be a reasonable alternative to help prevent avoidable nursing home admits. Along with reducing unnecessarily long lengths of stay, our program will provide more effective and coordinated hospital and nursing-home discharge services. We will develop person-centered community-based care so that we support the member in the community as much as possible.

We will evaluate processes to streamline prior authorizations to support medical management operations and to allow for flexibility in authorizing needed services. Claims detail will be consolidated so case management teams have both Medicare and Medi-Cal information to ensure coordination of care while having the flexibility to provide and coordinate the full array of services and benefits to members. Our Accounting and Finance staff will develop detailed policies and procedures to provide accurate reporting of a single capitation payment, including the reporting of utilization and diagnostic claims/encounter records on services provided to dual eligible members to both DHCS and CMS to inform the rate-setting process.

Question 1.2.3: Describe how the program is evidence-based.

CareMore's clinical teams use evidence-based clinical practice guidelines and nationally recognized protocols for the model of care and throughout the program's core-components. We draw upon guidelines from various specialty associations and committees, (such as the American

Diabetes Association, American College of Cardiologists, Joint National Committee, American Heart Association, Global Initiative for Chronic Obstructive Lung Disease and National Kidney Foundation), Medicare, the Agency for Healthcare Research and Quality, the U.S. Preventive Services Task Force, and published journal articles. Evidence-based practices are embedded into training materials and protocols for clinicians, as well as model of care materials and trainings provided to contracted providers. Clinical Managers and Directors also regularly assess research and literature, and organizational guidelines to update protocols on best practices. Extensivists (hospitalists) are trained using case studies based on published Journal articles. Our Medical Directors and Officers train extensivists on evidence-based medicine during initial training and as relevant case studies are released using our Intranet site. These are also communicated during quarterly hospitalist meetings. Medical Directors and Officers regularly assess research and literature to update best practices. Our Mental Health Program is committed to using effective treatments and staying informed about advances in evidence-based treatments. In order to provide the best possible outcomes for our members, our therapists practice evidence-based treatments including Cognitive Behavioral Therapy, Anxiety Management Treatments, and other treatments with proven efficacy through research. Our programs are recovery based. Our therapists are dedicated professionals who continue their training to stay current with the evidence-based data to meet members' needs stemming from mental illness and substance use.

Our Healthy Start and Healthy Journey Assessment tools are also evidence-based and include the Mini-Mental® State Exam™ (MMSE), PHQ9 depression screen, the Community Assessment Risk Scoring (CARS, for frailty screening) and the Barthel Index functional assessment screening tool. Utilization management authorization decisions and appeal reviews are guided for the most part by Medicare National and Local Coverage Determinations and

Kidney Disease Outcomes Quality Initiative (K/DOQI) Guidelines. We use Milliman Care Guidelines for our Medi-Cal programs.

CareMore consistently receives Medicare Advantage Star Ratings between 3.5 and 4 Stars, indicating high levels of clinical and service quality under the CMS rating system. Our unique approach to caring for the elderly is routinely achieving positive member outcomes: for example, a hospitalization rate 24 percent below average; hospital stays 38 percent shorter; and an amputation rate among diabetics 60 percent lower than average. See **Attachment 13** for The Atlantic article that speaks to these positive outcomes.

As we refine our program, we are also drawing upon the evolving evidence-based data in the developing areas of managed, integrated programs (such as the Demonstration), consumer direction and patient-centered care. There are promising practices and lessons learned in these areas that will help us as we implement the Demonstration. For example, experience from states with existing managed Medicaid LTSS programs demonstrates that the shift to more home and community-based services and better coordinated services requires that plans provide (and that states permit) a broad service package, health plan care/service coordinator autonomy, and clear expectations around what and how consumers may direct their own services. (Kaiser Family Foundation, "Expanding Medicaid Managed Care Long-Term Service and Support Programs: Key Issues to Consider," October 2011.)

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

As of 2009, Santa Clara County had a homeless population of approximately 7,086 people, of which 4,983 were unsheltered homeless people and approximately 2,103 were sheltered homeless people residing in emergency shelters and transitional housing facilities.

In addition, while Santa Clara's population enjoys relatively good health, health disparities exist among certain sub-populations. In particular, Santa Clara's Hispanic adult population suffers from obesity and has higher diagnoses of diabetes than the rest of the Santa Clara population.

Our clinical care model is designed to meet the needs of vulnerable, underserved populations. This model is tailored to the specific health, psychosocial, functional, and cognitive needs of individuals served by the model. Our program is organized and administered with the goal of improving the health and well-being of our members whether they are in underserved populations, have health disparities, multiple co-morbidities and/or other risk factors.

- We use a team of clinicians who are employed by CareMore and specifically trained to care for vulnerable, underserved populations of our members, including those with frailties, chronic conditions, and psychosocial and functional needs. (See response to **Question 4.3** for a description of these clinical roles.)
- Our CareMore Care Centers (CCCs) are in communities to serve as a "medical home" for our members and to deliver innovative, focused clinical programs and coordinated care.
- Our clinical leaders are involved in direct member care and are committed to keeping the philosophy of being member-oriented. They are responsible for the performance of our clinicians, network providers, and the entire community-based healthcare system
- Our clinical programs are premised on evidence-based medicine, designed with well thought-out outcomes reporting for continuous quality improvement and solidified using clinical protocols, measures, and training

Within the first 30 days of enrollment, our members are encouraged to come in for a "Healthy Start" (new enrollees) or "Healthy Journey" (existing enrollees) appointment with one of CareMore's specially trained nurse practitioners at a CCC. We know our members from the

moment they enroll with us and we don't wait for an episode of care to begin this process. During these appointments, the health risk assessment (HRA) is performed. Please see **Question 2.1.3** and **Attachment 15** for more details on the HRA. During face-to-face visits, clinicians are better able to assess and diagnose members' conditions and work with them and their care givers to produce a care plan tailored to their unique needs. As an example, we can perform a more detailed cognitive (dementia) screen during a face-to-face visit than is possible over the phone. A face-to-face visit also allows us to identify and arrange for urgently needed services quickly (e.g., nebulizers), manage their conditions more closely (thereby improving outcomes), and improve utilization by coordinating members care with the right providers. We use these visits to work with members to improve access to affordable care. Once a clinician establishes a relationship with a member, this clinician continues to work with the member to meet their care plan goals and to address any new conditions before they become an issue.

In addition to the Healthy Start assessment and our care plan, we have a comprehensive Cultural and Linguistics Program that is part of our Health Equities and Cultural and Linguistics Program Office (HECLPO). This unit works closely with the clinical improvement intervention and disease management teams to advise them on incorporating culturally and linguistically relevant content into our member clinical outreach programs.

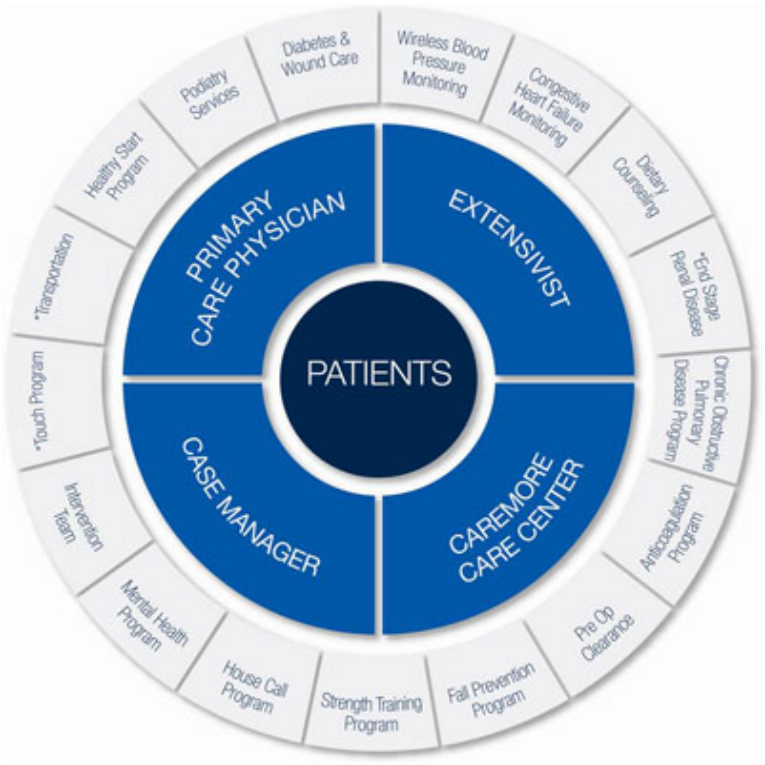
In California and Virginia, we recently completed targeted outreach campaigns to increase understanding of diabetes self-care in the African American and Hispanic population using culturally specific fotonovelas. A fotonovela is a photographic storybook that depicts characters dealing with diabetes and brings the information about diabetes to a culturally familiar level. It is designed to help educate members about diabetes and the importance of routine medical visits, annual lab testing, and lifestyle goals for good diabetes control. We surveyed our

members after this campaign and received positive feedback from 80% of our survey respondents. We will conduct a similar analysis for our dual eligible population, identify the needs that are unique, and create education or access solutions targeted at this population.

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

We currently operate Patient Centered Medical Homes (PCMHs) throughout the country and employ a health home model of care in the CareMore D-SNP. Our model is depicted below and includes:

CareMore Patient Centered Model



- A team of employed clinicians trained to care for frail and chronically ill members and members with complex health and social service needs.
- CCCs are opened in communities where our members live to serve as a medical/health home and to deliver innovative, focused clinical programs and coordinated care.
- Clinical programs are premised on evidence-based medicine. They are designed with well thought-out outcomes reporting for continuous quality improvement and then solidified using clinical protocols, measures, and training.

  Members often have co-morbid conditions and many have mental health conditions and

substance use disorders. We intervene to address specific disease states including asthma, diabetes, heart disease, and COPD. Members with one chronic condition, including those who have serious and persistent mental illness, often have at least one other chronic condition.

The model of care includes all of the following services:

- Comprehensive care management and care coordination and health promotion;
- Transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services as appropriate; and
- The use of health information technology to link services.

Component	Current Practice	Future Practice
Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services	X	
Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines	X	
Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders	X	
Coordinate and provide access to mental health and substance abuse services	X	
Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care	X	
Coordinate and provide access to chronic disease management, including self-management support to individuals and their families	X	
Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services	X	
Coordinate and provide access to long-term care supports and services		X
Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services	X	
Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate	X	
Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level		X

CareMore's approach uses a "health team" called the Interdisciplinary Care Team (ICT).

The ICT is an interdisciplinary, inter-professional team that includes the following providers: nurse practitioners, internists/hospitalists, case managers, fitness trainers, social workers, registered dieticians, mental health specialists, and other specialists based on the member's unique needs. Other specialists may include pharmacists, substance abuse specialists, and doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants. Members are engaged in care management and receive interventions based on their specific needs. We employ a whole person, person-centered approach to identify needed supports and services and provide care linkages.

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

We believe the key challenges related to the successful implementation of this program include:

Implementation Challenges and Risks	Mitigation Plans
Transitioning FFS dual eligible members into a managed care plan	In California, only 17% of dual eligible members are currently enrolled in managed care plans today. Enrolling fee-for-service dual eligible members into a managed care plan can be a major transition for new members not familiar with managed care programs. Based on some lessons learned enrolling SPD Medi-Cal members in several counties in California, we recognize the need to adequately and repeatedly educate new members for the transition to a managed care program, particularly those who utilize LTSS and behavioral health services. For example, once we are notified of our new members, we will reach out to these individuals to educate them on our new approach for developing their care plan with them. In particular, our approach includes proactive outreach campaigns, educational sessions, conducting an initial health risk assessment upon enrollment and a creating an individualized care plan, strengthening relationships with providers and medical group partners within the community, as well as advocacy groups and other external partners to help educate and assist these members with the transition. Please refer to **Question 5.5.2** for more details on how we will address the transition from FFS to a managed care plan.
Addressing the high prevalence of mental and cognitive impairments in the dual eligible population	According to CMS, 43% of dual eligibles have at least one mental illness or cognitive impairment while 60% of dual eligibles have multiple chronic conditions. Because of the high prevalence of mental and cognitive impairments among this population, we recognize that care management teams should be comprised of both physical and behavioral health care professionals. These multi-disciplinary care teams ensure that all aspects of member needs are addressed, and foster an ongoing consultative exchange between behavioral health and physical health care professionals. To address these challenges, we will conduct an HRA, develop plans of care, and build upon our existing care model to reinforce and support the implementation of multi-disciplinary care teams to provide care to dual eligible members. Please refer to the Model of Care for more information about our care management approach.

Implementation Challenges and Risks	Mitigation Plans
Ensuring a smooth transition of care and services and providing continuity of care	To the extent possible, we would like DHCS to provide details of the members enrolling in our plan (the enrollment file and up to 2 years of related members' claims data) at least 30 days prior to the member's effective date. This will allow for adequate time to reach out and properly transition members into our program. To minimize disruption of care and services to members during the transition, we will work with the members' treating physicians to determine the appropriate length of time needed to transition care and develop a transition care plan to ensure there is a smooth transition and continuity of care. Additionally, once enrolled, all members will receive an initial Healthy Start assessment where our clinicians will identify and address their immediate needs and develop an individualized care plan. Please refer to the Model of Care and **Section 5.5** on enrollment for more details.
Allowing adequate readiness / planning timeline to seamlessly integrate programs and resources	In addition to requesting DHCS to provide the enrollment file at least 30 days prior to the member's effective date, we will identify conflicting requirements from both programs across eligibility, enrollment, benefits, billing/claims payment systems, and quality reporting measures and create a detailed implementation plan, working with DHCS to ensure tight coordination and integration of requirements well in advance of the enrollment of the first member. With our current experience managing over 16,000 dual eligible members, we understand the conflict and potential overlap of these two programs and funding streams. We look forward to having full control of the resources of care and managing to improved outcomes of higher value. See **Section 6.1** on the Operational Plan for further details of how we will prepare for the implementation of the program by 2013.
Engaging stakeholders and community members throughout the planning process	We will work and collaborate, with expectations of further improvement, with all agencies and advocates to make effective use of and support others who are actively contributing to the overall success of our members and the support systems at large. Based on our experience implementing new programs in other states, we believe it is important to engage our stakeholders and community members early on in the process to ensure the programs address the needs and concerns of the community and this population, remove barriers to member access, and provide continuity of care while also allowing for a smooth transition into the new program. Key stakeholders include providers, members/families with disability or chronic conditions, advocacy groups, community/faith-based organizations, and potentially legislators and staff in state-related agencies. Our efforts to engage our stakeholders and community members are already underway. See **Section 5.4** on stakeholder input for further details on how we will engage our stakeholders.

Implementation Challenges and Risks	Mitigation Plans
Ensuring provider collaboration and engagement	Active provider engagement and collaboration is critical to the success of the implementation the program. To ensure active provider participation, we will use our employed clinicians and support staff to coordinate and collaborate with providers to provide a coordinated care model for the dual eligible populations. Our care system supports provider partners through care programs at a CareMore Care Center. Along with enhanced monitoring and clinical services delivered by our nurse practitioners, hospitalists, social workers and specialty staff with regular, timely communications back to the providers. Our other provider engagement activities include: face-to-face training and service, local and central provider relations support, frequent training opportunities, quarterly quality bonus check delivery options, regular progress reporting of financial and operational data share metrics, and a dedicated provider representative assigned to PCP to support establish PCP growth objectives. We will combine claims, authorizations, utilization, pharmacy and diagnostic profiles of our members and provide this information to their providers. We will also provide aggregated data to providers and facilities so that they can view their performance relative to market benchmarks and continuously improve their performance. We can also identify centers of excellence and refer selectively to them and single them out for praise amongst their peers so that their superlative performance is emulated by others. We will also work closely with DHCS prior to implementation to identify additional outreach strategies that prepare providers for a transition to a new model of care. See **Section 7** on network adequacy for further details on how we will engage our providers.

SECTION 2: COORDINATION AND INTEGRATION OF LTSS FUNCTIONS

Section 2.1: LTSS Capacity

Question 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.

Our approach to seamless care coordination starts with CareMore's comprehensive HRA, Healthy Start. This assessment occurs upon enrollment to identify a member's specific needs and includes the member's self-reported health status. We reassess the member, using the Healthy Journey Assessment, annually or sooner in the event of a significant change in health status. The member's functional, cognitive, and psychosocial needs are also assessed through a review of systems, diagnostic tests, comprehensive collection of medical and psychosocial history, functional assessment, and a medical exam (if the member participates in-person). The HRA includes the following screens: PHQ9 depression screening to identify members requiring

treatment for depression; Mini-Cognitive and Mini-Mental State Exam (MMSE) to identify dementia; Community Assessment Risk Screen (CARS) to identify members with an increased risk for hospitalization; fall risk screen to identify members at risk for falling and requiring additional assessment by clinical staff; on site lab testing which includes a complete metabolic panel for members participating in-person; pain assessment scale to identify members requiring additional treatment; Barthel index screening to identify members' ability to perform daily functional activities (e.g., bathing, dressing, preparing and meals). See **Attachment 15** for screen shots of the HRA. These HRAs are fundamental to understanding and improving our members' health status, access, health outcomes and utilization.

The HRA information is used by the Interdisciplinary Care Team (ICT), which includes the member and family member(s) when appropriate, to develop the member's plan of care (POC) (See **Question 4.3**). The POC identifies the needed services, supports and care coordination to address all of the clinical and non-clinical care needs of the individual. Throughout the care process, the member is encouraged to articulate his/her desired goals and outcomes (e.g., increased energy, continuing to live alone, leave the home, aggressive or conservative treatment, palliative care). The ICT designates a care manager to assist the member to make sure that all services identified in the POC are accessed and implemented. Ongoing contact with the member is maintained to monitor whether or not the services are resulting in achievement of the member's goals. We are already in discussions with the County to determine the best way to include county social services staff and County Mental Health Plan providers and case managers on the ICT and for sharing of assessment and POC information. The POC identifies the needed services, supports and care coordination to address all of the clinical and non-clinical care needs of the individual. See section 8C in the **Model of Care**, for more

information on the ICT's use of the POC to coordinate care. By the second year of the Demonstration, we expect to have fully integrated Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and In-Home Supportive Service (IHHS) including assessment and service authorization processes.

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

We are negotiating with three LTSS providers to manage LTSS: Independent Living Systems, Addus, and Univita. Each organization has expressed interest in working with us on this Demonstration in order to ensure a highly effective home and community-based program that supports our members in their home or other community-based setting. These experienced providers will share risk for LTSS services. We anticipate finalizing a contract(s) by March 2012 See **Attachment 14** for the LOIs for these vendors.

As part of our contracting relationship, the chosen LTSS provider(s) will manage all aspects of the LTSS network for our members including: network development and credentialing; hiring staff; serving as our representative with providers who are part of CBAS, IHSS, and MSSP; processing LTSS claims payment; and handling other administrative aspects of providing LTSS. Our partner LTSS provider(s) will be responsible for ensuring that there is no disruption in service for members and will work with the Santa Clara Department of Aging and Adult Services, Santa Clara County Public Authority for In-Home Supportive Services, and the LTSS provider network to make sure members are getting the services they need. We will bring health services (not just social support service) to the home when possible. We will create a partnership between home workers and our clinical teams to train home workers on basic information related to patient conditions so they can be the eyes and ears of the clinical team.

We believe that the traditional networks of aging and disability providers have significant experience and resources that should be valued and preserved. We intend to approach existing adult day care providers and MSSP providers and offer them a contract based upon their current rates of compensation. We also intend, as part of our discussions with the County of Santa Clara, to consider contracting options with the Santa Clara Department of Aging and Adult Services and Santa Clara County Public Authority for IHSS. We will also consider subcontracting certain MSSP-related functions to the Council on Aging of Silicon Valley.

Independent Living Systems, Addus, and Univita are each highly experienced LTSS organizations, with a track record of providing services in a cost-effective manner. We expect that reimbursement to these partners will be based upon a targeted fund established on a PMPM basis with the potential for bonuses for achieving both quality and efficiency targets. Our partners will use a variety of payment mechanisms to pay LTSS providers from their reimbursement, which may also include incentives for quality and efficiency. We will also focus on developing agreements with community-based residential providers and housing sites that will be useful in rebalancing care from the institution to the home.

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

We expect to use the Healthy Start Assessment and Health Journey Assessment as our foundational health risk assessment (HRA) tools in the Demonstration. See **Attachment 15** for screen shots. We will also leverage our Medi-Cal SPD experience in developing an HRA to meet DHCS requirements. Our HRA instruments are evidence-based and incorporate industry best practices in health and risk assessment: they are continuously improved as new and better

approaches are identified. This information is used by the ICT to develop the individual's POC. The POC is member-centered and identifies the needed services, supports and care coordination to address all of the clinical and non-clinical care needs of an individual. These assessments and the POC provide a current and comprehensive picture of the member's physical, mental and behavioral health, and social support needs. This approach is currently used in the CareMore D, C, and I-SNPs in California. These assessments will be amended to incorporate DHCS-required elements and will be refined as we identify the specific needs of members enrolling in the Demonstration. Revised HRAs will be tested to ensure accuracy, reliability, and relevance.

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

We work with LTSS providers in California as part of our Medi-Cal program and Medicare Advantage SNPs. In addition, we have extensive Medicaid health plan experience in other states. In all of these plans, we work with LTSS providers across the full spectrum of home and community based and institutional services. We work with LTSS providers in many ways, including: executing agreements that specifies each party's roles and responsibilities to support coordination of care and services; actively coordinating the member's care with Regional Centers, County Mental Health Plans, Community-Based Adult Services (CBAS), Multi-Purpose Senior Services (MSSP) and other programs; and contacting the county

CareMore Member Story: Helping seniors get a new lease on life

We found two members who needed help: an 80-year-old man married to 50-year-old woman. They were living in their car after they ran out of money, driving from Nevada to California to help a friend. The wife was disabled and couldn't work.

Our care manager helped them apply for Social Security benefits and helped the wife with the needed paperwork to qualify for Medicare. She referred them to the Department of Public Social Services where the couple got a motel voucher program for temporary shelter. Then she gave them a list of affordable housing and set them up with food vouchers.

social services agencies for Meals on Wheels and Older American's Act services, and Centers for Independent Living for member assistance with assistive technology and community transitions.

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

We will build upon our existing CareMore expertise in caring for individuals living in institutional settings. In this model, institutionalized members are assigned a mid-level practitioner, a nurse practitioner or physician's assistant, as the primary case manager who conducts the comprehensive assessment and works with the ICT to develop the POC (see Section 2.1.3 for more detail). The ICT includes the member and family and staff from the institutional setting including nurses and social workers.

We are committed to enabling our members to live in the most home-like setting possible given their health status and care needs. We work with members who have expressed an interest and those that we identify will benefit from a more home-like setting throughout the transition process. Transition to home or the community is a significant event requiring the addition of new members to the ICT and a revised POC. The member's case manager works with the member and the ICT to develop and oversee the new POC including a written transition plan for the member that identifies the "what, where, when and who" of the essential arrangements needed. For individuals who require housing, the case manager works with local housing agencies or housing coordinators to help the member identify a suitable unit, assists with identifying payment sources for room and board (including the member's resources such as SSI), and identifies the services and supports needed to move to the new setting. For those members who

have housing, the case manager works with the member to make sure that the residence is safe and accessible for their return. For all members transitioning to home or the community, the ICT identifies and the case manager arranges appropriate necessary physical, medical and behavioral health services (e.g., PCP appointment, lab testing, skilled nursing visits, mental health visits, peer supports) and coordinates access to community based services (e.g., MSSP, IHSS and/or CBAS) as well as other sources of support to maintain the individual safely in the community.

Section 2.2: IHSS

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

2.2.1a 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.

2.2.1b 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.

2.2.1c Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.

2.2.1d County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.

2.2.1e IHSS providers will continue to be paid through State Controller's CMIPS program.

2.2.1f 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.

We certify that we will develop and execute contracts to include the specifications listed in **Question 2.2.1a-f**.

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

Beginning in Demonstration Year 2, we intend to implement a strengthened care

coordination and care management model developed with input from key stakeholders, including the Santa Clara County Department of Aging and Adult Services and Santa Clara County Public Authority for In-Home Supportive Services; consumers of IHSS (and their family members as appropriate); network providers of LTSS, primary, specialty and inpatient care, including behavioral health care; and stakeholders of key carved-out services such as non-covered HCBS waiver services and non-covered behavioral health services. We will build on relationships with IHSS programs and work to maintain successful relationships that promote the vision and mission of the Demonstration. In addition, we are committed to working across all Demonstration stakeholders to develop an efficient and effective method for IHSS authorization and referral for Years 2 and 3 of the Demonstration.

Specifically address:
2.2.2a A proposed care coordination model with IHSS, including the referral, assessment, and care coordination process.

IHSS, as the single largest Medi-Cal in-home service, provides a tremendous and, at present, under-utilized vehicle for high-touch, in-home team based support. IHSS workers, many of whom are the consumer's family member, will play a critical and strengthened role in this new team-based care management model.

Assessment: CareMore's model of care includes the use of a Healthy Start comprehensive HRA. See our response to **Question 2.1.3** and **Attachment 15** for a sample HRA completed by a nurse practitioner (NP). The HRA is the basis for the member's individualized care plan which is developed by an interdisciplinary care team (ICT). We intend to assess members comprehensively once rather than require completion of multiple assessments (as is the case today across the fragmented service system). Therefore, we will work with DHCS to incorporate required elements into our broader assessment process so that we may identify the

member's total needs using a single assessment tool. The assessment process will be used to determine the need for all covered and non-covered health care services and LTSS, including IHSS and supplemental services. Assessments will include face-to-face assessments and periodic reassessments and will be conducted in the setting most appropriate for the member, which may include our CareMore Care Centers and the member's home. With consent from the member, we will also invite the member's IHSS worker to be present during the HRA so they are also informed about the member's care plan from the start.

Care Plan Development: We utilize an Interdisciplinary Care Team (ICT) model for development, implementation and monitoring of the plan of care. The ICT consists of the member, the NP, primary care provider, a nurse, behavioral health specialist, social worker and others of the member's choosing such as his or her family members, caregiver(s), and legal representatives. A regional medical officer has oversight responsibilities for the plan of care development, and provides consultation on difficult cases, as well as facilitate on-going follow-up for the most vulnerable beneficiaries. Additionally, a team of specialists have a role in oversight for their specialty. Other clinical disciplines, such as pharmacy, nutrition, rehabilitation therapy and specialists are included based on member need and/or member request. We will expand the ICT and invite LTSS providers to participate in the development of the POC, with member consent. Santa Clara County Department of Aging and Adult Services social workers and IHSS home care workers will be invited to participate on the ICT. IHSS home care worker participation will be encouraged and will include standard payment for time spent participating in the ICT and for communication with the member's ICT designated care coordinator. We believe this participation will be crucial to understanding member's daily living needs and will provide valuable information to the entire ICT. Section 2.2.2b describes our plan for enhancing

the IHSS home care worker role. ICT participation may be in-person at a CareMore Care Center or by teleconference. The plan of care (POC) employs a whole person orientation and a person-centered approach and specifies all the services and supports required to address the member's identified needs, including medical, behavioral health and LTSS. During the first year of the Demonstration, the existing IHSS assessment and authorization information developed by Santa Clara County Department of Aging and Adult Services social workers will be incorporated into the POC. During the development of the POC we will review the IHSS hours authorized by the County to ensure member's personal care needs are met considering all sources of LTSS. We will, with member consent, provide social workers and home care workers with a copy of the member's care plan.

Referrals: We will work with the Santa Clara County Department of Aging and Adult Services and Santa Clara County Public Authority for In-Home Supportive Services to develop a process to incorporate the existing referral and authorization process during Year 1 of the Demonstration. We will work with a broad group of stakeholders to develop an efficient and effective method for IHSS authorization and referral for Years 2 and 3 of the Demonstration. All of our program development activities will take place with input from key stakeholders including members and their families.

Technology: Finally, we intend to utilize our technology platform, described in **Section 7.1**, to support the assessment, referral and total care management process including for covered LTSS. IHSS assessment, referral, and delivery information will be incorporated into the member's electronic medical record (EMR).

2.2.2b 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.

We propose to provide IHSS workers with enhanced training and support. For example, a career ladder for IHSS workers could be implemented that enable workers to assume greater responsibilities for in-home assessment and referral to the ICT. This might also include additional payment for IHSS workers. We will develop enhanced training programs for IHSS workers. For example, we could develop competency-based training modules. Training would be provided by appropriately qualified professionals including both health plan professionals and external professionals. For example, we will consider working with a university such as California State University, Sacramento (CSUS), which previously developed and implemented a statewide "In-Home Supportive Services (IHSS) Training Academy" for DHCS. Training modules would include core competencies and advanced competencies (for workers who wish to assume greater responsibilities for care coordination). Competency-based training could be implemented through a variety of activities, such as:

- Individual training to understand the specifics in a member's care plan
- Group training classes on systems, protocols and policies
- Conferences to review and answer more detailed questions on protocols, processes, and best practices
- Shadowing case managers and senior front-line workers
- Meeting one-on-one with key members of the ICT
- Performing advanced tasks on their own while being shadowed by a preceptor
- Meeting one-on-one with their preceptor and supervisor to go over training status and assess their progress and knowledge, and develop an action plan for additional training

We will pay IHSS workers their hourly wage to participate in training. We will also provide free day care when requested in advance of the training and hold the training at public locations accessible by public transportation. We will also evaluate the feasibility of offering online training with an in-person preceptor observation requirement. Our training model will include appropriate, periodic oversight and monitoring of front-line workers by professional care management staff, emphasizing positive feedback and modeling to achieve desired outcomes. Core competency training will include training in the special needs of consumers who require LTSS. This includes training concerning Alzheimer's disease and other dementias and co-morbid mental illness, substance use and physical health conditions. We will work with stakeholders to develop training for IHSS workers that includes member and family perspectives on specific conditions (the member's experience), the latest evidence-base, and perspectives from the front lines across settings (in-home, in residential settings, health care settings and in the community). Training will focus on fostering understanding of the member's needs and practical ways to provide hands-on care and supervision when a member has a specific condition.

2.2.2c A plan for coordinating emergency systems for personal attendant coverage.

We understand that consumers who rely on a personal attendant to assist them with daily care needs must have a plan in place to ensure their urgent care needs are met when a worker has a personal emergency or does not show up to work. We also understand that it is the health plan's responsibility to ensure a viable plan is developed and implemented. We will implement a 4-pronged approach to ensure that no one is left for an extended period of time without appropriate personal assistance. The approach is as follows:

1) Written emergency back-up plans: The ICT will develop a written emergency back-up plan with each member who utilizes attendant care services (IHSS or other sources of attendant care).

This written plan will identify the paid and unpaid caregivers that will be available to the member if their attendant be unavailable, whether the member receives advance notice or not of the attendant's absence. The plan will also identify who is responsible for contacting the alternative attendant. The member will also know that he/she has access to CareMore clinical and mental health staff if needed 24 hours/7 days a week.

2) Rapid Response Worker Replacement: We will identify a method to quickly locate and provide replacement in-home workers when needed. This could be similar to the Rapid Response IHSS Worker Replacement Service utilized in some counties such as Alameda and Contra Costa Counties. Counties with this service contract with agencies that agree to provide a worker within two hours of a request for a back-up worker that is received between 6 AM and 8 PM. We will work with county agencies in a manner that makes the most sense and is favored by stakeholders. For example, we could fund the county program, take over the county contracts, or develop new contracts in each county in which we participate in the Demonstration.

3) Training: We will ensure that Member Services and Care Management staff are trained specifically to receive and respond rapidly to calls from consumers whose personal attendant has not showed up for work. We will develop specific protocols that ensure the member is connected to a social worker during normal business hours, and after normal business hours to their designated care manager who will ensure the need for a replacement worker is resolved before the call is ended. The protocol will also include prompts for assessment of the urgency of the member's situation and the appropriate response based on this assessed level of urgency. Members will be provided with the level of assistance needed to ensure a back-up attendant is dispatched to the member's home, including calling the replacement worker or agency, and recording the name of the replacement worker and his/her report time.

4) Emergency Response Devices: We will identify a suitable emergency response device or technology for those members who live alone, who need this option to remain safely at home and who choose to receive a device or use the technology. This will ensure that our most vulnerable members have immediate access to emergency services should the situation rise to this level.

Section 2.3: Social Supports

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

We certify that we will develop and execute a comprehensive operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

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

We will implement a rapid risk screening to identify members who are accessing social supports or who can benefit from accessing social supports as part of our "high-touch" model. The screening will consist of a live outbound call by our Member Services staff using carefully developed scripts to identify a member's risk status and to connect members with the appropriate level of support. High-risk members will be connected to a care manager who will arrange for the completion of an HRA within 30 days. All members receiving social supports will receive care coordination to ensure social supports are adequate in meeting the member's needs and that there will be no interruption in care. Members who indicate any concerns or gaps in care will be contacted by a case manager to address these concerns and close gaps in care. Home visits are central to our approach, especially for our frail members or members with more complex needs. Visiting members in their home allows the case manager to observe and assess the member's health status and their social support needs first hand. Home visits are also very important in

building a bond between the member and his/her case manager. Case managers assess and identify the LTSS available to member, both paid and unpaid, and have broad authority to authorize social support services to address the member's needs.

Following initial enrollment into our health plan, and completion of a Healthy Start HRA, the ICT, which includes the member and others of the member's choosing, develops an individualized plan of care. Case managers, individuals with social work backgrounds and an understanding of community social services, are able to address the member's "social ecosystem", for instance: nutrition: does the beneficiary have an adequate refrigerator; safety: are there steps; fall preventions: is there sufficient lighting; transportation: can the enrollee get to their appointments; language/understanding: does the enrollee have language barriers including limited English proficiency, limited health literacy or cognitive impairment. The ICT, with the help of the case manager, lays out the plan for providing, authorizing and/or accessing the social supports needed by the member, such as nutrition supports, IHSS, home modifications, homemaker visits, respite care for the family or informal caregiver, and family training. The case manager is responsible for working with the Santa Clara County Agency on Aging, County Social Services Agency, and other agencies and organizations to access supports such as Meals on Wheels and CalFresh.

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

We will build on our existing memorandum of understanding (MOU) process to maintain MOUs with local social service agencies specific to the Demonstration. We will augment existing MOUs to maintain agreements with the AAAs, ADRS, ILCs and Regional Centers specific to the Demonstration. These MOUs are and will be developed collaboratively and will

specify service level agreements, outline a common understanding of accountability of our plan and of the community partner, and the mechanisms that are to be used to make sure that information is shared regularly. Representatives of these agencies are invited to participate in the ICT (with member consent), in person or by phone, during the development of the individualized POC. Information about the member's status is shared routinely (with member consent). We also hold periodic planning meetings with our partners and collaborate on programs that are beneficial to our members and the community at large, such as health screening and community health fairs. We provide written descriptive materials to our partners and encourage them to share their materials with us so that our staff, network providers and members are up-to-date on the activities and services provided by these agencies and programs.

As part of our implementation process for the Demonstration, we anticipate developing reader-friendly materials and holding learning sessions throughout the community about the new program. We anticipate working with the social service organizations to disseminate information about the program, to brief their staff and to identify other opportunities for collaboration.

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

We are committed to enabling our members to live in the most home-like setting possible given their health status a care needs. We help our members both transition from less to more independent living settings, (e.g., nursing homes to assisted living facilities), and from home to settings where they have access to the higher levels of social and clinical supports they need, (e.g., continuing care retirement communities).

We will partner with housing providers, such as senior housing, residential care facilities,

assisted living facilities and continuing care retirement communities in the following ways:

- Visit these various facilities and providers to identify those that offer high-quality community living and who are committed to working through the transition process to support our member's relocation
- Provide written and in-person information about the services and support we offer to our members including care management, transition planning, follow-up care, and LTSS
- Work with interested providers to outline a process for referral and transition
- Help interested site providers develop and deliver descriptive material about their setting and any special features that will be used for members to select facility or housing options (Note: Members will have free choice of any willing provider given that the final arrangement ensures the health and welfare of the member.)
- Invite providers/provider staff, when appropriate and with member consent, to ICT meetings, either in-person or by phone and will share information about our members' individual needs when members elect this choice
- Explore ways to work with local agencies and providers to increase access to suitable facilities and housing and will participate in exiting community planning efforts focused on developing evidence-based practices

SECTION 3: COORDINATION AND INTEGRATION OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

Section 3.0: Coordination and Integration

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

Question 3.1a Incorporate screening, warm hand-offs and follow-up for identifying and

coordinating treatment for substance use.

Question 3.1b Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for mental illness.

We are an experienced Medi-Cal managed care plan that currently screens members for mental illness and substance use and completes referrals to County Mental Health Plans and providers when members need services covered by the County Mental Health Plan. We have procedures in place for our Medicare Advantage SNPs to ensure all new members are screened for mental illness and substance use issues as part of completion of the Health Risk Assessment, described in **Question 2.1**. The assessment includes a PHQ9 depression screen, screening for other mental illnesses, and for substance use. We provide a fully integrated health home to our members that include a mental health program implemented by a team of psychiatrists, therapists, and mental health nurse practitioners. The Mental Health Team addresses mental illness and substance use issues, and manages all of the member's needs (physical health, LTSS, and social supports) in coordination with the member's PCP. Our model is a fully integrated health home model - there is no hand-off care in this model. The Mental Health Team continues to manage all Medicare-covered mental health and substance use services and supports for as long as the member continues to needs these services, and continues to work with the primary care provider for complete coordination of physical and mental health/substance use care. We will utilize Anthem's Medi-Cal and CareMore's D-SNP Medicare experience to achieve integration across the full array of mental health and substance use benefits covered by Medicare and Medi-Cal, as well as physical health, LTSS, and social supports.

We recognize that dual eligibles with mental illness or substance use often have health conditions that are unmanaged and not coordinated with their behavioral health treatment. Primary care providers and mental health providers in the current siloed system struggle to meet

the complex needs of this population. We propose to send an individual of our Mental Health Team to the clinics where our dual eligibles receive Medi-Cal covered mental illness and substance use services to achieve integration of care. The team member may be a local psychiatrist, psychologist, or psychiatric nurse practitioner, depending on the situation and need. Our Mental Health Team will offer the following services:

- We will participate in treatment planning meetings, review medical records and review individual cases or group cases, and will be available to participate in treatment rounds.
- We will provide individual pharmacologic management.
- We will partner with providers and the county to address members' dementia related issues and will coordinate with Adult Protective Services or others when needed.
- We will provide specialty consultation such as neuropsychiatric evaluations.
- In concert with the County, we will work with the self-help community such as the local NAMI chapter and the Depression and Bipolar Support Association to ensure members take responsibility for their recovery.

The Mental Health Team will be the point of contact with the County Mental Health Plan for warm hand-offs. We will also use additional methods to support integration including:

- We will invite County Mental Health Plan providers and others involved in a member's mental health and substance use treatment to the ICT meeting, with member consent.
- We will provide copies of the member's plan of care, treatment notes, assessment information and other information to clinics and providers with member consent.
- We will incorporate member-specific information shared with us by Medi-Cal mental health and substance use providers into the member's EMR.

We believe our proposed model will be of great value to the county and its network of

providers and will benefit our members. We will develop details for this integrated model during the Demonstration planning period. We are now meeting with the County to develop MOUs that specify the responsibilities of each party for meeting members' mental illness and substance use needs, including specialty and non-specialty mental health services, and for coordinating primary care with mental health and substance use services under the Demonstration. We will develop policies and procedures with the County Mental Health Plan to support our proposed activities.

CareMore Member Story: Helping a dying member find a reason to live again

Our care manager was working with a 38-year-old member living in California with end-stage renal disease and severe depression. Wanting to die, she was refusing dialysis. The care manager found a family member who drove from the east coast to California to help, staying in touch the whole way. Just as the family member arrived, the member was hospitalized and refused treatment, so she lapsed into unconsciousness. With the help of the care manager, the family member got a healthcare durable power of attorney and was able to restart dialysis. Together, they convinced the member to continue treatment and continue to live.

Our care manager kept in touch and kept on helping. She connected the member with legal resources for help paying medical bills that started before she was insured, helped her find care for her four-year-old daughter, encouraged her to accept counseling and found her opportunities to volunteer in the community. Now the member knits blankets for seniors, has improved her functioning at home, and has fewer hospitalizations.

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

Our Mental Health Program is overseen by a dedicated Mental Health Director, who is a licensed psychiatrist and who has training in geriatric psychiatry. In addition, our Mental Health Teams are comprised of licensed psychiatrists, therapists, and mental health nurse practitioners.

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

Our proposed model extends beyond care coordination by achieving integration across services and providers so that the member has a functional health home, even while Medi-Cal services are carved out from the Demonstration. Our response to **Question 3.1** describes our

existing integrated model and our proposed model.

Our model uses an Interdisciplinary Care Team (ICT) process to develop the member's care plan. The ICT consists of the member, the NP, primary care provider, a nurse, social worker, and others of the member's choosing such as his or her designated family members, caregiver(s), and legal representatives. Members of the Mental Health Team participate in the ICT as needed. Other clinical disciplines, such as pharmacy, nutrition, rehabilitation therapy and specialists are included based on member need and/or member request. While we will also invite County Mental Health plan providers and case managers to participate in the ICT and development of the POC, with member consent, we anticipate that most interdisciplinary treatment planning will occur at the clinics. We also plan to take our medical care services to mental health centers and residential care facilities so we can see members at these facilities.

The Mental Health Team is accessible to the member through the CareMore Care Centers, special CareMore behavioral health clinics in high-volume areas, and home-based and facility-based visits. A CareMore Innovation Team provides feet-on-the-street case management, visiting shelters, emergency departments and other locations to meet with member's, assess their immediate needs, and coordinate service authorization, appointment scheduling, social supports and other needs. The Mental Health Team also uses a rounding process for members with the most acute and/or complex mental health/substance use issues where all key providers participate to coordinate care. We anticipate this process will occur primarily at the clinics.

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

Community Advisory Committees (CACs) at our organization have played an important role in shaping our program and policy decisions for many years. We will continue our

commitment to CACs for the Demonstration program and will form an effective member advisory committee for the dual eligible population in Santa Clara County. The member advisory committee will provide a critical link between the health plan, dual eligible members, and the county and community-based organizations. We will modify our existing CAC policy and procedures to reflect relevant differences for our dual eligible population. For instance, many CACs focus primarily on the medical care of the community members. For our dual eligible members, we feel it is imperative to seamlessly integrate medical care with behavioral care, including for mental illness and substance use. As such, advocates and members for all these groups will be invited to join our member advisory committee. We will include a Medical Director on the member advisory committee for clinical and quality purposes and we will also include a behavioral health specialist. As we have done in the past, to remove barriers to participation for our members, we will, wherever feasible, offer childcare assistance, transportation assistance, interpreter and sign language services, and other necessary accommodations. We need and will seek the input of our dual eligible members and their advocates to continuously improve our model of care coordination.

Our past experiences with these advisory committees provide insight on how they will function for our dual eligible community. For Medi-Cal, CACs are located in each county where we have a Medi-Cal contract, and are comprised of eight to 15 representatives from the local community. Our current CACs include Medi-Cal members and advocacy groups, including groups that advocate for seniors and persons with disabilities, and are chaired by one of our local Community Resource Coordinators. CAC membership reflects entities and organizations important to the delivery of culturally sensitive and appropriate health care. In recruiting individuals for our Medi-Cal CACs, we plan to include three provider representatives, three

public health representatives, six community-based organizations, and three Medi-Cal members, including at least one SPD member. We will take a close look at where we can leverage our existing, successful Medi-Cal CACs processes and also improve these processes to create the most beneficial care coordination impact for our dual eligible populations.

Recognizing that provider issues are often different than member issues, we will also create an advisory committee for providers of dual eligible members. Our experience with specialized provider advisory committees is that when providers and medical directors meet, program improvements are identified quickly to help our members. The providers tend to know the intricate details of patient care and what could be improved to help the member. We have used provider advisory committees with great success in the past to obtain provider feedback, resulting in improved communications and redesigned programs.

Through the effective use of member and provider advisory committees, we will be able to oversee the care coordination partnership and progress toward seamless integration of the medical and behavioral health needs of our dual eligible members.

Section 3.2: County Partnerships

Question 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.)

Our responses to **Questions 3.1, 3.2 and 3.3** describe our existing model of care and our proposed approach for integrating mental health/substance use services under the Demonstration. We will develop county-specific models to support integrated benefits in partnership with the key stakeholders including the County Mental Health Plans, dual eligible members with mental

illness and substance use, advocacy groups and providers across payors and systems. The specific design of each model will be developed with broad stakeholder workgroups.

CareMore's model of care is recovery-based and engages members in their recovery, provides a range of services and supports available to help them, including peer supports, and maintains valued, existing relationships. We intend to work with the County and County Mental Health Plan providers to develop a fully integrated model that preserves the provider network and supports continuity of care. Our approach is described in the table below.

Initial Period	Full Integration
• We (the dual eligible health plan) will be responsible for medical and LTSS benefits for all enrollees and for mental health services for those not meeting the medical necessity criteria for county specialty services. • The County Mental Health Plan will maintain primary responsibility for Medi-Cal mental health services and substance use services, as reflected in current law. • We will enter into written agreements that include incentives for participation in our proposed integrated model. • We will utilize agreed-to performance measures for tracking shared accountability. • The agreement will apply to all dual eligible members who utilize Medi-Cal specialty mental health services. • Our model is comprehensive and includes the County Mental Health Plan, clinics, the member, the Mental Health Team, and the member's primary care provider. • Outcomes Measures will reflect process improvements and evidence of collaboration and coordinated care, such as common member assessments, screening, stratification, jointly developed care/treatment plans, reductions in high-cost service utilization and improved access to home and community-based services, and real-time notification of hospital and ED admissions. • We will enter into a formal agreement for treatment planning and care coordination, specialty consultation (such as neuropscyh and geropsych), ICT participation, and information sharing with the County Mental Health Plan. • We will work with DHCS and the County Mental Health Plan to design an incentive pool and/or shared savings arrangement that will award bonus payments or shared savings to the health plan and to the County	• The health plan will receive capitated payments to cover all benefits, including specialty mental health services. • Dual eligibles who meet medical necessity criteria for specialty mental health services will have their care coordinated by the Mental Health Team/designated care manager. • The member health home and ICT process are the core components of CareMore's Model of Care. • The health plan will deliver specialty mental health services using contracted providers. • We will work with the County Mental Health Plan on a contracting strategy, which may include a direct contract with the County Mental Health Plan. • Reimbursement will use the most appropriate arrangement based on the final program design, and will include pay for performance incentives. • Outcomes Measures will be comprehensive and will focus on continued reductions in high-cost service utilization and improved access to home and community-based services, improved health and functional outcomes, and overall cost savings. • Measures of special importance to members will be included and could include access to peer supports, measures of entry into employment and sustained employment, and improved access to housing and on-site supports. • All mental health and substance use benefits

Initial Period	Full Integration
Mental Health Plan for meeting set performance measures tied to activities that promote integration and/or outcomes that indicate successful coordination of care and specific health outcomes. • Clear data sharing and privacy guidelines will be established to facilitate information exchange across systems, such as exchange of pharmacy data to inform care management.	will be included in our capitated payments. • We will work with DHCS and the County Mental Health Plan to identify a method to preserve funding in a fully-capitated environment that is currently based on county match and transfers (including CPEs). • All in-network providers and members of the ICT will have access to the member's EMR through the CareMore portal. • Data exchange and data access agreements will be developed for any sub-capitated arrangements and for out-of-network providers.

Question 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.

During the initial phase of the Demonstration, the Mental Health Team will work with PCPs to identify which carved-out Medi-Cal covered mental health and substance abuse services are required by members and will complete referral to the County Mental Health Plan (Mental Health Department) within the Santa Clara Valley Health and Hospital System. Our proposed information exchange described in **Question 3.2.2b** will also support this process. We will implement an MOU between both organizations and will establish policies and procedures to support this process. We describe our process during this initial phase in **Question 3.1**. During the first year of the program, we will also establish additional processes for ongoing communication. For example, we would develop a workgroup of key health plan and County stakeholders (including the Mental Health Department) to determine the best method for aligning our collective goals under the Demonstration. This workgroup will meet on a regular basis and will have clear roles and responsibilities. We will organize the meetings and help to facilitate discussions. The workgroup will be tasked with the objective of establishing collective measures for accountability and a plan for an integrated capitated payment by 2015.

Question 3.2.2.a Describe how you will work with County partners to establish standardized criteria for identifying beneficiaries to target for care coordination.

We will meet with County partners to discuss and analyze each other's screening, assessment, stratification, and treatment planning processes in order to understand the current state. These meetings will begin as peer meetings (medical directors and physicians, social workers, nurses, and others) with a goal to map out the existing processes. Once complete, meetings will be multi-disciplinary and will focus on assessing the value of unique processes and identifying how to standardize processes across the partners (health plan and County). Criteria will be evaluated for adherence to the existing evidence-base. A refined set of standardized criteria will result from this analysis. We believe this criterion should be reviewed with the broader stakeholder community, including with members who have a SPMI, with final criteria taking into account the feedback from the stakeholders. Finally, the criteria will need to be tested on a subset of members, analyzed and refined before being finalized and broadly implemented.

Question 3.2.2.b Describe how you will overcome barriers to exchange information across systems for purposes of care coordination and monitoring.

Exchange of information across systems for purposes of care coordination and monitoring will require several approaches. While exchange will be simplified once the Demonstration fully integrates LTSS, other HCBS waivers, and behavioral health services, members will always have a need to access social supports and other services not covered by the Medicare or Medi-Cal program. We propose to execute MOUs with service providers who are not part of the network or who are not fully integrated during Year 1, such as the Division of Aging and Adult Services case managers and Regional Center support coordinators, to specify the information that will be shared with specific parties, subject to member consent. Information exchange will include:

- Information obtained from participation in Interdisciplinary Care Team meetings
- Copies of plans of care, clinical notes, assessment information and other relevant information, and receipt of similar information from these external service providers
- Information obtained during clinical rounding: we will invite external physicians, NPs and other clinicians to participate in rounding and complex case management meetings, and will be available to participate in comparable external provider activities
- Scheduling of special conferences and consultations upon request, during which coordination of care will occur
- Inclusion of external providers' clinical notes, assessments, plans of care, and other documentation in our EMR, so that the member has a comprehensive member record

As services become fully integrated and the rendering providers join our network, they will have access to a member's EMR through the provider portal. The EMR provides access to comprehensive health risk assessment data, clinical notes, plans of care, lab test results, pharmacy data and other claims data.

SECTION 4: PERSON-CENTERED CARE COORDINATION

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

We implement a person-centered care coordination model for all of our members. The foundation of this model is communication with the member (and their family or legal representative as appropriate) aimed at ensuring the member receives the care, services and supports they want and need. Shared understanding is established and maintained through

effective and continuous communications among the member, the family, the ICT, PCP, specialists, direct care providers and other providers and social support organizations. The member's care is coordinated by an NP, behavioral health specialist or social worker, depending on the member's primary care needs. Care may also be self-directed with support available from a social worker as described in **Section 5**. We utilize the Healthy Start comprehensive health risk assessment when the member first joins the plan to identify each member's specific needs, including the level of support and type of support needed with coordination of care; a Healthy Journey assessment is done annually or in the event of significant change in health status. (See **Question 2.1.3** for more detail.) The ICT, which includes the member or his/her authorized representative, uses this information to develop the individual's plan of care (POC). The HRA findings are documented in the POC. The ICT designates the case manager depending on the members primary care need. The case manager is the member's primary point of contact and the one responsible for working with the ICT to oversee the POC and the coordination of the members care. The case manager relies on these assessments and the POC to provide a current and comprehensive picture of the member's physical, behavioral health and social support needs.

Throughout the care process, the member is encouraged to articulate his/her desired goals and outcomes (e.g., increased energy, continuing to live alone, leave the home, aggressive or conservative treatment, palliative care). In the event that the member has a cognitive impairment or is otherwise unable to represent him/herself, we work with the person's authorized representative or through the guardian ad litem program for members who have no representative, to support their decision making while ensuring their health and welfare.

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 our attached proposed model of care for the Duals Demonstration.

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

CareMore employs clinicians who work with primary care providers (PCPs) to ensure care is coordinated. These clinicians also form an Interdisciplinary Care Team (ICT), which develops a plan of care with the member. PCPs are trained in CareMore's model of care and while new PCPs are sometimes initially uncertain about our model and its impact on their practice, they quickly come to value the resources we make available to help them participate in care teams and coordinate the member's care. The ICT include the following:

ICT Team Member	Role
Extensivists (Internal Medicine)	See members who are in contracted hospitals and skilled nursing facilities, and develop the discharge plan that includes referral into our clinical programs and to network specialists. They also provide post-acute and SNF outpatient care to make sure all of their discharge follow-up is complete and the patient is stable.
Nurse Practitioners	Are available at each CCC and perform the member's comprehensive Health Risk Assessment, provide preventative services and referrals for routine preventive testing, chronic condition management, disease specific self-management education, and monitor hospitalized members in high-risk populations. They also organize the ICT.
Medical Assistants	Schedule appointments and follow-up services for members being seen with uncontrolled chronic conditions, frail members, and those receiving their annual Healthy Start or Healthy Journey health risk assessment. They also retrieve consultation and diagnostic reports from network specialists and enter the reports into the member's EMR.
Behavioral Health Specialists	Participate in the ICT and address member's mental health and substance use needs. They are members of the Mental Health Team that implements the Mental Health Program. They ensure that behavioral health interventions are coordinated with the PCP and relevant specialists and are implemented as specified in the plan of care.
Case Managers	Work with the Extensivists to implement the discharge plans and transition the member for outpatient follow-up care. They also closely follow member's health conditions and link them to appropriate resources.
Social Workers	Help to address members' psychosocial needs. For example, they arrange meals on wheels and financial benefits.
Specialists (e.g. Pulmonologists, Cardiologists, and Podiatrists)	Are actively involved in managing high-risk conditions with the NP and participate in the ICT as needed.

The ICT selects an individual from the team to be the designated care manager. The

designated care manager addresses member needs that arise on a frequent basis such as scheduling of in-home services, scheduling appointments and helping the member and ICT professionals to implement the plan of care.

We have an extensive on-boarding process for training newly contracted providers in advance of the effective date of the contract. This training consists of multiple office staff trainings, doctor-to-doctor discussions, and orientations with our team. Every PCP contract includes incentives to utilize our clinic services at our CCC. We have created a system that monitors these processes and assigned provider relations staff and Regional Medical Directors review the results on a quarterly basis with the PCPs.

SECTION 5: CONSUMER PROTECTIONS

Applicant must:
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.

We certify that we will be in compliance with all consumer protections described in the Demonstration and will be prepared to demonstrate compliance during the readiness review.

Section 5.1: Consumer Choice

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

Choosing a Primary Care Provider: Dual eligibles enrolled into our Demonstration will be able to choose their PCP from within our extensive provider network based on their preferences, including their linguistic needs, cultural considerations, and accessibility requirements. We have a strong provider network and infrastructure in the county today through our Medi-Cal plan and CareMore's Medicare Advantage SNP. The care and support needs of

dual eligible members will require additional providers, including certain safety net providers and specialists. We will execute an aggressive outreach and contracting plan to fill out our target provider network in advance of the readiness review.

CareMore's welcome packet, which includes a "How to Guide", provides information on how to choose a PCP and include a provider directory and a web-based provider finder search tool. The "How to Guide" provides members with answers to Frequently Asked Questions and important telephone numbers for the various people and departments that will be the most important to our new members. Member Services Representatives are available via a toll-free number to help members with PCP selection. Live outbound welcome calls are made to all new members shortly after enrollment and provide assistance as-needed during these calls including assistance with PCP selection. Members are free to switch PCPs for any reason by contacting a Member Services Representative. We recognize the importance of pre-existing relationships for newly enrolled members who may have a long-standing relationship with an out-of-network PCP. We will allow follow-up care as needed on a short-term basis for continuity of care, and we will work with the member to transition them to an in-network provider. If the PCP determines that the member requires more specialized/extensive treatment than is possible within a primary care setting, they will coordinate the referral to an appropriate specialty care provider.

Choosing a Specialist: Members are generally referred to a specialist by their PCP. The member may select from among available network specialists who are listed in the provider directory. Members may request a change in specialist, however changes are coordinated by the PCP when a member's request is made to a Member Services Representative to ensure continuity of care. Members who request a change in specialist during their ICT meeting will be assisted by the ICT to coordinate any changes with the PCP as part of the ICT process. Members newly

enrolling in our network may have a long-standing relationship with an out-of-network specialist. This is more common among members with chronic conditions or specific diagnoses. We acknowledge the importance of this pre-existing relationship and will allow follow-up care as needed on a short-term basis for continuity of care, but do require members to see contracted providers. During this time, we will invite the specialist to enter into an in-network agreement.

Participation in the Interdisciplinary Care Team: We utilize an ICT model for development, implementation and monitoring of the plan of care. The ICT consists of the member, a nurse practitioner, a PCP, a behavioral health specialist, a social worker and others of the member's choosing such as his or her designated family members, caregiver(s), and legal representatives. Other clinical disciplines, such as pharmacy, nutrition, rehabilitation therapy and specialists are included based on member need and/or member request. For example, the composition of the ICT may be expanded under the Demonstration to include LTSS providers, County Mental Health Plans and others providing case management or social supports to members, with member consent. The ICT will identify a designated care manager during the ICT meeting agreed to by the member. We are committed to supporting member's self-direction and participation in their care. We describe this in more detail in **Section 5.1.2**.

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

We support member's self-direction and participation in their care. Members can choose to be a part of the ICT, and are strongly encouraged to participate in the team and in the decision-making process to ensure optimal program benefits and care. However, we recognize that not all members may want to participate in the ICT, and we offer members the option of not having to do so. We seek informed consent from these members for their plan of care and for specific

interventions. Members will have access to assistance with self-direction and decision-making. For example, we will provide assistance with: scheduling the ICT – selecting the date, time and location of the ICT; identifying who they want to participate in the ICT, including family members, friends, providers and others of the member's choosing; developing a member-centered plan of care; and participating in medical decision-making PCP Managing in-home services including IHSS and wraparound supports. We will include training on self-direction for clinical staff, Member Services Representatives and network providers. This will include education on shared decision-making within a primary care setting.

Section 5.2: Access

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

We certify we will meet the rigorous accessibility standards of DHCS.

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

The following table provides additional details on our program:

Program Accessibility	Description
Physical Accessibility	To make sure that are members are able to access the services they need, Facility Site Reviews are completed when providers join our network and again every three years. Furthermore, our CCC facilities are designed with accessibility in mind, including: parking, ramp access, entry ways, reception area and furnishings, exam rooms, restrooms, scales, aisle ways, doors and thresholds, carpeting, and lighting.
Community Accessibility	When connecting members to providers and specialists, our case managers pay attention to issues of community accessibility including transportation needs and the ability of personal attendants to accompany a beneficiary.
Assistance for the Hearing Impaired	Members may contact the Member Services department using 711 Relay Services or through Text Telephone Typewriter (TTY) services during business hours. We also provide sign language interpreters for hundreds of member encounters.
Assistance for the Visually Impaired	Members can call Member Services and request materials in alternative formats including Braille, large font letters, audiotape, and verbal interpretations. The Member Handbook also reinforces that these alternative format materials are available and at no cost to the member.

Program Accessibility	Description
Assistance for Members with Cognitive Impairments and Members with Mental Illness	In order to accommodate members with cognitive impairments, Member Services will connect the member to a case management representative so that he or she receives any additional support required. If a Member Service representative determines that additional assistance is required they can: • Identify if a guardian or legal representative has been designated to speak on the member's behalf and coordinate any activities • Transfer the call to our 24/7 Nurse Line to get additional translation or assistance • Transfer the call to Case Management internally and make sure the individual is evaluated for special needs services and identified in the system for future reference
Document/Information Accessibility	Information is provided to our members through the Member Handbook as well as our website. Our materials and website are Section 508 compliant. This information can also be made available in alternate languages. To assist our members and providers, we subcontract with two national interpretation vendors to provide translation services. We also offer "Translation on Demand" (TOD), our program to translate non-vital documents at a member's request in his or her own language. We can also use TOD for alternate format requests such as Braille, large print, or audio CD.
Doctor/Provider Accessibility	We meet the time and distance requirements outlined by DHCS. We use a variety of monitoring mechanisms to verify the adequacy of the primary care provider, hospital, and specialist networks. Through analysis of these reports, our staff targets specific areas where improvement is needed.

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

CareMore's member intake process, as described in **Section 5.5**, is very hands-on. The high-touch approach includes the Healthy Start assessment, which is completed within the first 30 days of membership. This introduction to the plan includes a broad orientation of CareMore services and the care model. In addition to these in-person explanations of the accessibility levels of the provider network, information on accessibility is also provided through CareMore's member "How to Guide". See **Attachment 16** for an outline of the "How to Guide" as well as CareMore's website for the full document.

Section 5.3: Education and Outreach

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

We offer our members materials in alternative formats. Alternative formats include

Braille, large font, and audio format materials. If a member is not identified by DHCS as needing alternative format materials, once a member makes a request materials are provided to the member in the requested alternative format going forward, unless a request to change or stop is made by that member. Also see our response to **Question 5.2.2** regarding how we support our members who possess visual, hearing, or cognitive impairments.

For members with limited-English proficiency (LEP), we offer materials translation into threshold languages and utilize a translation on demand (TOD) tool for materials with rare or minimal requests. The TOD requirements include standards for delivery of materials to members within a specified time period. The translation unit works with vendors to ensure materials are available in threshold languages for members. Our materials are written at low reading levels and are visually friendly.

Provider offices have access to culturally competent training materials through a variety of sources including our provider website, lunch and learn sessions, live webinars, in-office one-on-one and group trainings by us and in collaboration with other health plans. The curriculum discusses how to provide culturally competent care, how to recognize cultural traditions in a member and how to best address the health needs of a member with consideration to their cultural beliefs. We offer our providers a cultural competency toolkit called "Caring for Diverse Populations". Providers are also given information on how to access an interpreter for members during their office visit. The office staff is quickly able to access a phone interpreter to assist in communication and establishing future appointments with an interpreter present in the member's language. We collaborated with health plans statewide to bring training to provider offices through live webinars on Seniors and Persons with Disabilities (SPD).

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

Our Cultural and Linguistics Program conducts a formal Group Needs Assessment (GNA) every five years, which includes an analysis of member demographics, health risks and behaviors, and member preferences for receiving health care and health information. The GNA is designed to assess the cultural characteristics of a community, including the languages and dialects spoken and their prevalence, health-related behaviors and practices, prevalence of health problems and conditions, or health risks, and particular learning needs and resources, such as community or social organizations that members belong to or utilize. The GNA outcomes are used to develop health education programs and materials to determine which languages our programs and materials should be translated into and to identify community partners.

To meet the linguistic and cultural needs of our members, we:

- Ensure providers and staff provide culturally appropriate health care services to our members and communicate clearly with members in their preferred language
- Employ and contract with culturally competent and proficient bilingual staff and providers who reflect the diversity of our members
- Employ experienced, educated, and qualified staff to administer and execute the cultural and linguistic program
- Provide qualified phone interpreters in over 150 languages and teletypewriter (TTY) services to members at no cost, 24 hours a day, 7 days a week
- Provide qualified face-to-face interpreter services for members with LEP and hearing-impaired members within a 72-hour request
- Train providers how to access free interpreters for members, and on the members' right

to receive qualified interpreter services, to discourage members from using friends and family and especially children as interpreters

- Maintain on-hand vital member materials translated in eight languages, and provide efficient and timely translation-on-demand for requests for translations in other languages
- Ensure quality translation services for our members through contracts with highly reputable vendors and monitoring of translation quality
- Ensure that translated member material meet our standards for clear communication at an appropriate reading level
- Use focus groups and presentations to obtain input from members, providers and internal experts to evaluate new communication efforts
- Ensure our staffing profile in each region reflects the cultural profile of the population
- Train our Member Services Representatives and local clinic staff on how to secure translators through our designated language service provider as the need arises

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

Question 5.3.3a: A detailed operational plan for beneficiary outreach and communication.

Question 5.3.3b: An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.

Question 5.3.3c: An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.

We certify that we will comply with the rigorous requirements established by DHCS in the Demonstration, including the information described in Question 5.3.3a, Question 5.3.3b and Question 5.3.3c as part of the Readiness Review.

Section 5.4: Stakeholder Input

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

We have a multi-faceted approach to engaging stakeholders in 2012 and it includes (i) leveraging existing stakeholder engagement begun over the past year, (ii) public forums during application process with county Medi-Cal health plans, (iii) leadership outreach for advisory boards, (iv) county outreach (v) outreach to organizations posting RFI comments, (vi) advisory committees, and (vii) a dual eligible survey. Our stakeholder engagement plan and timeline for this Demonstration began about a year ago with one-on-one meetings with SPD advocates to better understand the complex needs of this population. **Table 5.4.1a** lists some meetings that have been held in the past year. Over the past year, we have learned a lot about the SPD population and continuously enhance our Medi-Cal programs to meet their special needs. These valuable meetings with SPD advocates provided an excellent starting point and foundation for our outreach objectives for this Demonstration.

Table 5.4.1a – Pre-Application Vulnerable Populations Outreach

Date	Organization	Representative	Title	Topic	Details
February-2012	San Francisco Department of Public Health	Tangerine Brigham	Deputy Director of Health	LTCI	Strategic planning team
February-2012	Department of Aging San Francisco	Bill Haskell	Facilitator	LTCI	Long Term Care Integration Committee
January - 2012	California Association of Public Authorities (CAPA)	Karen Keeslar	Executive Director	IHSS	Community support services
December-2011	RTZ Associates	Rick Zawadski	President	ADHC/CBAS	Community support services
December-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
October-2011	Department of Aging San Francisco	Linda Edelstein	Long Term Care Operations Director	ADHC	ADHC funding

Date	Organization	Representative	Title	Topic	Details
October-2011	Department of Aging San Francisco	Anne Hinton	Executive Director	LTCI	Long Term Care Integration strategic planning
September-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
September-2011	Molina Health Care	Steven Soto	Regional Director	ADHC	Joint education/outreach meeting
September-2011	San Francisco Adult Day Services	LaNay Eastman	Executive Director	ADHC	ADHC contact coordination
August-2011	Adult Day Services Network of Alameda County	Anne Warner-Reitz	Executive Director	ADHC	ADHC planning partnerships
August-2011	SteppingStone	Moli Steinert	Executive Director	ADHC	Dual Eligible ADHC
August-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
August-2011	SteppingStone	Moli Steinert	Executive Director	ADHC	Providing care management services
August-2011	San Francisco Community Clinic Consortium	John Gressman	President, CEO	ADHC	ADHC strategy session
August-2011	California Association for Adult Day Services	Lydia Missaelides	Executive Director	ADHC	High risk member care management
May-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
April-2011	SteppingStone	Moli Steinert	Executive Director	ADHC	Patient provider list
April-2011	SteppingStone	Moli Steinert	Executive Director	ADHC	ADHC topics
April-2011	Alzheimer's Services of East Bay	Micheal Pope	Executive Director	ADHC	Alameda County ADHC providers
March-2011	Adult Day Services Network of Alameda County	Anne Warner-Reitz	Executive Director	ADHC	Managed Care and ADHC partnerships

We held a number of public forums as part of our stakeholder process, and plan to conduct additional forums. We reached out to our non-profit Medi-Cal county partners in these two counties, the Santa Clara Family Health Plan and the Alameda Alliance for Health, and found both plans very receptive and cooperative in efforts to have the two counties chosen for the Demonstration. We participated in public forums in Alameda on February 17, 2012, and in

Santa Clara on February 21, 2012. Additionally we participated in nearby public forums in Contra Costa on February 15, 2012, and in Sacramento on February 23, 2012. The purpose of these forums was to present the Demonstration, offer our thoughts on innovative care models, and to gather community thoughts on designing the best possible program for the dual eligible population. These forums were well attended and the ideas we heard influenced our program, especially concerning behavioral health. Seamless integration of medical, pharmacological, and behavioral health needs is on the minds of dual eligible advocates. A number of attendees were interested in attending the future advisory committee meetings that will be part of our Demonstration program.

Also during the application process, we began reaching out to leaders in the dual eligible community in Santa Clara to identify leaders who would like to either serve on an advisory board and/or attend our advisory meetings. **Table 5.4.1b** identifies the leaders that we reached out to in Santa Clara. We have already begun receiving letters of support from many of them.

Table 5.4.1b – Santa Clara County Leadership Outreach

Name	Title	Organization
Alejandra Herra Chavez	Policy Development Specialist	City of San Jose Housing
Amy Andonian	Program Director	Caregiver Support Services - Catholic Charities
Bob Campbell	Executive Director	Senior Housing Solutions – Milpitas
Cathy Lynch	Community Relations Coordinator	Pathways Health
Connie Langford	Chair Person	City of San Jose Senior Citizens Commission
Dawn Ngo	Geriatric Care Manager	City of Santa Clara - Council on Aging
Glenda Cresap	Executive Director	Heart of the Valley - Services for Seniors
Karen Storey	Executive Director	The Wellness Community - Silicon Valley
Kathy Whitcomb	Senior Services Rep	Campbell Adult Center
Laura Beeson	Director - Health Senior Services	Mexican American Senior Services
Lee Pullen	Director	Department of Aging and Adult Services
Lisa Hendrickson	Executive Director	Avenida
Lori Andersen	Director Healthy Aging	The Health Trust
Marita Grudzen	Deputy Director	Stanford Geriatric Education Center
Mindy Berkowitz	Executive Director	Jewish Family Services of Silicon Valley

Name	Title	Organization
Reymundo Espinoza	CEO	Gardner Family Health
Sarah Triano	Executive Director	Silicon Valley Independent Living Center
Stephen Schmolll	CEO	Council on Aging Silicon Valley
William C. Parrish Jr.	CEO	Santa Clara County Medical Society

During the RFS application process, our outreach team also contacted the county authorities to begin the signed Letter of Agreement process. The purpose of this letter is to confirm each party's intent to collaborate on a program for the California Duals Demonstration. **Table 5.4.1c** lists the county authorities that we have contacted. At the time of application filing, we are still awaiting the signed letters back from the county. Memorandums of Understanding between Anthem and the county authorities have also been drafted, and at the time of the application filing, are still being reviewed by our legal department.

Table 5.4.1c – County Authority Outreach

COUNTY AUTHORITY AGENCY	SANTA CLARA
IN-HOME SUPPORTIVE SERVICES (IHSS) AGENCY	Santa Clara County Public Authority For In-Home Supportive Services
COUNTY SOCIAL SERVICES	Department of Aging and Adult Services
COUNTY MENTAL HEALTH	Mental Health Department
COUNTY PUBLIC HEALTH	Public Health Department

Additionally, our outreach team reviewed in detail DHCS's Duals Demonstration RFI from last year and the many comments (positive and negative) that were received during the comment process. The team compiled a document detailing comments and concerns from organizations, along with contact information. We then proactively reached out to these specific organizations to introduce ourselves and to open a conversation about their concerns. We will

continue the process until we can contact as many organizations as we can. Organizations are reiterating their concerns, but they seem glad to be able to voice their issues to us, and to know we are listening to their concerns.

Additionally, to engage the opinions of all our dual eligible members, we will design a satisfaction survey that will survey all the dual eligible members in our Demonstration program. These surveys will be given to the members after they enroll and participate in our services, ideally within three months. In addition to soliciting their satisfaction with our program, these surveys will allow us to better understand their concerns, problems, and issues. We will then be able to take action based on consolidated responses to make any necessary corrections to improve the members experience with our organization.

The following table lists our 2012 key stakeholder engagement activities:

2012 Duals Demonstration Stakeholder Activity (Implementation)	Completion
Conduct outreach to SPD advocates to understand populations	1/27/2012
Hold forums in bidding counties to meet advocates and understand dual eligible issues	2/22/2012
Reach out to dual eligible community leaders about participating in advisory board	2/23/2012
Conduct outreach on RFI Comment organizations to understand issues and concerns	3/10/2012
Assemble Anthem Advisory Committee Development Project (ACDP) Team	3/17/2012
Develop an ACDP Project Plan for creating an effective advisory committee	3/28/2012
Hold discussions on identifying key stakeholders for CACs	3/31/2012
Reach to key stakeholders informally to begin building relationships	4/30/2012
Compile list of suggested committee members based on stakeholder conversations	5/1/2012
Design the dual eligible post-enrollment satisfaction survey	5/15/2012
Send invitations to become members of the Duals Demonstration advisory committee	5/31/2012
Update existing Advisory Committee P&P for Duals Demonstrations program	5/31/2012
Create and document the meeting procedures for Duals Demonstrations advisory committee	7/31/2012
Gain approval of dual eligible post-enrollment satisfaction survey	8/31/2012
Locate and schedule meeting space for the next year of meetings	9/30/2012
Determine list of presenters for the next year	9/30/2012
Finalize meeting schedule for the next year	9/30/2012
Submit meeting schedule and presenters to Duals Demonstrations program leadership	10/1/2012
Develop materials for first meeting	10/31/2012
Create group that will administer the dual eligible post-enrollment satisfaction survey	10/31/2012
Send invitations to presenters	10/31/2012
Send invitations to committee	10/31/2012
Facilitate first meeting	11/30/2012
Hold lessons learned and feedback session with program leadership and Quality department	12/15/2012

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

By 2013, as shown in the **Question 5.4.1**, we will have developed a strong presence with dual eligible stakeholders in Santa Clara County and will have already begun holding our Duals Demonstration advisory committee meetings, and will begin conducting our Dual Eligible Post-Enrollment Satisfaction Surveys. In our experience, we have found there are many keys to maintaining successful and effective advisory committees and we will employ these throughout the three-year Demonstration. The first is for the advisory committee to have engaged interested stakeholders to participate and to keep them fully engaged. Another key is to hold regular, purposeful formal meetings where every participant has a voice in the dual eligible issues at hand. We have also found that having a mission statement and a clear process for setting goals and objectives helps keep our advisory committees focused. A strong leader is also necessary to keep the discussion on track and the group focused on the issue at hand. A Community Resource Coordinator (CRC) will lead the member advisory committee and our provider network director will lead the provider advisory committee. We will also be reaching out to stakeholders in between meetings to keep them apprised of issues relating to the dual eligible community. Diversity is important to a successful advisory committee, and we will encourage diverse points of view in an open, accepting forum.

For 2013 and throughout the Demonstration program, we will follow the points noted above to successfully run our advisory committees and to continuously improve our program. The 2012 preparatory phase will allow us to engage the right stakeholders for all the community dual eligible issues and to launch the program to success. Throughout the Demonstration, our advisory committees will bring forward dual eligible issues and solutions, which our program

leadership and quality improvement will look to incorporate in order to improve the health and quality of life for our dual eligible populations.

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

We are committed to involving external stakeholders meaningfully in the development and ongoing operations of our Demonstration program in Santa Clara County. As discussed in **Question 5.4.1**, we are fully committed to several outreach programs that include dual eligible members, advocates, community leaders, and providers. We have already taken the information we have received through all these input channels, and have funneled them to our Demonstration program team. Changes have already been made to our program based on input from our outreach efforts mentioned above. The primary recommendations from any one group of stakeholders are to keep in place much of the currently existing support structure. Any process that enhances, improves the current process would help this population transition successfully. We have also learned that many dual members suffer from diagnosed or undiagnosed dementia and dementia-related conditions. Educating providers on how to best understand and manage these conditions will help dual members navigate their way into needed services. Further, the local field staff and central call center support staff can serve a significant role in simply making reminder calls to the members. Dual eligible members, like SPD members, will often have trouble remembering the day and time of appointments. Field staff has now been calling SPD members to remind them of their appointments. These individuals now have a higher rate of making their appointments with the outcome of better managing their overall health.

Going forward, we plan to use a similar outreach approach. The process will be for the Demonstration project manager to manage all of the outreach attempts in Santa Clara County and to ensure approved improvement suggestions are implemented. The project manager will make sure there is appropriate representation for all of the outreach events, including the advisory committee meetings. Each outreach will be documented and any suggestions for improvement will be forwarded to all of our departments that are relevant to the feedback. The project manager will keep a list of feedback that requires action by our quality, care management, provider network, or other departments. Periodically, the project manager will contact the appropriate departments to understand and document the resolution to the suggestions for improvement. Prior to the next outreach or advisory meeting, the project manager will provide the resolutions to the attendees so that updates may be provided to the group. This process will ensure that all the outreach feedback that could lead to improved program operations, benefits, access to services, or adequacy of grievance processes is documented, enacted, and reported.

Section 5.5: Enrollment Process

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

Beginning January 2013, we envision a rolling enrollment process where membership will be phased in over a twelve-month period based on the member's birth month. DHCS employed a similar approach for enrollment of the mandatory SPD members in 2011 and 2012. This approach worked well and enabled us to steadily enroll these members with complex health needs into the program. We were able to directly reach out to these members within a reasonable timeframe (within 90 days from enrollment date) to ensure a safe and effective transition to managed care. This approach makes the process more manageable than having to enroll the

entire population beginning January 2013. However, if DHCS decides not to phase in enrollment over the course of the year, and plans are to enroll all members at once, we will work with DHCS and CMS to enroll members in advance of the January 1, 2013 effective date.

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

In addition to incorporating the best practice of enrolling SPD members on a phased-in basis by birth month, we will also better prepare for transitioning this population from a fee-for-service environment to managed care. Based on our experience enrolling the SPD population into the managed care program, this population needs significant education and a clear explanation on how to access care and services in a managed care plan before they are actively enrolled in our plan. Many of the SPD beneficiaries were not familiar with managed care processes, including knowing where to go to determine whether their existing providers are in our network, and obtain authorizations for needed care. For example, to address these challenges prior to the official enrollment date, we will:

- Develop a checklist of Frequently Asked Questions (FAQs) for members based on the major areas of concern for members including, but not limited to: whether they already had an appointments with a provider that may be impacted by the switch to our managed care program, whether they have a provider they want to keep seeing, and if there are prior approved services/authorizations and/or surgeries scheduled
- Create and distribute outreach and welcome letters, FAQs, informational packets, and other educational material to help members learn more about our plan and how to access care
- Better partner with member advocacy groups to enhance member engagement in the transition process

- Conduct repeated outbound welcome calls to our beneficiaries to clarify the process and answer questions
- Hold educational and training sessions with members, and partner with DHCS and other county plans to expand prior information sessions to help transition members, explain the basics of managed care, the member's and the health plan's role in the transition and day-to-day activities
- Utilize claims data to identify high risk members through risk stratification tools and proactively reach out to these individuals, conducting face-to-face meetings or phone calls to help them understand the transition process and initiate engagement in a care management plan
- Provide a dedicated toll-free number to access specially trained member services representatives who can address questions and concerns
- Perform a post-enrollment satisfaction survey of our newly enrolled members to capture feedback and identify lessons learned to continuously improve the process.

Also upon enrollment, we will conduct outreach calls to new members. We will utilize the member claims data received to help prioritize initial calls based on an initial analysis of the health risks and reach out to the most vulnerable members first. All members will receive this initial telephone call within the first 14 days from their enrollment date. During this call, our staff will schedule the initial Healthy Start appointment, ask our members whether there are any needs related to transition of care, including existing appointments or surgeries scheduled, and help educate them about their new program. At the Healthy Start appointment, we will conduct an initial health risk assessment (HRA) of the member's medical, psychosocial, cognitive and functional needs. As a result of this HRA, members are referred for additional programs and

services. We intend to have each member receive their initial Healthy Start appointment within the first 30 days from enrollment date, but no later than CMS and Medi-Cal guidelines. We will make every attempt to contact the member to conduct the initial HRA, whether in person at CCCs, by telephone, at the member's home (or wherever they may reside) or by mail.

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

In order to accommodate potential administrative and network issues prior to enrollment of new members into the Demonstration, we will need to obtain a test enrollment file from DHCS at least 60 days prior to the Readiness Review. This file should provide all parameters for the enrollment data file, including the data field types, file formats and a crosswalk to integrate with existing Medi-Cal enrollment files. We have extensive knowledge of HIPAA ANSI X12 834 transactions as well as the current Medi-Cal file format. Use of either file type will reduce the delivery timeline. If DHCS utilizes a different file layout, this will require additional testing and system development effort. We will also need information regarding the frequency of data transmission, how to reconcile data discrepancies, and whether there are any new connectivity requirements in order to exchange enrollment and data files with DHCS and/or CMS.

In addition to important information about the enrollment process, the following items would also be helping in easing the transition and keeping costs and administrative overhead down once the Demonstration is operational:

- Detailed member demographic data, including age, address, and languages spoken, for the dual eligible members in selected Demonstration counties. This information will aid in our network adequacy planning and determination of the most accessible locations for additional CareMore Care Center sites.

- Up to two years of detailed claims and/or utilization data for dual eligible members including medical, behavioral health, and pharmacy data. This will help us better understand the diverse needs of this population for planning purposes and will support a seamless and member-friendly transition of care.
- We ask DHCS and CMS to consider a single, standardized set of reports and data exchange layouts that plans would utilize with both agencies, similar to what has been proposed for encounter data submission. Standardization of reporting formats will reduce administrative overhead for plans, thus helping to keep program costs down.

Section 5.6: Grievances and Appeals

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

We certify that we will be in compliance with the appeals and grievances processes for beneficiaries and providers described in the Demonstration and Federal-State MOU.

SECTION 6: ORGANIZATIONAL CAPACITY

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

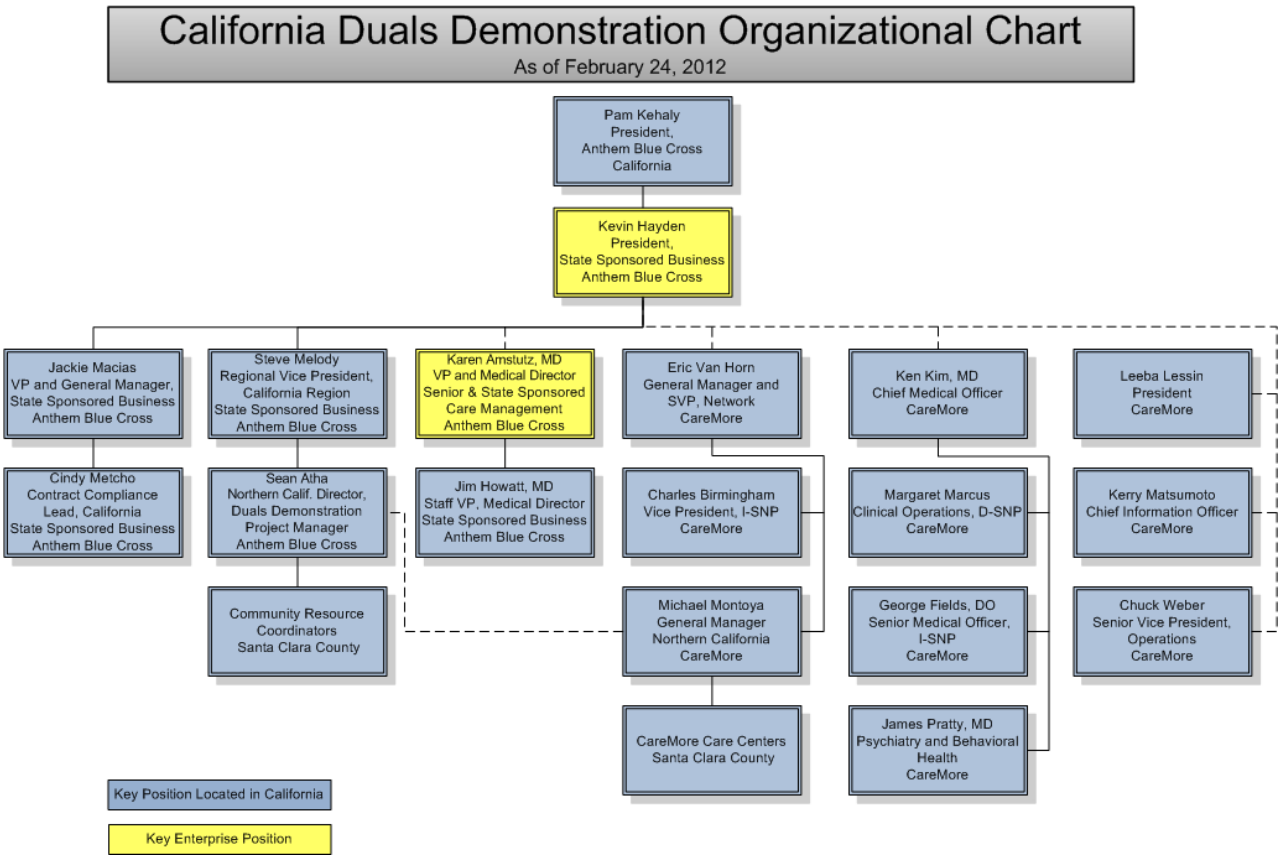
Our mission is to "improve the lives of the people we serve and the health of our communities". This mission guides our decisions and commitments. DHCS has a similar mission which is "to preserve and improve the health status of all Californians". Our mission is an integral and influential part of our culture and evidenced by the extraordinary passion our associates display in assisting our members to achieve optimal health and well-being. In fact, we believe so strongly in our mission that we have tied every employee's annual bonus to the health improvement of our members. This is done through our Member Health Index, which tracks

when we're making a difference in the most important metric of all – our members' health. The index tracks 40 different health measures across our more than 33 million members within the WellPoint family of companies. We are committed to working in partnership with our members, providers, community stakeholders, and DHCS to deliver better care and make a meaningful and important difference in the lives of Californians.

We have extensive experience serving dual eligible members across a broad spectrum of Medicare and Medicaid services, locally within the State of California and across the nation. Today we serve over 16,000 dual eligible members in our Medi-Cal plans and another 10,000 dual eligible Californians through CareMore's Medicare Advantage Special Needs Plans (SNPs). Additionally, we serve 75,000 SPD individuals under our Medi-Cal plans and over 50,000 members in the California County Medical Services Program (CMSP), which has brought us substantial experience and an understanding of the diverse and complex medical, social, and mental health challenges faced by vulnerable and high-risk populations. We have developed care management solutions tailored to the individual needs of our dual eligible and high-risk members. Our experience has also taught us that community and social supports are crucial elements to improving the health outcomes of these members. We have established an extensive community-based resource model, comprised of our Community Resource Coordinators, CareMore Care Centers, and partnerships with various local organizations and agencies throughout California and in Santa Clara County, to complement the continuum of care we deliver to our members. We are excited to work with DHCS, CMS, and Santa Clara County to expand upon our experience and existing capabilities in the delivery of an innovative model of fully integrated care that improves the lives and health of the Demonstration population.

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

The following organizational chart provides the key leaders for our Demonstration program:



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

To ensure the successful delivery of the Demonstration program, we have identified a cross-functional team of key personnel with a depth of expertise and over 150 years of collective experience in delivering state and federal programs. Our implementation team is led by local California leaders, seasoned project management professionals, and subject matter experts representing core business functions including Care Management, Operations, Information Technology, Provider Contracting, Compliance, and other key areas. Brief biographies for each of our key personnel are included in the following table.

Key Staff Member	Relevant Skills and Leadership Ability
Pam Kehaly, President, Anthem Blue Cross California	As President of Anthem Blue Cross California, Ms. Kehaly is responsible for the management of all local group health insurance business in California including sales, account service, marketing, underwriting and product delivery, as well as for maintaining customer relationships. In addition, she is responsible for the development of Anthem Blue Cross' long-term strategic direction and collaborating with local and state elected officials to improve the health of Californians. Ms. Kehaly has over 25 years of health insurance industry experience.
Kevin Hayden, President, State Sponsored Business, Anthem Blue Cross	As President of State Sponsored Business, Mr. Hayden is responsible for leading Anthem's Medicaid business division which currently serves more than 1.8 million members in 10 states. His dedicated service to the health care sector, coupled with his direct involvement to develop and shape Medicaid programs at the state level helps to meet the needs of this important market segment. Mr. Hayden's career spans more than 26 years in the private and public sectors. Mr. Hayden graduated from the University of Wisconsin at Madison with a Masters degree in Health Management.
Jackie Macias, VP and General Manager, State Sponsored Business, Anthem Blue Cross	Ms. Macias has direct oversight of Anthem Blue Cross, State Sponsored Business daily operations. She is responsible for profit and loss management, membership growth and operations of State Medicaid programs, Children's Health Insurance Programs (CHIP), and other publicly-funded programs for the uninsured and underserved populations. Ms. Macias has over 14 years of health insurance industry experience. Ms. Macias is anticipating receiving a Doctorate degree in Education and Organizational Leadership from Pepperdine University in Malibu in 2013. She graduated from American University in Washington, DC with a Masters of Science degree in Taxation.
Steve Melody, Regional Vice President, State Sponsored Business, Anthem Blue Cross	Mr. Melody is responsible for the management of Anthem's State Sponsored Business in California which includes account management, cost of care, operational oversight, product development, network strategy and overall profit and loss. Mr. Melody has more than 24 years of experience within the /managed health care industry, including previous roles in network development, strategy and innovation, and health care management.
Karen Amstutz, M.D., VP and Medical Director Medicaid and Medicare Care Management, Anthem Blue Cross	Dr. Amstutz specializes in the support of programs serving low-income populations, including Medicaid, CHIP and programs for the low-income and uninsured. She manages a dynamic staff of physicians leading innovations in quality medical care across the country. Dr. Amstutz has over 20 years of experience in the medical field. Dr. Amstutz received an M.D. from Washington University and an MBA from the University of Chicago.
James Howatt, M.D., Staff Vice President and Managing Medical Director Anthem Blue Cross	Dr. Howatt's responsibilities include overseeing the national medical director team serving 1.8 million members. He has accountability for clinical leadership and strategy, including cost of care in care management; managing the clinical physician review processes; and ensuring the clinical integrity of care management programs. Dr. Howatt has over 40 years of health care experience, received his medical degree from the University of California, San Francisco, and also holds a Masters of Business Administration degree in Health Management from the University of Phoenix. He is board certified as a family physician and is a member of the American College of Managed Care Medicine.

Key Staff Member	Relevant Skills and Leadership Ability
Sean Atha, Duals Demonstration Project Manager, Northern California Director, Anthem Blue Cross	Mr. Atha is responsible for Field Operations in Northern California for Anthem's State Sponsored Business. Located in Northern California, Mr. Atha manages a team of community resource coordinators who provide local supports and services to Medi-Cal members and providers. Mr. Atha has 17 years of experience in managed care, including extensive experience in strategic alliances, provider network relations, managed care regulatory compliance, health plan operations management, and medical group management. Mr. Atha holds a Masters in Health Administration from the University of Southern California.
Cindy Metcho, Contract Compliance Lead, California, Anthem Blue Cross	Ms. Metcho is responsible for overseeing Anthem's DHCS contracts from a compliance perspective. Ms. Metcho will be responsible for compliance matters related to the Duals Demonstration program. Ms. Metcho started with Anthem in 1998, and has progressively taken on positions with increasing responsibility and has ten years of compliance experience.
Leeba Lessin, President, CareMore	Ms. Lessin has over 18 years of experience in healthcare and managed care and has held key executive positions in CareMore, PacifiCare, and Monarch Health Systems. At CareMore, she is responsible for the core operations of the health plan. Ms. Lessin received her BA degree from Westmont College in Santa Barbara and an MBA from the University of Washington.
Ken Kim, M.D. Chief Medical Officer, CareMore	Dr. Kim joined CareMore as a Hospitalist in 1999. In 2007 he was appointed Regional Medical Officer responsible for Clinical Operations located in Downey, Lakewood, Long Beach, Los Alamitos and San Jose, CA. In 2008, Dr. Kim assumed responsibility for the management of all chronic care clinical programs and personnel based in the CareMore Care Centers. In addition, he oversaw CareMore's wireless monitoring programs and mental health program. Dr. Kim was appointed as CareMore's Chief Medical Officer in 2010, responsible for CareMore's entire clinical organization
Eric Van Horn, General Manager and Senior Vice President, CareMore	Mr. Van Horn joined CareMore Health Plan in May of 2006 as the General Manager, representing the companies' product-line growth, profitability and network strategy. Prior to joining the CareMore team, he spent 15 years in several executive roles at United Healthcare and PacifiCare Health Systems. Mr. Van Horn received his Bachelors of Arts degree in Quantitative Economics and Decision Sciences from the University of California, San Diego and an MBA in Operations from the Anderson School of Management at the University of California, Los Angeles.
Kerry Matsumoto, Chief Information Officer, CareMore	As CareMore's Chief Information Office, Mr. Matsumoto directs CareMore's digital transformation, strategic IT direction, and execution of key IT services and programs. Mr. Matsumoto has over 25 years in Information Technology leading technological innovation and delivery in the health care and aerospace industries. Mr. Matsumoto holds a Master's in Public Health from UCLA, as well as a Masters in Business Administration and Bachelors of Science degree in Quantitative Systems from California State University, Long Beach.

Key Staff Member	Relevant Skills and Leadership Ability
Margaret Marcus, Clinical Operations, D-SNP, CareMore	Ms. Marcus joined CareMore in October 2007 facilitating the continued development of CareMore's clinical model, which includes program design, quality, training and replication, and managing the operations of CareMore's Care Centers and Case Management functions. Prior to joining CareMore, she spent 18 years in various operations, integration and development roles at United Healthcare and PacifiCare Health Systems. Ms. Marcus received an MBA from the Graziadio School of Management at Pepperdine University and a Bachelors of Arts degree in Business Administration from University of Phoenix.
Charles Birmingham, Vice President, I-SNP, CareMore	Mr. Birmingham serves as the General Manager of CareMore's Medicare Special Needs Plan for frail seniors. Mr. Birmingham has over 25 years experience in the health care industry. Mr. Birmingham received his MBA from Vanderbilt University.
Michael Montoya, General Manager, Northern California, CareMore	Mr. Montoya is the General Manager of CareMore's Northern California operations, including management of CareMore Care Centers located in Northern California counties. He has over 12 years experience in the health care industry. Mr. Montoya received his MBA from the University of Iowa, Henry B. Tippie College of Business.
James Pratty, MD, Psychiatry and Behavioral Health, CareMore	Dr. Pratty practices psychiatry (general, adolescent, pediatric, addiction, and geriatric) in California. Dr. Pratty has over 30 years experience in the medical field. Dr. Pratty received his M.D. from the University of Guadalajara, Mexico.
Chuck Weber, Senior Vice President, Operations, CareMore	Mr. Weber has oversight of all operations for CareMore. In this capacity he leads the day-to-day activities as well as long-term planning in transforming the company to a leading consumer driven organization. Mr. Weber has over 16 years of experience in health care. Mr. Weber received his Masters of Science from the University of Wisconsin.
George Fields, D.O., Senior Medical Officer, I-SNP, CareMore	Dr. Fields is currently part of the clinical team for CareMore's Touch program, the organization's Institutional SNP. As part of his role, he oversees management of clinical programs for Touch members. Dr. Fields is a board certified family doctor.

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

Sean Atha, MPH

Mr. Sean Atha serves as a Regional Field Operations Director for the California region for Anthem. He has direct oversight for the following areas: provider network relations / strategic alliances, managed care, regulatory compliance, health plan operations management, medical group management, and provider network design.

Experience

Blue Cross, Director - Regional Field Operations (2006 – Present)
Accountable for managing all Medi-Cal Managed Care, Health Families and AIM medical services for 35 Northern California and Central Coast counties. Managing all physician services for the County Medical Services Program for indigent populations. Working directly from the Sacramento Community Resource Center (CRC) field operations office. Participates in multiple community organizations, including Long Term Care Integration Design Group for the City and County of San Francisco.

Health Net of California, Director - Provider Network Contracting (2002 – 2006)
Managed and negotiated IPA, medical group, hospital and individual provider contracts in the California Central Valley between Tulare and Sacramento Counties. Also managed commercial HMO, PPO & EPO and Medi-Cal contracts.

California Department of Health Care Services (DHCS) Health Services Specialist (1995 – 2002)
Developed, implemented and managed Medi-Cal Managed Care in California. Developed rate studies to create Medi-Cal rates.

California Department of Corrections, Management Analyst (1990 – 1995)
Internal Management Improvement / Process Analyst

Education

University of Southern California
MHA, Health Administration, 1990 - 1995
American College of Healthcare Executives, Medical Group Management Association

California State University-Sacramento
Teaching Credential, Education, 1990 - 1991

University of California, Santa Cruz
BA, Politics, Law and Economics, 1986 - 1990
University Student Senate, UC System-wide Policy Committee, UC Student Association Legislative Leader

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

We have developed a robust and proven governance model and methodology to ensure the successful delivery of Medicaid and Medicare programs. Our processes and tools have been honed over more than a decade of implementing large-scale government programs to achieve

three primary objectives: (1) a seamless transition for our members, providers, and other stakeholders with no disruptions to care (2) successful and timely completion of State Readiness Review activities; and (3) delivery of all capabilities and components required to support efficient and effective ongoing business operations. Some of the key functions we will employ to implement, monitor, and operate the Demonstration in Santa Clara County include:

Governance Function	Role
Governance Committee	Chaired by Steve Melody, Regional Vice President, Anthem State Sponsored Business, and comprised of functional leaders across Anthem and CareMore, this advisory and decision-making body meets twice monthly during the implementation period and monthly thereafter to provide strategic direction to the project team, proactively monitor progress, performance, and leading indicators, and facilitate resolution of escalated issues.
Program Management Office (PMO)	Led by Sean Atha, Director of Northern California and Duals Demonstration Project Manager, and comprised of a team of functional leads and project managers, the PMO is responsible for organizing, managing, and tracking all activities and deliverables during implementation. The PMO's disciplined approach includes identification, escalation, and resolution of cross-functional issues, risks, and dependencies, development and administration of the integrated, end-to-end project work plan, oversight of state and operational readiness activities, and frequent and transparent communications to key program stakeholders.
Communications	We have found that frequent and transparent internal and external communications are a crucial component of program success. We support this with a weekly project dashboard, daily integrated work plan updates, and regular meetings, including the Governance Committee, as noted above, and the Cross-Functional Leads meetings, which occur several times per week during the implementation period to monitor progress against the integrated work plan with an emphasis on at-risk critical path deliverables. We are pleased to share any status updates or deliverables with DHCS as requested.
Staffing Model	We have developed an implementation staffing model to ensure adequate resources, capacity, and expertise across a broad array of functional areas are in place to successfully deliver the Demonstration Program. We have begun to build a staffing model for the ongoing program operations which will be further developed as the program requirements are finalized across DHCS, CMS, and participating plans. On an ongoing basis, staffing levels are monitored and adjusted where needed to maintain optimal service and performance.

Governance Function	Role
Readiness Preparation	We emphasize system and operational readiness to ensure that our members and providers are afforded a smooth and seamless transition. Our comprehensive readiness framework and toolkit bring a disciplined approach to readiness activities, including extensive, end-to-end systems and quality assurance testing, network adequacy reviews, development and execution of operational policies and procedures; internal and external stakeholder training and outreach, internal compliance assessments, and formal attestation to system and operational readiness by key functional leaders. Prior to DHCS' Onsite Readiness Review, we conduct a comprehensive internal Readiness Review to ensure preparedness.

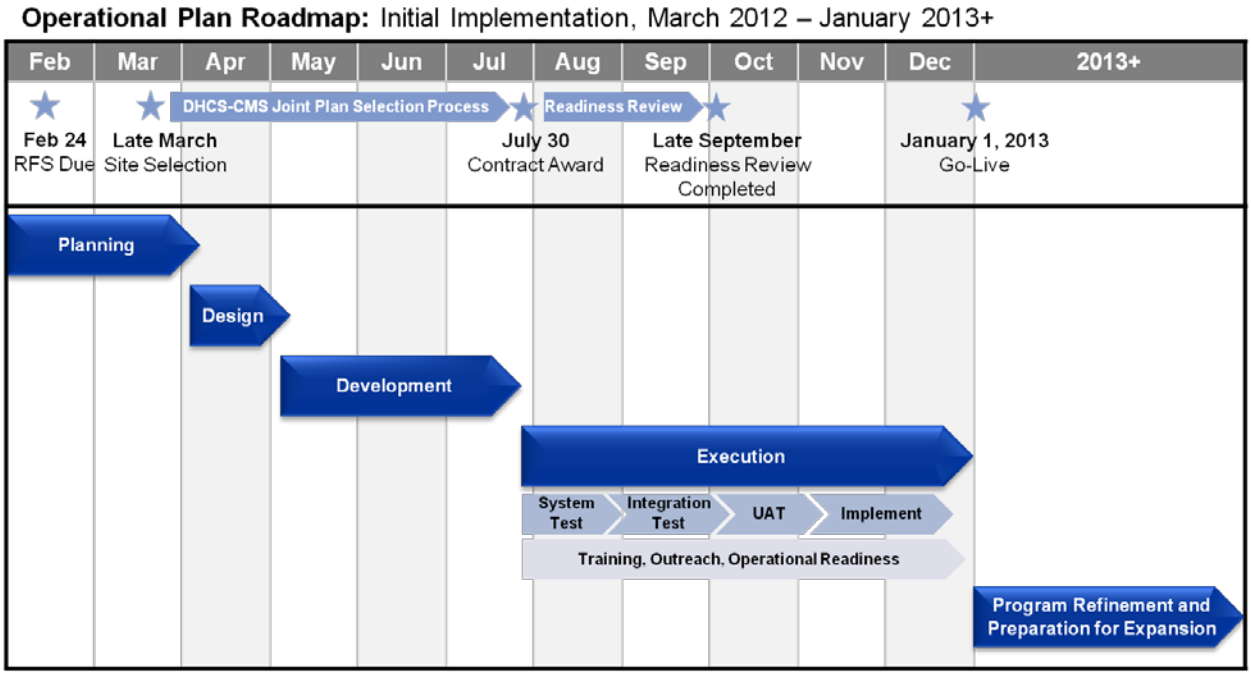
Section 6.2: Operational Plan

Question 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.

We are committed to providing the resources necessary to successfully implement the California Dual Eligible Demonstration Project in Santa Clara County. We recognize that we will have fewer than nine (9) months from DHCS site selection and five (5) months from CMS contract award to establish a comprehensive health care solution. We are confident that we can meet this timeline by leveraging the infrastructure and capabilities we already have in place and are prepared to execute against an aggressive operational plan in order to meet the requirements for DHCS's Readiness Review process and the January 1, 2013 operational go-live. In addition, we intend to demonstrate our commitment to serving California's dual eligible population by laying the foundation of capabilities and capacity necessary to participate in the planned expansion of the Demonstration project to additional counties in 2014 and statewide in 2015.

We have implemented dozens of Medicaid, Medicare, and other publicly-funded programs over the last eighteen years. In support of the unique needs of state and federal programs, we have developed a core business competency, governance model, and implementation framework to ensure that government programs are delivered seamlessly with no

disruptions in service to members, providers, or stakeholders. We have a highly qualified and experienced implementation team comprised of experts who support exclusively Medicare and Medicaid business. This cross-functional team will manage the completion of all activities necessary to support operational go live, Readiness Reviews, and ongoing business operations for the Demonstration. We have developed the preliminary high-level operational plan below, and we are in the process of creating a detailed operational plan for achieving all Demonstration requirements prior to the Readiness Review and operational go-live.



Our project methodology offers the appropriate levels of control and oversight throughout the delivery lifecycle of the Duals Demonstration. Each phase builds upon the previous phase, and quality controls are used to ensure completeness and traceability of requirements and activities from end to end.

Planning Phase - This phase is currently underway and will continue until shortly after DHCS

county selection. During this phase, we are defining the business and technical requirements that will enable us to meet the needs of the Demonstration, developing the end-to-end integrated work plan, and building the traceability matrix that will be used to ensure that all contract requirements and needed capabilities are built, tested, and implemented prior to go-live. All project artifacts currently in development will be refined as needed once the final Demonstration solution has received CMS approval. We have developed our process with flexibility in mind, knowing that our Demonstration solution may undergo changes throughout the review and approval process with DHCS, CMS, and impacted community stakeholders. High-level work plan activities in this phase include:

Activity	Target Start	Target Completion
Planning Phase		
Develop Project Charter (Complete)	1/27/2012	2/10/2012
Conduct stakeholder meetings and outreach to review proposed solution	1/2/2012	Ongoing
Conduct detailed capabilities gap assessment - systems, model of care, network	1/30/2012	2/17/2012
Develop high level requirements and capabilities needed (Complete)	2/6/2012	2/17/2012
Confirm scope requirements of DHCS draft proposal to CMS	3/15/2012	3/30/2012
Develop high level solution design for care management and system capabilities	1/30/2012	3/30/2012
Develop detailed business and technical requirements for implementation	2/20/2012	4/6/2012
Develop detailed, end-to-end, integrated implementation work plan	2/13/2012	4/13/2012
Review detailed program plans with key stakeholders, partners, and collaborating health plans	3/15/2012	4/13/2012
Refine staffing model of key personnel leading and supporting Demonstration project	3/15/2012	4/13/2012
Create traceability matrix	3/15/2012	4/13/2012
Confirm key network providers to support network adequacy	2/13/2012	4/13/2012
Develop provider recruitment materials, including contracts and fee schedules	2/20/2012	4/13/2012

Design Phase - During the Design Phase, we will develop the care management solutions for the Demonstration at a detailed, operational level, as well as create the technical design and system architecture documents that will guide the technology team. The Design Phase includes checks

and balances with internal and external stakeholders to ensure that the detailed solution meets the needs of the Demonstration Program and impacted stakeholders. High-level work plan activities in this phase include:

Activity	Target Start	Target Completion
Design Phase		
Develop detailed care delivery and care management solutions using gap assessment and high level solution design as input	4/2/2012	5/4/2012
Complete detailed Technical Solution and Systems Architecture	4/2/2012	5/4/2012
Engage key partners, including County agency, in review of detailed solutions	4/9/2012	5/11/2012
Identify eligibility verification process and interfaces	4/2/2012	5/4/2012
Confirm membership file layout	4/2/2012	5/4/2012
Confirm encounter data file layout	4/2/2012 (or when available)	5/4/12 (or when available)
Confirm reports required to meet contract requirements	4/2/2012 (or when available)	5/4/12 (or when available)
Assess and determine locations for additional CareMore Care Centers	4/2/2012	5/4/2012

Development Phase - During this phase, system changes are coded and unit tested to support new capabilities or changes to existing functionality in order to meet the needs of the Demonstration Program. Additionally, operational plans are developed, such as staff recruitment and training plans. High-level work plan activities in this phase include:

Activity	Target Start	Target Completion
Development Phase		
Build-out of technology and development of new business process capabilities	5/7/2012	7/27/2012
Create Joint Interface Plan for data exchanges between DHCS, CMS, plans, vendors, and other stakeholders	5/7/2012	6/15/2012
Update/refine Disaster Recovery Plan	5/7/2012	6/15/2012
Update/refine Business Continuity Plan	5/7/2012	6/15/2012
Update/refine Risk Management Plan	5/7/2012	6/15/2012
Update/refine Systems Quality Assurance Plan	5/7/2012	6/29/2012
Update/refine Security Plan	5/7/2012	6/29/2012
Develop code and conduct unit testing for Medical management capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Pharmacy capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Enrollment capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Claims Processing capabilities	5/7/2012	7/27/2012

Activity	Target Start	Target Completion
Develop code and conduct unit testing for Customer Service systems, voice and telephony capabilities, workflow, imaging	5/7/2012	7/27/2012
Develop code and conduct unit testing for Provider capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Data Analytics, Reporting and Encounters capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Financial systems capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for EDI and Disbursement systems capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Web capabilities	5/7/2012	7/27/2012
Develop code and conduct unit testing for Health Risk Assessment updates	5/7/2012	7/27/2012
Develop code and conduct unit testing for Electronic Medical Record updates	5/7/2012	7/27/2012
Complete benefits configuration and product set up	5/7/2012	7/27/2012
Begin build of new CareMore Care Centers (this has its own full work plan)	5/7/2012	7/27/2012
Develop Staff Recruitment and Training Plan	5/7/2012	7/27/2012

Execute Phase - This phase includes multiple levels of comprehensive, end-to-end testing, including system readiness testing, performance testing, and user acceptance testing in an environment built to model production. During this phase, provider contracts and partnership agreements are executed to ensure network adequacy. Additionally, business capabilities are delivered, including care management and quality programs, and operational policies and procedures are developed to support end user training. Extensive operational and system readiness activities are performed, including a full internal Readiness Review conducted prior to DHCS' visit. Detailed cutover planning occurs prior to implementation to ensure a smooth transition experience for all stakeholders of the Demonstration. High-level work plan activities in this phase include:

Activity	Target Start	Target Completion
Execution Phase		
Finalize contracts with subcontractors and vendors	3/19/2012	7/30/2012
Execute provider recruitment plan	3/19/2012	7/30/2012
Finalize contracts with providers and ensure network adequacy	3/19/2012	7/30/2012
Load providers into system	7/23/2012	9/7/2012
Credential providers	7/23/2012	9/7/2012

Activity	Target Start	Target Completion
Create provider directory	8/6/2012	8/30/2012
Conduct provider trainings	8/20/2012	11/30/2012
Establish partnership agreement with County for integrated financing and service delivery by 2015	4/2/2012	8/15/2012
Operationalize key partnerships (IHSS, MSSA, ADHC, etc.)	8/6/2012	9/28/2012
Complete system testing	7/30/2012	8/24/2012
Complete end-to-end integration and system readiness testing	8/27/2012	9/28/12 (or as required for Readiness Review)
Complete end-to-end and user acceptance testing of new business and systems capabilities	10/1/2012	10/31/2012
Complete performance testing	10/1/2012	10/31/2012
Engage key partners to finalize operational plan for member outreach and communication	7/30/2012	8/17/2012
Establish care management programs	4/2/2012	9/28/2012
Create/update operational policies and procedures to support Demonstration	6/4/2012	7/20/2012
Recruit, hire, and train staff	7/23/2012	10/31/2012
Confirm detailed work plan for Readiness Review, including details on achieving future Demonstration requirements	7/1/2012	7/30/2012
Conduct end-to-end Internal System and Operational Readiness Review	8/20/2012	9/14/2012
DHCS and CMS conduct Readiness Review(s)	TBD	TBD
Incorporate feedback from Readiness Review	TBD	11/30/2012
Deployment of member outreach and communication plan	11/1/2012	12/1/2012
Enrollment of members	11/1/2012	12/1/2012
Operational Go-Live	1/1/2013	1/1/2013

Program Refinement Phase - This phase includes warranty support and transition to "steady state" operations after the Demonstration is operational. During this phase, we expect refinements to the program will occur on an ongoing basis as we incorporate stakeholder feedback and evolve our county partnerships and contracts in preparation for year two. We will also develop capabilities to expand our solution to new counties throughout California in 2014 and 2015. High-level work plan activities in this phase include:

Activity	Target Start	Target Completion
Program Refinement Phase		
Stabilize solution and address any production issues	1/1/2013	Ongoing
Submit D-SNP applications for targeted expansion counties	1/1/2013	2/28/2013
First quarterly assessment with stakeholders to evaluate and adjust Demonstration project performance and effectiveness	3/1/2013	3/30/2013
Establish statewide dual eligible expansion plan and roadmap	TBD	TBD

Activity	Target Start	Target Completion
Recruit and train key personnel for participation in expansion efforts	3/1/2013	6/30/2013
Develop key partnerships in expansion counties	TBD	TBD
Respond to expansion RFS/RFP	TBD	TBD

Question 6.2.2: Provide roles and responsibilities of key partners.

We understand the complexities involved in serving the dual eligible population, and the need for strong community partnerships in order to collaborate and coordinate care for this population. We have already begun establishing many of the partnerships required to operationalize the Demonstration in Santa Clara County, and will continue to develop partner relationships as we move into the initiation and planning phases of the operational plan.

Partner	Role	Responsibilities
Collaborating Health Plan Partners*		
Santa Clara Family Health Plan	• Collaborating health plan	• Coordinate to identify opportunity for care and quality improvement for beneficiaries
Care1st Health Plan Health Plan of San Mateo Kaiser Foundation Health Plan, Inc.	• Regional D-SNP plan	• Ensure continuity of care
Community Health Agency and Health Care Provider Partners*		
Santa Clara County Public Authority for In-Home Supportive Services	• In-Home Supportive Services (IHSS) administration	• Helps match consumers with screened providers • Operates a registry of IHSS providers • Provides orientation enrollment for new IHSS independent providers • Offers training to IHSS consumers
Santa Clara Department of Aging and Adult Services	• IHSS assessments	• Authorizes and administers county IHSS program
Santa Clara County Valley Health and Hospital System	• County Mental Health Department	• Facilitate delivery of outcomes-focused mental health services
Council on Aging of Silicon Valley	• Multipurpose Senior Services Program (MSSP)	• Social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community
Avenidas Rose Kleiner Senior Day Health Center Gardner Adult Day Health Center (ADHC) Golden Castle ADHC Center Grace ADHC Great Endeavors ADHC Bascom	• Community-Based Adult Services Center (CBAS)	• Provide health, therapeutic, and social services to those at risk of being placed in a nursing home • Plan services needed to meet the individual's specific health and social needs

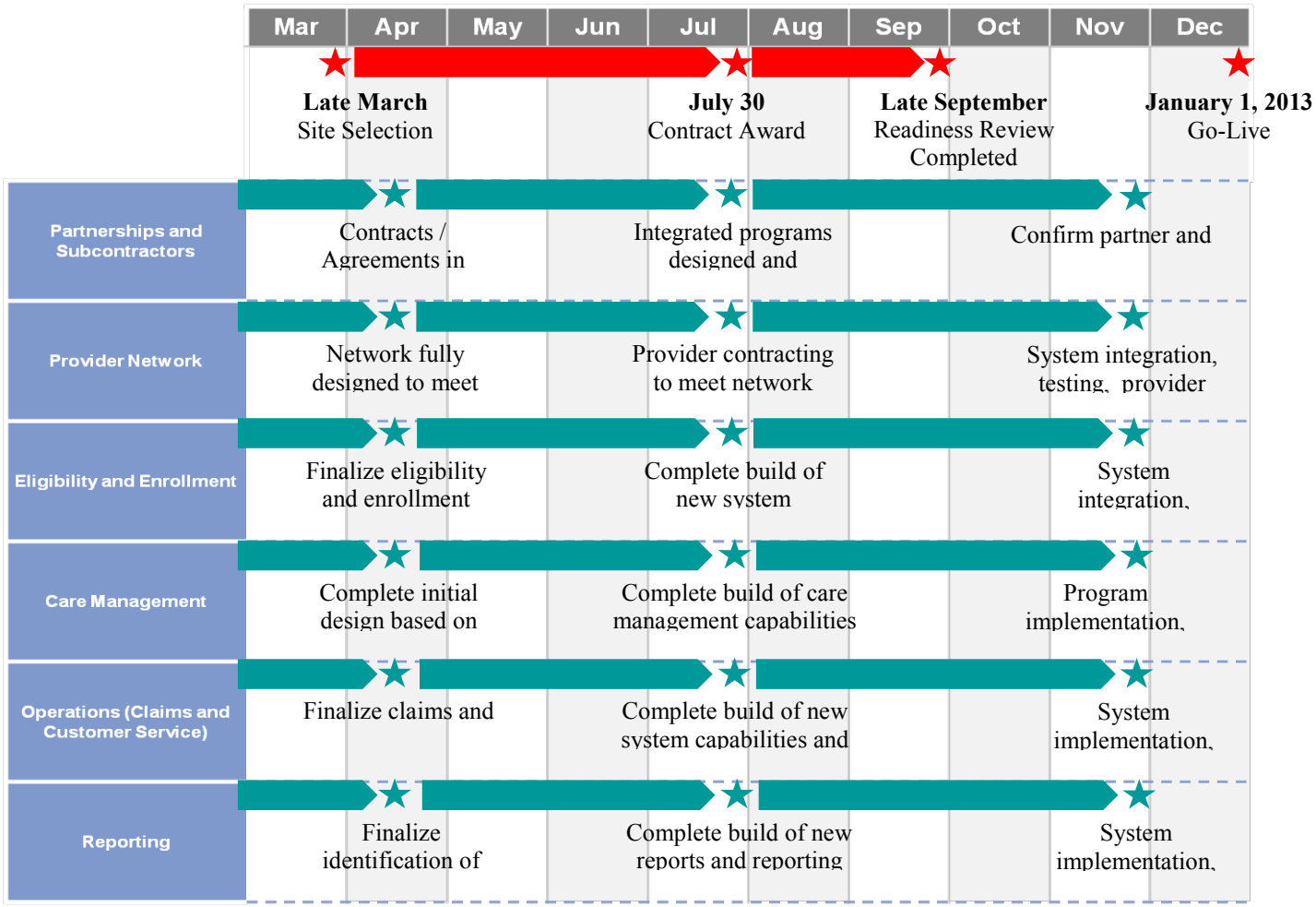
Partner	Role	Responsibilities
On Lok Senior Health Services – San Jose Center		
Prestige ADHC		
Silicon Valley ADHC		
Key Vendor and Subcontractor Partners*		
Express Scripts, Inc.	• Pharmacy vendor	• See question 7.6 response
BlueView Vision	• Vision vendor	• See question 7.6 response
Brand New Day	• Mental Health and Substance Use vendor	• See question 7.6 response
TBD (possibly Independent Living Systems, Addus, Univita)	• Long-Term Supportive Services vendors	• See question 7.6 response
American Logistics	• Transportation vendor	• See question 7.6 response

** Discussions are underway with key partners; however, contracts have not been definitively confirmed at this time.*

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

We have established a timeline and key milestones in order to meet a September Readiness Review and January 1, 2013 operational go-live for the Demonstration. We will drive toward key milestones by committing resources and relying on a dedicated team. The three key milestone dates below coincide with our operational work plan phases outlined in **Question 6.2.1**, as well as our target deadline for being "go-live ready" (November 30, 2012).

Key Milestones: March – December 2012



Question 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.

We certify that we will report monthly on progress made toward implementation.

SECTION 7: NETWORK ADEQUACY

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

In Santa Clara County, CareMore's network includes three hospitals, 40 PCPs and 70 specialists, and our Medi-Cal network includes four hospitals, over one hundred PCPs and a full

specialty network. We will cover 100% of the county by January 1, 2013. As we prepare to expand in the county, we will develop a Clinical Responsibility Grid to ensure all of the critical roles are in place. Additionally, contract overviews are prepared to ensure all provider types are contracted. In addition to a full contracted network of providers (e.g. PCPs, specialists), we employ clinicians with specialized expertise to provide additional services to the dual eligible population including: nurse practitioners specially trained in chronic care and in managing the needs of members who are frail or who have disabilities; medical officers and specialty medical directors who consult on complex cases as needed; and other clinicians and support staff who address specific member issues including behavioral health specialists, nurses, social workers, dieticians, podiatrists, pulmonologists, and fitness instructors. And we will evaluate offering benefits that are best practices in our current programs, such as 24 hour physician on-call. This program provides 24-hour physician on-call with experienced physicians who are empowered to authorize services for members with urgent healthcare issues, providing a comprehensive after-hours care program for every member. We have a comprehensive, cross-functional process to monitor network adequacy on an on-going basis. As we integrate LTSS and behavioral health services, similar methods will be used to assess the adequacy of contracted LTSS and behavioral health providers.

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

We have experience designing and implementing alternative payment arrangements with physicians, hospitals, and other healthcare providers. The goal of these arrangements is to measurably improve the quality and efficiency of health care. For the Demonstration project, we will use a mixed model that includes fee-for-service, various forms of capitation, and Pay-for-

Performance (P4P) mechanisms.

Primary care physicians (PCP) will be capitated on a predetermined basis. This payment is made to these physicians on a per member per month basis regardless of the actual services rendered. We bring additional clinical resources to support the PCP that will increase the PCP's practice capacity by at least 20%. This increase in practice capacity allows CareMore to add more members to the PCP's panel. We reimburse specialists on a fee-for-service basis at market rates. The usual contractual arrangements with hospitals are at per diem rates with carve outs that generally equate to a 10-30% discount off of Medicare allowed rates.

We also support these medical groups and enhance their ability to achieve high levels of performance through use of CareMore's model of care which provides a health home for each member. Our team of professionals, led by a Nurse Practitioner, supports the member and PCP by providing preventive care, performing health risk assessments, leading the development and monitoring implementation of the POC. Our extensivists (hospitalists) manage inpatient episodes and the period following discharge with the NP, supporting the PCP's role while freeing the PCP to focus on primary care. Our Mental Health Team manages the care of high-risk members with mental illness and substance use with the PCP, further supporting the PCP's role.

In addition, we have a number of P4P mechanisms that encourage our providers to achieve high quality outcomes. Several of these P4P activities are detailed below:

P4P Activity	P4P Mechanism
Referring of qualified members to the care center or into certain care programs or clinics	PCPs are encouraged to refer members that have been diagnosed with Diabetes, COPD and/or CHF (among other diagnoses) into the Care Center to better coordinate and support their care. Bonuses are provided for those PCPs who refer more than the threshold percentage of members "qualified" with the diagnoses above.

P4P Activity	P4P Mechanism
Meeting HEDIS quality measures	PCPs get paid for any member that receives treatment or is brought under control (e.g., meets HEDIS criteria). Additionally, PCPs are rewarded for achieving high STARs (as determined by the CMS STAR program) for medication adherence, diabetes treatment, and lowering the number of members on high risk medications.
Completing members' annual health assessments	PCPs are encouraged to see their members AT LEAST annually and in their first annual visit, complete an assessment such that the appropriate and correct diagnoses and necessary treatment plans for that member are captured. Completion and submission of a CareMore certified form results in a per form payment to the PCP.
Writing generic prescriptions	PCPs are accountable for ensuring that their members get the most appropriate medications and are encouraged to present generic alternatives whenever it makes sense. CareMore's formulary is built so that the majority of brand medications have an approved generic alternative. This practice saves CMS and and is in line with CareMore's model of care.
Meeting access and availability standards	CareMore calls PCP offices on a quarterly basis to ensure that all CMS Access and Availability standards are met. We believe there is strong correlation to this metric and lower Emergency Room (ER) visits. Any PCP scoring at 100% compliance are rewarded whereas those scoring lower on any metric are put on a correction action plan.

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

We continually recruit and encourage out-of-network providers to become part of our network in order to meet the needs of our members. Once gaps in our network have been identified, our local contracting team works to recruit additional providers into our network. Providers are contacted by the recruitment team using a variety of methods including onsite visits, telephonic outreach, and letters.

Our PCPs are not only attracted to our ability to grow their practice, but also to the benefits inherent in our care model. As part of this model, we support their ability to (a) get timely information on their patients, (b) offload services that they do not have time nor resources to provide, (c) reduce their overhead because we provide resources, (d) assist with complicated

patients. See our attached proposed **Model of Care**. When we contract with a new provider, we assign them a marketing representative to help create a growth plan. We offer alternative payment mechanisms that stress value-based payment which many providers find attractive. These mechanisms allow providers to earn more by demonstrating exceptional quality and efficiency, creating a win-win for providers and for the members they serve.

We strongly believe that providers will agree to work with us not only because of our local presence and strong commercial relationship, but also because of our experience with Medicare and Medi-Cal members and the value we can offer them in terms of clinical supports, accurate and timely claims payment, ease of administration, innovative payment structures that drive quality and efficiency, and our proven results in improving member treatment compliance. We use information collected through our provider satisfaction survey to understand how to make being part of our network as attractive as possible to providers. We work with the providers to understand their concerns and work to resolve these concerns. We provide feedback to our business owners so they can improve their processes and offer additional provider support.

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

Our network includes providers who understand not only the health disparities faced by low-income members and members with disabilities, but also the prevention and management of secondary disabilities. To ensure our members have appropriate physical access to our providers, we actively evaluate the accessibility of our providers' facilities by conducting Facility Site Reviews (FSRs). The FSR includes a detailed structural review of their office to make sure the site is accessible and useable by individuals with physical disabilities. Our Clinical Quality/Compliance Administrators send out a checklist to providers prior to the site review and

schedule a pre-FSR visit to educate the office staff if needed. If an issue is discovered, we give providers assistance in remedying the situation with advice and referrals to local agencies that can assist providers with these issues. While we currently conduct this type of activity on a case-by-case basis, we plan to formalize the process under the Demonstration by offering our providers a standardized set of resources and tools.

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

To best serve dual eligible members in Santa Clara County, we will look to augment CareMore's current provider network with additional providers who are serving the Demonstration population. Our contracting and field staff will conduct several outreach activities, including site visits, phone calls, and letter campaigns that outline the value proposition of joining our network. We will also participate in DHCS' outreach plan for the Demonstration.

From our experience, providers are interested in working with us because the CareMore model of care allows them to grow their practice while also alleviating administrative burdens by supplementing their practice with clinical support for their patients. See our proposed Model of Care for more details .The typical provider network supporting these members may not have the resources to spend a lot of time to help members manage their chronic conditions or educate them on prevention, monitoring, diet, exercise and self-management skills. Our clinical team offers providers with a clinical support system to help them better assist members.

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

As a Medi-Cal managed care plan, we have existing relationships with a number of

potential subcontractors and are confident in their ability to provide quality service. The following is a list of key subcontractors that could potentially be involved in this contract:

Name	Role	Responsibility
Independent Living Systems, Addus, Univita	LTSS vendors	We will work with one or more of the listed LTSS vendors to manage long-term care and home and community based care as outlined in **Question 2.1.2**
Brand New Day	Medicare Advantage SNP	Is a Knox-Keene licensed medical group that specializes in care of Severally and Persistently Mentally Ill (SPMNI) population. We are currently engaged with this provider to finalize an agreement in Southern CA; however we will be exploring opportunities with Brand New Day to expand their services into Santa Clara County.
Express Scripts, Inc. (ESI)	Pharmacy vendor	ESI handles prescriptions at retail pharmacies. In 2009, we established a 10-year vendor agreement with ESI to offer our integrated Prescription Drug Plan including retail network, retail network audits, and pharmacy claims adjudication. We utilize ESI to provide a real-time point-of-sale processing system for pharmacy claims. ESI will provide medication therapy management, process manual claims, and handle pharmacy help desk calls, in addition to making automated outbound calls to members, providing verbal translation service, and handling order fulfillment.
Vision Service Plan Insurance Company (VSP)/BlueView Vision	Vision vendor	We plan to provide members with a routine eye exam, lenses and frames if we have the ability to do so after final rates have been developed. We have worked with VSP since October 1995. VSP currently provides vision care to our Medicaid membership in Indiana, California, Kansas, and West Virginia.
American Logistics	Transportation vendor	American Logistics currently providers our members with needed transportation services.

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

We certify that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by our sub-contracted relationships.

Question 7.8: Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix,

and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

We certify that we will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks. We also certify that during readiness review we 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. Network adequacy will be monitored as described in **Question 7.1**.

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

We certify that we will meet all Medicare Part D requirements and submit formularies and prescription drug event data. As a current Medicare Advantage and Prescription Drug Plan, we currently meet all Medicare Part D requirements.

Section 7.2: Technology

Question 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.

We are a leader in using technology to improve the quality of care provided to California's citizens. Through our experience, we have developed the tools necessary to facilitate and coordinate high-quality care for one of the state's most challenging and vulnerable populations, dual eligibles. From our pioneering telemedicine program to our innovative IBM-Watson supercomputing pilot we have made consistently bold commitments and significant financial investments in improving care through technological advancement.

At the center of our robust clinical delivery system is our Electronic Medical Record (EMR) platform that has been tightly integrated with other clinical care applications to ensure that all clinicians in the delivery system can access the timeliest view of member information.

Our EMR platform meets the meaningful use requirements for a certified EMR technology. Below is a selection of some of the key technologies that we intend to leverage to improve the quality and coordination of care for California's dual eligibles. Additional technologies for in-home care are described in response to **Question 7.2.2**, and a diagram of our technology platforms has been provided in **Attachment 17**.

Technology	Highlights
Longitudinal Patient Record (Patient QuickView – PQV) *Note: Screenshot provided in Attachment 17*	• Longitudinal patient record, containing information on enrollment, PCPs, demographics, authorizations, claims history, appointments, prescriptions, lab results, clinical quality alerts, and more • Providers access PQV via our Provider Portal, providing HIPAA-compliant access for our external provider network • Internal staff can access PQV via our EMR or directly • Working closely with hospitals to make real-time population of PQV and EMR possible via HL7 feeds of clinical data
Electronic Medical Record	• Hub of information for our clinical delivery team • Supports collection of all vital clinical information • Contains key clinical business rules and alerts to promote standard and consistent care delivery and quality • Reinforces integration of clinical programs and simplifies handoffs by interconnecting care departments through workflow and information
Medication Adherence and Compliance Dispensing System	• Program uses a dispensing system to help members with complicated medication regimens consistently take their prescribed medications in a program proven to reduce both pharmacy spend and medical spend • Members in the program receive coordinated care management through nurse case managers, supplemented with specialized medication management resources
Hospital Admission Feeds and Monitoring	• Receive daily electronic feeds from participating hospitals showing members that have been admitted as inpatients • Enhances notification and coordination between hospitals and our organization • Allows for timely plan-facility-group coordination of discharge planning and early enrollment in our disease and case management programs • Leads to better efficiency in care delivery between the provider networks and the health plan

Technology	Highlights
Telehealth	• We are the only Medi-Cal plan to create, operate, and maintain a statewide telemedicine network • Over ten years of experience providing telehealth services in California • Telemedicine network has 18 "specialty sites" located within centers of excellence, medical centers, private specialty groups and individual specialist offices, and 58 "presentation sites"
IBM-Watson Pilot	• We are the first company – in any industry – to partner with IBM to create the first commercial applications of the IBM-Watson supercomputing technology to analyze and identify the latest evidence-based treatment options for clinicians. • The initial pilot provides decision support tool for outpatient utilization management of oncology, • Watson has the power to analyze millions of pages of information in just a few seconds to suggest individually tailored treatment protocols

Question 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.)

We are at the leading edge of care technology in California, and we intend to leverage our most advanced capabilities for serving this unique population. One of the most pressing issues, and a driving force of medical cost inflation for dual eligible, is the frequency with which beneficiaries are admitted to nursing homes for treatment of relatively manageable conditions. While we recognize that nursing homes are often the appropriate care setting for the chronically ill and frail, we are highly optimistic that advances in innovative technology solutions, coupled with appropriate care management and in-home support, can drive significant reductions in nursing home admissions and readmissions.

In addition to leveraging many of the key technologies discussed in **Question 7.2.1**, we intend to utilize a broad set of technologies to extend access to our EMR and other care information to practitioners and members in the field and other remote locations.

Technology	Highlights
In-Home Biometric Devices and Monitoring *Note: Screenshot provided in Attachment 17*	• Remote wireless scales and blood pressure cuffs used for patients with congestive heart failure or hypertension, transmitting data that allow caregivers to monitor blood pressure and weight fluctuations that might indicate complications • Web-based service feeds into the patient's EMR and has helped reduce hospital readmissions by fifty six percent among participants • Exploring use of similar systems to expand services to monitoring of diabetes and other conditions
Medication Adherence and Compliance Dispensing System	• In-home dispensing system to help members with complicated medication regimen (reviewed in **Question 7.1.1**)
Remote EMR Access for Clinicians	• Citrix Gateway and Citrix Receiver to allow HIPAA-compliant secure access of EMR from iPads and iPhones for field-based clinicians
Electronic Pen for Mobile EMR Syncing	• Secure method for data collection for clinicians in the field without direct connectivity to the EMR • Uses an electronic pen and printed paper templates to capture clinician's handwritten information and sync's to the EMR when the device is returned to its dock • Handwriting recognition converts written text to structured data
Telehealth	• Potential in-home applications for existing telehealth capabilities (reviewed in **Question 7.1.1**)

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

We currently are using PQV (described in **Question 7.2.1**) as our health information exchange (HIE) to publish information outside of our CareMore clinics. We are exploring use of the HIE product associated with our EMR, which has interconnected dozens of regional medical communities and would offer the following benefits for our care providers:

- Supports delivery of care across the continuum, interconnecting disparate technology systems and EMRs while reaping the associated benefits of controlled data flow and quality, helping to decrease costs and reduce errors
- Easy exchange of data for all community participants, including practices with different EMR systems or none at all

- A single-point connection, eliminating the need for point-to-point interfaces, to share lab or test results, ER visits, referrals, medications, allergies, and more, in real time
- A foundation to support eligibility of American Recovery and Reinvestment Act (ARRA) incentives under 'meaningful use' criteria

A key device protocol interoperability requirement is that our clinic-based biometric lab devices (e.g. spirometer) interconnect seamlessly with our EMR application. Through Bluetooth capabilities the device information is uploaded automatically and matched with the member record in our EMR. As we interconnect clinical data (ADT, CCD, clinical notes, lab, pharmacy, and radiology) from key hospitals, we will use standard HL7 formats for clinical data exchange to allow for real-time updates to our EMR.

SECTION 8: MONITORING AND EVALUATION

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

- **Enrollee satisfaction, self-reported health status and access to care**

Leveraging CareMore's Medicare Advantage SNPs, our organization is in compliance with CMS requirements to track and report enrollee satisfaction and access to care including the Healthcare Effectiveness Data and Information Set (HEDIS®), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), the Health Outcomes Survey (HOS) and the Minimum Data Set (I-SNP only). Our capacity to track and report on these tools prepare us to incorporate any additional performance measurement tools that DHCS chooses to measure specific to quality and satisfaction for other services, (e.g., with home and community based services via the Participant Experience Survey: Elderly/Disabled version or behavioral health via the Experience of Care and Health Outcomes Survey).

In addition to the measure sets mentioned above, we use other tools to measure and improve the quality and efficiency of the health care and services provided. We leverage longitudinal patient records, electronic medical records and claims to monitor and ensure that members have access to the care they need and want. (See **Question 7.1** for more detail.) The comprehensive Healthy Start and Health Journey Assessments are used for new enrollees and established members respectively. The health risk assessments (HRAs) include the member's self-reported health status, as well as several screens, lab results, and a physical exam. See **Question 2.1.3** and **Attachment 15** for more detail. These HRAs are fundamental to understanding and improving health status, access, health outcomes, and utilization. The HRAs are incorporated in to the individual's plan of care (POC), which improves our ability to adhere to the model of care and results in improved member outcomes. For example, HRAs have resulted in new diagnosis and treatment plans for many enrollees, as well as intervention on acute needs that had previously been undetected.

In addition, we regularly monitor enrollee satisfaction through surveys, customer service evaluations, enrollee grievances, and other inputs. We routinely analyze quality and satisfaction measures to systematically and objectively monitor, measure, and evaluate the quality and appropriateness of care and services provided to enrollees. These comprehensive data analyses are used by our clinical staff including Medical Directors, as well as by our non-clinical associates to identify and evaluate opportunities for improvement, as well as to deploy rapid implementation of meaningful quality improvement programs including enrollee-specific interventions to system-wide initiatives. The impact of those interventions is then assessed through iterative qualitative and quantitative data analyses.

- **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 part of our Medi-Cal operations and CareMore's Medicare Advantage operations, we currently comply with all tracking and reporting requirements associated with DHCS Medicaid encounter and CMS Medicare encounter data and Prescription Drug Event data (PDE) reporting requirements. We will build upon this experience to track and report the full range of encounter and PDE data required in the Demonstration. Our tracking and reporting activities include an audit function to make sure that what we are reporting is complete and accurate including encounter/PDE file submission and encounter/PDE error reconciliation services. We support industry standard file layouts and transmission standards. Should there be specific data interfaces and/or encounter/PDE file requirements unique to the Demonstration we will use our mature change management process to make sure that we respond effectively to state and federal guidance. Changes in any of aspect of the tracking and reporting processes for encounter and PDE data will be identified, tested, implemented and monitored post implementation.

- **Condition-specific quality measures**

Given our experience as a Medi-Cal plan and CareMore's experience as a Medicare Advantage plan, we are able to track and report HEDIS® measures. In addition, to effectively and efficiently manage the care of enrollees, we produce internal data analysis and dashboards that focus on high impact conditions in the Medicaid, Medicare and dual eligible populations including: heart disease, diabetes, arthritis, renal disease, pulmonary disease, spinal cord injuries, depression and substance use. Data are collected from a variety of sources, including: claims utilization and encounter data (for utilization data, such as colonoscopies, vascular access procedures, etc.); appointment information (e.g. Coumadin management), lab results, and filled prescription data. Condition specific measures are produced from these data (e.g., diabetes and

amputation studies, including HBa1C and LDL testing frequency and percent of members within goal range, retina exam compliance and nephropathy measures, blood sugar changes for members managed through our diabetes disease management programs, admission and length of stay for members with diabetes, as well as amputation, and readmission rates). Condition specific data are tracked and trended by both HEDIS® measures and internal condition specific measures. These data are tracked by a variety of demographic factors that are used to target interventions. We will work with DHCS to incorporate any additional condition-specific performance measures identified as part of California's Dual Eligible Demonstration.

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

We are committed to understanding fully the care needs, wants and outcomes of our members based on demographic factors affecting these aspects of care. We have a robust infrastructure to understand the cultural and linguistic needs of our members and to collect, integrate and analyze clinical performance and outcome measures. In addition, our Diversity Office supports the understanding and needs of our Lesbian, Gay, Bisexual, and Transgender members and staff through an award winning associate resource group "ANGLE": Associate Network for Gay & Lesbian Equality. In the Demonstration, we will leverage our Medi-Cal experience complying with California Senate Bill 853 standards for: enrollee assessment, providing language assistance, staff training and compliance monitoring.

We use the full range of clinical and administrative information available to produce and analyze structure, process and outcomes of care measures and to integrate these analyses in the design and implementation of our quality improvement interventions. We have demographic, including cultural or social factors that may affect the members POC, eligibility

categories for our Medicare members, and English proficiency data on our Medi-Cal members for analyses. We will work with DHCS to align our data specification with DHCS' desired outcome analysis for the Demonstration and to identify the best mechanism to capture beneficiary specific information on sexual identity or other variables for use in the data analyses. Through our experience, we have developed the tools necessary to facilitate and coordinate high-quality care for the variations evident in one of the state's most challenging and vulnerable populations, dual eligibles.

Examples of our outcome analysis include:

- County-specific results compared to state and national benchmark data to identify low and high performing rates
- Trend rates to identify consistency of performance trends (e.g., areas that exceed benchmarks and targets, but where downward trends indicate an improvement opportunity)
- Industry-wide/CMS measures (e.g., HEDIS® studies, admission and bed day measures, readmission rates)
- Plan developed measures of chronic condition members to evaluate targeted clinical programs, for example: diabetes and amputation studies, death in hospice vs. hospital

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

We certify that we will meet all DHCS evaluation and monitoring requirements once made available, including any mandated or partner collaborative quality improvement projects initiated by DHCS.

SECTION 9: BUDGET

Section 9.1: Budget

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

Information Exchange: Currently, information sharing between health plans and LTSS and behavioral health providers and/or the county is complicated and rarely occurs electronically. Differences in architecture, security and consent as well as the cost involved in developing system-appropriate interfaces create barriers for stakeholders. The architecture for data sharing must allow for web-based secure access and two-way exchange of information among stakeholders as well as secure data repositories within the context of the member and their care needs. Funding to support the cost of design sessions and implementation will be needed and should be directed primarily to the county. Even with integration of most LTSS and behavioral health services, the county contributes local financing and should have access to agreed-to data to analyze what is funded and the quality of care delivered. The county also administers non-Medi-Cal and non-Medicare services and programs that are accessed by members, such as substance abuse services, Older American's Act Services and housing programs.

Accessibility: While our provider network meets contractual requirements for accessibility, more could be done to accommodate our members with varying disabilities or with specific visual, hearing, cognitive or motor challenges. As one example of what is possible, our CareMore Care Centers use special exam tables designed for accessibility. Most providers do not have the infrastructure financing to purchase new and specialized equipment, including adaptive equipment, special signage and communication systems. In addition, providers do not always

understand the difficulty members with various physical and cognitive challenges face when trying to get to appointments, waiting to be seen, and understanding what can be confusing and complex discussion and instructions. Infrastructure funding to improve physical accessibility and to provide additional accommodations, as well as sensitivity training, would benefit both providers and their members.

Technology Training: There are many new and innovative technology options that support improved delivery of care. E-pens, EMRs, mobile devices with clinical applications and e-prescribing can improve the quality and timeliness of care. These devices can be used or accessed from various locations including from a member's home and can help link providers across systems. Even when these options are available, users may not have the time to learn how to use them or make the best use of these tools. Funding to support broad adoption and use of these and other new technologies would help providers take a giant step forward in important areas like improved coordination of care and adoption of evidence-based practices.

Anthem

Table of Contents for Attachments – Santa Clara County

Mandatory Requirements

Attachment 1 – Mandatory 1 – Knox Keene License 1
Attachment 2 – Mandatory 2 – Letter of Good Standing 3
*Attachment 3 – Mandatory 7A – Sanction, Penalties and Related CAPs 5
*Attachment 4 – Mandatory 8A – Quality Measures – Medi-Cal 7
*Attachment 5 – Mandatory 8B – Quality Measures – MA D-SNP 15
Attachment 6 – Mandatory 12 – Stakeholder Input 26

Additional Requirements

Attachment 7 – Additional 4 – NCQA Accreditation – Medi-Cal 70
Attachment 8 – Additional 5 – NCQA Accreditation – MA D-SNP 71
Attachment 9 – Additional 7 – Supplemental Benefits 74
*Attachment 10 – Additional 9 – Draft Agreement with County IHSS 84
*Attachment 11 – Additional 10 – Draft Agreement with County Mental Health Agency 90
Attachment 12 – Additional 11 – Providers with Experience with Duals 102

Additional Attachments to Support Project Narrative

Attachment 13 – Question 1.1.2 – The Quiet Health Care Revolution – Atlantic Monthly 104
Attachment 14 – Question 2.1.2 – Letter of Intent for LTSS Vendors 112
Attachment 15 – Question 2.1.3 – Healthy Start Assessment Screen Shot 118
Attachment 16 – Question 5.2.3 – Summary of How to Guide for Members 131
Attachment 17 – Question 7.2 – Technology Capabilities 135

**Note: The Attachments marked with an asterisk do not count against the 100-page limit, as specified in the RFS.*

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

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Sacramento, CA 95814
916-322-6727 voice
916-322-3968 fax

Blue Cross of California Partnership Plan, LLC
21555 Oxnard Street
Woodland Hills, CA 91367

December 30, 2004

IN REPLY REFER TO:
FILE NO: 933-0415

VIA ELECTRONIC AND U.S. MAIL

Re: Application for Licensure: Blue Cross of California Partnership Plan (BCC Partnership Plan), LLC (DMHC Filing No. 2004-2344) Filed December 21, 2004.

Dear Mr. Miller:

Congratulations on obtaining licensure as a Knox-Keene Health Care Service Plan.

Enclosed is the license issued by the Department of Managed Health Care approving the terms of the above-referenced Application filed on December 21, 2004, proposing the licensure of BCC Partnership Plan to operate the prepaid Medi-Cal program currently operated by Blue Cross of California, Inc. (BCC) in the counties previously approved for BCC.

Please contact me if you have any questions regarding this matter. Thank you.

Very truly yours,

Tina Dunlap
Senior Staff Counsel
Phone: (916) 327-9331
Fax: (916) 322-3968
Email: tdunlap@dmhc.ca.gov

Cc Douglas A. Schur

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF MANAGED HEALTH CARE

NONTRANSFERABLE AND NONASSIGNABLE

LICENSE
HEALTH CARE SERVICE PLAN

File No.: 933-0415

Licensee: BLUE CROSS OF CALIFORNIA PARTNERSHIP PLAN, LLC
21555 Oxnard Street
Woodland Hills, CA 91367

IS HEREBY LICENSED AS A FULL SERVICE HEALTH CARE SERVICE PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICES ACT OF 1975, AS AMENDED ("ACT"), AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A FULL SERVICE HEALTH CARE PLAN TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES WITHIN THE STATE OF CALIFORNIA IN THE COUNTIES PREVIOUSLY APPROVED FOR MEDI-CAL OPERATIONS OF BLUE CROSS OF CALIFORNIA, INC (FILE NO.: 933-0303), SUBJECT TO THE PROVISIONS OF THE ACT AND THE IMPLEMENTING RULES OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE ADOPTED PURSUANT THERETO AND SUBJECT TO ANY CONDITIONS INCORPORATED HEREIN, AND SHALL REMAIN IN EFFECT UNTIL SUCH TIME AS THE LICENSE IS SUSPENDED OR REVOKED BY ORDER OF THE DIRECTOR OR IS SURRENDERED.

THE LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

Dated: December 30, 2004
Sacramento, California

LUCINDA A. EHNES, J.D.
Director
Department of Managed Health Care

By: _____
WARREN BARNES
Assistant Deputy Director
Office of Legal Services
Department of Managed Health Care

Edmund G. Brown Jr., Governor
State of California
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Phone: 916-445-7401
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February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Bruce K. Bell
Business Development Consultant
State Sponsored Business
WellPoint, Inc.
One WellPoint Way
Mailstop: CAT201-M002
Thousand Oaks, CA 91362

Re: Letter of Standing – Blue Cross of California and Blue Cross of California Partnership Plan

Dear Mr. Bell:

On February 3, 2012, you requested a letter regarding Blue Cross of California Partnership Plan ("BCCPP") and Blue Cross of California DBA Anthem Blue Cross's ("ABC") standing as licensees under the Knox-Keene Health Care Service Plan Act.[1] BCCPP and ABC make 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, both BCCPP and ABC are licensed, and permitted to operate in the State of California, as Knox-Keene health care service plans.

A review of the Enforcement Action Database shows that there are currently 222 enforcement actions involving BCCPP and ABC. Of those, 214 involve grievance system violations; 2 regard compliance with the financial requirements of the Knox-Keene Act and related regulations; and 6 are complaints regarding health care standards. 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. Enforcement does not differentiate between BCCPP and ABC violations.

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

[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.

The DMHC's Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for Blue Cross of CA, Full Service, was issued on August 30, 2011, and is available on the DMHC's Public Web site. The Plan has submitted a Corrective Action Plan (CAP), but still has two unresolved deficiencies in the area of Quality Management, and two unresolved deficiencies in the area of Utilization Management. A Follow Up Medical Survey is scheduled for the third quarter 2012 to determine whether the Plan has fully implemented its CAP, and has corrected the outstanding deficiencies. The next Routine Medical Survey is due by November 21, 2013.

The last Routine Medical Survey Report for Blue Cross of CA, Dental was issued on January 3, 2011, and is available on the DMHC's Public Web site. The Plan has submitted a Corrective Action Plan (CAP) to address identified deficiencies but still has two unresolved deficiencies in the area of Quality Management, and three unresolved deficiencies in the area of Grievance and Appeals. A Follow Up Medical Survey is scheduled for third quarter 2012 to determine whether the Plan has fully implemented its CAP, and has corrected the outstanding deficiencies. The next Routine Medical Survey is due by March 30, 2013.

The last Routine Medical Survey Report for Blue Cross of CA, Behavioral Health, was issued on August 9, 2011, and is available on the DMHC's Public Web site. The Plan submitted a Corrective Action Plan (CAP) to address identified deficiencies, but has one unresolved deficiency in the area of Access and Availability. A Follow Up Medical Survey is scheduled for third quarter 2012 to determine whether the Plan has fully implemented its CAP, and has corrected the outstanding deficiencies. The next Routine Medical Survey is due by October 19, 2013.

Please contact me with any questions or concerns.

Sincerely,

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

cc: 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
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ATTACHMENT 3 - Mandatory 7A - Medi-Cal - Sanctions, Penalties and Related CAPs

Item No.	Title	Category	Issuing Agency	Date of Issuance	DHCS Contract ID	County(ies)	Reason for the CAP, Penalty or Sanction	CAP, Penalty or Sanction Resolution	Amount of Penalty Assessed
1	Claims Interest Underpayment	Penalty	DMHC	10/17/2008	Sacramento, Central Valley/ Bay Area, Fresno, Stanislaus	All: Sacramento, Alameda, Contra Costa, Fresno, San Joaquin, San Francisco, Santa Clara , Stanislaus, Tulare	Blue Cross underpaid certain claims from non-contracted emergency room providers by approximately five percent. The cause or mechanism of that underpayment was that Blue Cross implemented a non-mandatory five percent reduction in compensation due to providers under its Medi-Cal contract, and in doing so, inadvertently applied that reduction to a broader class of claims than was properly allowed. While the five percent reduction was appropriate as to certain claims, it was not appropriate as to the claims of the non-contracted emergency room providers. The over-broad implementation of the five percent reduction was attributed to a programming error which Blue Cross has since corrected and appropriate payments were made to the affected providers. Regarding the Plan's handling of the related provider dispute, the Department determined that the Plan's dispute resolution letter in January of 2006 and subsequent corrective provider payments were untimely.	Blue Cross executed a settlement agreement with the Department and agreed to pay a penalty of $7,500. With the execution of the agreement, the Department settled the enforcement matter and all the issues, accusations, and claims alleged therein. A CAP was not required.	$ 7,500.00
2	DMHC Enforcement Matter 08-330 (Claims)	Penalty	DMHC	10/13/2009	Sacramento,Tulare	Sacramento,Tulare (Los Angeles also impacted)	The Department determined that in four (4) Medi-Cal provider disputes Blue Cross failed to meet the appropriate standard for responding to disputes because it sent resolution letters providing only conclusory statements without any facts or explanation of its decision. The Department assessed an administrative fine against Blue Cross in the amount of $33,333.32 relative to the four (4) instances identified.	The Department and Blue Cross agreed to the execution of a Letter of Agreement and payment of the assessed penalty settled the enforcement matter. A CAP was not required.	$ 33,333.32

ATTACHMENT 3 - Mandatory 7A - Medicare - Sanctions, Penalties and Related CAPs

Sanction Narrative:

On January 12, 2009, the Centers for Medicare and Medicaid Services (CMS) suspended WellPoint and its affiliated plans from marketing to and enrolling new clients for Medicare Advantage and Part D business. Current membership at the time was not impacted by the sanctions.

WellPoint worked with CMS to resolve issues identified as a result of WellPoint's own internal compliance audits and findings from CMS' 2008 audit. WellPoint's work included detailed action plans, which were submitted and reviewed by CMS to remediate such findings.

In September 2009, CMS lifted the marketing and enrollment sanctions and WellPoint was able to market 2010 Medicare Advantage and 2010 Medicare Part D plans and enroll new members.

Item No.	Title	Category	Issuing Agency	Date of Issuance	CMS Contract ID	County(ies)	Reason for the CAP or Sanction	CAP or Sanction Resolution	Amount of Penalty Asssessed
1	Notice of Immediate Imposition of Intermediate Sanctions (Suspension of Enrollment and Marketing)*	Sanction	Centers for Medicare & Medicaid	1/12/2009	MA-PD Plans: H0540 H0564 H5419 PDPs: S5960	H0540 - Former PFFS plan; non-renewed; counties N/A for purposes of CA Demonstration Project H0564 - Kern, Los Angeles, Orange, Riverside H5419 - Former PFFS plan; non-renewed; counties N/A for purposes of CA Demonstration Project S5960 - Full state	During CMS' 2008 audit of WellPoint's MA-PD plans, numerous issues were identified. Due to the volume of the issues, CMS issued intermediate sanctions against WellPoint commencing 1/12/2009. The sanctions precluded WellPoint from marketing to prospective members, enrolling new members in to its plans or participating in auto-enrollments for low-income subsidy individuals.	A number of CAPs were requested as a result of the 2009 CMS sanction. WellPoint was able to successfully implement all required changes identified under the CAPs. CMS withdrew its sanctions by September 2009 allowing WellPoint to once again market its plans and enroll new members for 2010.	No monetary penalties
2	Notice of Immediate Imposition of Intermediate Sanctions (Suspension of Auto-Enrollments of LIS individuals in PDPs)*	Sanction	Centers for Medicare & Medicaid	1/12/2009	[see contract IDs above]	[see county listings above]			No monetary penalties
3	2008 Audit CAPs (relating to 2009 Sanction)	CAP	Centers for Medicare & Medicaid	1/12/2009	[see contract IDs above]	[see county listings above]			No monetary penalties

Santa Clara County, California HMO Medicaid

Three Year Trend HEDIS® Comparisons

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	Change from Prior Year	Percent Increase_ Decrease from Prior Year	2009 Method	2009 Rotated	2010 Method	2010 Rotated	2011 Method	2011 Rotated	Monitored Measure
Effectiveness of Care (EOC)												
Prevention and Screening												
Adult BMI Assessment		NR	**NR**					NR	NR	NR	NR	
Weight Assess/Counseling - BMI Total		55.96	**65.69**	↑	**9.73**			H	No	H	No	
Weight Assess/Counseling - Nutrition Counseling Total		54.99	**63.50**	↑	**8.51**			H	No	H	No	
Weight Assess/Counseling - Physical Activity Total		54.99	**35.52**	↓	**-19.47**			H	No	H	No	
Childhood Immunization Status - Combo 2	53.70	66.91	**74.70**	↑	**7.79**	H	No	H	No	H	No	
Childhood Immunization Status - Combo 3	48.15	64.23	**70.56**	↑	**6.33**	H	No	H	No	H	No	
Lead Screening in Children	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Breast Cancer Screening Total	64.52	69.60	**67.11**	↓	**-2.49**	A	No	A	No	A	No	
Cervical Cancer Screening	72.35	71.29	**72.02**	↑	**0.73**	H	No	H	No	H	No	
Chlamydia Screening in Women - 16-20 years	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Chlamydia Screening in Women - 21-24 years	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Chlamydia Screening in Women - Total	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Respiratory Conditions												
Appropriate Testing Children w/ Pharyngitis	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Appropriate Treatment Children w/ URI	90.50	91.49	**92.25**	↑	**0.76**	A	No	A	No	A	No	
Antibiotic Treatment Adults w/ Acute Bronchitis	NR	26.67	**28.83**	↑	**2.16**	NR	NR	A	No	A	No	
Spirometry Testing for COPD	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Pharmacotherapy Mgmt COPD - Systemic Corticosteroid	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Pharmacotherapy Mgmt COPD - Bronchodilator	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Use of Appropriate Medications - Asthma - Total	86.13	NR	**NR**			A	No	NR	NR	NR	NR	
Cardiovascular												
Cholesterol Management - LDL-C Screening	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Cholesterol Management - LDL-C Control <100	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Controlling High Blood Pressure	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Persistence of Beta-Blocker Treatment after AMI	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**

Santa Clara County, California HMO Medicaid

Three Year Trend HEDIS® Comparisons

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	Change from Prior Year	Percent Increase_ Decrease from Prior Year	2009 Method	2009 Rotated	2010 Method	2010 Rotated	2011 Method	2011 Rotated	Monitored Measure
Diabetes												
Comprehensive Diabetes Care - HbA1c Testing	81.59	81.27	**87.35**	↑	**6.08**	H	No	H	No	H	No	
Comprehensive Diabetes Care - HbA1c >9[1]	61.99	22.63	**31.87**	↓	**-9.24**	H	No	H	No	H	No	
Comprehensive Diabetes Care - HbA1c <8	NR	50.12	**60.10**	↑	**9.98**	NR	NR	H	No	H	No	
Comprehensive Diabetes Care - HbA1c <7	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Comprehensive Diabetes Care - Eye Exams	67.40	53.53	**53.77**	↑	**0.24**	H	No	H	No	H	No	
Comprehensive Diabetes Care - LDL-C Screening	80.41	81.75	**84.67**	↑	**2.92**	H	No	H	No	H	No	
Comprehensive Diabetes Care - LDL-C Control <100	36.99	36.01	**46.72**	↑	**10.71**	H	No	H	No	H	No	
Comprehensive Diabetes Care - Nephropathy	80.74	78.10	**82.97**	↑	**4.87**	H	No	H	No	H	No	
Comprehensive Diabetes Care - Blood Pressure <140/90	NR	66.42	**72.51**	↑	**6.09**	NR	NR	H	No	H	No	
Musculoskeletal												
Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Use of Imaging Studies for Low Back Pain	NR	80.08	**83.92**	↑	**3.84**	NR	NR	A	No	A	No	
Behavioral Health												
Antidepressant Medication Mgmt - Acute	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Antidepressant Medication Mgmt - Continuation	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
FU Care Children's ADHD Medication - Initiation	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
FU Care Children's ADHD Medication - Continuation	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
FU After Hospitalization For Mental Illness - 30 days	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
FU After Hospitalization For Mental Illness - 7 days	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Medication Management												
Annual Monitoring Persistent Meds - ACE or ARB	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Annual Monitoring Persistent Meds - Digoxin	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Annual Monitoring Persistent Meds - Diuretics	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Annual Monitoring Persistent Meds - Anticonvulsants	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Annual Monitoring Persistent Meds - Total	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**

Santa Clara County, California HMO Medicaid

Three Year Trend HEDIS® Comparisons

Measure	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate	Change from Prior Year	Percent Increase_ Decrease from Prior Year	2009 Method	2009 Rotated	2010 Method	2010 Rotated	2011 Method	2011 Rotated	Monitored Measure
Access/Availability of Care												
Adults' Access to Preventive/Ambulatory Health - Total		NR	**NR**					NR	NR	NR	NR	
Children & Adolescents' Access to PCP (12-24 mos)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Children & Adolescents' Access to PCP (25 mos-6 yrs)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Children & Adolescents' Access to PCP (7-11 yrs)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Children & Adolescents' Access to PCP (12-19 yrs)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Initiation of AOD - Age 13 - 17	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Initiation of AOD - Age 18+	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Initiation of AOD - Total (Combined Ages)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Engagement of AOD - Age 13 - 17	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Engagement of AOD - Age 18+	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Engagement of AOD - Total (Combined Ages)	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	**Y**
Prenatal/Postpartum Care - Timeliness of Prenatal Care	73.39	79.08	**83.45**	↑	**4.37**	H	No	H	No	H	No	
Prenatal/Postpartum Care - Postpartum Care	55.96	55.47	**65.69**	↑	**10.22**	H	No	H	No	H	No	
Use of Services												
Frequency of Ongoing Prenatal Care <21%	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Frequency of Ongoing Prenatal Care 21-40%	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Frequency of Ongoing Prenatal Care 41-60%	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Frequency of Ongoing Prenatal Care 61-80%	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Frequency of Ongoing Prenatal Care ≥81%	NR	NR	**NR**			NR	NR	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (0 visits)	2.88	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (1 visit)	1.83	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (2 visits)	3.40	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (3 visits)	5.24	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (4 visits)	19.90	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (5 visits)	26.18	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits in the first 15 Months of Life (6+ visits)	40.58	NR	**NR**			H	No	NR	NR	NR	NR	
Well-Child Visits 3 to 6 Years of Life	69.14	74.94	**70.07**	↓	**-4.87**	H	No	H	No	H	No	
Adolescent Well-Care Visits	39.68	48.66	**44.28**	↓	**-4.38**	H	No	H	No	H	No	

[1]Lower rate indicates better performance

[2]Rates not comparable across years if comparing different data collection methods

Anthem Blue Cross has implemented many Quality Improvement Projects (QIPs) in the last five years, both as part of statewide and small group collaboratives, as well as targeted toward internally identified quality improvement opportunities. At any given time, we concurrently work on several different QIPs in various states of completion. To demonstrate our comprehensive QIP process, we would like to highlight the following two QIPs implemented for our California Medi-Cal members:

- Improving Diabetes Management
- Reducing Avoidable Emergency Room Visits

Project 1: Improving Diabetes Management

***Start and End Dates*:** Anthem Blue Cross' QIP to improve diabetes management was a multi-year project initiated January 1, 2004. Baseline data represented the measurement year January 1, 2003-December 31, 2003 (HEDIS Reporting Year 2004), and five annual remeasurements conducted for the Reporting Years 2005 – 2009. In November 2009 the external auditor gave the notification that the QIP objectives had been met and the project was concluded.

***Problems Addressed/Targeted Populations*:** This QIP addressed diabetes management among our California Medi-Cal members 21 to 65 years of age who were identified as diabetics. Specifically, it addressed the low rates of Anthem Blue Cross members receiving an HbA1c screening and retinal eye exam. Results for Stanislaus County were 63 percent for HbA1c screening and retinal eye exam, 37 percent at baseline. HbA1c levels are considered indicative of whether an individual's diabetes is under control, and accordingly this screening is critical to good diabetes management. Likewise, diabetic retinopathy is a serious complication of diabetes and is usually asymptomatic until eye damage is severe, so regular retinal exams are also fundamental to diabetes management. Significant room for quality improvement is evidenced by these low baseline rates of screening combined with the high prevalence of diabetes among the California Medi-Cal population.

Study Questions: Do interventions targeted to diabetic members and physicians of noncompliant diabetic members improve the completion rate of HbA1c testing and retinal eye exams?

Study Indicator(s):

- HEDIS Comprehensive Diabetes Care – HbA1c testing (the percentage of members 21 to 65 years of age who were continuously enrolled in the plan during the measurement year with no more than 1 month gap in enrollment with type 1 or type 2 diabetes who had hemoglobin A1c testing)
- HEDIS Comprehensive Diabetes Care – Eye exam (retinal) performed (the percentage of members 21 to 65 years of age who were continuously enrolled in the plan during the measurement year with no more than 1 month gap in enrollment with type 1 or type 2 diabetes who had a retinal eye exam performed)

These measures are hybrid measures, meaning that a random sample of members are selected from the eligible population, and claims, encounter, and medical record data are all used to determine compliance with the measure.

Barrier Analysis: We assessed barriers in several key ways. First, we analyzed data in the Access and Availability study out to assess appointment availability for ophthalmologists within our network. No access barriers were detected.
We also surveyed provider experts and our Community Resource Center staff to determine what barriers might be preventing higher rates of compliance with ophthalmology visits and HbA1c testing. The following barriers were identified:

- Member knowledge – members lacked pertinent knowledge about diabetes management and the resources available
- Time constraints – members found it too time-consuming to coordinate a visit to either the specialist or the primary care physician
- Competing priorities for patients and providers –
    - Diabetes management competes with other demands in members' lives and isn't a top priority
    - Provider office visits are time-constrained, and competing demands sometimes result in members not receiving referrals for ophthalmologic exams from their primary care physician

Implemented Interventions to Address Identified Barriers:

- Sent a calendar with diabetic information to members annually to remind them when to get appropriate testing
- Sent member specific notices to providers of non-adherent diabetics to prompt PCP engagement with patients
- Used personal health trainers and case managers to assist members in managing their condition completing screening tests
- Sent educational and motivational mailings to diabetic members to inform them of the importance of diabetes management and how to access available resources
- Made reminder calls to the non-adherent members to encourage completion of HbA1c tests and retinal eye exams

Measurement Results (Baseline and Five Remeasurements):

Table 4.h-1: Diabetes Management in Stanislaus County, 2004 – 2009

Reporting Year	Measurement	HbA1c Screening (%)	Retinal Eye Exam (%)
2004	Baseline	63.39%	36.89%
2005	Remeasurement 1	60.49%	36.95%
2006	Remeasurement 2	67.25%	43.67%
2007	Remeasurement 3	73.80%	39.42%
2008	Remeasurement 4	82.28%	50.24%
2009	Remeasurement 5	77.89%	48.70%

Best Practices Related to Sustained Improvement Achieved:

As the above table shows, there was statistically significant improvement in rates of HbA1c screening and retinal eye exams among our members in Stanislaus County. These improvements took place over the course of the project, from 2004-2009. Further analyses of the data was conducted to determine if there were significant differences in the rates of screening and exams based on member language and ethnicity. Chi-square testing showed that the association between ethnicity and HbA1c testing and retinal eye exams was not statistically significant and the association between language and HbA1c testing and retinal eye exams was statistically significant. To address these discrepancies, we convened a panel of subject matter experts and addressed our interventions based on published research and anecdotal evidence as follows:

- Ensure that our current materials for members are provided with the appropriate language and cultural considerations
- Consider the feasibility of using health promoters (commonly called "promotoras" or "consejeras") from our members' communities, particularly in populations where language and culture are prominently associated with decreased health outcomes, to engage with members and promote necessary screenings and exams

While our formal QIP has officially ended, Anthem Blue Cross is committed to sustaining and improving diabetes management among our members. As such, we will continue to pursue these interventions to ensure positive health outcomes, and in addition will continue the following best practices:

- Notifying physicians when their diabetic members need services
- Using personal health trainers and case managers to assist members in managing their condition
- Identifying members with diabetes by assessing claims data for members with diabetes related glaucoma or other diabetes indicators, and targeting these members for intervention

Project 2: Reducing Avoidable Emergency Room Visits

***Start and End Dates*:** Anthem Blue Cross' QIP to reduce avoidable ER visits is part of the DHCS statewide Collaborative initiated July, 2007. Baseline data represented the measurement year January 1, 2006-December 31, 2006 (HEDIS Reporting Year 2007), and our third and most recent remeasurement was for Reporting Year 2010. Subsequent remeasurements will continue until it is determined the Collaborative has met its objectives.

Problems Addressed / Targeted Populations: Member and provider survey data for Anthem Blue Cross and other California Medi-Cal plans indicates a high rate of emergency room visits for upper respiratory infection (URI), a condition that could have been more appropriately managed in an office or clinic setting. This project addresses this high rate of avoidable ER visits for URI among Anthem Blue Cross' Medi-Cal members aged 1 to 19. Since URIs are acute infections and specific risk factors cannot predict who will develop a URI and present the ER, this project targets all members aged 1 to 19.

Study Questions: In accordance with the statewide Collaborative, our study question asks, do targeted interventions decrease the rate of avoidable ER visits during the measurement year?

Study Indicator(s):

- HEDIS Ambulatory Care – ED Visits (the number of emergency department, or ED, visits that occurred in the measurement year that did not result in an inpatient stay)
- "HEDIS-like" Avoidable ED Visits (the percentage of avoidable ED visits, i.e., ED visits that could have been more appropriately managed by and/or referred to a physician in an office or clinic setting, among members older than 1 year of age)

Barrier Analysis: Anthem Blue Cross conducted a three-pronged analysis to identify barriers, including research of peer reviewed journal articles, surveys of provider after-hours access, and appointment wait times, and outreach calls to Anthem Blue Cross Medi-Cal members who had presented in the ER. The following barriers were identified:

- Research-identified barriers:
  - Lack of access to a primary care physician
  - Transportation issues
  - Lack of knowledge on how to navigate through a managed care system
  - Convenience
- Lack of member knowledge regarding appropriate ER use (identified by providers and members)
- Member perception that primary care providers were not available for immediate appointments.

Implemented Interventions to Address Identified Barriers:

As part of the Collaborative, we worked to develop two statewide interventions:

- Developed a member health education campaign, including a provider toolkit to assist providers in educating their patients. The toolkit included a cover letter, instructions to the provider, talking points, a fact sheet, member brochures (in both English and Spanish) and a poster (in English and Spanish). As part of this campaign, our Community Resource Center staff conducted site visits to provider offices with a high volume of members making these ER visits to provide these materials.
- Developed a plan-hospital data collaboration to receive daily ER data feeds from the top ten hospital facilities in CA. Our Case Management and Health Management and Education departments use the member data to screen for focused intervention. This initiative provides real-time notification to providers/groups so that they can follow up with their members.

We also implemented our own Anthem-specific interventions:

- Implemented a toll-free 24/7 NurseLine for members to get nurse advice prior to going to an ER
- Provided monthly member-specific notices to inform PCPs of the member's ER visits

- Conducted outreach phone calls to assist members in making PCP appointments, changing their PCP, and arranging transportation to their PCP's office
- Disseminated an member education packet including an introductory letter, a magnet and information on our 24/7 NurseLine, a doctor visit check list, and self-care tips for common primary care conditions
- Developed the *Healthwise Handbook: A Self-Care Guide For You and Your Family*, which we distributed upon request
- Provided a digital thermometer with instructions on how to take a temperature for families with a member aged 12 or under who had at least one visit to the ER with a diagnosis of fever

Measurement Results (Baseline and Three Remeasurements):

Table 4.h-2: ED Visits and Avoidable ED Visits in Stanislaus County, 2007-2010 *(lower rate is better)*

Reporting Year	Measurement	ED Visits (per 1,000 MM)	Avoidable ED Visits (%)
2007	Baseline	47.59%	13.36%
2008	Remeasurement 1	50.59%	22.22%
2009	Remeasurement 2	53.00%	21.14%
2010	Remeasurement 3	64.37%	18.39%

Best Practices Related to Sustained Improvement Achieved (if any):
After an initial increase in the first year, our rate of avoidable emergency room visits has decreased in each subsequent year. While the ER rate went up, focused efforts on the avoidable ER rate led to a decrease in the number of avoidable ER visits. Stanislaus showed a statistically significant decrease two years in a row.

2011 Chronic Care Improvement Program: Care for Older Adults

Target Population for CCIP: Members enrolled in CareMore Connect D-SNP, dual eligible Special Needs Plan who meet eligible population criteria for HEDIS Care for Older Adults (COA) measure.

Methodology for Identifying Eligible MA Enrollees: Criteria for inclusion, numerator and denominator are according to technical specifications for the HEDIS Care for Older Adults (COA) measure. Members counted in this CCIP were from CareMore Connect D-SNP reported in HEDIS 2011.

Data and information sources from which data to determine eligibility for inclusion are obtained: Members age 65+, HEDIS rates: HEDIS Enrollment-Enrolled on RYEND2011; Data is stored in the CareMore Electronic Data Warehouse (EDW)

Number of Medicare Advantage enrollees identified as eligible for inclusion in the CCIP: 348, 80.37% of population; this number reflect unique enrollees; Eligible enrollees are automatically included in the CCIP through the HEDIS data collection process.

Chronic Disease/Condition: Older adults, age 65 and over
Prevalence Rate in D-SNP Population: 80.41%, 357 of 444 of members as of Sept 2011

Brief Rationale for Targeting the Chronic Disease/Condition: As stated by the "According to the 2000 United States Census report, there were 35 million people over the age of 65 in the year 2000—a 12-fold increase since 1990…As the elderly population ages, physical function decreases, pain increases and cognitive ability can decrease. With this, older adults become increasingly more depressed or have medication regimens of increased complexity. As people age, consideration should be given to their choices for end-of-life care and an advance care plan should be executed. Assessing functional status and pain, medication review and advance care planning can ensure that older adults receive comprehensive care that prevents further health status decline and considers their wishes." National Quality Measures Clearinghouse: http://www.qualitymeasures.ahrq.gov/content.aspx?id=32470

Data sources used to determine that a CCIP was needed for the conditions selected: Clinical quality measures described in the HEDIS COA technical specifications Data for the HEDIS COA measure is collected and analyzed annually.

Interventions: Success in this CCIP hinges on completing and documenting the four COA sub-measure assessments as part of each CCIP participants' routine care in the CHP healthcare system.

The Health Risk Assessment (HRA) "Healthy Start" or "Healthy Journey":

- Members are encouraged to come in for a "Healthy Start" (new enrollees) or "Healthy Journey" (existing enrollees) appointment with one of CHP's specially trained clinicians. During these appointments, the HRA is performed
- If members are not willing to come in for a "Healthy Start" or "Healthy Journey" appointment, the HRA is performed telephonically
- If a member cannot be contacted, the HRA is mailed to the member's home for completion
- Each beneficiary is contacted within 30 days of enrollment for their initial HRA and in the "care plan anniversary month" for on-going HRA
- Standardized assessment questions, screening tools, guidelines and protocols are used to identify patients and determine appropriate interventions, including assessments specific to the presence of an advance care directive, the member's ADL abilities, medications, and the presence and scale of pain

The Individualized Care Plan:

- Clinicians develop the Individualized Care Plans during Healthy Start and Healthy Journey face-to-face appointments and telephonic appointments and involve the ICT team based on the needs of the patient
- Our team measures the development of the Individualized Care Plans by conducting periodic reviews of the dictations and charts resulting from Healthy Start and Healthy Journey assessments to ensure that patients have a complete and appropriate care plan
- A copy of the patient's Individualized Care Plan is retained in the Electronic Medical Record System and a visit note and copy is forwarded to the patient's PCP
- Patients are provided with a copy of their Individualized Care Plan which includes:
  - Test results, goals, and due dates for retesting
  - Current medications and recommendations
  - Immunization history and needs
  - Disease management goals and self-management techniques
  - Tips and tools to manage symptoms, nutrition and physical activity
  - Sick day plan recommendations
  - Referrals
  - Other care plan recommendations identified by the clinician
- Patients are also provided with a Health Planner to self-document their healthcare between Healthy Journey visits

Program Monitoring:

- CareMore monitors progress of CCIP participants by comparing reported rates of the HEDIS COA measure on an annual basis against prior year rates and against regional and national benchmarks

- Elements/attributes that are monitored for CCIP participants are according to the HEDIS COA measure: Advance care planning, medication review, functional status assessment, and pain screening
- Opportunities for improvement are identified and presented to clinical leadership directly responsible for providing care to SNP members. Monitoring results for this CCIP occurs on an annual basis through HEDIS reporting

Outcome Measures:

- Numerator and denominator data sources are obtained from annual hybrid sample rates of the HEDIS measure
- Data for the HEDIS COA measure is collected and analyzed annually
- Data from annual HEDIS studies are utilized by Quality Management, Administration, and Clinical Operations to assess effectiveness of interventions
- Information gathered from this CCIP will be used to improve efficiency in clinical programs, to build similar reporting and analytics for other clinical programs, and to develop a company-wide strategy to improve Care for Older Adults

2011 Quality Improvement Project: Clinical Quality Outreach Efforts

Date of project initiation: 01/01/2011

Date of project completion or expected project completion: 12/31/2013

Indicate whether the project was initiated in order to participate in a local, regional or national quality improvement collaborative or incentive program (if yes, describe the larger program and its goals): Yes – Medicare STAR rating

Project Focus Area Type: Non-Clinical Focus Area; This QIP measures the efforts of the CareMore Quality Outreach team to assist members in completing preventive care screenings

Target population for this QIP project: Target population is CareMore enrollees in need of preventive screenings. Criteria for inclusion, exclusion, numerators and denominators are according to technical specifications for select HEDIS measures.

HEDIS Abbrev	Measure Description
BCS	Breast Cancer Screening
CDC	Comprehensive Diabetes Care/Eye Exam
CDC	Comprehensive Diabetes Care/HbA1c<8
CDC	Comprehensive Diabetes Care/HbA1c Test
CDC	Comprehensive Diabetes Care/LDL <100
CDC	Comprehensive Diabetes Care/LDL Test
CDC Comp	rehensive Diabetes Care/Nephropathy
CMC	Cholesterol Management for Patients with Cardiovascular Conditions/LDL <100
CMC	Cholesterol Management for Patients with Cardiovascular Conditions/LDL Test
COL	Colorectal Cancer Screening
GSO	Glaucoma Screening for Older Adults
MPM	Annual Monitoring for Patients on Persistent Medications
OMW	Osteoporosis Management in Women Who Had a Fracture
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Relevance of QI Project Topic to Medicare Population: After review of previous HEDIS scores against national benchmarks it was determined that some of CareMore's members had not been screened for a variety of health measures as defined by HEDIS. Since HEDIS measures relate directly to the health of the population CareMore serves this demonstrated an opportunity for improvement, for both those where CareMore was below the national average as well as those where CareMore exceeded the national average.

The root cause of our deficiencies appeared to be related to lack of coordinated outreach efforts and continuous monitoring of those efforts. Ensuring our members are properly screened for various conditions is essential to CareMore's membership.

The organization's prioritization process for selecting this specific topic: The CareMore Quality Management Committee reviews a variety of potential QI projects on an annual basis. When reviewing our 2010 HEDIS results several tactics for improvement were identified, one being a coordinated outreach team for members in need of preventive screenings.

Quality Improvement Indicators: Success is measured by the completion rates of the Outreach Effort as well as by the subsequent HEDIS rates for pertinent measures

Data Sources and Collection Methodology: Data on Outreach Efforts is maintained in an Access database; productivity and outcome reports are collected on a weekly basis for analysis and comparison against goals

Interventions:

- Outstanding HEDIS quality measures identified using HEDIS technical specifications and records loaded into Access database for outreach
- Clinical Outreach Specialist completes research prior to contacting member; validation measure still outstanding, member eligibility, etc.
- Three calls attempts made to members with outstanding HEDIS measures Coordination of outstanding measures completed by Clinical Outreach Specialist:
  - Appointments scheduled (i.e. eye exam, mammogram, etc.) and/or lab slips completed (i.e. LDL test/control, HbA1c test/control, etc.)
  - Follow up letter sent to member with appointment(s) scheduled and/or lab slip provided
  - Letter sent to PCP with update on outstanding measures (i.e. appointment scheduled, lab slip provided, etc.)
- If Clinical Outreach was unable to contact member after three call attempts follow up letter sent to the member and PCP
- PCP notified via letter if member refuses or if member reports test already complete

External Consultation and Delegation: None

ATTACHMENT 5 - Mandatory 8B - HEDIS MA - Quality Measures

CareMore Health Plan 2011 HEDIS® Measures Comparative Analysis			CareMore HEDIS Rates Medicare Advantage HMO			
HEDIS Data Source	HEDIS Measure	Description	2009 CareMore California H0544 MA	2010 CareMore California H0544 MA	2011 CareMore California H0544 MA	2010 Medicare HEDIS Mean
Prevention and Screening						
Admin	**Adult Body Mass Index Assessment (ABA)** Age 18-74. Every year. BMI assessment.	Reported Rate	NR	5.41%	**47.59%**	**38.8%**
Admin	**Breast Cancer Screening (BCS)** Age 40-69. Every two years. Mammogram for female members. Exclusion: Bilateral mastectomy.	Total	70.13%	73.37%	**78.23%**	**69.3%**
Hybrid	**Colorectal Cancer Screening (COL)** Age 50-75. One or more of the following: 1) Fecal occult blood test (FOBT) every year, 2) flexible sigmoidoscopy every 5 years, OR 3) colonoscopy every 10 years. Exclusions: colorectal cancer or total colectomy.	Reported Rate	55.96%	54.50%	**62.77%**	**54.9%**
Admin	**Glaucoma Screening in Older Adults (GSO)** Age 65+. Every year. Eye exam screening for glaucoma by an eye care professional. Exclusion: Prior diagnosis of glaucoma or glaucoma suspect.	Reported Rate	64.80%	66.56%	**74.72%**	**62.3%**
Respiratory Conditions						
Admin	**Pharmacotherapy Mgmt of COPD Exacerbation (PCE)** Age 40+. Multiple events for the same patient are possible. 1) Systemic corticosteroid within 14 days of discharge AND 2) bronchodilator within 30 days for members hospitalized or seen in ED for COPD exacerbation.	Bronchodilator	83.76%	84.51%	**84.76%**	**76.2%**
		Systemic corticosteroid	69.11%	70.37%	**75.91%**	**60.9%**
Admin	**Spirometry Testing for COPD (SPR)** Age 40+. Spirometry testing within 6 months of new diagnosis COPD, chronic bronchitis, emphysema.	Reported rate	15.68%	17.19%	**40.97%**	**28.5%**
Cardiovascular Conditions						
Hybrid	**Cholesterol Mgmt for Cardiovascular Pts (CMC)** Age 18-75. Every year. 1) LDL-C testing and 2) LDL level managed < 100 for members with a history of AMI, CABG, PTCA, or IVD.	LDL-C Testing	90.27%	87.83%	**93.67%**	**88.4%**
		LDL-C <100	56.93%	55.96%	**68.13%**	**55.7%**
Hybrid	**Controlling High Blood Pressure (CBP)** Age 18-85. Every year. Blood pressure managed <140/90 for members with HTN. Representative BP is the most recent BP reading documented in the calendar year. Exclusions: ESRD or pregnancy.	Rate - Total	NR	68.86%	**71.05%**	**59.8%**
Admin	**Persistence of Beta Blocker After a Heart Attack (PBH)** Age 18+. Beta-blocker treatment for at least 6 months for members hospitalized for acute MI. Measured as actual # calendar days covered w/ Rx in the 180 days after discharge.	Reported rate	90.51%	84.47%	**85.16%**	**82.6%**

ATTACHMENT 5 - Mandatory 8B - HEDIS MA - Quality Measures

CareMore Health Plan 2011 HEDIS® Measures Comparative Analysis			CareMore HEDIS Rates Medicare Advantage HMO			
HEDIS Data Source	HEDIS Measure	Description	2009 CareMore California H0544 MA	2010 CareMore California H0544 MA	2011 CareMore California H0544 MA	2010 Medicare HEDIS Mean
Diabetes						
Hybrid	**Comprehensive Diabetes Care (CDC)** Age 18-75. Every year. ALL of the following for members with diabetes: 1) HbA1c testing, 2) HbA1c control < 8.0, 3) HbA1c poor control >9.0% (Lower rates indicate better performance), R) LDL-C testing, 5) LDL-C control < 100, 6) Retinal eye exam, 7) Nephropathy screening test or evidence of nephropathy AND blood pressure control collected as 2 measures: 8) BP<140/90 and 9) BP<140/80 (as of 2011, changed from 130/80).	HbA1c Testing	87.59%	90.51%	**94.16%**	**89.6%**
		HbA1c Control <8.0%	69.10%	66.18%	**66.18%**	**63.7%**
		Poor HbA1c Control >9.0%	22.87%	26.52%	**24.82%**	**28.0%**
		LDL-C Testing	84.91%	91.73%	**91.24%**	**87.3%**
		LDL-C <100	50.12%	56.45%	**60.10%**	**50.0%**
		Eye Exams	69.34%	71.05%	**76.40%**	**63.5%**
		Med Att Diabetic Neph.	89.54%	91.97%	**92.21%**	**88.6%**
		BP Control <140/80	0.00%	45.50%	**62.04%**	**33.3%**
		BP Control <140/90	0.00%	77.65%	**77.13%**	**60.5%**
Musculoskeletal Conditions						
Admin	**Anti-Rheumatic Drug Therapy (ART)** Age 18+. Every year. Disease modifying anti-rheumatic drug (DMARD) for members with rheumatoid arthritis.	Reported rate	62.76%	59.45%	**59.14%**	**72.3%**
Admin	**Osteoporosis Mgmt in Women who had a Fracture (OMW)** Women age 67+. Bone mineral density (BMD) test OR osteoporosis medication within 6 months after fracture.	Reported rate	20.00%	17.30%	**36.30%**	**20.7%**
Behavioral Health						
Admin	**Antidepressant Medication Mgmt (AMM)** Age 18+. Antidepressant medication therapy for members diagnosed with a new episode of major depression. Measured in two treatment phases: 1) Effective Acute Phase Treatment (member remains on med for 84 days (12 wks)) AND 2) Effective Continuation Phase Treatment (member remains on med 180 days (6 mos)).	Acute Phase Treatment	62.50%	69.04%	**60.47%**	**63.7%**
		Continuation Phase Treatment	50.00%	52.06%	**52.45%**	**50.6%**
Admin	**Follow Up After Hospitalization for Mental Illness (FUH)** Age 18+. Outpatient visits OR Intensive outpatient encounters OR Partial hospitalization program for members hospitalized for mental illness. 1) Initial visit within 7 days of discharge AND 2) Additional treatment visits w/in 30 days.	30 Days	67.39%	58.24%	**49.09%**	**54.8%**
		7 Days	51.09%	36.26%	**41.82%**	**37.3%**

ATTACHMENT 5 - Mandatory 8B - HEDIS MA - Quality Measures

CareMore Health Plan 2011 HEDIS® Measures Comparative Analysis			CareMore HEDIS Rates Medicare Advantage HMO			
HEDIS Data Source	HEDIS Measure	Description	2009 CareMore California H0544 MA	2010 CareMore California H0544 MA	2011 CareMore California H0544 MA	2010 Medicare HEDIS Mean
Medication Management						
Admin	**Annual Monitoring for Pts on Persistent Medications (MPM)** Age 18+. Every year. Labs for members who receive at least 180 days of ambulatory medication therapy. **Serum potassium (K+) AND BUN/Creatinine :** ACE inhibitors/ARBs, Digoxin, OR Diuretics **Anticonvulsant drug serum concentration level :** Carbamazepine, Phenobarbital, Phenytoin, or Valproic acid	ACE inhibitors or ARBs	91.59%	92.28%	**95.58%**	**89.6%**
		Digoxin	93.07%	92.23%	**97.10%**	**92.0%**
		Diuretics	91.75%	93.18%	**96.21%**	**89.8%**
		Anti convulsants	70.08%	71.64%	**73.21%**	**69.7%**
		Total	91.26%	92.22%	**95.41%**	**89.2%**
Admin	**Use of High-Risk Medications in the Elderly (DAE)** Age 65+. Every year. Medication data is assessed annually for: 1) members on at least one DAE (some exposure to potentially harmful drugs) AND 2) members on at least two different DAE (exposure to multiple harmful drugs, increased risk adverse events). Lower rates indicate better performance.	One prescription	35.73%	36.47%	**27.11%**	**23.0%**
		At least 2 prescriptions	11.04%	10.96%	**6.53%**	**5.7%**
Admin	**Drug-Disease Interactions in the Elderly (DDE)** Age 65+. Potentially harmful drug-disease interactions. Identified per diagnosis. Lower rates indicate better performance. **Chronic Renal Failure :** Nonaspirin NSAIDs or Cox-2 Selective NSAIDs. **Dementia :** Tricyclic antidepressants or anticholinergic agents. **History of falls :** Tricyclic antidepressants, antipsychotics or sleep agents.	Chronic Renal Failure + Non Asp NSAIDs or Cox-2	18.66%	20.85%	**22.95%**	**11.5%**
		Dementia + Tricyclic Antidepress or Anticholi	41.56%	43.77%	**41.28%**	**28.6%**
		Falls + Tricyclic Antidepress or Antipsych	14.98%	17.69%	**18.70%**	**16.7%**
		Total	28.25%	30.55%	**30.55%**	**23.2%**
Access/Availability of Care						
Admin	**Adult Access to Preventive/ Ambulatory Health Services (AAP)** All adults. Every year. One or more office visits/outpatient services, preventive medicine, general medical exams, home visits, SNF/custodial visits, or ophthalmology or optometry.	20-44 Years	88.95%	91.10%	**90.97%**	**87.6%**
		45-64 Years	95.47%	95.33%	**95.51%**	**93.6%**
		65+ Years	95.72%	96.37%	**96.59%**	**93.9%**
		Total	95.65%	96.55%	**96.46%**	**93.7%**
Admin	**Initiation and Engagement of Alcohol or Drug Treatment (IET)** Age 18+. For members with a new episode of alcohol or other drug (AOD) dependence: 1) Initiation of AOD Treatment (AOD inpatient, outpatient visit or partial hospitalization within 14 days of diagnosis) AND 2) Engagement of AOD Treatment (initiation visit plus two or more additional visits in the following 30 days).	Engagement	2.36%	1.85%	**0.77%**	**4.6%**
		Initiation	36.65%	18.13%	**9.53%**	**46.2%**

Denotes rate above HEDIS 2010 mean or where CareMore HEDIS results indicate a demonstrable trend towards increasing success

Corrective Actions:

HEDIS Measure	Corrective Action Description
Antidepressant Medication Mgmt (AMM)	Efforts underway to improve antidepressant medication management through other CareMore medication adherence programs.
Follow Up After Hospitalization for Mental Illness (FUH)	CareMore Mental Health team tasked with identification and implementation of improvements related to follow up visits post hospitalization.
Initiation and Engagement of Alcohol or Drug Treatment (IET)	CareMore UM Medical Director to complete root cause analysis and develop corrective action plan with the CareMore Mental Health team and Network Management.

ATTACHMENT 5 - Mandatory 8B - HEDIS SNP - Quality Measures

CareMore Health Plan 2011 HEDIS® Measures Comparative Analysis				CareMore HEDIS Rates Connect SNP			
HEDIS Data Source	SNP-Only Measure ID	Element ID	Description	2009 Connect LA/OC H0544003	2010 Connect LA/OC H0544003	2011 Connect LA/OC H0544003	2010 Medicare HEDIS Mean
Hybrid	Care for Older Adults (COA) Age 65+. Every year. At least one of each of the following: 1) Advance care planning discussion (end of life, advance directives, living will, POLST, etc), 2) Medication review (by a pharmacist/prescribing practitioner + med list in the chart), 3) Functional status assessment (ambulation, cognitive, sensory and ADL status), AND 4) Pain screening (comprehensive assessment, pain management plan, pain scale)	rateacp	Advance Care Planning	2.83%	8.04%	**43.55%**	**27.20%**
		ratemr	Medication Review	37.74%	64.69%	**57.49%**	**47.50%**
		ratefsa	Functional Status Assessment	22.64%	31.12%	**60.63%**	**37.30%**
		rateps	Pain Screening	31.60%	25.87%	**64.11%**	**40.70%**
		rateall	All Criteria Met	0.47%	1.75%	**33.80%**	**NR**
Hybrid	Medication Reconciliation Post Discharge (MRP) Age 65+. Multiple discharges for the same patient are possible. Reconciliation of hospital/SNF discharge meds with current outpatient medication list by a prescribing practitioner or pharmacist within 30 days of each discharge. Does not require an outpatient visit but the following documentation must be in the outpatient chart: 1) notation that the meds prescribed/ordered upon discharge were reviewed, OR 2) notation that no meds were prescribed/ordered upon discharge.	rate	Reported Rate	0.00%	0.00%	**0.00%**	**17.70%**

Denotes rate above HEDIS 2010 mean or where CareMore HEDIS results indicate a demonstrable trend towards increasing success

	Corrective Actions:		
	HEDIS Measure	**Corrective Action Description**	
	Medication Reconciliation Post Discharge (MRP)	System enhancement made to CareMore's EHR (Electronic Health Record) in Q4 2011 to improve process and documentation of medication reconciliation post discharge.	

ATTACHMENT 5 - Mandatory 8B - CAHPS - Quality Measures

CareMore Health Plan CAHPS Survey Results 2009 - 2011				
	2009	2010	2011	National
Health Plan Composite Measures				
Getting Needed Care	3.46	3.5	3.46	3.57
Getting Care Quickly	3.11	3.11	3.19	3.28
Doctors Who Communicate Well	3.61	3.65	3.64	3.71
Health Plan Customer Service	3.71	3.75	3.64	3.63
Overall Health Plan Ratings				
Health Plan Overall	**8.81**	**8.94**	**9.00**	8.60
Care Received Overall	**8.31**	**8.45**	**8.70**	8.62
Personal Doctor	**8.82**	**8.95**	**8.90**	9.07
Specialist	**8.50**	**8.68**	**8.70**	8.91
Prescription Drug Composite Measures				
Getting Needed Prescription Drugs	3.73	3.79	3.76	3.74
Getting Information From the Plan About Prescription Drug Coverage and Cost	3.42	3.66	3.52	3.41
Overall Ratings of Drug Coverage				
Overall Rating of Drug Coverage	8.75	8.98	9.00	8.52
Willingness to Recommend Plan for Drug Coverage	3.67	3.74	3.70	3.50
Medicare-Specific and HEDIS Measures				
Influenza Vaccination	73.8%	74.0%	78.0%	69.7%
Pneumonia Vaccination	63.0%	69.6%	73.0%	70.5%
Getting Medical Equipment	3.31	3.34	N/A	3.35
Follow-up with Test Results			3.25	3.49
Single Item Measures				
After-hours call		10.4%	10.3%	9.5%
Call back as soon as needed		49.1%	36.1%	45.6%
Timing of call back		32.7%	25.7%	35.4%
Denotes rate above national average				

ATTACHMENT 5 - Mandatory 8B - SNP - Quality Measures

CareMore Health Plan
NCQA SNP Structure and Process Results
2009 - 2011

Requirement	Connect (D-SNP)					
	LA/OC			San Bernardino		
	2009	2010	2011	2009	2010	2011
Complex Case Management						
SNP 1A: Identifying Members	N/A	N/A	100	N/A	N/A	100
SNP 1B: CM Access	N/A	N/A	100	N/A	N/A	100
SNP 1C: CM IT Systems	N/A	N/A	100	N/A	N/A	100
SNP 1D: Frequency of ID Members	N/A	N/A	100	N/A	N/A	100
SNP 1E: Member Information	N/A	N/A	100	N/A	N/A	100
SNP 1F: Complex CM Process	N/A	N/A	100	N/A	N/A	100
SNP 1G: Educating Physicians	N/A	N/A	100	N/A	N/A	100
Improving Member Satisfaction						
SNP 2A: Assessment	N/A	N/A	100	N/A	N/A	100
SNP 2B: Opportunities	N/A	N/A	100	N/A	N/A	100
Clinical Quality Improvement						
SNP 3A: QI Relevance	N/A	N/A	100	100	N/A	100
Care Transitions						
SNP 4A: Managing Transitions	20	100	100	20	100	100
SNP 4B: Supporting Members	50	100	100	50	100	100
SNP 4C: Analyzing Performance	N/A	N/A	50	N/A	N/A	50
SNP 4D: Identify Unplanned	20	100	100	20	100	100
SNP 4E: Analyzing Transitions	N/A	80	100	N/A	80	100
SNP 4F: Reducing Transitions	50	80	100	50	80	100
Institutional SNP Relationship with Facilities						
SNP 5A: Monitoring Health Status	N/A	N/A	N/A	N/A	N/A	N/A
SNP 5B: Monitoring Changes Health Status	N/A	N/A	N/A	N/A	N/A	N/A
SNP 5C: Maintaining Health Status	N/A	N/A	N/A	N/A	N/A	N/A
Coordination of Medicare and Medicaid Benefits						
SNP 6A: Coord of Benefits Dual	0	100	100	0	100	100
SNP 6B: Admin of Dual Benefits	0	100	100	0	100	100
SNP 6C: Relationship with Medicaid	N/A	100	100	N/A	100	100
SNP 6D: Coord. For Chronic Conds. and Institutional Benefits	0	N/A	N/A	0	N/A	N/A
SNP 6E: Service Coordination	0	100	100	0	100	100
SNP 6F: Network Adequacy	N/A	N/A	0	N/A	N/A	0

Corrective Actions:

SNP S&P Measure	Corrective Action Description
SNP 4C: Analyzing Performance	Report template updated to incorporate qualitative (barrier) analysis and opportunities for improvement.
SNP 6F: Network Adequacy	P&P updated for Network Adequacy to address frequency of assessment. Process instituted to incorporate analysis of causes where availability standards are not meet, this analysis will be included in the summary report that is presented to the QI Committee on a semi-annual basis.

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

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February 16, 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 CareMore is an applicant on behalf of Anthem Blue Cross.

We also understand that CareMore is in the process of being acquired by Anthem Blue Cross. Given that Anthem Blue Cross and Santa Clara Family Health Plan are the local "two plan Medi-Cal providers" that are to collaborate to provide health care services to the Medi-Cal/Medi-Cal benficiaries in this county, we support the CareMore application on behalf of Anthem Blue Cross as a provider of services to the dual eligibles in Santa Clara County. With this support we also encourage consideration of project participation by behavioral health care subcontractors of the Santa Clara County Mental Health Department Specialty Managed Care Plan.

Published data is verifying that the integration of primary and behavioral health care is an effective treatment model for all persons and especially for those with mental health conditions. As a local provider serving older adults and disabled persons in need of behavioral and physical health care, we support the joint efforts of the applicant organizations to establish care services that are person-centered in order to help the beneficiaries achieve important health care goals.

Sincerely,

Katherine M. Mason

Katherine M. Mason, MSW
Director, Behavioral Health Services

United Way

PREMIER CARE
OF NORTHERN CALIFORNIA MEDICAL GROUP, INC.

February 12, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Services (RFS). We have worked in partnership with Anthem since 1997 to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem has made to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS. Anthem has demonstrated to our organization that they have a dedicated interest in helping vulnerable members of our community.

Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Tuyen Ngo, MD
President, Premier Care of Northern California Medical Group

1865 Alum Rock Ave San Jose, Ca 95116 Phone: 408-258-3229

PHYSICIANS MEDICAL GROUP OF SAN JOSE
EXCEL MSO, LLC
75 East Santa Clara Street, Suite 950
San Jose, CA 95113
(408) 937-3600

February 15, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization has been and will continue to work in partnership with Anthem to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem is making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. We have been impressed with Anthem Blue Cross in this regard for many years. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Stephen W. Ho, M.D.
Chief Medical Officer
Physicians Medical Group of San Jose
EXCEL MSO, LLC
(408) 937-3600

February 21, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) that will implement the CareMore Care Model for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization will work in partnership with Anthem to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem and CareMore are making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts and using CareMore's Care Model to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Print Name Oliver A. Melendez

Address 1899 Panama Ave

City San Jose State CA

Phone: (408) 229-3761

February 21, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) that will implement the CareMore Care Model for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization will work in partnership with Anthem to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem and CareMore are making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts and using CareMore's Care Model to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Catherine Yeager

Print Name Catherine Yeager

Address 440 Willow Glen Way #309

City San Jose State Ca

Phone: 723-2321

February 15, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) that will implement the CareMore Care Model for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization will work in partnership with Anthem to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem and CareMore are making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts and using CareMore's Care Model to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Guadalupe Soto

Guadalupe Soto

February 21, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) that will implement the CareMore Care Model for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization will work in partnership with Anthem to serve low-income and frail populations in the County of Santa Clara, and we applaud the contributions Anthem and CareMore are making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts and using CareMore's Care Model to provide a full continuum of care for dual eligible members in Santa Clara County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

MLLima

Print Name Marcelia Lima

Address 2080 Alum Rock Ave

City San Jose State CA

Phone: (650) 240-6304

www.alz.org

Northern California
& Northern Nevada
1060 La Avenida Street
Mountain View, CA 94043-1422

650 962 8111 **phone**
650 962 9644 **facsimile**
800 272 3900 **helpline**

alzheimer's association™

With Offices In:
Chico
Lafayette
Monterey
Mountain View
Reno
Sacramento
San Rafael
Santa Cruz
Santa Rosa

February 15, 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:

I am writing to applaud Anthem Blue Cross Partnership Plan (Anthem) for their interest in the California Dual Eligible Demonstration Request for Solutions (RFS). We look forward to working with them to serve low-income and frail populations in the Counties of Santa Clara and Alameda, and we applaud their intent to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem proposes providing Medi-Cal members with education on and connection to important community organizations and supporters. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

We appreciate Anthem's interest in helping vulnerable members of our community. Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in the above counties.

Sincerely,

Wm H Fisher

William H. Fisher
CEO

the compassion to care, the leadership to conquer

www.alz.org/californiasouthland
California Southland Chapter
Los Angeles Office
5900 Wilshire Blvd., Ste. 1100
Los Angeles, CA 90036
323 938 3379 p
323 938 1036 f

alzheimer's association®

February 15, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS), specifically in support of our sister Northern California Chapter's partnership with Anthem to serve low-income and frail populations in the counties of Alameda and Santa Clara. We have had a long standing relationship with Anthem and applaud the contributions they have made to increase health care access for Medi-Cal beneficiaries throughout the state. The California Southland Chapter also looks forward to working directly with them in the future as this effort comes to the counties we serve.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with critical education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supporters. We have seen the benefit of this for our clients since many physicians often don't refer to the Alzheimer's Association when someone is diagnosed with this devastating disease, leaving patients and families with questions, anxieties, and a sense of isolation. This outreach is vitally important as efforts are made to coordinate care for dual eligible members with the transition proposed under the RFS.

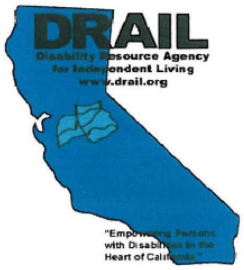
Anthem has demonstrated to our organization that they have a dedicated interest in helping vulnerable members of our community, and we support their efforts to provide a full continuum of care for dual eligible members. Should you have any questions regarding our support of Anthem's submission for the CA Dual Eligible Demonstration RFS, please don't hesitate to call me.

Sincerely,

Susan M. Galeas
President & CEO

the compassion to care, the leadership to conquer®

Please remember us in your will or estate plan
FEDERAL TAX ID #95-3718119



Modesto Office
920 12th Street
Modesto, CA 95354
Phone: 209-521-7260
Fax: 209-521-4763
TTY: 209-576-2409

Stockton Office
501 W. Weber Avenue,
Suite 200-A
Stockton, CA 95204
Phone: 209-477-8143
Fax: 209-477-7730
TTY: 209-465-5643

Mother Lode Office
67 Linoberg Street,
Suite A
Sonora, CA 95370
Phone: 209-532-0963
Fax: 209-532-1591
TTY: 209-288-3309

Board of Directors

President
Terry Gray

Vice-President
vacant

Treasurer
Bob Williams

Secretary
Desdemona Martinez

Youth Leadership
Hannah Boxell

Sam Jones

February 13, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). We have worked in partnership with Anthem since 2008 to serve low-income and frail populations in the County of Stanislaus and we applaud the contributions Anthem has made to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Anthem has demonstrated to our organization that they have a dedicated interest in helping vulnerable members of our community. In March of 2010 and 2011 DRAIL hosted its' 2nd and 3rd Annual César Chávez celebration events. This event creates an opportunity for DRAIL and other agencies to educate and inform the community regarding the services that are available in the community. The last two years Anthem Blus Cross has been a supporter of the events in which participant attendance has increased each year because of the dedication of outreach Anthem Blue Cross has provided DRAIL for this eevent.

Partially Funded By: CDBG of Modesto, San Joaquin, Stanislaus & Tuolumne Co., CDBG of the Cities of Manteca, Stockton and Tracy, Omega Nu and United Way of Stanislaus & Tuolumne.

Anthem Blue Cross is dedicated not only to deliver exceptional health care to all their members but has also been a great supporter of community events. Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members. DRAIL fully supports Anthem Blue Cross and we look forward to continuing our collaborative partnership. Please feel free to contact me should you have any questions regarding our support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely

Barry Smith
Executive Director
barry@drail.org
209-521-7260
209-532-0963

February 15, 2012

424 Pendleton Way
Oakland, CA 94621
510-638-5864 phone
510-638-8984 fax

lungusa.org/california

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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). We have worked in partnership with Anthem since 1998 to serve low-income and frail populations in California, and we applaud the contributions Anthem has made to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

Anthem has demonstrated to our organization that they have a dedicated interest in helping vulnerable members of our community. They have sponsored and participated with us on the following programs/projects:

- Air Quality Flags Program
- Provider Trainings on Asthma
- World Asthma Day Activities
- Asthma Camps
- Air Quality Flags Study with ALA, UCSF, and CSUF.
- Provided pillow case and mattress covers for FACES program.
- Member of the Board of Directors

Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in California. Please feel free to contact me at, at (916) 585-7670, should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Kimberly Weich
Vice President, Program and Advocacy

*Life is a journey
we know by heart.*

ADMINISTRATIVE/
GOETSCH CENTER
2320 Channing Way
Berkeley, CA 94704
(510) 644-8292
Fax: (510) 540-6771
www.aseb.org

ASEB - HAYWARD
561 A Street
Hayward, CA 94541
(510) 888-1411
Fax: (510) 888-1357

ASEB - OAKLAND
400 29th Street
Suite 105
Oakland, CA 94609
(510) 268-1410
Fax: (510) 268-1419

February 17, 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:

On behalf of the board of directors of Alzheimer's Services of the East Bay (ASEB) I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). Our organization will work in partnership with Anthem to serve low-income and frail populations in the County of Alameda.

ASEB will support and partner with Anthem Blue Cross in any effort to ensure that the Dual Eligible Demonstration Request for Solutions (RFS) is successful and meets the needs of our current and future program participants.

Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in Alameda County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

S. Micheal Pope
Executive Director

Community Resources for Independent Living
439 'A' Street, Hayward, California 94541
(510) 881-5743
Fax (510) 881-1593
TTY (510) 881-0218
Tri-Valley (925) 371-1531
Tri-Cities (510) 794-5735

February 17, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). Our disability resource and advocacy organization, Community Resources for Independent Living (CRIL), has been providing Medi-Cal Managed Care outreach and enrollment assistance to Medi-Cal only beneficiaries during the 2011-12 year. We have partnered with Senior Services Coalition, Health Care Options, Anthem and Alameda Alliance in providing this no-cost service to our community. CRIL will continue to work in partnership with Anthem to serve low-income and frail populations in the County of Alameda, and we applaud the contributions Anthem is making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has been instrumental in providing Medi-Cal members with education on how to access their health care benefits. Anthem also provides outreach to members so they are connected to important community organizations and supports. This is a significant attribute to note since it will be vitally important to coordinate care for dual eligible members as part of the transition proposed under the RFS.

CRIL supports Anthem's efforts to provide a full continuum of care for dual eligible members in Alameda County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Sheri Burns
Executive Director

家 橋 驛 社

FAMILY BRIDGES, INC.

A multi-service agency serving the East Bay community

February 15, 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:

This letter expresses the support of Family Bridges, Inc. for Anthem Blue Cross Partnership Plan's (Anthem) application for the California Dual Eligible Demonstration Request for Solutions (RFS).

Family Bridges' two adult day healthcare centers serve 420 dual eligible, monolingual Asian seniors and adults. We will work with Anthem to advise them regarding outreach, education, and crafting service models for this group and all other low income, frail populations.

We look forward to supporting Anthem's efforts to provide a full continuum of care for dual eligibles in Alameda County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Corinne S. Jan, RN, PHN
Chief Executive Officer

168-11th Street, Oakland, CA 94607
Phone: (510) 839-2022 • Fax: (510) 839-2435 • Website: http://www.FamBridges.org

LifeLong Medical Care
Health Services For All Ages

Mailing Address
P.O. Box 11247
Berkeley, CA 94712-2247

Administration & Member Services
2344 Sixth Street
Berkeley, CA 94710
510.981.4100
fax: 510.981.4191

Health Center Locations

Adult Day Health Center
Foothill Square
10700 MacArthur Blvd, Suite 14A
Oakland, CA 94605
510.563.4390

Berkeley Primary Care
2001 Dwight Way
Room 1363
Berkeley, CA 94704
510.204.4666

Downtown Oakland Clinic Supportive Housing Program
616 16th Street
Oakland, CA 94612
510.451.4270

Howard Daniel Clinic
9933 MacArthur Boulevard
Oakland, CA 94605
510.568.3206

LifeLong Dental Care
1860 Alcatraz Avenue
Berkeley, CA 94703
510.653.8500

LifeLong Medical Care-East Oakland
Foothill Square
10700 MacArthur Blvd, Suite 14B
Oakland, CA 94605
510.615.4870

Marin Adult Day Health Center
1905 Novato Boulevard
Novato, CA 94947
415.897.6884

Over 60 Health Center
3260 Sacramento Street
Berkeley, CA 94702
510.601.6060

West Berkeley Family Practice
2031 Sixth Street
Berkeley, CA 94710
510.981.4200

February 14, 2012

Department of Health Care Services
Office of Medi-Cal Procurement
1501 Capitol Avenue, Suite 71.3041
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Anthem Blue Cross Partnership Plan Dual Eligible Demonstration

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) as an applicant for the California Dual Eligible Demonstration Request for Solutions (RFS) in Alameda County. LifeLong Medical Care has a history of working with Anthem as a network provider to serve Alameda County's Medi-Cal beneficiaries and we fully support the intent of the RFS to:

- Preserve and enhance the ability for consumers to self-direct their care and receive high-quality care
- Improve health processes and satisfaction with care
- Improve coordination of care
- Improve timely access to care
- Optimize the use of Medicare, Medi-Cal and other State/County resources.

Anthem has invited us to serve on an advisory group and we intend to participate, bringing the perspectives and expertise of our providers and patients to demonstration planning and implementation efforts. LifeLong Medical Care is pleased that both Medi-Cal managed care plans in our Two-Plan county are eager to provide a full continuum of care for dual eligible beneficiaries. We look forward to working in coalition with the plans, providers, beneficiaries and community-based organizations to improve care and services to dual eligible beneficiaries.

Sincerely,

Marty Lynch
Executive Director/CEO

February 15, 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:

I am writing in support of Anthem Blue Cross Partnership Plan (Anthem) for the California Dual Eligible Demonstration Request for Solutions (RFS). The Regional Center of the East Bay (RCEB) is a private, non-profit corporation providing services and supports to individuals with developmental disabilities in Alameda and Contra Costa Counties under contract with the California Department of Developmental Services. Our organization will work in partnership with Anthem to serve individuals with developmental disabilities in the County of Alameda. We support the contributions Anthem is making to increase health care access for Medi-Cal beneficiaries throughout California.

In addition to creating a comprehensive health network of primary care providers and specialists, Anthem has provided Medi-Cal members with education on how to access their health care benefits. Anthem has also provided outreach to members to help them connect to community organizations and supports. These will be important components in planning for the coordination of care for dual eligible members as part of the transition proposed under the dual eligible demonstration project.

Our organization will support Anthem's efforts to provide a full continuum of care for dual eligible members in Alameda County. Please feel free to contact Lisa Kleinbub, Director of Health and Behavioral Services at (510) 618-7717 should you have any questions regarding our support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

James M. Burton
Executive Director

San Leandro (Main Office): 500 Davis Street Suite 100 San Leandro CA 94577 Tel: 510.383.1200 Fax: 510.678.4100
Concord: 2151 Salvio Street Suite 365 Concord CA 94520 Tel: 925.798.3001 Fax: 925.674.8001
Website: www.rceb.org

Senior Services Coalition

Adult Day Services Network of Alameda County
Afghan Elderly Association
Alameda Alliance for Health
Alameda County Commission on Aging
Alameda County Community Food Bank
Alameda County Meals on Wheels
Alzheimer's Services of the East Bay
Bay Area Community Services
Berkeley Adult Day Health Care
Center for Elders Independence
Crisis Support Services
Christian Church Homes
Eden I&R
Eden Housing Resident Services
Family Bridges, Inc
City of Fremont Human Services Department
J-Sei
Korean Community Center of the East Bay
Lavemer Seniors of the East Bay
Legal Assistance for Seniors
Lifelong Medical Care
City of Livermore Parks & Recreation Department
City of Oakland Commission on Aging
City of Oakland Department of Human Services
On Lok
RE CARES Network
Rebuilding Together Oaland
City of San Leandro Senior Services
Satellite Housing, Inc.
Senior Support Program of the Tri Valley
SOS Meals on Wheels
Spectrum Community Services
St. Mary's Center
Tri-City Elders Coalition
Unity Council/Fruitvale Senior Center
United Seniors of Oakland and Alameda County
Vietnamese American Community Center of the East Bay

February 14, 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

Re: Letter of Support for Anthem Blue Cross Dual Eligible Demonstration

Dear Mr. Quacchia and Mr. Sodergren:

This letter expresses Senior Services Coalition of Alameda County's (SSC) support for Anthem Blue Cross Partnership Plan's (Anthem) application for the California Dual Eligible Demonstration Request for Solutions (RFS).

Representing nonprofit and public providers of health and supportive services for seniors in Alameda County, SSC will work in partnership with Anthem to provide input on how their Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries. SSC staff look forward to serving on Anthem's Advisory Board and assisting Anthem as it serves low-income and frail Medi-Cal recipients in Alameda County, connects members to important community supports, and coordinating care for dual eligible members as part of the transition proposed under the RFS.

Our organization supports Anthem's efforts to provide a full continuum of care for dual eligible members in Alameda County. Please feel free to call me should you have any questions regarding my support of Anthem's submission for the CA Dual Eligible Demonstration RFS.

Sincerely,

Wendy Peterson

Wendy Peterson, Director
Senior Services Coalition of Alameda County

6955 Foothill Blvd., Suite 300 - Oakland, CA 94605 - (510) 577-3544 - seniorservicescoalition.org

Anthem. BlueCross

Santa Clara Family Health Plan

Join us!

Dual Eligible Demonstration Project: Learn what it is and share your thoughts!

Anthem Blue Cross wants you to join us for a community forum

Speaker

Leadership from both Anthem Blue Cross and the Santa Clara Family Health Plan will facilitate and receive thoughts and comments from community stakeholders.

When?

Day Tuesday
Date February 21st
Time 1:00pm to 3:00pm

Where?

CareMore
Community Room - 2nd Floor
255 North White Road
San Jose, CA 95127

Who should attend?

Stakeholders including dual eligible members, caregivers, community leaders, advocates, providers, and anyone else in the community with an interest in the project.

Why?

Learn more about the goals of the project, share your ideas and experience, and learn more about Anthem Blue Cross and The Santa Clara Family Health Plan.

What's in it for you?

An opportunity to better understand how this project effects you and to voice your opinions and thoughts on the project.

Additional information

Project Background:

In partnership with the Federal Medicare and Medicaid Coordination Office at Center for Medicare and Medicaid Services (CMS), California has a new opportunity to establish care coordination programs for Medicare/Medicaid enrollees that will coordinate services across the two programs to better align benefits, delivery, financing and administration. As envisioned by CMS, the "initiative is intended to alleviate fragmentation and improve coordination of services for Medicare/Medicaid enrollees, enhance quality of care and reduce costs for the State and the Federal government." The demonstration's focus is on creating a coordinated care delivery system that is tailored and responsive to beneficiaries' needs and overcomes the fragmentation and inefficiencies created by current categorical funding, service structures and regulatory requirements.

Make your reservation by:

Tuesday Morning - 2/21/2012

Call

Sean Atha @ 916-325-4214

E-mail

sean.atha@wellpoint.com

Anthem Blue Cross is the trade name of Blue Cross of California and Anthem Blue Cross Partnership Plan is the trade name of Blue Cross of California Partnership Plan, Inc. Independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County.
2/5/2012APSHABC 1/12

Attachment 6 – Mandatory 12D – Invitee List – Santa Clara County

1. Able People Foundation
2. Archstone Foundation and Santa Clara County Mental Health Department
3. Asian Americans for Community Involvement
4. Avenidas
5. Breathe California of the Bay Area
6. California Senior Legislature
7. Campbell Adult Center
8. Caregiver Support Services - Catholic Charities
9. Caremore Health Plan
10. Catholic Charities of Santa Clara County
11. Centennial Recreation Senior Center/Mt.
12. City of Mountain View
13. City of San Jose
14. City of San Jose Housing
15. City of San Jose Senior Citizens Commission
16. City of Santa Clara - Council on Aging
17. Community Services Agency of Mountain View and Los Altos
18. Community Solutions
19. Council on Aging Silicon Valley
20. County of Santa Clara
21. Eastside Neighborhood Center of Catholic Charities
22. Family Caregiver Alliance
23. Gardner Family Health
24. Health Trust (The)
25. Heart of the Valley - Services for Seniors
26. Hospice of the Valley
27. Jewish Family Services of Silicon Valley
28. Los Gatos Senior Center
29. Maxim Companion Services
30. Mendall Consulting

31. Mexican American Community Services Agency, Adult Day Health Care
32. Mexican American Senior Services
33. Minority Senior Services Providers Consortium
34. O'Connor Hospital
35. Office on Aging
36. Ombudsman Program, Catholic Charities
37. Palo Alto Medical Foundation
38. Pathways Health
39. Pathways Home Health, Hospice and Private Duty
40. Pathways Private Duty
41. PlaneTree Health Library
42. Rebuilding Together Silicon Valley
43. San Jose Senior Citizens Commission
44. Santa Clara County Department of Aging and Adult Services
45. Santa Clara County Medical Society
46. Santa Clara County Mental Health Department
47. Santa Clara Family Health Plan
48. Saratoga Senior Coordinating Council
49. Self-Help for the Elderly
50. Senior Helpers
51. Senior Housing Solutions
52. Senior Housing Solutions - Milpitas
53. Silicon Valley Independent Living Center
54. Stanford Geriatric Education Center
55. Stanford Hospital and Clinics
56. Sunnyvale Senior Center, Private, SJSU, NDNU
57. Traffic Safe Communities Network
58. Victim Witness Assistance Center- SV FACES
59. Wellness Community (The) - Silicon Valley
60. Yu-Ai Kai/Japanese American Community

February 10, 2012

Alejandra Herra Chavez, City of San Jose Housing
Amy Andonian, Caregiver Support Services - Catholic Charities
Bob Campbell, Executive Director, Senior Housing Solutions - Milpitas
Cathy Lynch, Community Relations Coordinator, Pathways Health
Connie Langford, Chair Person, City of San Jose Senior Citizens Commission
Dawn Ngo, Geriatric Care Manager, City of Santa Clara - Council on Aging
Glenda Cresap, Executive Director, Heart of the Valley - Services for Seniors
Karen Storey, Executive Director, The Wellness Community - Silicon Valley
Kathy Whitcomb, Senior Services Representative, Campbell Adult Center
Laura Beeson, Director - Health Senior Services, Mexican American Senior Services
Lee Pullen, Director, Department of Aging and Adult Services
Lisa Hendrickson, Executive Director, Avenida
Lori Andersen, Director Healthy Aging, The Health Trust
Marita Grudzen, Deputy Director, Stanford Geriatric Education Center
Mindy Berkowitz, Executive Director, Jewish Family Services of Silicon Valley
Reymundo Espinoza, CEO, Gardner Family Health
Sarah Triano, Executive Director, Silicon Valley Independent Living Center
Stephen Schmoll, CEO, Council on Aging Silicon Valley
William C. Parrish Jr., CEO, Santa Clara County Medical Society

Subject: Stakeholder Input for California Dual Eligible Demonstration Project

Sent via Electronic Mail

The Department of Health Care Services (DHCS) has released the final Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project. The RFS will be used to select Demonstration sites. The selection criterion intends to rebalance care away from institutional settings and into the home and community. The RFS promotes coordinated care models that provide seamless access to the full continuum of medical, social, long-term, and behavioral supports and services dual eligibles need to maintain good health and a high quality of life. The RFS reflects input provided by a wide array of consumers and stakeholders during numerous conversations and public meetings over the past six months.

Anthem Blue Cross (Anthem) is in the process of collaborating with the Santa Clara Family Health Plan to submit an application to the DHCS in response to the RFS process. Each health plan must complete their own application. Yet both plans must submit an application in order to have the County be considered as a possible demonstration site.

At this time, I am reaching out to you and other experienced experts in the area of long term care and dual eligible related services to respectfully request that you help Anthem better understand the unique services required to best serve dual eligible members. I

represent Anthem's Medi-Cal related State Sponsored Business program and am currently accountable for both Medi-Cal and Healthy Families beneficiaries receiving services through Anthem in Santa Clara County.

The completed RFS applications are due back to the DHCS by February 24th, 2010 and I am attempting to build a working county coalition of advisors by February 17th. There is a significant amount of interest in this project and the State and Federal governments have designed a process that aids in fostering the greatest amount of community collaboration possible. There is currently a significant amount of resources focused on designing the best possible services delivery process. I would like to take advantage of this opportunity and work with you closely though this process if you can make the time. I will soon be setting up both a public forum to gather the communities thoughts as well as an organizational advisory body. If possible, this effort will soon become a county collaborative effort between both Medi-Cal health plans. At this time, please take a look at the attached documents. If you could, I would like you to read, sign and fax or email back one or both of the attachments **(FAX to 916- 447-1579)**.

The first document requests your involvement in either a community public forum or a formal advisory body or both. The second requests you to sign a letter of support stating that you would be supportive of Anthem administering and coordinating dual eligible services. The letter provided is just a draft and you are encouraged to make any changes you need in order to make it fit your level of support.

If you have any questions at all with this documentation or would like to speak with either me or my area staff, please feel free to email or call. I am looking forward to meeting you as this process goes forward. Even if Santa Clara County is not selected this time, there is a good chance that it will be selected next time. Regardless of when the State actually starts the program in Santa Clara County, Anthem is starting today to build the network, programs and infrastructure needed to make these programs a success. It can only go to further supporting existing health services programs as well as those that come in the future. Thank you for your support.

Your Northern California Anthem contacts are the following:

Sean Atha, MHA
Director, Regional Field Operations
Anthem Blue Cross, State Sponsored Business
2015 J Street, Suite 100
Sacramento, CA 95811
Phone: (916)325-4214
BlackBerry: (916) 826-7548
Fax: (916) 447-1579

Norma Duran
Manager - Account Management
Phone: (916) 325-4211

Lesley Adair
Network Relations Consultant
Phone: (916)325-4205

Debbie Bos
Sr. Network Education Representative
Phone: (805) 713-3661

Robin Carroll
Sr. Network Relations Consultant
Phone: 805-713-3662

Lydia Serrian
Network Education Representative
Phone: (916) 325-4203

State Sponsored Business – Northern Region Field Office – 2015 J Street STE 100, Sacramento, CA 95811

PLEASE FAX BACK TO:
(916) 447-1579

OR

Email - Sean Atha
sean.atha@wellpoint.com

I am interested in helping Anthem Blue Cross and the greater County Medi-Cal Dual Demonstration project by **serving on an advisory board** that would meet quarterly throughout each year.

YES [X] Please place an X in one of the boxes. NO [ ]

I am interested in helping Anthem Blue Cross and the greater County Medi-Cal Dual Demonstration project by attending **community advisory meeting** to share concerns, ideas and best practices that could be taken into account while planning the overall care delivery model.

YES [X] Please place an X in one of the boxes. NO [ ]

PLEASE PROVIDE THE BELOW INFORMATION AND FAX OR EMAIL BACK BY FEBUARY 17TH, 2012

Name: Stephen W. Ho, M.D.

Title: Chief Medical Officer

Organization: Physicians Medical Group of San Jose / EXCEL MSO, LLC

Address: 75 East Santa Clara Street, #950, San Jose, CA 95113

Phone Number: (408) 937-3624

Email Address: Stephen.ho@excelmso.com

Anthem Blue Cross

State Sponsored Business – Northern Region Field Office – 2015 J Street STE 100, Sacramento, CA 95811

PLEASE FAX BACK TO:
(916) 447-1579

OR

Email - Sean Atha
sean.atha@wellpoint.com

I am interested in helping Anthem Blue Cross and the greater County Medi-Cal Dual Demonstration project by **serving on an advisory board** that would meet quarterly throughout each year.

YES [X] Please place an X in one of the boxes. NO [ ]

I am interested in helping Anthem Blue Cross and the greater County Medi-Cal Dual Demonstration project by attending **community advisory meeting** to share concerns, ideas and best practices that could be taken into account while planning the overall care delivery model.

YES [X] Please place an X in one of the boxes. NO [ ]

PLEASE PROVIDE THE BELOW INFORMATION AND FAX OR EMAIL BACK BY FEBUARY 17TH, 2012

Name: Maria Cruz
Title: Manager Provider Network
Organization: Cap Management / Premier Care N° California
Address: 1865 Alum Rock Ave #A San Jose CA 95116
Phone Number: 408 203.6971
Email Address: maria d. cruz @ teneth health. com

No RFI Submitted to the State for Santa Clara County

Dual Demonstration Workgroup
Feb 17, 2012

Name	Organization	Email
Greg Garrett	CEI	ggarrett@ceielders.org
Angelin Barrios	CEI	abarrios@cei.elders.org
GARY SNIDER	CEI	gsnider@cei.elders.org
Bob Edmondson	On Lok	REDMONDSON@ONLOK.ORG
Karyl Eckels	City of Oakland - MSSP	KEckels@oaklandnet.com
Karen Grumsich	City of Fremont	KGrumsich
Gary Spicer	Alameda County Behavioral Health	gspicer@acbhcs.org
Barbara Majak	Al Co. Behavioral Health	bmajak@acbhcs.org
MARIE BARRETT	AAH	
Rhonda Aubrey	CHEN	raubrey@chenelwork.org
Leila Y. Saadat	AAH	
MARTY LYNCH	LIFELONG MEDICAL CARE	MLynch@LifelongMedical.org
Ingrid		
Yomi Wrong	C.I.L.	ywrong@cilberkeley.org

Name	Organization	Email
Cristina Lopez-Pollard	Caremore - w/wellpoint	cristina.lopez-pollard@caremore.com
Sean Atha	Anthem Blue Cross	sean.atha@wellpoint.com
Allison Homewood	LifeLong	ahomewood@lifelongmedical.org
Michelle Rousey	Public Authority Advisory Board for IHSS in Alameda County	mlyn13@hotmail.com
Wendy Peterson	Senior Services Coalition	wendy@seniorservicescoalition.org
Eileen Kunz	On Lok	ekunz@onlok.org
LILY BORIS, MD	AAH	
Victoria Tolbert	Alameda Co. Social Services - IHSS	VTOLBERT@ACGOV.ORG
Anne Warner-Ruiz	Adult Day Services Network	anne@adsnae.org
Peter Szutu	Center for Elders Independence	pszutu@cei.elders.org
Ralph Silber	CHCN	RSILBER@CHCNETWORK.ORG

Anthem. BlueCross

Join us!

Dual Eligible Demonstration Project: Learn what it is and share your thoughts!

Anthem Blue Cross wants you to join us for a community forum

Speaker

Leadership from both Anthem Blue Cross and the Alameda Alliance will facilitate and receive thoughts and comments from community stakeholders.

When?

Day Friday
Date February 17th
Time Noon to 2PM

Where?

The Ed Roberts Campus (ERC)
3075 Adeline Street
Berkeley, California

Who should attend?

Stakeholders including dual eligible members, caregivers, community leaders, advocates, providers, and anyone else in the community with an interest in the project.

Why?

Learn more about the goals of the project, share your ideas and experience, and learn more about Anthem Blue Cross and the Alameda Alliance who is applying to become a health plan option.

What's in it for you?

An opportunity to better understand how this project effects you and to voice your opinions and thoughts on the project.

Additional information

Project Background:

In partnership with the Federal Medicare and Medicaid Coordination Office at Center for Medicare and Medicaid Services (CMS), California has a new opportunity to establish care coordination programs for Medicare/Medicaid enrollees that will coordinate services across the two programs to better align benefits, delivery, financing and administration. As envisioned by CMS, the "initiative is intended to alleviate fragmentation and improve coordination of services for Medicare/Medicaid enrollees, enhance quality of care and reduce costs for the State and the Federal government." The demonstration's focus is on creating a coordinated care delivery system that is tailored and responsive to beneficiaries' needs and overcomes the fragmentation and inefficiencies created by current categorical funding, service structures and regulatory requirements.

Make your reservation by:

Friday Morning - 2-17-2012

Call

916-325-4200

E-mail

sean.atha@wellpoint.com

Anthem Blue Cross is the trade name of Blue Cross of California and Anthem Blue Cross Partnership Plan is the trade name of Blue Cross of California Partnership Plan, Inc. Independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County.
27520CAPENABC 2/12

Attachment 6 – Mandatory 12D – Invitee List –Alameda County

1. Adult Day Services Network of Alameda County
2. Alameda County Behavioral Health Care Services Agency
3. Alameda County Social Services Agency
4. Alameda Health Care Services Agency
5. Asian Health Services
6. Center for Elders' Independence
7. Center for Independent Living
8. City of Fremont Human Services Department
9. City of Oakland – Department of Human Services Senior Services
10. Community Health Center Network
11. Disability Rights Education and Defense Fund
12. Lifelong Medical Center
13. On Lok
14. Satellite Housing
15. Senior Services Coalition

February 10, 2012

Micheal Pope, Executive Director, Alzheimer's Services
Wendy Peterson, Director, Senior Services Coalition Alameda
Yomi Wrong, Executive Director, Center for Independent Living
Marty Lynch, Ph.D, Executive Director/CEO, Lifelong Medical
Jane Garcia, Chief Executive Officer, Center for Independent Living
Donald Waters, Executive Director, Alameda - Contra Costa Medical Association
Frances D'Andrea, Executive Director, Health Insurance Counseling - Legal Assistance for Seniors
Anne Warner-Reitz, Executive Director, Adult Day Services Alameda County
Gilbert Ojeda, Director, California Program on Access to Care
Sheri Burns, Executive Director, CRIL
Maryann O'Sullivan, Executive Director, Effective Patient Care
Jamie Almanza, Executive Director, Bay Area Community Services
Jackie Krause, Senior Services Manager, City of Alameda
Kelly Wallace, Secretary, City of Berkeley Aging Services
Brendalynn Goodall, Manager, Human Services / Aging and Adult Services
Corrine Jan, Executive Director, Family Bridges, Inc.
Jim Burton, Regional Center of the East Bay

Sent via Electronic Mail

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better understand the unique services required to best serve dual eligible members. I represent Anthem's Medi-Cal related State Sponsored Business program and am

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Lesley Adair
Network Relations Consultant
Phone: (916)325-4205

Debbie Bos
Sr. Network Education Representative
Phone: (805) 713-3661

Robin Carroll
Sr. Network Relations Consultant
Phone: 805-713-3662

Lydia Serrian
Network Education Representative
Phone: (916) 325-4203

Organization	**Disability Rights California**
Leader Name	Daniel Brzovic
Title	Associate Managing Attorney
E-Mail	www.disabilityrightsca.org
Phone Number	(510) 267-1200
Address	1330 Broadway, Ste 500
City	Oakland
Zip	94612
Comments and Concerns	1. There is no need to include In-Home Supportive Services (IHSS) an integrated model. If integrated, the determination of need for services and the administrative structure for delivery should remain with the county welfare departments. This is to insure provision of services remain in control of IHSS recipients. 2. Mental Health services should be provided through mental health plans (MHPs) to insure individuals receive full scope of services the are entitled to under the Medi-Cal program, and existing relationships are not disrupted.
Called Organizations	This organization was contacted on Friday, February 17th, 2012 and asked to discuss their RFI comments. The conversation was held with staff in the Berkeley Ed Roberts Campus office.
Meeting / Date	Attended Stakeholder Meeting held on August 30, 2011
Presentation	PowerPoint Presentation Titled: Improving Care through Integrated Medicare and Medi-Cal Delivery Models: Comments on existing problems: 1. Specialty MH services: ensure sufficient numbers of outpatient Medicare providers 2. Long-term care: a. Eliminate institutional placement incentives b. Enable flexibility to providers for such services as home modification, money for moving into the community, and adult day health care

Organization	**Disability Rights Education and Defense Fund (DREDF)**
Leader Name	Silvia Yee
Title	Staff Attorney
E-Mail	www.dredf.org
Phone Number	(510) 644-2555
Address	3075 Adeline Street, Ste 210
City	Berkeley
Zip	94703
Comments and Concerns	Guiding Principles: 1. Choice which begins with "opt in" enrollment model to choose providers, participate in coordination of services, who will be part of team, right to self-direct, what services to receive and where to receive them. 2. Beneficiary-centered including feedback from dual eligibles, provide maximum benefit to beneficiary, strategies place beneficiary at the center, monitoring and eval measures start with impact on the beneficiary. 3. Best of both worlds

4. Increasing access to HCBS
5. Consumer Protections
6. Phased approach
7. Reinvestment of savings
8. Monitoring, Accountability and Data Collection
9. Which requirements should DHCS hold contractors to for this population? What standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc. prior to enrolling beneficiaries?

Follow Up with Organization: This organization was contacted on Friday, February 17th, 2012 and asked to discuss their RFI comments. The conversation was held with staff in the Berkeley Ed Roberts

Meeting / Date: Attended Stakeholder Meeting held on August 30, 2011

Presentation: PowerPoint Presentation Titled: Improving Care through Integrated Medicare and Medi-Cal Delivery Models – no documented comments

Organization: **National Senior Citizens Law Center**
Leader Name: Kevin Prindeville, Georgia Burke, Anna Rich
Title: Unknown
E-Mail: nsclc@nsclc.org
Phone Number: (510) 663-1055
Address: 1330 Broadway, Ste 525
City: Oakland
Zip: 94612
Comments and Concerns: Guiding Principles:

1. Choice which begins with "opt in" enrollment model to choose providers, participate in coordination of services, who will be part of team, right to self-direct, what services to receive and where to receive them.
2. Beneficiary-centered including feedback from dual eligibles, provide maximum benefit to beneficiary, strategies place beneficiary at the center, monitoring and evaluation measures start with impact on the beneficiary.
3. Best of both worlds - should receive care at least as good as the care they would receive if they were not integrated
4. Increasing access to HCBS - increasing access to home and community services
5. Consumer Protections appeals and complaint processes, network adequacy, cultural and linguistic competence, physician and programmic disability access, transition rights, meaningful notice and information about plan benefits and changes, etc.
6. Phased approach should be thought out carefully
7. Reinvestment of savings Medicare dollars must not be used to replace Medi-Cal dollars but should be used to availability and quality. What is the best enrollment model for this program? A voluntary, opt-in enrollment: autonomy and independence, right of choice of provider, retain access to non-par providers, quality checks on pilot providers, enrollees are willing participants, does not require waivers of federal laws or regulations. Want to ensure enrollment rights mirror Medicare

	with the right to enroll and disenroll from plans at any time of year. Have access to full range of LTSS including home health, IHSS, MSSP, ADHC, etc. Some of these should remain non-integrated MSSP, IHSS, Mental Health. Integration pilot should look to the less restrictive criteria for provide service. Coverage standards must be based on an individual determination of medical necessity.
Follow Up with Organization	This organization was contacted on Friday, February 17th, 2012 and asked to discuss their RFI comments. The conversation was held with a staff person in the Oakland office.
Meeting / Date	Attended Stakeholder Meeting held on August 30, 2011
Presentation	PowerPoint Presentation Titled: Improving Care through Integrated Medicare and Medi-Cal Delivery Models – no documented comments

Anthem

The Applicant has conducted a program of stakeholder involvement (with the Applicant providing a narrative of all activities designed to obtain community input.)

Anthem has conducted a comprehensive program of stakeholder involvement for our Duals Demonstration program. Our program began about a year ago with one-on-one meetings with SPD advocates trying to understand the complex needs of this population. Table 12e.1 lists some meetings that have been held in the past year. Over the past year, we have learned a tremendous amount about the SPD populations and have tailored our Medi-Cal programs to meet their special needs. These meetings with SPD advocates provided a starting point for our outreach objectives for this Duals Demonstration program.

Table 12e.1 – Pre-Application Vulnerable Populations Outreach

Date	Organization	Representative	Title	Topic	Details
February-2012	San Francisco Department of Public Health	Tangerine Brigham	Deputy Director of Health	LTCI	Strategic planning team
February-2012	Department of Aging San Francisco	Bill Haskell	Facilitator	LTCI	Long Term Care Integration Committee
December-2011	RTZ Associates	Rick Zawadski	President	ADHC/CBAS	Community support services
December-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
October-2011	Department of Aging San Francisco	Linda Edelstein	Long Term Care Operations Director	ADHC AD	HC funding
October-2011	Department of Aging San Francisco	Anne Hinton	Executive Director	LTCI	Long Term Care Integration strategic planning
September-2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting

Anthem

Date	Organization	Representative	Title	Topic	Details
September 2011	Molina Health Care	Steven Soto	Regional Director	ADHC	Joint education/outreach meeting
September 2011	San Francisco Adult Day Services	LaNay Eastman	Executive Director	ADHC	ADHC contact coordination
August 2011	Adult Day Services Network of Alameda County	Anne Warner-Reitz	Executive Director	ADHC	ADHC planning partnerships
August 2011	SteppingaStone M	oli Steinert	Executive Director	ADHC	Dual Eligible ADHC
August 2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
August-2011	SteppingStone M	oli Steinert	Executive Director	ADHC	Providing care management services
August 2011	San Francisco Community Clinic Consortium	John Gressman	President, CEO	ADHC	ADHC strategy session
August 2011	California Association for Adult Day Services	Lydia Missaelides	Executive Director	ADHC	High risk member care management
May 2011	Senior Services Coalition of Alameda County	Wendy Peterson	Director	SPD	SPD community meeting
April 2011	SteppingStone M	oli Steinert	Executive Director	ADHC	Patient provider list
April 2011	SteppingStone M	oli Steinert	Executive Director	ADHC AD	HC topics
April 2011	Alzheimer's Services of East Bay	Micheal Pope	Executive Director	ADHC	Alameda County ADHC providers
March 2011	Adult Day Services Network of Alameda County	Anne Warner-Reitz	Executive Director	ADHC	Managed Care and ADHC partnerships
July 2010	Madison MI, SPD strategic planning meeting with National Consulting team	Virginia Graves	Principal	ABD / SPD Planning	How to prepare for the SPD / ABD new enrollment.

As soon as the Duals Demonstration RFS was published, Anthem began the plans for holding public forums in the two counties in which we are bidding. We reached out to our non-profit Medi-Cal county partners in these two counties, the Santa Clara Family Health Plan and the Alameda Alliance for Health, and found both plans very receptive and cooperative in efforts

to have the two counties chosen for the Duals Demonstration program. We participated in public forums in Alameda on February 17, 2012, and in Santa Clara on February 21, 2012. Additionally, we participated in nearby public forums in Contra Costa on February 15, 2012, and in Sacramento on February 23, 2012. The purpose of these forums was to present the Duals Demonstration program, offer our thoughts on innovative care models, and most importantly, to gather community thoughts on designing the best possible program for the dual-eligible population. These forums were well attended and the ideas we heard at these forums influenced our program, especially concerning behavioral health. Seamless integration of medical, pharmacological, and behavioral health needs is on the minds of dual-eligible advocates. A number of attendees were interested in attending the future advisory committee meetings we plan to hold throughout the three year Duals Demonstration program.

Also during the application process, Anthem began reaching out to leaders in the dual-eligible community in Santa Clara and in Alameda to identify leaders who would like to either serve on an advisory board or attend our advisory meetings. Tables 12e.2 and 12e.3 identify the leaders that we reached out to in Santa Clara and Alameda. We have already begun receiving letters of support from these individuals/organizations.

Table 12e.2 – Santa Clara County Leadership Outreach

Name	Title	Organization
Alejandra Herra Chavez	Policy Develop Specialist	City of San Jose Housing
Amy Andonian	Program Director	Caregiver Support Services - Catholic Charities
Bob Campbell	Executive Director	Senior Housing Solutions - Milpitas
Cathy Lynch	Community Relations Coordinator	Pathways Health
Connie Langford	Chair Person	City of San Jose Senior Citizens Commission
Dawn Ngo	Geriatric Care Manager	City of Santa Clara - Council on Aging
Glenda Cresap	Executive Director	Heart of the Valley - Services for Seniors
Karen Storey	Executive Director	The Wellness Community - Silicon Valley

Anthem

Name	Title	Organization
Kathy Whitcomb	Senior Services Rep	Campbell Adult Center
Laura Beeson	Director - Health Senior Services	Mexican American Senior Services
Lee Pullen	Director	Department of Aging and Adult Services
Lisa Hendrickson	Executive Director	Avenida
Lori Andersen	Director Healthy Aging	The Health Trust
Marita Grudzen	Deputy Director	Stanford Geriatric Education Center
Mindy Berkowitz	Executive Director	Jewish Family Services of Silicon Valley
Reymundo Espinoza	CEO	Gardner Family Health
Sarah Triano	Executive Director	Silicon Valley Independent Living Center
Stephen Schmolll	CEO	Council on Aging Silicon Valley
William C. Parrish Jr.	CEO	Santa Clara County Medical Society

Table 12e.3 – Alameda County Leadership Outreach

Name	Title	Organization
Micheal Pope	Executive Director Alzheim	er's Services
Wendy Peterson	Director	Senior Services Coalition Alameda
Yomi Wrong	Executive Director	Center for Independent Living
Marty Lynch, Ph.D	Executive Director/CEO Lifelong	Medical
Jane Garcia	Chief Executive Officer	Center for Independent Living
Donald Waters	Executive Director	Alameda - Contra Costa Medical Association
Frances D'Andrea	Executive Director	Health Insurance Counseling - Legal Assistance for Seniors
Anne Warner-Reitz	Executive Director	Adult Day Services Alameda County
Gilbert Ojeda	Director	California Program on Access to Care
Sheri Burns	Executive Director	CRIL
Maryann O'Sullivan	Executive Director	Effective Patient Care
Jamie Almanza	Executive Director	Bay Area Community Services
Jackie Krause	Senior Services Manager	City of Alameda
Kelly Wallace	Secretary	City of Berkeley Aging Services
Brendalynn Goodall	Manager	Human Services / Aging and Adult Services
Corrine Jan	Executive Director	Family Bridges, Inc.
Jim Burton	Director	Regional Center of the East Bay

Additionally, during the application process, our outreach team carefully reviewed the DHCS Duals Demonstration RFI from last year and the many comments (positive and negative) that were received during the comment process. The team gathered a document detailing the organization commenting, contact information, and what their concerns were. We then

proactively reached out to these specific organizations to introduce ourselves and to open a conversation about their concerns with the program. Although this outreach program started during the application process, we will continue the process until we can contact as many organizations as we can. So far, the organizations are reiterating their concerns about the program, but seem glad to be able voice their issues to us, and we are listening to their concerns.

Additionally, the Community Advisory Committees (CACs) at Anthem play an important role in shaping our program and policy decisions. Anthem currently operates ten CACs in California including Alameda and Santa Clara as well as Tulare, Fresno, Madera, Kings, Stanislaus, San Joaquin, San Francisco, and Contra Costa counties. Sacramento participates on the Geographic Managed Care CAC in partnership with other area health plans. These CACs provide a critical link between the health plan, members, and community based organizations. They are chaired by a local Community Resource Coordinator (CRCs).

We also actively seek ways to remove barriers our members may face in participating in the CAC. For example, CAC meetings are conveniently scheduled over the lunch hour and a meal is served. We select central locations for the meeting to make it easy for all members to attend. Meetings are held in our local Community Resource Center or accessible community based organization or restaurant. To remove barriers to participation, we, wherever feasible, offer childcare assistance, transportation assistance, interpreter and sign language services, and other accommodations.

Our local CRCs work closely with our community partners and local advocacy organizations to help identify potential participants, including among the members we serve.

Local chapters of organizations like the American Heart Association, Alzheimer's Association and the American Diabetes Association are included in our outreach efforts in an attempt to recruit members with chronic conditions. Our local CRCs call or visit these organizations to explain the role of the CAC and to determine if there may be organization members enrolled in our health plan who might be interested in membership on the CAC.

For example, during the past four years, our Community Resource Coordinators have had the opportunity to work closely with one of our SPD members. They helped her to obtain a bed and clothing and coordinated the in-county (bus tokens) and out of county (Amtrak and Greyhound) transportation necessary to get her to her many medical appointments. Our Care Management Program nurses and social workers closely monitor her care, help her access in-county and out-of-county providers and specialists, and make sure her medications and other medical needs are taken care of. Last year the member joined our CAC as a committee member and, until recently, has been representing the SPD population on the committee. Sadly, she was recently diagnosed with a terminal illness and due to rapidly declining health can no longer attend our meetings.

Anthem believes very strongly in our commitment to continuously engage stakeholders and in so doing, we have a strong track record of implementing effective programs for the most vulnerable populations in California counties.

National Committee for Quality Assurance

has awarded

Anthem Blue Cross of California Partnership Plan

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

August 29, 2011	*May 05, 2013*
DATE GRANTED	EXPIRATION DATE

From: HPMS Web
To: Cindy Lynch; Leeba Lessin
Cc: Cindy Lynch; SNP Applications; HPMS Helpdesk
Subject: H0544 - SNP Conditional Approval - Dual-Eligible - All Duals
Date: Friday, May 27, 2011 11:53:21 AM

May 27, 2011

Leeba Lessin
Chief Executive Officer
CAREMORE HEALTH PLAN
12900 Park Plaza Drive
Suite 150
Cerritos, CA 90703

Re: Conditional Approval of SNP Application
H0544 - CAREMORE HEALTH PLAN - Dual-Eligible - All Duals

Dear Leeba Lessin:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has conditionally approved your organization's application to offer/expand a Special Needs Plans for 2012 Application and SNP Service Area Expansions posted in January 2011. This conditional approval includes any employer/union-only group waiver plan proposals (i.e., "800-series" plan benefit packages) submitted by your organization under the same application number.

The following are the overall scores you received for your Quality Improvement Program Plan and Model of Care evaluation:

Your Quality Improvement Program Plan passed.

Final Score

Element	Factor	Score
1	a	4
2	a	4
2	b	4
2	c	3
3	a	4
3	b	3
3	c	4
4	a	4
4	b	3
4	c	3
5	a	4
5	b	4
5	c	4
5	d	4
5	e	4
6	a	4
6	b	4
6	c	3
6	d	3
7	a	4
7	b	4
7	c	4
7	d	4
8	a	4

8	b	4
8	c	4
8	d	4
8	e	4
9	a	4
9	b	4
9	c	4
9	d	3
10	a	4
10	b	4
11	a	4
11	b	3
11	c	3
11	d	4
11	e	3
11	f	4

Element Summary

Element 1	4
Element 2	11
Element 3	11
Element 4	10
Element 5	20
Element 6	14
Element 7	16
Element 8	20
Element 9	15
Element 10	8
Element 11	21
Total Points	150
Total Possible Points	160
Score	93.75%

In order to contract with CMS as a SNP sponsor, your bid, including your formulary, must also be approved as required by 42 CFR 423 Subpart F. Additionally, your organization must complete all other pre-implementation activities including system and data testing with CMS before we will enter into a contract with your organization. You are also required to submit and receive CMS approval of your MIPPA compliant State Medicaid Agency Contract (if required) and marketing materials before you will be permitted to market or offer enrollment in your plan(s) to Medicare and Medicaid beneficiaries. CMS expects to send SNP contracts to applicants receiving final approval and notices of intent to deny/denial letters (should any be necessary) in late summer 2011.

The approval of your SNP proposal is based on the information contained in your application and accompanying documentation to date. If there are any changes to the information you have supplied during the application process, or we determine that any of the information upon which we based the approval is inaccurate, this approval may be withdrawn and a letter of intent to deny and/or denial notice may be issued. Accordingly, if there are any changes to your application or the accompanying documentation you must notify CMS so that your application can be reevaluated to determine whether the change(s) affects your approval.

Please note that a SNP can only be offered in an MA-approved service area. If you have applied for a new MA-approved service area, approval of your new SNP or SNP SAE is contingent upon approval of the new MA service area. If your MA service area has not been approved due to unresolved deficiencies, your new SNP or SNP SAE application cannot be approved.

Thank you for your interest in participating the SNP program and we look forward to working with you to fulfill our mission of providing Medicare and Medicaid beneficiaries with access to affordable specialized services and benefits. Please contact your Regional Office Account Manager if you have questions concerning your SNP proposal application.

Sincerely,

Danielle R. Moon, J.D., M.P.A.
Director
Medicare Drug & Health Plan Contract Administration Group

Supplemental Benefits

We plan to offer additional benefits including non-emergency transportation, vision care, dental care, substance use services beyond those available today in most Medicare Advantage (Part C) plans. In addition, we also could offer the "value added" services listed and described below. Once rates are developed, we will define our list of supplemental benefits. Benefit descriptions including cost sharing is for illustrative purposes only.

Services

Clinical Programs:

- Heart Program
- ESRD Program
- Breathe Program
- Diabetes Program
- Consultation with Exercise Coach
- Fall Prevention Program
- Healthy Journey
- Healthy Start
- HTN - Hypertension Program
- Enhanced Nutritional Training
- HelpLine (24-Hour NurseLine)
- OTC
- Health Alert
- House Call program

Other Benefits

- Exercise and Strength
- CSNP Exercise Programs
- Nutritional Consult
- Wound Care Program
- Additional Smoking Cessation
- Support Groups

Transportation

- Designated Number of Trips
- Limited Clinical Benefit
- Unlimited CCC and Dialysis
- Unlimited CCC
- Unlimited CCC, Dialysis - LA ESRD

Other Programs Offered

- Fall Prevention Program
- Wound Care Program
- Incontinence Care Program
- Comprehensive Health Assessment

Program Descriptions

Heart Program

The Heart program empowers members with extensive cardiac care to support a lifestyle that focuses on eating a healthy diet, and increasing physical activity. All members receive a comprehensive medical assessment to determine which type of cardiac care is appropriate for their cardiac special needs. Members have access to our clinical care team, including a Nurse Practitioner, Physician, Registered Dietician, and Exercise Coach.

Program services include:
- Healthy Start: Comprehensive assessment
- Personalized care plan
- Medication management
- Manage uncontrolled blood pressure levels
- Wireless Health Monitoring
- Coumadin Clinic
- Enhanced nutritional training
- Exercise and Strength Training and Prescribed Fitness TM
- Nurse HelpLine is available 24 hours a day
- Education classes
- Stop Smoking Program
- Educational pamphlets and handouts

Diabetes Program

The Diabetes Care program offers personalized diabetes care designed to help a member manage their diabetes. Members learn to live well—on friendly terms with diabetes. They receive individualized attention and a personalized care plan created by an expert team including a Nurse Practitioner, Physician, Registered Dietician, and Exercise Coach. Our goal is to teach the member necessary self-management techniques to allow them to live successfully with diabetes.

Program services include:
- Healthy Start: Comprehensive assessment
- Personalized care plan
- Nurse Practitioners provide individual assistance to lower uncontrolled blood sugar levels
- Self-management skills
- Importance of preventive exams
- Medication management
- Wound care management and supplies
- Foot care including toenail trimming
- Exercise and Strength Training and Prescribed Fitness TM
- Educational classes

- Enhanced nutritional training customized to individual dietary preference
- Nurse HelpLine 24 hours a day
- Stop Smoking Program
- Diabetes educational pamphlets and handouts
- Wireless Health Monitoring

ESRD Program

The End-Stage Renal Disease (ESRD) Care Program provides an individualized member evaluation and risk assessment to support the complex and specialized needs of End-Stage Renal Disease. A Nephrologist manages dialysis care by providing additional services to maintain a member's health, as well as focusing on complicating conditions and special care needs. The main goal of the program is to help members reach the highest level of wellness and quality of life by providing them access to all services in a single visit.

Program services include:

- Healthy Start: Comprehensive End-Stage Renal Disease (ESRD) medical assessment
- Personalized care plan
- Nurse Practitioners who are specially trained in ESRD care will provide individual assistance to closely manage chronic conditions and overall health
- Wound care management and supplies
- On-going evaluation of dialysis treatments
- Self-management skills
- Medication management
- Enhanced nutritional training customized to individual dietary preference
- Nurse HelpLine 24-hours a day
- Individualized education classes
- Educational pamphlets and handouts
- Exercise and Strength Training and Prescribed Fitness TM
- Wireless Health Monitoring

Breathe Program

The Pulmonary Care program provides support for members living with the following chronic lung disorders - asthma, chronic bronchitis, emphysema, pulmonary fibrosis and pulmonary hypertension (COPD). The Pulmonary Care program actively assists members in managing their respiratory condition effectively.

Each member will be provided with individually-focused attention with a clinical team: Physician, Nurse Practitioner, and Case Manager. Care is coordinated in relation to the member's personalized plan of pulmonary care. The team helps members understand their pulmonary condition and its implications, and how to live well and "breathe easy" through self-management skills.

Program services include:
- Healthy Start: Comprehensive assessment
- Specialized breathing test to determine the lung capacity
- Self-management skills training to lessen the impact of pulmonary disease
- Medication management
- Personalized care plan
- Enhanced nutritional training customized to individual dietary preference
- Prescription for easy filling of relief medication in case of unexpected symptoms
- Pulmonary exercises focused on strength and endurance
- Nurse HelpLine 24-hours a day
- Health Alert
- Education classes
- Stop Smoking Program
- Educational pamphlets and handouts
- Exercise and Strength Training and Prescribed Fitness TM
- Wireless Health Monitoring

Fall Prevention Program

If a member has a history of falls or is at risk for falls, the team arranges for and covers participation in the Fall Prevention Program.

The Fall Assessment includes:
- Physical exam
- Medication review
- Physical mobility and balance assessment
- Vision and hearing acuity check
- Bone density measurement
- Safety evaluation
- Exercise and Strength Training

Wound Care Program

Members receive focused wound care by a Wound Certified Nurse Practitioner. Some wounds may be slow to heal and can be related to circulatory problems, diabetes, nutrition or other conditions. The Nurse Practitioner addresses each of these specific conditions that may slow healing. In addition to regular wound care, members are provided with wound care supplies to take home.

Wound Care assessment includes:
- Foot Care
- Self Management
- Education classes
- Future Wound prevention

House Call Program

For members that are homebound or have limited mobility, they are eligible to receive a house call from a medical professional. Members are provided with one or more of the following house call services if medically necessary:

- Initial assessment with comprehensive medical history and physician exam
- Assessment of physical mobility
- Post-hospitalization and wound care assessment
- Safety evaluation
- Medication evaluation and education
- Assessment of nutrition
- Assessment of skilled nursing needs
- Assessment of immediate care needs

Consultation with Exercise Coach

A one-on-one consultation with an exercise coach is designed to provide a comprehensive fitness and balance assessment. Members are covered for one consultation with a plan approved exercise coach each year and at a plan approved designated location. The personal consultation and assessment session helps members to begin an exercise plan to increase muscle mass. Muscle mass loss can result in poor balance, falls, and fractures. The exercise coach explains how resistance training is a therapeutic approach to improving muscle mass and strength.

Nutritional Consultation

Proper nutrition is one of the primary keys to good health. Members receive nutritional counseling through group education and/or with a registered dietitian as provided by the plan. Adequate nutrition helps slow down the progression of degenerative disease and aging by increasing the intake of healthy nutrients. The consultation is designed to help members make better nutritional choice, provide guidance for nutritional needs related to specific health concerns, such as diabetes, weight loss, or high blood pressure. Members are covered for one consultation each year.

Education includes the following:

- Evaluation of eating habits
- Understand member's concerns and goals
- Personalized meal planning
- Review and educate on body characteristics and measurements
- Counseling on lifestyle and behaviors
- Teach self-management techniques on how to manage nutritional health

Exercise and Strength Training

This program is a medically supervised exercise training program to improve and increase muscle strength, balance, mobility, flexibility, and overall fitness. Members are supervised by Physical Therapists or fitness coaches specially trained in kinesiology, who develop a personalized plan for each member. The goal of the program is to help members achieve maximum functional potential.

CSNP Exercise Programs

We offer two exercise programs to members of our CSNP plans. Together, exercise and strength training is a medically supervised exercise training program to improve and increase muscle strength, balance, mobility, flexibility, and overall fitness. Members are supervised by Physical Therapists or fitness coaches specially trained in kinesiology who develop a personalized plan for each member. The goal of the program is to help members achieve maximum functional potential.

Prescribed Fitness TM – a disease specific exercise program designed to meet the special exercise needs of members who have functional limitations associated with chronic disease, such as COPD, CHF, and ESRD. Members are supervised by Physical Therapists or fitness coaches specially trained in kinesiology, who develop a personalized plan for each member. Members are referred by a Physician, CM staff, or other HealthCare Professional.

Healthy Start/Healthy Journey

Members receive a personalized comprehensive assessment. During this visit, we identify how to best serve members' health care needs. The goal of the Clinical Team is to build a healthy relationship with members by offering benefits and unique health programs. The Clinical Team makes specific recommendations tailored to members' personalized care plan. Members receive this care plan, which includes a summary of their health, medical and social needs, along with preventive and proactive recommendations for follow-up care focusing on overall wellbeing. This information is shared with the Primary Care Physician.

Program services include:

- Head-to-toe comprehensive assessment of medical and psychosocial needs
- Evaluation of medications
- On-site lab results
- An extensive assessment of chronic conditions specific to member needs
- Referral for preventive services and any other necessary services
- Enrollment in clinical programs to better manage chronic condition(s)
- As a takeaway, an individual annual care plan for the member and PCP

Healthy Start program

Our members receive a personalized comprehensive assessment. During this visit, we identify how our Clinical Team can best serve members' health care needs. The Clinical Team makes specific recommendations specifically tailored and provided in a personalized care plan. Members are given the care plan, which offers a summary of their health, medical and social needs, along with preventive and proactive recommendations for follow-up care that focuses on overall wellbeing. This information is shared with the Primary Care Physician.

Program services include:
Head-to-toe comprehensive assessment of medical and psychosocial needs
Evaluation of medications
On-site lab results
An extensive assessment of chronic conditions specific to members' needs
Referral for preventive services and any other necessary services
Enrollment in clinical programs to better manage chronic condition(s)
As a takeaway, members receive an individual annual care plan for them and their Primary Care Provider

Chronic Hypertension Program

The Hypertension Care program empowers and supports members in managing blood pressure. Untreated high blood pressure and hypertension can lead to life-threatening complications such as stroke and heart conditions. All members receive a comprehensive medical assessment to determine the specialized high blood pressure care they need. They have access to a care team consisting of a Nurse Practitioner, Physician, Registered Dietician, and Exercise Coach. For high blood pressure levels, the care team may recommend a home-based wireless blood pressure monitor, which transmits blood pressure readings to our Clinical Team. These services as well as educational classes and periodic wellness checkups are all located in one convenient location in our Care Centers.

Program services include:
- Healthy Start
- Personalized care plan
- Medication management
- Wireless Health Monitoring
- Enhanced nutritional training customized to individual dietary preference
- Exercise and Strength Training
- Education classes
- Stop Smoking Program
- Educational pamphlets and handouts

Additional Smoking Cessation

Stop Smoking program

This program addresses members who are trying to quit smoking or stop using tobacco. Care is provided by a Nurse Practitioner who is licensed and has training from the American Lung Association. The smoking and tobacco cessation program provides members with support and encouragement while teaching the most effective ways to stop smoking and/or using tobacco. The Nurse Practitioner provides members with practical approaches and behavior shaping techniques to prepare them to quit, understanding ways of quitting, knowing what to expect on the day they quit, and quitting tools to minimize withdrawal symptoms and the health benefits and advantages of stopping smoking. Medication treatment and management may be part of their personalized treatment plan if medically necessary.

Program services include:

- Initial assessment with comprehensive medical history and physical exam
- Personalized care plan
- Medication management
- Telephonic monitoring
- Member education classes
- Education pamphlets and handouts

If medically necessary, certain medications may be recommended and prescribed to members to aid in the treatment of their care plan.

HelpLine

Members receive assistance to plan-contracted and designated Nurse Practitioners through a toll-free number, 24-hours a day. These Nurse Practitioners are trained to answer questions and offer prompt confidential information regarding their care.

Support Groups

Participation in Support Group meetings provide members with a forum for ongoing support and motivation to enhance member health and independence. These Support Groups offer a supportive atmosphere where participants share experiences and challenges, problem solve, and develop coping strategies. Also includes continuation education on self-management techniques and shared community resources.

Health Alert

This is a program aimed at members who suffer from allergies and respiratory problems. The purpose of Health Alert is to provide telephonic communication on general information, tips, reminders, alerts, and updates for members who have chronic breathing problems. Even simple day-to-day tasks can trigger breathing flare-ups and worsen symptoms, so we connect members with their very own Health Alert Screener that provides the following:

- Safety and wellness alert call communication
- Reminders and prevention tips
- Sends updates to the health care provider on member's current status
- Emergency preparation

Transportation - Designated Trip Number

Transportation services are provided by contracted and designated transportation service carriers. Other modes of transportation may be used other than vans and taxicabs if plan approved. Transportation services are provided to plan approved medical appointments, however, extended hours are available for dialysis treatment.

Members inform transportation carriers about their ability to walk from their residence and get into the transportation vehicle unassisted; their ability to visually see the transportation vehicle from their residence; if they use a cane or walker and/or have any limiting medical condition that may restrict their ability to use standard means of transportation, such as buses, vans, taxicabs, or from riding with others. Covered transportation services are for non-emergency and routine medical care visits for ambulatory members or those members with standard-sized wheelchairs, who do not have any limiting medical condition that would restrict them from normal means of public transportation. Limiting medical conditions includes requiring oversized wheelchairs, continuous infusion requirements, and reclining positions.

Transportation - Limited Clinical Benefit

Transportation services are limited for trips to Care Centers for scheduled annual health assessments, pre-operative exams, post-hospitalization follow-up, wound clinic, COPD and CHF programs services. The same conditions apply as stated above.

Transportation - Unlimited CCC/Dialysis

Members are provided with unlimited trips to dialysis and a Care Center. The same conditions apply as stated above.

Unlimited CCC, Dialysis - LA ESRD

Transportation services are limited for trips to a Care Center for scheduled appointments, dialysis treatment, and ESRD Program services. All transportation is must be authorized and coordinated through our plan. Other modes of transportation may be used other vans or taxis if plan approved.

Over the Counter Items

Members are given a monthly coverage limit for a plan approved list of over-the-counter items, including fiber supplements, anti-arthritics, minerals, certain vitamins, antacids, pain relievers, antibiotic ointments, denture creams, eye allergy drops, antihistamines, saline nasal sprays, antifungal cream and cough medicine.

Incontinence Care Program (Los Angeles and Orange Counties only)

The Incontinence Care Program provides members with a supplement of adult absorbent products and individualized incontinence education. A Nurse Practitioner performs an incontinence assessment upon enrollment, on an annual basis. This assessment assists the Nurse Practitioner in defining the member's type of incontinence and in developing an incontinence care plan. Incontinence supplies are provided to members.

Comprehensive Health Assessment

Upon enrollment, all members receive an on-site comprehensive medical assessment from a Clinician. During this personal visit, the Clinician identifies to best serve a member's health care needs. The Clinician in coordination with the Primary Care Provider makes specific recommendations tailored to each member in a personalized care plan. The care plan offers a summary of a member's health, medical, and social needs along with preventive and proactive recommendations for follow-up care that will focus on overall well-being.

Program services include:

- Comprehensive medical assessment
- Evaluation of medications
- Disease Management
- Clinical program management for chronic conditions
- Personal care plan

Enhanced Nutritional Training

Members receive enhanced nutritional training designed to instruct them how to manage their conditions and prevent complications. For health-related condition(s), our team provides training designed to address dietary and nutrient imbalances contributing to any current health problems, including reduced tolerance to stress, low energy, poor immunity, and insomnia. Food and nutrition are integral to health. The training is designed to help slow down the progress of chronic degenerative disease, chronic health conditions and aging by increasing intake of healthy nutrients and empowering members to take control of their health.

For members with diabetes, all instruction is based on the standard of the American Diabetes Association and includes:

- Basic information for controlling blood sugar levels
- Nutrition information – carbohydrates, fat proteins and eating plans
- Exercise, blood sugar control, medication and insulin management
- Cholesterol control
- Restaurant meals
- Effects of alcohol and blood sugar levels
- Importance of calcium

DRAFT

DRAFT MEMORANDUM OF UNDERSTANDING

SANTA CLARA COUNTY DEPARTMENT OF AGING AND ADULT SERVICES

and

ANTHEM BLUE CROSS PARTNERSHIP PLAN

CALIFORNIA DUALS DEMONSTRATION

This MEMORANDUM OF UNDERSTANDING (MOU) is made and entered into as of this day February XX, 2012, by and between the Santa Clara County Department of Aging and Adult Services (hereinafter referred to as County Department of Aging and Adult Services), and Anthem Blue Cross Partnership Plan (hereinafter referred to as Plan), in order to implement certain provisions of the California Duals Demonstration program (hereinafter referred to as the Demonstration). The term of this MOU shall commence as of January 1, 2013, and extend through December 31, 2013. The MOU may be terminated by either party by giving at least 10 days written notice to the other party.

The purpose of this MOU is to describe the responsibilities of the County Department of Aging and Adult Services and the Plan in the delivery of IHSS benefits to Medi-Cal members served by both parties. It is the intention of both parties to coordinate care to ensure there is no disruption in IHSS benefits for members. All references in the MOU to "Members" are limited to the Plan's Santa Clara County Medi-Cal Members enrolled in the Demonstration.

The County Department of Aging and Adult Services and the Plan agree to perform their respective services under their respective agreements with the State of California, as specified in the attached Table A, to the extent not inconsistent with law, regulation, or the parties' respective agreement with the State of California. Nothing contained herein shall add to or delete from the services required by each party under its agreement with the State of California.

Signature_____ Date_____

Name County official

Position

Signature_____ Date_____

Name Anthem Blue Cross Representative

Position

DRAFT

MEMORANDUM OF UNDERSTANDING

SANTA CLARA COUNTY DEPARTMENT OF AGING AND ADULT SERVICES

and

ANTHEM BLUE CROSS PARTNERSHIP PLAN

CALIFORNIA DUALS DEMONSTRATION

Table A

	County Department of Aging and Adult Services	Anthem Blue Cross Partnership Plan
A	IHSS consumers enrolled in the Demonstration retain their ability to select, hire, fire, schedule and supervise their IHSS home care worker, participate in the development of their care plan, and select who else participates in their care planning.	Plan will work with County Department of Aging and Adult Services and IHSS Public Authority to ensure no disruption in IHSS benefits for members enrolled in the Demonstration.
B	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.	Plan will coordinate with County Department of Aging and Adult Services to receive assessment and authorization data for each member authorized for IHSS; will include county IHSS social workers and IHSS home care workers in members' Plan interdisciplinary care team (ICT); and will share relevant member information with the County
C	Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS home care workers.	Plan will work with County Department of Aging and Adult Services and IHSS Public Authority to ensure no disruption in IHSS benefits for members enrolled in the Demonstration.
D	County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.	Plan will work with County Department of Aging and Adult Services and IHSS Public Authority to ensure no disruption in IHSS benefits for members enrolled in the Demonstration.
E	IHSS providers will continue to be paid through State Controller's Case Management, Information and Payrolling System (CMIPS) program.	Plan will work with County Department of Aging and Adult Services and IHSS Public Authority to ensure no disruption in IHSS benefits for members enrolled in the Demonstration.

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	County Department of Aging and Adult Services	Anthem Blue Cross Partnership Plan
F	The County Department of Aging and Adult Services in collaboration with the IHSS Public Authority will develop a process with the Plan 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.	Plan will develop a process with the County Department of Aging and Adult Services and the IHSS Public Authority 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.

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DRAFT MEMORANDUM OF UNDERSTANDING

SANTA CLARA COUNTY PUBLIC AUTHORITY

FOR IN-HOME SUPPORTIVE SERVICES (IHSS)

and

ANTHEM BLUE CROSS PARTNERSHIP PLAN

CALIFORNIA DUALS DEMONSTRATION

This MEMORANDUM OF UNDERSTANDING (MOU) is made and entered into as of this day February XX, 2012, by and between the Santa Clara County Public Authority for In-Home Supportive Services (IHSS) (hereinafter referred to as the IHSS Public Authority), and Anthem Blue Cross Partnership Plan (hereinafter referred to as Plan), in order to implement certain provisions of the California Duals Demonstration program (hereinafter referred to as the Demonstration). The term of this MOU shall commence as of January 1, 2013, and extend through December 31, 2013. The MOU may be terminated by either party by giving at least 10 days written notice to the other party.

The purpose of this MOU is to describe the responsibilities of the IHSS Public Authority and the Plan in the delivery of IHSS benefits to Medi-Cal members served by both parties. It is the intention of both parties to coordinate care to ensure there is no disruption in IHSS benefits for members. All references in the MOU to "Members" are limited to the Plan's Santa Clara County Medi-Cal Members enrolled in the Demonstration.

The IHSS Public Authority and the Plan agree to perform their respective services under their respective agreements with the State of California, as specified in the attached Table A, to the extent not inconsistent with law, regulation, or the parties' respective agreement with the State of California. Nothing contained herein shall add to or delete from the services required by each party under its agreement with the State of California.

Signature_____ Date_____

Name County official

Position

Signature_____ Date_____

Name Anthem Blue Cross Representative

Position

DRAFT

MEMORANDUM OF UNDERSTANDING

SANTA CLARA COUNTY PUBLIC AUTHORITY

FOR IN-HOME SUPPORTIVE SERVICES (IHSS)

and

ANTHEM BLUE CROSS PARTNERSHIP PLAN

CALIFORNIA DUALS DEMONSTRATION

Table A

	IHSS Public Authority	Anthem Blue Cross Partnership Plan
A	IHSS consumers enrolled in the Demonstration retain their ability to select, hire, fire, schedule and supervise their IHSS home care worker, participate in the development of their care plan, and select who else participates in their care planning.	Plan will work with IHSS Public Authority and County Department of Aging and Adult Services to ensure no disruption in IHSS benefits for members enrolled in the Demonstration
B	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.	Plan will coordinate with County Department of Aging and Adult Services to receive assessment and authorization data for each member authorized for IHSS; will include county IHSS social workers and IHSS home care workers in members' Plan interdisciplinary care team (ICT); and will share relevant member information with the County
C	Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS home care workers.	Plan will work with IHSS Public Authority and the County Department of Aging and Adult Services to ensure no disruption in IHSS benefits for members.
D	County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.	Plan will work with IHSS Public Authority and the County Department of Aging and Adult Services to ensure no disruption in IHSS benefits for members.
E	IHSS providers will continue to be paid through State Controller's Case Management, Information and Payrolling System (CMIPS) program.	Plan will work with IHSS Public Authority and the County Department of Aging and Adult Services to ensure no disruption in IHSS benefits for members.

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	IHSS Public Authority	Anthem Blue Cross Partnership Plan
F	The IHSS Public Authority in collaboration with the County Department of Aging and Adult Services will develop a process with the Plan 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.	Plan will develop a process with the IHSS Public Authority and the County Department of Aging and Adult Services 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.

Memorandum Of Understanding (MOU) Between Blue Cross Of California (BCC) And The Santa Clara Valley Health And Hospital System Mental Health Department (SCVMHD)

DATE: _____ REV. DATE: January 2005

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
LIAISON	The SCVMHD liaison will coordinate activities with BCC and will notify the SCVMHD providers of the roles and responsibilities of the SCVMHD liaison. The SCVMHD will meet with Blue Cross at least quarterly to resolve issues regarding appropriate and continuous care for members and to review roles. The SCVMHD Liaison will be responsible for communicating suggestions for MOU changes to the SCVMHD leadership and Blue Cross Liaison. The SCVMHD will also communicate MOU changes to the State Department of Mental Health and SCVMHD providers. At the discretion of the SCVMHD, the Liaison may represent the SCVMHD in the dispute resolution process. The SCVMHD will assist and provide BCC with the phone numbers of its beneficiaries and provider services and support programs that provide liaison services.	The BCC liaison will coordinate activities with the SCVMHD and will notify its BCC providers of the roles and responsibilities. The BCC liaison will meet with the SCVMHD at least quarterly to resolve issues regarding appropriate and continuous care for members and to review roles. BCC will be responsible for communicating suggestions for MOU changes to BCC leadership and the SCVMHD liaison. BCC will also communicate MOU changes to the State Department of Health Services (DHS) and BCC providers. At the discretion of BCC, the Liaison may represent BCC in the dispute resolution process. BCC will provide the SCVMHD with the phone numbers of its member services, provider services, and support programs that provide liaison services. With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, BCC member, clinical, or other pertinent information will be shared between BCC and the SCVMHD and its providers to ensure coordination of care.
ANCILLARY MENTAL HEALTH SERVICES	When medical necessity criteria are met, the SCVMHD will provide hospital based ancillary services, which include but are not limited to electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a psychiatric inpatient hospital for other than routine services.	BCC will provide ancillary services to the SCVMHD members when medically necessary. BCC will direct contracting providers to provide covered ancillary physical health services to BCC members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.
CLINICAL CONSULTATION AND TRAINING	The SCVMHD will provide and make available clinical consultation and training, including consultation and training on psychotropic medications, available to meet the needs of a beneficiary whose mental illness is not being treated by the SCVMHD. The SCVMHD will include consultation to BCC providers on medications given to BCC members whose mental illness is being treated by BCC. Clinical consultation between the SCVMHD and BCC will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by the SCVMHD to BCC on psychotropic drugs prescribed by the SCVMHD	BCC will direct contracting providers to provide clinical consultation and training to the SCVMHD or other providers on physical health care conditions and on medications prescribed through BCC providers. BCC will direct contracting providers to provide clinical consultation to the SCVMHD or other providers of mental health services on a member's physical health condition. Such consultation will include consultation by BCC to the SCVMHD on medications prescribed by BCC for a BCC member whose mental illness is being treated by the SCVMHD.

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	for a BCC member whose mental illness is being treated by BCC.	
CONFIDENTIALITY OF MEDICAL RECORDS	The SCVMHD will arrange for appropriate management of a member's care, including the exchange of medical records information with a member's other healthcare providers or providers of specialty mental health services. The SCVMHD will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participating in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.	BCC will facilitate appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers or providers of specialty mental health services. BCC will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. BCC will not release any information pertaining to a member's mental health treatment without a signed release from the member and a signed written statement by the requester describing the information requested, its intended use or uses, and a statement that the information will not be used for other purposes and will be destroyed within the designated timeframe. The timeframe may be extended, provided that BCC is notified of the extension, the reasons for the extension, and additional intended uses and the expected date that the information will be destroyed. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.
DIAGNOSTIC ASSESSMENT	The SCVMHD will provide evaluation, triage, and when authorized, specialty mental health services to BCC members whose psychological conditions would not be responsive to mental health or physical health care by their PCP. The SCVMHD will evaluate a member's symptoms, level of impairment and focus of intervention to determine if a member meets medical necessity criteria for specialty mental health services. When medical necessity criteria is met, the SCVMHD will arrange for an appointment with the appropriate provider and will relay appointment information to the member. When medical necessity criteria is not met, the SCVMHD staff will refer the member back to the referring PCP, notify BCC and/or refer the member to community service as appropriate. Individual mental health providers may arrange for records transfer by direct communication with the referring physician.	BCC will advise its contracting providers to furnish and BCC will then pay for appropriate medically necessary assessments of BCC members to identify co-morbid physical and mental health conditions, to: • Rule out general medical conditions causing psychiatric symptoms • Rule out mental disorders and/or substance-related disorders caused by a general medical condition. • Identify and treat those general medical conditions that are causing or exacerbating psychiatric symptoms. The PCP will be advised to identify and treat non-disabling psychiatric conditions that may be responsive to primary care, i.e.: mild to moderate anxiety and/or depression, if within the scope of practice of the PCP. The member's PCP or appropriate medical specialist will be advised to identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the member to specialty physical health care for such treatment.

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
EMERGENCY SERVICES & CARE – EMERGENCY ROOM FACILITY CHARGES AND PROFESSIONAL SERVICES	The SCVMHD will be responsible for the facility charges resulting from the emergency services and care of a BCC member whose condition meets the SCVMHD medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay. The SCVMHD will be responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in the admission of the member for psychiatric inpatient hospital services at that facility or any other facility. The SCVMHD will cover and pay for the professional services of a mental health specialist provided in an emergency room to a BCC member whose condition meets the SCVMHD medical necessity criteria or when the mental health specialist services are required to assess whether the SCVMHD medical necessity is met. Payment for professional services of a mental health specialist required for the emergency services and care of a BCC member with an excluded diagnosis is the responsibility of the Medi-Cal fee-for-service system.	BCC will cover and pay at the Medi-Cal rates for the facility charges resulting from the emergency services and care of a BCC member, whose condition meets the SCVMHD medical necessity criteria, when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility. BCC will cover and pay at the Medi-Cal rates for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets the SCVMHD medical necessity criteria. BCC will cover and pay at the Medi-Cal rates for the facility charges and the medical professional services required for the emergency services and care of a BCC member with an excluded diagnosis or a BCC member whose condition does not meet SCVMHD medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.
HOME HEALTH AGENCY SERVICES	The SCVMHD will notify BCC of members who need home health services or who are receiving home health services through the Home and Community Based Services Waiver Program (HCBS) or the In-Home Supportive Services Program (IHSS). The SCVMHD will pay for services solely related to included mental health diagnoses, or for Specialty Mental Health Services determined to be necessary by the SCVMHD. The SCVMHD is not responsible to provide or arrange for Home health Agency Services as described in Title 22, Section 51337.	BCC will cover and pay at the Medi-Cal rates for home health agency services prescribed by a BCC provider when medically necessary to meet the needs of homebound members. A homebound BCC member is a patient who is essentially confined to his home due to illness or injury. If ambulatory or otherwise mobile, member is unable to be absent from his home, except on an infrequent basis or for periods of relative short duration, e.g., for a short walk prescribed as therapeutic exercise. BCC is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a BCC member. For example, BCC would not be obligated to provide home health agency services for the purpose of medical monitoring when those services are not typically medically necessary or for a patient who is not homebound. Home health agency services prescribed by BCC

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
		providers to treat mental health conditions of BCC members are the responsibility of BCC.
HOSPITAL OUTPATIENT DEPARTMENT SERVICES	The SCVMHD will be responsible for the payment of specialty mental health services provided by hospital outpatient departments, for BCC members who meet medical necessity criteria for specialty mental health services Hospital outpatient services will be reasonably available and accessible to BCC members.	BCC will cover and pay at the Medi-Cal rates for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and BCCs contract with his subcontractors and the DHS. Separately billable outpatient services related to electro-convulsive therapy, such as anesthesiologist services are the contractual responsibility of BCC.
LABORATORY, RADIOLOGICAL AND RADIOISOTOPE SERVICES	Prescribed drugs as described in Title 22, Section 51513 and laboratory radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the SCVMHD, except when provided as hospital based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the SCVMHD. The SCVMHD will coordinate with BCC as appropriate, to assist beneficiaries in receiving laboratory services, prescribed through the SCVMHD including ensuring that any medical justification of the services required for approval of payment to the laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedure. Information will be disseminated to the SCVMHD providers primarily through quarterly provider meetings conducted by the SCVMHD staff. Secondly, targeted outreach will be extended to interested providers in the form of written communication and/or office visits to present a review of the claims process.	BCC will be responsible for providing medically necessary laboratory, radiological, and radioisotope services described in Title 22, Section 51311. BCC will cover and pay at the Medi-Cal rates for services to BCC members who require the specialty mental health services by the SCVMHD or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis and treatment of BCC member's mental health condition. BCC will also cover and pay at the Medi-Cal rates for services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. BCC will coordinate these services with the member's specialty mental health provider.
MEDICAL TRANSPORTATION SERVICES	The SCVMHD will not be responsible for medical transportation services, except when the purpose is to transport a beneficiary from one psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24-hour facility because: • The services in the facility to which the beneficiary is being transported will result in lower cost to SCVMHD.	BCC will cover and pay at the Medi-Cal rates for all medically necessary emergency and non-emergency medical transportation services for BCC members including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services. BCC will cover and pay at the Medi-Cal rates for medically necessary non-emergency medical transportation services, when prescribed for a BCC member by a Medi-Cal mental health provider outside the SCVMHD, when authorization is obtained.
DICAL NECESSITY CRITERIA	The SCVMHD will provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries served by the SCVMHD who meet specified medically necessity criteria and when	Beneficiaries whose diagnoses are not included in the applicable listing of SCVMHD covered diagnoses may obtain specialty mental health services through the Medi-Cal Fee-for-Service

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	specialty mental health services are required to assess whether the medical necessity criteria are met. Medical necessity criteria, is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. The SCVMHD will accept referrals received through beneficiary self-referral or through referral by another person or organization.	(FFS) system. BCC members whose mental health diagnoses are covered by the SCVMHD but whose conditions do not meet the program impairment and intervention criteria, are not eligible for specialty mental health care under the Medi-Cal FFS program. These beneficiaries are eligible for care from a primary care or other physical health care provider. The Medi-Cal FFS system will deny claims from mental health professionals for such beneficiaries.
NURSING FACILITY SERVICES	The SCVMHD is not responsible for any nursing facility services. However, the SCVMHD will arrange and pay for all medically necessary specialty mental services (typically visits by psychiatrists and psychologists) in a skilled nursing facility.	BCC will arrange and pay at the Medi-Cal rates for nursing facility services for members who meet Blue Cross's medical necessity criteria for the month of admission, plus one month. Blue Cross will arrange for disenrollment from the managed care program if the member needs nursing services for a longer period of time. Skilled nursing facility services with special treatment programs, for the mentally disordered, are covered by FFS program. These services are billed to the FFS system using accommodations codes 11, 12, 31, and 32 for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs).
'ARMACEUTICAL .RVICES AND PRESCRIBED DRUGS	The SCVMHD is not responsible to cover and pay for pharmaceutical services and prescribed drugs, including all medically necessary Medi-Cal psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services. However, the SCVMHD is responsible for coordinating with pharmacies and BCC as appropriate to assist beneficiaries in receiving prescription drugs and laboratory services prescribed through the SCVMHD, including, ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. The SCVMHD will utilize the existing services of BCCs laboratory or the services of BCCs contracted laboratory providers, as needed in connection with the administration and management of psychotropic medications.	BCC will cover and pay at the Medi-Cal rates for pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, except when provided as inpatient psychiatric hospital based ancillary services or otherwise excluded under BCC contract. BCC will cover and pay at the Medi-Cal rates for psychotropic drugs not otherwise excluded by their contract, which are prescribed by out-of-plan psychiatric providers for the treatment of psychiatric conditions. BCC may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists. Application of utilization review procedures should not inhibit a BCC member's access to prescriptions. If BCC requires that covered prescriptions written by out-of-plan BCC psychiatrists be filled by pharmacies in BCCs provider network, BCC will ensure that drugs prescribed by out-of-plan BCC psychiatrists are not less accessible to BCC members than drugs prescribed by network providers. BCC will not cover and pay for prescriptions for

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
		mental health drugs written by out-of-plan physicians who are not psychiatrists; unless, these prescriptions are written by non-psychiatrists contracted by the SCVMHD to provide mental health services in areas where access to psychiatrists is limited. Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD policy letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the FFS system whether these drugs are provided by a pharmacy contracting with BCC or by a FFS pharmacy providers.
PSYCHIATRIC INPATIENT HOSPITAL SERVICES	The SCVMHD will be responsible for psychiatric inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c). Psychiatric Inpatient Hospital Services for a FFS/Medi-Cal hospital will include: • Routine hospital services • All hospital based ancillary services Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal hospital will include: • Routine hospital services • All hospital based ancillary services, and • Psychiatric inpatient hospital professional services The SCVMHD will utilize BCC contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for BCC members unless otherwise covered by the hospital's per diem rate.	BCC will cover and pay at the Medi-Cal rates for all medically necessary professional services to meet the physical health care needs of BCC members who are admitted to the psychiatric ward of a general acute hospital or a free standing licensed inpatient psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations. BCC is not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.
PHYSICIAN SERVICES	The SCVMHD will not be responsible to provide or arrange and pay for physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, Psychiatrist Services.	BCC will cover and pay at the Medi-Cal rates for physician services related to the delivery of outpatient mental health services, which are within the PCPs scope of practice, for both BCC members with excluded mental health diagnoses and BCC members with included mental health diagnoses, whose conditions do not meet the SCVMHD medical necessity criteria. BCC is not required to cover and pay for physician services provided by Psychiatrists, Psychologists. Licensed Clinical Social Workers, Marriage, Family and Child Counselors, or other specialty mental health providers. BCC will cover and pay for physician services provided by Specialists such as Neurologists, when medically necessary.
PROVIDER NETWORK AND MEMBER EDUCATION	The SCVMHD will credential and contract with sufficient numbers of licensed mental health professionals to maintain a SCVMHD provider network sufficient to meet the needs of BCC members.	The coordination of Medi-Cal physical health care services and specialty mental health services is a dual BCC/SCVMHD responsibility, BCC is responsible for arranging appropriate management of a BCC member's care between BCC and other care providers or providers of specialty mental

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	The SCVMHD will assist with identification of SCVMHD providers who have the capacity and willingness to accept BCC reimbursement to serve the needs of BCC members who do not meet the SCVMHD medical necessity criteria and require services outside the scope of practice of the PCP. The SCVMHD will continually monitor the SCVMHD provider network to ensure beneficiary access to quality mental health care. The SCVMHD will assist BCC in arranging for a specific SCVMHD provider when BCC is unable to locate an appropriate mental health service provider for a BCC member. The SCVMHD will also assist BCC to develop and update a list of provider or provider organizations to be made available to BCC members. Any updates to the list will be provided to BCC at the quarterly MOU meetings or as changes occur to the list.	health services as required by contract. BCC will utilize the SCVMHD to identify SCVMHD providers who are willing to accept FFS payment, to provide services for BCC members who do not meet SCVMHD medical necessity criteria for SCVMHD services and require services outside the scope of practice of the PCP. BCC will request assistance from the SCVMHD whenever BCC is unable to arrange for an appropriate SCVMHD provider for a BCC member. BCC will initiate a referral to the appropriate SCVMHD provider or provider organization as recommended by the SCVMHD. For those services that do not meet the SCVMHD medical necessity criteria, a copy of the referral will be kept in the member's referral chart. BCC will collaborate with the SCVMHD to develop and maintain a list of providers or provider organizations to be made available to BCC members. Amendments to the list will be provided to the SCVMHD at the quarterly MOU meetings or as changes occur to the list.
REFERRALS	The SCVMHD will accept referrals from BCC staff, BCC providers and BCC Medi-Cal members for determination of SCVMHD medical necessity. When medical necessity criteria are met, the SCVMHD will arrange for specialty mental health services by a SCVMHD provider. In the case of self-referrals or referrals from providers other than the member's PCP, in which BCC specialty mental health services involves a SCVMHD psychiatrist, the SCVMHD will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information. When medical necessity criteria are not met, or if it is felt that the member's mental health condition would be responsive to physical health care based treatment, the SCVMHD will refer the member back to BCC and the referring physician with the assessment results, diagnosis, need for service and/or recommendations for an appropriate provider to treat the member's symptoms. These referrals will be made through a referral form to assist in providing referrals to providers, provider agencies, or other sources of care for services not covered by the SCVMHD. Referrals may include a provider with whom the member already has a patient-provider relationship, or a provider in the area that has indicated a willingness to accept referrals. This will include but is not limited to a Federally Qualified Health Center	BCC will maintain responsibility for physical healthcare based primary mental health treatment, which includes: • Basic education, assessment, counseling, and referral and linkage to other services for all beneficiaries. BCC will refer to the SCVMHD for an assessment and appropriate services when: • An assessment is needed by the SCVMHD to confirm or arrive at a diagnosis. • Mental health services other than medications are needed for a beneficiary with a diagnosis included in the responsibilities of the SCVMHD. • BCC identifies mental health conditions not responsive to physical health care based primary mental health treatment. After the PCPs diagnostic assessment, BCC or PCP will refer those members whose psychiatric condition would not be responsive to physical health care, to the SCVMHD to determine if SCVMHD medical necessity criteria are met. The SCVMHD will inform BCC and BCC providers when a member does not meet the SCVMHD criteria and will provide results of psychological assessment and treatment recommendations. BCC will arrange for primary mental health services within the PCPs scope of practice.

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	(FQHC), a Rural Health Clinic, an Indian Health Clinic, or an Indian Clinic. The SCVMHD is not required to ensure a member's access to physical health care based treatment or to treatment from licensed mental health professionals for diagnoses not covered by the SCVMHD. When the SCVMHD has provided specialty mental health services and has determined that the member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, the SCVMHD will refer the member back to BCC and referring physician with the assessment and treatment results, diagnosis, need for ongoing service and recommendations for an appropriate provider to treat the member's symptoms. With the member's consent, the SCVMHD will inform the PCP of services provided and/or medications prescribed. The SCVMHD will attempt to coordinate information with the member's other health care providers and ensure that contact with BCC is made.	When the SCVMHD informs BCC and the BCC provider that a member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, BCC will refer member for primary mental health services within the PCPs scope of practice. Some specialty mental health services will continue to be covered and provided through the Medi-Cal FFS program for a specified set of diagnoses specifically excluded from SCVMHD responsibility.
RESOLUTION OF DISPUTE	The SCCMHD will provide a resolution of dispute process in accordance to Title 9, Section 1850.505. When the SCCMHD has a dispute with BCC that cannot be resolved to the satisfaction of the SCCMHD, concerning the obligations of the SCCMHD, or BCC, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the SCCMHD may submit a request for resolution to the State Department of Mental Health (DMH). A request for resolution by either department will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services	BCC will provide a resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between BCC and the DHS. When BCC has a dispute with the SCCMHD that cannot be resolved to the satisfaction of BCC, concerning the obligations of the SCCMHD or BCC under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, BCC may submit a request for resolution to the DHS. A request for resolution by either department will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	included by the other in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the SCCMHD and BCC will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the SCCMHDs beneficiary problem resolution process or any similar process offered by BCC or to request a fair hearing.	services included by the other in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between BCC and the SCCMHD will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing BCCs beneficiary problem resolution process or any similar process offered by the SCCMHD or to request a fair hearing.
SERVICE AUTHORIZATIONS	The SCVMHD will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the SCVMHD for services that meet SCVMHD medical necessity criteria. This will be done through the SCVMHD Call Center program or a SCVMHD linkage agency. Services will be rendered according to the SCVMHD responsibility. Emergency services will be provided in accordance with State and Federal laws and regulations. If necessary, SCVMHD case management staff will be available to assist in coordinating care, including service authorizations. If a dispute occurs between the member and SCVMHD or BCC, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.	BCC and its delegated entities will authorize medical assessment and/or treatment services by providers who are credentialed by BCC and contracted with a BCC partner or delegated entity for covered physical health care services. BCC and/or its delegated entities will authorize all inpatient and outpatient medical assessment, consultation, and/or treatment services required for BCC members and coordinate with the SCVMHD for those members receiving care from the SCVMHD. BCC case management staff will be available to assist in coordinating care and obtaining appropriate service authorizations. If a dispute occurs between the member and BCC or SCVMHD, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.
SERVICES FOR THE DEVELOPMENTALLY DISABLED	The SCVMHD will refer members with developmental disabilities to Regional Centers for psychiatric medical services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. When appropriate, the SCVMHD will inform BCC, its delegated entity, and the PCP of such referrals.	BCC PCPs will refer members with developmental disabilities to Regional Centers for psychiatric and non-medical services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed.
SPECIALTY MENTAL HEALTH SERVICES PROVIDERS AND COVERED SPECIALTY MH SERVICES (ESPDT)	The SCVMHD will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 is eligible for EPSDT supplemental services. If these criteria are met, the SCVMHD will be responsible for arranging EPSDT supplemental services provided by specialty mental health professionals. The SCVMHD will pay for EPSDT supplemental services as part of the member's	BCC will cover specialty mental health services related to mental health diagnoses that are not the responsibility of either the SCVMHD or BCC. When BCC determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, BCC will refer the child to the PCP for treatment of conditions within the PCP's scope of practice.

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	specialty mental health treatment. The SCVMHD will also provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Section 1820.205 and 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. If EPSDT supplemental services or SCVMHD medical necessity criteria are not met, the SCVMHD will refer children who have a CCS eligible condition requiring specialty mental health services to their PCP for a referral to CCS. Children who do not have a CCS eligible condition will be referred to their PCP with recommendations for mental health treatment. Hospitals not affiliated with the SCVMHD may provide psychiatric inpatient hospital services to Medi-Cal beneficiaries in emergency situations at FFS rates established by regulation.	Referrals to the SCVMHD for an appropriate linkec program will be made for treatment of conditions outside the PCPs scope of practice; BCC will assist the SCVMHD and members by providing links to known community providers of supplemental services. BCC will also provide all medically necessary professional services to meet the physical health care needs of BCC members admitted to a general acute care hospital, psychiatric inpatient hospital.
SERVICES EXCLUDED FROM COVERAGE	The SCVMHD will not be responsible to provide or arrange and pay for the following services: • **Out-of-State Specialty Mental Health Services except** when it is customary practice for a California beneficiary to receive medical services in a border community outside the State. • **Specialty Mental Health Services** provided by hospitals operated by the State Department of Mental health or Developmental Services. • **Specialty Mental health Services** provided to Medi-Cal beneficiary eligible for Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRG) when the DRG reimbursement covers administrative day services according to Medicare (Part A). • **Specialty Mental Health Services** covered by the Medi-Cal Managed Care BCC. • **Psychiatric Inpatient Hospital Services, billable to FFS** Medi-Cal, under an "Allowable Psychiatric Accommodation Code", as defined in Section 1820.100(a). • **Medi-Cal Services** that may include specialty mental health services as a component of a larger service package as follows: > **Psychiatric and Psychological Services provided** by adult day health centers. > Home and Community Based Waiver Services as defined in CCR Title 22, Section 51176.	BCC is not responsible to arrange and pay for the services listed below to its members in accordance with this MOU and as contractually required. • Medi-Cal Services, that are specialty mental health services. (A copy of "Drugs Excluded from BCC Coverage" list should be included as part of this MOU package. The drug list can be found as Enclosure 2 to the MMCD policy letter #00-01)

CATEGORY	SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM MENTAL HEALTH DEPARTMENT	BLUE CROSS OF CALIFORNIA
	> **Specialty Mental Health Services, other than psychiatric inpatient hospital services,** authorized by the California Children's Services (CCS) program to treat CCS eligible beneficiaries. > **Local Education Services as defined in Title 22, CCR, Section 51190.4.** > **Specialty mental Health Services,** provided by Federally Qualified health Centers, Indian Health Centers, and Rural Health Clinics. > Beneficiaries who have an excluded diagnoses or may obtain specialty mental health services under applicable provisions of Title 22, Div. 3, Subdivision1.	
Term and Amendments	**Term.** Unless modified, amended, or terminated as provided herein, this MOU begins March 15, 2004 and expires June 30, 2009 ("TERM"). **Amendments.** This MOU may be modified provided the Santa Clara County Board of Supervisors has delegated authority to SCVMHD to amend this MOU, and provided the parties execute a written amendment reflecting the modification.	

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the Santa Clara County Mental Health Department and Blue Cross of California Medi-Cal Program interface.

Dated 3/8/06

Blue Cross of California

Chad Westover, Vice President,
Business Development
Blue Cross of California State Sponsored Business

Dated 8/1/2006

Santa Clara Valley Health And Hospital System Mental Health Department

Nancy Peña, Ph.D.
Director

Approved as to Form and Legality:

By: 4/25/05
Deputy County Counsel Date

4/25/05
Office of County Executive Date

MEMORANDUM OF UNDERSTANDING
RESOLUTION OF DISPUTE ADDENDUM
BETWEEN
BLUE CROSS OF CALIFORNIA PARTNERSHIP PLAN, INC. (BCC)
AND THE
LOCAL COUNTY MENTAL HEALTH PLAN (MHP)

RESOLUTION OF DISPUTE Title 9, Section 1850.505 MMCD 00_01 Rev pg. 23 MS & LI Contracts 6.7.3.3 & 6.7.9.1 GMC 7.6.2	The MHP will provide a resolution of dispute process in accordance to Title 9, Section 1850.505. When the MHP has a dispute with BCC that cannot be resolved to the satisfaction of the MHP, concerning the obligations of the MHP, or BCC, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the MHP may submit a request for resolution to the State Department of Mental Health (DMH). A request for resolution by either department will be submitted to the respective department within 15 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the MHP and BCC will not delay medically necessary specialty mental	BCC will provide a resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between BCC and the DHS. When BCC has a dispute with the MHP that cannot be resolved to the satisfaction of BCC, concerning the obligations of the MHP or BCC under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, BCC may submit a request for resolution to the DHS. A request for resolution by either department will be submitted to the respective department within 15 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between BCC and the MHP will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the

Provider Listing - Alameda County

Medical

- Community Health Center Network (CHCN)
  - Asian Health Services
  - Axis Community Health
  - La Clinica de la Raza
  - Lifelong Medical Care (includes Over 60 Health Centers)
  - Native American Health Center
  - Tiburcio Vasquez Health Center
  - Tri-City Health Center
  - West Oakland Health Council

Community

- Alameda Health Consortium
- Spanish Speaking Unity Council
- Health Insurance Counseling and Advocacy Program (HICAP)

Provider Listing – Santa Clara County

Medical

- San Jose Medical Group
  - Lincoln Clinic and Urgent Care
  - Good Samaritan Clinic
  - Jackson Clinic

Community

- Asian Americans for Community Involvement (AACI)
- Catholic Charities of Santa Clara County
- Health Insurance Counseling and Advocacy Program (HICAP)
- Health Trust - Meals on Wheels
- Pathways
- State of California, Public Utilities Commission, energy bill discounts

November 2011 ATLANTIC MAGAZINE

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The Quiet Health-Care Revolution

While legislators talk about "bending the cost curve," one company serving Medicare patients has discovered how to provide better care at lower cost—with wireless scales, free transportation, regular toenail trimmings, and doctors who put the patient first.

By Tom Main and Adrian Slywotzky

ELLEN, AN 82-YEAR-OLD widow, lives in Anaheim, California. One Wednesday morning last year, she got on her scale, as she does every morning. One hundred and forty-six pounds—wasn't that a little high? Ellen felt vaguely troubled as she poured herself a bowl of oat bran.

Half an hour later, the phone rang. It was Sandra at the clinic. She too was concerned about Ellen's weight, which had jumped three pounds since the previous day. Sandra knew this because Ellen's scale had transmitted its reading to the clinic over a wireless connection.

Given that Ellen had a history of congestive heart failure, a three-pound weight gain in 24 hours was a potentially dangerous development, a sign of possible fluid buildup in the lungs and increasing pressure on an already stressed heart. Sandra wanted her to come in for an immediate visit: the clinic would provide a car to pick her up and bring her back home. Ellen's treatment began that very morning and continued for two weeks until she was out of danger. Had the warning signs not been noticed and addressed so quickly, she might easily have suffered a long, painful, and expensive hospitalization.

Dan, a retired letter carrier, is a patient at a clinic in the same system. At 87, he is decidedly frail, his once-sturdy legs now weak and unsteady. He is a classic candidate for a fall of the kind that has injured many of his friends, in some cases leading to weeks in the hospital and months of rehab. The elderly are prone to falls for many obvious reasons, including weak limbs, impaired vision, and medication side effects. But Dan's doctors knew that some less obvious causes included shag carpets and long, untrimmed toenails. Because of this, they'd sent someone from the clinic to visit Dan's apartment and make sure that his daughter replaced the 1980s-vintage carpets with low-pile rugs. Dan also visits the clinic regularly for light muscle-training sessions and periodic toenail clipping. Due to these preventive measures, Dan and his fellow clinic patients are one-fifth as likely as comparable patients elsewhere to suffer falls.

Joe, a 79-year-old diabetic, cut his foot when he banged it against a door. When it didn't heal after a couple of days, he limped into the office of his family physician. After glancing at the cut, his doctor immediately sent Joe to a clinic in the same system as those that treated Ellen and Dan. For diabetics, even small cuts can be a serious matter: untended, they can become infected and contribute to an alarmingly high rate of amputation.

At the clinic, a nurse practitioner cleaned and dressed the wound, and told Joe she wanted to see him there in two days so she could inspect and treat it again—and two days after that, and two days after that, until it was fully healed. The clinic would arrange for transportation if needed. Thanks to the steady, regular care, Joe's foot healed without any infection or threat of amputation.

Ellen, Dan, and Joe are all real people, though their names have been changed. The clinics that serve them are all affiliated with CareMore, a company based in Cerritos, California, that operates 26 care centers across the Southwest, serving more than 50,000 Medicare Advantage patients. Those numbers are likely to grow, perhaps dramatically, in the next few years: in August, CareMore was acquired by the insurer and health-services provider WellPoint, which serves 70 million people nationwide directly or through subsidiaries, and has plans to expand the CareMore model.

CareMore, through its unique approach to caring for the elderly, is routinely achieving patient outcomes that other providers can only dream about: a hospitalization rate 24 percent below average; hospital stays 38 percent shorter; an amputation rate among diabetics 60 percent lower than average. Perhaps most remarkable of all, these improved outcomes have come without increased total cost. Though they may seem expensive, CareMore's "upstream" interventions—the wireless scales, the free rides to medical appointments, etc.—save money in the long run by preventing vastly more costly "downstream" outcomes such as hospitalizations and surgeries. As a result, CareMore's overall member costs are actually 18 percent below the industry average.

In addition to policies designed to extend health-care benefits to more than 30 million previously uninsured Americans, the Affordable Care Act, which President Obama signed into law in 2010, contains a host of provisions aimed at lowering overall health-care costs and improving quality of care at the same time. These provisions include the adoption of electronic medical records, programs to increase at-home care and preventive care, the development of evidence-based protocols to improve quality, disincentives for unnecessary rehospitalizations, and other measures, many of them focused on Medicare, which is a primary driver of increasing costs.

The central idea that quality can be improved while costs are being reduced has been met with varying degrees of hope and skepticism. Yet many of the provisions called for have been standard operating practice at CareMore for years. And the company's success to date suggests that such efforts to "bend the curve," achieving better outcomes at a lower cost, may be more plausible than they sound. The implications for the future of Medicare—and the nation's fiscal health—may be substantial.

THE CAREMORE STORY begins almost two decades ago, with a man named Sheldon Zinberg, a gastroenterologist who was deeply concerned about the changing economics of health care in

Southern California. There, as in other U.S. markets, health-maintenance organizations, or HMOs, had come to dominate the landscape. The theory behind HMOs was attractive: "managed care" was supposed to coordinate and guide treatments in order to maximize both patient wellbeing and economic sustainability. But under pressure from corporate health-insurance sponsors and government agencies (as well as investors seeking profits), HMOs increasingly focused on reducing costs by any means necessary—including short-term fixes that often led to worse patient outcomes and, in the long run, even higher medical expenses. Patients were suffering, doctors were getting squeezed, and costs, after falling for a time, were soon spiraling upward again.

Zinberg was alarmed. Back in the 1960s, he'd founded a large internal-medicine practice that had grown to include some 20 physicians in a range of specialties, from cardiology and oncology to rheumatology and nephrology. But by the late 1980s, with a small number of HMOs growing more dominant, referrals were dwindling and restrictions on services were multiplying. Zinberg and his colleagues were forced to spend ever more time on the phone with "benefits coordinators," whose main job seemed to be finding reasons to deny coverage.

Already in his late 50s, Zinberg could have simply retired and walked away from the problem, as many of his colleagues were doing. Instead, he made a different decision. Zinberg had long been mulling the elements of a coordinated-care system that would be centered on reducing hassles and improving outcomes for patients rather than simply cutting costs. He began to envision a health-care organization in which teams of doctors, nurses, therapists, trainers, and other professionals worked together, continually sharing information and insights about their mutual clients and providing whatever services were needed to keep those clients in the best possible physical and mental health.

Zinberg spent almost two years struggling to recruit physicians to launch his program. "During 1991 and '92 my wife barely saw me," he recalls. "I was having dinner four nights a week with groups of doctors, explaining my concept. I was begging them, literally begging them, to help me create a new health-care-delivery system."

Fortunately, a few of the doctors Zinberg approached were moved to join by their personal connections with him or by the depth and sincerity of his commitment to the cause. By 1993, physicians and teams of physicians operating 28 separate medical offices had agreed to become affiliates of Zinberg's new system, CareMore Medical Group.

Zinberg had always seen his vision of coordinated care as especially well suited to the needs of the elderly. As a gastroenterologist, he naturally saw a high percentage of older patients in his practice, and as he himself grew older, his interest in the physiology of aging deepened. (His ideas on the subjects of exercise, nutrition, genetics, and memory retention would lead to his 2003 book, *Win in the Second Half*.) And Zinberg recognized that elderly patients covered by Medicare—the people normally regarded as the greatest drain on the health-care system—could benefit the most from special attention. Because the existing system failed to connect the dots, they experienced a variety of unnecessary complications: avoidable hospitalizations, duplication of treatment, misdiagnoses, needless suffering, and sheer neglect.

At first, CareMore accepted patients of all ages, but in 1997 Zinberg and his team restructured the company around his original concept, focusing on the elderly and eventually accepting payment exclusively from the Medicare Advantage program. Rather than paying for services rendered (the traditional fee-for-service model), Medicare Advantage pays CareMore an annual per-patient fee, adjusted according to each client's risk profile. This system, by replacing the distorted incentives of the fee-for-service economic model, allows CareMore to be rewarded for innovative, results-oriented care. In particular, it enables the company to build specialized programs for its highest-risk patients, who generally suffer more—and run up astronomical costs—under traditional fee-for-service plans.

One of CareMore's critical insights was the application of an old systems-management principle first developed at Bell Labs in the 1930s and refined by the management guru W. Edwards Deming in the 1950s: you can fix a problem at step one for $1, or fix it at step 10 for $30. The American health-care system is repair-centric, not prevention-centric. We wait for train wrecks and then clean up the damage. What would happen if we prevented the train wrecks in the first place? The doctors at CareMore decided to find out.

An early discovery was that CareMore's elderly patients failed to show up for as many as one-third of their doctor appointments. As Charles Holzner, one of Zinberg's initial partners at CareMore and now a senior physician with the company, explains, "About one in three of the elderly people we were taking care of were home by themselves. They'd outlived their family resources, they couldn't drive, and their kids lived out of town. So when they got sick, they ended up calling 911. And when it came to routine doctor visits, they sometimes just couldn't make it at all."

CareMore's unconventional solution to the problem was to provide transportation, at no charge, to get patients to their medical appointments. Local car-service companies were happy to have the business, and while the transportation cost money, it ultimately saved a lot more. Increased regularity and consistency of medical care meant that many simple problems were recognized and treated in their early stages: complications were avoided, and rates of hospitalization and nursing-home admittance began to fall.

The problem of "noncompliance" isn't limited to missed appointments, either. Patients, especially elderly ones, also leave prescriptions unfilled, medicines untaken, exercise-and-diet regimens unfollowed, and symptoms unnoticed and unreported. Health-care professionals often grumble about noncompliance, but given the myriad demands on their time, they generally can do very little about it. At CareMore, by contrast, Zinberg decided, "noncompliance is *our* problem, not the patient's." So the company began adding more nonmedical services to its routine care in order to improve compliance rates—for example, sending health-care professionals to its patients' homes to make sure they had scales to keep tabs on their weight, to look for loose throw rugs that might cause falls, and to provide "talking pill boxes" that remind patients to take their medicine with preset alarms. Each of these innovations led to a small improvement in patient wellness and a corresponding improvement in the economics of providing care.

Next, CareMore began experimenting with an aggressive treatment of diabetes, one of the most widespread and debilitating illnesses suffered by elderly patients. The primary treatment for diabetes, insulin injection, had long been considered inappropriate for the elderly—too intrusive, too difficult, and too costly for patients whose life expectancy was already short. But CareMore doctors made insulin-injection treatment available to their patients. They also set about investigating exactly how the worst complications associated with diabetes occurred.

Take amputations, for example. The typical chain of events begins with a small cut on the foot suffered by a diabetic patient and self-treated using an ordinary home remedy such as a Band-Aid. If the cut resists healing for a week or more, the patient visits her primary-care physician. The doctor cleans the wound, changes the dressing, and advises the patient on further care, but with no way of knowing whether the advice will be followed. A week later, with the wound getting worse, the patient visits her doctor again and is referred to a surgeon. After the typical two-week wait for an appointment, the patient learns from the surgeon that gangrene is now beginning to develop, and she is referred to a specialized vascular surgeon. After yet another two-week delay, the vascular surgeon sees a wound so serious that a hospital stay and amputation are now inevitable—at a cost of many thousands of dollars and an untold degree of suffering. All beginning with a single, scarcely noticeable cut.

CareMore responded by creating a wound clinic, staffed by nurses whose primary job was to care for diabetic patients with small cuts. The wound-clinic nurses would change the dressing every other day and spend a few minutes talking with the patient, making sure the wound was healing on schedule. Over time, amputation rates for CareMore's diabetic patients fell to 60 percent below the Medicare average.

Another recent CareMore innovation is wireless monitoring for patients with congestive heart failure or hypertension: the former, such as Ellen, receive wireless scales on which to weigh themselves every day; the latter, wireless blood-pressure cuffs. After six months of using the wireless-scale system, CareMore found that hospital readmissions for congestive heart failure had fallen by 56 percent. Now the company is testing similar systems for diabetes monitoring, as well as the use of camera phones for daily conversations with a nurse practitioner.

Not all of these innovations are unique to CareMore—wound clinics for diabetics, for example, are becoming more common. But the company's focus on integrated care is exceptional, and at the center of it all is a care manager called an "extensivist." The term originated to describe a physician who served as a bridge, or "extension," connecting hospital care with outpatient follow-up treatments. At CareMore, it refers to a doctor who coordinates multiple kinds of care for an individual patient. The underlying philosophy is simple: a patient is one unified human being, not a collection of disconnected symptoms. One *New England Journal of Medicine* study looking at the care received by Medicare beneficiaries found that those with chronic conditions such as diabetes, heart disease, and lung cancer were typically visiting several different primary-care doctors and specialists. These doctors only rarely speak to one another, coordinate their plans, or consult on the possible interactions among their treatments. In such cases, it generally falls to the patients to keep track of their various treatments—a role that very few laypeople have the time, energy, and expertise to play effectively. "When we started CareMore, we found … a sizable fraction of our patients would inevitably get readmitted over and over again, if you

treated them like routine patients," explains Charles Holzner. "So to keep our patients out of the hospital, I began seeing them myself every week or two. I basically became their personal doctor, making sure they understood their postoperative regimen and were following it correctly. But very rapidly, I became overloaded. So I told Dr. Zinberg, 'We need more people like me.'"

An extensivist must be a knowledgeable physician, of course, and must have the proper tools available. (One such tool is QuickView, a system of unified electronic health-care records of the kind that the Affordable Care Act aims to promote on an experimental basis around the country, but which is already up and running at CareMore.) But people skills and a talent for clear, effective communication are even more important. "I saw that when I got involved in a patient's care, if I gained his trust, he would do anything I told him to do," Holzner emphasizes. "So showing patients that we have their best interests at heart—unlike some of the HMOs and other providers out there—is key to a strong and healthy relationship."

THE CHIEF BENEFICIARIES of CareMore's innovations are, of course, its patients. According to polls conducted by the company, 97 percent are either very satisfied or somewhat satisfied with their CareMore health plan, and more than 80 percent have recommended the company to a friend.

In the long run, though, the company's impact on the economics of health care may be more important still. When he launched CareMore in 1993, Sheldon Zinberg told his partners, "If you put people before profit, everyone profits." During its first four years, operating as a more-or-less conventional health-care provider, CareMore accumulated losses of about $11 million. But as the system of Medicare-financed, coordinated care Zinberg had initially envisioned came into being, the company turned the corner, showing a $24 million profit in 2000. It has remained solidly in the black ever since.

The economic logic behind CareMore is unusual. Every additional service it provides costs money, and the professionals at CareMore have to take on tasks and responsibilities that physicians don't traditionally assume. CareMore employs more staffers per patient than other companies, and they spend more time with patients and their families than is typical. But every dollar CareMore spends saves multiple dollars down the line, resulting in those member costs that are 18 percent below the industry average.

The crucial question is whether the CareMore model—or models like it—can work on a much larger scale. The American health-care marketplace, after all, has had many one-off success stories that have defied replication. The few examples of successful expansion—Kaiser Permanente and the Mayo Clinic, for instance—tend to highlight just how slow and difficult the process can be. And many medical groups have found to their dismay that something peculiar to their culture or leadership does not translate to new clinics or markets.

It was with this challenge in mind that a group of private-equity investors purchased CareMore from Zinberg and his partners in 2006 and made Alan Hoops the CEO. Hoops's experience and mind-set were well suited to the task of expanding and replicating the CareMore model for new regions and patients. As the chairman and CEO of PacifiCare in the 1990s, he'd led the health-care company to achieve exceptional growth, with revenues increasing from $2 billion in 1993 to

$11 billion in 2000. Hoops also started PacifiCare's Secure Horizons program, which under his leadership became the country's largest Medicare HMO, serving more than 1 million beneficiaries.

Hoops knew from the beginning that CareMore's operational and clinical processes could be documented, systematized, streamlined, and replicated. But he also knew that the real magic of the company was in the physician-led culture and the top-to-bottom commitment to patients. The growth challenge, as he saw it, involved replicating the model in local communities, not building "scale" in a single location. "*Scale* implies we need huge numbers of patients to make our system work," Hoops explains. "That's not so. We can set up shop in a community, attract 3,000 to 5,000 patients, and begin having an impact in terms of reduced costs and improved patient outcomes right away."

Hoops's focus has been on making this replication strategy work—and so far he appears to have been successful. From 2005 to 2010, CareMore managed to grow its membership by 15 percent each year. And despite differences in population demographics and community environments, CareMore has branched out into Arizona and Nevada, while expanding in its native California. The company hires a leadership team for a new market almost a year in advance and has them work in an existing clinic to learn the specific CareMore patient-care model. When the new center opens, an experienced leadership team works side by side with the new team for the first six months of operation. New employees are integrated into the company culture and encouraged to become active members of the continuous-learning and -improvement environment.

Hoops's efforts to replicate the CareMore model should gain new momentum following the company's August acquisition by WellPoint, which operates Blue Cross and Blue Shield plans across the country. WellPoint serves 34 million members in its affiliated health plans and another 35 million through subsidiaries. "CareMore was a perfect strategic fit with the direction in which we're moving our company," said Angela Braly, the CEO of WellPoint. "We have been focused on delivering greater health-care value, and finding ways to put the patient in the center of the system … That's the entire focus of the CareMore model."

WellPoint's extensive infrastructure, access to capital, national Health Information Technology capabilities, and existing relationships with patients and physicians could all accelerate the process of replicating the CareMore model. "In our service areas, 1 million Baby Boomers will be joining Medicare from now until 2030," Braly said. "That's an extraordinary level of potential demand."

Moreover, the population that CareMore serves—the elderly, and in particular the frail, high-risk elderly—is crucial when it comes to controlling overall health-care costs. "We talk as if we need to overhaul the entire health-care system," Hoops says. "But that's not quite correct. The biggest problem—and opportunity—lies with the part of the system that serves our high-risk populations. That's the part of the system that's unsustainable."

Braly believes that as CareMore continues to expand, it will help redirect the health-care conversation in Washington. "Many people are skeptical that it is possible to significantly improve quality and reduce costs at the same time," she says. "The CareMore experience shows

that if you change the underlying process, you can, in fact, achieve both objectives, and you can do so consistently."

It remains to be seen whether the WellPoint-CareMore partnership will work as planned and replicate CareMore's experience on a mass scale. But whether this endeavor succeeds or not, the integrated, early-intervention model pioneered by Sheldon Zinberg in the mid-1990s is likely to offer lessons for American health-care reform, now and in the future.

Adrian Slywotzky and Tom Main are partners at Oliver Wyman, a global consulting firm. This article is adapted from Slywotzky's new book, Demand: Creating What People Love Before They Know They Want It.

Letter of Intent to Participate in Blue Cross of California Partnership Plan, Inc Medi-Cal Managed Care Program

This Letter of Intent (the "Letter") sets forth the understandings between Blue Cross of California Partnership Plan, Inc and Affiliates ("BLUE CROSS") and Addus HealthCare, Inc. (hereinafter "PROVIDER") regarding PROVIDER's participation in the BLUE CROSS Medi-Cal Managed Care Program (MCMCP).

BLUE CROSS is responding to the California Department of Health Care Services (DHCS) Request for Solution ("RFS") released on January 27, 2012 for the purpose of identifying qualified health plans to provide health care services to Dual Eligible persons that will be transitioned to managed care programs within California as determined by DHCS, (such enrollees being hereinafter referred to as "Members" or a "Member" in MCMCP).

BLUE CROSS is building a network of providers to participate in the BLUE CROSS Anthem's MCMCP (such network being hereinafter referred to as the "Network"). Accordingly, the parties agree to the following provisions.

1. Provider agrees to be a participating provider in the Network, subject to (i) the execution of a definitive agreement (the "Agreement") between BLUE CROSS Anthem and PROVIDER setting forth the terms of their relationship regarding PROVIDER's participation in the Network; (ii) BLUE CROSS being selected by DHCS following BLUE CROSS' response to the RFS; and (iii) a satisfactory due diligence review by BLUE CROSS of PROVIDER. The parties agree to negotiate in good faith and use their best efforts to finalize the execution of the Agreement.

2. Prior to execution of the Agreement, PROVIDER consents and agrees that BLUE CROSS is authorized to include the name and address of PROVIDER as part of the BLUE CROSS response to the California DHCS Dual Eligibles RFS, and other information regarding, PROVIDER in any draft of a provider directory or other Network listing of participating providers which BLUE CROSS prepares or makes available to DHCS, Network participants, potential Network participants or other agencies, entities or persons in connection with the BLUE CROSS MCMCP.

3. The parties acknowledge and agree that none of the provisions of this Letter is intended to create any binding obligations on the parties except as otherwise specified herein.

4. This letter shall be governed by and construed in accordance with applicable federal law and the laws of the State of California.

IN WITNESS WHEREOF, the parties have executed this Letter by their respective signatures below.

BLUE CROSS

Authorized Signature

Jeff Flick, Staff VP
Print Name/Title

2-22-12
Date

PROVIDER

M D Heany
PROVIDER Signature

Mark Heaney / CEO
Print Name/Title

2/20/2012
Date

PROVIDER Address Information

PROVIDER Address: __2401 S. Plum Grove Road_____

City: _Palatine_____ State: ____IL_____ Zip: _____60067_____

Telephone: ___847.303.5300_____ Fax: _____847.303.5435_____

Tax Identification #: ___42-1014070_____

Letter of Intent to Participate in
Blue Cross of California Partnership Plan, Inc Medi-Cal Managed Care Program

This Letter of Intent (the "Letter") sets forth the understandings between Blue Cross of California Partnership Plan, Inc and Affiliates ("BLUE CROSS") and Univita Health, Inc (hereinafter "PROVIDER") regarding PROVIDER's participation in the BLUE CROSS Medi-Cal Managed Care Program (MCMCP).

BLUE CROSS is responding to the California Department of Health Care Services (DHCS) Request for Solution ("RFS") released on January 27, 2012 for the purpose of identifying qualified health plans to provide health care services to Dual Eligible persons that will be transitioned to managed care programs within California as determined by DHCS, (such enrollees being hereinafter referred to as "Members" or a "Member" in MCMCP).

BLUE CROSS is building a network of providers to participate in the BLUE CROSS Anthem's MCMCP (such network being hereinafter referred to as the "Network"). Accordingly, the parties agree to the following provisions.

1. Provider agrees to be a participating provider in the Network, subject to (i) the execution of a definitive agreement (the "Agreement") between BLUE CROSSAnthem and PROVIDER setting forth the terms of their relationship regarding PROVIDER's participation in the Network; (ii) BLUE CROSS being selected by DHCS following BLUE CROSS'response to the RFS; and (iii) a satisfactory due diligence review by BLUE CROSS of PROVIDER. The parties agree to negotiate in good faith and use their best efforts to finalize the execution of the Agreement.

2. Prior to execution of the Agreement, PROVIDER consents and agrees that BLUE CROSS is authorized to include the name and address of PROVIDER as part of the BLUE CROSS response to the California DHCS Dual Eligibles RFS, and other information regarding, PROVIDER in any draft of a provider directory or other Network listing of participating providers which BLUE CROSS prepares or makes available to DHCS, Network participants, potential Network participants or other agencies, entities or persons in connection with the BLUE CROSS MCMCP.

3. The parties acknowledge and agree that none of the provisions of this Letter is intended to create any binding obligations on the parties except as otherwise specified herein.

4. This letter shall be governed by and construed in accordance with applicable federal law and the laws of the State of California.

IN WITNESS WHEREOF, the parties have executed this Letter by their respective signatures below.

BLUE CROSS	PROVIDER
Authorized Signature	PROVIDER Signature
Jeff Flick, Staff VP	PETER M. GOLDSTEIN, EVP
Print Name/Title	Print Name/Title
2-22-12	2/20/12
Date	Date

PROVIDER Address Information

PROVIDER Address: 400 N. Continental Blvd, Suite 310

City: El Segundo State: CA Zip: 90245

Telephone: (952) 516-6238 Fax: (310) 335-9813

Tax Identification #: 27-1217010

Letter of Intent to Participate in
Blue Cross of California Partnership Plan, Inc Medi-Cal Managed Care Program

This Letter of Intent (the "Letter") sets forth the understandings between Blue Cross of California Partnership Plan, Inc and Affiliates ("BLUE CROSS") and Independent Living Systems, LLC (hereinafter "PROVIDER") regarding PROVIDER's participation in the BLUE CROSS Medi-Cal Managed Care Program (MCMCP).

BLUE CROSS is responding to the California Department of Health Care Services (DHCS) Request for Solution ("RFS") released on January 27, 2012 for the purpose of identifying qualified health plans to provide health care services to Dual Eligible persons that will be transitioned to managed care programs within California as determined by DHCS, (such enrollees being hereinafter referred to as "Members" or a "Member" in MCMCP).

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BLUE CROSS

Authorized Signature

Jeff Flick, Staff VP
Print Name/Title

2-22-12
Date

PROVIDER

PROVIDER Signature

Nestor S. Plana President + CEO
Print Name/Title

2/20/12
Date

PROVIDER Address Information

PROVIDER Address: 5201 Blue Lagoon Drive
Suite 270

City: Miami State: Florida Zip: 33126

Telephone: 305-262-1292 Fax: 305-262-9322

Tax Identification #: 45-0421648

CareMore's

HOW TO **Guide**

WELCOME TO **CareMore**

This How To Guide was created as a quick reference tool to help you navigate through the CareMore System of Care. In this book you will find answers to Frequently Asked Questions and important telephone numbers for the various people and departments that we think will be the most important to you as a new CareMore Member. We recommend that you hang onto this How To Guide as it may be helpful in the months to come.

TABLE OF CONTENTS

Now that I'm a Member...

Does enrolling with CareMore mean I'm losing my Medicare coverage? 2

What do I do with my red, white and blue Medicare card? 2

If I'm not using the Medicare card, do I have to keep paying the Part B premium? 2

Who will tell my previous Medicare plan that I've switched to CareMore? 3

Who will tell my previous PCP that I've switched to CareMore? 3

If I choose a new PCP, how will my medical records be transferred to my new PCP? 3

How do I know if I qualify for a Low-Income Subsidy (LIS)? 4

How can CareMore help me find other assistance programs I might qualify for? 4

When will I receive my Part B premium reduction (StartSmart)? 4

CareMore Care Centers

What is a CareMore Care Center (CCC)? 6

How do I find out about special events at the CCC's? 6

What services are available at the CCC? 7

How do I make a CCC appointment? 8

Health Services

How do I change my PCP? 10

What if I am unhappy with my PCP and want to change? 11

What if I move? 11

What if my PCP leaves the plan? 12

What is a Healthy Start™? 13

What is a Specialty Referral, and when is it required? 14

Do I need Prior Authorization to see a gynecologist, and/or for a mammogram? 14

How can I get a second opinion? 14

Where do I go for x-rays or lab services? 15

How do I use my Vision Plan? 15

How do I use my Exercise and Strength Training Benefit? 16

How do I use my Dental Plan? 17

How can I tell if I need to go to an urgent care or an emergency room? 17

What urgent care facilities or emergency rooms can I use? 18

How can I be sure that my durable medical equipment (DME), like my bed, oxygen and wheelchair are not taken away? 18

TABLE OF CONTENTS

Special Benefits

How do I use my Over-the-Counter Items benefit? 20

What is Nifty After Fifty? 22

Medication and Supplies

How do I use CareMore's mail-order pharmacy? 24

How do I find out what drugs are covered? 25

How do I request a formulary exception? 25

What is the difference between brand and generic drugs? 26

How do I get my diabetic supplies? 26

Plan Documents

Where can I go for copies of my Evidence of Coverage, Formulary and Directories? 28

How do I download my Evidence of Coverage, Formulary and Directories? 28

Can my plan premium and dental be charged together and taken from my Social Security or bank account? 29

How can I change the payment processing option for my premium? 29

I heard that Health Care Reform will close the "Coverage Gap" (Donut Hole) is that true? 30

Where to Call

How may I request materials in alternate formats? What alternate formats are available? 32

I want to refer a friend to CareMore… who should they call? 32

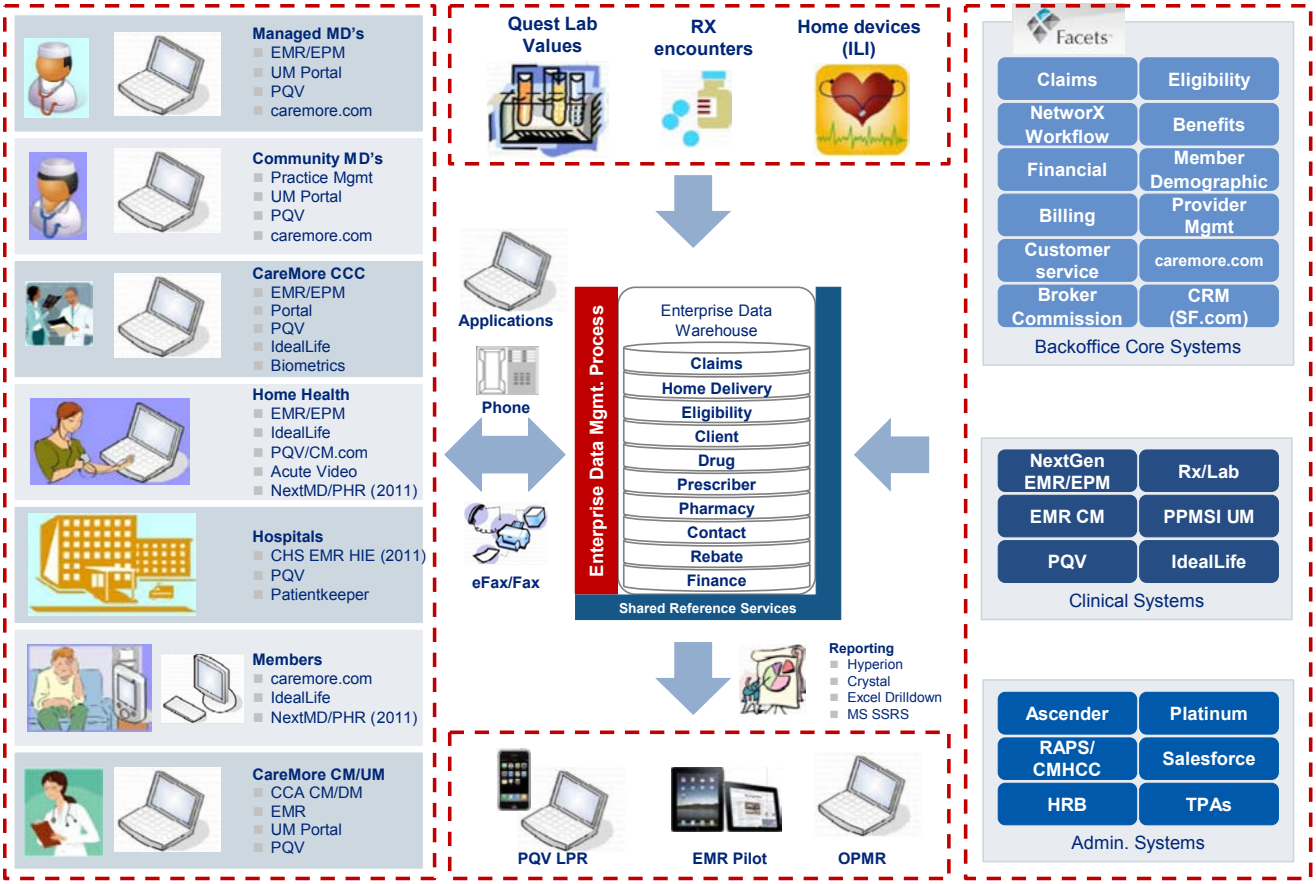
What if my questions were not answered in this guide, or I need additional help navigating CareMore's processes? 32

Important Phone Numbers 33

Where is my closest CCC? 34

Question 7.1: Technology Capabilities

Our technology platform is focused on providing the most timely, accurate, and accessible clinical and administrative data to all stakeholders.



Patient QuickView – Member Overview Screen:

CareMore Believe it.™

Logged in as: Mireille Sire

What's New | Home | Patients | Comments | Patient QuickView

Thursday, January 07, 2010 2:12:34 PM

MEMBID	COMPANY_ID	REV_FULLNAME	SEX	BIRTH	AGE	PCPNAME	PCPFROMDT	PCPTHRUDT	HPNAME
[redacted]	CMMC	[redacted]	M	06/02/1931	79	HONIGMAN MD,DANIEL	06/01/2006		CAREMORE VALUE PLUS (HMO)

Overview | Clinical Quality | Demographics | Enrollment | Authorizations | Claims | Laboratory | Pharmacy (Rx) | Transportation | Appointments | Clin. Documents

Chart Inserts

HCC Chart Insert | Clin. Quality Measures | HCC & Clin. Quality Reports | Medication Adherence | Home Monitoring | CCC Clin. Qual.

Disease Conditions

Chronic Only | All

No Chronic (HCC) Conditions Currently On Record For This Member.

Suggested Disease Conditions

No Suggested Disease Conditions For This Member

Clinical Quality Measures

This Member Has Pending Clinical Quality Measures Due.
Click Here To View.

Disease Management Programs

No DMP Visits Currently On Record For This Member.

Recent Pharmacy Prescriptions (60 Days)

DateOfService	Drug Name	PrimAgent
12/29/2009	LOVASTATIN TAB20MG	Lovastatin
12/16/2009	ENALAPRIL TAB20MG	Enalapril & Comb.
12/09/2009	HYDROCHLOROTTAB25MG	Hydrochlorothiazide
11/29/2009	FLUOCINONIDE CRE0.05%	Fluocinonide, S/M
11/24/2009	LOVASTATIN TAB20MG	Lovastatin
11/20/2009	AMOXICILLIN CAP500MG	Amoxicillin & Comb.
11/11/2009	KETOCONAZOLE SHA2%	Ketoconazole, S/M
11/08/2009	ENALAPRIL TAB20MG	Enalapril & Comb.
11/08/2009	HYDROCHLOROTTAB25MG	Hydrochlorothiazide

Member Conditions

No Member Condition Records Currently on File.

Recent Lab Test Results (60 Days)

No Recent Lab Test Results Currently On Record For This Member.

Biometric Monitoring – Provider Portal Data Summary:

- Summary
- Personal Details
- Alerts
- **Readings and Events**
- Tasks
- Notes
- Device Assignments
- Medical Records
- Network Assignments
- Plan Assignments

Reading Date	Weight	BMI	Alert	Source	Suppress
Feb 15, 2012 8:12 AM	275.80	47.3		Manager	☐
Feb 14, 2012 8:13 AM	274.20	47.1		Manager	☐
Feb 13, 2012 9:10 AM	273.40	46.9		Manager	☐
Feb 12, 2012 7:49 AM	273.20	46.9		Manager	☐
Feb 11, 2012 7:35 AM	273.10	46.9		Manager	☐
Feb 10, 2012 8:11 AM	273.90	47		Manager	☐
Feb 9, 2012 7:50 AM	272.70	46.8		Manager	☐
Feb 8, 2012 8:51 AM	272.90	46.8		Manager	☐
Feb 7, 2012 8:27 AM	272.40	46.8		Manager	☐
Feb 6, 2012 8:00 AM	271.70	46.6		Manager	☐
Feb 5, 2012 8:49 AM	272.20	46.7		Manager	☐
Feb 4, 2012 8:10 AM	273.00	46.9		Manager	☐
Feb 3, 2012 7:01 AM	273.80	47		Manager	☐
Feb 2, 2012 8:05 AM	274.40	47.1		Manager	☐
Feb 1, 2012 8:04 AM	275.10	47.2		Manager	☐
Jan 31, 2012 8:15 AM	275.90	47.4		Manager	☐
Jan 30, 2012 8:18 AM	277.20	47.6		Manager	☐
Jan 29, 2012 8:22 AM	277.70	47.7		Manager	☐
Jan 28, 2012 8:35 AM	276.30	47.4		Manager	☐
Jan 27, 2012 8:00 AM	275.00	47.2		Manager	☐
Average of displayed data	274.2	47.1			

1 2 3 4 5 6 7 8 9 10

Anthem

CareMore
It's what we do.™

Care Management Plan for Dual Eligible Demonstration
February 2012

Contents

Purpose 2

Organization and Philosophy 3

Element 1: Description of Duals Demonstration Target Population 6

Element 2: Measureable Goals/ Care Management Goals 9

Element 3: Staff Structure and Roles 14

Element 4: Interdisciplinary Care Team (ICT) 22

Element 5: Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols 28

Element 6: Model of Care Training for Personnel and Provider Network 36

Element 7: Health Risk Assessment 43

Element 8: Individualized Care Plan 47

Element 9: Communication Network 55

Element10: Care Management for the Most Vulnerable Subpopulations 60

Element 11: Performance and Health Outcomes Measurement 65

Purpose

The purpose of this Care Management Plan is to document the model of care (MOC) for the State of California Department of Health Care Services (DHCS) Dual Eligible Demonstration population. This MOC is a comprehensive care management and care coordination program that includes elements from our existing operations and processes in our Medi-Cal plan and CareMore's Medicare Advantage Special Needs Plans (SNPs). We intend to make additional modifications to this Demonstration MOC for 2013 to incorporate the DHCS- specified assessment for this population and to include additional quality measures as agreed upon with DHCS.

We recognize that the needs of the dual eligible population are vast and complex, and may require services that are not comprehensively addressed by either the traditional Medicare or Medi-Cal programs. Data from the DHCS show that dual eligible individuals have multiple chronic conditions (see Table 1). These conditions are often exacerbated by poorly managed and uncoordinated care.

Table 1. Clinical Comorbidity - Disabled Dual Eligible and Medi-Cal Only Samples

	Dual Eligible Only		Medi-Cal Only	
Number of Diagnostic Conditions	**#**	**%**	**#**	**%**
No Services	39	3.9%	111	11.1
No Specific Disease Diagnosis	36	3.6%	51	5.1
One Condition	54	5.4%	100	10.0
Between 2 and 4 Conditions	154	15.4%	232	23.2
Between 5 and 9 Conditions	265	26.5%	274	27.4
Between 10 and 19 Conditions	318	31.8%	192	19.2
Twenty or More Conditions	134	13.4%	40	4.0
Grand Total	1,000	100%	1,000	100%

Source: DHCS - Research Analytical Studies Section, "Medi-Cal's Dual Eligible Population Demographics, Health Characteristics and Costs of Health Care Services", April 2010

Together, Anthem Blue Cross (Anthem) and CareMore Health Plan (CareMore) will build a health care delivery model that cuts across traditional Medicare-Medi-Cal service boundaries so that the two programs' services are delivered in the best overall way – that is, with good health outcomes, high consumer satisfaction, and overall cost-effectiveness and with appropriate incentives. As dual eligible individuals are enrolled into our program and become our members, we recognize that they have entrusted in us to take care of their health and well-being. We take this responsibility very seriously and are committed to ensuring that our members receive the care they need and deserve.

Organization

Anthem has partnered with the DHCS in serving the needs of the Medi-Cal population for over 18 years. We are able to leverage our national Medicaid and Children's Health Insurance Program expertise and draw upon best practices through serving over 1.8 million members in 10 states. As part of our current operations in California, we have processes in place for dual eligible members enrolled in our Medi-Cal plan, such as: 1) identifying members who need Medi-Cal wraparound services; 2) administering Medi-Cal benefits and services to avoid gaps in care; and 3) adhering to service accessibility and availability requirements for emergent, urgent, and routine service requests. Our locally-based Medi-Cal staff work collaboratively with county agencies to ensure that members are aware of and can access their benefits under the Medicare and Medi-Cal programs. We also have experience in providing care management for Seniors and Persons with Disabilities (SPDs), many of whom have similar needs to the dual eligible population. We currently serve about 75,000 SPD members in California.

As a current Medi-Cal managed care plan in Santa Clara County, Anthem will build upon our local infrastructure, and will leverage our existing relationship with CareMore Health Plan (CareMore) an innovative Medicare Advantage plan owned by WellPoint, to develop and implement a comprehensive Duals Demonstration plan in the county. CareMore operates Medicare Advantage SNPs in multiple counties in California. Dual eligible members make up approximately 25% of the membership in CareMore's Institutional SNPs. Additionally, CareMore serves dual eligible members in Dual Eligible SNPs in Los Angeles and Orange Counties.

Model of Care Philosophy

The Model of Care (MOC) for the Dual Eligible Demonstration will be built on CareMore's unique and proven MOC that is focused on the needs of the frail and chronically ill, especially members with complex diseases, multiple chronic conditions and social support needs. The goal for this program is improve the health and well-being of our members by implementing the following:

- An Interdisciplinary Care Team (ICT) of employed clinicians, such as nurse practitioners (NPs), and other health care staff, such as case managers, social workers, behavioral health specialists, nutritionists, home care providers, foot care providers and others who are trained to care for frail and chronically ill members and members with complex health and social service needs. For these members, the ICT becomes the primary facilitator of care plans to ensure efficiency and continuity of services. The ICT is a comprehensive team of health care professionals that can address the member's needs in totality, including the member's physical health, mental health and social care needs. An individual from the ICT is the member's single point of contact that manages and coordinates care for the member.

- CareMore Care Centers (CCCs) are opened in communities to serve as a "medical home", and to deliver innovative, focused clinical programs and coordinated care.
- Clinical Leaders continue to be involved in direct member care and are committed to a member-oriented philosophy. They are responsible for the performance of our clinicians, network providers, and the entire community-based healthcare and social support system.
- Clinical programs are premised on evidenced-based medicine. They are designed with well thought-out outcomes reporting for continuous quality improvement and then solidified using clinical protocols, measures, and training.
- All non-clinical Directors and above are required to participate in a clinical orientation, which includes exposure to interdisciplinary teams, interaction with clinical departments, and rounds with clinicians.
- The clinical model continues to evolve as a result of innovative ideas from our clinical team. Their involvement in healthcare delivery and its issues, combined with available resources, empowers and inspires them to make improvements to the healthcare system.

For the purposes of our submission to the Dual Eligible Demonstration, we provide DHCS with CareMore's Model of Care, with key additions to ensure that the MOC meets the requirements of the Demonstration. The following information references CareMore's health care delivery model for the Demonstration population.

CareMore's "Philosophy of Health Care" guides improvements to the clinical model and propels it forward. We believe:

- Members require ***overtly coordinated*** care with a personal ***care plan*** that takes into account their multiple conditions and LTSS needs and addresses them ***simultaneously***.
- A physical and human ***care home*** is required to create care coordination in a setting where care habits of members can be sustained.
- Clinicians in key roles must be ***confident generalists,*** persistent and deliberate, with competence as clinical decision makers, communicators and team players.
- All providers of service have a ***buy-in for the system of care***, not just their individual capabilities.
- A complete care continuum requires equal ***attention to medical, social, psychological and pharmacological needs*** of the member.
- An ***explicit approach to care*** is required for each chronic condition, for high-frequency acute episodes, for end-of-life and for members in specific settings such as institutional care, assisted living and group homes, housing, own home/family home, and for a smaller group of members, no permanent setting (homeless, in shelters).
- An ***obsessive attention to detail*** in both micro matters (individual care) and macro matters (care programs) permits optimal outcomes.
- A ***willingness to thoughtfully challenge the status quo*** provides windows of insight into clinical innovation and care pattern redesign which can optimize member health and comfort, and conserve financial resources.

An example of CareMore's clinical model is how health care is delivered when a member experiences an acute event. When a member is hospitalized:

- An Extensivist (Hospitalist) is notified immediately about the admission.

- The Extensivist has access to all of the member's previous medical history, medication lists, lab results, ancillary services and encounters through Case Managers and on-line systems. This improves the quality and timeliness of the member's care, because the Hospitalist is able to make information-based decisions quickly.
- During the inpatient treatment period, the Extensivist contacts the member's PCP and family to get information and serve as a point of contact regarding the member's health status, issues, and needs.
- The Extensivist and the Case Manager communicate daily to coordinate the member's care and to start planning for the member's transition out of the acute setting.
- As part of the discharge plan the Extensivist and Case Manager will assess what outpatient services are required to stabilize the member, and resolve any factors contributing to the member's admission. This includes arranged services, appointments with physicians, psychosocial and functional needs, and enrollment in clinical programs (such as Diabetes Management, House Call, and Exercise and Strength Training).
- At the time of discharge, a Case Manager coordinates the member's discharge services and schedules their follow-up appointments. The member is contacted within 48 hours to make sure they understand their discharge instructions and to address any questions or concerns about their health status.
- The member is scheduled for a follow-up visit with an Extensivist within a week of their discharge.
- Case Managers and Extensivists continue to follow the member until they feel the member is clinically stable and all necessary outpatient workup has been completed.
- If the member is discharged to a skilled nursing facility (SNF), the discharging Extensivist will follow the member in the SNF until the acute episode is resolved.
- Both the Extensivist and Case Manager will follow the member indefinitely if the member is high-risk based on frailty, co-morbidity and/or social situation.

As a result of our hospitalization and post-hospitalization programs, our readmission rate is 40% less than national averages. This is due to the teamwork, systems, rigor, and standardization that are part of our clinical model.

Our members in institutional care or at an institutional level of care and living in licensed residential settings receive specialized management that sends Mid-Level Providers (MLPs) into the facility.

- A Mid-Level Providers (MLPs), such as a Physician Assistant or Nurse Practitioner, is immediately assigned to assess and oversee the long-term care and case management services for the member, assisted by case managers, social workers, behavioral health specialists, nutritionists, home health care providers, foot care providers and others as appropriate for the specific member's needs. An individual from the ICT is the single point of contact for the member to manage and coordinate care for the member. When the designated ICT individual is other than the NP, the designee coordinates their activities with the NP.
- NPs/MLPs are trained to:
    - Care for and coordinate services for extremely frail or medically-complex patients.
    - Bring resources to patients and their families and improve their quality of life.

  - Address end-of-life issues and hospice needs.
- Within a month of the member's effective date:
  - The MLP performs an initial face-to-face member assessment and comprehensive physical exam, including a history and physical, review of medications, assessment using multiple screening tools (e.g. depression scale, mini mental status exam, pain scale), and review of advanced directives and codes status.
  - The MLP will request medical records to gather additional information on the member as needed.
  - The MLP will arrange for any necessary mobile diagnostic testing and podiatry to be performed at the member's nursing, assisted living, or board and care setting.
  - The MLP also communicates with the family and/or person who has a durable power of attorney (DPOA), the Primary Care Provider, and facility staff to gather information, updates them on the plan of care, and serves as a point of contact regarding the member's health status, issues, and needs.
- Because of the initial assessment and comprehensive exam, the MLP establishes the plan of care.
  - The plan of care may be reviewed by the Medical Director and assessed at regular Interdisciplinary Team meetings.
  - The plan of care continues to be reviewed regularly and as frequently as daily, depending on the acuity of the member. The frequency of MLP visits is adjusted as the member's condition changes.
- The MLP and/or Medical Director will arrange for Specialists, as needed, to see the member at a nursing home or living in the community, but requiring the same level of care as someone in a nursing home. In instances where the Specialist cannot see the member in their home setting, the MLP will arrange for transportation or the family to take the member to their appointment.
- On an on-going basis the MLP continues to see the member, coordinates their plan of care, and arranges for needed services. If a member has an acute event, skilled need, or elective surgery:
  - Our Extensivists will take over the care of the member while hospitalized and coordinate services.
  - Hospitalists work in close collaboration with the Medical Director or MLP to ensure continuity.

Element 1: Description of Duals Demonstration Target Population

For this model of care, we are targeting full benefit Dual Eligible members who have Medicare Parts A, B, D and Medi-Cal. This includes:

- Qualified Medicare Beneficiary Plus (QMB+) dual-eligible
- Specified Low-income Medicare Beneficiary Plus (SLMB+) dual-eligible
- Qualified Medicare Beneficiary (QMB) dual-eligible
- Specified Low-income Medicare Beneficiary (SLMB) dual-eligible

These patients are mostly low income seniors or non-elderly adults with disabilities (but may also include a small number of children). The top 10 chronic conditions among dual eligibles

based on total expenditures include acute and chronic medical conditions, mental illness and developmental disorders:

- Hypertension
- Diabetes
- COPD
- Spondylosis
- Coronary atherosclerosis
- Congestive heart failure
- Mood disorders
- Pneumonia
- Schizophrenia
- Chronic renal failure
- Respiratory failure
- Septicemia
- Acute cerebrovascular disease
- Developmental disorders

A significant portion of our members have one or more of the following:

- Cognitive impairment
- Functional impairment (e.g. combinations of ADL/IADL impairments)
- Varying ability in social and care giver support
- Increasing need for assistance and monitoring for such things as medication management, safety and fall prevention, and general care giving services
- Complex medical management needs
- Are within the last five years of their lives, when end of life planning and hospice are important options to which the member and his/her family should be exposed.

The typical provider network supporting these members does not have the resources to:

- Spend a lot of time to help them manage their chronic conditions, LTSS and social support needs
- Educate patients on:
  - Diet, exercise and self-management skills
  - Provide prevention and monitoring

They are also variable in their competency managing conditions; for example: some do not always follow evidenced based medicine (e.g. the American Diabetes Association).

Our MOC is designed to provide members with self-management tools, education, and support with the goals of reducing acute complications and improving long-term outcomes based on their specific needs. For example:

- One member could have well-controlled diabetes, however also have chronic kidney disease that has not been managed by their Primary Care Physician. For this member, CareMore's model of care would enroll them in a Chronic Kidney Disease Program.

- A second member could also have diabetes, a diagnosed mental illness and have no formal education on how to manage their diabetes, and have uncontrolled hypertension. This member would be enrolled in our Diabetes Management Program and Diabetes Education Programs and Hypertension Home Monitoring Program, and be referred to our Mental Health Program. This member also would be provided Nutritional Counseling and could be enrolled in a Strength and Exercise Program.
- A third member could have COPD and be working with a Pulmonologist, but still have issues performing their basic activities of daily living. They also could be of advanced age and falling; this same member may have wounds that are not healing. This member would be managed by our COPD Management program and also, overseen by our Wound Management Program, assessed by an Extensivist to identify and intervene on the reasons for falls, and enrolled in a Strength and Exercise Program to help with their balance and assisted by a social worker, who will coordinate their care including LTSS.

In order to match the care our members and families want, with the care our members actually receive, requires a tremendous amount of communication with patients, their families, our Nurse Practitioners (NPs), PCPs, subspecialists, facilities and a myriad number of other participants as individual situations may warrant.

- For example, one of our members developed a malignant melanoma on her nose. The Dermatologist, ENT and Plastic Surgeon all wanted to do a facial reconstruction in this very pleasantly demented member. The daughter cried tears of joy when we offered her and her mother options of doing the requested surgery and <u>not</u> doing the requested surgery. She knew her mother wouldn't be able to understand why and what was being done to her. It is now nearly a year later and her mother continues to do very well, without the potential and real complications of anesthesia and surgery in a frail elderly demented member.
- Another example is one of our frail, elderly members living in the community at an ALF who developed a vulvar mass and groin swelling. She was a very private woman and refused well-woman exams and health care maintenance. On examination, she had obvious cancer. Outpatient evaluation and eventual surgery was done at UCLA, returning her back to her home, the ALF, for further outpatient treatment, which included radiation therapy. Informed consent was given at each step of the way, and we simply matched the medical care desired, with the medical care this member actually received. Our member predictably slowly deteriorated and eventually was transferred to a skilled nursing facility for IV fluids. During this SNF stay, the Member opted to go back home to her ALF with Hospice/End of Life Care. She died a few weeks later in her own home/ALF.
- A third example is our care manager was working with a 38-year-old member living in California with end-stage renal disease and severe depression. Wanting to die, she was refusing dialysis. The care manager found a family member who drove from the east coast to California to help, staying in touch the whole way. Just as the family member arrived, the member was hospitalized and refused treatment, so she lapsed into unconsciousness. With the help of the care manager, the family member got a healthcare durable power of attorney and was able to restart dialysis. Together, they convinced the

member to continue treatment and continue to live. Our care manager kept in touch and kept on helping. She connected the member with legal resources to help pay for medical bills that started before she was insured, helped her find care for her four-year-old daughter, encouraged her to accept counseling and found her opportunities to volunteer in the community. Now the member knits blankets for seniors, has improved her functioning at home, and has fewer hospitalizations due to self-neglect and depression.

Every aspect of these examples was coordinated by a treating NP and Medical Director, with the assistance of care managers and other key staff on the interdisciplinary care team (ICT). Our goal of care is to truly become a part of the member's family, and you can see from these examples that we did.

All of these patients have regular health risk assessments to identify any new needs on an annual basis, at a minimum. A care plan is also developed with them to ensure their care is tailored for their individual needs and preferences.

Element 2: Measureable Goals/ Care Management Goals

Care Management goals focus on improving member access to affordable care and essential services such as medical, mental health, long-term supports and services (LTSS), including home and community-based services (HCBS) and social services; improving coordination of care through an identified point of contact; improving seamless transitions of care across health care settings, providers and HCBS; assuring appropriate utilization of services; and Improving access to preventive health services and health outcomes.

Element 2a:

For the calendar year 2012, our Medical Officers selected the following goals to improve member care:

1. 100% of new enrollees complete a Healthy Start/Healthy Journey health risk assessment and care plan in order to improve access, health outcomes and utilization, with the following conducted face-to-face to improve the quality of the assessment
    a. 80% of new enrollees
    b. 70% of existing enrollees

    We selected this goal because we found a face-to-face encounter produces a better quality assessment and care plan. During a face-to-face encounter, clinicians are better able to assess and diagnose member' conditions, and work with them and their care givers to produce a care plan tailored to their specific situation. As an example: we can perform a more detailed cognitive (dementia) screen during a face-to-face encounter, than is possible over the phone. A face-to-face encounter also allows us to identify and arrange for urgently needed essential services quickly (for example: nebulizers), manage their conditions more closely (thereby improving outcomes) and improve utilization by getting patients to the right providers. We also use these visits to work with patients to improve access to affordable care; for example: part of this visit is to assess patients' medications to identify generic opportunities. Once a

clinician establishes a relationship with a member, this clinician continues to work with the member to meet their care plan goals and identify new conditions that need to be addressed before they become an issue.

2. Admission to a hospital will be below the following bed day thresholds:
    a. 962 bed days / 1000 members (note: this is a 2011 goal, as of the time of this document: we have not finalized the 2012 goals. Also this is an annual average; we monitor to monthly thresholds (to account for seasonality).

    Reduction in hospital admission rates by providing preventative services which improve access, health outcomes, utilization, and coordination of care.

    - We aim to reduce hospital admission rates using preventative services. Historically, we have found many hospitalizations could be prevented by better monitoring and interventions.
        - Example: By aggressively monitoring hypertension, Nurse Practitioner's can intervene on dangerously high blood pressures which aids in stroke prevention. Also, if the member has a wound, this NP will work with the member to heal the wound (our wound healing rates are better than national averages). As a result, an admission may be averted when the wound does not worsen, thus we are able to improve the health outcome for the member.

3. Readmission to a hospital will be below 14% across all markets and reduced by 10% in markets that are above 14%, excluding ESRD members.

    Reduction of readmission rates to a hospital to improve access, health outcomes, utilization, and coordination of care.

    We aim to reduce readmission rates by improving care transitions between clinical settings. Some of the approaches used by the clinician are to review reasons for admission and address those issues as part of the discharge plan.
    - Example: A member's safety in their usual home environment may be compromised due to decreased mobility leading to a fall. Therefore, as part of the discharge plan from the hospital, we would provide physical therapy at a skilled facility and reassess the home environment for appropriateness.

4. HEDIS score improvements to Five Stars or a minimum of One Star improvement to the following services and outcomes:
    a. LDL testing on patients with cardiac disease
    b. LDL control on patients with cardiac disease
    c. HgbA1c control
    d. Retinopathy
    e. Nephropathy
    f. Glaucoma screening

5. Enrollment in Clinical Programs for high risk patients as follows:
    a. 95% of patients with hgbA1c > 10 accepted enrollment in the Diabetes Program.
    b. 95% of patients with COPD on oxygen accepted enrollment in the COPD Management Program.
    c. 95% of patients on Coumadin/Warafrin accepted enrollment in the Anticoagulation Management Program

    We added HEDIS type preventative services (e.g. cholesterol control) to the scope of the services provided by its NPs in late 2010; we also added an outreach team in its Quality Department. We found some patients were not accessing their PCP, and getting referred for these services. The NPs assess each member at a minimum of annually, as part of Healthy Start and Healthy Journey health risk assessment and care plan, and as a result, are able to arrange for preventative services and follow up with patients when they do not receive them.
6. Improve seamless transitions of care across healthcare settings, providers, and health services: The goal is to decrease the 30-day return to acute by December 31, 2012. This will be accomplished by improving communication between Hospitals, Extensivists, Nursing Homes, and Community Settings. The MLP's will act as a gatekeeper to ensure consistent communication across settings and providers.
7. Improve coordination of care through an identified point of contact (e.g. gatekeeper): As the point of contact, the MLP inputs patients' medical information into EMR which allows providers involved in the member's care to access the same information. The Baseline use of EMR was less than 10% in 2010. The goal is to have 90% EMR utilization by MLP's by December 31, 2012. This will improve the coordination of care by centralizing the availability of medical records, including the care plan, so that it can be reviewed, for example, by the Interdisciplinary Care Team.
8. Improve the number of members that utilize hospice services appropriately: we understand that most patients prefer to die at home. As a result, we train our clinicians to begin the end-of-life discussion at the initial assessment, and to continue addressing end-of-life issues as they surface. For example, with every member, clinicians review advance directives and patients' preferred intensity of care to ensure that the clinician knows the patients' wishes.

For 2013 we intend to include DHCS-specified measures.

<u>Element 2b:</u>

The specific outcomes measures we have selected for 2012 are as follows:

1. 100% of new enrollees complete a Healthy Start/Healthy Journey health risk assessment and care plan in order to improve access, health outcomes and utilization, with the following conducted face-to-face to improve the quality of the assessment
    a. 80% of new enrollees
    b. 70% of existing enrollees
2. Admission to a hospital will be below the following bed day thresholds:

   a. 962 bed days / 1000 members (note: this is the 2011 goal, as of the time of this document, we had not yet finalized 2012 goals. Also this is an annual average; we monitor to monthly thresholds (to account for seasonality).

3. Readmission to a hospital will be below 14% across all markets and reduced by 10% in markets that are above 14%, excluding ESRD members.
4. HEDIS score improvements to Five Stars or a minimum of One Star improvement to the following services and outcomes:
   a. LDL testing on patients with cardiac disease
   b. LDL control on patients with cardiac disease
   c. HgbA1c control
   d. Retinopathy
   e. Nephropathy
   f. Glaucoma screening
5. Enrollment in Clinical Programs for high risk patients as follows:
   a. 95% of patients with hgbA1c > 10 accepted enrollment in the Diabetes Program.
   b. 95% of patients with COPD on oxygen accepted enrollment in the COPD Management Program.
   c. 95% of patients on Coumadin/Warafrin accepted enrollment in the Anticoagulation Management Program
6. Improve seamless transitions of care across healthcare settings, providers, and health services: Decrease the 30-day return to acute care to 10% by December 31, 2012. The current baseline is 12%.
7. Improve coordination of care: Baseline use of EMR was less than 10% in 2010. The goal is to have 90% EMR utilization by MLPs by December 31, 2012
8. We are working to increase the percentage of patients that utilize hospice services to 84% by December 31, 2012. The baseline hospice utilization is 82%. EMR will allow us to identify every member discussion concerning their desired advance directives. This metric will be reported on the dashboard.

These goals will be measured and monitored, at a minimum of quarterly, by reviewing clinical measure and outcomes reports during the Quality Management Program, Medical Officer and Interdisciplinary Oversight meetings.

For goals that are not met or on target to be met, a CareMore Medical Officer/Director will be assigned to develop and execute a corrective action plan overseen by the Quality Management Program.

For 2013 we intend to include DHCS-specified outcomes measures.

<u>Element 2c:</u>

Medical Officers in conjunction with the Quality Improvement team oversee these goals. Admissions are monitored by the Medical Officers on a daily basis when the "Daily Census"

reports come out; if there is a negative trend, a Medical Officer may intervene and start working with local hospitalists to identify causes and necessary interventions. Readmissions are evaluated monthly using the monthly "Hospital Metrics Report", and similar to admissions, Medical Officers may intervene and work on issues in local neighborhoods; additionally, many neighborhoods track readmissions real-time and assess weekly in ICT meetings. On a quarterly basis, a Clinical Dashboard is produced, which shows performance against all goals. The Medical Officers, led by the Chief Medical Officer, review the performance and agree on specific interventions and timeframes for resolution. Performance reviews may include the following: focused chart reviews to determine if clinicians are following protocols, in-person supervisory oversight of clinicians (e.g. round table with them), and reassessment/review of protocols. The Medical Officer team determines and follows the improvement plans in the Medical Officer meeting (which meets every other week), meets monthly and reviews clinical performance reports and reassesses performance during the next scheduled Dashboard Review meeting.

These activities are also reported through the Quality Improvement Committee, for additional assessment and tracking of progress on a quarterly basis. The Medical Officer and NP Clinical Director, responsible for the model care, present to the committee their performance against goals, along with action plans to remediate any unmet goals for feedback from the Committee. The Quality Improvement Committee could provide additional feedback such as:

- Changes to the model of care, such as additional staffing levels as described above or additions to the interdisciplinary care team.
- Performance improvement initiatives, such as working with the ICT for a particular neighborhood to improve the clinical care.
- Additional measurement and trending of outcomes, such as tracking of reasons for hospitalization.
- A change to the goal, if they find the original goal was not appropriate for the population.

As an example, a monitoring outreach effort was put in place in early 2011. In late 2011 we identified that the outreach effort was not resulting in the program enrollment level at goal. Therefore, in 2012, we are undertaking another initiative to have neighborhood-based clinicians outreach to high-risk patients to increase the enrollment in our Clinical Management Programs. The reason for the change to this outreach approach is that the existing team is staffed by unlicensed clinical support staff; our experience shows us that licensed clinicians and staff based in a member's neighborhood have better enrollment success rates.

Another example of actions on readmissions: in late 2011, our Medical Officers identified that two of its neighborhoods had consistently lower readmissions than all other markets. As a result, the Medical Officers of these neighborhoods have been assigned to spearhead a clinical initiative to work with all other Medical Officers to deploy best practices to reduce and stabilize readmission rates in all neighborhoods. This initiative will be monitored by our Senior Medical Officers to ensure progress is being made.

The Quality Improvement Committee will follow up on its recommendations in future meetings to validate they were implemented, and to assure the suggested interventions result in performance improvement of the goals.

Element 3: Staff Structure and Roles

Staff structure and roles are organized to perform the administrative, clinical and oversight functions required to support Dual Eligible population of patients.

Element 3a: Administrative

- Membership and Eligibility for Medicare enrollment under CareMore's Medicare Advantage SNPs
  - Process all enrollments with information provided by the sales team.
    - Enrollment Specialists obtain applications from sales representative, validate the data by comparing the application demographics to CMS MARx system, and submits the transaction for nightly upload to CMS.
    - Enrollment specialists ensure there is a signed pre-attestation for each member, and if it is not available, follows policy to obtain it.
    - IT schedules an automatic nightly upload to CMS.
    - Enrollment Specialists then receive the daily and weekly batch transmission acknowledgement to validate all enrollment transactions were successfully accepted by CMS MARx system. The Enrollment Specialists also correct any errors and resubmit them.
- Member Services and Enrollment
  - Verify eligibility
    - As an example: members typically call Member Services to find out if they're eligible and what their benefits are; the Member Services representative will quote benefits, look up eligibility history, and send a new membership identification card to the member if needed.
  - Additionally functionality is available through our portal for contracted providers to verify eligibility.
    - IT produces a monthly eligibility file for select providers who want to receive this information electronically.

For the Dual Eligible Demonstration, we assume that enrollment data will be provided by DHCS. We will work with DHCS to ensure our processes for enrollment and eligibility verification of the Demonstration population is timely and accurate.

- Claims
  - Process claims
  - Staff includes Clerks, Claims Adjudicators, Claim Phone Representatives and Auditors.
    - Clerks receive mail, batch correspondence, produce reports (such as: inventory, production, and quality).

        - Claims Adjudicators are specialists in areas such as: non-contracted, inpatient, professional, ancillary services (e.g. DME) and LTSS.
            - Auditors review Claim Adjudicator's work pre-payment to ensure appropriate processing of the claim.
    - Claim phone representatives work with provider offices on claim questions and disputes; they also work as the intermediary with Member Services for member questions and disputes.
- Member Services
    - Provide members or their authorized legal representative (with power of attorney) with general information about the plan (e.g. how to get a prescription drug refilled)
    - Facilitate resolution of consumer needs (e.g. a member may need assistance with transportation to their fitness and strength training appointment or to access community-based social supports)
    - Receive consumer complaints and enter them into a tracking database
    - Communicate telephonically and disseminate written plan information to beneficiaries and network providers (e.g. they will give a member a replacement member identification card)
    - Address service complaints and triage quality complaints (e.g. member believes they received inadequate care (e.g. did not get a prescription they thought they needed)) to the Quality Improvement Department
- Provider Services
    - Facilitate resolution of provider complaints
- Quality Improvement:
    - Obtains medical records and responses from providers or other involved parties
    - Reviews them with the Medical Director and assigns a severity level to the grievance
    - Facilitate resolution

<u>Element 3b: Clinical</u>

- Quality Improvement Nurses and Nurse Extenders:
    - Facilitate the Quality Management Program, and work with Medical Officers to formally monitor and oversee the performance of the Dual Eligible program
    - Survey beneficiary satisfaction
        - The Quality Improvement (QI) staff work with a vendor, MORPACE, who conducts the CAHPS survey on our behalf.
        - When the QI staff receives the results, they present them to the QI Committee for analysis and recommendation of improvement.
- Utilization Management staff, including Medical Directors:
    - Review and analyze utilization data
    - Authorize and/or facilitate access to specialist and therapies
        - Additionally CareMore clinicians seeing patients who are frail and with uncontrolled chronic conditions will authorize and facilitate access to services; these services are usually authorized without delays
        - Furthermore, we have dedicated case managers who work with Hospitalists and post discharged patients. Services for these patients are arranged and authorized

on an urgent and emergent basis. For example: patients are scheduled with the hospitalist for a post discharge assessment, generally within 1 week of discharge, to make sure all follow up occurs and the member is compliant with their discharge plan (e.g. medication reconciliation).

- Member Services Representatives
  - Advocate, inform and educate beneficiaries on services and benefits; for example: answering questions regarding DME coverage, helping them understand how to get prescriptions refilled when they first join the plan.
  - Facilitate transportation services. Member Services have coordinators who schedule transportation for members.
  - Identify and facilitate access to LTSS, including HCBS, community resources and social services.
  - Schedule appointments for member's Healthy Start and Healthy Journey visits, as well as preventative HEDIS type services (e.g. colonoscopies).

Our clinicians (including Hospitalists, certain Specialists, Nurse Practitioners, Case Managers, Social Workers, Pharmacists, Mental Health Professionals, and other support staff) comprise the Interdisciplinary Care Team supporting Dual Eligible patients.

- A NP leads the team and brings in other team members, such as care managers, social workers, behavioral health specialists, and other non-clinical health care professionals when needed The NP:
  - Performs preventative services like chronic condition management (Diabetes, COPD, ESRD, CHF, Hypertension and Cardiovascular Disorders).
  - Educates patients on disease-specific self-management skills
  - Provides health maintenance (e.g. flu shots, referrals for colonoscopies)
  - Closely monitors hospitalized patients in high risk populations (ESRD, CHF and COPD)
  - Provides effective communication with facility staff, family members and clinical team to ensure implementation of the member's care plan.
  - Visits members in institutional settings weekly and visits members in RCFEs, housing or at home as appropriate to the member's needs
  - Identifies other risk factors, like depression and social issues, and triages patients for additional services through other Interdisciplinary Care Team members.
    - For example: the Social Worker will arrange for LTSS and community resources at home or in a community-based residential facility for members who are not safe living at home.
  - Completes the Health Risk Assessment and Care Plan – see details documented in HRA section below.
  - Triages beneficiary care needs; this is especially important in this member population where many of the care needs are urgent to prevent hospitalization and a decline in health status.
  - Visit members in RCFEs, housing or at home as appropriate to the member's needs.

- As an example, during an NP's initial comprehensive evaluation of a new member, finding out our new member had metastatic cancer to the lung. Because the Mid-Level

Provider was not sure if the member was hospice appropriate or not, she arranged a family meeting with the member, the nephew (DPOA for medical and financial), his wife, and our Medical Director. During this meeting, informed consent was given, including all of the options available to the member. At the end of this discussion, the member changed from full code to DNR and opted to not go with Hospice just yet. This all happened within the first week of admission. This Nurse Practitioner saw the member weekly, based on the model of care, and all agreed to arrange another meeting in one month to review the expected progressive decline. The NP was instructed to immediately report any changes of condition to the DPOA/family

The ICT provides assistance to members who wish to take a more active role in the team, in areas such as:

- Selecting the date, time and location of the ICT.
- Identifying who they want to participate in the ICT. This includes family members, friends, providers and others of the member's choosing.
- Developing a member-centered plan of care.

- Other team members are actively engaged in helping to manage care for patients who are frail, in acute settings or who have chronic or other conditions requiring specialist interventions, e.g.
  - Medical assistants support the NP and:
    - Schedule appointments and follow up services for patients being seen with uncontrolled chronic conditions, frail patients, and those receiving their annual Healthy Start or Healthy Journey health risk assessment. For example: if a member has not seen their Primary Care physician at their initial Healthy Start health risk assessment, the appointment will be scheduled for them.
    - Retrieve consultation and diagnostic reports from network specialists to obtain a more complete medical record for the ICT to access (for example: the results of an echocardiogram).
    - Facilitate translation services
    - Facilitate transportation services
  - Extensivist:
    - See patients who are hospitalized in contracted hospitals and skilled nursing facilities, and develop the discharge plan which includes clinical programs and network specialists. The Extensivist also may see the member outpatient to make sure all of their discharge follow up is complete, and the member is stable. For example: a member could be seen post discharge to ensure they are taking their medications appropriately and to follow up on the results of an MRI and intervene on any issues.
    - Also may see the member outpatient to make sure all of their discharge follow up is complete, and the member is stable
  - Case Managers:
    - Work with the Extensivists to implement the discharge plans and transition the member to the NP.

    - Perform telephonic, fax and/or on-site reviews with skilled nursing facilities, home health agencies or other contracted service agencies as appropriate to determine need for continued care.
    - Helps address the patient's health, LTSS and psychosocial needs.
  - Visit members in RCFEs, housing or at home sites as appropriate to the member's needs.
  - Social Workers:
    - Help address patients LTSS and psychosocial needs. For example: they will work with patients to arrange LTSS and bring community resources into their home to support their activities of daily living such as: meals on wheels, and financial benefits.
    - Visit members in RCFEs, housing or at home sites as appropriate to the member's needs
  - Behavioral health specialists address members' needs related to a mental illness and/or substance use diagnosis and help coordinate and integrate the member's medical and behavioral health services.
    - Visit members in RCFEs, housing or at home as appropriate to the member's needs
    - Refer members with complex needs who are hard to reach to the CareMore Intervention Team (CIT) for outreach and delivery of preventive care and social supports.
  - Specialists, (e.g. Pulmonologists, Cardiologists, Podiatrists), are actively involved in managing high risk conditions with the NP.
  - Compliance and Information Technology staff:
    - Ensure maintenance and sharing of healthcare records. For details, refer to the Communication Network section below
    - Ensure HIPAA compliance following the HIPAA compliance policy

<u>Element 3c: Administrative Oversight</u>

- Operations
  - Oversee plan operations and develop policies
    - Department Directors develop policies and procedures, for example: LEP Billing Procedures, Appeals and Grievance Determination and Processing
    - Department Directors also oversee the performance of their teams; for example: customer service call times are monitored real time, reported monthly and put into a dashboard quarterly.
    - Additionally Operations performs an end to end audit two times per year.
- Compliance
  - Oversee plan operations and policies
  - Ensure statutory and regulatory compliance. For example: the Compliance Director works with functional Directors and Vice Presidents to make sure they have appropriate policies and monitoring in place to meet regulatory needs; for example: completion of health risk assessment.

- Utilization Management
  - Authorize and/or facilitate access to specialists and therapies
- Credentialing
  - Credentialing Coordinators
    - Gather and verify credentials from contracted and employed providers, including: license, DEA, education and training, background screening, sanctions, malpractice history, OIG exclusions, and Medicare opt out.
    - Gather data specific to performance monitoring for re-credentialing decisions (e.g. member satisfaction survey results, access survey results)
    - Monitor providers for sanctions in between credentialing cycles.
    - Facilitate approval of providers through the Credentialing Committee at initial credentialing and re-credentialing.
    - Track and monitor member complaints (e.g. physical accessibility, compliance with home care schedule and duties, etc.) to determine if complaint threshold is met to trigger a site visit or home visit. Then follow up on the results of the site visit, and present to the credentialing committee.
  - Credentialing Committee – comprised of Medical Directors and practicing physicians, who review and approve credentialing applicants, and applicants applying for network participation.
- Quality Management staff and committees who:
  - Monitor and evaluate the model of care is delivering its intended outcomes; see description under Care Management Goals above
  - Lead the Quality Improvement Program and peer review process; this program includes the composition of the QI Committee, how often they meet, the topics they will assess and analyze, audits and surveys we will conduct and participate annually (e.g. audit of care transitions), review any identified peer review issues, and oversee care management goals and program improvements.
  - Review medical records, in conjunction with Medical Directors, to assess the use of evidence based medicine by network practitioners.
- Pharmacy
  - Manage the pharmacy program to improve costs and quality; including:
    - Internal medication error identification and reduction system; this system includes, but is not limited to:
      - Monthly Beers' Review targeting inappropriate drugs in the elderly
      - Quarterly Physician Utilization Reports
      - Monthly Health Risk Assessment/Healthy Heart Process including CHF and COPD
      - Ongoing Drug-drug interaction review performed by contracted PBM and provider network
      - Quarterly Medication Therapy Management Program
      - Monthly utilization reports from PBM including Top 100 Reports, High Utilization Pattern Alerts, and High Cost Member reports
    - Pharmacy cost management programs:
      - Drug Utilization Review

        - Retrospective - Physician Utilization Reports are developed and distributed to providers to identify areas of improvement including, but not limited to generic substitution, simplification of therapy, avoidance of medications deemed inappropriate for the elderly, and poly-pharmacy or poly-prescribers.
        - Initial - All new member drug regimens are reviewed by the CareMore physician and/or pharmacist as part of the Health Risk Assessment (HRA) or Healthy Start Program within the first month of the member being enrolled.
        - Concurrent drug utilization review
            - Member drug regimens may be reviewed at the request of the Physician or member
        - Drug regimens are also reviewed in concert with the Medication Therapy Management Program (See Medication Therapy Management Program (MTMP)
    - Formulary Design
    - The Formulary is generic-driven Step Therapy, Quantity Limits and Prior Authorization
        - Step Edits are in place for certain classes of drugs whereby the member must satisfy the requirement prior to receiving a higher costing formulary medication.
        - Quantity Limits are in place for many formulary medications to ensure appropriate utilization, reduced costs and prevent over-utilization.
        - Prior Authorization requirements are in place for certain medications to ensure appropriate utilization.
    - Preferred drugs are encouraged in all utilization reports, physician mailings, and physician newsletters
- Information Technology
    - Create databases and internet based applications to support clinical care (e.g. EMR); see Communication Network section below.

<u>Element 3c: Clinical Oversight</u>

- Led by the Chief Medical Officer and includes Medical Officers, Medical Directors, and Clinical Vice Presidents, Directors and Managers who:
    - Create and monitor clinical quality outcome and utilization measures, as described in the Care Management Goals section above and the Performance and Health Outcome Measurement section below.
    - Lead, innovate, and ensure the quality of the clinical model. They enhance the model of care to improve outcomes.
    - Examples from 2010 - we:

  - Enhanced our NP based chronic care programs to include NP resources to work with patients with COPD and Cardiovascular Disorders, because many patients were not accessing Pulmonologists and Cardiologists; additionally, sometimes contracted providers were not providing preventable services we had deemed a best practice (e.g. giving COPD patients a prescription for rescue medications) and educating all patients on what to do for symptoms that may lead to an acute event (e.g. hyperglycemia in diabetics).
  - Identified "preferred" Cardiologists to work with plan members to better engage them in the model of care, and provided them with training (for example: encouraging their patients with risk factors like diabetes to participate in the Diabetes Management Program and patients on Coumadin to participate in the Coumadin Management Program.
  - Implemented an Outreach Program for members with risk factors not participating in clinical programs – for example: patients with hbgA1c > 8, on Coumadin, with COPD not being treated by a Pulomonologist, with ESRD, and with CKD.

We currently have 4 Medical Officers working with the clinical team on these initiatives, which are continually evolving the model of care.

- Keep our philosophy member oriented; the majority of our Medical Officers and Directors still see patients on a regular basis, which keeps them informed on the performance of the delivery system.
- Integrate the clinical model into new markets as we grow; in addition to the Medical Officer responsible for the Dual Eligible program, there are local Regional Medical Officers and Directors responsible for each neighborhood; the Medical Officer works directly with the Regional Medical Officers and Directors on neighborhood specific needs. For example: a particular neighborhood may have a high readmission rate and the Medical Officer will get involved with the local Medical Director, Hospitalists, and Case Managers to assess patients and their discharge plans. Our Medical Officers will often work and round in the local hospitals to get first-hand knowledge of the local challenges.
- Develop model of care protocols based on evidenced based protocols; the Senior Medical Officers, along with Specialty Medical Directors (e.g. Cardiology, Nephrology, and Psychiatry) and the Director of Clinic Programs keep abreast on changes in protocols and incorporates them into the model of care.
- Train clinical personnel
- Provide input to the care plans for frail patients and non-elderly adults with disabilities; this happens as member cases are reviewed in ICT meetings for difficult and post discharge cases.
- Monitor the quality and efficiency of services provided by PCPs and Specialists in the region
  - Manage proper follow up of patients post discharge, from a hospital or skilled nursing facility; admissions are seen by the MLP with direct oversight and feedback by the Medical Director. The average length of stay for a member in SNF is 9.8 days, well below the national average.
- Monitor utilization patterns for appropriateness

- In conjunction with the Quality Management Program, monitor performance of the clinical model and implementation of corrective actions to address deficiencies; see Care Management Goals section above.
- Educate enrollment and field representatives on the clinical model so they appropriately represent it to new and potential members; Chief, Senior and Regional Medical Officers are directly involved in these education efforts. We have found member compliance and satisfaction improves when new enrollees understand the model of care when they join the plan.

Element 4: Interdisciplinary Care Team (ICT)

Element 4a:

We have multiple Interdisciplinary Care Teams that evaluate the needs of members based on their risk levels. These teams are dedicated to populations of patients:

- Residing in a "neighborhood" (defined in a specific geographic area based on membership. Each "neighborhood also has a bricks and mortar CareMore Care Center.)
- Who have chronic conditions
- Who require high-risk member management (e.g. have complex psychosocial issues, are medically complex, have co-morbid MI/SA, are at the end of life)

These teams continue to evolve under the leadership of our Medical Officers and Directors responsible for improving member care.

The main team that collaborates on Dual Eligible Members is the Neighborhood ICT. It is led by the local Medical Officer/Director and includes interdisciplinary and multidisciplinary input from:

ICT Member	Role
Nurse Practitioners	• Perform initial health risk assessment • Bring in other ICT members as necessary • Develop the care plan, by collaborating with other ICT members • Management of chronic co-morbid conditions • Wound management • Follow patients post hospitalization and update care plan as necessary • Refer for preventative services • Visit members in institutional settings weekly • May visit members at home or in a community-based setting when needed • Available to patients 24/7
Internist/Hospitalist	• Manage hospitalized patients and develop discharge plans • Consult with NP on difficult cases • Assess and treat fall risk patients

ICT Member	Role
	• Perform case reviews, with NP Clinical Managers and NPs
Case Managers	• Support Internist / Hospitalists • Coordinate discharge plans • Help address the member's health care, behavioral health and LTSS needs. • May visit members at home or in a community-based setting when needed
Fitness Trainers	• Provide strength and exercise training, with programs tailored to member specific needs
Social Worker	• Assess and coordinate resources to support member's psychosocial needs. • Help coordinate LTSS • May visit members at home or in a community-based setting when needed
Registered dietician	• Educate patients and develop member specific dietary plans
Mental Health Team member(s)	• Assess and manage member's clinical depression and other psychological needs. • Help develop innovative interventions for co-morbid, dual diagnosis and/or hard to reach members with mental illness and substance use issues • May visit members at home or in a community-based setting when needed • Make referrals for CIT outreach
Other specialists	• Manage and treat specialty needs as necessary
Member and/or family when appropriate, and others of the member's choosing	• Identify needed services and supports • Review issues of concern and importance to the member or member's family • Help develop the POC

This team is referred to as the "Neighborhood ICT". Their role is to:

- Identify and manage patients from the "neighborhood"
- Coordinate all available resources to provide comprehensive care
- Ensure effectiveness of programs at the neighborhood level
- Develop Primary Care Physician relationships in the neighborhood to engage them in the clinical model

A NP leads the team and includes other team members, such case managers, social workers and behavioral health specialists and other non-clinical health care professionals, as needed. The ICT is a comprehensive team of professionals that can address the member's needs in totality, including their physical health, mental health and social care needs.

Our ICT for patients with severe psychosocial issues is referred to as the CareMore Intervention Team (CIT); it is dedicated to patients with severe psychosocial issues and end-of-life needs. They meet at least weekly to manage and assess the complex needs of this vulnerable population. The team is comprised of:

- Medical Supervisors
- Nurse Practitioners
- Specialists, if applicable
- Extensivists, Board Certified in Internal Medicine
- Case Managers
- Mental Health Professionals
- Social Workers
- Other Professionals as needed (e.g. Dieticians, Clergy)

These teams manage the most frail and/or complex members from the neighborhood by using a war board to track the member's care plan, and follow any non-stable issues; the teams get together to collaborate on the best approach to these member's care.

In addition, an example of our ICT in action occurred when one of our NPs had a member with increasing confusion. Appropriate exam, labs and discussion with the Family, PCP, Facility, Lead NP and Medical Director followed. It turns out our member developed significant hyponatremia. Our NP talked to our Pharmacist and Mental Health Team, managed her depression while stopping her antidepressant, which in all likelihood was causing the hyponatremia. The hyponatremia and confusion resolved, all while continuing to treat the Major Depression effectively.

Our NP brought this to our Regional ICT for cross training and the Team reviewed all of the myriad causes, work-up and treatment of hyponatremia, as well as reviewed the differential, work-up and treatment for all the many treatable causes of confusion.

Two more examples of our flexible approach to bringing ICT resources to members are:

- Firstly, we had a very frail elderly 94 year-old new member who had a difficult time getting to doctor follow-up appointments, labs, etc. She had no family to provide transportation and no one advocating for her overall care and well-being. It took her 4 to 5 hours just to get an urinalysis. She had just bought hearing aids. Our team did a Comprehensive Initial Evaluation, HRA and Care Plan. Through our Regional ICT we brought a team of support, including a weekly follow-up visit by an NP who cleaned her cerumenous ear canals, a monthly PCP visit, a Medical Director to assist in her care, a Podiatrist every other month, a Pharmacist Team to manage her medications optimally with her NP and PCP, HHC PT to build her up and optimize her physical strength and any lab/x-rays she needed, right to her home. And, by the way, she threw away her hearing aids because she no longer needed them with clean canals!

- Secondly, our NP, through our Regional ICT, arranged a meeting with the member, family of the member, the PCP, the facility where the member lives, our NP and Medical Director. The facility was upset the member was calling 911 so often that the paramedics were threatening to report the facility for so many false alarms. By meeting with all of the parties concerned, we were able to develop a Plan of Care that made sense to everyone. We also worked through our member's anxiety issues with the support of our Mental Health and Pharmacy Teams. Since the meeting, our member hasn't called 911 in over 2 months.

  - Monitor the quality and efficiency of services provided by PCPs and Specialists in the region
    - Manage proper follow up of patients post discharge, from a hospital or skilled nursing facility; admissions are seen by the MLP with direct oversight and feedback by the Medical Director. The average length of stay for a member in SNF is 9.8 days, well below the national average.

Element 4b:

We involve the beneficiary in the ICT directly, by scheduling them and their care givers for appointments with ICT members:

- All beneficiaries are scheduled for Healthy Start and Healthy Journey appointments with the NP; these are conducted primarily at CareMore Care Centers but may be conducted at a member's home when necessary.
  - During these appointments, the NP determines which other ICT members the beneficiary needs to be seen by.
- Beneficiaries are then scheduled for follow-up appointments with these ICT members.
  - For example:
    - A beneficiary and their care giver attend their Healthy Start appointment within 30 days of enrollment at the CareMore Care Center.
    - During this appointment, the Health Risk Assessment is performed, and based on the results the beneficiary is referred for additional programs and services. For example:
    - One member is referred to:
      - The Dietician for one on one education and meal planning.
      - The Podiatrist to treat an ingrown toe nail
    - A second member is referred to:
      - An Extensivist to provide a more thorough assessment of their frailties, including falls, and multiple hospitalizations in the past year.
      - An Exercise and Strength Training program.
      - Mental Health services for their advancing Dementia.
    - A third member is referred to:
      - The COPD Management Program to help them manage their COPD.
      - The Hypertension Monitoring Program to provide daily wireless monitoring of their blood pressure, and appropriate intervention until it is well controlled.

- Continued follow-up with the NP to regularly monitor and manage their co-morbidities.
- These appointments are scheduled at the time the beneficiary and their care giver leave the Healthy Start appointment.
- The beneficiary and their care giver attend these follow up appointments, where their needs are further assessed, treatment and education is given, and care planning continues.

If a member is unable to make the appointment at the Care Center, the NP may visit their home to work with them or assess their needs and develop the care plan telephonically. Again as a result of the NP activities, the beneficiary may be scheduled for follow up activities with other members of the ICT.

The member is also given access to the 24/7 Nurse Practitioner line so they can contact the ICT as any time.

The NP conducts an annual baseline assessment of members and brings in other members of the ICT based on the needs and risk factors of each member. The criteria for these risk factors are included in guidelines, developed by the ICT, are part of the Nurse Practitioner Standardized Procedures. Based on the results of the health risk assessment, other disciplines will assess the member (e.g. Mental Health will assess patients who are identified as depressed using a PHQ9 screening tool). The ICT works virtually using a variety of communication tools including Patient QuickView, Portal and Electronic Medical Record Systems. These systems communicate the member's medical conditions and treatment needs, along with information on services being provided by all of our providers (within and outside of the ICT). Additionally, ICT members have access to other ICT member's complete assessments and treatment plans, medication refills and lapses in refills, lab results and current plan of care. ICT members conference on difficult cases, and also regularly conduct random chart reviews to assess how the ICT is performing. The majority of a beneficiaries' interaction with the ICT is face-to-face, however it is customized to the member and may be telephonic as necessary. The Nurse Practitioner also works with beneficiaries more frequently to educate them on their disease process and manage uncontrolled blood sugars, wounds, high LDL levels, and other complicating chronic conditions such as COPD.

It is physically challenging for some patients to physically attend an ICT meeting. To address this, the plan of care is managed on an on-going basis by the NP who visits patients in institutional care and licensed residential settings and who may be assisted by case managers, social workers and behavioral health specialists. These visits are made as frequently as required based on each patient's clinical conditions. Patients at home who are not able to attend an ICT meeting may participate by phone. The NP or another designated member of the ICT is responsible for communicating ICT findings to families.

The preferred approach to the interaction with the family for members with complex care needs or who are frail or at-risk, is face to face, but the availability of family members frequently makes it necessary to communicate this information by telephone. Other individual ICT members may be involved in this process as necessary.

We are currently exploring the feasibility of offering a secure Family/DPOA Portal to which the EMR system would automatically publish updates to Care Plans. Such an update would, in turn, trigger a secure email to the family member or DPOA of record that such an update is available. Family members and DPOAs will receive sign on privileges shortly after enrollment of a member. This additional resource would complement but not replace personal contact between Clinicians and Family members/DPOAs.

Element 4c:

The NP communicates routinely with other ICT members. For example:

- The Hospitalist will be contacted to coordinate hand-offs on discharge plans and for co-management of co-morbid conditions.
- Mental Health Professionals will be contacted and brought in to assess patients with clinical depression and other psychological issues.
- The Dietician will be contacted to assess patients dietary status, provide comprehensive dietary education and develop individual meal plans,
- Case Management will be contacted to coordinate member care needs like referrals to specialists.
- Specialists will be contacted to consult on difficult member cases (e.g. member not improvement on medication treatment regimen per protocol) and to assess unstable conditions (e.g. COPD stage III and IV patients, unstable angina).
- The social worker will work with the member to schedule transportation, in-home care and ancillary services. They will also arrange access to social supports available from community resources

The ICTs also works virtually using a variety of communication tools including Patient QuickView, Portal and Electronic Medical Record (EMR) Systems. These systems communicate the member's medical conditions and treatment needs, along with information on services being provided by all of our providers (within and outside of the ICT). For example, member assessments, reviews of systems, exams and care plans are maintained in our EMR; members of the ICT have access to EMR so they can understand member's conditions and care plans. Additionally, ICT members have access to other ICT member's complete assessments and treatment plans, medication refills and lapses in refills, lab results and current plan of care. ICT members conference on difficult cases, and also regularly conduct random chart reviews to assess how the ICT is performing.

Additionally the Medical Officer/Director, responsible for oversight of ICTs, regularly meets with the NP Clinical Leaders to assess quality results, clinical practices, and operational performance. In these meetings, the team:

- Assesses the Individualized Care Plans of high risk patients to identify additional interventions to improve the member's care; for example: the team may review charts of patients where the NP is having difficulty managing patients not improving on standard protocol to identify additional interventions.

- Reviews samples of hospitalized member records, to ensure they have an appropriate care plan based on the assessment and collaboration of the team. This frequently includes patients who have been readmitted. For example: after discussion, the team could decide that they do not know enough about the support system in a member's home and decide to send a social worker to perform a home assessment.
- Evaluates clinical practice issues, and cost and utilization trends as appropriate; as an example, in 2010 the American Association of Diabetes (ADA) changed their guidance on lowering blood sugar; as a result, we adopted the practice of discharging patients from their Diabetes Management Program with a Hba1c < 7.5% when they experience 2 or more episodes of hypoglycemia.
- Reviews clinical program performance reports, case management statistics (if applicable), results of chart review processes, and the status of health risk assessments and care plans
- Is responsible for the clinical protocols, including any additions and improvements resulting from new evidenced based clinical practice guidelines, nationally recognized protocols, and/or findings after assessment of the above
- Reports their progress to the Senior Medical Officers and Medical Directors who are ultimately responsible for the performance of the programs

The Neighborhood ICT meetings are set up by an Administrative Assistant, working for the Vice President of Clinical Operations, to ensure each Neighborhood has the meetings calendared for the year. A team member is assigned in each Neighborhood to document the minutes of these meetings; generally this person is the Case Manager, however this role is sometimes designated to Program Manager working with that Neighborhood. The reports used by this team are pulled from the data warehouse and include Inpatient Admissions, Readmissions, SNF Reporting, ER Reporting and clinical performance reports geared at specific disease states (e.g. COPD, diabetes)

The CIT ICT meetings are calendared at the beginning of the year by the Case Manager. This team has a census of patients it works from, which is managed by the Case Manager and distributed to the team members prior to and during meetings; this census includes some high level details on the case. Additionally, specific details on the assessments and care plan for these patients is maintained in the Case Management System, CCA and EMR.

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

We coordinate with health care providers to deliver our clinical model and strategies to ensure that there is targeted clinical expertise for each setting.

In addition to a full contracted network of providers (e.g. PCPs, specialists), we employ clinicians with specialized expertise to provide additional services to the Dual Eligible population, for example:

- Nurse Practitioners are specially trained in chronic care and, frail and disabled member management. This includes training in assessing and treating Institutionalized Members and members at institutional level of care. NPs actively engage patients, their family and direct care provider(s), community-based residential facility staff for members in these settings, and coordinate with the ICT to deliver all services. Medical Officers and specialty Medical Directors consult on difficult cases as needed.
- Dieticians have programs designed for the chronic disease populations, as well as the specialized needs of various cultures

Additionally we contract with providers who work closely with the ICT:

- Podiatrists and Pulmonologists work out of CareMore Care Centers
- Preferred specialists
- Fitness Instructors

Before entering a new market, we develop Clinical Responsibility Grids to ensure all of the critical roles are in place. Additionally contract overviews are prepared to ensure all provider types are contracted.

Our approach is to provide beneficiaries access to services, which is tailored to their needs. All beneficiaries have a Primary Care Provider who acts as a gatekeeper for their patients. All beneficiaries are also provided with immediate access to services and benefits by clinicians during their annual Healthy Start and Healthy Journey Assessments. Beneficiaries who are frail or with uncontrolled chronic conditions are managed by a clinician; our clinicians improve outcomes and access to care for this vulnerable population.

We analyze and report the performance of our provider network through our ICTs and Clinical Performance Meetings.

- The activities of the ICTs are described above
- Clinical Performance Meetings are attended by clinicians, Case Managers, and Regional Performance Managers who review information on the clinical performance of the local provider network. At these meetings:
  - Reports are analyzed including:
    - Regional clinical statistics - bed days, length of stay, admissions, readmissions, and clinical program performance
    - PCP and provider group statistics - bed days, generic pharmacy utilization, encounters, and use of clinical programs for frail and/or complex patients

  The statistics that support these meetings continue to evolve as data analytic capabilities are being developed.
- Clinicians discuss any significant clinical issues that surface as they work with the local providers.

We analyze the performance of our provider network by having Clinicians and Case Managers either working or engaged in the local healthcare delivery. This strategy varies by setting:

- For facilities:

  - Extensivists work in inpatient and SNF settings to coordinate the needs of its patients along with the interdisciplinary team, and to ensure there is a smooth transition to outpatient care.
    - Extensivists have specialization in geriatrics and are Board Certified in Internal Medicine.
    - We train Extensivists to care for frail and chronically ill patients, as well as patients near the end-of- life.
  - Extensivists are responsible for long-term outcomes for these patients across the continuum of care;
  - We set up CareMore Care Centers (CCCs) in each geographic region we operate, to provide a medical home for frail patients and to provide chronic care programs and preventative services for all patients.
  - We contract with exercise and strength training centers to provide rehabilitative services, strength and balance training, and activity in order to make patients stronger and more mobile.
- For medical specialties:
  - We contract with specialists and identify "preferred" specialists, particularly in high impact specialties, to direct care for patients (note: in some markets, We have employed specialists as well)
  - Extensivists help to coordinate needed services for frail patients.
  - We employ and contract with Medical Directors and Subject Matter Experts to help develop evidence-based protocols, and train employed personnel and consult on difficult cases.
- For behavioral and mental health:
  - We employ a Psychiatrist to oversee the Mental Health Program.
  - The Mental Health program uses a multidisciplinary team of employed and contracted Psychiatrists, Clinical Psychologists and Nurse Practitioners to provide services in facilities and outpatient settings.
  - Mental Health professionals are part of the CareMore Intervention Team (CIT). This Interdisciplinary Team develops interventions and care plans for high risk patients.
  - The goal of the mental health program is to align with the member's support system and provide patients with ease of accessibility, elimination of barriers to treatment and innovative approaches to mental health care.
- For nursing:
  - We employ Nurse Practitioners to provide chronic care management programs and preventative services.
  - We also employ Registered Nurses, Licensed Vocation Nurses, and Nurse Extenders to provide case management services.
  - The Nursing staff is responsible for development of care plans in collaboration with the interdisciplinary teams.
- For allied health professionals:
  - We employ pharmacists to manage the Pharmacy Program, which includes services like:
    - Medication Therapy Management

  - Continual evaluation of pharmaceuticals to lower member out of pocket expenses (both at the drug class and member level)
  - Evaluation of complex cases
  - Training and communications to PCPs regarding pharmaceuticals that should be avoided in the elderly (e.g. BEERS list)
- We contract with other allied health professionals and identify "preferred" providers to direct care for patients.

Additionally, the Quality Management program has many processes in place to assess what is going on in local provider networks, as described above.

Element 5b:

The Credentialing Department is responsible for ensuring all providers are actively licensed and competent. The credentialing process follows established policies and procedures, and includes three distinct activities: initial credentialing prior to contracting, ongoing monitoring, and re-credentialing. The credentialing review process includes:

- Primary source verification – verify that the license is active and current with the appropriate state agencies prior to and within 180 days of the Credentialing Committee issuing a decision for participation. For example: verify directly with CA Medical Board, AZ Medical Board, or NV State Board of Medical Examiners etc. that the practitioner is licensed by the state in which he/she will be practicing and is credentialed as appropriate as a physician, podiatrist, chiropractor etc before forwarding the file to Committee for review. Also verify within 180 days and prior to Committee issuing a decision: Board Certification or highest level of education and training in specialty the practitioner is applying to the panel for (e.g. a Cardiologist must have either a Board Certification in Cardiology or completed a training program in Cardiology). DEA is verified within 180 days and prior to the Committee issuing a decision - primary source verification of DEA is not required. Query of the following must also be included and completed within 180 days and prior to Committee decision: NPDB /HIPDB (National Practitioner Data Bank & Healthcare Integrity Data Bank), Department of Health Human Services OIG (office of inspector general) List of Excluded Individuals and Entities, Medicare Opt Out list
- On-going monitoring – includes monthly review of all disciplinary actions published by the state licensing agencies for identification of adverse actions issued or pending against providers in the network, (e.g. pending accusations, probations, or any disciplinary actions issued against a practitioner), that may arise outside of the 36 month credentialing cycles. Also includes monthly review of Department of Health & Human Services OIG Listing of Excluded Individuals/ Entities and Medicare Opt-out List by State. Findings and summaries are presented to the Credentialing Committee for review and consideration.
- Application and attestation – review of the credentialing application data provided by the practitioner in comparison to verification results to ensure accuracy. Application provides a history of education, training, practice information. The attestation as part of the application must be signed and dated by the practitioner and address the following: 1) Reasons or inability to perform the essential functions of the position with or without

accommodation 2) Lack of present illegal drug use or impairment due to chemical dependency/ substance abuse 3) voluntary or involuntary history of loss or limitation of privileges or disciplinary activity 4) work history, education, training, hospital privileges 6) current malpractice insurance coverage 7) correctness and completeness of the data provided on the application

- Receipt and review of information on provider sanctions – information on a state licensure sanctions (such as pending probations, non renewals of license, pending accusations) is gathered and presented to the Credentialing Committee at the time of the initial credentialing and recredentialing decision, and also in between credentialing cycles for a determination on continuation of the providers participation. (e.g. DHHS OIG List of Excluded Individuals/Entities or California Medical Board disciplinary actions issued, CA or AZ Medical Board list of disciplinary actions, NV state board list of disciplinary actions)
- Office site visits - site visit is to be conducted for Office sites that meet the established complaint threshold related to Physical accessibility; Physical appearance; Adequacy of waiting space; or Adequacy of examining room space and followed up at least every six months until established criteria is met. Information is reported up to the Credentialing Committee for consideration. Should the practitioner site not pass an audit, a corrective action plan will be established and presented to the office site within 30 days of the review. When a corrective action plan is required, a re-review of the office site shall take place within six (6) months of the original office site date, which identified the deficiencies. Should the second or follow up office site visit continue to show non-compliance, revisits will be conducted at least every six months until deficient office sites meet the established thresholds . Corrective Actions are to be reviewed mid-cycle through the Credentialing Committee for peer review and appropriate action prior to the third. (e.g. A Corrective Action may be issued for but not limited to the following: Exit signs visible, fire protection equipment, accommodations for persons with disabilities, appropriate licensure is available as applicable for registered nurses, licensed vocation nurses, medical assistants etc.)
- Performance data : providers are queried with the Quality Management department prior to submitting to Credentialing Committee for Recredentialing consideration: query results include information on member satisfaction surveys, access surveys, Complaints & Grievances resulting from Quality of Care issues or Quality of Service or Access, Site Audit or Medical Record audits as applicable
- Member complaints and grievances related to: Physical accessibility; Physical appearance; Adequacy of waiting space; or Adequacy of examining room space are queried to Member Services department monthly, and monitored by the Credentialing Coordinators monthly to determine if the complaint threshold is met to trigger a provider site visit. If the complaint threshold is met (identified under office site visits above) the Credentialing Coordinator will request a site visit through the Regional Performance or Quality Department and report the actions taken through the Credentialing Committee
- Assessment and identification of Health Delivery Organizational providers and HIV/AIDs specialists: Are held to credentialing process: application data to undergo verification process as applicable to organizational providers or non organizational providers and submitted to the Credentialing Committee chairperson for review and

approval of "clean record" files. Must include verification of licensure through appropriate state agency, evidence of Accreditation or recent DHS Survey as applicable, evidence of Malpractice Insurance, organizational provider list includes but is not limited to Skilled Nursing Facilities, Home Health Agencies, Hospitals, Dialysis Facilities etc,

- Delegation of credentialing, where appropriate – delegated providers are included in the on-going monitoring efforts to ensure consistency from state licensing agencies, Medicare Opt Out lists, Office of Inspector General "OIG" List of Excluded Individuals/Entities. If delegated providers are identified to have an adverse action report from a state agency, the delegated entity is required to provide a summary of actions instituted through the Credentialing Committee in return for review and continued participation consideration. Quarterly reports from delegated providers are reviewed to ensure appropriate reconciliation of provider data and credentialing activities, delegated provider files are reviewed at least annually to ensure consistency with credentialing requirements
- Delegation of credentialing, where appropriate – delegated providers are included in the on-going monitoring efforts to ensure consistency from state licensing agencies.
- Follows NCQA and CMS Credentialing Standards

Corrective action plans are developed and termination is performed as dictated by the credentialing policy. For example: Recredentialing is required every 36 months; any providers that do not meet the timeframe are reported to the credentialing committee and terminate.

We will modify this Demonstration MOC for 2013 to incorporate all credentialing requirements for Medi-Cal providers including licensed and unlicensed providers.

Element 5c:

The approach to providing beneficiaries with access to services is tailored to their needs.

- All beneficiaries have a Primary Care Provider who acts as a gate keeper for their patients.
  - PCPs make referrals for services through our portal; PCPs also have access to our Regional Medical Officers/Directors, along with Nurse Practitioners for any urgently needed services, for example PCPs referring patients with wounds to NPs for wound management and patients requiring cardiac care to Cardiologists.
  - Regional Medical Officers/Directors form relationships with local PCPs to improve the delivery of care; this is done through formalized POD (provider group) meetings and one on one meetings with PCPs.
- All beneficiaries are provided with immediate access to services and benefits by clinicians during their annual Healthy Start and Healthy Journey Assessments, and as part of on-going management through various CareMore Clinical Programs.
  - The NP acts as the gatekeeper in this scenario, and will refer patients for additional services based on identified needs such as: mental health for clinical depression and colonoscopy for preventative screening.
  - The NP is able to arrange for urgently needed services by coordinating with case management, for example patients needing DME equipment urgently.

- Beneficiaries are provided with immediate access to services during and after hospitalizations by Hospitalists and Case Managers. As part of the discharge plan, the case manager will arrange for and schedule all services and appointments.
- Beneficiaries in need of LTSS are provided with access to these services by Case Managers or Social Workers working with the NP.

Clinicians improve outcomes and access to care for this vulnerable population.

Element 5d:

Coordination between the Provider Network and ICT occurs through several communication channels. Care needs are communicated as follows:

- PCPs receive copies of every visit note and care plan.
- Specialists interact directly with Hospitalists and Medical Officer in hospital settings.
- PCPs are called by Extensivists at the time of admission.
- Medical record information is posted on our portals for the Provider Network to view.

Our providers assume the responsibility for scheduling and following up on urgently needed services; for example:

- Post hospital and discharge appointments are arranged by the Case Manager instead of the member
- The NP follows the member to make sure they receive necessary services.

Medical Assistants, who support the NPs, gather medical records from specialists and diagnostic providers and upload them to our EMR; this gives the NP and the ICT a more complete medical record.
Patients are coordinated with in several ways. For example:

- Members of our clinical teams coordinate with them directly, such as:
  - Extensivists (Hospitalists) see the patients in the hospitals, skilled nursing facilities, and then as an outpatient (after they are discharged) to assess their conditions and arrange for services; a significant part of an Extensivist's work is to spend time with patients and their families to understand what factors contributed to their hospitalizations to develop an appropriate discharge plan and to follow up on those services to make sure they were provided.
  - Case Managers contact patients over the phone, and sometimes also see them at CareMore Care Centers, to arrange for discharge services, including DME, appointments, etc.
  - NPs conduct HRAs and develop a care plan with patients; the care plan is documented on paper and given to the member. NPs also see patients in the CareMore Care Centers to address their chronic conditions.
- Correspondence is mailed to patients homes including:
  - Authorization for services.
  - Appointment confirmation letters.

- An essential part of our MOC includes recognizing the need to treat our patients Palliative, and we define Palliative Care as simply matching the care our patients and their family's desire, with the care they actually receive. For example, we had one of our patients dying of metastatic cancer. Her husband, who lived in the ALF with her, could not accept his wife dying in their home, and hence, he and his wife refused hospice care. She and her husband wanted to die in the Acute/Hospital setting. We developed a POC that included End-of-Life Care, without going to hospice care. Her pain and symptoms were managed well. When our member was in the last few days of life, we directly admitted our member into the hospital (not through the ER), we didn't start an IV and we didn't order painful x-rays or labs. We just continued to follow the POC exactly as developed by the Team through our ICT. She died peacefully in the hospital a few days later, matching the care our member and family wanted with the care they actually received.

Element 5e:

Clinical teams use evidenced-based clinical practice guidelines and nationally recognized protocols in CareMore's model of care. These include sources such as: guidelines from various Specialty Associations, Medicare Guidelines, Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force, and published Journal articles. These are embedded into training materials and protocols for clinicians, as well as model of care materials provided to contracted providers, such as:

- NP Protocols are based on sources including: American Diabetes Association, American College of Cardiologists, Joint National Committee, American Heart Association, Global Initiative for Chronic Obstructive Lung Disease and National Kidney Foundation. An example in how these are used in the protocols is; management of diabetes, COPD staging guidelines, lab monitoring (e.g. kt/V and serum albumin levels) and fistulas.
  - Clinical Managers and Directors train NPs on these protocols and communicate new changes during monthly NP staff meetings.
  - They also perform quarterly record reviews for compliance with the protocol, and counsel NPs if protocols are not being followed.
  - Clinical Managers and Directors also regularly assess research and literature, and organizational guidelines to update protocols on best practices.
- Extensivists are trained using case studies based on several published Journal articles. For example: "Evaluation and Management of Patients with Acute Decompensate Heart Failure", Heart Failure Society of America; "Cardio: PCI and Coronary Disease", The New England Journal of Medicine; "Comparing Hospice and Non-hospice Patient Survival Among Patients Who Die Within a Three-year Window", Journal of Pain and Symptom Management.
  - Extensivists work with other involved specialists while patients are hospitalized to assure evidenced based medicine is being followed.
  - Medical Directors and Officers train Hospitalists on evidenced based medicine during initial training and as relevant case studies are released use CareMore's University Intranet site. These are also communicated during quarterly Hospitalist meetings.

  - Medical Directors and Officers participate in daily hospital rounds and perform regular record reviews for compliance with best practice guidelines.
  - Medical Directors and Officers regularly assess research and literature to update best practices.
- Healthy Start and Healthy Journey screening tools are based on sources.
  - MMSE was first published in the Journal of Psychiatric Research by Dr. Marshal F. Folstein, Dr. Susan E. Folstein, and Dr. Paul R. McHugh.
  - The functional assessment screening tool is the Barthel Index.
  - The depression screen is the PHQ9 depression screen.
  - The frailty screening tools is the Community Assessment Risk Scoring (CARS).
- Written protocols are often gathered from providers for Medical Director review, for example transplant protocols.
- Utilization management authorization decisions and appeals reviews are guided for the most part by Medicare National and Local Coverage Determinations and Kidney Disease Outcomes Quality Initiative (K/DOQI) Guidelines. We use Milliman Care Guidelines for Med-Cal services.
  - Utilization management team members will be cognizant of the Model of Care elements, including those developed for C-SNPs and will help coordinate care with the ICT where appropriate. For example, if it is determined during the utilization authorization process that a member has not been seen at one of our CCC's, then the UM team will help effect a referral through coordination with the case management team.
  - The Utilization Management Medical Directors review member medical records, as a standard part of the Utilization Management process, to validate requested services and procedures are consistent with evidenced based guidelines and nationally recognized protocols.
  - Medical records will be reviewed as part of the appeals and grievance process, to assess consistency with evidenced based guidelines and nationally recognized protocols.
  - Utilization Management will work with the Quality Management team and local Medical Directors and Officers to identify preferred providers to direct services (these preferred providers are identified in our portal); this is based on their use of evidenced based medicine, as well as quality outcomes and accessibility.

Element 6: Model of Care Training for Personnel and Provider Network

Element 6a:

All departments are required to have training manuals and programs to support its training efforts. CareMore's Model of Care Training is tailored to the employed personnel and includes:

- Training programs for new personnel which are delivered via:
  - Face-to-face training classes and audio and video conferencing. Group training classes are usually conducted for things like systems training, overviews of roles in the delivery of care, review of policies and procedures, and clinical protocol and case study reviews.

  - Formalized preceptor / rounding with experienced staff. Most clinical staff are trained in this manner; this training is outlined in competency checklists which the trainee and preceptor sign off on as activities are completed.
  - Printed training and reference materials such as Nurse Practitioner Protocols detailing documentation of NP assesses, treats, and manages patients.
- CMEs for medical staff and support personnel. CMEs are generally provided by outside entities. However, we are currently working on developing our own CME programs and using current end-of-life initiatives as a CME pilot program.
- Clinical program orientation for all non-clinical Directors and above. As part of these sessions, Directors and above attend a day of presentations by clinical leaders and observe live interdisciplinary team meetings. They also go on "rounds" and attend member visits with our clinicians at Hospitals, Skilled Nursing Facilities, CareMore Care Centers, and member homes.
- Department meetings conducted in person and via video conference and audio conference for staff unable to attend in person. This is where we generally give our annual model of care training which includes, at a minimum, a review of new benefits and the model of care annually. However it also frequently includes changes to policies, procedures and protocols, and refresher training on specific topics.
- On-going training initiatives – e.g. in 2010 we rolled out "Learning Maps" to all employees on the model of care. These are group training sessions, in person at the home office. It was set up as a facilitated interactive session, where participants went through a "map" of the typical healthcare environments and then went through a "map" of the model of care.
- All employee meetings, which include clinical model topics.
- Training and communication pieces developed to support new programs, processes and systems.
- Additional staff training as identified through performance reviews and management initiatives.
- Training and communication pieces developed to support new programs, processes and systems.

In addition to the department specific training efforts, Human Resources manage "CareMoreization" a required class for all new hires. CareMore hosts monthly new employee training classes; employees are scheduled into these sessions as part of new employee on-boarding. CareMore Medical Officers provide an overview of the clinical model (model of care) as part of "CareMoreization". Annually, we hold retraining efforts. In 2010, all employees were trained on "Learning Maps". "Learning Maps" was an interactive session where groups of employees learned how the typical health care delivery system works and then went on to learn how our specific health care delivery system works and improved the model of care for patients.

The training strategy and content is dependent on what each employee needs to do their job. For example:

- All employees are provided with an overview of our organizational structure, network model, clinical model (model of care), and products and benefits as part of CareMoreization training described above.

- The Clinical staff is provided with more detailed training through a four-eight week training program completed through a variety of activities, including:
  - Group training classes on systems, protocols and policies
  - Conferences to review and answer more detailed questions on protocols, processes, and best practices
  - Shadowing existing clinical staff on rounds, appointments, and case work
  - Meeting one-on-one with key members of the ICT
  - Seeing patients and performing case work on their own while being shadowed by a preceptor
  - Meeting one-on-one with their preceptor and supervisor to go over training status and assess their progress and knowledge, and develop an action plan for additional training

An example of department training is: every new Medical Assistant is put through a formalized training program based on manual and competency checklist. This includes:

- An overview of our organizational structure
- Benefits, products and services
- Use of systems and medical equipment
- Workflows
- Department policies
- Customer service
- Clinical protocols
- Medical technique (e.g. how to perform vitals, Coumadin labs)
- The clinical model
- Compliance, FWA and HIPAA

Below is a page from the training manual, which shows how the competency check list is used when a Medical Assistant is being trained of the back office workflows to support various types of appointments at CareMore Care Centers:

Clinical Program Training Checklist
Mark each stage as complete with the date completed. Preceptor will review the entire program with the Trainee at the end and initial when Trainee is ready to see patients without guidance

	Workflow Review Date	**Entire Visit Observation Date**	**Observe MA Date**	**Perform visit under guidance Dates *Perform visit 5 times under guidance**	**MA Initials**	**Preceptor Initials**
ACC						
Cardiology						
CCC (Hospitalist)						
CHF - IdealLife						
COPD						
Dietician						

	Workflow Review Date	Entire Visit Observation Date	Observe MA Date	Perform visit under guidance Dates *Perform visit 5 times under guidance	MA Initials	Preceptor Initials
Dermatology						
ESRD						
Fall						
Healthy Start						
Healthy Journey						
HTN - IdealLife						
Mental Health						
Skilled Facilities						
End of Life: Palliative Care vs. Hospice Medication Management						
When to refer to Hospital vs. Skilled Nursing Facility						
The self-directed care model and helping members participate in medical decision-making						
Nutrition Classes						
Pre Op						
Pulmonary						
Smoking Cessation						
Wound						
Routine Podiatry						
For Routine Podiatry use training materials found at X:\Clinical Operations - Resources and Training\Clinical Competency Checklists\MA. MA needs to observe a Podiatry Clinician and an MA performing Routine Podiatry.						

Annual model of care training, again, varies based on what each employee needs to do their job. For example:

- All employees are brought into meetings to go over changes in benefits and the clinical model, as part of an annual initiative at the end of the year to roll out benefit changes. Additionally updates to the model of care are featured in all employee newsletters and company-wide meetings.
- Clinical staff are included in the benefits meetings, but also retrained as changes to the model of care, systems and workflows are implemented. This is generally done in Department Meetings hosted by the Managers and Directors and includes updates to training materials, protocols, and policies. At these meetings, the clinical staff may also be trained on how to perform certain medical tests and procedures (for example: how to use a new lab machine in the CareMore Care Center).

Additionally, Office Managers hold monthly meetings with their staff to go over changes in the model of care including clinical protocols, customer service, compliance, and administrative policies. For example: in a monthly training program called "iCareMore", a Medical Assistant is trained on the specifics of various disease states to better collaborate with the ICT (e.g. Symptoms of Dementia patients) and also work with other team members to develop tactics to improve customer care.

Network Providers are oriented by Provider Services and Medical Officers/Directors.

- Provider Services conducts initial orientation programs which are conducted in group settings (when large network expansions are occurring) or one-on-one with providers and their staff. These orientation programs are supported by written materials on:
  - Programs, services, benefits, products and communications, e.g. information available via the intranet
  - How to use communication systems and staff
  - How to submit data and coordinate with the ICT
- Provider meetings occur quarterly and are co-led by Regional Performance Managers and Medical Officers/Directors. Typically these are in the form of Joint Operating Committees with Provider Groups and Hospitals, Provider Office Meetings and Provider Dinners. Agenda items may include, but are not limited to:
  - Review of various reports
    - HEDIS performance
    - PCP report cards
    - ER usage and other utilization information
  - Review of communication materials and discussion
    - Communication systems
    - New programs and services offered
    - Refresher training on model of care
    - Member benefits, and how to help members to reduce co-pays
- Communication materials are sent out at a minimum of once a year (e.g. provider manuals, notices), such as:
  - Detailed descriptions of clinical programs and how to assist members in accessing services
  - Product and benefit overview
  - How to reach and communicate with us
  - Compliance training materials
  - Annual flu campaign
- Provider portal on our website. We use this tool to send "announcements" to the entire provider network regarding the model of care, for example, Provider Services will use this to remind providers of upcoming training events.
- One-on-one meetings with Regional Medical Officer and Directors, these meeting occur primarily with Primary Care Physicians, but also with network providers who are highly involved in the model of care. For example, Medical Officers meet and conference frequently with certain types of specialists who are critical to the model of care, such as Cardiologists.

- Training and communication pieces developed to support new programs, processes and systems.

An Administrative manual is provided to all contracted skilled nursing facilities and is updated on an annual basis with any benefit, product, or process changes.

Element 6b & d:

Managers and Directors monitor, record, and oversee participation in training activities. The accountability varies by role, e.g.:

- The Clinical, and Operations Team have Training Program Managers who work with Department Managers on their training plans. For example:
  - New hires are assigned a Preceptor, who tracks the progress of training and competency of each employee on formalized training checklists; the Department Managers review the status of this training before releasing employees to perform on their own. This includes both observation of how the employee is performing their work, as well as quizzing and testing the employee on how to perform certain activities. These checklists are maintained in employee files for the Department Manager's review. See sample from the Medical Assistant Training Checklist in the section above.
  - The Product Manager organizes a company-wide effort on annual benefit changes. The Product Manager also works with the Training Managers to develop content, and set up sessions for each department. Attendance is tracked on attendance lists, and managers are notified of attendance. The attendance lists are forwarded to the Training Program Manager, who participates in the Model of Care Training and Communications team described in section C below, which validates that all employees are trained and works with Managers to complete all training.
- Human Resources work with Department Heads on new employee and annual Model of Care Training:
  - They track and oversee annual retraining efforts in the HR system (HRB).
  - For new hires, "CareMoreization" training is scheduled as part of their on-boarding process before new hires are released to their departments.
  - Before annual model of care training starts, Senior Management communicates to all employees the importance and requirement of this initiative.
  - HR schedules the training for all employees, and maintains sign in sheets to track attendance.
  - Managers are notified if an employee misses this training to reschedule the training, and HR follows up and reports any issues to Senior Management.
- Provider Services has a Director and Regional Performance Managers accountable for overseeing Provider Training. As new providers are added, and annual training initiatives are developed, these teams calendar and track the roll out of training to the network as part of their work plan.
  - These work plans are maintained in Department Files, and overseen by the Model of Care Training and Communications team described in Element C below. For example: when we rolled out training to providers on new features in the Provider Portal and Patient QuickView communication systems, this allowed the Network providers access to more clinical information on patients. Provider Services:

    - Hosted provider dinners to introduce the system features.
    - Staff visited provider offices to review the specifics of the features with the office staff.
  - For offices that did not participate, Provider Services:
    - Used delivery of bonus checks to providers as an opportunity to reengage the providers, to set up meetings.
    - Mailed copies of training materials to provider offices.
  - Provider Services also mailed copies of the training materials to the offices that did participate in other activities, in case the participant did not share the information with the other staff.
  - This effort was tracked on project plans to ensure it was executed over a three month time frame. Additionally, this effort was managed centrally by a resource working out of our main office in Cerritos, and was executed locally by the Regional Performance Managers who work with Providers in neighborhoods.
  - We invite both community and facility based leadership, as well as our ancillary vendors critical to the delivery of the model of care, to an annual meeting to review upcoming benefit changes, as well as reviewing CareMore's model of care. Typically these are conducted at a hotel where they are easily accessible for all facility staff. Handouts and training materials are distributed.

Element 6c:

The Model of Care Training and Communications team is responsible for oversight of the model of care training for staff, brokers, network providers and vendors. This team includes staff from Clinical Operations, Product, Member Services and Provider Services. The team is responsible for:

- Planning initial and annual model of care training activities.
- Facilitating the development of training and communications content specific to the model of care. For example: they will work together to develop overview materials on clinical programs to use in provider network training, and new hire training. This is currently in the form of a table that lists out the names of the programs, who qualifies and how members get referred in for services. For example:
  - Diabetes Management Program
  - Qualified patients: patients new to insulin or with hbAg1c> 8
  - Referred by: PCPs, Extensivists, NPs, Specialists, or self
- Working with their individual departments to plan out detailed training activities, as described in the section above.
- Overseeing the completion of training activities, including tracking completion of these activities. This team is currently exploring use of a Learning Management System to roll out and track training activities; the first initiative was general compliance training.
- Sharing tools and best practices for training between teams. As an example: in 2010, the team purchased a video camera so they could incorporate videos into the training; one of the first projects was to record a Chief Medical Officer giving a talk on the value of the Healthy

Start and Healthy Journey appointments to members, so that new Member Services staff could have a detailed understanding of the benefits to members.

- Coordinating between teams to ensure messaging is consistent across functions, and particularly to ensure that the member experience with the model of care is consistent with the message from everyone involved in it (e.g. what the member is told by Member Services staff is actually what happens when the member goes to receive services and access benefits). As an example: in 2009, this team started hosting "enculturation sessions", which included participation from the Provider Network and the ICT where they walked through the model of care from enrollment to the provider network message to the actual delivery of the care. During 2011, one of the activities in the enculturation session was to conduct a member simulation where multiple parties had to communicate effectively to ensure the member was getting all of the services they need.

This is also the team that is responsible for development and oversight of communication that is described in Element 9.

Element 7: Health Risk Assessment

- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Element 8: Individualized Care Plan

Element 8a:

Individualized Care Plans are developed with the patients and their care givers during Healthy Start and Healthy Journey appointments and at every appointment with the NP, and members of the ICT. This is done after the Health Risk Assessment is completed, along with the member vitals, labs, and history & physical. The member and NP jointly go over the HRA results and develop the Care Plan to meet the specific needs of the member considering the member specific barriers, preferences and limitations (e.g. cultural), care giver resources available, etc. For example, a member having trouble managing their diet due to cultural food preferences will be referred for a 1 on 1 consultation with a Dietician. The member is given a copy of their Care Plan at the end of their Healthy Start and Healthy Journey appointment.

Every new institutionalized member is assigned to a NP of their enrollment month. Individualized Care Plans are developed with the patients and their care givers. The Care Plan is created after the Health Risk Assessment is completed, along with the member vitals, labs, and history & physical. The member and MLP jointly review the HRA results and develop the Care Plan to meet the specific needs of a member considering the member specific barriers, preferences and limitations (e.g. cultural), care giver resources available, etc. For example, a member experiencing episodes of urinary incontinence will be referred to the incontinence program to receive education and treatment for the underlying problem as well as incontinence supplies as appropriate.

The provider is required to complete their member's initial plan of care during the first 90 days the member is becomes effective in our system and after they complete the HRA. The initial plan of care is developed with the Medical Director and discussed with the ICT. The member is given a copy of their Care Plan after completion of the HRA.

Element 8b:

The Individualized Care Plan includes elements like:

- Diagnostic test results, along with goals for these results and when the next test is due. The tests are specific to the conditions of the member; for example: all patients receive their LDL and Triglyceride levels, diabetes patients will receive their hbgA1c levels, and COPD patients will receive their spirometry testing results.
- Preventive screenings like mammography and colonoscopies, when they were last done and the next due date if applicable.
- Medications and frequency.
- Immunization history and needs.
- Individual goals for member self-management of their condition, how and when to access the 24 hour nurse line and goals specific to their conditions. For example: if a member also has COPD, they may be given breathing exercises to follow at home.
- Individual goals related to functional status (ADLs, IADLs, cognitive status) and community inclusion (work, community life).
- Nutrition and Health Management guidelines for things like what type of diet to follow and symptoms to watch for. For example, a heart member may receive the following on their care plan:

- If you experience any of the following symptoms, contact your healthcare provider immediately:
  - Shortness of breath, coughing while sleeping, chest pain.
  - Weight gain of 3 lbs or more overnight, swelling in the legs, or palpitations.
  - If you have unrelieved chest pain after 3 doses of Nitroglycerin 5 minutes apart, go to the emergency room or call 911

- Referrals and additional benefits and services to access (such as telephonic monitoring of blood pressure), and when the next scheduled follow up is with the NP.
- A sickness plan.
- An emergency plan, including an emergency back-up plan to address instances when a direct care provider (personal attendant) is unexpectedly delayed or absent from the member's home.
- Other recommendations.
- Note: as part of our End-of-Life Initiative being developed in 2011, a more robust End-of-Life Care Plan will be included.

A sample Care Plan is on the next page.

Care Plan example: Page 1

Anthem

CareMore
It's what we do.™

My Care Plan

Patient Name: [redacted]
Date: February [redacted]

DOB: 05/22/1934

My Test Results	Goal	Result	Date	Next Due
General				
Total cholesterol - annually Goal: < 200	< 200			
LDL - annually Goal: < 100, < 70 if CVD	< 100, <70 if CVD			
HDL - annually Goal Female: > 50-55, Male: > 40-45	> 50-55			
Triglycerides - annually Goal: < 150	< 150			
Weight - every visit Goal: See Body Mass Index	See BMI	145.0	02/24/2011	02/24/2012
Body Mass Index - every visit Goal: < 26	< 26	30.30	02/24/2011	02/24/2012
Blood Pressure - every visit Goal: <135/85	130/80	126/78	02/24/2011	02/24/2012
Diabetes				
HBA1C - quarterly Goal: < 7	< 7	6.6	02/24/2011	05/24/2011
Microalbumin - annually Goal: < 30	< 30			
Diabetic lab panel - annually Goal: Normal values	normal values			
ABI - annually Goal: > 0.9	> 0.9	0.91	02/24/2011	02/24/2012

My Individual Goals - I will:

General

- Take my medications as prescribed.
- Keep emergency medications for use if I develop chest pains:<130/80
- Follow my recommended diet:
- Follow my recommended exercise plan:
- Prepare a list of medications, allergies and important telephone numbers to keep in my wallet or purse.
- Exercise 5-6 times per week. Stay hydrated by drinking water before, during, and after any physical activity.
- Call 1-888-250-5800 to make transportation arrangements to get to my appointments.
- Choose whether to have an advanced healthcare directive, if I do not already have one prepared.

Diabetes

- Call the Diabetes/ESRD HotLine at 1-800-589-3148 Monday-Friday from 8-00 a.m.-midnight if I feel ill or have symptoms.
- My blood glucose target is: 80-180
  - Call the Diabetes/ESRD HotLine at 1-800-589-3148 Monday-Friday from 8-00 a.m.-midnight if I feel ill or have symptoms. < 80 and symptoms of hypoglycemia.
- Eat 5-6 small meals a day and snacks in between meal and bed time.

Diabetes & Nutritional Management Guidelines

- Call your Health Care Provider immediately if there are any changes in your health including: numbness or tingling in your feet or symptoms of hypoglycemia or hyperglycemia.
  - For any questions about your symptoms or Diabetes, call the Diabetes Helpline at 1-800-589-3148 Monday-Friday from 8:00 a.m.-midnight

Care Plan example: Page 2

Anthem

CareMore
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- Keep all appointments to manage and treat your Diabetes.
- Bring glucometer and all medications to every visit.
- Combine carbohydrates and protein with each meal or snack. Avoid salt and fat.
- Check feet and skin daily for calluses, warts, bunions, lesions, and wounds; report any skin breakdown to healthcare provider immediately.
- Protect feet by wearing comfortable shoe and socks regularly.
- Obtain annual retinal exam.
- Attend comprehensive diabetes education classes.

My Sick Day Plan

- Keep at least 2 week supply of your medicines, a list of all the medicines you take, a supply of food, your doctors telephone number and a caregiver or significant other telephone number.

Prepare a sick day plan that includes:

- A supply of food and medicine on hand in case I get sick.
- A caregiver / support person to call.
- Emergency contact #'s, including clinician.

- Stay hydrated and monitor my temperature, if I get sick.

Health Maintenance

Test/Exam	Date of Last	Due Date	Declined	Not Needed	Never Had
Physical Examination(s)					
H & P		02/24/2011			
GYN		02/24/2011			
Cardiovascular Disease					
Lipid Panel		02/24/2011			
Cancer Screening					
Colonoscopy		02/24/2011			Yes
Sigmoidoscopy		02/24/2011			
FOBT		02/24/2011			
PAP		02/24/2011			
Mammogram	02/17/2009	02/17/2010			
MD/RN Breast Ex		02/24/2011			
Adult Immunizations					
Influenza	10/12/2010	10/12/2011			
Pneumococcal		02/24/2011			Yes
Td		02/24/2011			Yes
Musculoskeletal Disease					
DEXA scan		02/24/2011			

My Allergies

Description	Reaction
Lisinopril	

My Medications

Medication	Directions
Actos 15 mg Tab	1 tab daily
glyburide 5 mg Tab	1 tab before breakfast
amlodipine 10 mg Tab	1 tab daily
lovastatin 40 mg Tab	1 tab daily

Referrals

Provider	Specialty	Reason	Timeframe
	Dietician	low albumin, CKD, DM	

Care Plan example; Page 3

Anthem

CareMore
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Additional Recommendations/ Notes:
No more metformin d/t declined kidney function
Take Glyburide 5 mg 1 tab 30 minutes before breakfast
Continue Actos 15 mg daily
Blood tests in 5 weeks with fasting
Return to us in 6 weeks

Signature: _____ **Date:** February 24, 2011

Signature: _____ **Date:** February 24, 2011

An example of how our HRA impacts the actual plan of care (POC), and how critical it is to involve this POC with the ICT, involves a very pleasant and determined 95 year-old Scottish woman we recently admitted to our program. Upon going through the HRA and developing the POC, this very clear and not in any way demented woman, absolutely wanted to be DNR (Do Not Resuscitate) and DNH (Do Not Hospitalize). "I think it would be cruel to do that" were her exact words. When we talked to her daughter and son-in-law about all of this, they voiced complete surprise. So the Team, under the direction of our MOC and ICT, got together with this dear woman, family and facility, talking through her Advanced Directives. The member felt so heard and supported. The family felt like they had an opportunity to voice their concerns but also to talk to their mom/mother-in-law about a subject they never had talked to her before. In completing her POLST (Physicians Orders for Life Sustaining Treatment) form, there was such gratitude for facilitating this discussion. From a team point of view, we were just doing what we do every day, making sure we match the care that Patients and Families want, with the care they actually receive.

Another example of how the HRA intake process and developing an individualized POC is connected has to do with one of our patients. Both families and facilities, nearly obsessing over this woman's diabetes, was concerned because her blood sugars were "edging up to the 120s to 130s." Our member wanted to increase her insulin and though very thin, frail and elderly, wanted to go on a diet. This was found through the HRA intake process, while developing the Care Plan for this member. Through the MOC and ICT, labs showing a HbA1C of 6, meeting with our member, the team, her family and the facility where she lived, we were able to reassure her to such a degree, that she is actually eating more and gaining a few much needed pounds, as we do strengthening exercises to make sure we are building muscle mass, not body fat.

CareMore's model of care specifically communicates with the DPOA/family member after the initial evaluation monthly and any change of condition. This is communicated to the Medical Director, Lead Mid-Level Provider or DPCS, and PCP. The treating MLP communicates ICT results to the facility to ensure proper implementation of the POC.

Element 8c:

The ICT reviews the Individualized Care Plans and involves the Neighborhood, CareMore Intervention Team based on the needs of the member.

- NP or Program MLP uses Healthy Start, Healthy Journey and Nurse Practitioner guidelines to protocolize what should be in the care plan and when to involve other members of the ICT
  - Example: The Mental Health Team is involved when a member scores > 15 on a PHQ9 Depression Screen and the Pulmonologist will be involved if the member has certain conditions, such as: malignancy, pulmonary fibrosis, etc., requiring additional assessment.
- NPs update the Care Plans regularly as they see the patients, for example member may develop an ulcer and needs to be part of active wound management.
- Most patients are on a minimum of a quarterly reassessment cycle; however some patients refuse to actively participate, these patients are reached out annually to complete the HRA and care plan.
- Care Plan is reviewed and revised with the member and their care giver if possible, during the Healthy Journey annual health assessment. It is reviewed and revised more frequently if the member is being seen by an NP or Doctor for an uncontrolled chronic condition or frailty.

Additional care planning revisions occur when patients are discharged from hospitals and skilled nursing facilities or during transition across other types of settings (from home to a residential care facility and vice versa) or living arrangements (transition from living alone to living with roommates and vice versa) to manage their transition of care until they stabilize and to plan for an appropriate level of ongoing contact and care coordination. This occurs first as part of the discharge plan prepared by the Extensivist, Case Manager and member (for institutional transitions) or an NP for members in the community. They will arrange for immediate services to support safe transitions of care.

- Example: Member may need home health services for a period of time or DME equipment to be safely discharged home. This discharge also includes scheduling an appointment with the NP, so they can conduct an additional comprehensive assessment of the member and incorporate any additional elements into the member's care plan.

We also measure the development of the Individualized Care Plans by having its Clinical Managers and Medical Directors conduct periodic reviews of the dictations and charts resulting from Healthy Start and Healthy Journey assessments to ensure patients have a complete and appropriate care plan consistent with NP Protocols for its models of care. Each NP has a minimum of quarterly sample chart review.

Additional reviews and monitoring occurs in the formal ICT meetings. These teams monitor completion of care plans, as well as round on the details of care plans for members who are not meeting clinical goals.

The Individualized Plan of Care, developed through our MOC and ICT, included the fact we needed to have frequent communication with the family, teaching them the disease trajectory associated with Alzheimer's disease. They came to understand that these declines were not only not unusual, but predictable. At the next sign of decline, the family not only wasn't surprised, but understood what was happening. Also, through the ICT, it was decided to have one of our Clinicians speak at the Facility Family Night to explain to Family Members and to Facility workers, the disease trajectory of Alzheimer's disease. The family and facility were so appreciative of this.

Element 8d:

A copy of the patients Individualized Care Plan is documented and retained in the Electronic Medical Record System, which is available to members of the ICT.

The Chief Information Officer and Vice President of Clinical Operations oversee protection of documentation and maintenance of records. This is done through Policies and Procedures and back up procedures for clinical data. For example, IT's preservation backup and restoration policy provides the process protocol for ensuring our data is protected and recoverable for enterprise applications such as EMR (NextGen). This policy, DS4.9 Backup and Restoration Policy, includes the following guidelines:

- Backup scheduling includes frequency and types of backups (Incremental, differential, and Full).
- Automated data retention tools such as NetBackup, BackupExec, and Commvault for Backups of CareMore databases / file systems.
- Backup Status reports:
  - Offsite storage routing to Archive America for retention.
  - Offsite Encryption policy for offsite storage.
  - Offsite Retention period of 10 years.

Care plans and revisions are communicated by the following practices:

- If they are an employee or contracted specialist (generally these are member of the ICT) working out of a CareMore Care Center they will access the care plan and visit note directly in the EMR; the information is populated when the provider accesses a medical a record.
  - Podiatrist – able to view wound measurements completed by the Nurse Practitioner.
  - Mental Health Professionals - able to access screening results.
  - Hospitalists and case managers - able to view results of all labs, physical exam, and assessments.
  - NP – may contact a provider directly if a member is high risk and there is something in their HRA they want to address immediately, for example, they may call a Cardiologist if a member has an abnormal heart rate.
- If they are a network provider the information is faxed after the health risk assessment is completed annually.
  - PCPs - are provided with a complete summary of medications, lab results, screening results, etc. and the full care plan.

- Beneficiaries leave their Healthy Start and Healthy Journey appointments with a Care Plan in hand. The member specific needs are captured in the care plan, and are reviewed with the member verbally by the NP during this appointment. For example:
  - Member obtains a copy of their lab results and goals for these labs if they are not within range.
  - NP reviews the preventative services needed, such as flu and pneumonia vaccines and administers.
  - NP reviews their medical conditions, and the plan of care to address them, including referrals.
  - NP goes over all self-management goals to make sure the member/care giver understands them and reinforce their importance.

If the member/care giver does not attend these appointments in person, and instead it is conducted telephonically, this same information is reviewed with patients over the phone and the Care Plans are mailed to their homes.

We continue to strive to improve the care plan process for its members. In 2010, we:

- Added infrastructure to the chart review process to conduct more rigorous assessment of patients who are not making progress towards improving their condition.
- Enhanced member surveys to obtain feedback from members on care plan process.
- Enhanced clinical systems to communicate patients Individualized Care Plan goals.

Another example included a new member who was using a Power Operated Vehicle (POV) he had acquired from a previous Health Plan. He was able to ambulate short distances but was very much deconditioned by not exercising as much as he did before getting the POV. Our Individualized Care Plan included many things but specifically: getting him structured PT right in his own home; education on how deconditioned he was and how he could turn that around with a focused exercise program; mental health support to turn his hopelessness back into hopefulness; pharmacologic intervention to optimize his Care Plan; and family and facility involvement to support his change in behavior. Today, he doesn't even use his electric wheelchair.

Element 9: Communication Network

- [redacted]

[redacted]

[redacted]

- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Element10: Care Management for the Most Vulnerable Subpopulations

Element 10a:

We identify vulnerable beneficiaries or "frail and chronically ill" patients in several ways:

- Based on stratification from the Healthy Start and Healthy Journey appointments and assessments, which includes a complex Health Risk Assessment comprised of several screening tools. For example, fall risk screens, depression screens, and activities of daily living screens identify at risk patients and triage them into specialty programs designed to meet their needs.
- All ESRD, CHF, COPD patients on oxygen, Institutionalized and institutional level of care members are considered vulnerable and closely managed by NPs.
- From referrals by PCPs and Clinical Programs

  - PCPs are both trained on and incentivized to refer their patients into programs for patients who are frail and with chronic conditions. A PCP report card is produced which shows the participation levels of each PCPs patients based on their qualification for each program (e.g. % of Coumadin patients being managed by the Coumadin program, % of patients with hgbA1c > 8 managed by the Diabetes Management Program); the purpose of this Report Card is to engage PCPs in getting patients enrolled in the programs.
- As a result of hospitalization by Extensivists. At the time of discharge, the Extensivist (Hospitalist) designates a member as being Red, Yellow or Green; the Red patients are the most vulnerable and require more intensive follow up by the Extensivist outpatient and the Case Manager. Note: all hospitalized patients with CHF are designated automatically as "red".
- Through data queries (e.g. HBa1c > 8, members on Coumadin, COPD members not accessing Pulmonary Care) that identify members who are not being managed. The results of these data queries are provided to an "Outreach Team" in Case Management. Members with these at risk conditions, who are not participating in clinical programs, are contacted and enrolled; if they refuse to enroll, the member's PCP is contacted and asked to work with the member to enroll them in the program.
- By performing case reviews on patients with readmissions and frequent emergency room visits. This is done in the monthly Neighborhood ICT meetings. The teams are provided with lists of readmitted patients and those with > 3 emergency room visits during the year; the Case Manager, along with the Regional Medical Officer/Director reviews these lists and the entire team evaluates whether there is an appropriate care plan.

Element 10b:

Frail and chronically ill patients are provided the following extra services and benefits to meet their needs:

- Clinical programs and telephonic monitoring programs for patients with uncontrolled chronic conditions (e.g. diabetes, CHF)
- Clinical programs for frail and medically complex patients; e.g.
  - Acute hospitalization and SNF management by Hospitalists/Extensivists. Hospitalists/Extensivists round up patients in inpatient and skilled settings to oversee their hospital stay, as well as ensure they are connected to the model of care at the time of discharge. The Hospitalist/Extensivist also sees the member after discharge until the member is clinically stable and all outpatient follow up is complete.
  - Fall prevention by Hospitalists/Extensivists; when patients have fallen or at risk for falling, an Extensivist performs a comprehensive assessment of their medications, gait, and eye sight to identify and resolve any contribution factors to their falling. As a result of this assessment, patients are often prescribed assistive devices, and/or referred to strength training programs.
  - Anti-coagulation monitoring; this program runs out of CareMore's Care Centers. Members' Coumadin levels are monitored, as frequently as several times a week, and adjusted until their INR level stabilizes within range.
  - Mental health program; we have psychiatrists, therapists, and mental health NPs who address mental and substance abuse issues in a coordinated fashion.

- Specialized Strength Training Programs; we have strength training programs run by Fitness Instructors specially trained in geriatrics and chronic conditions including: ESRD, Heart Disorders, COPD and Back Pain. As part of these programs, members are provided customized Fitness Programs using equipment specially designed for seniors and frail members, tailored to their individual needs. This program is different than Fitness Center memberships designed for seniors; it is focused on developing strength, mobility and stability for members. It also has exercises designed for specific chronic conditions that improve functioning, as well as monitor members while exercising.

- CareMore Intervention Team support for members with complex psychosocial issues. This is an Interdisciplinary Care Team of Medical, Mental Health, Social Workers, and Case Managers who collaborate and intervene on members with the most severe psychosocial issues; they have been successful in improving member outcomes and compliance using a variety of tactics including: placement, coordinating with community resources, and addressing elder abuse.
- Case management support, which includes frequent phone calls for frail and medically complex members.
- Specially designed benefits for this population (e.g. transportation, home health services, respite services, nutritional products, affordable generics, CareGiver on line resources).

An example of how these services will be provided to a particular member includes:

- The member visits the NP for their diabetes at the CareMore Care Center every 3 months to:
  - Monitor their vital signs and blood sugar readings
  - Assess their feet for ulcers
  - Make sure there has not been a change in their health status
  - Get any needed labs done
  - Review their medications, and adjust as needed
  - Reinforce education on:
    - Dietary management
    - What to do in case hypo and hyper glycemia
    - What to do for emergencies
  - Refer to other members of the ICT to address any identified issues (such as: additional Dietary counseling).
- When the member is hospitalized, a Hospitalist will visit the member in the hospital and work with a Case Manager to develop the discharge plan. As part of the discharge plan, there will be a hand-off back to the NP.
- Refer to other members of the ICT to address any identified issues (such as: additional Dietary counseling).

Because of the frailty of institutionalized members, under the clinical model they are provided with the following additional services and benefits to meet their needs:

- Clinical programs for institutionalized members (including: on-site delivery of services such as rehab, labs, X-rays, podiatry, etc.).
- Regular MLP visits for management of chronic conditions and frailty; the number of visits is unlimited and determined by the MLP and local medical director according to the

Red/Yellow/Green stratification approach. For example, a minimum of weekly and more frequently for members with multiple hospitalizations and at risk conditions (e.g. wounds that are slow to heal).

- 24-hour access to a MLP; MLPs are available to members to answer any of their questions and help guide them if they are experiencing symptoms. Every member and care giver is given this phone number as part of their care plan.
- Clinical programs for members admitted to the hospital (including Hospitalists/Extensivists and case management services).
- Clinical programs for frail and medically complex members; e.g.
  - Acute hospitalization and SNF management by Hospitalists/Extensivists. Hospitalists/Extensivists round up members in inpatient and skilled settings to oversee their hospital stay, as well as ensure they are connected to the model of care at the time of discharge. The Hospitalist/Extensivist also sees the member after discharge until the member is clinically stable and all outpatient follow- up is complete.
  - Fall prevention by Hospitalists/Extensivists; when members have fallen or at risk for falling, an Extensivist performs a comprehensive assessment of their medications, gait, and eye sight to identify and resolve any contribution factors to their falling. As a result of this assessment, members are often prescribed assistive devices, and/or referred to strength training programs.
  - Anti-coagulation monitoring; this program runs out of CareMore's Care Centers. Members' Coumadin levels are monitored, as frequently as several times a week, and adjusted until their INR level stabilizes within range.
  - Mental health program; psychiatrists, therapists, and mental health MLPs address mental and substance abuse issues in a coordinated fashion.
  - Specialized Strength Training Programs; strength training programs run by Fitness Instructors specially trained in geriatrics and chronic conditions including: ESRD, Heart Disorders, COPD and Back Pain. As part of these programs, patients are provided a customized Fitness Program, using equipment specially designed for seniors and frail members, tailored to their individual needs. This program is different than Fitness Center memberships designed for seniors; it is focused on developing strength, mobility and stability for members. It also has exercises designed for specific chronic conditions that improve functioning, as well as monitor members while exercising.
- CareMore Intervention Team support for members with complex psychosocial issues. This is an Interdisciplinary Care Team of Medical, Mental Health, Social Workers, and Case Managers who collaborate and intervene on members with the most severe psychosocial issues; they have been successful in improving member outcomes and compliance using a variety of tactics including: placement, coordinating with community resources, and addressing elder abuse.
- Additionally, institutionalized members are provided with expertise, assessment tools, protocols, and monitoring of outcome and health status measures supporting chronic SNPs, and clinical programs (e.g. diabetic care, hypertension management, and congestive heart failure monitoring).
- Specially designed benefits for this population (e.g. home health services, over the counter products, affordable generics, Caregiver on-line resources, incontinence program).

In 2012, we are working on several clinical initiatives geared at further enhancing the services provided to vulnerable beneficiaries. These include:

- A Clinical Program Variability Reduction Initiative focused on clinical intervention on populations of members with Diabetes, CHF, ESRD, and those who are hospitalized.
- A pilot program for Dementia members and their families.
- A pilot program using predictive modeling software to identify high risk members that are not currently involved in programs for members who are frail.
- A program being designed to provide additional services to members with cancer.
- A Mental Health supportive program being designed for members with serious health conditions.

The entire clinical model is designed to support frail and chronically ill members by providing:

- Proactive Intervention: integration and coordination of care that fosters compliance.
- Intimacy of Contact: to manage complexity, which requires constant knowledge of the member's condition?
- Speed of Action: resources available and mobile to adequately intervene.

The clinical programs, along with the staff and processes supporting them (e.g. staff roles, ICTs, clinical model measurements), are designed with the above goals in mind. We selected these goals because it is a competency that is largely missing from today's healthcare system and we believe this focus will have the greatest impact on the health and well-being of its members.

Our Mission, to take best care of the frail elderly includes an absolute belief we can change the Focus and Locus of care, from the all too frequent utilization of hospitals and skilled nursing homes to right to where our members live.

One of our members was a frail elderly woman who never had a pap smear, or mammogram or colonoscopy, because she never wanted any of those things to be done. (While this may do havoc with our Star Rating, remember our definition of Palliative Care, to simply match the care that our members and family want, with the care they actually receive.) She was never married and never had any children. All of her generation had died. She had a nephew who lived about an hour away that visited her about once a month. Her only visitor was her weekly NP and monthly PCP. After being in our team MOC for about 2 years, she asked her NP to take a look at a growth she had. Her NP felt she had cancer and asked the Medical Director to take a look. She didn't even need a biopsy, having a vulvar mass with hard inguinal enlarged lymph nodes. Our member was about 5'4" and had lost 10 pounds in the 6 or so months before, now weighing 120 pounds. After giving informed consent, our member decided she wanted to have surgery.

We set this up at a tertiary hospital as we felt it was complicated and would require a very experienced surgical team to care for her. She had a Radical Vulvectomy requiring a 3-night, 4-day hospital stay. She had a minor post-op wound dehiscence that was handled as an outpatient. She wanted post-op radiation and this was handled, all on an outpatient basis, losing another 10 pounds. Eventually, 2 months later, having lost another 10 pounds, having metastatic lesions, her NP said we needed to Skill this member for IV fluids, "or she would get admitted to the acute

over the weekend." It was a Friday afternoon and we did skill her and started those IVs. Later that Friday afternoon, the Medical Director, holding the hand of our dear member, asked her what she wanted us to do, fully expecting, given her desire to do everything up until that point, expected her to say put in a feeding tube. Our member simply asked "What does my dear friend Paula (her NP) think I should do?" We reviewed all of her progress and Individualized Care Plan. With tears on everyone's part, she went home with hospice care that Monday and died a few weeks later in her own home with all of the extra care hospice delivers. During her whole nearly 3 years with CareMore, she required only one stay in the Hospital (3 nights) and one stay in the Nursing Home (3 nights), despite being very frail and having metastatic cancer.

Element 11: Performance and Health Outcomes Measurement

Element 11a:

We collect, analyze and report data to evaluate the performance of our clinical programs for the SNP targeted special needs population.

Data is collected from a variety of sources, including:

- Claims and encounter data (for utilization data, such as colonoscopies, vascular access procedures, etc.)
- Authorization data (for data such as hospital and SNF admissions)
- Appointment data for employed clinicians, to report on members participating in the clinical program (e.g. NP, Coumadin management)
- Lab results, to assess whether members are being well controlled (e.g. kt/V, phosphorous levels); lab values are imported to our data warehouse via data feeds implemented by our Information Technology Department
- Filled prescription data, filled prescription data feeds are imported to the data warehouse via data feeds implemented by the Information Technology Department
- Enrollment and CMS data
- Wireless monitoring system for Hypertension and Congestive Heart Failure
- Manual chart reviews, such as blood pressure readings; this data is collected by Quality Management as part of Quality Improvement efforts
- Other internal databases (e.g. ESRD tracking)
- Electronic medical records

We have a strategy to import the majority of its data into a data warehouse, to use as a single repository for reporting.

Measures produced from this data include:

- Industry-wide measures, for example:
  - HEDIS studies
  - Admission and bed day measures
  - Readmission rates.
- Measures developed to evaluate clinical programs supporting the clinical model, for example:
  - Diabetes and amputation studies, which includes measurements of:

    - Qualified members enrolled in the Diabetes Management Program (DMP)
    - HBa1C and LDL testing frequency and % of members within goal
    - Retina exam compliance and nephropathy HEDIS measure
    - Blood sugar changes for members managed through DMP
    - Admission and length of stay for members with diabetes
    - Amputation rates
  - COPD studies, which include measurements of:
    - Participation in Pulmonary Management Program
    - Visits to Pulmonologists
    - Fills of Pulmonary prescriptions
    - Scripts for rescue medications
    - Members on oxygen or pulmonaid machines
    - Rates of flu and pneumo vaccines
    - Spirometry testing
    - Smoking cessation referrals
    - Admission bed days, length of stay, and ER visits for dual eligible members
  - Studies of other chronic conditions members may have, similar to the studies above (e.g. ESRD, CHF)
  - Studies of the results of fall prevention and exercise and strength training programs.
- Advance directives and code status
- Pharmacy utilization rates
- Other measures developed to assess outcomes or quality on an ad hoc basis, for example:
  - Death in hospice vs. hospital
  - Medical expenses at end of life

We also monitor to ensure beneficiaries are receiving access to necessary services and benefits.

- Monitoring of rates of members participating in our "Healthy Start Program" and "Healthy Journey Programs" which enhances access by:
  - Identifying their immediate needs upon enrollment
  - Enrolling them in programs and services to deliver CareMore's model of care
  - Triaging them for needed medical, mental health, social services and community resources
- Monitoring of post discharge member follow-up appointments and phone calls by Extensivists and Case Managers
  - Extensivists are internal medicine trained, board certified hospitalists, who also perform outpatient care for frail and chronically ill members
  - Extensivists and Case Managers are trained to optimize our clinical programs and services
- Monitoring of enrollment in Clinical Programs for frail and chronically ill members, for example:
  - Home based wireless monitoring programs for Congestive Heart Failure and Hypertension
  - Diabetes and Wound Care
  - Anticoagulation
  - Fall Prevention

  - Exercise and Strength training
  - COPD
  - Chronic Kidney Disease
  - Hypertension
  - End Stage Renal Disease
  - Cardiovascular Disorders
- Measures developed to evaluate the clinical model for institutionalized and institutional level of care members, for example:
  - Advanced directives and code status
  - Development of pressure ulcers
  - Number of visits per month by an MLP
  - Pharmacy utilizations rates
  - Fractures of consequence rates
  - Infection rates
- Other measures developed to assess outcomes or quality on an ad hoc basis, for example:
  - Death in hospice vs. hospital
  - Medical expenses at end of life
- Access to clinician and case management on call programs, for critical needs that arise after regular business hours
- Regular reviews of our specialty network are performed by geographic region to evaluate network composition and specialist coverage, as well the effectiveness of critical types of providers (e.g. hematologists/oncologists)
- Frequent interdisciplinary team reviews of care plans for members requiring high risk member management, by the CareMore Intervention Team (CIT)
- Monitoring and evaluation of authorization requirements, which allow auto authorization and self-referral for access to Clinical Programs.
  - Evaluation of benefits and service needs. We have unique benefits and services to address the needs of the population being served by the special needs plans.
  - PCP and physician specialists services
  - Preferred generic drugs and insulin, and other pharmaceuticals supporting the models of care such as: ace inhibitors, beta blockers, and oral diabetic medications.
  - Our clinical programs, including:
    - Chronic care programs (e.g. Diabetes, ESRD, CHF, COPD)
    - Preventative programs (e.g. fall prevention, anti-coagulation program, strength training, smoking cessation, Healthy Start)
    - Other programs designed for frail and high risk members (e.g. Extensivists, House Call, Mental Health, CIT)
  - Nutritional counseling
- Evaluation of pharmacy costs and utilization for member out of pocket expenses and generic/formulary utilization at the plan level and for each Primary Care Physician
- HEDIS measurement of preventative services
- Utilization reports including data by:
  - Specialty
  - Geography
  - Specialist

  - Medical Group
  - Product
  - Type of service
  - Unique member
- A PCP report card that demonstrates Primary Care Physician's performance for metrics that are important to the clinical model, for example:
  - Generic pharmacy utilization supports access to affordable pharmaceuticals
  - Qualified member care center usage supports access to clinical programs
- Formal access surveys are conducted to determine next available appointment

Focused access studies are conducted as a result of complaint and grievance trends indicating potential issues. Summaries of this data are reported in various formats for analysis. For example:

- Monthly performance effectiveness metrics reports are produced which are reviewed by the ICTs. These reports include more detailed analysis of certain measures to help the team fine-tune their plans; for example these reports include trends over time. The ICT reviews these trends, and may conduct chart reviews, then acts on any issues where the model of care is not working as designed and makes recommendations to the Medical Officers for improvements to the model of care.
- Daily and monthly hospital metrics reports are produced and reviewed by the Medical Officers/ Directors. If negative trends are noted, the Medical Officer/Director will review cases with the hospitalists real-time to make recommendations.
- A Dashboard is produced quarterly that is reviewed and analyzed by Medical Officers and Clinical Directors, then reported through the Quality Management Committee. This report includes goals for most performance measures. The Medical Officers and Clinical Directors meet prior to the Quality Management Committee meeting, analyze results, incorporate feedback from the ICT, and make recommendations for corrective actions as well as additional analysis required, like chart reviews. This information is then presented to the Quality Management Committee, who provides additional feedback into the plans, and tracks progress. Below is a sample of the performance measures and goals.

Clinical Program	Goal
Clinical Quality Diabetes	
# of Qualifying members with Hb1ac > 8	
# of Qualifying members with a DMP CCC visit	
% of Qualifying members with 10 Hb1ac ≥ who are enrolled	95% **
% of Qualifying members with Hb1ac > 8 < 10 who are enrolled	75% **
% of Qualifying Members with:	
HbA1c Testing	90% **
Hb1Ac Control	85% *
LDL Testing	90% *
LDL Control	65% *
Diabetes Nephropathy Testing	92% *
Diabetes Retina Exam	75% *
Amputations PTMPY Qualifying members (ESRD)	75% Lower than Medicare National

Clinical Program	Goal
	Rate **
Amputations PTMPY for Qualifying members (Non- ESRD)	75% Lower than Medicare National Rate **
Clinical Quality COPD	
# of Qualifying members (member has COPD)	
# of Qualifying members with COPD CCC visit	
# of Qualifying members on Oxygen	
% of Qualifying members on Oxygen who are enrolled	95% **
# of Qualifying members on COPD Rx or Nebulizer	
% of Qualifying members on COPD Rx or Nebulizer who are enrolled	75% **
% of Qualifying members with Spirometry test within 6 months after initial diagnosis	85% **
Yearly Augmented Pulmonary Initiative Completed by end of October	Yes **
Clinical Quality ESRD	
# of Qualifying members (member has ESRD)	
# of Qualifying members with ESRD CCC visit or ESRD NP Home visit	95% **
% of ESRD members with A/V Fistula	70% **
% of ESRD members with Albumin of $\geq$ 3.8	90% **
Clinical Quality CKD IV/V	
# of Qualifying CKD IV/V members (per GFR values)	
# of Qualifying CKD IV/V members enrolled in CKD program	
# of Qualifying CKD IV/V members with assigned Nephrologists	
% of Qualifying CKD IV/V members that end up on dialysis/Yr	
% of Qualifying CKD IV/V members with LDL under control	65%***
% of Qualifying CKDIV/V members with Hb1ac under control (Hb1ac $\leq$ 8)	85% **
% of Qualifying CKDIV/V members with last blood pressure reading $\leq$ 140/90 (excluding ESRD members)	
Qualifying CKDIV/V members Amputation rate/1000	75% Lower than Medicare National Rate **
Clinical Quality CHF	
# of Qualifying members (member has CHF- per criteria)	
# of Qualifying members enrolled in Ideal Life Program	
% of Qualifying members enrolled in Ideal Life Program	30%
% of Qualifying members on (Ace Inhibitors or ARB) and Beta Blockers	92%***
Clinical Quality Heart SNP	
# of Qualifying members (member has a history of MI)	
# of Qualifying members enrolled in Heart SNP program	
% of Qualifying members enrolled in Heart SNP program	
% of Qualifying members with LDL Testing	95%*
% of Qualifying members with LDL under control	65%*
% of Qualifying members with last blood pressure reading $\leq$ 140/90 (excluding ESRD members)	
% of Qualifying members with Hb1ac under control (Hb1ac $\leq$ 8)	85%**

Clinical Program	Goal

* HEDIS RFERENCE
*** BEST IN CLASS
** INTERNAL GOAL
Some HEDIS metrics have a 75 year age limit and for this we may have set our goals lower than that of HEDIS due to our average population age being > 75

Signifies new addition to dashboard

Element 11b and c:

Reports are produced by our Clinical Data Analytics team. The reports are designed by Medical Officers and Directors, members of the ICTs, along with an Engineer and the Actuarial team. These reports were described earlier, such as:

- Daily hospitalization census reports
- Monthly clinical performance reports (Admissions, Readmissions, Emergency room usage, clinical performance,)
- Quarterly Regional Dashboards, HEDIS reports, and PCP report cards

The Neighborhood ICT reviews performance reports on a monthly basis; this effort is in addition to collaborating on specific member cases. They analyze and act on the clinical program performance reports; this team includes Nurse Practitioners, Case Managers, and an Internist. In 2010, we also added an Engineer to this team, trained in Lean Six Sigma methodologies in order to improve processes and the measurements of the program. The ICT reviews the trends against predefined goals for each measure, and identify remediation for any outliers to include corrective action and enhancements to the model of care.

This review is most frequently conducted by the team in round table meetings, however sometimes additional chart review is required; the chart review will be conducted by the clinician with the expertise on the topic (e.g. an Internist will review hospital records, a NP will review NP visit records). These efforts are directed by the Medical Officer and Clinical Director responsible for the model of care. An example of how these results were used is in 2010 when the ICT identified many of its members were not receiving cardiac care, it:

- Enhanced the NP Protocols and had NPs start managing members with Cardiovascular Disorders
- Employed and contracted with “preferred” Cardiologists to work at CareMore Care Centers, then started actively managing these members.

Additionally, the members of the ICT may bring up and act on improvement opportunities that do not surface as part of the performance reports; for example: the IDT started assessing depression using additional screening questions after an NP brought up many of her members were passing the PHQ9 Depression screen, but were exhibiting other symptoms of depression.

Element 11d:

The evaluation of the model of care is documented in meeting minutes from the ICTs, Medical Officer Meetings, and Quality Management Committee meetings.

- ICT meeting minutes are documented by the Program and Clinical Managers and stored on Shared Drives. These are also distributed to participants in hard copies, and cc'd to those having oversight responsibility for the performance.
- Medical Officer Meetings are documented by the Vice President of Clinical Operations and hard copies are provided to all meeting participants. Hard copies are also printed and stored in Medical Officer Meeting binders.
- Quality Management Committee meetings are documented by the Director/Manager of Quality Management, printed and given to participants in hard copy and stored in Quality Management Meeting binders. These meetings are documented and preserved as evidence of the effectiveness of the model of care per the Quality Management policy as follows:
    - Meeting Supporting Documents
        - Electronic version of meeting materials sent via email to QI Committee members prior to meeting for review
        - Binder with hard copies of materials provided to all meeting participants at meeting. This includes:
            - Copies of the program effectiveness metrics and dashboard, along with meeting minutes and recommendations from the ICT and Medical Officer meetings.
        - Binders collected at end of meeting, one kept for records, all others copies shredded
        - Electronic copies of materials stored on QM lead drive
    - Meeting Minutes
        - Minutes documented during meeting, capturing discussion and action items for all topics regarding the evaluation of the model of care, discussion of its effectiveness, and improvement responsibilities.
        - Minutes from previous meeting reviewed at the following meeting, necessary changes identified and QI Committee approval obtained during meeting.
        - Signature from medical director obtained on final version of minutes.
    - Meeting Participants
        - All participants required to sign meeting participation sign in sheet indicating their presence during the meeting

<u>Element 11e:</u>

There also is oversight responsibility by the Medical Officers Team and the Quality Management Committee. Currently, we have a Medical Officer team which is led by the Chief Medical Officer and includes four Senior Medical Officers, the VP of Clinical Operations, and the Program Manager for Quality. They receive the clinical performance results quarterly in the form of a Dashboard, review them, and assess the interventions planned by the ICTs. If they think there is a gap in the model of care, its performance and/or the planned intervention by the ICT, they will give direction to the Senior Medical Officer who is responsible for the program,

and oversee progress. This team also evaluates and defines the goals for the performance measurement to ensure continuous improvement. Additionally, the Quality Management Committee provides a final level of oversight; this committee reviews the clinical performance reports and the reports from the ICT meetings, then gives additional feedback and tracks action items from this review.

The Quality Management Medical Director, with support from the Quality Manager, has formal oversight responsibility of the model of care reporting to the Board of Directors. Below is an excerpt from our Quality Management Policy which describes this responsibility:

Board of Directors

The BOD of is responsible for organizational governance, and as such, has the ultimate responsibility for performance of improvement activities by establishing and supporting the QI Committee.

The BOD delegates the ongoing responsibility for the development and implementation of the QI program to the Quality Improvement Committee. The QI Committee has adopted and effectively employed an approach to performance improvement that includes: Planning the improvement process; Setting priorities for improvement; systematically measuring and assessing the improvement Process; implementing improvement activities based on assessment of Activities; Maintaining achieved improvement; and Analyzing and assessing the effectiveness of performance projects.

The BOD is responsible for the quality of care and services provided to the members. The BOD requires the Medical Director to implement and report on the activities and the mechanisms for: Monitoring, assessing, and evaluating member safety practices and the quality of member care; Identifying and resolving problems; identifying opportunities to improve both quality of care and quality of services or performance throughout the organization. This process addresses those departments and disciplines that have direct or indirect effect on member care, including management, administrative functions and contracted services.

The BOD requires the detail and frequency of data collection for all indicators and performance processes as outlined in this program (i.e., reporting of all identified member care and service indicators to the QI Committee on a quarterly basis.) As outlined in this Program, the BOD further delegates the authority for data analysis, evaluation, action determination, implementation and outcome evaluation to the individuals, departments and committees listed in this program. It is expected that the health information systems utilized to produce the reports will fully comply with HIPAA and privacy laws, and professional standards of health information management. This will be accomplished through specific designated roles and responsibilities, established policies and procedures developed or approved by the HIPAA officer and implemented throughout the organization with ongoing, routine monitoring and reporting through Information Systems.

The BOD provides for resources and support systems for the performance improvement, quality improvement, utilization management, case management, clinical operations, health information

management and risk management functions related to member care and services. The BOD has a responsibility to evaluate the effectiveness of the performance improvement activities performed throughout the organization and the Quality Improvement Program as a whole.

In carrying out these duties, the BOD: Reviews and annually approves the QI Program; Reviews and approves the annual QI Work plan (which includes UM); Receives a presentation and/or written report(s) from the QI Committee delineating and identifying opportunities to improve care/service, actions taken and improvements noted resulting from monitoring and evaluation activities; Receives, reviews, makes recommendations, and approves the annual evaluation of the QI Program; Discusses reports, requests additional information when required and directs action to be taken independent of the QI Committee on opportunities to improve care and service or resolve problems, when indicated; Takes appropriate action on recommendations for changes in the QI Program; and Delegates responsibility for the QI Program to the QI Committee and the Medical Director.

There is some redundancy between the Medical Officer Team and the Quality Management Committee who are both responsible for the oversight of the model of care; however they both have important and critical roles. Medical Officers have day to day responsibility for the performance of the model of care, and they also are usually the innovators and executers for improvements to the model. The Quality Management Committee has a formalized oversight role, and they also have a cross functional team where corrective action and improvement plans can be further vetted.

Examples of how this works in practice includes:

- An End to End Audit of Clinical Performance was initiated by the Medical Officer Team. A team was formed to conduct the audit and compile the results. They were presented to the Medical Officer Team, along with other Departmental Medical Directors who agreed on a corrective action plan. This effort was managed by the Program Manager for Quality. The results were presented to the Quality Management Committee for feedback; this information was incorporated into the Quality Management reports.
- The Medical Officer Team reviewed the quarterly Clinical Dashboard. As a result of this review, the Medical Officers initiated a revamping of the clinical outreach process to improve engagement of high risk members. The program redesign was designated to the VP of Clinical Operations and 2 of the Senior Medical Officers. This was reported to the Quality Management Committee, and both the Medical Officer Team and the Quality Management Committee tracked progress.
- QI staff attended the Medical Officer Meeting to assess options for the annual Chronic Condition Improvement Program (CCIP). An initiative was selected and a Senior Medical Officer was assigned to oversee the effort with a member of the QI Team. Progress was tracked and reported on regularly in the Medical Officer and Quality Management Committee meetings.

<u>Element 11f:</u>

Improvements to the model of care are communicated in various formats, depending on the stakeholder it affects. For example:

- Improvements to the model of care are communicated to the ICT and employees during its team meetings. Also, many of these improvements are also documented and included in:
  - Protocols - NP protocols are updated every time their procedures are enhanced. For example: when we decided to change its model of care to have NPs assess and refer for preventative services (in addition to PCPs, who were already doing this), the NP protocols were updated.
  - Training materials
  - Tools (e.g. assessment tools and care plans)
  - Company newsletters
- Improvements are communicated to contracted providers via:
  - News bulletins, provider bulletins and meetings; for example: when we added Cardiologists to its Care Centers, local PCPs were notified to refer members.
  - Another example is when we changed the model of care to have NPs assess and refer for preventative measures and a letter was drafted and sent to all PCPs. Also this was added as an agenda topic on standing provider meetings and discussed in Provider Service site visits to the offices.
  - In Provider Manuals and on our Internet site so stakeholders can access reference materials. Sometimes we may also produce handouts for providers to keep in their offices.
- Improvements are communicated to members via:
  - Member newsletters
  - Our internet site
  - Appointments with providers (e.g. NPs started assessing preventative measures as part of Healthy Start and Health Journey)
  - Targeted outreach campaigns to affected members