Care1st HEALTH PLAN
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601 Potrero Grande Dr., Monterey Park, CA 91755

February 24, 2012

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

Dear Mr. Quacchia:

We are pleased to submit our Application for the California Dual Eligible Demonstration Request for Solutions for San Diego County.

We applaud DHCS's efforts to support the development of integrated models for dual-eligibles, and look forward to the opportunity to participate in the Duals Demonstration to serve this vulnerable population in San Diego County.

Thank you for your consideration of our Application.

Sincerely,

Anna Tran
Chief Executive Officer

Applicant Name: Care1st Health Plan, Inc. Date: February 24, 2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

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

Signature: _____

Applicant Name: Care1st Health Plan, Inc. Date: February 24, 2012

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	X	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	X	See Attachment #9
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	X	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	X	See Attachment #10
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.		
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	X	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	X	

Signature: _____

Applicant Name: Care1st Health Plan, Inc. Date: February 24, 2012

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	5	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?		
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes	
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	
6	How long has the Plan had a Medi-Cal contract?	16 years	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	Transportation to medical appointments, gym membership, over-the-counter drugs, hearing aids, dental, refraction, eye wear, chiropractic, acupuncture, in-home fitness program for frail homebound members, post-discharge meals.
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?	Yes	See Attachment 11 Behavioral Health, Aging Services, In Home Support Services and Public Authority
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes	See Attachment #12
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 #13

Signature: _____

Applicant Name: Care1st Health Plan, Inc. Date: February 24, 2012

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

Signature: _____

EXECUTIVE SUMMARY

Care1st Health Plan, Inc. (Care1st), an NCQA accredited Knox-Keene licensed, provider-owned organization, operating since 1994, caring for Medi-Cal, Healthy Families and Medicare members. The Plan currently operates in Los Angeles, Orange, San Bernardino, Riverside, San Diego, San Joaquin, Stanislaus and Santa Clara counties. Its total membership is approximately 340,000: Medi-Cal 307,000 - Medicare 23,000 of which 6,000 are dual eligibles. The Plan also operates in Maricopa County, Arizona. In 2006, Care1st expanded to San Diego County, quickly building strong community relationships and using outreach efforts to grow from zero to over 32,000 lives, with 3,103 of them dual eligibles.

It is Care1st's goal to work with its partners to integrate medical and behavioral health care, long-term services and support (LTSS), and home and community-based services (HCBS) for dual eligibles in San Diego County. Through a comprehensive health risk assessment strategy, Care1st will identify medical, behavioral and social services needs to create tailored, individualized care plans to improve members' quality of care, reduce health care costs and institutionalization using our Model Of Care, which was approved by CMS for three years.

Care1st partnered with the Area Agency on Aging, Region One (AAA) in Maricopa County, AZ for an Integrated Care Management Pilot (Pilot) in 2010 – integrating case management functions for the Plan's at-risk dual-eligible members resulting in improved health outcomes and cost savings – decreased utilization of preventable inpatient and ER visits. The Demonstration project in San Diego will build on the success of the Pilot in Arizona, to create a similar Interdisciplinary Care Team (ICT) responsible for navigating at-risk dual eligibles throughout the care continuum. Plan staff and external providers can document and share pertinent data in order to reduce duplicative case management functions, fragmented service delivery, and health care costs through the existing medical management system.

Care1st is proposing San Diego County as the geographical area, with approximately 20,000 dual eligible beneficiaries. This totals twenty-five percent (25%) of the approximately 80,000 dual eligible beneficiaries in the county.

Care1st has partnered with key providers within the community, including Federally Qualified Health Centers (FQHCs) and Sharp Community Medical Group (SCMG), to care for the dual-eligible population. One of the FQHC's, Family Health Centers, received Joint Commission Primary Care Medical Home (PCMH) Designation. SCMG is Independent Physician Group has a strong, proven track

record of innovative processes and programs to care for the dual eligible population. Care1st is proud to be the only managed care Plan contracted with SCMG for dual eligible members. The Dual Demonstration includes, but is not limited to, the following partnerships:

- County of San Diego Health and Human Services Agency (HHSA):
    - Healthy San Diego, Aging & Independence Services (AIS), In-Home Supportive Services (IHSS), Behavioral Health Services, Mental Health Plan (MHP)
- Senior and independent living service providers
- Key provider groups, including Community Clinics and SCMG, that have systems and networks in place to work with the Plan to meet the unique needs of dual eligibles

The Plan applauds DHCS's efforts to support the development of integrated models for dual-eligibles and looks forward to the opportunity to participate in the Duals Demonstration Project.

SECTION 1: PROGRAM DESIGN

1.1: Program Visions and Goals

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

Care1st has been a Medi-Cal Managed Care Plan since 1994. The Plan currently serves 277,000 Medi-Cal beneficiaries including 3,800 dual eligible

members in Los Angeles County. In San Diego County, the Plan serves 27,000 Medi-Cal enrollees and 5,600 Medicare enrollees of which 3,103 are dually eligible. The Plan also operates a Medicare Advantage Special Needs Plan (SNP) in Los Angeles, Orange and San Bernardino counties as well as Maricopa County, Arizona.

Approximately eighty-percent (80%) of dual eligible beneficiaries in Medi-Cal managed care are not enrolled in Care1st's Medicare Advantage SNP. For these beneficiaries, the Plan manages Medi-Cal services and benefits not covered by Medicare. Also, our Social Services staff provides care transition services and assists beneficiaries with access to Health and Community Based Services (HCBS) and Long Term Care (LTSS) when appropriate. For remaining beneficiaries, Medicare is the primary payor. The Plan manages all the medical needs and benefits as provided under the Medicare Advantage SNP through our contracted provider network. As such we have been required to coordinate both Medi-Cal and Medicare benefits for our members. In addition, Care1st has a three year approved Model of Care and Care (MOC) Transition program for our SNP members. Care1st has been very successful in reducing costs, improving quality of care and satisfaction of both the Medi-Cal and Medicare members we serve.

1.1.2 Explain why this program is a strategic match for Care1st's overall mission.

This project is in alignment with the Plan's mission and commitment to providing health care that is medically excellent, ethically driven, and delivered in a patient-centered environment. As such, the Plan recognizes the positive relationship between health education, a culture of wellness, with an emphasis on prevention and cost-effective delivery of care. Within the Plan's mission is the desire to share pertinent data and information with all providers via a medical management system that reduces duplicative case management functions and service fragmentation. This is in line with the Plan's goal to be a leader in applying advanced technology to achieve excellence in customer satisfaction for its members, providers and employees. Care1st has significant experience managing and coordinating the care of high-risk Medicare and Medi-Cal beneficiaries.

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

Coordinated benefits and access to care, improving continuity of care and services for dual eligibles. Care1st's current Model of Care (MOC) is focused on continuous care coordination throughout an Interdisciplinary Care Team (ICT). As an NCQA Accredited Plan, Care1st has demonstrated, through formal audits, the

ability to coordinate Medi-Cal and Medicare benefits for its members. The Plan is committed to improving and ensuring continuity of care, and will conduct outreach to beneficiaries to work with them to ensure their care remains uninterrupted. During the last six months as Seniors and Persons with Disability members enrolled with Care1st, the plan has reached out to non-contracted providers extending them an opportunity to join the network and thereby maintaining continuity of care. Once new providers are in the network, all necessary education and training is provided so that they become integral members of the ICT. Care1st will ensure that there is continuous care coordination between the Plan case management and ancillary staff, physicians and any existing external programs such as Multi-Purpose Senior Services Program (MSSP), Home and Community Based Services (HCBS), In-Home Supportive Services (IHHS) and county Mental Health in order to ensure that dual eligible beneficiaries receive person-centered, high quality and cost effective care.

Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and support in lieu of institutional care. The Plan's member-centric approach to care includes a comprehensive health risk assessment strategy, which will allow for identification of medical, behavioral health and social service needs, and create Individualized Care Plans tailored to

improve quality of care, reduce cost, and avoid institutionalization. The integration of social services into Medicare and Medi-Cal benefits provides the opportunity to access appropriate LTSS and home and community-based alternatives to institutional care. The linchpin of the Plan's ICT model includes Care Navigators who are responsible for navigating members throughout the entire continuum of care to ensure that they have a choice of LTSS and HCBS in lieu of institutional care.

The Plan is committed to ensuring successful care transitions between all levels of care and providers in the integrated care delivery system. Hospitalized members will receive care transition assistance so that members who must remain in a skilled nursing facility for necessary rehabilitation may be able to return home and avoid institutional care. Care1st supports member directed care such as their ability to select their IHHS worker which in many instances will allow them to remain in their home. Other options such as, HCBS, CBAS, Board and Care or Assisted Living may need to be considered based on the individual member's needs.

Increasing availability and access to home and community-based alternatives. The Plan is committed to working with duals to provide access to appropriate LTSS, MSSP and home and community-based alternatives to

institutional care. The Plan's partnership with the San Diego County AIS, IHSS and community-based social service providers will increase the availability and access to home- and community-based alternatives.

Senior Coordinators (SCs) in senior affordable housing will be invited to join the ICT to assist in making sure that duals residing in their facilities have access to HCBS to assist them to receive needed services to allow them to continue to live independently in their homes for as long as possible. The Plan will work with HCBS providers to make arrangements for clustering of services for members with similar service needs to maximize economies of scale. For example, home care companies providing custodial care services could waive their four-hour minimum requirements to service multiple residents living at the same facility.

Preserve and enhance and ability of consumers to self direct their care and receive high quality care. The integration of LTSS and HCBS into the Plan will allow duals to continue to live independently in the community, or in the care setting of his or her choice. Qualified duals with unmet long-term care needs will continue to receive IHSS and self-direct their care. The Plan will assist those who are not able to self-direct their care to ensure that quality services are available and provided. The Plan is committed to ensuring that duals receive the highest possible quality of care in the care setting of their choice. Through the use of a

Care Navigator, the member will have an advocate that will ensure proper coordination and access to all available services.

Improve health processes and satisfaction with care. Through the Duals Eligible Demonstration, it is the Plan's intention to connect the case management functions of all providers - medical, behavioural health and social services, via its medical management technology system that will allow Plan Case Management staff and external providers to document and share pertinent data on a common platform to reduce duplicative case management functions, fragmented service delivery, and health care costs. This integrated technology system will allow the Plan to effectively deliver a more comprehensive care management program that enhances its ability to; track and manage case activity, deliver assessments and care plans, interface with external criteria sets, automate workflow to support case managers and increase efficiencies, use dynamic logic that will display only data relevant to the current scenario, and integrate with external systems so all case managers and providers have the data necessary to complete tasks.

Integrating segregated systems involves many challenges, which require all partners to continuously communicate and work together to jointly problem solve, share knowledge, and learn from best practices to develop new processes that will most efficiently and cost-effectively meet the needs of duals eligibles.

The Plan is committed to creating a collaborative environment, both internally and externally, that will allow for continuous improvement in operational processes that will result in better care, improved health outcomes and reduced costs. Specific process measures will be tracked on a regular basis to ensure processes are in alignment with desired performance measurements, including more satisfied members.

Improve coordination of and timely access to care. Dual eligibles suffer from costly and debilitating conditions and in many cases multiple chronic health conditions, and represent some of the most costly and medically complicated health cases in the Medi-Cal and Medicare program. Over forty percent (40%) suffer from cognitive or mental impairments and substance abuse conditions.

In addition to high levels of co-morbidity and co-occurrence of physical and behavioral health conditions, dual-eligibles face challenging social and economic situations, such as lack of emotional and social support and residential instability, which frequently impairs their ability to adhere to treatment Plans and to maximally benefit from them. The biopsychosocial complexities of the population mandate a multifaceted, member-centric approach to care based on physical and mental health integration and intensive coordination and case management interventions.

The Care1st MOC is driven through the integration of medical and behavioral health, LTSS and HCBS providers and the various case managers into the Plan's ICT. This will significantly improve coordination of services to ensure that dual eligible beneficiaries receive person-centered, high quality and timely access to appropriate cost-effective care.

Optimize use of Medicare, Medi-Cal and other State/County resources. It is the Plan's intention to optimize any and all San Diego County and state resources to expand access to a seamless, integrated system of care that will reduce duplication and service fragmentation, improve care and lower costs. The County of San Diego Health and Human Services Agency (HHSA), Aging and Independence Services (AIS), serving as the local Area Agency on Aging (AAA), is the umbrella agency for more than thirty (30) different programs for older adults and adults with disabilities, including dual eligibles. Additionally, the agency's Aging and Disability Resource Center (ADRC), was one of the first established in the country. ADRC provides "a no wrong door", integrated service delivery system for information and assistance, and is the gateway to AIS programs and services. The Plan will partner with the AIS and its contracted providers to coordinate access to and maximize the use of these services and programs for

dual eligible members. The following is a list of some of the resources that the Plan will work with the County to make available to its dual eligible members:

- In-Home Supportive Services (IHSS)/personal care services, such as homemaker/chore services, including, but not limited to housecleaning, laundry, shopping and errands, personal care (bathing, dressing, feeding, bowel and bladder care, and ambulation) As a result of combined funding, the Plan may be able to expand IHSS hours for individual members from existing levels.
- Home modifications, repairs, maintenance
- Home health/personal and respite care
- Counseling
- Money management
- Nutrition – home-delivered meals and nutrition counseling
- Assistive devices
- Legal assistance
- Multipurpose Senior Services Program (MSSP)
- Long-term care services (skilled nursing facilities, intermediate care facilities, sub-acute services, etc.)
- Other services and programs, as appropriate and available

Additionally, the Plan has partnered with the San Diego County's Healthy San Diego (HSD) program since 2006, and will continue to coordinate with the County's MHP. Through HSD, the Plan has been participating in the AIS's Long Term Care Integration Project (LTCIP) and has excellent relationships with the San Diego AIS and senior service providers

1.2 Comprehensive Program Description

1.2.1 Describe the overall design of the proposed program, including the number of enrollees, proposed partners, geographic coverage area and how you will provide the integrated benefit package, along with any supplemental benefits you intend to offer.

Following Care1st's Model of Care, it will develop a person-centered health delivery program that integrates medical and behavioral care, long-term care, including HCBS.

Care1st will create an Integrated Care Team (ICT) that includes the Plan's Complex Case Managers, Social Workers, Care Transition Managers, Disease Management Specialists, and Care Navigators who will be responsible for navigating at-risk dual eligibles throughout the care continuum. When appropriate, the Plan will also partner with Service Coordinators (SCs) working at senior affordable housing and include them in the ICT. Through a comprehensive

health risk assessment strategy for all enrollees, the ICT will identify medical, behavioral and social needs to create Individualized Care Plans tailored to meet their needs. Through Care1st's existing medical management system, the Plan will utilize a common platform where both case management and ancillary staff, physicians and any external providers such as MSSP, HCBS, IHSS and County Mental health can document and share pertinent data in order to effectively manage the continuum of care for the dual eligibles beneficiaries. The goal is to reduce duplicative case management functions, fragmented service delivery, and health care costs.

Care1st is proposing San Diego County as the geographic area with a projected enrollment of approximately 20,000 dual eligible beneficiaries, representing twenty-five (25%) of the approximately 80,000 dual eligibles in the County.

Strategic Partnerships: Care1st's Dual Demonstration includes, but is not limited to, the following partnerships:

- County of San Diego Health and Human Services Agency:
  - Healthy San Diego
  - Aging & Independence Services (AIS)
  - In-Home Supportive Services (IHSS)

- Behavioral Health Services, Mental Health Plan (MHP)
- Affordable Housing Owners and Property Management Companies of senior affordable housing in San Diego County
- American Association of Service Coordinators (AASC)
- Contracted medical and behavioral health providers
- HCBS providers including, but not limited to:
  - Senior service providers
  - Independent Living Centers
- Home health and home care companies
- Key provider groups, including FQHC and Sharp Community Medical Group, that have the systems and network in place to work with the Plan to meet the needs of dual eligible beneficiaries
- Hospitals
- Pharmacies
- Durable medical equipment and other ancillary providers and services
- Skilled nursing facilities and other long-term care providers and services
- End-of-life, palliative care and hospice services

Proposed Supplemental Benefits. The Plan is committed to filling as many gaps in services as the final reimbursement rate allows. The following are

examples of supplemental benefits the Plan currently offers in the SNP plan and proposed benefits under the Dual Demonstration Pilot:

BENEFIT	CURRENT	PROPOSED
***Transportation to medical appointments**	48 one-way trips per benefit year	**Unlimited**
Gym Membership	All Facilities that contract with Silver Sneakers	**Same**
Over-the-counter Drugs	$50.00 allowance per quarter	**Same**
Hearing Aids	$1,000.00 allowance per benefit year	**Same**
Dental	$0 copayments $500 allowance per benefit year	**Same**
Refraction Eye Wear	$200.00 allowance per benefit year	**Same**
Chiropractic	15 visits per benefit year	**Same**
Acupuncture	15 visits per benefit year	**Same**
In-home Fitness Program for frail home bound members		**Benefit based upon medical necessity**
Post Discharge meals		**Two (2) meals a day post discharge for 7 days**

*Care1st non-emergent transportation vendor requires all drivers to have certification in first aid and CPR. Drivers must also attend four hour training on

Passenger Assistance and Senior Sensitivity (PASS) training, plus a four hour hands-on training on how to properly secure a wheelchair.

1.2.2 Describe how you will manage the program within an integrated financing model.

The program will be managed as a standalone product line with its own revenue sources and expenses as defined in the program requirement. Care1st maintains a core system that allows for identification of members with all their association to the various product lies in which Care1st operates. Services are authorized based on medical necessity and continuity of care, independent from the financial component. Benefits configuration is set up in the system to align with a particular product line, in this instance the Dual Demonstration Project. Within the configuration, services and benefits are established on the program level thus eliminating the need to classify the revenue sources of these services. Care1st will provide a global payment that reflects the full set of covered services, as well as administrative and care management costs to contracted providers.

1.2.3 Describe how the program is evidence-based.

As an NCQA accredited plan, Care1st is required to utilize clinical practice guidelines for the provision of both medical and behavioral services. In addition, these guidelines must be evidence based.

Care1st utilizes a number of evidence-based guideline for the provision of nonpreventive acute and chronic medical, behavioral and pharmacy services. Some of the most widely used guidelines include but are not limited to: Milliman Care Guidelines, Apollo Medical Care Criteria, American Diabetes Association, National Comprehensive Cancer Network, National Osteoporosis Foundation, National Heart, Lung and Blood Institute, American College of Chest Physicians.

All of Care1st Disease Management Programs are developed using evidence based criteria. These include National Heart, Lung, and Blood Institute (NHLBI) National Education and Prevention Program (NAEPP), Expert Panel Report 3 (EPR3): Guidelines for Diagnosis and Management of Asthma 2007, Global Initiative for Chronic Obstructive Lung Disease, 2007, Heart Failure Society of America Comprehensive Heart Failure Practice Guideline, 2006 and ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults 2009.

Care1st uses McKesson's Care Enhance Care Management System (CCMS) as its Medical Management system. It contains a large number of condition specific assessments which are used by our case managers to assess and coordinate the member's care. All of the assessments contain a comprehensive bibliography supporting the medical decision process.

An example of how a process that utilizes evidence-based guidelines, results in positive outcomes is illustrated by our Complex Case Management Program. An analysis of 148 Medicare members receiving complex care management services between February to December 2011 showed a reduction in hospital admissions of 43% a reduction in re-admissions of 39% and a reduction in ER utilization of 37%.

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.

The Plan and its Partners will focus on reducing health disparities by ensuring that all dual members, regardless of ethnicity, receive access to the same health care, behavioral health and social services. Additionally, the Plan is confident that the proposed interventions and focused monitoring by the ICT will improve health outcomes and reduce the effect of co-morbidities for its members.

Through the use of Care Navigators, Care1st will enhance the ability to coordinate and/or provide critical social support and HCBS will mitigate and/or modify some of the risk factors that contribute to poor health outcomes and costly health care utilization, (i.e., poor social support, the involvement of numerous providers and case managers that do not share information with each

other, multiple medications, low socioeconomic status, and others). These factors will be taken into consideration during the assessment process to identify members who are likely to benefit from the assistance of case management and in-home assessments, disease management programs and other interventions.

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

Care1st's integrated care management model for the Duals Demonstration will include all the Health Home Services for dual eligible beneficiaries meeting the criteria included in the Federal Health Home Plans SPA. Care1st will work with DHCS to develop a Federal Home Health model, which includes linkages to behavioral health and LTSS, if the state decides to apply for funding for this program.

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

The key to overcoming the project challenges will be communication between partners, providers and with dual eligible members.

POTENTIAL CHALLENGES	SOLUTIONS
Members participating in the Dual Eligible Demonstration are	Care1st will have a comprehensive outreach effort designed to educate and incorporate members into the Plan. This begins with educational mailings in all

new to Managed Care.	necessary threshold languages and a phone call by our Member Services Department at which time the member is introduced to Care1st, the concept of the Care Navigator is presented and the member is assisted with making an initial visit with the Primary Care Physician (PCP) for a comprehensive evaluation. In addition, the member is told that a HRA will need to be completed to assist us in understanding their medical, psychosocial and home care needs.
Duplication, service fragmentation, and lack of communication and sharing of pertinent data between medical, behavioral health, and social services. Educating existing provider network about the goals of the Dual Eligible Demonstration Expanding the network to meet the needs of all members.	Care1st will create a number of task forces that will meet with the various representatives of the various agencies that are presently not part of managed care. Some of these include IHSS, LTSS and HCBS providers and County Mental Health. The purpose of these meetings will be to create a standardized process for identification and assessment of member needs, creating the necessary procedures to facilitate the exchange of information and avoid duplication of services. Care1st will work closely with Healthy San Diego and any other participating Plans so that all necessary contractual requirements are met and these new "partners" can be fully integrated with the least amount of disruption Care1st will develop a comprehensive outreach effort to ensure that all existing and new providers are fully aware and capable to fulfill the goals and objectives of the Dual Eligible Demonstration Through its collaborative work with Healthy San Diego and member advocates Care1st will assess its provider, facility and ancillary network in order to identify any gaps and make necessary additions to the network so that newly enrolled members have the least amount of disruption possible.

SECTION 2 - COORDINATION AND INTEGRATION OF LTSS

2.1: LTSS Capacity

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

The Plan's member-centric approach to care includes a comprehensive health risk assessment strategy, which will allow Care1st to identify medical, behavioral health and social service needs, and create individualized care Plans tailored to improve quality of care, reduce costs and institutionalization. The integration of social services into Medicare and Medi-Cal benefits provides the opportunity to access appropriate LTSS and home and community-based alternatives to institutional care. The Plan's partnership with the San Diego County AIS, IHSS, MSSP, community-based social service and independent living providers will increase the availability and access to home- and community-based alternatives.

The ICT, which includes the beneficiary and/or their representative, the Plan's complex Case Managers, Social Workers, Care Transition Managers, Disease Management Specialists, Care Navigators, Primary Care Providers (PCPs) and other providers, will assess and monitor members' conditions on an on-going basis. They will also work together to ensure seamless coordination of medical

and LTSS to keep members living in their homes for as long as possible. The Plan's medical management system will allow the ICT and providers to share a common platform to document and share pertinent data to reduce duplicative case management functions, fragmented service delivery, and health care costs by providing the right services, at the right time and in the right setting, based on dual members' needs and preferences.

Service Coordinators (SCs) in senior affordable housing will be invited to join the ICT to assist in making sure that dual eligibles residing in senior affordable housing have access to LTSS and HCBS to assist them in receiving needed services so they can continue to live independently in their homes for as long as possible. Additionally, the Plan will work with LTSS and HCBS providers to make arrangements for clustering of services for members with similar needs to maximize economies-of-scale. For example, home health care companies providing custodial care services could waive their four-hour minimum requirements to service multiple residents living at the same facility.

Through its Care Transition Program, Care1st has invested the necessary resources and planning to ensure successful care transitions as members move through hospital, nursing facility and home. Once members are ready to transition back to their homes, the Plan will work closely with LTSS providers, IHSS

workers and HCBS providers to ensure a successful transition and reduce re-admissions. Depending on the member's functional status, Care1st has programs in place where physicians or nurse practitioners will see him or her in their own home on a regular basis until they are well enough to see their PCP. If members are home bound for long periods of time, but are able to remain safely in their home, the "house call" physician will become the defacto PCP.

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

The Plan will contract with the existing LTSS providers in San Diego County as directed in the Dual Demonstration Proposal. The Plan intends to develop a contract with the County of San Diego to administer IHSS services and follow the reimbursement structure as provided by the State for Year One of the program. The Plan also intends to contract with Community –Based Adult Services (CBAS) centers and reimburse the providers according to State guidelines for Year 1 of the program. The reimbursement arrangements for subsequent years will be determined by actuarial review of the State FFS claims data and usual and customary rates as driven by the marketplace. The Plan intends to develop an incentive and risk sharing model with certain LTSS providers in Year Two and Three operations.

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 numerous assessment tools currently used for specific medical care and LTSS.

The Care Management process begins with members completing a Health Risk Assessment (HRA) within 90 days of becoming a Plan member, which is used to develop an Individualized Care Plan. The HRA questions are weighted to calculate stratification levels to determine the acuity level of the member, scope of intervention(s) needed, including unmet long-term care needs that require social and HCBS services. Members are stratified into one of three distinct levels that establish the priorities for performing follow up calls with members, and performing in-depth assessments that will assist the Case Manager in further identifying member needs and fine tuning individualized care plans. Based on the member's health status, co-morbidities and social needs, the Case Manager will establish a schedule of follow-up call frequency, care coordination needs, and determine if an in-home assessment is needed to further evaluate the member's need for LTSS and HCBS. The in-home assessment may be performed by a nurse, social worker or specially trained Care Navigator, who is the member's direct point of contact with the Plan and responsible for assisting and coordinating the member through the care continuum. The in-home assessment identifies

members that may need LTSS and HCBS, which include, but are not limited to: counseling, legal assistance, homemaking/chore assistance, CBAS, home delivered meals, benefits assistance program, home repairs for safety, family caregiver support program, transportation centered on instrumental activities of daily living, and behavioral health interventions. In addition to the HRAs, members are also identified as having medical and social service needs through concurrent review rounds, hospital discharge Planners, claims, case managers, and ICT referrals from providers and beneficiaries, which can trigger the need for an in-home assessment.

The San Diego County AIS has indicated that they will work with all managed health care plans through its LTCIP stakeholder meetings and the State to standardize and consolidate the numerous assessments tools that are currently used by the various providers to develop a uniform assessment tool. The Plan will participate in this process with AIS and the state, and adopt the uniform assessment tool that is developed.

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.

The Plan has experience managing populations with a similar incidence of chronic conditions, working with providers of LTSS, both for Medi-Cal-only Seniors and Persons with Disabilities (SPD) and its Medicare Special Needs Plan (SNP) members in San Diego, Los Angeles, Orange and San Bernardino counties.

The Plan currently has an informal relationship with the Aging and Independent Living networks in San Diego County, which is primarily centered around making referrals to IHSS and other senior service programs as well as with the Regional Center. The Plan looks forward to the opportunity to formalize these partnerships to expand the ability of its dual eligible members to access critically needed services to help them maintain the highest possible health and functionability, and to avoid institutionalization.

Additionally, the Plan's Pilot with the AAA in Maricopa County, Arizona has experience working with the Aging Network, and LTSS and HCBS providers. The Plan contracts with the AAA to conduct comprehensive in-home assessments for at risk dual eligible members and Medicaid/AHCCCS adults, and to provide linkages to HCBS. However, a barrier that has surfaced during the Pilot is the lack of funding and long waiting lists for home-delivered meals, in-home custodial care, and other HCBS that could assist Care1st acute members with unmet long-term care needs, who do not currently have access to these services because they

are not yet "nursing home certifiable," according to Arizona's Medicaid's eligibility requirements for LTSS. It has been our experience that waiting to provide HCBS for Medicaid members until they are deemed "nursing home certifiable" is often too late for home-based interventions to improve health outcomes. The AAA has been very creative in assisting Plan members to access much-needed services, but since the health Plan does not receive funding for these services, access is limited. The Plan is hopeful that the reimbursement structure for this Duals Demonstration project will be adequate to provide the right services, at the right time and in the right setting, based on dual members' needs and preferences.

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

The Plan is committed to helping individuals in institutional settings who would like to return to their home. For those members who have resided in inpatient facilities, e.g., nursing, sub-acute, and acute care facilities, and intermediate facilities for the developmentally disabled, for a minimum of six months or longer, the Plan will work with ElderHelp of San Diego, which is the California Community Transitions/Money Follows the Person Rebalancing Demonstration provider, to coordinate supportive services that assist these

individuals with transitioning to community living. For those who have resided in an institutional setting for less than six months, the Plan will partner with the San Diego AIS/AAA and its wide range of HCBS providers to ensure that in-home alternatives to care are available.

Additionally, the Plan will work with the local Aging and Independent Living network, the senior affordable housing industry and local members of the AASC, the national association for Service Coordinators working at affordable housing communities to provide opportunities for dual eligible members to transition to affordable independent living settings with appropriate LTSS and HCBS.

Through its Care Transition Program, Care1st has invested the necessary resources and planning to ensure successful care transitions as members move through hospital, nursing facility and home. Once members are ready to transition back to their homes, the Plan will work closely with LTSS providers, IHSS workers and HCBS providers to ensure a successful transition and reduce re-admissions. Depending on the member's functional status, Care1st has programs in place where physicians or nurse practitioners will see him or her in their own home on a regular basis until they are well enough to see their PCP. If members are home bound for long periods of time, but are able to remain safely in their home, the "house call" physician will become the defacto PCP.

SECTION 2.2: ***IHSS***

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

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

Care1st hereby certifies its intent to develop a contract with San Diego County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1.

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

- ***A proposed care coordination model with IHSS, including the referral, assessment, and care coordination process***

- ***A vision for professional training for the IHSS working, including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease***
- ***A plan for coordinating emergency systems for personal attendant coverage.***

The Plan will partner with the San Diego County Public Authority, and integrate the IHSS program into its care model for dual eligible members, and coordinate, to the extent possible, the services provided by self-selected caregivers. The Plan envisions dual eligible members being able to continue to self-direct their IHSS services in Year two and three, if they are able to continue to choose a caregiver. If they are not able to self-direct their care, the Plan will assist them in selecting their care provider.

The Plan will collaborate with the local Aging and Independent Living network and other providers such as home health agencies to provide training and support for caregivers and recipients, including training with regards to dementia, Alzheimer's disease, first aid, CPR certification, wound care and proper positioning techniques.

The integration of LTSS and HCBS into the Plan will allow dual eligibles to continue to live independently in the community, or in the care setting of his or her choice. Dual eligibles with unmet long-term care needs will continue to receive IHSS and self-direct their care. The Plan will assist those who are not able

to self-direct their care to ensure that quality services are available and provided. The Plan is committed to ensuring that dual eligibles receive the highest possible quality of care in the care setting of their choice.

Care1st will coordinate with the registry at IHSS to develop a plan for coordinating emergency systems for personal attendant coverage.

SECTION 2.3: SOCIAL SUPPORT COORDINATION

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

Care1st certifies that it will provide DHCS with an operational Plan for connecting

beneficiaries to social supports that includes clear evaluation metrics.

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.

The Care Management process begins with members completing a Health Risk Assessment (HRA) within ninety (90) days of becoming a Plan member which is used to develop an Individualized Care Plan. The HRA questions are weighted to calculate stratification levels to determine the acuity level of the member, scope of intervention(s) needed, including unmet long-term care needs that require LTSS and HCBS services. Members are stratified into one of three distinct levels

that establish the priority for performing follow-up calls with the members and performing in-depth assessments that will assist Case Managers in further identifying members' needs and fine tuning individualized care Plans. Based on the member's health status, co-morbidities and social needs, the Case Manager will establish a schedule of follow up call frequency, care coordination needs, and determine if an in-home assessment is needed to further evaluate the member's need for LTSS and HCBS. The in-home assessment may be performed by a nurse, social worker or specially trained Care Navigator, who is the member's direct point of contact with the Plan and is responsible for assisting and coordinating the member through the care continuum. The in-home assessment identifies members that may need LTSS and HCBS, which include, but are not limited to: counseling, legal assistance, homemaking/chore assistance, CBAS, home delivered meals, benefits assistance program, home repairs for safety, family caregiver support program, and transportation centered on instrumental activities of daily living, and behavioral health interventions. In addition to the HRAs, members are also identified as having medical and social service needs through concurrent inpatient rounds, Plan claims, Case Managers, and ICT referrals from providers and beneficiaries, which can trigger the need for an in-home assessment.

Through this comprehensive HRA strategy for all enrollees, the Plan will be able to identify medical, behavioral and social service needs and create Individualized Care Plans which will assist members to continue to live in their homes with appropriate social supports to avoid institutionalization. The Plan will create a Community Outreach Program which will expand the social services department to include Care Navigators and Community Resource Liaisons who will help the members get access to community services. Through the assessment, different risk levels will be determined which the plan will use to assign by category the member's specific needs and address them accordingly.

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

The Plan has a long-standing relationship with the San Diego AIS, which is the designated AAA for San Diego County, which also administers the county's ADRC. The Plan will, at a minimum, partner with the AIS/AAA, ADRC and Access to Independence, the local Independent Living Center (ILC) and the San Diego Regional Center to coordinate LTSS and HCBS.

The Plan has started a dialogue with the AIS/AAA to determine if they have the capacity to provide services for dual eligible beneficiaries in San Diego County. If the AIS/AAA is not in a position to provide these services at this time, the Plan will partner with existing LTSS and HCBS providers, either through a Memorandum of Understanding with the AIS/AAA, or directly with their contracted service providers that have the expertise and track record to provide these services. In either case, the Plan will coordinate with AIS's ADRC and other programs, as appropriate.

Additionally, the Plan will develop a partnership with the San Diego Regional Center and Access to Independence to obtain access to its services for dual eligible beneficiaries with disabilities.

2.3.4 Describe how you would partner with housing providers, such as senior housing,

residential care facilities, assisted living facilities, and continuing care retirement communities, to arrange for housing or to provide services in the housing facilities for beneficiaries.

The Plan has an existing relationship with the AASC, and several property management companies that employ Senior Coordinators (SCs) working in senior affordable housing in San Diego County. Care1st's care management model for dual eligible beneficiaries in San Diego County will include on-site housing SCs in senior affordable housing as important partners in the ICT to assist the Plan with identifying high-risk members residing in their facilities. SCs will assist with conducting assessments, monitoring and linking residents with appropriate HCBS to achieve a better match between unmet long-term care needs and service delivery to reduce costs. Congregate housing facilities provide an opportunity for economies of scale and reduced costs by clustering HCBS for multiple residents.

The ICT will coordinate with SCs at residential care facilities, assisted living facilities, and continuing care retirement communities to assess member's unmet long-term care needs that may not be met by the facilities. If additional HCBS are needed to supplement the services currently provided at these facilities, the Plan will coordinate with HCBS providers to help meet those needs.

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

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

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

Care1st is committed to creating a seamless and coordinated delivery system between physical and mental health care that ensures members have access to the full array of appropriate mental health and substance use services in a timely manner. The Plan uses a team approach to care management; the ICT includes the member, the PCP, care managers, including nurses, social workers and Care Navigators, and is supplemented by behavioral health specialists, LTSS and HCBS providers, and other health care practitioners as needed based on individual needs. The Plan's Care Navigators are responsible to navigate members throughout the continuum of care, including ensuring warm hand-offs and coordination between medical and behavioral health providers. All providers, including behavioral health providers, will have access to information about care services provided to dual eligibles through the Plan's medical management system.

Members are screened for behavioral health and substance use through a variety of sources such as the HRA, which members complete within ninety (90) days of becoming a member with the Plan, concurrent inpatient rounds, claims and pharmacy review, and referrals from members such as case managers, providers and beneficiaries. Members found to have behavioral health or drug and alcohol issues will be evaluated by a case manager to further assess the severity of their condition. Subsequent to this assessment, the Case Manager will make appropriate referral to a behavioral health provider. Care1st is contracted with a NCQA Accredited Managed Behavioral Healthcare Organization (MBHO) which provides all Medicare covered behavioral and substance use benefits. The MBHO has dedicated staff that work with our Case Managers or any provider to assist the member with making appointments. Any clinical information, including results of the HRA or case management assessments is available to the MBHO in a HIPAA compliant manner. In the event that a dual eligible member would need to access any Medi-Cal mental health and substance use benefit, the member will be referred to an appropriate provider within the plan's network. Based on discussions with the Behavioral Health Division of the San Diego County Health and Human Services Agency, many of the FQHCs that Care1st is contracted with have integrated medical and behavioral providers that can provide services

covered by the Specialty Mental Health Consolidation Program. As previously described, all necessary information will be provided to the provider in a HIPAA compliant manner.

Care1st will monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the network.

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).

As an NCQA Accredited Plan, Care1st contracts with a MBHO to provide all Medicare covered behavioral care services. As part of this arrangement, the MBHO has a designated behavioral health practitioner that is responsible for the following:

- Representing the behavioral health program at Medical Services Meetings
- Reporting to the Plan on behavioral health related aspects of care
- Participating in activities related to continuity and coordination of care between medical and behavioral care providers

- Participating and/or coordinating behavioral health related clinical activities, including but not limited to use of evidence-based clinical practice guidelines, and development of a complex case management program
- For the dual project, he/she would be in charge of collaborating with the Behavioral Health Division of the San Diego County Health and Human Services Agency in order to integrate both the Medi-Cal and Medicare benefits in a seamless fashion

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

Care1st's integrated dual eligibles model will support behavioral health and medical providers working together collaboratively to address both the physical and mental health care needs of dual eligible beneficiaries. Several of Care1st contracted FQHCs in San Diego County currently co-locate behavioral health and medical providers. The Plan will support FQHCs and medical providers who do not currently co-locate these services with training and other resources, as appropriate. Care1st has initiated discussions with the Behavioral Health Division of the San Diego County Health and Human Services Agency regarding this very topic. Depending on the number of members with high-need complex mental health and/or substance use needs, the Plan will also consider placing a medical provider at some of the county's mental health and/or drug and alcohol clinics,

and will work with FQHCs to support and enhance their ability to treat members with behavioral health needs. Care1st will provide Care Navigators, Case Managers and Social Workers to further support and coordinate care between the ICT.

Family Health Centers of San Diego, an FQHC contracted with Care1st, has recently received Joint Commission Accreditation as a Primary Care Medical Home (PCMH). Care1st believes that the PCMH model is a great vehicle for the integration of medical and behavioral care. Care1st will assist and support other FQHCs and primary care sites that are interested in developing a PCMH to deliver care to our members.

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

Care1st will meet with stakeholders through Aging and Independent Services throughout the Demonstration Project to obtain input about their experience regarding program operations, if the benefits being offered are meeting members' needs, if access is adequate and timely, and if the grievance process has assisted them in any issues they may have encountered. Additionally, the HSD health plans will continue to meet quarterly with the Consumer Center for Health Education and Advocacy. These stakeholder meetings are an

opportunity to discuss the cases they have been involved in on behalf of consumers, to determine what is working and where there may be areas for improvement to progress toward integration. Grievance and Appeals will be a standing agenda item, and plan data will be distributed.

SECTION 3.2: COUNTY PARTNERSHIPS

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

The Plan is committed to developing a comprehensive care management program that integrates physical and behavioral health services and that has the requisite staff and resources to develop appropriate care interventions for beneficiaries with mental illness and substance use disorders. This will require working with medical, behavioral health providers, as well as LTSS and HCBS providers, to educate them about the Plan's processes and procedures to improve coordination between and among providers across the care continuum

As previously mentioned, several of our contracted FQHCs currently have an integrated medical and behavioral delivery system. The providers at these sites are able to provide all medical and behavioral Medicare benefits. In addition

some are contracted with the County of San Diego to provide the Medi-Cal benefits under the Specialty Mental Health Consolidation Program and to some extent the Drug Medi-Cal Program. Based on our initial discussions with the Behavioral Health Division of the San Diego County Health and Human Services Agency , some of these FQHCs are equipped to manage up to 95% of the members with Serious Mental Illness (SMI), but less so for those with substance use problems. The Plan will work with our MBHO and the Behavioral Health Division of the San Diego County Health and Human Services Agency to further support and develop the capacity of the FQHC clinics to deliver high quality and integrated medical and behavioral benefits to members with mental illness and substance use disorders.

Also, the Plan will work directly with the Behavioral Health Division of the San Diego County Health and Human Services Agency to coordinate the delivery of integrated services for the plan's most severely affected members that cannot be cared for at sites such as an FQHC. Care1st is willing to provide, when feasible, a physician or nurse practitioner at County facilities were the most severely affected members are receiving their care for their mental illness or substance use disorders.

Regardless of where the services are provided, the members will still receive care coordination from the ICT in order to provide a seamless care continuum.

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

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

Care1st is committed to working with the Behavioral Health Division of the San Diego County Health and Human Services Agency and its providers to develop a plan for the 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.

For the first year of the Dual Demonstration the capitated payment for mental health services for Serious Mental Illness and Drug Use under the Medi-Cal benefit will remain carved out from the Plan. A significant number of dual members with SMI will be able to receive the full array of these benefits under the Medicare benefit through our existing MBHO. Prior to the commencement of

the program in 2013, and during the first part of 2013, Care1st will work closely with the Behavioral Health Division of the San Diego County Health and Human Services Agency and through our MBHO to create a collaborative Task Force that will be charged with developing a Care Coordination Plan that will focus on identifying all existing administrative, clinical and reimbursement barriers to care, and implement proper solutions that are mutually agreeable and for the ultimate benefit of the members. The Care Coordination Plan will address the following areas:

- Member Identification and Outreach. Through the creation of a standardized screening tool between the Plan and the Behavioral Health Division of the San Diego County Health and Human Services Agency we will be able to properly identify members that qualify for the Medi-Cal Behavioral/Drug Use benefit. This tool will stratify members' behavioral needs so that those that can be cared for in the Plan's MBHO can do so, and those with more severe disease can be referred to the County clinics. Regardless of where the member is referred to, this is accomplished via a warm transfer between Case Managers.
- Care Coordination. Once members are referred for a behavioral/drug use condition there will be a need for continued care coordination between medical and behavioral providers. This is best accomplished by utilizing an

integrated medical and behavioral delivery system. Our existing MBHO has such clinics in several of our contracted FQHCs. Family Health Centers is one of our contracted FQHCs that has recently received Joint Commission Accreditation as a PCMH. For those members that are referred to County clinics, Care1st will collaborate with the County clinics so that all relevant clinical/pharmacy data is shared between medical and behavioral providers in a HIPAA compliant fashion. Case Managers on the medical and behavioral side will work hand in hand to ensure that proper referrals and communication is in place. In effect this process allows for the integration of the County providers into the ICT.

- Care Management. The goal of treating members with SMI/drug use is to be able to meet their medical and psycho social needs and be able to re-engage them as much as possible with society and into a traditional healthcare delivery system through the use of medical and behavioral health interventions, vocational/occupational rehabilitation treatment will be focused on outpatient care to avoid costly inpatient utilization. Proper resources will be invested to further develop the capabilities of our behavioral network to deliver all necessary case management and rehabilitation services.

- Financing. Although initially the payments for mental health services for SMI/drug use are carved out from the Plan, proper incentives need to be in place so that the County and its partners are adequately compensated for their efforts integrating care. A bonus pool can be funded to pay for achievable milestones such as: development of a standardized tool, ability to share data between medical and behavioral providers, decrease in readmission rates, Emergency Room rates and bed days from an established baseline; achieving established medication compliance and adherence rates.

In subsequent years as integration becomes complete and the Plan receives full capitation for all mental and substance use benefits, there will need to be formal contracting between the Plan and the County clinics to address reimbursement. This arrangement can be either a FFS or a capitated basis with continued incentives as previously described.

SECTION 4: PERSON-CENTERED CARE COORDINATION

4.1 Describe how care coordination would provide a person-centered approach for a 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.

Care1st's Integrated Care Teams (ICT) are highly trained to address the complex care needs of chronically ill populations. The Plan's "care coordination"

model is a holistic, person-centered, assessment-based, interdisciplinary approach to integrating members' care across all elements of the system in a cost-effective manner in which every member's needs and preferences are assessed, a comprehensive Individualized Care Plan is developed, and services are managed and monitored by the ICT, which includes the member's Primary Care Physician. Member involvement in the development of the care Plan and the management of their care is critical. When a member is not able to participate, his or her family caregivers, or Power of Attorney will be included in the process.

The Plan's person-centered approach to care includes the recognition that not all services will be appropriate for all members. The complexity and variability of individual needs requires linkages and collaboration across the full spectrum of medical, behavioral health, LTSS and HCBS. The Plan understands that it is difficult to adequately manage the care of individuals with complex care needs telephonically, and will give complex care members, as required, the opportunity to have a Case Manager come to their home to conduct a comprehensive assessment to further assist the ICT and the member in determining care options and members' preferences. The Plan's Care Navigators will be responsible for navigating the members' care across the care continuum, and to coordinate the provision of appropriate care and services with members and their family

caregivers, providers and the various case managers, including, but not limited to, subspecialty care, hospitals, home health agencies, nursing homes, HCBS, etc. Members who are eligible for IHSS will continue to self-direct their care and be able to hire, fire, and manage their personal care workers.

Members with cognitive impairment, including dementia and Alzheimer's disease, who are not able to self-direct their care, will be provided with appropriate care and services. The Plan will encourage family caregivers and friends who know the member to assist in conveying the member's preferences in the person-center care planning process and in the development of the care plan. Family members and caregivers who are authorized to make decisions on behalf of members will be included in the decision-making process to ensure that members receive the best possible care in the most appropriate care setting, based on their preferences whenever possible.

Members with serious mental illness will be treated with appropriate care using evidence-based protocols and guidelines individually tailored to meet their needs. The ICT will work with the member's PCP and behavioral health provider, and family with consent, to ensure progress towards treatment goals. Medication for medical and psychiatric conditions will be reviewed on an ongoing basis, and

counseling and coaching will be available for members and their families to work toward resolving any barriers to care.

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 attached current Care1st Model of Care (MOC), which has been updated to include the Duals Demonstration.

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.

Care1st has received a 3 year approval for its MOC from CMS. As a requirement of such it has conducted extensive training with its current contracted medical providers so that they may be familiar with the goals and objectives of the MOC. The concept of care coordination is not a new concept for our existing provider network..Care1st providers are significantly involved in the care coordination of our members. As previously stated, all SNP members are encouraged to complete a HRA. The results of the HRA and an Individualized Care Plan (ICP) are sent to the PCP for care coordination purposes. The member is also given a copy of the ICP and encouraged to follow up with their PCP. The Case Manager presently coordinates care in conjunction with other ICT members such as PCPs, specialists, behavioral care providers and members.

Since this demonstration creates the opportunity to bring services previously carved out under the Plan's umbrella of care, and new providers such as County Behavioral Health, LTSS , CBAS and HCBS providers will be incorporated in our network, a comprehensive training program regarding the MOC will be developed. A variety of venues such as large group meetings, webinars and on line training will be available to ensure that the necessary training is made available to all participating providers. When necessary, incentives will be made available to ensure participation.

SECTION 5: CONSUMER PROTECTIONS

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

Care1st certifies that it will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU.

SECTION 5.1: CONSUMER CHOICE

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

Care1st meets all NCQA, DMHC and DHCS requirements for continuity of care. The Plan has a robust network of contracted providers in San Diego County and is committed to improving and ensuring continuity of care. The Plan will conduct outreach to beneficiaries to educate them on their benefits, right and

responsibilities, and will work with new members to ensure continuity of care. If their current medical provider(s) of choice is not currently contracted with the Plan, Care1st will work with providers to add them to its network as long as they accept the Plan's established rates and meet minimum credentialing requirements. The member has the freedom to choose his or her PCP and specialists as long as they are in the Plan network. Members will also have the freedom to include participants in their ICT if they so desire and make the appropriate request.

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.

Care1st will ensure that dual eligible members will continue to self-direct their care and to determine where they receive care, if they have the capacity to do so. The Plan will work with members' families and caregivers to better understand members' preference if they are not able to self-direct their care or to participate in care coordination activities. At every step of the care management process, the ICT will work with members to provide home-based alternatives to institutionalization to allow them to continue to stay in their homes and in the community, if they choose to do so. The Case Manager and the ICT will make all necessary efforts to empower the member to make his/her decisions and select

network providers that they feel most comfortable with. If members elect not to participate in care coordination, they will be provided with the same access and resources as members who are under care coordination. Any member who elects to forgo care coordination may return to a care coordinated model at anytime.

SECTION 5.2: ACCESS

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

Care1st certifies that during the readiness review process it will demonstrate compliance with rigorous standards for accessibility established by DHCS.

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

Members can access information about providers with accessible offices via Care1st's website or through calling the Member Services department. The Plan also provides 24-hour phone and face-to-face interpreter services in all languages. Members are educated about their right to these services through member newsletters, classes, letters, and Public Policy Meetings. Free sign language interpretation is also available for hearing impaired patients. All members receive an insert with their membership mailings that states, in several languages, "*If you need this in your language, please call 1-800-605-2556.*"

The Plan's Physical Accessibility Review Survey sets forth the Plan's audit of providers' physical place to ensure access for members with disabilities as follows:

- ***Basic Access:*** Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
- **Limited Access*:*** Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the CE are encountered.
- **Medical Equipment Access*:*** PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patients). This is noted in addition to level of Basic or Limited Access as appropriate.

Access to Services*:* Care1st's Quality Improvement (QI) Department has established standards and mechanisms to assure the accessibility of primary care, specialty care, behavioral health and member services. Standards include but not limited to:

- Preventive care appointments
- Regular and Routine care appointments
- Urgent care appointments
- Emergency care
- After-hours care
- Wait times
- Member Services by Telephone

Care1st conducts an annual access to care audit using the standards to implement and measure improvements made in performance.

Availability of Practitioners by Geographical Distribution: In creating and developing our delivery system of practitioners, Care1st takes into consideration assessed special and cultural needs and preferences of our members. Care1st establishes availability of primary care, specialty care, hospital based and ancillary Practitioners by:

- Ensuring standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc).
- Each member must be assigned to a Practitioner within five miles of their home unless specifically requested by the member or family.

- Each member should be referred to a specialist within ten (10) miles of their home unless specifically requested by the member or family.
- Ensuring a database is in place which analyzes practitioner availability and ability to meet the special cultural need of plan members.
- Ensuring members are within fifteen (15) miles or thirty (30) minutes from a contracted hospital and ancillary service.
- Care1st provides members with transportation as needed.
- Care1st has processes in place for member requests of special cultural and language needs.
- Care1st will annually review and measure the effectiveness of these standards through specialized studies.

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

Upon enrollment, outbound welcome calls are conducted providing new beneficiaries with clear information about the Plan, including significant differences from fee-for-service Medicare/Medi-Cal and how services are accessed. A list of available medical and behavioral care providers, including specialists and hospitals are included as part of the call information. Beneficiaries can request specific provider listings filtering the information requested by the

members such as area, language and accessibility. Upon enrollment and annually thereafter, beneficiaries receive an updated provider directory with the pertinent accessibility information along with a Member Handbook which contains the accessibility standards. Changes in the network communicated to beneficiaries no less than 30-days from the effective date of the change. For urgent situations that do not allow for a 30-day notice, beneficiaries will receive a call from the Plan.

SECTION 5.3: EDUCATION AND OUTREACH

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

Care1st provides free interpreter services at all points of contact. This includes services for hearing and speech impaired members. The Plan has adopted and is guided by the National Standards on Culturally and Linguistically Appropriate Services established in December 22, 2000, by the Office of Minority Health of the Department of Health and Human Services. The Plan has policies and procedures in place to ensure that limited English proficient (LEP) members have equal access to health care services through the provision of high quality interpreter and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member's spoken language at no cost. The Plan has policies and procedures in place for translating Member Informing Materials

and Health Education Materials, and provides free access to member informing materials in alternative formats. These include member documents in Braille, Electronic Text File, Audio or Large Print.

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

The Plan has policies and procedures in place to ensure that LEP members have equal access to health care services through the provision of high quality interpreter and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member's spoken language at no cost

The Plan's providers receive continual education and reminders on the patient's right to interpreter services. Providers and contracted networks are educated on how to access these services. The Plan requires its providers to post visible signs in threshold languages in their offices to inform patients of their right to access an interpreter to facilitate communication with their provider(s). The Plan diligently monitors provider compliance with this requirement because it has identified the need to provide interpretation services as being an issue that members in the Community Advisory Committee and Group Needs Assessments have brought to the plan's attention. To facilitate Care1st's monitoring, the Plan

utilizes the state-approved Facility Site Review Tool during its provider office visits.

Care1st provides 24-hour phone and face-to-face interpreter services in all languages. Members are educated about their right to these services through member newsletters, classes, letters, and Public Policy Meetings. Free sign language interpretation is also available for hearing impaired patients. All members receive an insert with their membership mailings that states, in several languages, "*If you need this in your language please call 1-800-605-2556.*"

The Plan contracts with multiple translation vendors, who are thoroughly researched by the Plan's Cultural and Linguistic Department. The Plan's vendors employ individuals that are certified by the American Translation Association (ATA) or similar qualified vendors, have formal education in the target language, and are familiar with health and managed care terminology. After materials are translated, several Plan employees who have passed a translation test by an outside vendor by greater than 80% conduct a second level review on all translated materials. If the Plan does not have staff qualified in a specific target language, the translated materials are sent to a second vendor for a second level review of the translation.

Additionally, the Health Education Department gives providers upon request a Cultural and Linguistic (C&L) Services Community Resource Directory consisting of culturally and linguistically appropriate materials related social services such as domestic violence, counseling, cultural adaptation resource, elder care, interpreter resources and many other topics.

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

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

Care1st certifies it will comply with the rigorous requirements established by DHCS and provide the items indicated above as part of the Readiness Review.

SECTION 5.4: STAKEHOLDER INPUT

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

Care1st has participated in Healthy San Diego (HSD) since its expansion to San Diego in 2006. HSD is a stakeholder collaboration through San Diego County that includes representatives from various areas of the community including consumers, advocates, health plans, physicians, hospitals, public health,

community clinics and AIS to ensure Medi-Cal beneficiaries are informed of their health care choices.

San Diego County, including AIS, began a twelve-year effort to implement an integrated system of care for Seniors and Persons with Disabilities through the Long Term Care Initiative Project (LTCIP). More than 800 stakeholders (health and social service providers, aging and disabled consumers and advocates) have spent more than 30,000 hours over the twelve years to envision and recommend a better model of care. For the past two years, County staff has been tracking the development of the Dual Eligible Demonstration Project, and have been meeting with HSD plans since last summer to discuss the integration opportunities now afforded due to this endeavor. Care1st has been part of the discussion for the last two years through regular attendance of the LTCIP Stakeholder Meetings. As part of the stakeholder engagement plan, through HSD, it was determined the plans will receive ongoing input through the AIS Advisory Committee who represent the LTCIP stakeholders. A meeting was held February 14, 2012, to specifically discuss the Dual Eligible Demonstration Project Request for Solutions. The Plan was able to obtain feedback from the Stakeholders, including their strong desire to have broad access to providers in the community, input into their

care and a continuation of current programs, including IHHS. Their comments helped form the responses contained in this RFS.

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

Through HSD, the health plans will continue to work with AIS and their LTCIP Advisory Committee during the implementation and throughout the Demonstration to gather input regarding the improvement of care coordination, alignment of program responsibilities, and the impact of the changes in their overall health due to their transition to managed care.

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 protection.

Care1st will meet with the LTCIP AIS Advisory Committee on an ongoing basis throughout the Demonstration project to obtain input about their experience regarding program operations, if the benefits being offered are meeting members' needs, if access is adequate and timely, and if the grievance process has assisted them in any issues they may have encountered. Additionally, the HSD health plans will continue to meet quarterly with the Consumer Center for Health Education and Advocacy. These stakeholder meetings are an

opportunity to discuss the cases they have been involved in on behalf of consumers, and to determine what is working and where there may be areas for improvement. Grievance and Appeals will be a standing agenda item, and Plan data will be distributed.

Additionally, the Public Policy Committee from Care1st includes Medi-Cal, Seniors and Persons with Disability, Medicare and Dual Eligible members, physicians, and representatives of the Plan from key departments including Pharmacy, Member Services, Corporate Communication, Cultural and Linguistics, Quality Improvement, Legal and Provider Network Operations. It is a forum for the members to provide input and insight into their experience with the Plan, including what is working for them and opportunities for improvement.

SECTION 5.5: ENROLLMENT PROCESS

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

The Plan envisions enrolling dual eligible beneficiaries by birth month. This methodology worked well for the Seniors and Persons with Disability members, allowing for integration into the Plan over the year rather than all at once.

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

A lesson learned from the enrollment of SPDs is to ensure that DHCS clearly identifies to the Plan that the individual being enrolled is part of the Duals Demonstration. Providing the Plan with TAR , pharmacy and claims data is useful. Additionally, Healthy San Diego was instrumental in the transition to managed care of the SPDs by providing outreach to both consumers and caretakers on the timing, process, how to choose a plan, etc. For example, over four hundred representatives from the County Mental Health and Regional Centers received training on the changes so they could advise beneficiaries accordingly. It is anticipated a similar approach will be taken if the county is chosen as a participant in the Dual Eligible Demonstration.

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.

The Plan would like as much FFS utilization as possible to determine the providers currently treating the members so it can be proactive in their recruitment to the network. Additionally, the Plan would like to know how DHCS will select dual eligible beneficiaries for enrollment in multiple plans in a county, i.e. the default enrollment process.

SECTION 5.6: APPEALS AND GRIEVANCES

5:6:1 Certify that your organization will be in compliance with the appeals and grievances processes for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

Care1st certifies that it will be in compliance with the appeals and grievances processes for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

SECTION 6: ORGANIZATIONAL CAPACITY

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

Care1st is an NCQA accredited health plan with a "patients first" philosophy of care. Since the Plan's expansion to San Diego, in 2006, the Plan has established strong community relationships. These relationships allow Care1st to use outreach efforts to connect and maintain a strong presence with local residents – helping the Plan grow from zero to over 32,000 lives across its Medi-Cal (27,000) and Medicare (5,600) lines of business; 3,103 of these members are dual eligible beneficiaries. In addition to its community ties, the Plan works collaboratively with the other health plans in San Diego County's Geographic Managed Care program as well as Healthy San Diego (HSD), and has participated in AIS's LTCIP for several years.

Care1st has successfully serviced dual eligible beneficiaries in San Diego County since 2008, and has strong relationships with key providers, including

Federally Qualified Health Centers (FQHCs), and IPA/Medical Groups like Sharp Community Medical Group (SCMG), which has a proven record of providing care to this most vulnerable of populations.

With a focus and commitment to access to care and the provision of the highest quality of care for its members, Care1st's Medicaid HEDIS results have continually improved across the majority of the scoring markers - including areas that greatly impact dual eligible beneficiaries: Comprehensive Diabetes Care, Controlling High Blood Pressure, Weight Nutrition and Physical Activity as well as Cervical and Breast Cancer Screenings.

On the first attempt (2008), Care1st was awarded a Commendable Accreditation for its California Medicaid (Medi-Cal) and Medicare lines of business, by the National Committee for Quality Assurance (NCQA). The Plan completed its re-accreditation audit last October and passed – maintaining the Commendable Accreditation for both lines of business for another three years, and adding a deemed status as a Medicare HMO to its credentials. Earlier in the year (May 2011), Care1st received a three-year approval from The Centers for Medicare and Medicaid Services (CMS) on its Dual Eligible Special Needs Plan (SNP) Application submission with a score of 96.25%.

Medicaid San Diego HEDIS Results

Measure	2009	2010	2011	09-11 Difference	10-11 Difference	Most Recent Benchmark Met
Adolescent Well Care	40.9%	42.6%	45.0%	+4.9 %Points	+2.4 %Points	25th Percentile
Well Child Care 3-6 Years of Age	68.4%	75.9%	76.8%	+8.4 %Points	+0.9 %Points	50th Percentile
Well Child Care in First 15 Month of Life	N/A	N/A	61.6%	N/A	N/A	50th Percentile
Weight, Nutrition and Physical Activity- BMI Assessment	N/A	50.4%	57.2%	N/A	+6.8 %Points	75th Percentile
Weight, Nutrition and Physical Activity- Nutritional Assessment	N/A	49.6%	63.3%	N/A	+13.7 %Points	75th Percentile
Weight, Nutrition and Physical Activity- Physical Activity Assessment	N/A	29.2%	36.3%	N/A	+7.1 %Points	50th Percentile
Childhood Immunizations (Combination 3)	76.4%	79.8%	79.8%	+3.4 %Points	No Change	75th Percentile
Lead Screening	N/A	N/A	74.5%	N/A	N/A	50th Percentile
Timeliness of Prenatal Care	81.7%	86.5%	80.0%	-1.7 %Points	-6.5 %Points	10th Percentile
Timeliness of Postpartum Care	62.7%	60.0%	60.5%	-2.2 %Points	+0.5 %Points	25th Percentile
Cervical Cancer Screening	60.6%	68.4%	64.5%	+7.8 %Points	- 3.9 %Points	25th Percentile
Breast Cancer Screening	34.4%	48.7%	45.9%	+14.3 %Points	-2.8 %Points	10th Percentile
Comprehensive Diabetes Care- HgbA1c Screening	85.5%	81.4%	83.6%	-4.1 %Points	-1.9 %Points	50th Percentile
Comprehensive	38.7%	39.8%	30.9%	+1.1	-7.8	< 25th

Diabetes Care- HgbA1c Poor Control (lower rate is better)				%Point	%Points	Percentile (lower is better)
Comprehensive Diabetes Care- HgbA1c Result <8	45.3%	46.9%	52.7%	+1.6 %Points	+8.4 %Points	50th Percentile
Comprehensive Diabetes Care- LDL Screening	72.6%	77.9%	80.6%	+5.3 %Points	+2.7 %Points	75th Percentile
Comprehensive Diabetes Care- LDL Result <100	40.3%	47.8%	46.1%	+7.5 %Points	-1.7 %Points	90th Percentile
Comprehensive Diabetes Care- Retinal Eye Exam	48.4%	51.3%	41.8%	+2.9 %Points	-9.5 %Points	25th Percentile
Comprehensive Diabetes Care- Monitoring Nephropathy	87.1%	82.3%	87.3%	-4.8 %Points	+0.2 %Points	90th Percentile
Controlling High Blood Pressure	N/A	N/A	53.0%	N/A	N/A	25th Percentile
Appropriate Treatment for URI	91.3%	91.6%	91.8%	+0.3 %Points	+0.2 %Points	75th Percentile
Avoidance of Antibiotic Treatment for Bronchitis	N/A	23.3%	28.0%	N/A	+4.7 %Points	75th Percentile
Use of Imaging for Low Back Pain	N/A	75.4%	61.0%	N/A	-14.4 %Points	10th Percentile

Below are the most recent three years of MA-SNP quality performance HEDIS measures.

Medicare SNP San Diego HEDIS Performance

Measure	2009	2010	2011	09-11 Difference	10-11 Difference	Most Recent Benchmark Met

Care for Older Adults- Advanced Directives	2.8%	17.0%	57.9%	+55.1 %Points	+40.9 %Points	50th Percentile
Care for Older Adults- Medication Reconciliation	50.6%	40.4%	42.1%	-8.5 %Points	+1.7 %Points	25th Percentile
Care for Older Adults- Functional Assessment	4.4%	11.9%	58.4%	+54.0 %Points	+46.5 %Points	50th Percentile
Care for Older Adults- Pain Assessment	28.7%	24.6%	61.6%	+32.9 %Points	+37.0 %Points	50th Percentile
Medication Reconciliation Post Discharge	N/A	63.9%	48.0%	N/A	-15.9 %Points	90th Percentile
Potentially Harmful Drug and Disease Interactions	N/A	38.3%	38.1%	N/A	-0.2 %Points	90th Percentile
Use of High Risk Medications in the Elderly- One Prescription	18.8%	20.4%	21.3%	+2.5 %Points	+0.9 %Points	25th Percentile
Use of High Risk Medications in the Elderly- Two Prescription	3.5%	2.9%	3.4%	-0.1 %Points	+0.5 %Points	25th Percentile
Annual Monitoring of Persistent Medications	67.3%	80.1%	87.3%	+20.0 %Points	+7.2 %Points	10th Percentile
Controlling High Blood Pressure	58.9%	56.9%	60.6%	+1.7 %Points	+3.7 %Points	25th Percentile
Colorectal Cancer Screening	N/A	51.9%	42.5%	N/A	-9.4 %Points	10th Percentile
Glaucoma Screening	N/A	47.7%	53.4%	N/A	+5.7 %Points	10th Percentile

6.2 Current Care1st Organizational Chart

The Plan's current organizational chart with names of key leaders is included in the attachments to this Application.

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

Table 1. Care1st Key Staff Members

Name	Position	Experience
Anna Tran	CEO	25 years' experience in health care administration including hospital and health plan.
Jorge Weingarten, MD	Chief Medical Officer	Physician licensed with the Medical Board of CA; 23 years' clinical experience, 15 years' experience with Medi-Cal and Medicare.
Kimberly Fritz	San Diego GMC Administrator	25 years' managed health plan operational experience
Jose Wong, RN	Vice President, Medical Management	Registered Nurse with 15 years' experience with Medi-Cal and 10 Medicare health Plans.
Robert Lonardo	Chief Administrative Officer – Care1st Medical Division	31 years' health care experience (27 years serving MA-PD members at FHP, Blue Shield, CareMore, CalOptima and Care1st. 6 years' experience working with duals, most recently worked on the Duals Demonstration project at CalOptima in Orange County. Member of the Special Needs Plan Alliance in Washington, DC.
Janet Jan	Chief Financial Officer	20+ years' experience in health care industry covering various facets including hospital, skilled nursing, home, rural and Indian health with more than 15 years' experience in managed health care in financial and operational operations.
Michael Rowan	Chief Information Officer	IT professional with 25 years' technical management experience;

		20 years healthcare industry experience, including management positions with Foundation Health, Health Net, UHP Healthcare and Care1st, all served Medicaid and Medicare populations as direct state contractors or subcontractors.
Brooks Jones, CHC	Vice President of Administration, Corporate Compliance Officer, and Privacy Officer	Over 30 years' health care experience, including 14 years' managed health plan administration experience; Certified in Healthcare Compliance (CHC), and Licensed CA Laboratory Scientist (CLS).
Tracie Howell	Vice President, Medi-Cal Operations	20 years' managed health plan operational experience.
David Wedemeyer, RN	Vice President, Quality Management	Registered Nurse with 16 years' experience in Quality Improvement within managed care working with Medicaid and Medicare.
Jamie Ueoka, PharmD	Vice President, Pharmacy & Medicare Operations	12 years' experience in managed healthcare operations with direct responsibility for overseeing Care1st's Medicare Advantage Program since 2006. Prior experience includes 13 years' acute care clinical pharmacy practice and 5 years managing Care1st's Pharmacy Services.
Walter Gray	Vice President, Business Development	37 years' public and private experience in health care including as Assistant Director of Health Los Angeles, hospitals and health plans.
Herbert Woo	Vice President, Technology	14 years' experience in information technology in health care setting.
Pamela Mokler, MS	Consultant	Gerontologist with 22 years' experience in the Aging Network

		and senior housing industry, including 10 years' experience consulting with Medicare and Medicaid managed health Plans.

6.4 Provide a resume of the Duals Demonstration Project Manager.

Kimberly Fritz will be the Project Director for the Duals Demonstration Project Manager. Her resume is included as an attachment.

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

Under the current Plans' organizational structure, Care1st has passed all medical, financial and administrative audits and reviews conducted by LA Care, DHCS, DMHC and CMS since 1995. Most recently, Care1st received its second consecutive three year NCQA accreditation.

The Plan has extensive current experience addressing dual eligibles in coordinating the care of this unique population. The Medical Services Department works synergistically with the Quality Improvement Department to ensure members' healthcare needs are met on every front. Member Services personnel are constantly trained to address members' varying needs and status – Dual Eligible, SNP, Medicare, Medi-Cal, FFS, etc. Resources are brought in as necessary

to maintain staff-to-member ratios to ensure all members receive quality assistance with their healthcare needs and questions.

Care1st's Administration oversees all aspects of Plan's operations to ensure operations are running at peak efficiency. Monthly committee meetings held to discuss and address any new situations that may arise or to address issues. The Board of Directors maintains monthly meetings to address issues – medical and non-medical - and to be kept informed of the Plan's operations.

The Plan's Members Services department also holds quarterly forum with its members – any issues/recommendations are forwarded to Administration and/or the Board. This meeting is also attended by a Board member.

6.2 Operational Plan

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

Preliminary Operational Plan for 2012-2013

Activity	Who	Target Date in 2012/13
Operational Activities		
Finalize operational budget and conduct project launch meetings with Senior Executive Team	CEO, CFO, CMO, CIO and Senior Leadership team	4/1 – 4/30/2012
Develop project Advisory Committee and schedule initial meetings with internal departments	CEO, CMO, SD GMC Program Administrator	4/15 – 4/30/2012
Secure additional office space in San Diego to accommodate additional staff	Facilities Director, San Diego GMC Administrator, CFO	4/1 - 6//2012
Hire new management program staff such as Operational Manager and Nursing managers.	CEO, SD Administrator, Human Resources,	4/1 - 6/2012
Complete Job Descriptions for all new positions and begin hiring process	HR, Department Directors and Managers	6/1 – 9/2012
Update Policies & Procedures to include Demonstration	All Departments	4/15 - 10/2012
Finalize MOUs and contracts with new providers, including behavioral health, LTSS and HCBS	Provider Contracting, Legal and Regulatory, CFO, San Diego GMC Administrator	4/1 – On-going
Schedule project launch training for all providers	SD GMC, Med Mgmt,	8/1 - ongoing
Coordinate with AASC to identify, notify and invite SCs and senior affordable housing to	Project Management	6/1/ - 8/31/2012

participate in project	Specialist	
Set up meetings with SCs & senior property management at properties interested in participating and finalize arrangements	Project Management Specialist	6/1/ - 10/30/2012
Coordinate Health Ed, Fitness, Disease Self-Management Workshops with Service SCs, AIS/AAA	Health Education	11/1/2012 – ongoing
Conduct regular operational meetings to access readiness reviews Continue to evaluate program requirements after "Go-live"	CEO, CMO and all departments CEO, CFO, CMO and all relevant departments	4/1 - Ongoing 2/1/2013 - Ongoing
Medical Management Activities		
Begin hiring process for Med Mgmt positions: Care Navigators, Social Workers, Nurses etc	HR, Medical Management	4/15- 11/1 2012
Work with DHCS and SD AIS to develop new uniform assessment tool	Med Management	On-going
Train Med Management Staff on Model of Care protocol	Med Management	5/1 – On going
Conduct meetings with key community providers such as County Mental Health agencies, IHSS providers, LTSS and CBAS providers to develop operational procedures for communication and collaboration	Med Management	7/1/ - Ongoing
Train existing providers on the goals and objectives of the Demonstration Project	Med Management	7/1 – Ongoing
Information Technology Activities		
Assess current system capabilities, identify gaps, and mitigate deficiencies Purchase and install additional servers, storage capabilities, and workstations Expand infrastructure and system capabilities to support user access to the Plan's core Managed Health Care (MHC) system Define and configure MHC to support new dual eligible benefits	Information Technology Information Technology & Procurement Information Technology Informational Technology	4/1-6/2012 5/1-9/2012 5/1 – 10/2012 7/1 – 10/2012

Expand secure FTP access for exchanging information between network providers and the Plan	Informational Technology	7/1 - Ongoing
Develop portals for all providers for web-based medical management system	Informational Technology	7/1 - Ongoing
Schedule provider trainings, in-person and Webinars to give overview of web-based medical management system and Provider Web Portal for all providers	Informational Technology	7/1 - Ongoing
Provide training to new and existing staff	Informational Technology	7/1 - Ongoing
Quality Management Activities		
Determine Demonstration reporting requirements	QI Department	4/15 – 6/2012
Develop and implement QI Program Description that details the QI purpose, scope, goals, objectives, and structure.	QI Department	4/15 – 6/2012
Develop policies and procedures that detail the process for performing QI activities such as Standards of Practice, Access to Services, Member Satisfaction Grievance Process, Satisfaction Surveys, Outreach Programs, Public Policy Meetings, Clinical Practice Guidelines , Potential Quality Issue Reviews, Peer Review, Corrective Actions Plans , Continuity and Coordination of Care1st Sentinel Events, Member (Patient) Safety, HEDIS, Quality Improvement Projects (activities), Practitioner Satisfaction Surveys, Facility Site Reviews , Medical Record Audits and Credentialing.	QI Department	4/15 – Ongoing
Regulatory and Compliance Activities		
Review the Dual Demonstration Project Contract requirements and establish schedule of deliverables	Legal , Regulatory and Compliance	4/15 - Ongoing
Identify the responsible department for program deliverables	Legal, Regulatory and Compliance	4/15 - Ongoing

Review and revise current Provider Contract templates to incorporate new regulatory requirements	Legal, Regulatory and Compliance	4/15 – 6/2012
Finance Activities		
Set up new accounts in accounting system as well as core managed care system	Accounting	4/15 - 6/2012
Set up Provider profile and reimbursement rates in core managed care system	Accounting	7/1 - Ongoing
Establish management reports for regulatory and operational needs	Accounting	7/1 - Ongoing
Medicare Operation Activities		
Submit Notice of Intent to Apply (NOIA) to Center for Medicaid for Medicare (CMS) to offer demonstration plans	Medicare Operations	3/31/2012
Submit CY 2013 Medication Therapy Management program (MTMP)	Medicare Operations	5/7/2012
Submit CY 2013 Formulary	Medicare Operations	5/14/2012
Prepare for readiness reviews by CMS	Medicare Operations	4/1 - Ongoing
Submit to CMS proposed Plan benefit package that includes all Medicare and Medi-cal benefits for the Demonstration Project	CEO, CFO, CMO , Medicare Operations	6/4/2012

6.2.2 Provide roles and responsibilities of key partners.

Key Partners Roles and Responsibilities

Partner	Roles and Responsibilities
San Diego Health and Human Services Agency (HHSA), Aging & Independence Services (AIS)	Partnership to coordinate LTSS and HCBS
San Diego HHSA, Behavioral Health Services /Healthy San Diego	Partnership to coordinate behavioral health services for dual eligible beneficiaries who are experiencing persistent and severe mental illness or a mental health or substance use crisis
Access to Independence (Independent Living Center)	Partnership to provide services to dual eligible beneficiaries with disabilities to maximize independence and fully integrate them into their communities.
Provider Network	Federally Qualified Health Centers (FQHCs) and IPAs such as Sharp Community Medical Group who have a proven track record of caring for dual eligibles, providing quality care and appropriate cost savings.

6.2.3 Provide a timeline of major milestones and dates for successfully executing the Operational Plan.

The following is a timeline of major milestones and dates:

MILESTONE	PROJECTED DATE
Contract Award	April 1, 2012
Project Launch	April 1, 2012
Expansion of Office Space	June 1, 2012
Expansion of current IT infrastructure	June 1, 2012
Hiring of additional Management Staff	June 1, 2012

Secure MOUs with County Mental Health and IHSS	October 31, 2012
Hiring of additional Medical Services Staff	October 1, 2012
Expansion of essential provider network	November 30, 2012
Hiring of additional program staff	October 31, 2012
Training/In-Service of Providers'sites	November 30, 2012
Readiness Review	On-going until January 2013

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.

Care1st certifies that it will report monthly on the progress made toward implementation of the timeline.

SECTION 7: NETWORK ADEQUACY

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

The Plan has analyzed the network to ensure that: 1) there are an adequate number of PCPs and specialists in each specialty to serve the future enrollment; 2) the PCPs and office locations are within thirty (30) minutes from the members residence or workplace which covers 100% of eligible beneficiaries; 3) specialists' office locations are within (30) minutes from the members residence or workplace with a coverage of no less than 95.9%; and 4) there is a significant representation of Traditional and Safety Net providers among the PCPs to ensure

continuity of care for these members within thirty (30) minutes from the member's residence or workplace which covers 100% of eligible beneficiaries.

Geographic Map distribution:

Maps which indicate the distribution of the proposed PCP Network present in sufficient detail the following information:

- The boundaries of the proposed County
- Major highways and streets in the proposed County
- Locations of each PCP that is contracted with IPAs and Medical Groups that have contracted with the Plan. In the proposed County, the Plan has chosen to contract with established provider networks (IPAs, Medical Groups, clinics, Federally Qualified Health Centers, Traditional & Safety Net providers, County facilities and Disproportionate Share Hospitals) instead of contracting directly with providers. The PCPs indicated on the Map have service or employment contracts with these provider networks.

Specialty Network:

The specialty network has also been analyzed by the Plan to ensure that there is adequate specialty access for the future members. The Plan used historical utilization statistics gathered for the current members and other utilization statistics from DHCS to calculate the potential referrals to each type of

specialist. The required numbers in each specialty type is then compared to the number of contracted specialists in that type to ensure adequate coverage.

Care1st is currently monitoring its network capacity on an ongoing basis and will do the same for the proposed demonstration. The Plan's policy and methodology for monitoring Network Capacity is summarized as follows:

Care1st will ensure that all PCPs and specialty care providers are within the availability standards for geographical regions and distribution. Compliance with these standards is monitored through member complaints and grievances, Provider Quality Incentives (PQI), member satisfaction surveys, medical record reviews, disenrollments, PCP transfers, and annual availability of practitioner studies and mapping.

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

Care1st anticipates that various payment methodologies will be utilized given the Plan's experience in San Diego County. As the physician network is comprised with physicians group, individual physicians and FQHCs, Care1st anticipates deploying payment of capitation, Medi-Cal/Medicare FFS rates or a modified form of the FFS reimbursement, and incentive and/or a combination thereof with providers. The flexibility of the arrangement will allow Care1st to

recruit quality providers in the Plan's network, instigate the coordination of benefits and care, and capture HEDIS measures to ensure that Care1st members are receiving quality and necessary care.

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

As Care1st is a closely held, provider owned health plan, the Plan's mission is to delivery quality care and maximize the benefits to optimize the health care premium to our members. Unlike health plans with significant size and capital shares, Care1st works closely with providers to establish reimbursement methodologies that are fair and equitable for the services provided. Over the years, Care1st has focused its efforts to meeting providers and members needs simultaneously. Care1st's experience with the Senior and Person with Disabilities (SPD) expansion to the Medi-Cal program, have enable the Plan to further develop our contracting efforts to providers who have not been traditional Medi-Cal partners.

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

Access to Care standards are included in the Care1st *Practitioner Manual*. IPAs are expected to ensure that each practitioner in their network receives and complies with Access to Care standards. Care1st annually distributes the

advanced access standards, criteria and a log tool to all practitioners and IPAs through the Provider Manual, web portal and direct mailings. Access to Care standards are detailed in the provider newsletter annually. These standards are also available on the website for both providers and members.

Care1st will ensure that all contracted providers, including, but not limited to, PCPs, Specialty Care Practitioners (SCP), and Behavioral Health Practitioners (BHP), are in compliance with approved access to care standards**.** In addition, Care1st will provide or arrange for the provision of access to health care services in a timely manner and establish metrics for measuring and monitoring the adequacy. Compliance with these standards is monitored through member complaints and grievances, PQIs, member satisfaction surveys, medical record reviews, dis-enrollments, PCP transfers, and annual Access Surveys and Studies.

All quality improvement activities, including access to care and services, are presented and reviewed by the Medical Services Committee. Results of these activities are communicated to practitioners and members through the following, but are not limited to:

- Direct correspondence with members
- Member Handbook
- Newsletter articles

- Website Updates

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 and not in the network.

Care1st will take a proactive approach to working with the providers not currently participating in its network. Utilization data provided by the State prior to the effective date of the Demonstration will be reviewed to determine those providers who are currently treating the beneficiaries. Outreach will be conducted to educate providers on the transition to managed care and to ensure they are given the opportunity to participate in the Care1st network. Once they are part of the Plan's network, the providers will receive training on the operational processes and ongoing support will be given to ensure they have a positive relationship with the Plan.

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

Care1st has a strong network currently providing care to existing dual eligible members, including IPAs, FQHCs, directly contracted specialist and ancillary providers, and hospitals throughout the county. The Plan will continue to monitor the network adequacy to ensure compliance with the goal of integrated delivery.

The Plan has a long standing relationship with MedImpact to provide Pharmacy Benefit Management (PBM) services. The PBM works closely with Care1st on utilization data and reporting, which is shared with the applicable providers to ensure the member's medication needs are met in an appropriate manner.

Care1st will also be contracting through HHSA for IHHS and other home based services and coordination to community services within the County such as Meals on Wheels, etc.

The Plan also anticipates the potential need for one-time, emergency agreements and Memorandums of Understanding with out-of-network specialists for special cases or whenever a contracted specialist may not be available. The Plan's contracted provider network has policies and Procedure which describe the process for these one-time, emergency agreements and Memorandum of Understanding. To avoid any delay in care to members, the Plan will assist its provider network in negotiating and contracting with out-of-network providers as required and requested.

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.

Care1st certifies that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by its sub-contractual relationships.

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.

Care1st certifies that it 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.

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.

Care1st certifies that it will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug even data.

Section 7.2: Technology

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

Care1st fully supports and promotes the use of technology as a vehicle to enhance quality care. The Plan has developed a Provider Web Portal Dashboard for all PCPs that have assigned members. The Plan utilizes NCQA Certified software programs to identify all members who have a gap in completing required services. This data is updated every month. PCP office sites are trained on how to access their dashboard and how to utilize the functions and tools provided. The gap services are listed on the member eligibility printout so this information is on the record at the time the member is being seen by the PCP. If a practitioner completes a specific service, they can submit encounter data directly to Care1st through the submission form on the web portal. Practitioners are provided incentives for completing all gap services for each member. The PCP dashboard also lists the member's chronic conditions that have been identified and the year the condition was last documented by a face-to-face visit. There are specific tools provided for the practitioner to utilize to assure a complete comprehensive assessment and that specific components are documented. The web portal dashboard is also available for the IPAs and FQHCs to enable them to track their HEDIS gap services.

The Plan has also populated our Member Services screens with HEDIS gap data so they can be addressed directly when the member contacts our Member

Services department with questions. The Quality Improvement Department also utilizes automated telephone technology to send reminders to members about specific services they need to complete. The automated phone system offers members an opportunity to schedule an appointment with their PCP.

The Plan promotes the use of EMR/EHR systems and provides access to relevant incentive programs, as well as offers direct assistance in the selection and implementation of these systems based on the plan's experience. The Plan's assistance covers direct advice and project support, as well as education related to various incentives programs available. A number of contracted medical groups and partners are participants of the San Diego Beacon Community, including the Council of Community Clinics, Family Health Centers of San Diego, Rady Children's Hospital San Diego, Sharp HealthCare and Scripps Health. The Beacon Community Program goals include building and strengthening a health information technology infrastructure; improving health outcomes, care quality, and cost efficiencies; and spearheading innovations to achieve better health and health care. The Beacon Community coordinates with California Health Information Partnership and Services Organization, the local Regional Extension Center that is supported by the Office of the National Coordinator for Health Information Technology. Other providers in the network utilize EMR/EHR systems,

including but not limited to, Vantage Medical Group and Multicultural IPA via their Management Service organization or independently. Care1st will continue to provide the required access to education and assistance to remaining groups and individual providers to attain 'meaningful use' status and take advantage of local, state and federal incentive programs. On a case by case basis, Care1st may provide financial assistance to providers requiring aid in initiating these programs within their practice.

The Plan interacts with contracted IPAs to exchange service information in standardized formats, as well as current treatment status where the Plan is are providing case management and disease management services using a range of specialized internal technology tools, which includes: Milliman CareWebQI for guideline adherence and advice as well as on-line authorization submission; McKesson Care Enhance Clinical Case Management (CCMS) software for simple and complex case and disease management and as a single point of reference for all member health assessments and care plans; and Krames medical resource data, which includes instructional videos and other member and provider oriented medical information. Care1st also uses a number of contracted vendor technologies for Risk Stratification, Health Risk Assessments, etc. The Plan views its medical management role as primary in assuring the highest level of care for

its members and so utilizes numerous technology solutions to both expedite and automate the medical oversight processes. A significant portion of the company's technology resources and budget are devoted to this initiative.

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.)

Home Telehealth Technology

Care1st utilizes home telehealth technology as a solution strategy to monitor members at high-risk for admissions. This electronic platform provides objective data for Case Managers to effectively oversee member clinical status and proactively intervene to improve health outcomes. It bridges the gap between the member and the healthcare professional. These products provide an effective solution in chronic condition management as they are at the point of care for the member. This system captures and communicates member information using an interactive, secure wireless technology to deliver the data. For the healthcare professional involved in members' care delivery, this enhances decision-making for more targeted interventions based on real time data. This technology incorporates the following monitoring capabilities to meet the needs

of this population: Vital Sign Measurements; Health Surveys; and Appointment Reminders.

- **Vital Sign Measurements:**

  The telehealth solution for chronic conditions management can objectively monitor blood pressure, weight and glucose in real time. This information is instantly available to the health professional via dedicated software and a web-enabled dashboard to assist in monitoring the members' clinical data/values. Based on the data captured, the software application has automated triggers that will initiate a cascade of events utilizing established or threshold care guidelines. The goal is to preemptively identify at-risk members, intervene to prevent and minimize avoidable ER visits, hospitalization and nursing home admissions. The healthcare professional monitors data for all members in the system by trigger alerts or exception management. The alerts or data parameters are programmed specifically per individual member's clinical needs. The system alerts/ triggers the healthcare professional to review the member clinical data and determine applicable interventions.

- **Health Surveys**

  The telehealth application has the capabilities to incorporate health surveys as an adjunct in monitoring members' clinical condition. The surveys can be customized for specific conditions or general health questions, which can be sent to an individual member or a population or group. Members are electronically asked a series of questions (displayed on a device) based on the member's clinical condition. Members' responses may generate automated alerts to the healthcare professional indicating the member needs further evaluation. The health surveys are designed to capture members' subjective clinical symptomology with pre-established alerts.

- **Appointment Reminders**

  The telehealth technology provides the flexibility to send an electronic message to an individual, group or to an entire population. The reminders can be specific to a member such as for a scheduled physician appointment, a medication refill, or to a group for preventive health measures.

Case Management Application

Care1st has an electronic software application called Care Enhance Clinical Management Software (CCMS). CCMS is utilized by the Plan as the workflow solution through an integrated approach for effective member centric case management. This is accomplished with the application's capabilities for data integration and automated functionality. With CCMS, services and procedures are structured to ensure a standardized process for all members identified as high-risk for admissions requiring enrollment in Case Management.

CCMS as a member centric electronic platform allows the integration of information from multiple data sources. This member health information is accessible to facilitate continuity of care for members. Through the use this centralized electronic application, Case Managers have the ability to ensure the timely and appropriate delivery of care and support to participating members. This integrated information provides the opportunity to customize interventions appropriate for the severity of the member.

Medication compliance monitoring is a vital aspect of care management and care coordination. The Plan offers a Medication Therapy Management (MTM) program through our Pharmacy Department. This program is offered to all Medicare members who fulfill certain criteria, i.e., two or more chronic diseases, seven or more maintenance medications, likely to incur annual cost of $3,000 for

covered part D drugs. A clinical pharmacist reviews quarterly the member's medication profile and provides the PCP with pertinent prescription utilization data and written communication regarding opportunities to enhance medication regimen, potential drug interactions, drug age/disease precautions, as well as non-adherence data. The members enrolled in the MTM program are also contacted telephonically by a Clinical Pharmacist for an annual Comprehensive Medication Review (CMR) including over-the-counter (OTC) medications and herbal supplements. Cases requiring coordination of care beyond pharmaceutical intervention are referred to Case Management. All pertinent information derived from these activities is available to Case Managers through CCMS.

Care1st has also developed a comprehensive Medication Adherence Program. The primary goal of the program is to ensure that beneficiaries with chronic medical conditions such as diabetes, hypertension, and hypercholesterolemia are compliant with filling the medications prescribed to them by their physicians. Every member who first fills a medication for a chronic condition receives a letter explaining the importance of taking the medication as prescribed and refilling on time. The Plan is able to identify members who fail to refill their medication on time through regular monthly reviews of pharmacy claims data. These members receive a second letter reminding them to renew their prescription. If, despite

these interventions, they are still non adherent to their medications, they will receive a phone call reminder to identify the reasons why the medications have not been filled, to reinforce importance of adherence, and to facilitate refilling of their medications.

CCMS is an integrated application provides the documentation platform for all aspects of case management. All disciplines document in CCMS at a member-centered level, which provides an interdisciplinary approach to member management and includes the following:

- Complex Case Management
- Disease Management
- Inpatient Case Management
- Social Services
- Home Health Case Management
- Wound Care Case Management

Data captured and available includes, but is not limited to:

- Hospital and Skilled Nursing Facility concurrent reviews
- Acute care admission and discharge data
- Complex Case Management assessments and documentation
- Pharmacy Data

- Laboratory Data

7.2.3 Describe how technologies will be utilized to meet information exchange and devise protocol interoperability standard, if applicable.

Provider Web Portal

Care1st utilizes industry standard transactions for data exchange and interacts with a variety of enabling services for providers and organizations facing challenges in meeting standard transaction requirements. The Plan uses state of the art EDI tools, including Gentran by Sterling Software, to process, accept and distribute data in 4010, 5010 and proprietary formats, and utilizes several intermediary vendors including Emdeon and others, to act as Clearing House operations for providers unable to accommodate direct transaction production or use in their environments. The Plan also assures that its web-based portal tools are functional in all major web browser platforms. The Plan has always been flexible in accepting data formats other than standard, and provides both translation and onsite support for groups or individual providers who need assistance in their basic data exchange requirements for eligibility, service

reports, census and other utilization reporting, as well as regular notice of underserviced members or missing services from a medical quality perspective.

SECTION 8: MONITORING AND EVALUATION

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

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

Care1st contracts with vendors to conduct an annual child and adult CAHPS survey. These CAHPS surveys are conducted to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. CAHPS surveys are conducted at least annually, including Proactive CAHPS survey which is given to members to identify areas of dissatisfaction where the Care1st's Member Services Department works with the member to resolve all issues identified. Care1st also conducts Health Outcome Surveys (HOS) on its Medicare members to document self-reported health status and track improvements. These surveys are analyzed and intervention programs are developed to address concerns. Access to care studies are also conducted by the Plan that monitor appointment availability for PCPs, specialists, and ancillary service providers. These studies include after-hours access, geographical distribution and coverage,

telephone access and hospital access. In addition, the QI Department has a very robust Facility Site Review program where the Plan assesses the site for meeting physical access requirements for members who may have a disability.

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

Care1st requires that all contracted providers submit encounter data on a monthly basis and a "sweep" on a quarterly basis. Care1st's encounter data collection system has been audited and passed by NCQA auditors for Medicare and Medicaid lines of business. Encounter data reporting is standardized as HIPAA 4010 with conversion to 5010 in the current year. Encounter data and claims data analyzed and merged on a regular basis; this includes HCBS and behavioral health data.

Condition-specific quality measures

Care1st reports on all required Medicare and Medicaid HEDIS measures each year. This reporting is done annually for the past service year, and also during the current service year and reported to contracted provider groups. This reporting includes HEDIS measures and Care1st quality pharmacy measures. Care1st also maintains disease management programs for asthma, congestive heart failure, and chronic obstructive pulmonary disease.

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

Care1st collects and maintains member information by age, gender, primary language, ethnicity/race for all members. Care1st does not collect or maintain data by sexual identity.

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

Care1st certifies that it will work to meet all DHCS evaluation and monitoring requirements, once made available.

SECTION 9: BUDGET

9.1 Describe any infrastructure support that could help facilitate integration of LTSS and behavioral health services.

The Plan supports the integration of LTSS and behavioral health services in several ways, including the regular practice of providing internal care management services, risk stratification and the sharing of this information in data and reports to the Plan's provider network. Care1st will contract with a number of specialized providers and services for the delivery and management of those members that require LTSS and HCBS, and employs technology solutions including mobile technology to gather information during the performance of in-home assessments, assisting in the management of this membership by

employing Social Work Case Managers and enabling them with appropriate technology to provide education and resources in an efficient manner.

Care1st is considering operating local 'resource' centers, connected to its system's infrastructure to allow beneficiaries easy access to Plan's staff in order to facilitate referrals to LTSS and behavioral health when needed. Establishing interaction with providers and members through the resource centers are examples of the way Care1st has extended its technology infrastructure to the point of assistance or point of service.

State of California Dual Eligible Demonstration
Request for Solutions

ATTACHMENTS

Attachment #1

Mandatory Qualifications Criteria 1,
"Applicant has a current Knox Keene License or is a COHS and exempt."

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF MANAGED HEALTH CARE

File No. 933-0326
Material Modification No. 20054948
Order No. S-06-1575

Licensee: Care 1st Health Plan

ORDER APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed on September 15, 2005, requesting approval of Licensee's proposal to expand its service area into San Diego for the purpose of providing health care services to Medi-Cal eligibles, are approved as of the date set forth below.

This Order shall be in force and effect commencing on the date below and shall remain in effect until revoked or superceded by further Order of the Director.

Dated: January 24, 2006
Sacramento, California

LUCINDA A. EHNES
Director
Department of Managed Health Care

By_____

TINA DUNLAP
Chief, Licensing Division

Post-it™ Fax Note 7671	Date 11-1-95	# of pages ▸ 8
To MICHAEL DOWELL	From LINDA AZZOLINA	
Co./Dept Miller & Holquin	Co. Dept. of Corporations	
Phone #	Phone #	
Fax # (310) 557-2205	Fax # (213) 736-2118	

OF CALIFORNIA
ATION AND HOUSING AGENCY
OF CORPORATIONS

NONTRANSFERABLE

LICENSE
HEALTH CARE SERVICE PLAN

CAREFIRST HEALTH PLAN
6255 SUNSET BLVD., STE. 1700
LOS ANGELES, CA. 90028

File No. 933-0326

IS HEREBY LICENSED AS A HEALTH CARE SERVICE PLAN PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975, AS AMENDED, AND IS AUTHORIZED TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES IN THOSE PORTIONS OF THE COUNTY OF LOS ANGELES IN THE ZIP CODES ATTACHED AND INCORPORATED BY REFERENCE, SUBJECT TO THE UNDERTAKINGS ATTACHED AND INCORPORATED BY REFERENCE.

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

Dated: November 1, 1995

GARY S. MENDOZA
Commissioner of Corporations

By Linda D. Azzolina
LINDA D. AZZOLINA

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

Plan No. 933-0326
Assignment Nos. 00-01466
and 00-00843
Order No. S-00-685

Licensee: CARE 1st HEALTH PLAN

ORDER

APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed by Care 1st Health Plan on October 2, 2000 and amended November 15, 2000 to expand its service area in certain zip codes in Los Angeles County are hereby approved.

Dated: January 10, 2001
Sacramento, California

DANIEL ZINGALE
Director
Department of Managed Health Care

By: Brian J. Bartow
Brian J. Bartow
Chief, Licensing Division

EXHIBIT H-1

Description of Service Area for Care 1st Health Plan

EXPANSION ZIP CODES

Regions:

2 San Fernando NW

91303	Canoga Park
91304	Canoga Park
91305	Canoga Park
91306	Winnetka
91307	West Hills
91308	West Hills
91309	Canoga Park
91311	Chatsworth
91312	Chatsworth
91313	Chatsworth
91324	Northridge
91325	Northridge
91326	Northridge
91327	Northridge
91328	Northridge
91329	Northridge
91330	Northridge
91335	Reseda
91337	Reseda
91393	North Hills
91394	Granada Hills
91396	Winnetka
91409	Van Nuys
91410	Van Nuys
91482	Van Nuys
91495	Sherman Oaks
91499	Van Nuys

4 San Fernando SW

91301	Agoura Hills
91302	Calabasas
91356	Tarzana
91357	Tarzana
91359	Westlake Village
91361	Westlake Village
91362	Thousand Oaks
91363	Westlake Village
91364	Woodland Hills
91365	Woodland Hills
91367	Woodland Hills
91371	Woodland Hills
91372	Calabasas
91376	Agoura Hills
91399	Woodland Hills
91416	Encino
91426	Encino
91470	Van Nujys

7 San Gabrield East

91009	Duarte
91711	Claremont
91715	City of Industry
91716	City of Industry
91747	La Puente
91749	La Puente
91750	La Verne
91765	Diamond Bar
91766	Pomona
91767	Pomona
91768	Pomona
91769	Pomona
91788	Walnut
91793	West Covina
91795	Walnut
91797	Pomona

8 Metro

90030	Los Angeles
90051	Los Angeles
90053	Los Angeles
90054	Los Angeles
90055	Los Angeles
90060	Los Angeles
90069	W. Hollywood
90070	Los Angeles
90072	Los Angeles
90074	Los Angeles
90075	Los Angeles
90076	Los Angeles
90078	Hollywood
90079	Los Angeles
90084	Los Angeles
90086	Los Angeles
90087	Los Angeles
90088	Los Angeles
90093	Los Angeles
90099	Los Angeles
91608	Universal City
91618	N. Hollywood

9 West

90009	Los Angeles
90024	Los Angeles
90025	Los Angeles
90049	Los Angeles
90064	Rancho Park
90066	Los Angeles
90067	Century City
90073	Los Angeles
90077	Los Angeles
90080	Los Angeles
90083	Los Angeles
90094	Los Angeles
90095	Los Angeles
90209	Beverly Hills
90210	Beverly Hills
90211	Beverly Hills
90212	Beverly Hills
90213	Beverly Hills
90231	Culver City
90233	Culver City
90263	Malibu
90264	Malibu
90265	Malibu
90272	Pacific Palisades
90290	Topanga
90291	Venice
90292	Marina del Rey
90293	Playa del Rey
90294	Venice
90295	Marina del Rey
90296	Playa del Rey
90312	Inglewood
90401	Santa Monica
90402	Santa Monica
90403	Santa Monica
90404	Santa Monica
90405	Santa Monica
90406	Santa Monica
90407	Santa Monica
90408	Santa Monica
90409	Santa Monica
90410	Santa Monica
90411	Santa Monica

12 South Bay

90245	El Segundo
90254	Hermosa Beach
90261	Lawndale
90266	Manhattan Beach
90267	Manhattan Beach
90274	Palos Verdes Penninsula
90275	Rancho Palos Verdes
90277	Redondo Beach
90278	Redondo Beach
90503	Torrance
90505	Torrance
90506	Torrance
90507	Torrance
90508	Torrance
90509	Torrance
90510	Torrance
90704	Avalon
90733	San Pedro
90734	San Pedro
90748	Wilmington
90749	Carson
90801	Long Beach
90809	Long Beach
90831	Long Beach
90832	Long Beach
90833	Long Beach
90834	Long Beach
90835	Long Beach
90840	Long Beach
90842	Long Beach
90844	Long Beach
90845	Long Beach
90846	Long Beach
90847	Long Beach
90848	Long Beach
90853	Long Beach
90888	Long Beach

Service Area for Care 1st Health Plan - 2001

Regions:

1	2	3	4	5	6	7	8	9	10	11	12
Lancaster/Palmdale	San Fernando NW	San Fernando (Entire)	San Fernando SW (part)	San Fernando SE (entire)	San Gabriel - West Entire Region	San Gabrield East (partial)	Metro (partial)	West	South (entire)	East (entire)	South Bay (partial)
91310	91343	91040	91316	91401	90031	91010	90004	90034	90001	90022	90247
91321	91344	91042	91436	91403	90032	91702	90005	90035	90002	90023	90248
91322	91406	91331	91301	91411	90041	91706	90006	90045	90003	90033	90249
91350	91303	91340	91302	91423	90042	91722	90010	90056	90007	90040	90260
91351	91304	91342	91356	91501	90063	91723	90012	90230	90008	90058	90501
91354	91305	91345	91357	91502	90065	91724	90013	90232	90011	90201	90502
91355	91306	91352	91359	91504	91001	91740	90014	90009	90016	90240	90504
91380	91307	91402	91361	91505	91006	91741	90015	90024	90018	90241	90710
91381	91308	91405	91362	91506	91007	91744	90017	90025	90037	90242	90717
91383	91309	91605	91363	91601	91011	91745	90019	90049	90043	90255	90731
91384	91311	91041	91364	91602	91016	91746	90020	90064	90044	90270	90732
91385	91312	91043	91365	91604	91020	91748	90021	90066	90047	90601	90744
91386	91313	91333	91367	91606	91024	91773	90026	90067	90059	90602	90745
93243	91324	91334	91371	91607	91030	91789	90027	90073	90061	90603	90802
93510	91325	91341	91372	91404	91101	91790	90028	90077	90062	90604	90803
93523	91326	91346	91376	91408	91103	91791	90029	90080	90220	90605	90804
93524	91327	91353	91399	91413	91104	91792	90036	90083	90221	90606	90806
93532	91328	91388	91416	91496	91105	91009	90038	90094	90222	90638	90807
93534	91329	91392	91426	91497	91106	91711	90039	90095	90250	90639	90808
93535	91330	91395	91470	91503	91107	91715	90046	90209	90262	90640	90810
93536	91335	91407		91507	91108	91716	90048	90210	90280	90650	90813
93539	91337	91412		91508	91201	91747	90057	90211	90301	90660	90814
93543	91393	91615		91510	91202	91749	90068	90212	90302	90670	90815
93544	91394			91521	91203	91750	90071	90213	90303	90701	90822
93550	91396			91522	91204	91765	90030	90231	90304	90703	90245
93551	91409			91523	91205	91766	90051	90233	90305	90706	90254
93552	91410			91526	91206	91767	90053	90263	90723	90712	90261
93553	91482			91603	91207	91768	90054	90264	90746	90713	90266
93560	91495			91609	91208	91769	90055	90265	90805	90715	90267
93563	91499			91610	91214	91788	90060	90272	90052	90716	90274
93584				91611	91731	91793	90069	90290	90082	90091	90275
93586				91612	91732	91795	90070	90291	90089	90096	90277
93590				91614	91733	91797	90072	90292	90097	90102	90278
93591				91616	91754		90074	90293	90101	90202	90503
93599				91617	91755		90075	90294	90185	90239	90505
					91770		90076	90295	90223	90607	90506
					91775		90078	90296	90224	90608	90507
					91776		90079	90312	90251	90609	90508
					91780		90084	90401	90306	90610	90509
					91801		90086	90402	90307	90612	90510
					91803		90087	90403	90308	90631	90704
					90050		90088	90404	90309	90632	90733
					91003		90093	90405	90310	90633	90734
					91012		90099	90406	90311	90637	90748
					91017		91608	90407	90313	90651	90749
					91021		91618	90408	90397	90652	90801
					91023			90409	90398	90659	90809
					91025			90410	90747	90661	90831
					91031			90411		90662	90832
					91046					90665	90833
					91050					90702	90834
					91051					90707	90835
					91066					90711	90840
					91077					90714	90842
					91102						90844
					91109						90845
					91110						90846
					91114						90847
					91115						90848
					91116						90853
					91117						90888

Red denotes new zip codes approved for Care 1st
Blue denotes excluded zip codes for Care 1st

Service Area for Care 1st Health Plan - 2001

Regions:

1	2	3	4	5	6	7	8	9	10	11	12
Lancaster/Palmdale	nSan Fernando NW	San Fernando (Entire	San Fernando SW (part)	San Fernando SE (entire)	San Gabriel - West Entire Region	San Gabrield East (partial)	Metro (partial)	West	South (entire)	East (entire)	South Bay (partial)
					91118						
					91121						
					91123						
					91124						
					91125						
					91126						
					91129						
					91131						
					91175						
					91182						
					91184						
					91185						
					91186						
					91187						
					91188						
					91189						
					91191						
					91209						
					91210						
					91221						
					91222						
					91224						
					91225						
					91226						
					91734						
					91735						
					91756						
					91771						
					91772						
					91778						
					91802						
					91804						
					91841						
					91896						

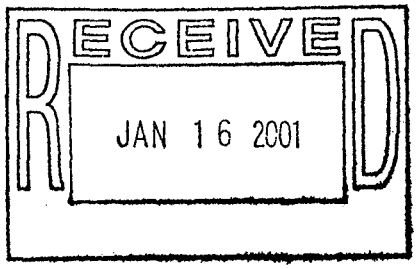
Red denotes new zip codes approved for Care 1st
Blue denotes excluded zip codes for Care 1st

State of California
Gray Davis, Governor
State Business, Transportation and Housing Agency

980 9th Street
Suite 500
Sacramento, CA 95814
916-423-8137
KLoyer@dmhc.ca.gov

In Reply Refer to:
File No. 933-0326

January 10, 2001



Via Facsimile and U.S. Mail

Donald S. Comstock, CEO
Care 1st Health Plan
1000 S. Fremont Avenue, Bldg. A-11
Alhambra, CA 91803

Re: Care 1st Health Plan's Notice of Material Modification for Expansion of Service Area filed October 2, 2000 and its subsequent Amendment filed November 14, 2000

Dear Mr. Comstock:

Enclosed is an Order of Approval for Care 1st Health Plan's Notice of Material Modification proposing the expansion of its service area into certain zip codes in Los Angeles County.

The Department of Managed Health Care has reviewed the above-referenced Notice of Material Modification and subsequent Amendment for compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended,[1] and the regulations[2] promulgated pursuant to the Act. However, the Department has reviewed only those revisions explicitly indicated and/or redlined by the Plan. Therefore, the Department's approval of these filings is limited to the revisions explicitly stated by the Plan and not to any other provisions.

[1] California Health and Safety Code Section 1340 *et seq.* (the "Act").
[2] Title 10 of the California Code of Regulations, commencing at Section 1300.43.

If you have any questions or concerns regarding this determination, please feel free to contact me at the e-mail address or telephone number indicated.

Sincerely,

Kelly Loyer
Counsel
(916) 324-8137

KEL:al

cc: Brian Bartow, Chief, Licensing Division
Maria Marquez, Financial Examiner

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

980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Phone: (916) 324-9014
Fax: (916) 327-6352
Email: jwillis@dmhc.ca.gov

August 21, 2006

VIA ELECTRONIC MAIL AND U.S. MAIL

Anna Tran
Chief Financial Officer
Care1st Health Plan
1000 S. Fremont Avenue, Bldg A-11
Alhambra, CA 91803

Re: Notice of Material Modification Proposing the Purchase of Certain Assets from WATTSHealth Foundation, Inc., a Service Area Expansion, and the Ability to Provide Medicare, Commercial and Denti-Cal Coverage in Specific Areas; Filed on May 24, 2006; Filing No. 20061002

Dear Ms. Tran:

Enclosed is Order No. 20061002 issued by the Department of Managed Health Care ("Department") approving the terms of the above-referenced Notice of Material Modification ("Notice") filed by Care1st Health Plan (the "Plan"), requesting approval to purchase certain health care assets from WATTSHealth Foundation, Inc., dba UHP Healthcare ("UHP"), including the use of UHP's tradename for a specified period of time, the Plan's service area expansion into parts of Orange and San Bernardino Counties, and authorization for Care1st to provide Medicare, Commercial and Denti-Cal coverage in specific areas.

Please note that the License and the Order are issued subject to and conditioned upon the Plan's full compliance with the Undertakings attached to the Order issued approving the Notice.

The Department's review of this Notice was limited to the information specifically described in the Exhibit E-1 and highlighted in the filed documents by strikeout, underline or other method in accordance with Rule 1300.52.

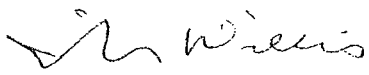
This Order does not constitute a waiver of any compliance issues that may be identified on subsequent review and analysis of the Plan's operations or documents as described in the Notice, whether or not highlighted to reflect a change, or of any other Plan documents or operations, whether or not disclosed in this Notice.

The revisions necessary to correct the compliance concerns identified by the Department in this Notice apply to all Plan documents that contain similar language or provisions, whether previously filed or not. Plan documents and operations that do not reflect compliance with the

Act and Rules in accordance with the Department's determinations regarding this Notice are not approved. Accordingly, please review and revise all Plan documents as necessary to identify and correct similar compliance concerns where they may exist. If language approved in the context of this Notice is the only change made by the Plan to its existing variations of the same forms of documents as submitted in this Notice, the Plan need not file those revised documents. The Department reserves the right to require additional revisions to the Plan's operations and documents, including but not limited to subscriber and provider documents, and written policies and procedures, as further review may indicate is necessary for compliance with the Act.

Please contact me if there are any questions regarding the above.

Sincerely,



JENNIFER WILLIS
Staff Counsel
Division of Licensing

cc: John M. Puente, Deputy Director, Plan and Provider Relations
Kevin Donohue, Deputy Director, Office of the Director
Tina Dunlap, Chief, Division of Licensing
Amy Dobberteen, Assistant Deputy Director, Office of Enforcement
Nancy Pheng, Staff Counsel, Division of Licensing

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF MANAGED HEALTH CARE

File No. 933-0326
Material Modification No. 20061002
Order No. 20061002

Licensee: Care1st Health Plan

ORDER APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed on May 24, 2006, requesting approval of Licensee's proposal to purchase certain assets from WATTS Health Foundation dba UHP Health Care, are approved as of the date set forth below. In accordance with this Order, Licensee is authorized to arrange for and provide health care services as follows:

(1) Los Angeles County: Medi-Cal Dental, Medicare, and Commercial coverage in all zip codes;

(2) Orange County: Medicare and Commercial coverage in specific zip codes [Attachment A];

(3) San Bernardino County: Medicare and Commercial coverage in specific zip codes [Attachment B].

This Order is issued subject to and conditioned upon the Licensee's full performance to the Department's satisfaction of the Undertakings attached hereto [Attachment C] and incorporated herein by this reference. This Order shall be in force and effect commencing on the date below and shall remain in effect until revoked or superceded by further Order of the Director.

Dated: August 21, 2006
Sacramento, California

By Lucinda A. Ehnes
LUCINDA A. EHNES
Director
Department of Managed Health Care

Attachment A: Licensed Expansion Area in Orange County

92698	92821	92641	92697	90743
92801	92822	92642	92655	92683
92802	92823	92643	92657	92685
92803	90622	92644	92868	92686
92804	90624	92645	92601	92687
92805	92626	92840	92670	92885
92806	92610	92841	92870	92886
92807	92708	92842	92871	92887
92808	92728	92843	92673	90620
92812	92831	92844	92701	90621
92814	92832	92845	92702	90630
92815	92833	92846	92703	90631
92816	92834	92646	92704	92694
92817	92835	92647	92705	90720
92825	92836	92648	92706	90740
92850	92837	92649	92707	
92899	92838	92619	92735	
92622	92640	92620	90742	

Attachment B: Licensed Expansion Area in San Bernardino County

92315	92337	91764	92402	92411
92316	92346	92369	92403	92412
92317	92352	91739	92404	92413
92318	92350	92376	92405	92414
92324	92354	92377	92406	92415
92325	92357	92378	92407	92416
92334	91761	92382	92408	92418
92336	91762	92401	92410	92420
92423	92424	92427	91710	91709
92313	92400			

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF MANAGED HEALTH CARE

File No. 933-0468
Material Modification No. 20100557
Order No. 20100557

Licensee: Care 1st Health Plan

ORDER APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed on March 26, 2010, requesting approval of Licensee's proposal to expand its Medicare Advantage service area into certain zip codes in Santa Clara and Los Angeles Counties, are approved as of the date set forth below.

This Order shall be in force and effect commencing on the date below and shall remain in effect until revoked or superseded by further Order of the Director.

Dated: April 26, 2010
Sacramento, California

LUCINDA A. EHNES
Director
Department of Managed Health Care

By _____ for
MAUREEN MCKENNAN
Assistant Deputy Director, HPO, Licensing Division

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF MANAGED HEALTH CARE

File No. 933-0326
Material Modification No. 20054948
Order No. S-06-1575

Licensee: Care 1st Health Plan

ORDER APPROVING
NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed on September 15, 2005, requesting approval of Licensee's proposal to expand its service area into San Diego for the purpose of providing health care services to Medi-Cal eligibles, are approved as of the date set forth below.

This Order shall be in force and effect commencing on the date below and shall remain in effect until revoked or superceded by further Order of the Director.

Dated: January 24, 2006
Sacramento, California

LUCINDA A. EHNES
Director
Department of Managed Health Care

By_____

TINA DUNLAP
Chief, Licensing Division

Attachment #2

Mandatory Qualifications Criteria 2,
“Applicant is in good financial standing with DMHC.”

DEPARTMENT OF
Managed
Health Care

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

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

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Kimberly Fritz
GMC Administrator San Diego
Care 1st Health Plan
601 N. Potrero Grande Drive
Monterey Park, CA 91755

Re: Letter of Standing – Care 1st Health Plan

Dear Ms. Fritz:

On February 6, 2012, you requested a letter regarding Care 1st Health Plan's ("CHP") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] CHP makes this request to satisfy requirements for a Request for Solutions ("RFS") issued by the California Department of Health Care Services, for the Dual Eligibles Demonstration Project.

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

A review of the Enforcement Action Database shows that there are currently no enforcement actions involving CHP. The plan is not currently under supervision, a corrective action plan or special monitoring by the Office of Enforcement. The Office of Enforcement does not comment on past, pending, or anticipated Enforcement actions against any plan that might potentially impact its licensing with the State.

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

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for CHP was issued on May 12, 2011. The Plan submitted a Corrective Action Plan ("CAP") to address identified deficiencies on April 4, 2011. The Plan has one unresolved deficiency in the area of Quality Management for not ensuring that quality of care problems are identified and corrected as per section 1370 and rule 1300.70(b)(1)(B). A Follow Up Medical Survey is

[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.

currently underway to verify that the Plan has completed the implementation of its CAP and has corrected the outstanding deficiencies. The next Routine Medical Survey is due by December 18, 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
Linda Azzolina, Division of Licensing
Dayana Joseph, Division of Financial Oversight

Attachment #3

Mandatory Qualifications Criteria 3a,
"Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years."

From: HPMS Web [hpms@cms.hhs.gov]
Sent: Friday, May 27, 2011 11:58 AM
To: Anna Tran; Jamie Ueoka
Cc: SNP Applications; Brooks Jones; HPMS Helpdesk
Subject: H5928 - SNP Conditional Approval - Dual-Eligible - All Duals

May 27, 2011

Anna Tran
Chief Executive Officer
CARE1ST HEALTH PLAN
601 Potrero Grande Drive
Monterey Park, CA 91755

Re: Conditional Approval of SNP Application
H5928 - CARE1ST HEALTH PLAN - Dual-Eligible - All Duals

Dear Anna Tran:

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	
1	a	4
2	a	4
2	b	4
2	c	4
3	a	4
3	b	4
3	c	4
4	a	4
4	b	4
4	c	4
5	a	4
5	b	4
5	c	4
5	d	4
5	e	4
6	a	4
6	b	3
6	c	4
6	d	3
7	a	4
7	b	3
7	c	3
7	d	4
8	a	3
8	b	4
8	c	4
8	d	4
8	e	4
9	a	4

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

Element 1	4
Element 2	12
Element 3	12
Element 4	12
Element 5	20
Element 6	14
Element 7	14
Element 8	19
Element 9	16
Element 10	8
Element 11	23
Total Points	154
Total Possible Points	160
Score 96.25%	

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

HPMS

Health Plan Management System

Home

View Contract Materials

Contract Number: H5928
Organization Name: CARE1ST HEALTH PLAN
Organization Type: Local CCP
Contract Plan Type: HMO/HMOPOS
Contract Type: Renewal
SAE Indicator: Yes
Contract Status: Active
Part D Offered: Yes
SNPs Offered: Yes
Type(s) of SNPs offered: Dual-Eligible
800-Series Only: No
Employer Plans Offered: No
2012 Contract Approval Date: 09/06/2011
Electronic Contracting Plan Sign-off Date: 8/24/2011 7:44:04 PM (JANET JAN)
Electronic Contracting CMS Part C Countersign Date: 9/16/2011 2:35:02 PM (DANIELLE MOON)
Electronic Contracting CMS Part D Countersign Date: 9/16/2011 9:41:27 AM (CYNTHIA TUDOR)

Select a document link to view/download the document.

Documents	Reviewed by the Plan
CCP Contract	8/24/2011 7:20:17 PM (JANET JAN)
CMS Mark License Agreement	8/24/2011 7:21:06 PM (JANET JAN)
MA-PD Addendum	8/24/2011 7:25:29 PM (JANET JAN)
Benefit Attestation	8/24/2011 7:43:08 PM (JANET JAN)
DUA Agreement	8/24/2011 7:43:52 PM (JANET JAN)
Signature Attestation	8/24/2011 7:44:04 PM (JANET JAN)

Back

Go To: Electronic Contracting 2012 Start Page

Attachment #4

Mandatory Qualifications Criteria 3a,
“Applicant has a current Medi-Cal contract with DHCS.”

STATE OF CALIFORNIA

STANDARD AGREEMENT AMENDMENT

STD 213A_DHCS (1/08)

☒ Check here if additional pages are added: 244 Page(s)

Agreement Number	Amendment Number
09-86153	A03
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:

State Agency's Name (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

Contractor's Name (Also referred to as Contractor)
Care1st Partner Plan, LLC

2. The term of this Agreement is: July 1, 2010 through June 30, 2015

3. The maximum amount of this Agreement after this amendment is: $ Budget Act Line Items 4260-601-0912 and 4260-601-0555

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. **Amendment effective date:** June 1, 2011

II. **Purpose of amendment:** This amendment incorporates new language regarding the mandatory enrollment of Seniors and Persons with Disabilities (SPD) with changes to Exhibit A, Scope of Work, and Exhibit E, Additional Provisions, Attachment 1, Definitions; updates contract language to be in compliance with the Balanced Budget Act (BBA) with changes to Exhibit A and Exhibit E; amends Exhibit A, Attachment 2, Financial Information; adds Health Information From (HIF)/ Member Evaluation Tools (MET) language to Exhibit A, Attachment 10, Scope of Services, Exhibit A, Attachment 18, Implementation Plan and Deliverables, and Exhibit E, Attachment 1; amends language in Exhibit A, Attachment 10, regarding Hospice Care; deletes Plan Initiated Disenrollment language in Exhibit A, Attachment 16, Enrollments and Disenrollments; and adjusts the capitation rates for SPD enrollment for the period from June 1, 2011 through December 31, 2011 by amending Exhibit B, Budget Details and Payment.

III. Changes made have already been incorporated and this amendment is submitted as a complete contract. Certain changes in Exhibit B are displayed in **bold and underline**, deletions are displayed as strike through text (i.e., ~~Strike~~).

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		CALIFORNIA Department of General Services Use Only
Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)* Care1st Partner Plan, LLC		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)* 5/3/2011	
Printed Name and Title of Person Signing Anna Tran, Chief Executive Officer		
Address 601 Potrero Grande Monterey Park, CA 91755		
STATE OF CALIFORNIA		
Agency Name Department of Health Care Services		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing Tanya Homman, Chief, Medi-Cal Managed Care Division		☒ Exempt per: Welfare and Institutions Code section 14089.8(b)
Address 1501 Capitol Avenue, Suite 71.4.4006, MS 4400, P.O. Box 997413, Sacramento, CA 95899-7413		

Problems in Plan Financial Reporting

Report	Due Date(s)	* Contractual Provisions	** Other Requirements	Cause
	GMC/Two Plan	GMC/Two Plan		
Annual Consolidated (All Lines of Business) Financial Report	120 Day After the PLAN Fiscal Year End	Section 2 B1		Did not submit
				Late
Quarterly Consolidated Financial Reports	Feb 14th, May 15th, Aug 14th, Nov 14th	Section 2 B2		Did not submit
Annual Medi-Cal Only Financial Report	120 Days After the STATE Fiscal Year End	Section 5	1, 2	Did not submit
				Late
				County Specific Breakdown
Quarterly Medi-Cal Only Financial Reports	Feb 14th, May 15th, Aug 14th, Nov 14th	Section 2 F	1, 2	Did not submit
				County Specific Breakdown
Annual Audited Financial Statements	120 Days After the PLAN Fiscal Year End	Section 2 B1		Did not submit
				Late
Annual Forecast for All Lines of Business (for the following Plan/State Fiscal Year)	60 Days Prior to Plan Fiscal Fiscal (for the following State Fiscal Year)	Section 1 C; Section 5	2, 3	Did not submit
				Late
				Did not include assumptions
Annual Forecast for Medi-Cal Only Line of Business (for the following Plan/ State Fiscal Year)	60 Days Prior to Plan Fiscal Fiscal (for the following State Fiscal Year)	Section 1 C; Section 5	1, 2, 3	Did not submit
				Late
				County Specific Breakdown
				Did not include assumptions
Monthly Consolidated Financial Reports (5 Plans required)	30 Days After the Fiscal Month	Section 5		Did not submit
Monthly Medi-Cal Only Financial Reports (4 Plans required)	30 Days After the Fiscal Month	Section 5	1, 2	Did not submit
				Late
				By County

* Contractual Provisions can be found in Exhibit A, Attachment 2.
Please refer to the California Code of Regulations, Health and Safety Code, and Welfare and Institutions Codes for applica
** Other Requirements

1 Include cost, revenue and enrollment information applicable to Medi-Cal beneficiaries enrolled in the plan through
2 If operating in multiple counties, reports #2 and #4 are to be expanded to show financial and enrollment informatio
3 Prepare using reports #2 and #4 of the Financial Reporting Form in addition to underlying assumptions used to de

21 Plans include COHS, GMC,

NOTE:
Plans are contacted within 7 calendar days after a due date. Plans response or lack of responses are documented and pro
Plans are contacted immediately after a submission if required items are missing. For example if a plan operates in multiple
by county, is then contacted to complete the submission.

Attachment #5

Mandatory Qualifications Criteria 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."

Sanctions, Penalties and Corrective Action Plans (CAP) Issued by Medicare or a State of California Government Entity During the Five Year Period January 2007 through December 2011

1. Sanctions

None

2. Penalties

None

3. Corrective Action Plans (CAP)

AGENCY/DATE	ISSUE	CAP SUBMITTED	RESOLUTION
DHCS 2008 HEDIS	Low compliance rate for cervical cancer screening	New provider report card and incentives	CAP Accepted. Exceeded minimum performance levels following year
DHCS 2009 HEDIS	Low compliance rate for breast cancer screening	A Women's Health program; Toll free access to members to schedule screening; Member education	CAP Accepted. Exceeded minimum performance levels following year
DHCS 2010	Facility site review and medical records standards at 3 of 10 physician offices surveyed	These offices provided education and monitored closely by dedicated coordinator	CAP Accepted.
DMHC	Completing investigation	Revised policies	CAP Accepted.

2011	of quality of care issues within reasonable timeframes	and procedures for identifying quality of care issues; Training for UM nurses	Increase in actual quality issue cases identified. Meeting timelines increased from 26.4% to 58.5%
DMHC 2011	Revise credentialing policies and review standards	Credentialing policy and Procedures revised	CAP Accepted Credentialing file samples submitted to DMHC
Medicare August 2011	Strengthen internal procedures to accurately identify and process claims	Provider education on referrals to network providers; Additional training for claims staff; New internal audit procedures for non contracted provider claims implemented; Claims determination and payment policies and procedures revised.	CAP Accepted. Completed November 2011
Medicare August 2011	Clear and concise denial notices to providers	Revision of denial explanation codes and explanation;	CAP Accepted. Partially completed and ongoing
Medicare August	Compliance with claims payment timelines	Updated policies and procedures;	CAP accepted. Partially

2011		Claims staff education and training;	completed and ongoing
Medicare August 2011	Enrollment and disenrollment processing. - Valid election period; - Accurate and timely processing of transmission; - Appropriate and timely communication; - Incomplete enrollment timely and correct processing - Enrollment denial processing, communication - Voluntary disenrollment: timely communication - Involuntary disenrollment issues;	Revision of policies and procedures; Staff training in processing enrollments; Increased auditing of processes; Process improvements to ensure timely issue of acknowledgement notices; Contacting enrollees within 10 days; Simplification of information request process and language;	CAP accepted. Partially completed and ongoing
Medicare August 2011	Improving Compliance Program	Updating Compliance Program	CAP accepted. New Plan completed and accepted by CMS.
Medicare August 2011	Marketing and surveillance	New member Welcome Verification policy and procedure revised; Improve outbound enrollment	CAP accepted. Completed November 2011.

		verification process; Enhanced monitoring of process; Staff training	
Medicare August 2011	Marketing and surveillance	Enhanced investigation process for marketing complaints; Marketing agents trained further; Secret shopping increased;	CAP accepted. Non complaint agents terminated.
Medicare August 2011	Appeals and grievances: - denial letters format - denial letters content - approval notices	Revised policies and procedures; Modified letters; Staff training; Education of delegated entities; Monitoring delegated entity letters; Establishment of a Grievance Committee to meet weekly and resolve grievances;	CAP accepted. Completed December 2011.
DMHC 2011	Material modification filing needed for claims processing outsourcing agreement	Agreement revised to meet DMHC requirements and filed	Accepted by DMHC
DMHC 2010	Claims payment: - accuracy	Claims processing	CAP accepted.

	- explanations - timeliness - denials	guidelines revised; Interest application procedures revised; Random audit of claims; Explanation codes improved; Matching original claims date to follow up improved; Staff training	
DMHC 2010	Grievance resolution letters - - need to include envelope to direct IMR applications to DMHC - need to include availability of free language assistance services	Staff trained; Quarterly monitoring	CAP accepted
CMS November 2011	Refer grievances involving fraud allegations for immediate processing of disenrollment.	Policies and procedures revised; Training for grievance specialist staff;	CAP accepted December 2011
CMS November 2011	Member educational field representatives cover information related to special election period (SEP) for SNP enrollees.	Training for these staff.	CAP accepted. December 2011

Attachment #6

Mandatory Qualifications Criteria 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."

Care1st Health Plan, Inc.
CA Duals Demonstration RFS Application for San Diego County
ATTACHMENT 8a

Mandatory Qualifications Requirements

8.a. Provide the most recent three years of DHCS quality indicators for Medi-Cal managed care plans, including HEDIS measures.

Medicaid San Diego HEDIS Performance

Measure	2009	2010	2011	09-11 Difference	10-11 Difference	Most Recent Benchmark Met
Adolescent Well Care	40.9%	42.6%	45.0%	+4.1 %Points	+2.4 %Points	25th Percentile
Well Child Care 3-6 Years of Age	68.4%	75.9%	76.8%	+8.4 %Points	+0.9 %Points	50th Percentile
Well Child Care in First 15 Month of Life	N/A	N/A	61.6%	N/A	N/A	50th Percentile
Weight, Nutrition and Physical Activity- BMI Assessment	N/A	50.4%	57.2%	N/A	+6.8 %Points	75th Percentile
Weight, Nutrition and Physical Activity- Nutritional Assessment	N/A	49.6%	63.3%	N/A	+13.7 %Points	75th Percentile
Weight, Nutrition and Physical Activity- Physical Activity Assessment	N/A	29.2%	36.3%	N/A	+7.1 %Points	50th Percentile
Childhood Immunizations (Combination 3)	76.4%	79.8%	79.8%	+3.4 %Points	No Change	75th Percentile

Lead Screening	N/A	N/A	74.5%	N/A	N/A	50th Percentile
Timeliness of Prenatal Care	81.7%	86.5%	80.0%	-1.7 %Points	-6.5 %Points	10th Percentile
Timeliness of Postpartum Care	62.7%	60.0%	60.5%	-2.2 %Points	+0.5 %Points	25th Percentile
Cervical Cancer Screening	60.6%	68.4%	64.5%	+3.9 %Points	- 3.9 %Points	25th Percentile
Breast Cancer Screening	34.4%	48.7%	45.9%	+11.5 %Points	-2.8 %Points	10th Percentile
Comprehensive Diabetes Care- HgbA1c Screening	85.5%	81.4%	83.6%	-1.9 %Points	+2.2 %Points	50th Percentile
Comprehensive Diabetes Care- HgbA1c Poor Control (lower rate is better)	38.7%	39.8%	30.9%	-7.8 %Point	-9.1 %Points	< 25th Percentile (lower is better)
Comprehensive Diabetes Care- HgbA1c Result <8	45.3%	46.9%	52.7%	+7.4 %Points	+5.8 %Points	50th Percentile
Comprehensive Diabetes Care- LDL Screening	72.6%	77.9%	80.6%	+8.0 %Points	+2.7 %Points	75th Percentile
Comprehensive Diabetes Care- LDL Result <100	40.3%	47.8%	46.1%	+5.8 %Points	-1.7 %Points	90th Percentile
Comprehensive Diabetes Care- Retinal Eye Exam	48.4%	51.3%	41.8%	-6.6 %Points	-9.5 %Points	25th Percentile
Comprehensive	87.1%	82.3%	87.3%	+0.2	+5.0	90th

Diabetes Care-Monitoring Nephropathy				%Points	%Points	Percentile
Controlling High Blood Pressure	N/A	N/A	53.0%	N/A	N/A	25th Percentile
Appropriate Treatment for URI	91.3%	91.6%	91.8%	+0.5 %Points	+0.2 %Points	75th Percentile
Avoidance of Antibiotic Treatment for Bronchitis	N/A	23.3%	28.0%	N/A	+4.7 %Points	75th Percentile
Use of Imaging for Low Back Pain	N/A	75.4%	61.0%	N/A	-14.4 %Points	10th Percentile

Attachment #7

Mandatory Qualifications Criteria 8b,
"Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements."

Care1st Health Plan, Inc.
CA Duals Demonstration RFS Application for San Diego County
ATTACHMENT 8b

Mandatory Qualifications Requirements

8.b. ***Provide the most recent three years of MA-SNP quality performance HEDIS measures.***

Medicare SNP San Diego HEDIS Performance

Measure	2009	2010	2011	09-11 Difference	10-11 Difference	Most Recent Benchmark Met
Care for Older Adults- Advanced Directives	2.8%	17.0%	57.9%	+55.1 %Points	+40.9 %Points	50th Percentile
Care for Older Adults- Medication Reconciliation	50.6%	40.4%	42.1%	-8.5 %Points	+1.7 %Points	25th Percentile
Care for Older Adults- Functional Assessment	4.4%	11.9%	58.4%	+54.0 %Points	+46.5 %Points	50th Percentile
Care for Older Adults- Pain Assessment	28.7%	24.6%	61.6%	+32.9 %Points	+37.0 %Points	50th Percentile
Medication Reconciliation Post Discharge	N/A	63.9%	48.0%	N/A	-15.9 %Points	90th Percentile
Potentially Harmful Drug and Disease Interactions	N/A	38.3%	38.1%	N/A	-0.2 %Points	90th Percentile
Use of High Risk Medications in the Elderly- One Prescription	18.8%	20.4%	21.3%	+2.5 %Points	+0.9 %Points	25th Percentile

Use of High Risk Medications in the Elderly- Two Prescription	3.5%	2.9%	3.4%	-0.1 %Points	+0.5 %Points	25th Percentile
Annual Monitoring of Persistent Medications	67.3%	80.1%	87.3%	+20.0 %Points	+7.2 %Points	10th Percentile
Controlling High Blood Pressure	58.9%	56.9%	60.6%	+1.7 %Points	+3.7 %Points	25th Percentile
Colorectal Cancer Screening	N/A	51.9%	42.5%	N/A	-9.4 %Points	10th Percentile
Glaucoma Screening	N/A	47.7%	53.4%	N/A	+5.7 %Points	10th Percentile

9

Attachment #8

Mandatory Qualifications Criteria 9,
"Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration."

NCQA
Measuring quality.
Improving health care.

December 1, 2011

Anna Tran
CEO
Care1st Health Plan
601 Potrero Grande Dr.
Monterey Park, CA 91755

Dear Mrs. Tran:

We are pleased to inform you that based on the information gathered during your recent HP survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded Care1st Health Plan the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://iss.ncqa.org and looking under the section entitled Survey and Results.

Product Line/ Product	**Accreditation Status**	**Effective Date**	**Expiration Date**
Medicaid-HMO	Commendable	November 21, 2011	November 21, 2014
Medicare-HMO	Commendable	November 21, 2011	November 21, 2014

The NCQA Health Plan Report Card will be updated to reflect this status by no later than the 15th of January. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the 'Guidelines for Advertising NCQA HPA Survey Accreditation,' enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2011 *Standards and Guidelines for the Accreditation of Health Plans.* This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for HP Accreditation Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

In order to maintain your accreditation status(es), Care1st Health Plan will need to participate in a survey approximately three months prior to the expiration date. Your next survey will be conducted in two stages using NCQA's Interactive Survey System (ISS) and standards in effect at the time of the survey. The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin eight weeks after your Survey Tool is submitted to NCQA.

We have tentatively reserved August 27, 2014, as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set October 20 - 21, 2014 for your two-day onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please contact Cindy Francis, Program Manager, Accreditation, at (202) 955-5147 or e-mail francis@ncqa.org.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or e-mail customersupport@ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this accreditation survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Dayna S McKnight

Dayna McKnight, MBA, MS
Assistant Vice President, Accreditation

Enclosures

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Care1st Health Plan

Medicaid HMO

an accreditation status of

COMMENDABLE

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

November 21, 2011

DATE GRANTED

November 21, 2014

EXPIRATION DATE

National Committee for Quality Assurance

has awarded

Care1st Health Plan

Medicare HMO

an accreditation status of

COMMENDABLE

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

November 21, 2011	*November 21, 2014*
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

December 6, 2011

Anna Tran
CEO
Care1st Health Plan
601 Potrero Grande Dr.
Monterey Park, CA 91755

Dear Mrs. Tran:

NCQA is pleased to inform you that Care1st Health Plan has satisfied the requirements for Center for Medicare & Medicaid Services (CMS) Medicare Advantage Deeming. The National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded Care1st Health Plan the status listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://iss.ncqa.org and looking under the section entitled Survey and Results.

Product Line / Product	Status	Effective Date	Expiration Date
Medicare HMO	**Deemed**	**November 21, 2011**	**November 21, 2014**

Congratulations on your achievement. We enjoyed working with your organization and we wish to acknowledge all your efforts, which were evident throughout the review process. We thank you for participating, and we look forward to working with you to improve the quality of healthcare everywhere.

Sincerely,

Dayna S McKnight

Dayna McKnight, MBA, MS
Assistant Vice President, Accreditation

1100 13th Street, NW Suite 1000 Washington, DC 20005 www.ncqa.org Toll Free 888.275.7585 P 202.955.3500 F 202.955.3599

National Committee for Quality Assurance

has awarded

CareIst Health Plan

Medicare Advantage Deemed Status

in accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS).

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

November 21, 2011

DATE GRANTED

November 21, 2014

EXPIRATION DATE

Attachment #9

Mandatory Qualifications Criteria 12,
"Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement."

Mandatory Qualifications Criteria

12. Stakeholder Involvement

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

a. The Applicant has created an advisory board of dually eligible consumers reporting to the board of directors (or will do so as part of the Readiness Review).

Care1st has a Public Policy Committee that includes Medi-Cal, Seniors and Persons with Disability, Medicare and Dual Eligible members, physicians, and representatives of the plan from key departments including Pharmacy, Member Services, Corporate Communication, Cultural and Linguistics, Quality Improvement, Legal and Provider Network Operations. It is a forum for the members to provide input and insight into their experience with the plan, including what is working for them and opportunities for improvement.

Data is shared with the committee, including Call Center reports, an overview and update on Cultural and Linguistics, membership, and a review of grievances received by the plan and the applicable resolution. The California Dual Demonstration Request for Solutions was an agenda item on the February 9, 2012 meeting. It will remain on the agenda, and an update will be provided on an ongoing basis.

The committee will continue to solicit comments and input on the current Dual Eligible program as a stakeholder process in the development, implementation and continued operation of the pilot project.

b. The Applicant has provided five letters of support from the community, with sources including individual dual eligible consumers, advocates for seniors and persons with disabilities, organizations representing LTSS, such as community based organizations, and/or individual health care providers.

Care1st has included five letters of support in this response to the California Dual Eligible Demonstration Request for Solutions.

c. The Applicant sought and accepted community-level stakeholder input into the development of the Application, with specific examples provided of how the plan was developed or changed in response to community comment.

Care1st has participated in Healthy San Diego (HSD) since the plan expanded to San Diego in 2006. HSD is a stakeholder collaboration through San Diego county that

includes representatives from various areas of the community including consumers, advocates, health plans, physicians, hospitals, public health, community clinics and Aging and Independent Services (AIS) to ensure Medi-Cal beneficiaries are informed of their healthcare choice.

San Diego County, including AIS, began a twelve-year effort to implement an integrated system of care for seniors and persons with disabilities through the Long Term Care Integration Project (LTCIP). More than 800 stakeholders (health and social service providers, aging and disabled consumers and advocates) have spent more than 30,000 hours over the twelve years to envision and recommend a better model of care. For the past two years, County staff has been tracking the development of the dual eligible demonstration project, and have been meeting with HSD plans since last summer to discuss the integration opportunities now afforded due to this endeavor.

Care1st has been part of the discussion for the last two years through regular attendance of the LTCIP Stakeholder Meetings. As part of the stakeholder engagement plan, through HSD, the plans will receive input through the AIS Advisory Committee who represents the LTCIP stakeholders. A meeting was held February 14, 2012, (agenda and meeting invitation included as part of this response) to specifically discuss the Dual Eligible Demonstration Project Request for Solutions. The plan was able to obtain feedback from the Stakeholders, including their strong desire to have broad access to providers in the community, input into their care and a continuation of current programs, including IHHS. Their comments helped form the responses contained in this RFS.

Through HSD, the plans will continue to work with AIS and their LTCIP Advisory Committee throughout the demonstration project to obtain input about their experience regarding program operations, if the benefits being offered are meeting members' needs, if access is adequate and timely, confirm improvement of care coordination, alignment of program responsibility, and if the grievance process has assisted them in any issues they may have encountered. Also to be discussed is the impact of the changes in their overall health due to their participation in the demonstration.

Additionally, the HSD health plans will continue to meet quarterly with the Consumer Center for Health Education and Advocacy. These stakeholder meetings are an opportunity to discuss the cases they have been involved in on behalf of consumers, and to determine what is working and where there may be areas for improvement. Grievance and Appeals will be a standing agenda item, and plan data will be distributed.

Public Policy Meeting
Care 1st Health Plan Corporate Office
Thursday, February 9, 2012
1:00-2:00 p.m.

AGENDA

I. Introduction

II. Approval of Minutes from last Meeting

Review Open Items

III. California Dual Demonstration Request for Solutions (RFS)

IV. Call Center Reports

V. Review Grievances

VI. Cultural & Linguistics

VII. Open Discussion

AASC
American Association of
Service Coordinators

Toby Douglas, Director
Department of Health Care Services
Office of Medi-Cal Procurement
MS Code 4200
PO Box 997413
Sacramento, CA 95899-7413

February 14, 2012

Re: CA Duals Demonstration RFS - Care1st Health Plan's Application for San Diego County

Dear Mr. Douglas:

On behalf of the American Association of Service Coordinators (AASC) and its 2,700 members, representing 3,000 affordable housing properties throughout the country, we enthusiastically support Care1st Health Plan's application for the California Duals Demonstration project in San Diego County.

Service Coordinators play a critical role in the care continuum by assisting low-income elderly and disabled residents to not just live on their own longer, but to thrive in life. Service Coordination also prevents premature transitions to higher and more expensive levels of care, as well as preventable hospitalizations and re-hospitalizations. More than one million low-income seniors and individuals with special needs and families residing in affordable housing benefit from the programs created or coordinated by Service Coordinators.

It is our understanding that Care1st's model for integrating medical, behavioral health, long-term services and supports and home- and community-based services, also includes incorporating Service Coordinators into its Interdisciplinary Care Teams to improve health care and reduce costs for dual eligible beneficiaries in San Diego County. AASC is committed to working with Care1st and its partners on this exciting project.

Again, we wholeheartedly support Care1st's application, and appreciate your consideration of this innovative project.

Sincerely,

Janice C. Monks

Janice C. Monks
President & Chief Executive Officer

489 Village Park Dr. | P.O. Box 1178 | Powell, OH 43065
Phone 614.848.5958 | Fax 614.848.5954 | www.servicecoordinator.org

CONSUMER CENTER FOR HEALTH EDUCATION AND ADVOCACY
1764 SAN DIEGO AVENUE, SUITE 200 • SAN DIEGO, CA 92110 • TOLL FREE 1.877.SD HEALTH (1.877.734.3258) • FAX 619.471.2782

Karen Luton
Advisory Board Chair

Gregory E. Knoll, Esq.
Executive Director

Carol Neidenberg
Mental Health
Program Manager

Paula Barron
Physical Health
Program Manager

February 13, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

On behalf of Care1st Health Plan, it is my pleasure to offer support and agree to serve as reference for their application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligible Project.

It is our understanding that through this demonstration it is the goal of DCHS to promote coordinated care models that will provide full access to a complete spectrum of medical, social and behavioral support and services that Dual Eligibles require in order to maintain good health and a high quality of life.

Through my chairmanship of the Healthy San Diego Joint Consumer & Professional Committee, I have worked collaboratively with Care1st since 2006. Care1st has been dedicated to serving Medi-Cal recipients since 1994. In 2003, the plan expanded to Arizona, where a majority of their 40,000 members are Dual Eligibles. Considering the plan's background and experience serving both Medi-Cal and Medicare special needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration within San Diego County.

The Consumer Center for Health Education and Advocacy fully supports the Care1st application to DHCS, and is looking forward to working with them to improve the lives and health of Dual Eligible beneficiaries. If you have any questions or require further information, please let me know.

Thank you.

Very truly yours,

Gregory E. Knoll

GREGORY E. KNOLL, ESQ.
Executive Director

COUNCIL OF COMMUNITY CLINICS

February 13, 2012

Toby Douglas
Director
Department of Health Care Services
1501 Capitol Avenue
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Toby:

On behalf of Care1st Health Plan, it is my pleasure to offer support and agree to serve as reference for their application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligible Project.

It is our understanding that through this demonstration it is the goal of DCHS to promote coordinated care models that will provide full access to a complete spectrum of medical, social and behavioral support and services that Dual Eligibles require in order to maintain good health and a high quality of life.

The Council of Community Clinics has worked collaboratively with Care1st since 2006. Care1st has been dedicated to serving Medi-Cal recipients since 1994. In 2003, the plan expanded to Arizona, where a majority of their 40,000 members are Dual Eligibles. Considering the plan's background and experience serving both Medi-Cal and Medicare special needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration within San Diego County.

The Council of Community Clinics fully supports the Care1st application to DHCS, and is looking forward to working with them to improve the lives and health of Dual Eligible beneficiaries. If you have any questions or require further information, please let me know.

Thank you

Sincerely,

Stephen O'Kane
Chief Executive Officer

619.542.4300 • Fax 619.542.4350 • www.ccc-sd.org
7535 Metropolitan Drive • San Diego, CA 92108 • Mailing Address: P.O. Box 880969 • San Diego, CA 92168

FAMILY HEALTH CENTERS OF SAN DIEGO
823 Gateway Center Way, San Diego, CA 92102
Tel 619-515-2300 • Fax 619-237-1856 • www.FHCSD.org

- Beach Area Family Health Center, 3705 Mission Boulevard, San Diego, CA 92109
- Black Infant Health Program, 12 North Euclid Avenue, National City, CA 91950
- Chase Avenue Family Health Center, 1111 West Chase Avenue, El Cajon, CA 92020
- Chula Vista Family Health Center, 251 Landis Avenue, Chula Vista, CA 91910
- City Heights Family Health Center, 5379 El Cajon Boulevard, San Diego, CA 92115
- Diamond Neighborhoods Family Health Center, 220 Euclid Avenue, Suite 40, San Diego, CA 92114
- Downtown Family Health Center, 1145 Broadway, San Diego, CA 92101
- Grossmont Spring Valley Family Health Center, 8788 Jamacha Road, Spring Valley, CA 91977
- Healthy Development Services-Central Region, 2114 National Avenue, San Diego, CA 92113
- Healthy Development Services-East Region, 1234 Broadway, El Cajon, CA 92021
- Lemon Grove Family Health Center, 7592 Broadway, Lemon Grove, CA 91945
- Logan Heights Family Counseling Center, 2204 National Avenue, San Diego, CA 92113
- Logan Heights Family Health Center, 1809 National Avenue, San Diego, CA 92113
- North Park Family Health Center, 3544 30th Street, San Diego, CA 92104
- Sherman Heights Family Health Center, 2391 Island Avenue, San Diego, CA 92102
- Teen Health Center, 1643 Logan Avenue, San Diego, CA 92113

February 13, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Toby:

On behalf of Care1st Health Plan, it is my pleasure to offer support and agree to serve as reference for their application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligible Project.

It is our understanding that through this demonstration it is the goal of DCHS to promote coordinated care models that will provide full access to a complete spectrum of medical, social and behavioral support and services that Dual Eligibles require in order to maintain good health and a high quality of life.

Family Health Centers has worked collaboratively with Care1st since 2006. Care1st has been dedicated to serving Medi-Cal recipients since 1994. In 2003, the plan expanded to Arizona, where a majority of their 40,000 members are Dual Eligibles. Considering the plan's background and experience serving both Medi-Cal and Medicare special needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration within San Diego County.

Family Health Centers fully supports the Care1st application to DHCS, and is looking forward to working with them to improve the lives and health of Dual Eligible beneficiaries. If you have any questions or require further information, please let me know.

Sincerely,

Fran Butler-Cohen
CEO

Accredited by the Joint Commission

February 7, 2012

Toby Douglas
Director
Department of Health Care Services
1501 Capitol Avenue
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Toby:

On behalf of Care1st Health Plan, it is my pleasure to offer support and agree to serve as reference for their application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligible Project.

It is our understanding that through this demonstration it is the goal of DCHS to promote coordinated care models that will provide full access to a complete spectrum of medical, social and behavioral support and services that Dual Eligibles require in order to maintain good health and a high quality of life.

Sharp Healthcare has worked collaboratively with Care1st since 2006. Care1st has been dedicated to serving Medi-Cal recipients since 1994. In 2003, the plan expanded to Arizona, where a majority of their 40,000 members are Dual Eligibles. Considering the plan's background and experience serving both Medi-Cal and Medicare special needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration within San Diego County.

Sharp fully supports the Care1st application to DHCS, and is looking forward to working with them to improve the lives and health of Dual Eligible beneficiaries. If you have any questions or require further information, please let me know.

Thank you

Sincerely,

Ann Pumpian
Senior Vice President and
Chief Financial Officer

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

Long Term Care Integration Project (LTCIP)

STAKEHOLDER MEETING REMINDER

February 14, 2012

Please join us on **Tuesday, February 14, 2012** from **1:00 PM to 3:00 PM** for a LTCIP Stakeholder Meeting. The meeting will be held in the JA Training Room at the **Aging & Independence Services (AIS) Headquarters located at 5560 Overland Ave., Suite 310, San Diego, 92123.** There is two hour visitor parking behind the building and also on the first floor in the parking garage, which can be accessed from Farnham Drive. Please contact Cindy Vogel at (858) 514-4652 or **cindy.vogel@sdcounty.ca.gov** if you have any questions about the parking or need directions. For those unable to attend in person, you may participate by phone. A conference line, 888-689-5577, passcode 7356959#, has been established for your convenience.

California is one of fifteen states competitively selected by the Center for Medicare and Medicaid Services (CMS) to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees (dual eligibles). SB 208 (Chapter 714, Statutes of 2010) authorized pilot projects for integration of services to dual eligibles in up to four counties. The recently released Governor's proposed budget includes the expansion of pilot sites from four to eight-ten in California.

To improve care coordination and align program responsibility and financial incentives, the proposed budget increases the number of dual eligible beneficiaries in managed care and broadens the scope of managed care services in California. Managed care plans will receive a blended payment consisting of federal, state, and county funds and will be responsible for delivering the full array of health and social services to dual eligible beneficiaries. The transition of dual eligibles to managed care in California will occur over a three-year period starting first with the eight to ten counties selected as pilot sites. The selected pilot sites must demonstrate that they already have the capacity to coordinate care for these individuals.

In the Governor's proposal, In-Home Supportive Services (IHSS), other home and community-based services, and nursing home care funded by Medi-Cal will become managed care benefits. In all managed care counties, the IHSS program will essentially operate as it does today in the first year, except that all authorized IHSS benefits will be included in managed care plan rates. Beneficiaries in the eight to ten selected dual

eligible pilot counties will also receive their Medicare benefits and long-term services and supports through their managed care plan.

In January, the Department of Health Care Services (DHCS) released the Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project final Request for Solutions (RFS). The RFS will be used to select pilot sites. The selection criteria reflect DHCS' aim 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.

Several managed health plans are interested in serving dual eligible beneficiaries in San Diego, and are optimistic that San Diego will be selected as a demonstration pilot site. Consistent with the stakeholder process over the past 12 years, AIS will host a LTCIP Stakeholder meeting to discuss the impact of the changes proposed in the Governor's budget, and to hear from health plans their vision for Dual Eligible Demonstration Pilot in San Diego County. You are encouraged to participate in this meeting.

More information about the LTCIP is available at www.sdltcip.org. Please do not hesitate to contact Brenda Schmitthenner, Manager of the LTCIP, at brenda.schmitthenner@sdcounty.ca.gov or (858) 495-5853 with questions.

LTCIP Meeting Agenda- February 14, 2012

I. Welcome – **Pam Smith (10 minutes)**

II. Introductions - **Brenda Schmitthenner (10 minutes)**

III. LTCIP Strategies Overview – **Brenda Schmitthenner (5 minutes)**

IV. Development of Dual Eligible Pilots in CA – **Brenda Schmitthenner (10 minutes)**

V. Overview of Governor's Proposed Budget – Impact on Medi-Cal programs-**Ellen Schmeding (10 minutes + 5 minutes for questions)**

VI. San Diego as a Dual Eligible Demonstration Site – Review of Final RFS Site Selection Criteria-**Ellen Schmeding (10 minutes + 5 minutes for questions)**

VII. Establishment of an Advisory Committee – Proposed Representation - **George Scolari (10 minutes)**

- Consumer Center for Health Education and Advocacy
- County In-Home Supportive Services (IHSS)
- County Behavioral Health Services
- Program of All-Inclusive Care for the Elderly (PACE)
- Community Based Adult Services **(**CBAS)
- Senior Alliance
- United Domestic Workers (UDW)
- Hospital Association of San Diego and Imperial County
- Community Clinics
- AIS Aging Services (ADRC)
- Skilled Nursing Facility

- Consumers (up to 3)
- San Diego Regional Center
- Access to Independence
- Health Plans
- IHSS Public Authority

VIII. Panel for Q&A- **Health Plans and AIS (30 minutes)**

Attachment #10

Mandatory Qualifications Criteria 14,
"If Applicant is a corporation, it is in good standing and qualified to conduct business in California."

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

CARE 1ST HEALTH PLAN

FILE NUMBER:	C1870888
FORMATION DATE:	03/07/1994
TYPE:	DOMESTIC CORPORATION
JURISDICTION:	CALIFORNIA
STATUS:	ACTIVE (GOOD STANDING)

I, DEBRA BOWEN, Secretary of State of the State of California, hereby certify:

The records of this office indicate the entity is authorized to exercise all of its powers, rights and privileges in the State of California.

No information is available from this office regarding the financial condition, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of February 22, 2012.

Debra Bowen

DEBRA BOWEN
Secretary of State

Attachment #11

Criteria for Additional Consideration 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?"

PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
SAN DIEGO COUNTY

February 15, 2012

Letter of Agreement to Work in Good Faith:

With the passage of AB 1040 in 1995 supporting the development of integrated care models, in February 1999, with Board of Supervisors support, San Diego County began a 12 year effort to implement an integrated system of care for seniors and persons with disabilities through the Long Term Care Integration Project (LTCIP). Employee representatives of the County of San Diego In-Home Supportive Services Public Authority (Public Authority) have participated in the LTCIP since its inception.

The Public Authority was established in 2001 by the County of San Diego Board of Supervisors, who serves as the Governing Body. The Public Authority assists eligible low-income elderly and persons with disabilities (consumers) on the In-Home Supportive Services (IHSS) program in San Diego County to live high quality lives in their own homes. Although the PA is an independent public agency, the organization works closely with the County of San Diego IHSS program and with other programs serving older adults and persons with disabilities to provide the best possible assistance to consumers and providers.

The Public Authority acts as Employer of Record for 21,000 IHSS providers and maintains a relationship with United Domestic Workers (UDW) as established through a Memorandum of Understanding. In addition, the Public Authority provides Registry services to IHSS consumers, conducts home visits to consumers, and offers voluntary training to a group of provider participants using six-week National Caregiver Training Program modules.

In addition, the Public Authority fulfills several functions on behalf of the County, including provider payroll using an electronic scanning and software system and provider enrollment for all new IHSS providers.

For the past few months, Public Authority staff have been meeting with IHSS representatives, Healthy San Diego plans and with SCAN Health Plan to discuss the integration opportunities now afforded by the Dual Eligibles Demonstration Project. The plans have communicated a strong interest in working collaboratively with the Public Authority to build upon the long-standing efforts of local stakeholders to create an integrated system for the dual eligibles in our community.

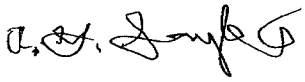
As the Executive Director of the IHSS Public Authority, I commit our organization to continue working in good faith with health plans to develop an integrated system of care for the dual eligibles in our community. We will coordinate our efforts with those of the County to ensure that we take a consistent approach in working with the health plans to build a system that

780 BAY BOULEVARD, SUITE 200, CHULA VISTA, CA 91910
PHONE: 866.351.7722
WEBSITE: WWW.SDIHSSPA.COM

benefits both IHSS consumers and providers. With Public Authority Governing Body approval, the Public Authority will be prepared to engage in a formal agreement with health plans to support the Dual Eligibles Demonstration Project.

Should you have any questions, please contact me at 619-476-6296.

Sincerely,



Albert G. "Bud" Sayles
Executive Director

cc: Walt Ekard, Chief Administrative Officer, County of San Diego
Stephen Magruder, Senior Deputy, County Counsel
Nick Macchione, Director, HHSA
Dean Arabatzis, Chief Operations Officer, HHSA
Dale Fleming, Director, Strategic Planning and Operational Support, HHSA
Pamela B. Smith, Director, Aging & Independence Services, HHSA
Mike Van Mouwerik, Director, Financial & Support Services, HHSA
Meredith McCarthy, Assistant Director, County of San Diego IHSS Public Authority

NICK MACCHIONE, FACHE
DIRECTOR

DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1600 PACIFIC HIGHWAY, SAN DIEGO, CA 92101-2417
(619) 515-6555 • FAX (619) 515-6556

February 8, 2012

Letter of Agreement to Work in Good Faith:

With the passage of AB 1040 in 1995 supporting the development of integrated care models, in February 1999, with Board of Supervisors support, San Diego County began a 12 year effort to implement an integrated system of care for seniors and persons with disabilities through the Long Term Care Integration Project (LTCIP). San Diego County's Health and Human Services Agency (HHSA), through its Aging & Independence Services (AIS) Department, received funding from a variety of sources including three planning grants and two demonstration grants from the State Department of Health Care Services totaling $750,000, as well as additional funding from the California Department on Aging ($610,000), the County of San Diego ($500,000), the California Endowment ($400,000) and the Alliance Healthcare Foundation ($250,000).

More than 800 stakeholders (health and social service providers, aging and disabled consumers and advocates), have spent more than 30,000 hours over 12 years to envision and recommend a better model of care for low income seniors and persons with disabilities in our community. Their motivation came from the recognition of the difficulty these individuals and their caregivers have in navigating the fragmented and duplicative network of medical, social, and long-term care services.

After thorough examination of various service delivery models, in January 2001 by consensus decision, LTCIP stakeholders recommended exploring the feasibility of using San Diego County's existing geographic Medi-Cal managed care program, Healthy San Diego (HSD), as the preferred delivery system model to explore. Referred to as the "HSD+ model," it would have built on the "medical home" approach provided by the County's Healthy San Diego managed care program for Medi-Cal beneficiaries, which now includes all those seniors and persons with disabilities receiving Medi-Cal only. Though legislation was introduced in 2006 to initiate a pilot integration project built upon the HSD+ model, it was not passed.

In March 2009, the County Board of Supervisors directed staff to pursue reform of the In-Home Supportive Services (IHSS) program. After reviewing available local and State options for reform, staff returned to the Board in November 2009 with a number of recommendations, including reviewing the opportunity to re-initiate long-term care integration as part of the State's 1115 Hospital Waiver renewal. For the past two years, County staff have been tracking the development of the dual eligible demonstration project. San Diego responded to the State's Dual Eligible Request for Information (RFI) and presented San Diego's vision for integration at the State's RFI session in August 2011.

County staff have been meeting with Healthy San Diego plans and with SCAN Health Plan since last summer to discuss the integration opportunities now afforded by the Dual Eligibles Demonstration Project. The plans have communicated a strong interest in working collaboratively with the County to build upon the long-standing efforts of local stakeholders to create an integrated system for the dual eligibles in our community.

Also during the past year, the County contracted with the actuarial firm, PricewaterhouseCoopers, to analyze Medicare, Medi-Cal and home and community based service expenditures to develop a capitated rate for an integrated service delivery system and assist the County with understanding the financial implications for IHSS. Unfortunately, the County consultant has been unable to access needed data to complete these analyses.

As the Director of the Health and Human Services Agency (HHSA), which includes Behavioral Health, Aging Services (including IHSS and the Area Agency on Aging/Aging & Disability Resource Connection) I commit my agency to continue working in good faith with health plans to develop an integrated system of care for the dual eligibles in our community that is consistent with the efforts of the past 12 years. With the receipt of necessary data to complete the actuarial analysis, after continued collaboration with the health plans on program design, and with Board of Supervisors' approval, HHSA will be prepared to engage in a formal agreement with health plans to support the Dual Eligibles Demonstration Project.

Should you have any questions, please contact Pamela Smith, Director, Aging & Independence Services, at (858) 495-5858.

Sincerely,

NICK MACCHIONE, MS, MPH, FACHE
Director

cc: Walt Ekard, Chief Administrative Officer, County of San Diego
Stephen Magruder, Senior Deputy, County Counsel
Dean Arabatzis, Chief Operations Officer, HHSA
Dale Fleming, Director, Strategic Planning and Operational Support, HHSA
Jennifer Schaffer, Ph.D., Director, Behavioral Health
Pamela B. Smith, Director, Aging & Independence Services, HHSA
Mike Van Mouwerik, Director, Financial & Support Services, HHSA

Attachment #12

Criteria for Additional Consideration 10, "Does the Plan have a draft agreement or contract with the County agency responsible for mental health?"

Criteria for Additional Consideration

10. Does the plan have a draft agreement or contract with the County agency responsible for mental health?

Through Healthy San Diego, Care1st has a Memorandum of Agreement (MOA) with San Diego County Division of Mental Health, Mental Health Plan (MHP) in order to implement certain provisions of Title 9 of the California Code of Regulations, Chapter 11 (Medi-Cal Specialty Mental Health Services).

The purpose of the MOA is to describe the responsibilities of the MHP and the plan in the delivery of specialty mental health services to Medi-Cal beneficiaries served by both parties. It is the intention of both parties to coordinate care between providers of physical and mental health care.

HEALTHY SAN DIEGO

AMENDMENT TO MEMORANDUM OF AGREEMENT BETWEEN HEALTH AND HUMAN SERVICES AGENCY AND MEDI-CAL MANAGED CARE PLANS

Amendment effective date: July 1, 2006

The County of San Diego Health and Human Services Agency and the Medi-Cal Managed Care Health Plan agree to abide by the amended terms of the executed Memorandum of Agreement in the following sections:

Section 1.0 **Community Epidemiology (CE).** Sub-sections 1.1, 1.2 , 1.4, 1.6, 1.9,and 1.11 are amended as attached. Added reference to the Business Associate Agreement.

Section 2.0 **California Children's Services (CCS).** Sub-sections 2.2, 2.3, 2.6 and 2.7 are amended as attached. Added reference to the Business Associate Agreement.

Section 3.0 **Child Health and Disability Prevention (CHDP).** Sub-sections 3.4, 3.7 and 3.11 are amended as attached. Added reference to the Business Associate Agreement.

Section 4.0 **Hansen's Disease Control Program.** Sub-sections 4.1, 4.7, 4.9 and 4.11 are amended as attached. Added reference to the Business Associate Agreement.

Section 5.0 **Immunization Program (IP).** Sub-sections 5.7 and 5.12 are amended as attached. Added reference to the Business Associate Agreement.

Section 6.0 **Maternal and Child Health (MCH) Network.** Sub-sections 6.3 and 6.12 are amended as attached. Added reference to the Business Associate Agreement.

Section 7.0 **Sexually Transmitted Disease (STD) Control Program.** Sub-sections 7.2, 7.3, 7.4, 7.6, 7.8 and 7.12 are amended as attached. Added reference to the Business Associate Agreement.

Section 8.0 **Tuberculosis (TB) Control Program.** Sub-sections 8.6, 8.7, 8.8, 8.10, and 8.13 are amended as attached. Added reference to the Business Associate Agreement.

Section 9.0 **Children's Emergency Shelter Care Center (dba A.B. and Jessie Polinsky Children's Center).** Sub-sections 9.4, 9.7.1, 9.7.2 and 9.7.6 are amended as attached. Added reference to the Business Associate Agreement.

Section 10.0 **Office of Aids Coordination (OAC).** Sub-section 10.6 and 10.13 are amended as attached. Added reference to the Business Associate Agreement.

Section 11.0 **Mental Health Services.** Sub-sections 11.5, 11.6, 11.7, 11.10, 11.12, 11.13, 11.15, 11.17, 11.18, 11.21, 11.22 and 11.23 are amended as attached. Added appendix 1. Added reference to the Business Associate Agreement.

Section 12.0 **Health Plan Facility Site Review (FSR) Program.** Sub-sections 12.1, 12.2, 12.3, 12.4, 12.5, 12.6, 12.7, 12.8, 12.9, 12.10, 12.11, 12.12, 12.13, 12.14, 12.15, 12.16, 12.17, 12.18,

HEALTHY SAN DIEGO

MEMORANDUM OF AGREEMENT
BETWEEN
HEALTH AND HUMAN SERVICES AGENCY
AND
MEDI-CAL MANAGED CARE PLANS

11.0 MENTAL HEALTH PLAN (MHP)

11.1 BACKGROUND

This Memorandum Of Agreement (MOA) is made by and between San Diego County Division of Mental Health, Mental Health Plan (hereinafter referred to as MHP) and Medi-Cal Managed Care Plan (hereinafter referred to as Plan) in order to implement certain provisions of Title 9 of the California Code of Regulations, Chapter 11 (Medi-Cal Specialty Mental Health Services).

The purpose of this MOA is to describe the responsibilities of the MHP and the Plan in the delivery of specialty mental health services to Medi-Cal beneficiaries served by both parties. It is the intention of both parties to coordinate care between providers of physical and mental health care. All references in the MOA to "Members" are limited to the Plan's San Diego County Medi-Cal Members.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.2 Liaison (MHP & Plan Responsibilities)	The MHP will maintain responsibility for: • Medication treatment and other mental health services for mental health conditions that would not be responsive to physical health care based treatment and meet criteria for specialty Mental Health services. • Consultation services to Plan providers, particularly PCPs about specialty mental health issues and treatments, including medication consultation. • The treatment of physical reactions induced from medications prescribed by the MHP providers. The MHP liaison will coordinate activities with the Plan and will notify the MHP providers of the roles and responsibilities of the MHP Liaison. The MHP will meet with the Plan at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and	The Plan liaison will coordinate activities with the MHP and will notify its contracting Primary Care Providers (PCPs) of the roles and responsibilities of the Plan Liaison. The Plan Liaison will meet with the MHP at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and update the MOA as necessary. The Plan will be responsible for communicating suggestions for MOA changes to the Plan leadership and the MHP Liaison. The Plan will also communicate MOA changes to Healthy San Diego (HSD), the State Department of Health Services, and Plan providers. At the discretion of the Plan, the Liaison may represent the Plan in the dispute resolution process. The Plan will provide the MHP with the phone numbers of its member services, provider services, and support programs that provide

CCS	=	California Children's Services	LEA	=	Local Education Agencies
DHS	=	Department of Health Services	MHP	=	Name of Local Mental Health Plan
DMH	=	Department of Mental Health	PCP	=	Primary Care Provider
FFS	=	State Fee-For-Service	Plan	=	Name of Health Plan
FQHC	=	Federally Qualified Health Center			

Final 5/11/06

See Addendum 15 Business Associate Agreement.

Attachment #13

Criteria for Additional Consideration 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?"

Criteria for Additional Consideration

11. Does the plan have intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligible? Which groups?

Care1st and Sharp Community Medical Group (SCMG) entered into an agreement effective January 1, 2012 to provide care to the plan's dual eligible members. SCMG is the only fully vertically integrated network of providers and hospitals that are serving the dual eligible population in San Diego under managed care. Care1st is very pleased to be the only plan contracted with SCMG for dual eligible members.

Attached is an overview of the programs implemented by SCMG. The plan will continue to partner with the IPA during the demonstration to ensure integration and collaboration among their physicians, hospitals and community based services that will benefit the dual eligibles.

Sharp Community Medical Group
Case Management for Dual Eligible Special Needs Plan (Care 1st)

A dedicated team consisting of Complex Case Manager(s) and a Case Management Care Coordinator manage and coordinate the care of special needs patients under dual eligible plan. This population with high risk, high acuity needs requiring intensive care coordination will be identified upon enrollment. A completed Health Risk Assessment (HRA) and Individualized Care Plan (ICP) from the health plan (Care 1st) will be forwarded to Sharp Community Medical Group (SCMG) within 90 days of member enrollment.

The program management is geared toward proactive engagement of the patients, identifying their special needs and initiating interventions to meet those needs. The program is also focused on implementing, maintaining, tracking and monitoring members through transitions to various levels of care in the continuum based on requirements set forth on Transitions of Care (NCQA-SNP1). All dual eligible (Care 1st) members are entered into the ICM Essette system to facilitate the transitions of care monitoring and documentation. The case manager will utilize the patient's ICP prepared based on the HRA survey response by the patient/patient designee as basis for case management intervention. The ICP is shared with patient, PCP, case manager and other interdisciplinary team members to provide consistent care for patient across the care continuum. SNP members will be eligible for services under various Ambulatory Case Management programs; Disease Management, Medication Therapy Management, Anticoagulation, Transplant CM, Post Discharge Call, Case Management and Resource Education (C.A.R.E.) and Frail Elderly programs as appropriate to meet their needs.

The program case manager serves as resource and collaborates with the Inpatient Case Manager and the SNF UR/Discharge Planners when patients are admitted to the hospital or discharged to acute rehab or skilled nursing facility. When special needs patients are admitted to out of network hospitals the Sharp HealthCare Out of Network Case Management team monitors the patient and facilitates repatriation to a Sharp HealthCare hospital if deemed appropriate based on patient status and needs. This collaborative communication also extends to other care continuum such as Home Health, Outpatient services (wound care, home infusion, outpatient infusion, therapies), Advance Life Care Planning, Palliative Care and Hospice. The Case manager facilitates referrals to

resources within Sharp HealthCare system and the community at large with follow up to ensure establishment of service(s). Case Management serves as patient liaison with the Primary Care physicians, Specialist and other providers to ensure patient gets quality and efficient care in adherence with the medical plan. The case manager will assist in the transition and/or coordination of care for members when it is determined that their benefits have ended or when a provider has terminated their contract with SCMG and the care remains medically necessary.

Attachment #14

Resume of Kimberly A. Fritz,
Project Manager

Kimberly A. Fritz

3513 Villa Terrace, San Diego, CA 92104
H: 619-688-9462, C: 619-894-9462, Email: kfritz1@sbcglobal.net

Summary

An accomplished healthcare executive with extensive experience including contracting, provider and client relations, operational excellence and business development who has worked with Fortune 100 health plans as well as small entrepreneurial companies. Strengths include collaborative leadership and partnership, analytical thinking, relationship building and a results driven attitude.

Specific areas of proficiency include negotiating contracts, meeting or exceeding the company's expectations, building and maintaining provider networks, implementation of educational programs to improve efficiency, and addressing both internal and external operational issues to lower administrative costs.

Professional Experience

CARE1ST HEALTH PLAN **2009 - Present**
San Diego GMC Administrator

- Responsible for the oversight of the San Diego Medi-Cal and Medicare operations and staff management
- Project Director for the transition of Seniors and Persons with Disabilities to the Plan
- Ensures all reporting requirements are met and in compliance with regulatory and contractual obligations
- Plan liaison to Healthy San Diego, the managed Medi-Cal plan collaborative through the County of San Diego Health and Human Services Agency
- Oversees and maintains expansions of the provider network to ensure quality and adequacy for the Medi-Cal, Medicare and Medi-Medi membership
- Act as a community liaison to enhance resource availability for members, including working with Aging and Independent Services and the Consumer Center for Health Education and Advocacy

ANTHEM BLUE CROSS **2006 - 2009**
Regional Director, Provider Contracting

- Responsible for contracting with hospitals and IPA/Medical Groups for the commercial and Medicare books of business, including Centers of Expertise for transplant and bariatric surgery
- Monitored network adequacy and resolved contract/claim interpretation issues to ensure regulatory and operational compliance
- Worked with internal teams to address operational issues to improve provider outcomes and objectives, saving on administrative expenses

MOLINA HEALTHCARE OF CALIFORNIA, INC.
2005 - 2006
Regional Manager, Provider Relations and Contracting

- Conducted high level negotiations and re-negotiations of provider contracts
- Successfully re-negotiated provider agreements resulting in over $100,000 savings per month
- Responsible for oversight of the provider network and supervision of the Contracting, Provider Relations and Database Operations staff

RE:VOLUTION INSURANCE SERVICES
2003 - 2005
Co-Owner

- Started this firm with a business partner to manage a large book of reinsurance and employee benefit accounts
- Emphasis for the firm was risk management, new plan/product implementations, resource alignment, and organizational consistency
- Developed brand identity and marketing materials for the firm, and implemented the marketing plan to ensure success of the company

AON HEALTHCARE INSURANCE SERVICES, INC.
1999 - 2003
Account Executive

- Managed large book of reinsurance and employee benefit clients, including 16 accounts, with an annual premium of $8.1 million
- Interfaced with hospital and IPA/Medical Groups and reinsurance markets in various capacities including determination of risk and corresponding stop loss needs, negotiating coverage and pricing, and reviewing policies to ensure appropriate protection on behalf of clients

- Analyzed claim data to assist in development of the coverage and pricing terms
- Day-to-day client contact for all operational issues

AMERICAN PHYSICIANS NETWORK 1996 - 1999
Director of Business Development

- Developed and negotiated contracts with national healthcare companies, bringing an additional 200,000 capitated lives to the company and increasing contract revenue over a million dollars
- Negotiated and implemented a disease management program, focusing on congestive heart failure
- Developed and implemented provider networks for all managed care products on a multi-regional basis

FPA MEDICAL MANAGEMENT, INC. 1994 - 1996
Director, Payor and Provider Relations

- Responsible for the negotiation and maintenance of all commercial and Medicare payor agreements
- Established provider recruitment systems including contract negotiations, developed primary and specialty care agreements and guidelines and implemented all operational components involved in the transition of providers to FPA. Market share was increased by 10% under the programs initiated and implemented
- Managed overall compliance with health plan requirements such as NCQA, claim turnaround time, authorization process, etc.
- Enhanced the in-service training for the physicians and office staff as a form of continuing education

AETNA HEALTH PLANS 1989 - 1994

Manager, Provider Contracting

- Developed and implemented provider networks for all managed care products, both commercial and Medicare, including negotiating capitated and non-risk based agreements with hospitals, IPA/Medical Groups, individual physicians and ancillary providers
- Developed contract strategies
- Analyzed financial results of provider contracts to determine appropriate provider rates and increases

- Developed mental health network strategies
- Responsible for supervision, hiring and management of the Provider Services Department
- Interfaced and assisted within the health plans in southern California on a regional level to assist on special projects

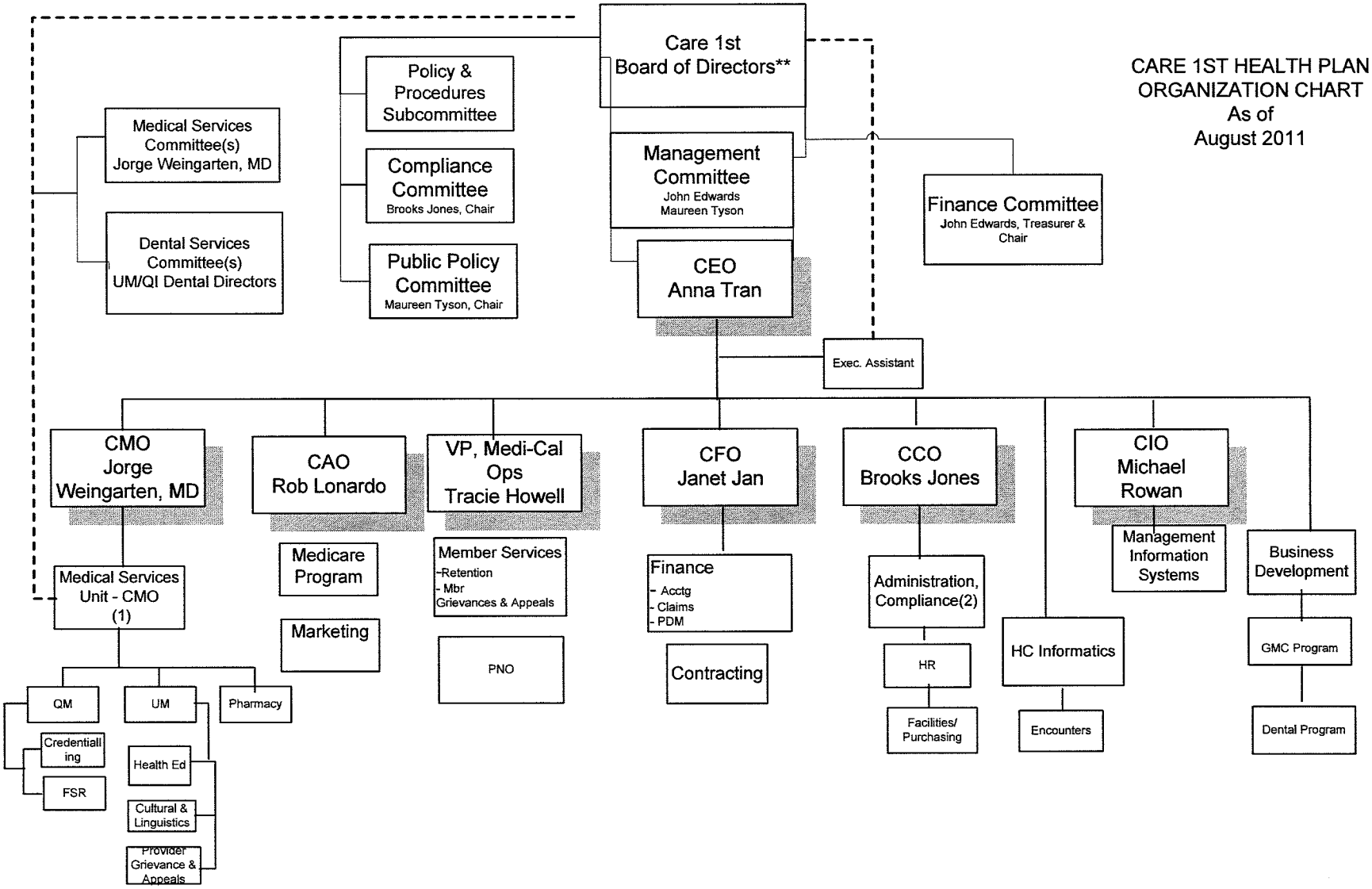
Education and Affiliations

- Webster University, Bachelor's of Science, Business Administration
- Chaffey College, Alta Loma, CA, Associates of Art Degree
- Completed the Certificate of Achievement programs at the University of Notre Dame Mendoza College of Business – Strategies for Conflict Management and Advanced Negotiations
- Board of Managers, Jackie Robinson Family YMCA

Attachment #15

Care1st Health Plan
Organization Chart
As of August 2011

CARE 1ST HEALTH PLAN ORGANIZATION CHART
As of
August 2011



(1) The CMO reports to the CEO, however, for medical policy issues, quality issues related to the Medical Groups, provider sanctions, and the annual quality report, the CMO reports directly to the Board.

(2)The CCO reports to the CEO, however, for compliance issues, and the annual compliance report, the CCO reports directly to the Board.

(3) The Dental Directors report to the CEO for operational issues; and reports directly to the Board for overall dental activities as approved through the Dental Quality Committee.

** Board of Directors is as follows: Dr. Walter Jayasinghe, Dr. Refaat Abraham, Mrs. Maureen Tyson, Dr. S. Y. Wong, Dr. Carl Moy, and Mr. John Edwards

Care1st Health Plan
Model of Care for Dual-Eligible Special Needs Population – SAN DIEGO COUNTY ONLY
Revised 2.24.12 for California Duals Demonstration Project

Contract ID: H5928
Plans: 009

PURPOSE:
Care1st Health Plan's Model of Care is designed to provide specialized benefits that are focused on meeting the needs of the beneficiaries enrolled in Care1st's "All Duals" Special Needs Plans in San Diego County.

Element 1 – Description of the SNP-specific Target Population

Care1st currently administers four "All Dual" Special Needs Plans under the CMS Contract ID of H5928. These plans operate in Los Angeles County (Plan 004), Orange County (Plan 005), San Bernardino County (Plan 007) and San Diego County (Plan 009). This Model of Care is for the San Diego County Special Needs Plan only.

As defined by CMS, an "All Duals" Special Needs Plan is a SNP that has a State Medicaid agency contract to enroll all categories of Medicaid eligible individuals, who are also Medicare entitled, e.g., FBDE, QMB, QMB+, SLMB, SLMB+, QI and QDWI.

SNP Target Population 01 – Age Group by County – San Diego

AGE GROUP	Row Total	%	Cumul	Cumu %	San Diego
20-24	3	0%	3	0%	3
25-29	7	1%	10	1%	7
30-34	10	1%	20	2%	10
35-39	10	1%	30	3%	10
40-44	22	2%	52	5%	22
45-49	31	3%	83	7%	31
50-54	43	4%	126	11%	43
55-59	50	5%	176	16%	50
60-64	63	6%	239	21%	63
65-69	254	24%	493	44%	254
70-74	231	21%	724	65%	231
75-79	163	15%	887	80%	163
80-84	131	10%	1018	92%	131

85-89	64	5%	1082	97%	64
90-94	20	2%	1102	99%	20
95-99	10	1%	1112	100%	10
All Ages	1112				1,112

Notes: 44% of SNP population is under the age of 60. 3% (N=94) of population is age 85 or greater.

SNP_1 Target Population 02 – Age Group by Gender – San Diego

	Both M and F		San Diego	
AGE GROUP	Row Total	%	Total F	Total M
20-24	3	0%	0	3
25-29	7	1%	5	2
30-34	10	1%	2	8
35-39	10	1%	8	2
40-44	22	2%	8	14
45-49	31	3%	16	15
50-54	43	4%	21	22
55-59	50	4%	22	28
60-64	63	6%	38	25
65-69	254	23%	158	96
70-74	231	21%	141	90
75-79	163	15%	99	64
80-84	131	12%	85	46
85-89	64	6%	42	22
90-94	20	2%	17	3
95-99	10	1%	7	3
All Ages	1112	100%	669	443
% of Total			60%	40%

60% of the target population is female, 40% is male.

SNP Target Population 03a – Age Group by Primary Language – San Diego

AGE GROUP	Row Total	Arabic	Cambodian	Chinese	English	Laotian	Other Non-English	Spanish	Tagalog	UNK	Vietnamese
20-24	3				3						
25-29	7				3					4	
30-34	10				6			1		3	
35-39	10				3			3		4	
40-44	22				13			3		6	
45-49	31		2		16			7		6	
50-54	43				21			9		13	
55-59	50		1		16	2		19	1	11	
60-64	63		1		28	1		19		14	
65-69	254	1	1	1	65	1		143	1	41	
70-74	231		4	1	51	2		124	2	46	1
75-79	163	1	1		46	1		85	4	25	
80-84	131				23	2		74	1	31	
85-89	64		1		9		1	32	1	20	
90-94	20				9			7		4	
95-99	10				3			5		2	
All Ages	1112	2	11	2	315	9	1	531	10	230	1
% of Total		0.2%	1.0%	0.2%	28.3%	0.8%	0.1%	47.8%	0.9%	20.7%	0.1%

47.8% of the SNP target population has primary language as Spanish. The next highest Non-English percentage is Cambodian and then Tagalog. 20.7% of the population has an unknown primary language.

SNP Target Population 03b – County by Primary Language – San Diego

SERVICE AREA	Row Total	Arabic	Armenian	Cambodian	Cantonese	English	Korean	Laotian	Mandarin	Other Non-English	Other Sign Language	Spanish	Tagalog	Thai	UNK	Vietnamese
San Diego	1,112	2		11	1	315		9		1		531	10		231	1
% of Total		0%	0%	1%	0%	28%	0%	1%	0%	0%	0%	48%	1%	0%	21%	0%

There are 531 members with primary language as Spanish in San Diego County.

SNP Target Population 10a – County by Chronic Disease and Selected Conditions (Member Counts) – San Diego

SERVICE AREA	Total	NO_CHRONIC_DISEASE	CHRONIC_DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC_HEART_DISEASE	CHRONIC_RENAL_DISEASE	KIDNEY_TRANSPLANT	RHEUMATIC_DISORDER	LIVER_TRANSPLANT	ANY_TRANSPLANT

A															
San Diego	1,112	308	804	97	122	149	109	18	30	210	23	1	47	0	73
% of Total	100%	28%	72%	9%	11%	13%	10%	2%	3%	19%	2%	0%	4%	0%	7%

Notes: 72% (804) of the target population has one or more chronic disease diagnoses. 19% (210) have ischemic heart disease, 13% (149) have Cancer, and 11% (122) have COPD.

SNP Target Population 10a2– County by Chronic Disease and Selected Conditions (Incidence 2010) – San Diego

Number of members with selected conditions that are new for 2010.

SERVICE AREA	Total Members	NON CHRONIC DISEASE	CHRONIC DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC HEART DISEASE	CHRONIC RENAL DISEASE	KIDNEY TRANSPLANT	RHEUMATIC DISORDER	LIVER TRANSPLANT	ANY TRANSPLANT
San Diego	1,112	88	31	29	21	39	28	7	11	40	9	0	5	0	23

Notes: There are 31 members that have been newly diagnosed in 2010 with a chronic disease.
There are 39 members that have been newly diagnosed in 2010 with cancer.
There are 11 members that have been newly diagnosed in 2010 with Alzheimer's Disease.
There are 40 members that have been newly diagnosed in 2010 with ischemic heart disease..

SNP Target Population 10b – Age Group by Chronic Disease and Selected Conditions – San Diego

AGE_GROUP	Row Total	NO_CHRONIC_DISEASE	CHRONIC_DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC_HEART_DISEASE	CHRONIC_RENAL_DISEASE	KIDNEY_TRANSPLANT	RHEUMATIC_DISORDER	LIVER_TRANSPLANT	ANY_TRANSPLANT
20-24	3	2	1	0	0	0	0	0	0	0	0	0	0	0	0
25-29	7	3	4	0	0	0	0	0	0	0	0	0	0	0	0
30-34	10	5	5	0	0	1	0	0	0	0	0	0	0	0	0
35-39	10	2	8	0	1	2	1	0	0	1	0	0	0	0	0
40-44	22	5	17	1	1	2	3	0	0	1	0	0	0	0	1
45-49	31	11	20	3	5	4	3	0	0	3	0	1	2	0	2
50-54	43	10	33	3	10	7	2	1	0	2	1	0	0	0	2
55-59	50	14	36	4	6	4	3	2	0	8	0	0	3	0	3
60-64	63	14	49	4	9	7	6	0	2	8	0	0	4	0	2
65-69	254	85	169	20	28	32	16	3	3	46	7	0	13	0	14
70-	23	66	165	14	21	33	22	2	4	35	3	0	7	0	13

74	1														
75-79	163	39	124	23	28	20	17	3	7	48	4	0	5	0	10
80-84	131	32	99	13	13	21	22	4	4	33	4	0	9	0	14
85-89	64	11	53	12	4	13	12	3	4	20	3	0	2	0	10
90-94	20	5	15	1	0	2	2	1	4	4	0	0	1	0	0
95-99	10	2	8	0	0	2	1	0	2	2	1	0	2	0	2
Total	1112	306	806	98	126	150	110	19	30	211	23	1	48	0	73
% of Total		28%	72%	9%	11%	13%	10%	2%	3%	19%	2%	0%	4%	0%	7%

Notes: 72% (806) of the target population has one or more chronic disease diagnoses. 19% (211) have ischemic heart disease, 13% (150) have Cancer, and 11% (126) have COPD.

SNP Target Population 10b2 – Age Group by Chronic Disease and Selected Conditions (Incidence 2010) – San Diego

Number of members with selected conditions that are new for 2010.

AGE GROUP	Total	NO CHRONIC DISEASE	CHRONIC DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC HEART DISEASE	CHRONIC RENAL DISEASE	KIDNEY TRANSPLANT	RHEUMATIC DISORDER	LIVER TRANSPLANT	ANY TRANSPLANT
55-59	8	7	1	2	1	2	1	1	0	2	0	0	0	0	0
65-69	21	16	5	6	6	7	2	1	1	10	2	0	0	0	4
50-54	6	4	2	0	0	2	1	1	0	0	1	0	0	0	1
90-94	1	0	1	0	0	0	1	0	2	1	0	0	0	0	0
95-99	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
35-39	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
60-64	10	8	2	1	2	3	1	0	2	2	0	0	0	0	0
45-49	4	2	2	2	2	2	1	0	0	1	0	0	0	0	0
85-89	6	4	2	2	0	2	5	1	1	2	1	0	1	0	5
40-	3	2	1	0	0	0	0	0	0	0	0	0	0	0	0

44															
20-24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
80-84	13	10	3	4	2	5	6	2	0	6	0	0	1	0	6
30-34	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
25-29	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
75-79	18	14	4	8	5	6	8	1	2	10	3	0	1	0	2
70-74	27	19	8	4	3	9	2	0	3	6	1	0	1	0	5
	119	88	31	29	21	39	28	7	11	40	9	0	5	0	23
% of Total		74%	26%	24%	18%	33%	24%	6%	9%	34%	8%	0%	4%	0%	19%

Notes: 74% (88) of new members have one or more chronic disease diagnoses. 34% (40) have ischemic heart disease, 33% (39) have Cancer, and 18% (21) have COPD.

SNP Target Population 10c – Primary Language by Chronic Disease and Selected Conditions – San Diego

LANG_DESC	Total	NO_CHRONIC_DISEASE	CHRONIC_DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC_HEART_DISEASE	CHRONIC_RENAL_DISEASE	KIDNEY_TRANSPLANT	RHEUMATIC_DISORDER	LIVER_TRANSPLANT	ANY_TRANSPLANT
Arabic	2	0	2	0	1	0	1	0	0	0	0	0	0	0	0
Cambodian	11	2	9	1	1	1	1	1	0	1	0	0	0	0	0
Chinese	2	1	1	0	0	0	0	0	0	0	0	0	0	0	1
English	315	130	185	14	32	26	16	0	3	23	2	0	11	0	13
Laotian	9	1	8	0	0	0	0	0	0	1	0	0	0	0	0
Other Non-English	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Spanish	531	153	378	54	46	74	54	8	16	116	11	1	27	0	37
Tagalog	10	1	9	0	1	3	3	0	0	0	2	0	1	0	2
UNK	230	17	213	29	45	46	35	10	11	70	8	0	9	0	20
Vietnamese	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Z_Total	1112	306	806	98	126	150	110	19	30	211	23	1	48	0	73

Notes: 378 of the target population has one or more chronic disease diagnoses and has Spanish as primary language.

SNP Target Population 10c2 – Primary Language by Chronic Disease and Selected Conditions (Incidence 2010) - San Diego

Number of members with selected conditions that are new for 2010.

Lang Desc	Total	NO_CHRONIC_DISEASE	CHRONIC_DISEASE	CHF	COPD	CANCER	CEREBROVASCULAR	AMI	ALZHEIMER	ISCHEMIC_HEART_DISEASE	CHRONIC_RENAL_DISEASE	KIDNEY_TRANSPLANT	RHEUMATIC_DISORDER	LIVER_TRANSPLANT	ANY_TRANSPLANT
Arabic	2	2	0	0	1	0	1	0	0	0	0	0	0	0	0
Cambodian	7	6	1	0	0	0	1	0	0	0	0	0	0	0	0
Chinese	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
English	26	14	12	5	1	11	5	0	2	4	1	0	1	0	3
Laotian	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Spanish	53	41	12	19	10	20	16	2	5	29	3	0	4	0	12
Tagalog	1	1	0	0	0	1	0	0	0	0	1	0	0	0	1
UNK	27	21	6	5	9	7	5	5	4	7	4	0	0	0	6
Z_Total	119	88	31	29	21	39	28	7	11	40	9	0	5	0	23

SNP Target Population – Total Paid by Age Group and Service Area – San Diego

YOS	Age Group	Members	Total Paid	% of Paid	% of Members
2010	20-24	1	$6,219	0%	0%
2010	25-29	4	$15,140	1%	1%
2010	30-34	2	$949	0%	1%
2010	35-39	4	$13,771	1%	1%
2010	40-44	6	$24,406	1%	2%
2010	45-49	12	$63,809	3%	3%
2010	50-54	19	$156,850	6%	5%
2010	55-59	19	$235,783	10%	5%
2010	60-64	25	$123,421	5%	7%
2010	65-69	85	$461,679	19%	23%
2010	70-74	79	$477,014	20%	21%
2010	75-79	56	$431,712	18%	15%
20	80-84	35	$299,	12%	9%

10			647		
2010	85-89	19	$101,954	4%	5%
2010	90-94	3	$9,886	0%	1%
2010	95-99	2	$630	0%	1%
Total		371	$2,422,872	100%	100%

Notes: While age groups 70-74 and 75-79 are relatively over-represented in total paid amounts as compared to their percent of the total population, the distribution of costs appear to segment by their proportion of the total population.

SNP Target Population – Total Paid by Top Diagnosis Categories – San Diego

YOS	CATEGORY_2	Total Paid
2010	Trauma	$156,635
2010	Gastrointestinal	$140,179
2010	Arrhythmia Disorder	$128,891
2010	Septicemia	$116,992
2010	Neurologic Disorder	$105,962
2010	Osteoarthrosis	$104,298
2010	Bone or Joint Disorder	$85,505
2010	Opthalmologic	$79,689
2010	Diabetes	$73,324
2010	Cerebrovascular Disorder	$73,278
2010	CHF	$72,500
2010	Lower Respiratory	$71,176
2010	Cancer	$62,968
2010	Acute Ulcer/Peritonitis	$54,367
2010	Psychosis	$42,020
2010	Surgery Complication	$41,768
2010	Reproductive Female	$38,899
2010	Chest Pain	$37,074
2010	Ischemic Heart Disease	$36,403
2010	Dyspepsia	$35,835
2010	AMI	$34,674
2010	COPD	$34,498
2010	Acute Renal Disease	$33,738
2010	Cellulitis	$33,076

2010	Otologic	$25,477
2010	Infectious Disease	$24,392
2010	Pneumonia	$21,377
2010	Backache	$20,913
2010	Joint Pain	$20,046
2010	Urinary Tract Disorder	$19,612
2010	Cardiovascular	$19,097
2010	Abdominal Pain	$18,471
2010	Respiratory Disorder	$18,155
2010	Cardiomyopathy	$16,488
2010	Arteriovascular Disease II	$16,369
2010	Reproductive Male	$15,229
2010	Hypertension	$14,480
2010	Carditis	$12,897

Highest costs were incurred by diagnosis conditions relating to trauma, gastrointestinal, and septicemia diagnoses.

SNP Target Population – Top 40 Members by Total Paid 2010 – San Diego

RANK PAID	MEM NO	YOS	TOTAL PAID
1	873953*01	2010	$93,634
2	1003522*01	2010	$91,743
3	1074107*01	2010	$69,100
4	868574*01	2010	$60,025
5	866484*01	2010	$53,728
6	1003867*01	2010	$51,108
7	860505*01	2010	$50,263
8	889157*01	2010	$50,121
9	896638*01	2010	$48,153
10	1130974*01	2010	$44,882
11	1071685*01	2010	$40,457
12	860171*01	2010	$40,099
13	866912*01	2010	$36,614
14	896630*01	2010	$33,460
15	1009779*01	2010	$33,142
16	1084127*01	2010	$32,315
17	867521*01	2010	$32,140
18	996236*01	2010	$28,344
19	1073571*01	2010	$28,284
20	1038946*01	2010	$26,335
21	903819*01	2010	$25,785
22	883788*01	2010	$24,335
23	849662*01	2010	$23,891
24	862915*01	2010	$23,469
25	1110918*01	2010	$21,915
26	1111140*01	2010	$21,893
27	867789*01	2010	$21,235
28	1160913*01	2010	$20,826
29	849257*01	2010	$20,465
30	1152023*01	2010	$20,403
31	1078923*01	2010	$19,718
32	860129*01	2010	$19,638
33	905578*01	2010	$19,281
34	1116837*01	2010	$19,075

35	1078399*01	2010	$18,698
36	1079695*01	2010	$17,616
37	1112508*01	2010	$17,332
38	1117467*01	2010	$17,319
39	1175037*01	2010	$16,705
40	874439*01	2010	$16,397

All members paid claims totals are known and used for risk assessment, case management, and other interventions.

Element 2 – Measurable Goals

Describe specific goals

Care1st's Medicare SNP Model of Care in San Diego County, CA, is designed to meet the following goals:

1. **Improving access to essential services such as medical, mental health, substance use, social services, long term services and supports and home- and community-based services:**

- Care1st has established access to care standards to ensure members' accessibility to primary care, specialty care, behavioral health care, substance use, long term services and supports (LTSS) and home and community-based services (HCBS). These standards are distributed to the provider network annually and all PCPs and high volume specialist are audited annually. *(See attachment, Element 2, Factor A, 1-3,).* Behavioral Health Services are provided through an NCQA Accredited MBHO and they are delegated the responsibility for access to care studies, which are provided to Care1st and reported through our Medical Services Committee. Any Health services for members with Serious Mental Illness (SMI) and Substance Use which are not provided through our MBHO will be provided through the Behavioral Health Division of the San Diego County Health and Human Services Agency and its contracted clinics. The same access standards as referenced above will apply. LTSS, including HCBS, are provided through contracts with the existing organizations in the Aging and Independent Living network in San Diego County that have the expertise and track record to provide these services.
- Care1st conducts annual access to care audits to measure performance to standards and are analyzed for improvement opportunities *(see attachment Element 2, Factor A, 4).* Physician offices are audited compared to these standards, through survey and secret shopper
- analysis. Care1st performs an annual appointment availability audit of all PCPs and high volume specialists. High volume specialist is defined on our Availability of Specialist policy and procedure, which details they must have greater than 2% of the referral volume. Physicians that do not meet a 95% or higher compliance score on

audit are required complete a corrective action plan addressing the deficiency and they will be re-audited to document improvements.

- Care1st has a Nurse Advice toll free phone line 24 hours a day 7 days a week for members to contact for questions or how to access care. Providers are required to be available or have coverage 24 hours a day 7 days a week.
- Care1st utilizes grievance data and member satisfaction (CAHPS) data to further evaluate members experience with access to care *(see attachment Element 2, Factor A, 4).* Grievance data is annualized per 1000 members and is utilized to give validity to our audit results.
- Geographic standards are in place to ensure beneficiaries are appropriately assigned to practitioners and have the required access to PCP, specialty care, hospital and ancillary care. These specialized geographical standards are audited biannually using a Geo Access software system that maps out the coverage and measures compliance to identify opportunities for improvement *(see attachment Element 2, Factor A, 5).* Care1st P&Ps detail that we conduct these audits on all high volume specialties but we run the Geo Access on all specialty types to measure and monitor improvements. Geo Access mapping is done to measure that the PCPs, specialists, hospitals and ancillary service providers are within 15 miles or 15 minutes from the member home. Care1st has a goal to meet 95% compliance with all PCPs, high volume specialties, hospitals and ancillary services.
- Care1st Health Plan conducts Facility Site Reviews (FSR) on all our PCPs and high volume specialist. In addition to the routine FSR we also complete a Physical Accessibility Review Survey, which is not scored and a corrective action plan (CAP) is not required. Results of the Physical Accessibility Review Survey will be available to members on Care1st website. The website will display the level of access met per provider site as either Basic Access or Limited Access, and they can also qualify as meeting Medical Equipment Access as detailed in the table below. In addition results will include at a minimum whether each provider site has or does not have access in the following categories: parking, building exterior, building interior, waiting room/reception area, exam room, restroom and medical equipment (ex: height adjustable exam table and patient accessible weight scales).

Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.

This survey will be completed on all high volume specialist and ancillary service providers that provide care to a high volume Seniors and Persons with Disabilities (SPD) and Dual Eligible SNP members, in addition to PCP sites. Care1st will offer physical accessibility reviews to any provider that request to be evaluated *(see attachment Element 2, Factor A, 6).*

2. Improving access to affordable care:

- The appointment access and geographical availability standards address Care1st ability to provide affordable PCP, specialist, hospital and ancillary services to our target population. The specialized FSR enhancements focus on members with physical accessibility, where these needs are greater among our Dual Eligible SNP population.
- In addition to the access to care and geographical access standards, Care1st provides transportation services to beneficiaries to assist in promoting access to affordable care. Transportation is coordinated and utilization is monitored by the Member Services Department. The Member Services Department monitors beneficiaries' access to affordable care by evaluating member grievance reports to identify barriers to care as well as coordinating benefits to beneficiaries. In early 2010 the volume of members who needed transportation with a medical transportation service (gurney or wheelchair accommodations) increased and because we measure these

requests we were able to contract with additional transportation vendors that are able to accommodate the member's needs.

- Care1st Case Managers are trained and understand both Medicaid and Medicare product lines. Case Managers work collaboratively with the physicians, medical groups and regulatory agencies to assure continuity and coordination of benefits, assuring affordable care is provided to the member.
- Member grievance data is monitored, tracked and trended to identify any possible access to care or service related issues. These reports are supplied to our Medical Services Committee for discussion and action. These grievances are annualized per 1000 members, which allow us to measure improvement.

3. Improving coordination of care through an identified point of contact;

- The PCP is a gatekeeper for the member in providing their clinical care and medical needs. The PCP works with the Medical Group, Case Manager and Health Plan to coordinate care needs appropriately. Care1st measures the member satisfaction with the PCP through member satisfaction surveys. ..
- The Utilization Management Department provides Case Management services to the member, where a Case Manager (Nurse) is assigned to the member to coordinate care and services. The Case Manager works with the provider or medical group to fast track authorizations, assist in arranging care, and assure the coordination of the member's benefits (Medicare and Medicaid). The Case Manager will also refer the member to appropriate Disease Management Programs available to help the member learn about their medical problems, learn self-care strategies and identify opportunities to improve health outcomes. Care1st measures the satisfaction with Case Management and Disease Management services through member satisfaction surveys that measure member quality of life improvements.
- SNP Members are assigned to a Care Navigator, who is responsible to navigate them throughout the care continuum, including medical, behavioral health, long term services and supports (LTSS) and home- and community-based services (HCBS). For duals members residing in senior affordable housing that have on-Service Coordinators, the Service Coordinators will be invited to be part of the plan's ICT, to assist with conducting in-home assessments, provide ongoing

monitoring of members' health and functional status, and to provide assistance with care transitions. Care1st goal is for the Care Navigator to develop a strong relationship with the member so they feel confident we will provide them with the appropriate information and services. The member can contact their assigned Care Navigator with any issue and they will work with the appropriate department or entity to resolve or provide the information to the member (i.e. authorization, transportation, translation, grievances, provider issues, claims, etc.). Care1st will measure the success of this concept through member satisfaction surveys

- The Quality Improvement Department conducts annual continuity and coordination of care studies that measure specific aspects of care. Examples of recent studies include documented follow-up with the member on lab or diagnostic study results and documented communication from the specialist to the PCP on status and care plan.

4. Improving seamless transitions of care across healthcare settings, providers, including Long-Term Services and Supports and Home- and Community-based Services

- The Care1st Care Transition Team contacts beneficiaries during planned and unplanned transitions of care. The primary purpose is to ensure the beneficiary understands the transition process, to assist in coordination of care and services and timely notification to the beneficiaries' primary care physician. The beneficiaries are followed by the Care Transition Team from their usual setting of care and throughout the transition of care. The required elements for the programs processes are captured in the Care Enhance Clinical Management Software (CCMS). Effective measurement reports are generated to analyze for improvement opportunities and presented to the Medical Services Committee *(see attachment Element 2, Factor A, 7).*
- All members that have been admitted to the hospital will have inpatient case management and discharge planning. The Care1st Case Manager works to transition the member from the inpatient setting to skilled nursing or home depending upon needs and member preferences. If the member's preference is to receive services in his or her home versus skilled nursing care, the Case Manager and/or Care Navigator will work with its partners providing LTSS and HCBS, to provide services in the home, i.e., IHSS, home-

delivered meals, etc., and other social services supports, as appropriate, and completes a medication reconciliation with the member and PCP to assure continuity and coordination of care is established. This is measured through the Medication Reconciliation Post Discharge HEDIS measure and evaluation of re-admissions per 1000.

5. Improving access to preventive health services

- Care1st provides members with required and pending preventive health services information at several points of service where the member would access health care services. These points of service includes the following:
    - Member required and pending preventive health services are posted on the Care1st provider web portal. This data is updated monthly and the beneficiaries' practitioner has the ability to update the posted data and communicate this to Care1st. When the provider office prints the eligibility check the required preventive services are posted on the printout as well, reminding the physician to complete these services.
    - The Care1st Member Services representatives have access to the beneficiaries' preventive health information, which is populated on their member service screens. This information is updated monthly and the representative will review and reinforce the importance of completing these preventive services. The Member Services Representative will assist the member in scheduling appointments and transportation if needed to ensure access to preventive health services.
    - Beneficiaries are mailed an annual newsletter that contains preventive health guidelines information. In addition, members that have not complete these required preventive services by August will be mailed a reminder in September from Care1st that preventive services are still due. The member is provided with a toll free phone number to contact us and we will help them schedule the appointment for the service.
    - Practitioners receive Profile Reports demonstrating their compliance to required preventative health services for their beneficiaries *(see attachment Element 2, Factor A, 8).*
- All of the above interventions are measured through HEDIS measures, which are completed and audited annually.

6. Improving access to Long-Term Services and Supports and Home- and Community-based Services

Care1st has a partnership with the Adult and Independent Services (AIS) and its contracted providers, to provide LTSS and HCBS in the home for complex care members with unmet long-term care needs. Members are identified as having potential social services needs through the following: health risk assessments (HRAs), concurrent inpatient rounds, case management, interdisciplinary care team (ICT) referrals, and provider and member referrals. Once a beneficiary is identified as at-risk, the plan will send a Case Manager to the member's home to perform a comprehensive in-home assessment, which looks at financial need, activities of daily living, orientation, behaviors, environmental problems/barriers, medications, medical and behavioral health conditions, nursing services and treatment, fall risk assessment , and nutritional status. The assessment identifies members that may qualify for CBAS, LTSS and HCBS through including but not limited to: transportation, home care, counseling, legal assistance, home making /chore assistance, home delivered meals, benefits assistance program, and a family caregiver support program. The information from the assessment and qualifications for additional services is provided to the member's ICT. The ICT will develop or update individualized care plans (ICP) and define member goal setting; identify education for member self care skills and monitor defined outcomes. Outcomes are defined as: reduction in inpatient stays, reduction in emergency room visits, reduction in skilled nursing facility stays and an increase in medication compliance. The plan will continue to monitor the member on an ongoing basis, and will conduct a follow up assessment within six months of the interventions to determine improvements in the member social and long-term care needs status.

7. Assuring appropriate utilization of services

- The Care1st Care Transition, Complex Case Management, Inpatient Case Management and Social Services staff oversee the care of the SNP beneficiary during any transition of care. Their collective integrated responsibilities for assuring appropriate utilization of services include ensuring the beneficiary or responsible party is informed of their health status, access to and coordination of available care and services, coordination with practitioners' plan of care, researching community resources, transportation, assistance

with authorization referrals, coordinating services with the beneficiaries' medical group *(see attachment Element 2, Factor A, 7).*

8. Improving beneficiary health outcomes (specify MAO selected health outcome measures)

Below are outcome measures for the SNP population:

Clinical Improvement- HEDIS

- Annual Monitoring of Persistent Medications (MPM)
- Care for Older Adults (COA)
- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Glaucoma Screening (GSO)
- Medication Reconciliation Post Discharge (MRP)
- Use of High Risk Medications in the Elderly (DAE)

Clinical and Service Improvement- Potential Quality Issue (PQI) Reviews

Accessibility to Care and Service

- Appointment Availability
- After Hours Availability
- Primary Care Practitioner (PCP) Geographical Availability
- Specialist Geographical Availability
- Hospital and Ancillary Care Geographical Availability
- Physical Accessibility Review Survey

Member Satisfaction

- Member Grievances
- Member Satisfaction

Element 2, Factor B

Describe the goals as measureable outcomes and indicate how MAO will know when goal is met

All measures described above will be analyzed on an annual basis. A comprehensive qualitative and quantitative analysis will be done. Goals for

each of these measures will be established by the Medical Services Committee.

All of the measurable outcome goal benchmarks described below are based on 2010 Reporting year data. All measurable outcome goals described below will be based on 2011 reporting year.

Clinical Improvement- HEDIS Annual Monitoring of Persistent Medications (MPM)-

i. Care1st has experienced improvements with SNP SD.
ii. Goal to improve the SNP SD by 10 percentage points.

- Care for Older Adults (COA)-
  i. We exhibited improvement with SNP SD plan for the Advanced Directive measure and have set a goal to improve by 25 percentage points.
  ii. We exhibited improvement with SNP SD plans for the Functional Assessment measure and have set a goal to improve by 25 percentage points.
  iii. We exhibited a decline for SNP SD for the Pain Assessment measure and have set a goal to improve by 25 percentage points.
  iv. We exhibited improvement with SNP SD for the Medication Reconciliation measure and have set a goal to improve by 15 percentage points.
- Colorectal Cancer Screening (COL)-
  i. For SNP SD 2010 was the first year we reported this measure. We met 50th percentile and have set a goal to increase the rate by 10 percentage points.
- Controlling High Blood Pressure (CBP)-
  i. SNP SD revealed a slight decrease in rate (not significant) and we met the 25th percentile, we have set our goal to increase our rate by 5 percentage points.
- Glaucoma Screening (GSO)-
  i. SNP SD has a baseline rate of 47.7%, which is below the 25th percentile. We have set a goal to reach the 25th percentile and a 10 percentage point increase.

- Medication Reconciliation Post Discharge (MRP)-
    i. SNP SD revealed significant increases from 2009 to 2010 (P= <0.05)
    ii. We have set our goals to increase the rate for SNP SD by 5 percentage points.
- Use of High Risk Medications in the Elderly (DAE)-
    i. There are two measures for this measure, one high risk medication and two high risk medications. The lower the rate the better. We have seen a decrease in rate for SNP SD Our goal is to sustain the rate for SNP SD.
    ii. We have seen an increase in rate for SNP SD. We have set our goal to decrease our rate for SNP SD by 2 percentage points.

Clinical and Service Improvement- Potential Quality Issue (PQI) Reviews

1. We review all Potential Quality Issues (PQIs) and keep them in a tracking and trending database. We have seen a significant decrease in member generated and sentinel event related PQIs.
2. We will continue to monitor these through routine review and have set goals to improve member satisfaction by identifying trend issues with member generated grievances and providing process improvements.
3. *Attachment Element 2, Factor A, 9* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.

Accessibility to Care and Service Measureable Outcomes and Goals

- Appointment Availability
    i. Measured through survey and secret shopper audits with a requirement for the providers to meet 95% compliance rates.
    ii. *Attachment Element 2, Factor A, 4* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.

iii. Member grievances and CAHPS survey results are also analyzed and included on the overall measurement of these standards.

- After Hours Availability
  i. Measured through secret shopper audits with a requirement for the providers to meet 100% compliance with providing after hours coverage and assuring emergency instructions are given to members if they have a recorded answering service.
  ii. *Attachment Element 2, Factor A, 4* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.
  iii. Member grievances and CAHPS survey results are also analyzed and included on the overall measurement of these standards.
- Primary Care Practitioner (PCP) Geographical Availability
  i. Measured through Geo Mapping software programs every six months with a requirement for Care1st to meet 95% compliance with coverage within 15 miles of members home for all PCPs.
  ii. *Attachment Element 2, Factor A, 5* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.
  iii. Member grievances and CAHPS survey results are also analyzed and included on the overall measurement of these standards.
- Specialist Geographical Availability
  i. Measured through Geo Mapping software programs every six months with a requirement for Care1st to meet 95% compliance with coverage within 15 miles of members home for all high volume specialists.
  ii. *Attachment Element 2, Factor A, 5* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.
  iii. Member grievances and CAHPS survey results are also analyzed and included on the overall measurement of these standards.

- Hospital and Ancillary Care Geographical Availability
    i. Measured through Geo Mapping software programs every six months with a requirement for Care1st to meet 95% compliance with coverage within 15 miles of member's home for all hospitals and ancillary service providers.
    ii. *Attachment Element 2, Factor A, 5* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.
    iii. Member grievances and CAHPS survey results are also analyzed and included on the overall measurement of these standards.
- Physical Accessibility Review Survey
    i. Measured through an on-site audit of PCP, high volume specialist and ancillary service providers. Physical site audit is completed when provider is first contracted and every three years thereafter. Results are posted on the website for members to review and compare.
    ii. *Attachment Element 2, Factor A, 6* is a copy of the actual audit tool used for these reviews.

- Member Grievances
    i. Measured by the utilization of database to track and trend member grievances and we use an annualized per 1000 comparisons to profile providers and medical groups for interventions.
    ii. *Attachment Element 2, Factor A, 10* details the most current outcomes analysis with key findings, goals, interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.
- Member Satisfaction
    i. Measured through CAHPS survey and scored in cohorts and individually by question. Our goal is to meet at least the 50th percentile of the national rates.
    ii. *Attachment Element 2, Factor A, 10* and *Attachment Element 2, Factor A, 11* details the most current outcomes analysis with key findings, goals,

interventions, quantitative and qualitative analysis, and follow-up actions taken or planned.

Element 2, Factor C

Discuss actions that will be taken if goals are not met in the expected timeframe

In case individual measures do not meet goal, there will be a root cause analysis made. Any program changes that are needed will be presented to the Medical Services Committee for approval.

Clinical Improvement- HEDIS Measures (MPM, COA, COL, CBP, GSO, MRP AND DAE):

- Specific measureable goals have been established and described above.
- All of these measures are conducted annually
- If goals are not met Care1st will complete a written action plan that details current interventions, evaluation of any new interventions and re-establishing an appropriate new goal for improvement. Previously used corrective action plan included incentives to providers for specific measures in order to improve compliance. In addition when individual goals have not been met for specific measures a targeted outreach to members has been instituted which consisted of telephonic and mail outreach, facilitating appointments and transportation for preventive visits or testing.
- The written action plan is presented to the Medical Services Committee and through this committee to the Board of Directors for recommendations and approval.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.

Clinical and Service Improvement- Potential Quality Issue (PQI) Reviews

- Specific measureable goals have been established and described above.

- The annualized per 1000 analysis is conducted and reported to the Medical Services Committee (and through this committee to the Board of Directors) quarterly.
- All individual quality issues identified with each review has an individual corrective action plan completed to close the investigation and review process. Each case is given a severity level which is entered into out database for tracking and trending purposes.
- Providers or medical groups where trends have been identified (higher rates annualized per 1000) are given education and are required to submit a corrective action plan on how they will improve the identified trend.
- If goals are not met Care1st will forwards individual providers to the Peer review/Credentialing Committee for recommendation and action. The Committee can take actions such as requiring CME up to termination of their contractual agreement.
- If goals are not met Care1st will forwards Medical Group trends to the Board of Directors for recommendation and action. The Board can take actions such as requiring de-delegation up to termination of their contractual agreement.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.

Accessibility to Care and Service- Appointment availability, After hours availability, Geographical availability (PCP, Specialist, Hospital and Ancillary services), and Physical accessibility:

- Measured through survey and secret shopper audits with a requirement for the providers to meet specified compliance rates.
- Each provider that does not meet compliance with these standards must complete an individual corrective action plan (in writing) that addresses how they will correct the deficiency and timeframes for completion.
- Care1st will re-audit each provider that completes a CAP to document improvements.
- Providers who fail to submit a CAP or correct the issues identified are forwarded to the Credentialing Committee for

recommendations and corrective actions up to termination of their contract.

- Geographical mapping study results are provided to the Provider Network Operations (PNO) department for follow-up and actions. The PNO department works to contract with additional physicians, specialists, hospital and ancillary service providers to cover gaps identified with the study. Areas not meeting the 95% compliance rate must have an action plan that addresses how Care1st will meet member needs. For example: we have a remote area that does not have specific specialty types available within the distance requirements. Care1st has an action plan that provides free transportation to members needing these specialty types that are not available near their home.
- The Physical Accessibility Review Survey is not scored and there is no CAP process. Providers that do not meet specific needs for members are identified on our website for members to evaluate and compare. This process allows members to choose a provider that best fits their needs.

Member Satisfaction

- Each member grievances is reviewed and investigated individually and a severity level is applied to the case.
- Each case where a quality issue has been identified the provider or medical group is required to submit a written corrective action plan that addresses the issue identified.
- All cases are trended and annualized per 1000 comparisons are presented to the Medical Services Committee for recommendations and action.
- Providers or medical groups where trends have been identified (higher rates annualized per 1000) are given education and are required to submit a corrective action plan on how they will improve the identified trend.
- If goals are not met Care1st will forwards individual providers to the Peer review/Credentialing Committee for recommendation and action. The Committee can take actions such as requiring CME up to termination of their contractual agreement.

- If goals are not met Care1st will forwards Medical Group trends to the Board of Directors for recommendation and action. The Board can take actions such as requiring de-delegation up to termination of their contractual agreement.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.
- We also utilize the CAHPS survey to measure member satisfaction, which is scored with specific cohorts groups and individually by question.
- When specific cohorts or questions are indentified as not meeting our goals of improvement these results are presented to the Quality Improvement Activity Steering Committee (QIASC) for recommendations and actions. The QIASC is a sub-committee of the Medical Services Committee and through this Committee reports are given to the Board of Directors.
- The QIASC has representatives from all departments within Care1st Health Plan because most interventions aimed at improving member satisfaction requires interdepartmental interface to accomplish. For example: We established the Primer Member Services department, where Medicare SNP members have a specific Member Services representative assigned to them to develop a strong working relationship and serves as a gatekeeper for the members in accessing the plans services. This was established due to corrective action recommendations based on CAHPS survey results through this committee.
- If we do mot meet our goals of improvement with the CAHPS survey we will follow the process and re-establish new interventions and goals.

Care1st Health Plan has a continuous quality improvement process in place and we conduct a root cause analysis to identify barriers to meeting our goals. Prioritized action plans are developed to address the barriers identified and are reported to the Medical Services Committee for review, recommendations and approval.

Interventions will be implemented, measured, and evaluated for the effectiveness and metrics will be in place to continually measure improvement and if goals are met. Most measures are re-measured on an annual basis.

The below is an example of the Medical Services Committee agenda, which details the types of SNP population projects and measures that are being tracked continuously.

CARE 1ST HEALTHPLAN

Medical Services Quarterly Committee Meeting

February 23, 2011

AGENDA

I. Call to Order

II. Old Business **David Wedemeyer**

A. PSS Survey Project Incentive
B. Provider Portal Enhancements- Demo
C. State Collaborative – ER –verbal update

III. Review and Approval of December 14, 2010 Minutes **1 min**

IV. Annual Confidentiality Statements

V. Quality Management - David Wedemeyer, Associate VP of Quality Imp.

A. 2010 4th Quarter Report **15 min.**
- Grievance/PQI Report
- FSR Report
- Credentialing Report

B. Annual Evaluation Report
- LA/SD Medi-cal
- LA/SD Medicare
- Healthy Families

C. 2011 Program Description/ Work Plan **15 min.**
- LA/SD Medi-cal
- LA/SD Medicare
- Healthy Families

D. P&P Updates/Annual Approvals

E. QI Updates
- NCQA Update
- Provider Satisfaction Survey Update – Web portal demo
- HCC & Quality Outreach
- CAHPS Update

F. Organizational Chart
- Committee Structure
- QI Outreach Departments

G. Continuity of Care (Lab & Radiology 2nd Year Validation)

H. State Collaborative QIA Project Updates **10 min.**
- ER Collaborative Update
- Aware/URI Collaborative Update

I. QM Sub-Committee Minutes for Review and Approval **1 min.**
- Credentialing Minutes
- Peer Review Minutes

VI. Utilization Management - Josie Wong, VP of Medical Services

A. 2010 4th Quarter/Annual UM Evaluation Report **5 min.**

B. 2010 4th Quarter IPA Oversight Reports **2 min.**
- Audit Results
- Denial Oversight

C. 2011 UM Criteria Approval **2 min.**
- 2011 Milliman Care Guidelines – 13th Edition, 2009
- 2011 Apollo's Medical Review Criteria Guidelines – 7th Edition, 2008
- UpToDate
- Nelson Textbook of Pediatrics
- Ingenix Current Procedural Coding Expert (CPT Codes)
- 2010 UM Disclosure Log

D. 2011 UM Program **2 min.**

E. 2011 UM Work Plan **2 min.**

F. 2011 UM Policies and Procedures **2 min.**

G. UM Special Programs - **Robert Feldman, Dir of Medical Services** **5 min.**
- Model of Care
- 2011 Case Management Program
- 2011 Complex Case Management Policies and Procedures
- Complex Case Management Reports
- Disease Management
  - i. 2010 4th Quarter/Annual DM Evaluation Report
  - ii. 2011 Disease Management Program
  - iii. 2011 DM Policies and Procedures
  - iv. Clinical Guidelines
  - v. DM Reports
- Nurse Advice Line

VII. Health Education - Linda Fleischman, Health Education Manager

A. Year End HE Evaluation **5 min.**

B. 2011 HE Work Plan **5 min.**

C. 2011 HE Program **5 min.**

	D. 2011 HE Policies and Procedures	**5 min.**
	E. Year End CLAS Evaluation	**5 min.**
	F. 2011 CLAS Work Plan	
	G. 2011 CLAS Program	**5 min.**
	H. CLAS Policies and Procedures	**5 min.**
VIII.	**New Business**	
VIV.	**Next Meeting**	

Below are examples of quality improvement projects and measures we track on a continuous basis.

Examples of measures we continuously monitor and provide analysis on include but are not limited to:

Clinical Improvement- HEDIS Measures (MPM, COA, COL, CBP, GSO, MRP AND DAE):

- Specific measureable goals have been established and described above.
- All of these measures are conducted annually
- If goals are not met Care1st will complete a written action plan that details current interventions, evaluation of any new interventions and re-establishing an appropriate new goal for improvement. Previously used corrective action plan included incentives to providers for specific measures in order to improve compliance. In addition when individual goals have not been met for specific measures a targeted outreach to members has been instituted which consisted of telephonic and mail outreach, facilitating appointments and transportation for preventive visits or testing.
- The written action plan is presented to the Medical Services Committee and through this committee to the Board of Directors for recommendations and approval.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.

Clinical and Service Improvement- Potential Quality Issue (PQI) Reviews

- Specific measureable goals have been established and described above.
- The annualized per 1000 analysis is conducted and reported to the Medical Services Committee (and through this committee to the Board of Directors) quarterly.
- All individual quality issues identified with each review has an individual corrective action plan completed to close the investigation and review process. Each case is given a severity level which is entered into out database for tracking and trending purposes.
- Providers or medical groups where trends have been identified (higher rates annualized per 1000) are given education and are required to submit a corrective action plan on how they will improve the identified trend.
- If goals are not met Care1st will forwards individual providers to the Peer review/Credentialing Committee for recommendation and action. The Committee can take actions such as requiring CME up to termination of their contractual agreement.
- If goals are not met Care1st will forwards Medical Group trends to the Board of Directors for recommendation and action. The Board can take actions such as requiring de-delegation up to termination of their contractual agreement.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.

Accessibility to Care and Service- Appointment availability, After hours availability, Geographical availability (PCP, Specialist, Hospital and Ancillary services), and Physical accessibility:

- Measured through survey and secret shopper audits with a requirement for the providers to meet specified compliance rates.
- Each provider that does not meet compliance with these standards must complete an individual corrective action

plan (in writing) that addresses how they will correct the deficiency and timeframes for completion.

- Care1st will re-audit each provider that completes a CAP to document improvements.
- Providers who fail to submit a CAP or correct the issues identified are forwarded to the Credentialing Committee for recommendations and corrective actions up to termination of their contract.
- Geographical mapping study results are provided to the Provider Network Operations (PNO) department for follow-up and actions. The PNO department works to contract with additional physicians, specialists, hospital and ancillary service providers to cover gaps identified with the study. Areas not meeting the 95% compliance rate must have an action plan that addresses how Care1st will meet member needs. For example: we have a remote area that does not have specific specialty types available within the distance requirements. Care1st has an action plan that provides free transportation to members needing these specialty types that are not available near their home.
- The Physical Accessibility Review Survey is not scored and there is no CAP process. Providers that do not meet specific needs for members are identified on our website for members to evaluate and compare. This process allows members to choose a provider that best fits their needs.

Member Satisfaction

- Each member grievances is reviewed and investigated individually and a severity level is applied to the case.
- Each case where a quality issue has been identified the provider or medical group is required to submit a written corrective action plan that addresses the issue identified.
- All cases are trended and annualized per 1000 comparisons are presented to the Medical Services Committee for recommendations and action.
- Providers or medical groups where trends have been identified (higher rates annualized per 1000) are given education and are required to submit a corrective action plan on how they will improve the identified trend.

- If goals are not met Care1st will forwards individual providers to the Peer review/Credentialing Committee for recommendation and action. The Committee can take actions such as requiring CME up to termination of their contractual agreement.
- If goals are not met Care1st will forwards Medical Group trends to the Board of Directors for recommendation and action. The Board can take actions such as requiring de-delegation up to termination of their contractual agreement.
- All key findings, goals, interventions, qualitative and quantitative analysis and action plans are formally summarized in our annual evaluation each year.
- We also utilize the CAHPS survey to measure member satisfaction, which is scored with specific cohorts groups and individually by question.
- When specific cohorts or questions are indentified as not meeting our goals of improvement these results are presented to the Quality Improvement Activity Steering Committee (QIASC) for recommendations and actions. The QIASC is a sub-committee of the Medical Services Committee and through this Committee reports are given to the Board of Directors.
- The QIASC has representatives from all departments within Care1st Health Plan because most interventions aimed at improving member satisfaction requires interdepartmental interface to accomplish. For example: We established the Primer Member Services department, where Medicare SNP members have a specific Member Services representative assigned to them to develop a strong working relationship and serves as a gatekeeper for the members in accessing the plans services. This was established due to corrective action recommendations based on CAHPS survey results through this committee.
- If we do mot meet our goals of improvement with the CAHPS survey we will follow the process and re-establish new interventions and goals.

Element 3 – Staff Structure and Care Management Roles

Each department at Care1st Health Plan is involved in supporting and/or directly participating in the Model of Care. An organization chart with emphasis on Medicare responsibilities is included as an exhibit. (*Please refer to attachment Element 3)*

Element 3, Factor A

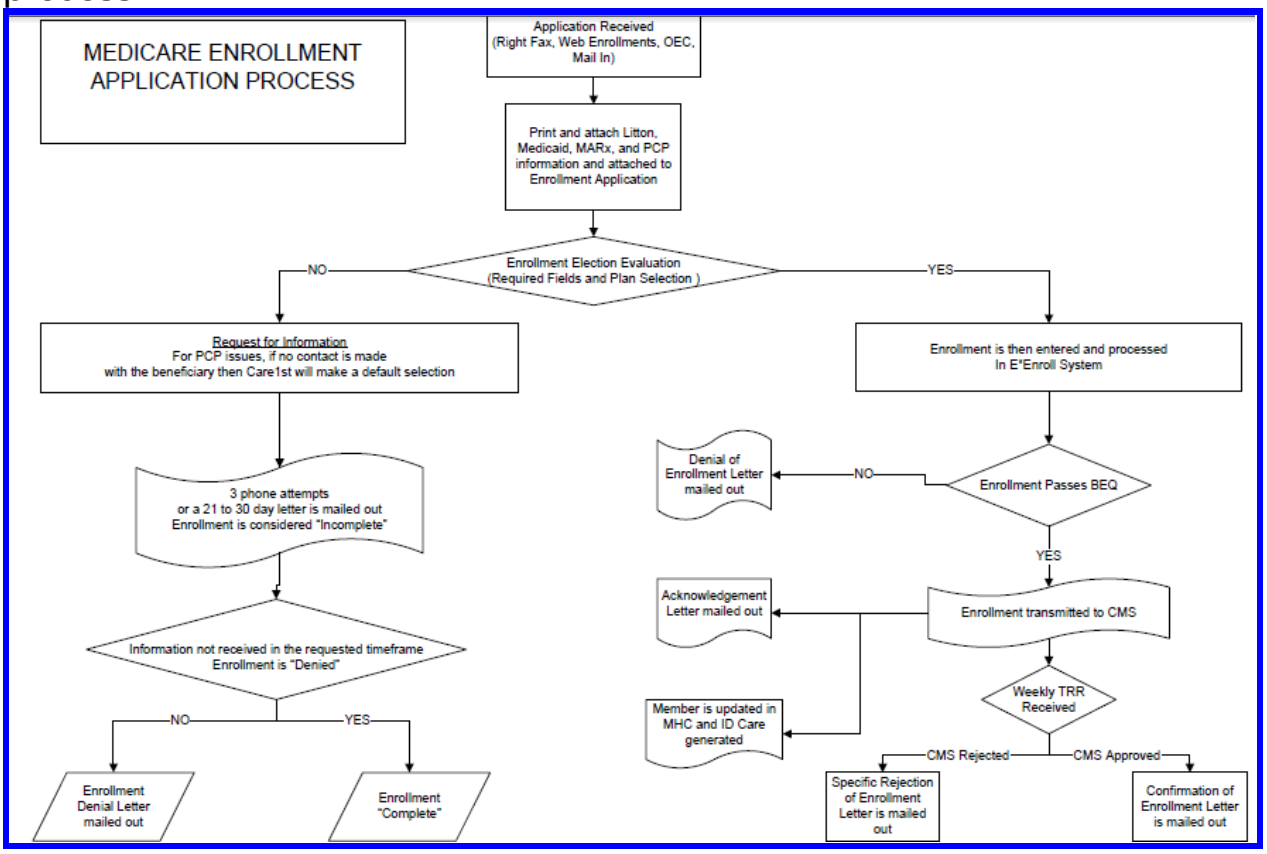
Identify the specific employed or contracted staff competent to perform administrative functions.

Administrative support starts with the beneficiary enrollment process. Care1st Marketing and Medicare Enrollment teams are instrumental in ensuring that beneficiaries who select Care1st Health Plan's Dual-Eligible SNP meet the eligibility criteria.

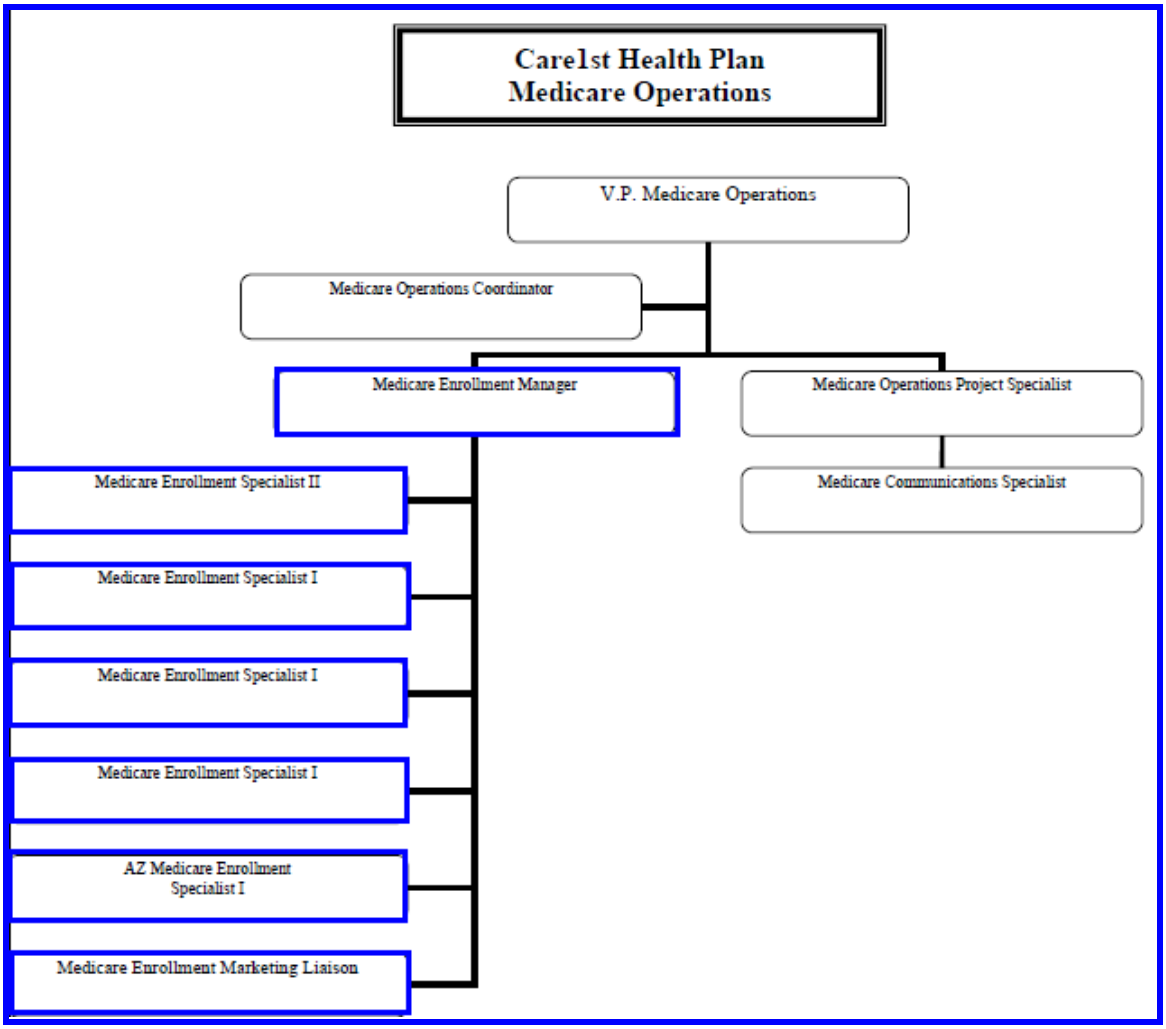
Care1st's Medicare Marketing Department is led by a Vice President of Marketing and Sales. Additionally, we have two Medicare Marketing Managers. One manager is responsible for overseeing employed internal sales agents. The second manager oversees the external sales agencies. The Marketing Management's responsibility is to train, educate and monitor the sales process to ensure that all activities are conducted in accordance with CMS requirements. Care1st believes that it is very important to assure that the benefit plan is clearly explained to the beneficiary and that the decision to select Care1st Health Plan's SNP for their healthcare insurance is a choice that suits the beneficiaries' needs. Care1st employs twelve internal Medicare sales agents and is contracted with twelve external Field Marketing Organizations. Agent certification training sessions are conducted throughout the year and include presentations by the Marketing Manager and Care1st's Compliance Officer.

Coupled with the efforts of the Marketing team, Care1st's Medicare Enrollment team evaluates each application to validate the beneficiaries' eligibility to enroll in Care1st Health Plan's Dual-Eligible SNP plans. Validation includes, but is not limited to, verification of Medicaid and Medicare eligibility. The Medicare Enrollment Department is comprised of a Manager and four Enrollment Specialists. The Medicare Enrollment Manager is responsible for monitoring changes in CMS enrollment guidance and providing enrollment training to the Medicare Enrollment, Medicare Marketing, and Medicare Member Services staff.

The following flow sheet illustrates the Medicare Enrollment application process.



The following is the organizational chart for the Medicare Enrollment Department.



Job description of staff involved in the processing of Medicare applications:

1. Manager Medicare Enrollment -
    - Review incoming enrollment data to ensure accuracy in processing and timeliness in accordance with regulatory guidelines
    - Actively monitor and audit production, quality and timeliness of data
    - Provide monthly reconciliation efforts to identify and resolve discrepancies in enrollment records
    - Assure that all enrollment process schedules are met
    - Provide oversight to member verification and member retention programs in order to aid in the retention of members by educating them about their enrollment, Plan benefits and processes and resolution of issues prompting requests to cancel their membership
    - Generate accurate member correspondence notifications in conjunction with regulatory guidelines in a timely manner
    - Provide oversight on the management of member documents in accordance with regulatory guidelines.
    - Responsible for maintaining knowledge and understanding of current Medicare guidance and regulations.
    - Responsible for coaching and training Medicare Enrollment personnel.
    - Responsible for implementing Care1st policies and procedures.
    - Responsible for interacting with other departments to resolve Medicare Enrollment issues.
    - Responsible for maintaining the Medicare Enrollment Department performance objectives.
    - Responsible for informing the V.P. of Pharmacy & Medicare Operations of all unresolved issues or questions and act as facilitator to resolve them.

2. Medicare Enrollment Specialist II -
    - Reconciliation of monthly CMS Reply Report, analyzing each section of the report, including enrollments and disenrollments, CMS facilitated transactions, special status codes, and state county code transactions. Analyze and update member records. Contact members to obtain information necessary to resolve discrepancies. Generate and process appropriate letters.

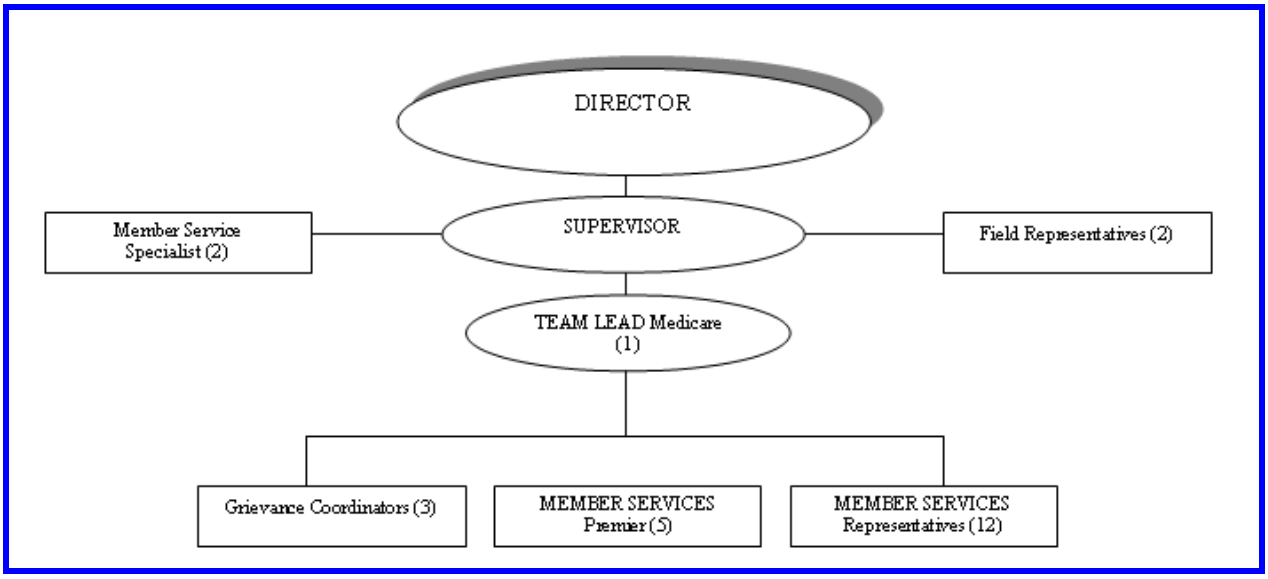
- Analyze and resolve monthly rejection report, contact enrollees, update system and generate appropriate letters accurately and timely.
- Analyze and resolve all exception reports, including enrollment database transactions.
- Address all calls from members requesting disenrollment. Generate necessary letters in a timely manner.
- Responsible for accurate processing of retroactive requests for disenrollment. Gather appropriate documentation, contact members and thoroughly prepare correspondence to be sent to regulatory agencies.
- Interface with Member Services Call Center to assist with discrepancies in regards to enrollments and disenrollments.

3. Medicare Enrollment Specialist I -
    - Analyze and process incoming Medicare enrollment requests. Responsible for reviewing accuracy of application information, verifying eligibility and processing applications into the enrollment database.
    - Contact members to resolve discrepancies.
    - Interface with Medicare Marketing to ensure all applications are accurate and complete.
    - Send regulatory required member notifications related, but not limited to enrollment and disenrollment transactions, late enrollment penalty, and low-income subsidy letters.

Following the enrollment process, Care1st's Medicare Member Services team reaches out to the beneficiaries to welcome them to Care1st Health Plan. Their goal is to introduce Care1st's Premier Member Services Program and assist the beneficiary with the plan transition, ensure that they understand how to use their benefit and access services and answer any questions. In particular, the focus for the dual-eligible population is explaining how to coordinate their Medicaid and Medicare benefits so that they may appropriately utilize the services that are available. The Care1st Premier Member Services Program is designed to provide the member with a personal plan advocate. The member has the option of contacting the plan advocate directly. This individual understands the member's particular needs and concerns. The Medicare Member Services Department is overseen by the Director of Member Services and a Medicare Supervisor.

There are five member service representatives in the Medicare Premier Member Services Division and an additional twelve Medicare Member Service Representatives in the general call center. Should the call volume require additional support, all Care1st's Member Service Representatives are trained on the Medicare benefit and can assist with calls. The total number of Member Service Representatives available to assist our members is fifty-five.

The following is the organizational chart and the job descriptions for the Medicare Member Services Department.



1. Member Services Director: Responsible of development and implementation of an effective Member Services Department, providing staff with the tools to efficiently respond to member inquiries and complaints in culturally sensitive and linguistically competent manner.

2. Member Services Supervisor: Assists with the over-site of the department including assistance with the coordination of member care, continuity of care, access, eligibility, and assignment/disenrollment issues. In addition, the Supervisor is responsible for ensuring adequate staff coverage at all times as well as other duties as required by the Director of Member Services.

3. Member Services Specialists: Responsible for ensuring the delivering of high quality customer service to Plan members reviewing and auditing

call center process and procedures by listening to recorded calls. In addition to providing detailed reports showing results of the audit and providing corrective action plans.

4. MS Field Representative: Responsible for educating new members and maintaining individuals in the Care1st Health Plan program by providing them with the tools that allow them to access care. Responsible for representing the Plan at all times and when needed in Public events.

5. Team Lead: With the supervisor guide, Team Lead is responsible to provide support and guidance to Call Center staff by giving direction and assistance to resolve issues.

6. Member Services Premier: Responsible for delivering high personalized quality customer service in an efficient, effective and timely manner promoting a positive image to Plan members, providers and Plan personnel.

7. Member Services Representative: Acts as a liaison between plan and members efficiently assisting and guiding them to navigate the system, in addition to assist members with inquiries related to their benefits, eligibility, and access to care.

8. Grievance Coordinator: Reviews, process and resolves all member grievances/complaints related to quality of care and or service adhering to regulatory agencies guidelines. In addition to report, track and trend issues to prevent future complaints.

In line with Care1st's commitment to provide support for our members, Care1st's Grievance is structured under the Director of Member Services. Thus, we are able to carefully track and trend all member calls to monitor and detect issues that may require process improvements. There is a Grievance lead and two Grievance coordinators who are responsible for acknowledging and resolving all member grievances in compliance with CMS guidelines and timeframes. Communication with the beneficiaries is conducted telephonically and by formal written notification.

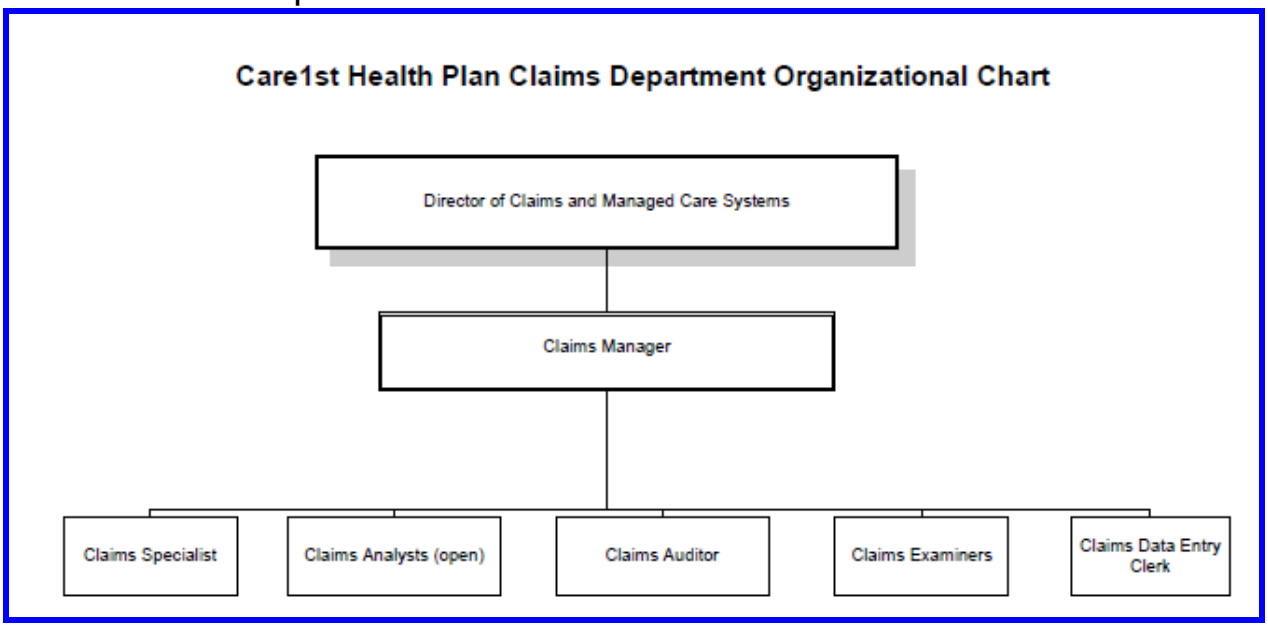
Similar to the Grievance process, Care1st has an Appeals process that is designed to receive appeal requests from members and providers. The Appeals Department is overseen by Care1st's Vice President of Medical

Services and includes a Manager of Appeals, who is an LVN, two clinical nurses, and two Appeals coordinators. The Appeals Department handles both Part C and Part D appeals. Communication with the beneficiaries and providers is conducted telephonically and by formal written notification.

Claims payment is another important administrative function. Care1st's Claims Department includes a Claims Director, Claims Manager, Claims Supervisor, Claims Auditor and five Claims Examiners focused on processing claims for our Medicare product line. The Claims Director is responsible for the benefit set-up in the claims system and for monitoring accuracy and timeliness of claims processing. Reports on claims perfomance is presented at Care1st's Compliance Committee Meetings.

It is the responsibility of the department heads to monitor CMS guidance and provide staff training and assessment to ensure competency.

The following represents the organizational chart and the job descriptions for the Claims Department.



- **Claims Director (employed)-** Responsible for the benefit set-up in the claims system and for monitoring accuracy and timeliness of claims processing. Reports on claims performance is presented at Care1st's Compliance Committee Meetings.

- **Claims Manager (employed)-** Responsible for the management of the day to day operations of the Claims Department and to assess performance and resource needs.
- **Claims Supervisor (employed)-** Responsible to provide claims auditor and examiners close support and track process flow to identify areas for improvement. Responsible for providing reports to the Manager concerning accuracy and timeliness of claims processing.
- **Claims Auditor (employed)-** Responsible to audit claims and the process to assure accuracy, timeliness and compliance. Responsible for providing reports to the Manager concerning accuracy and timeliness of claims processing.
- **Claims Examiners (5) (employed)-** Responsible to process claims for the Medicare product line
- **Claims Specialist (employed)** Responsible for the accuracy and appropriateness of capitation deductions, payment recoveries and reconciliation. This position assists the Claims Management in improving processes by identifying claims processing deficiencies and root causes of claims payment issues. The Claim Specialist also assists in the regular audits of delegated entities
- **Claims Analyst (employed)** Responsible for analyzing and adjudicating medical claims. Generates and develop Management reports which include but not limited to timeliness reports and inventory reports. Performs payment reconciliations and/or adjustments related to retro-active contract rate and fee schedule changes. Identifies root-causes of claims payment errors and reports to the Management.

- **Claims Data Entry (employed)** Performs routine data entry and provides clerical support for the Claims Department. The Claims Data Entry Clerk is responsible for performing clerical activities to include but not limited to copying, filing, data entry, and verifying member eligibility and provider information.

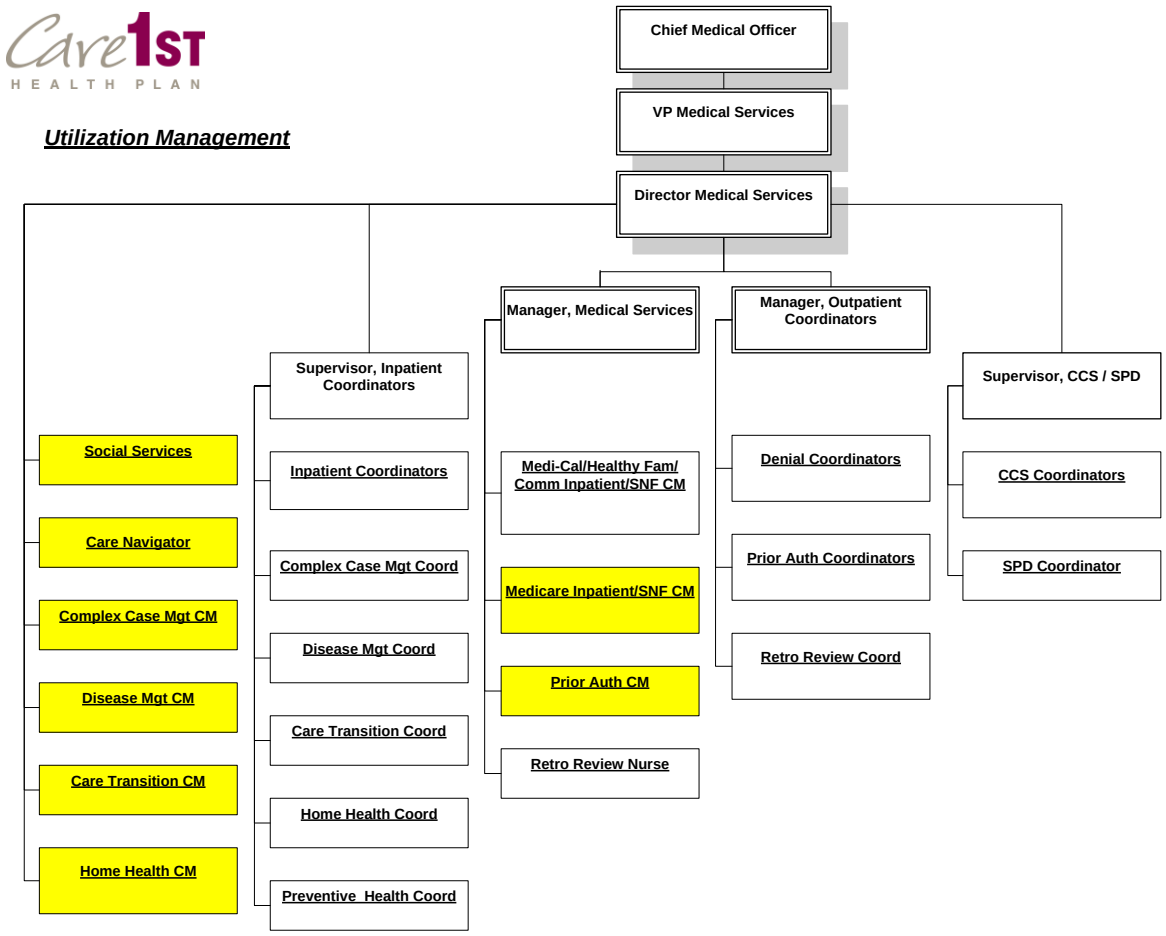
<u>Element 3, Factor B</u>

Identify the specific employed or contracted staff competent to perform administrative and clinical functions.

Coordinating care for the dual-eligible population involves multiple departments.

Care1st's Utilization Management Department is responsible for authorizing and coordinating access to medical services. The Vice President of Medical Services oversees all aspects of medical care including inpatient and outpatient services. To assist with the care management programs, the Director of Medical Services is involved in developing and directing the staff who are involved in Care1st's Complex Case Management and Disease Management Programs. The Utilization Management Department also has a Manager and Supervisors for the inpatient and outpatient services. Utilization Management Coordinators support the clinical managers by managing incoming authorizations, processing authorizations and ensuring that member and provider communication is completed. The Care1st Utilization Management Department reports to Care1st's Chief Medical Officer. All individuals in this department are aware of the Medicaid and Medicare benefits and are able to assist beneficiaries in coordinating their care. All duals members will be assigned to a Care Navigator, who is responsible to navigate members throughout the care continuum, including medical, behavioral health, LTSS and HCBS. The Utilization Management nurses and coordinators assist the members with scheduling appointments and follow-up care. If necessary, they request assistance from Care1st's Health Education and Cultural and Linguistics Department to access interpreter services or to arrange for health education. Care1st's Member Services Department coordinates all transportation requests. Care1st offers free transportation to medical and pharmacy services as necessary. This way we assure that the beneficiaries are able to keep their appointments, stay on track with their treatment plan and obtain their medications.

Below is the Utilization Management Department Organization Chart. The Highlighted positions perform clinical function in coordinating care and services.



Identified clinical staff includes:

Care1st employs nurses, social workers, physicians, and other experienced licensed clinicians to interface with our Members and Providers. They receive ongoing training on communication skills, motivational interviewing, clinical best practices, HIPPA, cultural competency to name a few in an effort to provide Members with a rewarding healthcare experience. Members develop a connection with their Case Managers and often realize that these dedicated clinicians are their advocates. Below is a summary of the types of roles and clinical functions they perform:

1. **Complex Case Manager:** (*employed*) Coordinate care and services across continuum of illness, promotes effective utilization and monitors healthcare resources. Review, analyze and stratify Member healthcare needs based on HRA data and Case Management

activities/communication with Member/caregiver and ICT. Provides Member education on self- management plans, consults with pharmacy on Member medications, refers to Behavioral Health vendor. Assumes a leadership role within the ICT to achieve optimal clinical and resource outcomes. Assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Member. A Complex Case Manager is a Licensed Nurse available to assist the member with care coordination, community resources, provide condition specific education, assess the member's condition, coordinate benefits, generate an individualized care plan, and is the main driver of the ICT.

2. **Prior Authorization Nurse:** (*employed*) Review of prior authorization requests and adjudicates requests or consults under the direction of the medical director.

3. **Concurrent Review Nurse:** (*employed*) Evaluates inpatient treatment and clinical progress of members admitted to acute care facilities, skilled nursing facilities and inpatient rehabilitations facilities.

4. **Appeals Review Nurse:** (*employed*) Reviews clinical information provided by the facility and providers to evaluate the medical necessity and clinical appropriateness of requested services for a member.

5. **Medical Director:** (*employed*) Oversight and guidance to Case Managers and conduct peer to peer interventions as needed.

6. **Clinical Pharmacist:** (*employed*) Provides clinical pharmacy direction for the health plan. Assists in the preparation of drug review evaluations. Provides regular formulary updates to pharmacy technicians and Medical Directors.

7. **BH Care Manager:** (*contracted*) Provide Behavioral Health coordination, collaboration and assistance (resources) to the Member.

8. **Licensed Clinical Social Worker:** (*employed*) Provides Members with community service resources and overall assistance with the identification of the Member's needs.

9. **Home Health Case Manager**: (*employed*) Review of referrals requesting home health services, coordinates care/services ancillary providers, member's PCP, specialist when applicable and with Case Management team.

10. **Disease Management Case Manager:** (*employed*) Provides focused education for members with CHF, COPD or Asthma. Oversees care for this population by coordinating with member, PCP and Case Management Team. Establishes care plan based on HRA data and information received from comprehensive assessments and identifies opportunities for member self-management.

11. **Care Transition Case Manager:** (*employed*) Communicates with all SNP members during any transition from usual setting of care to another setting. Assists member/caregiver by providing information related to the transition and coordinates care and services for member during and after the transition. Develops care plan based on members' individual needs and coordinates with PCP.

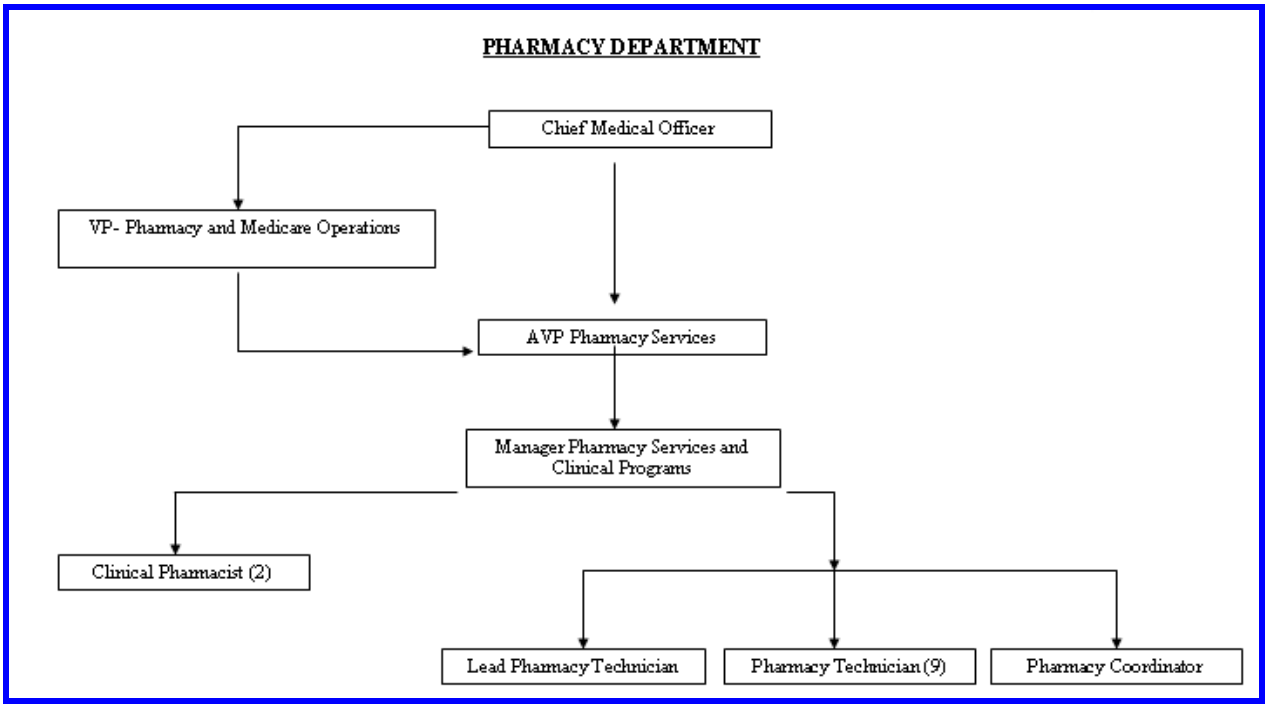
12. **Care Navigator:** ***(employed)*** Responsible to navigate dual members throughout the care continuum, including medical, behavioral health, LTSS and HCBS.

Example: The PCP faxes a request for DME to the Prior Authorization department. The Prior Authorization nurse reviews the request and approves requested DME. The Prior Authorization nurse generates a notice via the EMMA system that notifies the Member's case manager of the DME approval. The case manager updates the Member's care plan, shares information with the ICT, including verbally with the Member.

Care1st's Pharmacy Department is responsible for authorizing and coordinating access to pharmaceuticals and pharmaceutical services. The Associate Vice President of Pharmacy Services is a licensed pharmacist and has clinical, operational and pharmacy benefit management experience. This individual's responsibility is to oversee all Part D Pharmacy functions. Assisting the Associate Vice President of Pharmacy Services is the Pharmacy Manager, two Clinical Pharmacists and nine Pharmacy Technicians. Their responsibility is to ensure that all Care1st members receive clinically-appropriate, cost-effective, and timely access to

pharmaceutical care. The clinical pharmacists are also involved in the interdisciplinary care team providing input and conducting medication regimen reviews. CMS requires that all plans administer a Medication Therapy Management Program. Based on program criteria, dual-eligible beneficiaries are oftentimes identified for participation in this program. Care1st clinical pharmacists conduct this program and interface with the provider and members directly to provide recommendations on improving their medication therapy.

The following represents the organization chart and job descriptions for the Pharmacy Department.



Job description of staff involved in the review of Pharmacy Utilization data:

1. Manager Pharmacy Services and Clinical Programs-
    - Responsible for identifying, reviewing and compiling clinical drug information resources and maintaining Pharmacy Department access to data library.
    - Develop, review and update pharmacy prior authorization guidelines and clinical therapeutic guidelines

- Responsible for identifying, developing and implementing drug use evaluations (DUEs) and Retrospective Drug Reviews (DURs) as well as clinical interventions focused on promoting appropriate medication use and improving clinical outcomes.
- Responsible for maintaining current clinical drug knowledge.
- Assures efficient and effective operations of the Pharmacy Department and the Prior Authorization process.
- Conduct pharmacy prescription claims queries, utilizing on-line analytical program, in an effort to ensure appropriate medication use and accurate adjudication in accordance with Care1st Health Plan Pharmacy & Therapeutics Committee Formulary decisions.

2. Clinical Pharmacist-
    - Assists the Pharmacy Services and Clinical Programs Manager in assuring efficient and effective operations of the Pharmacy Department and the Prior Authorization process.
    - Receives phone inquiries from providers regarding clinical pharmacy and pharmacy benefit issues.
    - Responsible for identifying, reviewing and compiling clinical drug information resources and maintaining Pharmacy Department access to data library.
    - Assist in the oversight of the injectable medication program and interface with the Specialty Pharmacy vendor.
    - Develop, review and update pharmacy prior authorization guidelines and clinical therapeutic guidelines.
    - Responsible for identifying, developing and implementing drug use evaluations (DUEs) and clinical interventions focused on promoting appropriate medication use and improving clinical outcomes.
    - Conduct pharmacy prescription claims queries, utilizing on-line analytical program, in an effort to ensure appropriate medication use and accurate adjudication in accordance with Care1st Health Plan Pharmacy & Therapeutics Committee Formulary decisions.
    - Assist Pharmacy Services and Clinical Programs Manager with Formulary Maintenance. This includes communicating P&T Committee decisions and conducting continual review of prescription claims processing.

3. Pharmacy Technician-

- Receives phone inquiries from providers (physicians and pharmacy personnel) via an (ACD) system, Automatic Call Distribution.
- Responsible for reviewing Prior Authorization based on approved clinical guidelines.
- Document clinical information into the pharmacy Prior Authorization data base.
- Assist pharmacies/pharmacist with claims adjudication issues.
- Provide formulary support to internal and external departments.
- Support clinical programs developed management.

Care Management, triaging beneficiary needs, conducting risk assessments and facilitating the implementation of the individualized care plan is conducted by the Care1st Medical Services Division under the guidance of Care1st's Chief Medical Officer. Nurses, pharmacists, social workers, health educators, and other health service personnel are involved in the process.

Care1st recognizes the unique needs of the SNP membership it serves and provides the clinical and support staff to perform the functions needed to service this population.
The Case Management Nurse is required to meet the following requirements, minimum of three years in Case Management, minimum of three years' experience in the acute care setting, licensed as an active California registered nurse or vocational nurse and ability to coordinate the management of complex medical and social problems. Case Managers must have current understanding of case management principles, concepts and processes to effectively address clinical and psychosocial issues.

The Case Manager is responsible for coordination of care and services for beneficiary's enrolled in the Case Management Program. The primary role of the Case Manager is to coordinate and optimize care in the ambulatory care setting. The Case Manager is responsible for working closely with the beneficiary and/or caregivers regarding their identified condition(s) and provides appropriate education directed toward beneficiary self-management. Frequency of member contact/communication is determined by the acuity and needs of each member.

The Care Navigator is responsible to navigate dual members throughout the care continuum, including medical, behavioral health, LTSS and HCBS. Frequency of member contact/communication is determined by acuity and the needs of each member.

The Case Management process begins with contacting the member and performing the following critical functions in sequential order. Complete a comprehensive Risk Evaluation Assessment and review of the Health Risk Assessment and Individualized Care Plan in order to develop an effective plan of care. Stratification based on specific criteria to determine the acuity level of the member to be assigned to one of 3 distinct levels for Case Management. The stratification levels of High, Medium or Low drives the beneficiary /caregiver contact frequency, interventions and level of multi-disciplinary team involvement. Milestone Process is the specific timed beneficiary contact based on the Stratification level to reassess the beneficiary's condition(s) as compared to their previous assessment. Finalize an Individualized Care Plan to include specific Problems, Interventions and Goals to meet member/caregiver needs and assessment of beneficiary progress to self-management plans and beneficiary /caregiver participation level in the case management program. The Case Managers can work collaboratively with additional staff for a multi-disciplinary approach to optimize member outcomes that includes but is not limited to Social Workers, Pharmacists, Primary Care Physician and specialist, Medical Director, and other allied health professionals.

The Initial Health Risk Assessment (HRA) questions are weighted to calculate stratification levels to determine the scope of intervention needed for the SNP population. All beneficiaries stratified to a Tier Level 3 are referred to Complex Case Management. An example of this process is a new member identified through the HRA as having heart failure, depression, and no advance directive and has no scheduled appointment with their Primary Care Physician. The Case Manager conducts the comprehensive telephonic assessment and identifies barriers and needs to coordinate care, education on clinical condition and provides assistance with coordination and access to LTSS and HCBS.

The Case Manager refers the member to the Licensed and Masters prepared Social Worker, who is responsible for identifying and addressing unmet long-term care needs and behavioral health issues, provides psychosocial interventions through resource identification and program

development. The social worker assists members in identifying and providing information and guidance on federal, state and privately funded programs and community based resources. The social worker conducts a psychosocial assessment and depression screening to determine the appropriate interventions for the member or caregiver. Also discusses and assists with the advance directive process, including mailing the required documents to the member. The Case Manager ensures the member has access to their primary care provider, schedules appointments, educates member/caregiver on their clinical condition, provides educational material. In addition will facilitate transportation as appropriate to ensure member has access to care and services.

Based on the member's health status, comorbidities and social needs, the Case Manager will establish a schedule of follow up call frequency, care coordination needs, and determine if an in-home assessment is needed to further evaluate the member's need for LTSS and HCBS. The in-home assessment may be performed by a nurse, social worker or specially trained Care Navigator, who is the member's direct point of contact with the Plan and responsible for assisting and coordinating the member through the care continuum. The in-home assessment identifies members that may need LTSS and HCBS, which include, but are not limited to: counseling, legal assistance, homemaking/chore assistance, CBAS, home delivered meals, benefits assistance program, home repairs for safety, family caregiver support program, transportation centered on instrumental activities of daily living, and behavioral health interventions. In addition to the HRAs, members are also identified as having medical and social service needs through concurrent review rounds, hospital discharge planners, claims, case managers, and ICT referrals from providers and beneficiaries, which can trigger the need for an in-home assessment.

Care1st is contracted with a NCQA Accredited Managed Behavioral Health Organization (MBHO), to provide behavioral health and substance abuse services to our SNP members. The MBHO is responsible to coordinate all behavioral care services in conjunction with Care1st Case Managers and PCPs. Members are identified through weekly clinical rounds with Care1st Case Manager, or by referral from PCPs or Social Workers. The MBHO works in tandem with the Care1st Case Manger to coordinate behavioral and physical care needs. The MBHO Case Managers receive referrals for behavioral health and drug rehab services from many sources such as crisis lines, PCPs, family members, social workers and Care1st Case

Managers. As a NCQA accredited Managed Behavioral Health Organization, Case Managers utilize evidence based clinical guidelines to determine best practice and appropriateness of care. The MBHO physician reviewers also conduct peer to peer discussions with the attending physicians to determine the most appropriate level of care based upon many factors, i.e., the degree of functional impairment, appropriate setting of care, and intensity of services. (see *attachment Element 3, Factor B*)

Care1st's Social Workers are also part of the Utilization Management Department. They participate in interdisciplinary care rounds with the nurses and coordinators and directly interact with beneficiaries who require assistance. Examples of the valuable role of our social workers is their involvement in assisting dual-beneficiaries with providing resources available to low-income individuals, family support with end-of-life decision making, in-home living condition assessments, LTSS and HCBS, etc.

The responsibility to collect, analyze, report and act on performance and health outcome data is shared by several departments that include the Encounter Data Department, Healthcare Informatics Department and Quality Improvement Department.

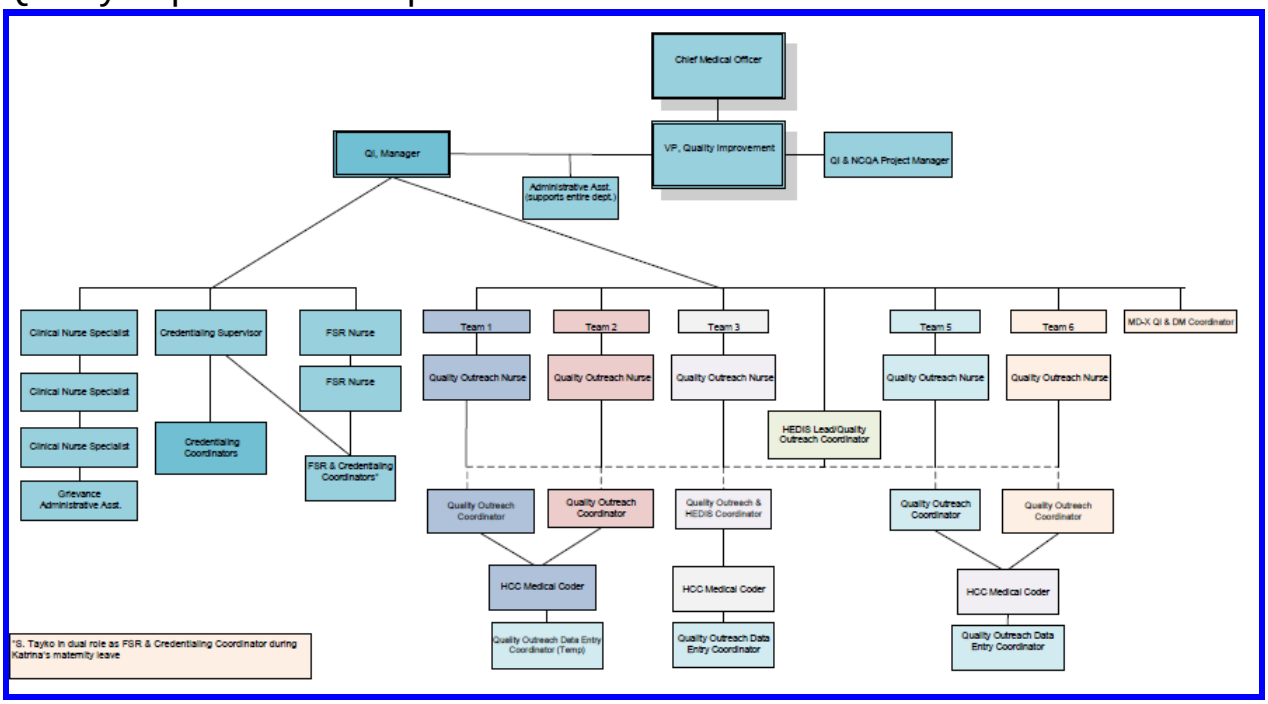
The Encounter Data Department is responsible for interfacing with all delegated entities to collect encounter data. The Encounter Data Manager provides information to the delegated entities so that they submit data files in formats that promote data storage, data mining and regulatory compliance. The Encounter Data Manager is responsible for monitoring the delegated entities performance. Encounter data submission performance is reported to Care1st's Contract Committee. The Encounter Data Manager reports to the Medical Director of Healthcare Informatics.

The Healthcare Informatics Department is comprised of the Medical Director of Healthcare Informatics and six data analysts. Their responsibility is to mine and analyze health care data. The Medical Director of Healthcare Informatics is a medical physician. By combining clinical expertise, analytical skills and business process awareness, Care1st is able to fully utilize the health care data that is available to evaluate utilization trends, detect issues, identify opportunities for improvement and measure outcomes. The Medical Director of Healthcare Informatics works closely with Care1st's Chief Medical Officer so that all

clinical departments involved in the Model of Care have the information necessary to perform their duties and responsibilities.

Care1st Health Plan has a Quality Improvement Department. The Quality Improvement Department is comprised of a Vice President of Quality Improvement, a Quality Improvement Manager, Clinical Quality Review Nurses, Data Analysts, Credentialing Coordinators, HEDIS Coordinators and HEDIS Nurses, Facility Site Review Nurses, a Quality Improvement Project Manager and administrative support staff. The Vice President of Quality Improvement reports to Care1st's Chief Medical Officer. The Quality Improvement Department is also engaged in clinical data through their HEDIS outreach efforts and medical chart collection and review activities. Data collected is warehoused and available to the Informatics Department for analysis. The Quality Improvement Department leads the Quality Improvement Activities throughout the organization. All improvement activities comply with the National Committee for Quality Assurance (NCQA) standards and include measurable parameters so that baseline and outcome assessments are valid. All Quality Improvement Activities are reported at the Quality Improvement Committee Meetings.

The following represents the organization chart and job descriptions for the Quality Improvement Department.



Vice President of Quality Improvement (employed)- Registered Nurse responsible for the oversight and of the Quality Improvement Department functions such as but not limited to: Credentialing, Facility Site Review, Potential Quality Issues reviews, HEDIS, CAHPS, QIP/QIAs, and Quality Outreach. Has the following support staff:

1. **Quality Improvement Manager (employed)-** Registered Nurse responsible to provide day to day direction to the Quality Improvement department functions. Serves as a direct resource to staff and evaluates resources for the department.
2. **Credentialing and Facility Site Review Supervisors (employed)-** Credentialing Supervisor directly oversees the credentialing staff and functions. Is responsible to provide delegated oversight to delegated groups. The FSR Supervisor is in the field and has responsibility to provider oversight of the FSR staff and process. Has reporting responsibility to regulator agencies.
3. **Facility Site Review Nurse (2) (employed) and Contracted Nurses (2)-** Responsible for performing facility site reviews, medical record reviews, specialized Seniors and Persons with Disabilities assessments and education to provider offices and ancillary facilities.
4. **Clinical Review Nurses (3) (employed)-** Responsible for reviewing Potential Quality Issues (PQI) and summarize the content of the issue for the Chief Medical Officers review and determination. Responsible for preparing cases for Peer Review and specialist consultation reviews.
5. **HEDIS Outreach Nurses (6) (employed)-** Responsible for providing direct oversight of Quality Outreach Coordinators. Provides education on Quality related functions and needs such as; HEDIS, CAHPS, HCC, Regulatory requirements, Clinical Practice Guidelines, Preventive Health Guidelines, Medical record documentation improvement practices, and provides tools and resources for the providers office to meet goals. Provides physicians with Quality profile reports detailing their rates among their peers.
6. **Quality Outreach Coordinators (12) (employed)-** Serves as a field representative addressing all quality improvement programs and services. Provides a direct contact to the plan for physicians and office staff for answering questions and coordination of services. Works directly with Outreach Nurses. Collects and scans medical records for quality purposes and provides reminders valuable to helping provide practice management tools for provider sites.

7. **Medical Coders (3) (employed)-** Provides coding of medical records for the Risk Adjustment process for submission to CMS. Works to provide valuable data back to the providers concerning gaps in documentation.
8. **Administrative Assistants (2) (employed)-** Provides day to day administrative support to the management and staff. Helps field staff in assuring specific data is available and provides internal support.
9. **Credentialing Coordinators (3) (employed)-** Provides for all the primary credentialing functions, provides audit support for delegated oversight audits of the medical groups. Credentials the Health Delivery Organizations (HDO) and works closely with Provider relations to resolve provider issues.
10. **NCQA Project Manager (employed)-** Responsible for providing all aspects of the organizations directions and guidance for understanding NCQA Accreditation Guidelines. Assures all aspect of NCQA standards are being met and provides direct communication of changes and supports the audit process.

Care1st prioritizes the importance of ensuring that the providers who care for our members are properly credentialed. The Care1st Credentialing Department is run by a Credentialing Supervisor and Credentialing Technicians. Their responsibility is to perform pre-contracting credentialing verification and re-credentialing reviews. All credentialing reports are submitted to Care1st's Credentialing Committee for review and approval.

All clinical departments report to the Chief Medical Officer. Thus, authorizing the Chief Medical Officer to ensure that all medical services are clinically appropriate and in the best interest of the beneficiary.

It is the responsibility of the department heads to monitor CMS guidance and provide staff training and assessment to ensure competency.

Element 4 – Interdisciplinary Care Team (ICT)

As previously stated all care delivered to our members is through contracted physicians with our delegated Medical Groups. The composition of the ICT is delegated to the Medical Groups, but must consist of all CMS required participants such as:

- Primary Care Physician
- Specialists
- Case Managers
- Social Workers
- Mid Level Providers such as Nurse Practitioners
- Pharmacists
- Health educators
- Behavioral Health Providers
- IHSS workers
- CBAS providers
- HCBS providers
- LTSS providers

Element 4, Factor A

Describe how the Plan will determine the composition of the ICT.

The composition of the ICT will be individualized according to the beneficiaries' clinical and psychosocial needs. For instance, a member that has congestive heart failure and depression will have a cardiologist and a behavioral care specialist in the ICT. A member who has cancer will have an oncologist and a palliative care specialist as part of the ICT. In some instances the member's ICT composition may be augmented by the recommendations of one of the ICT members. For example, in the case of a member with COPD, the pulmonologist evaluates the member and identifies the need for a respiratory therapist to assist with pulmonary rehabilitation. Based on this recommendation, a referral is made for a respiratory therapist who would then become a new member of the ICT.

Taking into consideration our SNP membership and disease prevalence for cancer, cardiac and pulmonary diseases, (see Element 1) it is reasonable to expect that cardiologists, oncologists and pulmonologists will very often be ICT participants.

Once the HRA has been completed it is stratified into 3 categories: low, medium and high risk.
In addition all answers to the HRA are entered into our case management software, CCMS and based on pre programmed information; the answers to the HRA will generate an individualized care plan (POC) that contains a series of Problems, Interventions and Goals.

All members that fall into the high risk are automatically referred to a Complex Case Manager (CCM).All other members are referred to a Case Manager. The CCM or Case Manager (as applicable) will contact the member telephonically and complete a comprehensive assessment, which will lead to the development of a comprehensive POC

The core ICT composition consists of:

- Member and or care giver(if applicable),
- case manager,
- social worker,
- Primary Care Physician,
- Medical Director,
- Clinical Pharmacist,
- Additional members of the ICT such as behavioral care providers, specialists, IHSS workers, HCBS providers will be determined by the core ICT based on the individual needs of the member.

Frequency of meetings: The core ICT members meet on an average **twice a week** to discuss SNP members that are either hospitalized or have high acuity issues.

Member participation: Based on member's acuity level, follow up calls are made monthly to every 6 months.

Method of communication and documentation: Face to face and via conference call .All discussions, and subsequent action plans are documented in CCMS. This record is a member centric, HIPAA complaint electronic medical record. The information in this record is available to all ICT members either electronically or via fax.

Case Study below is to illustrate interventions with Initial call by Complex Care Manager after identification as a Tier 3 level for stratification and the determination and composition of membership for ICT:

Member Name/ID	Call type:	Person Calling: (to or from)	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes
XXXXXX	☒ **CCM** ☒ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **DM** ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **SW** ☐ Initial	☒ Member ☐ Provider ☐ Family ☐ Other	Initial call to regarding HRA, (stratification for Tier 3 CM), recently discharged from hospital w/ CHF. Comorbidities: 1. IDDM 2. Diabetic Retinopathy-mild 3. Chronic Renal Failure (non dialysis) 4. Depression Mbr. Agreed to participate in ICT and	S/W her PCP who confirmed her new diagnosis of CHF will forward labs and notes. Asked if he or designee would participate in ICT, was in agreement. S/w DM case manager she will assess member and participate in ICT. CTCM will participate for any transition needs. S/w Cardiologist nurse made	☒ Member ☒ Family ☐ Caregiver: ☒ CT: M. Rodriguez, LVN ☒ CCM: N. Cabaccang, LVN ☒ DM: V. Silla, LVN ☒ SW: S. Chang, MSW ☒ MD: Dr. Peters ☒ Specialist: Cardiology ☐ Rx: ☒ BH: CompCare ☐ Other: _____	ICT via teleconference; all in agreement for POC: ☒ Ed. Materials sent: CHF Management Brochure ☒ Referrals: ☒DM educ. Classes @ CA Hospital MC ☒ Adult Yoga ☐ Depression (mbr

	☐ Routine ☐ Care Conference ☐ Outlier ☐ **CT:** ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **Premier Member Service** ☐ Initial ☐ Routine ☐ Outlier		understand need for being compliant with all meds and appts.	arrangement for f/u appt., will participate in ICT. S/w member about transportation, no needs for transportation to be arranged.	Frequency: ☐ Tier 1 q 6 months ☐ Tier 2 q 3 months ☒ Tier 3 q month	declined) ☒ F/U 2 weeks w/ MSW and 1 week w/ DM ☒ Prevent Care: Podiatrist /Ophthalmologist visits within 6 months Documentation: ☒ CCMS (records attached) ☐ MHC ☒ POC sent to Mbr. 4/29/11 ☒ POC sent to PCP 4/29/11 ☒ Other: POC Cardio 4/29

Element 4, Factor B

Describe how the Plan will facilitate the participation of the beneficiary in the ICT whenever feasible.

Care1st encourages beneficiary participation by providing each beneficiary with a copy
of his/her Individualized Care Plan(POC). A cover letter accompanies the POC and provides information that encourages the member to make an appointment with his/her Primary Care Physician in order to review the POC and make any changes based on any additional information the beneficiary may provide. In addition the POC may be modified based on the findings made by the Primary Care Physician. (see *attachment Element 4, Factor B)*

In addition, the Case Manager through his/her routine interaction with the member and other ICT members will be able to elicit additional information which will further encourage the member's participation. Members are contacted telephonically in their primary language, if possible, or by using a language line interpreting service or through a TTD/TTY line for those that are hearing impaired. For instance, the preferred language is approximately 51% Spanish for our LA County members. We therefore have ensured that we have an adequate number of Spanish speaking case managers. In the case of our Santa Clara County members there is a predominance of Vietnamese speaking members. We therefore have recently hired a Vietnamese speaking Case Manager to serve their needs. Through a comprehensive assessment, the Case Manager will be able to identify educational, psychosocial and care management needs. The Case Manager has access to the Krames Educational Materials in hard copy and electronic format. Depending on the member's preference the educational materials can be mailed to the member, or may be accessed electronically. If members happen to have a diagnosis of congestive heart failure, COPD, or asthma, they may be enrolled in our Disease Management Programs. These programs offer in-depth education and outreach that complement the support provided by the Case Manager. In some cases the Case Manager will identify certain needs such as lack of transportation. In those instances free transportation will be offered to the member in order to access care. The Case Manager through his/her routine involvement with the member and the caregiver becomes the member's proxy and advocate in the ICT.

Each delegated Medical Group must establish Policies and Procedures as to the how often the ICT will meet and how information is disseminated. Meetings must have minutes kept that properly document the meeting's findings, and identify the meeting participants. ICTs may meet in person, via teleconference or webinar. The information may be disseminated between participants either through electronic medical records,fax or mail. All information must be disseminated in a HIPPA compliant fashion.

All information received from the delegated Medical groups will be aggregated and presented to the Care1st Medical Services Committee on a quarterly basis. The Chief Medical Officer will in addition present data it receives from its NCQA Accredited Behavioral Care Providers and data it analyzes from its own Complex Case Management Department and Informatics Department.

Element 4, Factor B

Describe how the MAO will facilitate the participation of the beneficiary whenever feasible.

Case Study below is to illustrate interventions with Initial call by Complex Care Manager after identification as a Tier 3 level for stratification and the participation by member with the ICT: This includes education and community outreach.

Member Name/ID	Call type:	Person Calling: (to or from)	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes
XXXXXX	☒ **CCM** ☒ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **DM** ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **SW** ☐ Initial ☐ Routine ☐ Care	☒ Member ☐ Provider ☐ Family ☐ Other	Initial call to regarding HRA, (stratification for Tier 3 CM), recently discharged from hospital w/ CHF. Comorbidities: 5. IDDM 6. Diabetic Retinopathy-mild 7. Chronic Renal Failure (non dialysis) 8. Depression Mbr. Agreed to participate in ICT and understand need for being compliant with	S/W her PCP who confirmed her new diagnosis of CHF will forward labs and notes. Asked if he or designee would participate in ICT, was in agreement. S/w DM case manager she will assess member and participate in ICT. CTCM will participate for any transition needs. S/w Cardiologist nurse made arrangement for f/u appt, will	☒ Member ☒ Family ☐ Caregiver: ☒ CT: M. Rodriguez, LVN ☒ CCM: N. Cabaccang, LVN ☒ DM: V. Silla, LVN ☒ SW: S. Chang, MSW ☒ MD: Dr. Peters ☒ Specialist: Cardiology nurse ☐ Rx: ☒ BH: CompCare ☐ Other: _____	ICT via teleconference; all in agreement for POC: ☒ Ed. Materials sent: CHF Management Brochure ☒ Referrals: ☒ DM educ. Classes @ CA Hospital MC ☒ Adult Yoga ☐ Depression (mbr declined) ☒ F/U 2 weeks w/

	Conference ☐ Outlier ☐ CT: ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **Premier Member Service** ☐ Initial ☐ Routine ☐ Outlier		all meds and appts.	participate in ICT S/w member about transportation, no needs for transportation to be arranged.	Frequency: ☐ Tier 1 q 6 months ☐ Tier 2 q 3 months ☒ Tier 3 q month	MSW and 1 week w/ DM ☒ Prevent Care: Podiatrist visits within 6 months Documentation: ☒ CCMS (records attached) ☐ MHC ☒ POC sent to Mbr. 4/29/11 ☒ POC sent to PCP 4/29/11 ☒ Other: POC to Cardio 4/29

Care Managers and Care Navigators present the list of classes available to member in demographic area and the ICT agrees on appropriate and most beneficial classes.

Sample of list of Monthly classes available to Care1st Health Plan members:

January 2012

Smoking Cessation Counseling, Mon-Fri 9 am-9 pm & Sat 9 am-1 pm:

English: -800-NO-BUTTS; Spanish: 1-800-456-6386; Cantonese: 1-800-456-6386; Vietnamese: 1-800-778-8440 Korean: 1-800-556-5564; TDD/TTY: 1-800-933-4833

1 SD_January.xls Hospital-based Health Education Programs Care1st Health Plan

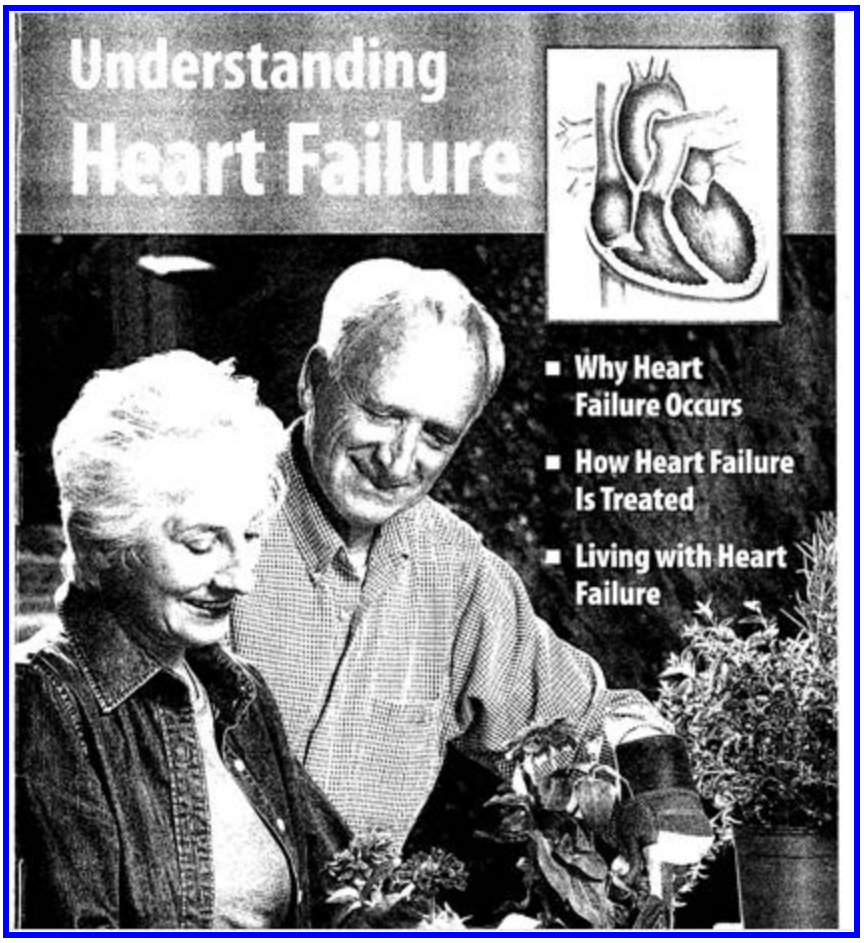
January 2012					
Hospital	**Topic/ Title**	**Date/Time**	**L**	**Cost**	**Phone Number**
California Smokers' Helpline					
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	E	FREE	1-800-NO-BUTTS
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	Sp	FREE	1-800-456-6386
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	Cant.	FREE	1-800-838-8917
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	Viet.	FREE	1-800-778-8440
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	Ko.	FREE	1-800-556-5564
Smoking Cessation Counseling		Mon-Fri 9 am-9 pm & Sat 9 am-1 pm	TDD/TTY	FREE	1-800-933-4833
Children's Hospital and Healthcare Center		**3020 Children's Way, San Diego 92123**	**858-576-1700**		**http://www.chsd.org/**
following class held at:		***Wellness Center- 4440 Wightman St., Suite 200, San Diego 92105***			
Zumba		Tue and Thu noon-1pm	E/Sp	FREE	619-321-2920
Standing Proud Martial Arts Class		Mon 4:30-6:30pm and Wed 2:30-4pm	E	FREE	619-321-2920
Ask a Nurse		Wed 3:30-4:30pm	E/Sp	FREE	619-321-2920
Support Groups	Breastfeeding	Mon 1/2-1/30 10:30am	E/Sp	FREE	619-321-2920
Paradise Valley Hospital		**2400 East Fourth St., National City 91950**	**619-470-4321**	**http://www.paradisevalleyhospital.org/**	
"Help, I'm going to be a Mommy		call for more information	E	619-470-4346	
Smoking Cessation (6 wks) Registration is		call for schedule	E/Sp	FREE	619-472-4628

Required					
following class held at:	***Westfield Shopping Town Plaza Bonita***				
Club Walk	call for schedule		--	FREE	619-470-4346
following class held at:			***Center for Health Promotion***		619-472-4628
Cholesterol/Nutrition/ Hypertension	Tue 2/7 9:45-10:45am		E	FREE	619-472-4628
Diabetes Management	call for schedule		E	FREE	619-472-4628
Individual Diabetes Counseling	Every Tue by appointment		E	FREE	619-472-4628
Individual Nutrition Counseling	Every Tue by appointment		E	FREE	619-472-4628
Stress Management	Thu 3/1 11am-noon		E	FREE	619-472-4628
Asthma	call for schedule		E	FREE	619-472-4268
Compassionate Communication	call for schedule		E	FREE	619-472-4268
Weight Management	2nd & 4th Wed 11am-noon		E	FREE	619-470-4346
Hepatitis C	4th wed 5 pm		E/Sp	FREE	619-470-4346
Scripps Well Being Center, Chula Vista cont.	Parenting Classes (Infants, Todddlers, & Preschoolers)		call for schedule	E/Sp	619-862-6609
Stroke/Parkinson's Exercise Group	Thu 11am-noon		E	FREE	619-862-6600
Total Joint Replacement (Must RSVP)	Thu 1/12 1-2pm		E	FREE	619-862-6600
Thu 1/12 2-3pm	Sp	FREE	619-862-6600		
Support Groups	Breastfeeding	Mon 1-2 pm	E/Sp	FREE	619-862-6600
Diabetes	2nd Thu 5-6pm	E		FREE	619-862-6600
1st Thu 4-5pm	Sp	FREE	619-862-6600		
Widowed	2nd & 4th Mon 10am-noon		E	FREE	
following class held at:	***Norman Park Center- 270 F Street , Chula Vista***				

Exercise	call for schedule		E	FREE	619-691-5086
Strength Training	Wed 6pm		E	FREE	619-691-5086
Yoga (Chairs)	Wed 4:30pm		E	FREE	619-691-5086
Yoga (Gentle)	Thu 4:30pm		E	FREE	619-691-5086
Parkinson's Disease	1st Tue 10am		E	FREE	619-691-5086
A Women's Wellness Center	call for schedule		E	FREE	619-425-5927
following class held at:		***Scripps Mercy Training Center, 499 H Street, Chula Vista***			
Support Groups	Overeaters Anonymous	Tue & Thu 7-8 pm	Sp	FREE	619-862-6600
Scripps Hospital, Encinitas	**354 Santa Fe Dr., Encinitas 92024**	**760-633-6501**	**http://www.scrippshealth.org/ClassFinder.asp?sType**		
Support Groups	Breastfeeding (681 Encinitas Blvs., #307 Encinitas)	Fri 1-2pm	E	FREE	800-727-4777
Scripps Memorial Hospital, La Jolla	**9888 Genesee Ave., La Jolla 92037**	**858-626-4123**	**http://www.scrippshealth.org/ClassFinder.asp?sType=CLA**		
Support Groups	Breastfeeding	Tue 2-3pm	E	FREE	800-727-4777
Postpartum Depression	by appointment	E		FREE	800-727-4777

Scripps Mercy Hospital	**4077 5th Avenue, San Diego 92103**	**616-294-8111**	**http://www.scrippshealth.org/ClassFinder.asp?sType=CLA**	
Breastfeeding	Thu 2-3pm	E	FREE	800-727-4777
Tri-City Medical Center	**4002 Vista Way, Oceanside 92056**	**760-724-8411**	**http://www.tri-citymed.com/**	
Parkinson's	call for schedule	E	FREE	760-940-7272
Stroke	call for schedule	E	FREE	760-940-7272
Total Joint Replacement (Must RSVP)	call for schedule	E	FREE	760-940-5788
Support Groups AA Young People's	Sat 7:30-9pm	E	FREE	760-758-2514
Better Breathers	call for schedule	E	FREE	760-940-3055
Cancer	Wed 1/11 10:30-11:30am	E	FREE	760-940-3632
A.W.A.K.E. - Sleep Apnea	Tue 1/24 7-9pm	E	FREE	760-630-1964

Sample of the CHF brochure that is mailed to the member:



Element 4, Factor C

Describe how the ICT will operate and communicate

All medical groups and their ICT participants are notified of future meetings. The notification is sent by email and fax using SNP administrative support staff.

As an example of information presented in the latest Medical Services meeting, we presented information about the correlation between the HRA tier level and hospital utilization rates. All members that complete the HRA are tiered into levels 1-3. This tiering is based on numerical values that are assigned to each question in the HRA. Those that are tiered level 3 are considered to be clinically more fragile, tier 1 would be considered to be clinically more stable.

SNP

			Members				Acute Days				Acute Admits			
Year_of_Survey	Plan Type	Grouping	Members	Mbrs Tier 1	Mbrs Tier 2	Mbrs Tier 3	Total Days	Days Tier 1	Days Tier 2	Days Tier 3	Total Admits	Admits Tier 1	Admits Tier 2	Admits Tier 3
2010	SNP	Has Inpatient Days	257	22	201	34	1,762	102	1,326	334	393	25	300	68
2010	SNP	No Inpatient Days	1,836	442	1,341	53								
			2,093	464	1,542	87	1,762	102	1,326	334	393	25	300	68
		Percent of Total		22%	74%	4%		6%	75%	19%		6%	76%	17%

The most important information from this chart is that members who are in tier 3, represent 4% of the SNP population but account for 17% of the admissions. It is therefore imperative to assess these members and enroll them in Complex Case Management.

Agenda and minutes of the Medical Services Meeting where the above information was presented. (see *attachment Element 4, Factor C, 1* and *attachment Element 4, Factor C, 2*)

The minutes of the Medical Services Committee are presented by the Chief Medical Officer at the monthly Care1st Board Meeting for approval. Based on information and data received from claims and pharmacy data, all POCs, Case Managers, ICT members, Social Workers, beneficiaries and their caregivers, a comprehensive analysis by the Medical Informatics and Quality Improvement Departments will be made to identify best practices. This information will then be shared with all ICT members, Medical Groups

and the beneficiaries in order to further enhance the quality of care our SNP members receive. This information will be shared quarterly in different venues or formats such as Joint Operations Meeting, mailings or newsletters. All information is either member de-identified, or transmitted in a HIPAA compliant manner.
An example of this will be our ongoing analysis of all the HRA questions in order to establish correlation with future hospitalization. In effect it will be able to assign a predictive value for certain HRA questions and answers. This information is valuable as it will be able to further identify certain subsets of our SNP members who may need to be assessed sooner and require closer observation.

In addition to the quarterly meetings, where aggregated data and reports are presented, the ICT meets twice a week to discuss and review all SNP members who are presently hospitalized. The ICT members who participate include:

- Medical Director,
- VP of Medical Services,
- UM Director,
- UM Manager,
- Care Transition Specialist,
- Social Workers
- Case Managers
- Care Navigators

The Case Manager will present all clinical information including any discussions with the PCP or specialist. These interactions occur at least every other day. The social worker or Care Transition specialist will present any discussions that have occurred with the member or caregiver. The member or caregiver is always contacted within two days of admission in order to keep them informed regarding their care transition The ICT will jointly make changes to the POC based on the member's clinical condition and social needs. The case manager will document the changes in the minutes of each meeting and preserved in CCMS, the member's centric medical record. This information is available to all ICT members via electronic distribution or via fax in a HIPAA compliant fashion.

Case Study below illustrates communication and frequency of ICT:

Member Name/ID	Call type:	Person Calling: (to or from)	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes
XXXXXXX	☒ **CCM** ☒ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **DM** ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **SW** ☐ Initial ☐ Routine ☐ Care	☒ Member ☐ Provider ☐ Family ☐ Other	Initial call to regarding HRA, (stratification for Tier 3 CM), recently discharged from hospital w/ CHF. Comorbidities: 9. IDDM 10. Diabetic Retinopathy-mild 11. Chronic Renal Failure (non dialysis) 12. Depression Mbr. Agreed to participate in ICT and understand need for being compliant with	S/W her PCP who confirmed her new diagnosis of CHF will forward labs and notes. Asked if he or designee would participate in ICT, was in agreement. S/w DM case manager she will assess member and participate in ICT. CTCM will participate for any transition needs. S/w Cardiologist nurse Cardiologist nurse made	☒ Member ☒ Family ☐ Caregiver: ☒ CT: M. Rodriguez, LVN ☒ CCM: N. Cabaccang, LVN ☒ DM: V. Silla, LVN ☒ SW: S. Chang, MSW ☒ MD: Dr. Peters ☒ Specialist: Cardiology nurse ☐ Rx: ☒ BH: CompCare ☐ Other: _____	ICT via teleconference; all in agreement for POC: ☒ Ed. Materials sent: CHF Management Brochure ☒ Referrals: ☒ DM educ. Classes @ CA Hospital MC ☒ Adult Yoga ☐ Depression (mbr declined) ☒ F/U 2 weeks w/

	Conference ☐ Outlier ☐ CT: ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **Premier Member Service** ☐ Initial ☐ Routine ☐ Outlier		all meds and appts.	arrangement for f/u appt, will participate in ICT S/w member about transportation, no needs for transportation to be arranged.	Frequency: ☐ Tier 1 q 6 months ☐ Tier 2 q 3 months ☒ Tier 3 q month	MSW and 1 week w/ DM ☒ Prevent Care: Podiatrist visits within 6 months --- Documentation: ☒ CCMS - records attached ☐ MHC ☒ POC sent to Mbr. 4/29/11 ☒ POC sent to PCP 4/29/11 ☒ Other: POC to Cardio 4/29

Case Study below sample of the twice weekly IDCP Meeting minutes identifying hospitalized SNP members that represent collaboration and communication with multiple disciplines:

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up
XXXXXX	☐ MCR ☒ SNP: ☐ Tier 1 ☐ Tier 2 ☒ Tier 3	Admitted thru ER (identified thru IP census) w/ SOB, to ICU vent. Transfer to Rehab, new diagnosis of CHF. First acute hospitalization	Will stay in Rehab until safe with minimum assist will get home PT. 4/21: Per MSW PT progressing, Coumadin level stable, had h/o of bld clot so family concern, monitoring closely. 4/26 Refer to CCM, member going to live with sister (25 miles from doctors) will set-up transportation to assure visits.	☒ Referral to: Psych Consult 4/12 ☒ Referral to: Home Health SN/PT 4/29 ☒ Referral to: CCM 4/26 ☒ Referral to: MSW 1/26 ☒ CT initiated: 4/10/11	G. Hernandez, LVN – IP-CM N. Cabaccang, LVN – CHF CCM - Primary V. Silla, LVN - DM	☒ w/ Cardiologist 5/1 ☒ CCM to discuss classes available: done 4/27 ☒ Transportation to MD visits: done 4/27 ☐ None Documentation: ☒ CCMS (records attached) ☐ MHC ☒ Other: <u>Minutes IDCP folder</u>

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

Element 5, Factor A

Describe the facilities pertinent to the care of the targeted special needs need population and providers (at a minimum includes: inpatient, outpatient, rehabilitative, long-term care, medical specialists, mental health specialists, nursing professionals, allied health professionals, dialysis facilities, specialty outpatient clinics)

Care1st's provider network is continually assessed to identify additional specialized needs of our population and gaps in coverage, then actions are taken to assure we have the appropriate medical specialists, mental health specialists, specialty facilities, and clinics necessary to provide care to the dual-eligible special needs population.

- Care1st works to assure our provider network has the appropriate number and type of facilities to meet our target population needs. In addition to assuring we have appropriate hospital (inpatient and outpatient), radiology and lab facilities our population needs additional rehabilitative, long-term care, psychiatric and day care facilities available. Care1st performs an availability assessment every six months to identify additional need. This assessment consists of a Geo Access mapping study, assessment of claims and authorization data to identify our dual eligible population needs. In our most recent assessment we documented appropriate coverage for rehabilitative, long-term and psychiatric care for SNP LA, OC and SD and found some gaps in coverage with SNP SB (mostly rural area), which our provider contracting department is working to cover. Care1st has a comprehensive network of contracted care facilities to cover our dual eligible populations needs, which includes but is not limited to: hospitals, emergency facilities, dialysis centers, urgent care centers, radiology centers, diagnostic/surgery centers, skilled nursing, rehabilitation, psychiatric, day care, and respite

- Care1st conducts access to care studies in additional to Geo Access mapping studies. Member complaints and the assessment of CAHPS study results help us to identify additional areas where coverage can be improved (i.e., Members who report through a complaint or survey

that they are having issues getting appointments for specific specialties. The QI department will analyze Geo Mapping, grievance trends, access to care studies and trends with surveys to identify provider network needs. Then take action to contract additional providers to meet those needs better). Care1st has a comprehensive network of PCPs and specialist available to cover our dual-eligible populations needs, which includes but is not limited to: Allergy, Anesthesia, Audiology, Cardiology, Chiropractic, Dermatology, ENT, Endocrinology, Gastroenterology, Geriatrics, Gynecology/Oncology, Hematology/Oncology, Hepatology, HIV Specialist, Infectious Disease, Nephrology, Neurology/Neuro Surgery, Nutritionists, Nuclear Medicine, OB/GYN, Occupational Medicine, Ophthalmology/Optometry, Orthopedic, Pathology, Physical Therapy, Podiatry, Proctology, Psychiatry/Psychology/Mental Health, Pulmonary Medicine, Radiology, Radiation Therapy, Rheumatology, Speech Therapy, Substance Abuse Counselors, Surgery, Urology, and Vascular Surgery

- *See attachment Element 5, Factor A*

- Care1st contracts with an NCQA Accredited MBHO. It is delegated the responsibility for providing for the coverage of all Behavioral Health needs, such as but not limited to: psychologists, psychiatrists, substance abuse counselors, after hours support and coverage. Any Medi-Cal mental health benefits for those with SMI, or with substance use that cannot be provided through our MBHO, will be provided through the Behavioral Health Division of the San Diego County Health and Human Services Agency and its contracted clinics

- Care1st contracts and employs nursing professionals within our network and internal departments such as: case management, disease management, complex case management, utilization management, quality management, grievance and appeals to name a few. Within our network of providers we have physician extenders such as Nurse Practitioners and Physician Assistants, who are required to complete the credentialing process and have a supervising physician on-site with them. Care1st employs nurses throughout our organization with medical management expertise and they serve multiple roles.

Utilization Management:

- Vice President of Medical Services, Utilization Manager and Utilization Supervisor are all Registered Nurses licensed in California and have comprehensive experience in all aspect of medical management.
- 2 Inpatient Case Managers, who are Registered Nurses or Licensed Vocational Nurses licensed in California. Although Care1st delegates specific Utilization Management functions Inpatient Case Management is conducted by Care1st clinical staff.
- 2 Care Transition Case Managers, who are Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses are experienced case managers that work to improve seamless transitions of care across multiple healthcare settings, providers and health services.
- 4 Complex Case Managers, who are Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses have years of case management experience and work to identify and provide comprehensive and coordinated case management services for members with multiple or complex medical needs.
- 4 Disease State Managers, who are Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses are experienced case managers who have been specifically trained to monitor, provide effective interventions and education to member identified with specific disease states. Although members are enrolled into a disease management program because they have a specific disease state these case managers case manage all the medical conditions the member has.
- 3 Medical Group Compliance Nurses, who are Registered Nurses or Licensed Vocational Nurses licensed in California. Care1st delegates Utilization Management functions to contracted Medical Groups and these nurses are responsible for delegated oversight of these functions. Care1st still provides Disease State Management, Inpatient Case Management and Complex Case Management to SNP members who belong to delegated entities.

Quality Improvement:

- Vice President of Quality Improvement and the QI Manager are Registered Nurses licensed in California and have comprehensive medical management and quality management experience. They are responsible for directing the day to day operations of the QI, Credentialing, Facility Site Review (FSR), and clinical outreach programs.
- 2 Quality Improvement Nurse Specialists, who are Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses are responsible for reviewing potential quality issues (PQI's), which can be sentinel events, grievances, clinical or service issues referred from other entities, departments or providers. They are responsible to prepare case files for the Peer Review Committee (PRC).
- 7 Quality Outreach Nurses, who are Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses are very experiences with HEDIS measures and outreach. They work with coordinators to visit physician offices to educate the providers and office staff concerning quality improvement goals and functions (i.e. trained HEDIS measures, distribution of clinical practice and preventive care guidelines, provider web portal use, Health Risk Assessments (HRA), the Interdisciplinary Care Team (ICT) and various other clinical outreach needs.

Other Support Services:

- A nurse is employed in our Premier Member Services department and is a Licensed Vocational Nurse licensed in California. This nurse is responsible for providing clinical support to the Premier Member Services department. Examples include: working to fast track authorization requests, educating members on their medical conditions, discussing the member conditions with them to identify possible needs, collaborate with other departments to resolve member clinical issues quicker and more efficiently.
- Medical Grievances and Appeals department has Registered Nurses or Licensed Vocational Nurses licensed in California. These nurses have responsibility to review grievances and appeals, summarize issues and work to get determination decisions from Medical Director or Chief Medical Officer.

- Care1st contracts with allied health professionals and ancillary care services, such as but not limited to: Physical therapists, occupational therapists, speech therapists, radiology services, laboratory services and pharmacists. Care1st employs three pharmacists who work to review and improve clinical medication therapy. For example: all members who are being discharged from the hospital after having a heart attack are referred to the clinical pharmacist to track and monitor that the member is filling and being compliant with their Beta-Blocker therapy. All women who have had a fracture are referred to the clinical pharmacist to work with the PCP to schedule a bone density study or prescribe a medication to treat or prevent osteoporosis. All members who have been diagnosis with rheumatoid arthritis are referred to the clinical pharmacist to assure they have seen a rheumatoid specialist, have been evaluated appropriately and are being treated with a DMARD medication.

- Care1st provides access to LTSS and HCBS, including but not limited to, In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), long-term care services (skilled nursing facilities, intermediate care facilities, sub-acute services, etc.), home-delivered meals, home modifications, etc., through its partnership with the San Diego Aging and Independence Services (AIS), the local Area Agency on Aging (AAA), and its contracted senior service providers. The plan also works with AIS's Aging and Disability Resource Center (ADRC), which provides an integrated service delivery system for information and assistance, and serves as the gateway to AIS programs and services, and with Access to Independence, which is the Independent Living Center for San Diego County.

- Care1st conducts credentialing functions for all direct contracted providers in accordance with all federal and state regulations. Care1st also conducts a credentialing assessment on all Health Delivery Organizations (HDO) and these include but are not limited to: Hospitals, home health agencies ("HHA"), skilled nursing facilities ("SNF"), freestanding surgical centers, hospices, clinical laboratories, comprehensive outpatient rehabilitation facilities ("CORF"), outpatient physical therapy and speech pathology providers, providers of end-

stage renal disease services ("ESRD"), providers of outpatient diabetes self-management training, portable x-ray suppliers, rural health clinics ("RHC"), federally qualified health centers ("FQHC"), inpatient, residential and ambulatory behavioral healthcare providers, durable medical equipment, and other HDO's as deemed necessary.

- The primary care provider is the gatekeeper and responsible for identifying the needs of the beneficiary. Care1st, in conjunction with its delegated Medical groups and the primary care physician, works together to ensure that the beneficiary has access to the necessary services. Care1st conducts a Health Risk Assessment (HRA) on all newly enrolled members and every year thereafter. This information is used to produce an Individualized Care Plan (POC) for each member.

- The HRA and POC are provided to the PCP and details specifics on needs the member has. If a member has urgent needs Care1st will take a more proactive role in getting the member to appropriate care or working to obtain medical equipment or services. The PCP is responsible to utilize the HRA and POC in assessing the member for a full comprehensive physical when they become eligible and every year thereafter. The full comprehensive physical examination includes; a full risk assessment, medical and surgical history, medication reconciliation, vital signs and BMI, full functional assessment, full pain assessment, discussion of advanced directives, full head to toe physical examination and an assessment, documentation with a status and plan of all member chronic conditions. When the member needs specific specialty services the PCP submits an authorization request (to the Medical Group or Care1st as appropriate) and once the services are authorized, the beneficiary is notified in writing. Care1st provides unlimited transportation benefits. Therefore any beneficiary may access our free transportation in order to see their primary care physicians, specialist, receive dialysis or diagnostic services or to fill medications. In the event that beneficiaries require assistance with scheduling of appointments, they may seek assistance through Care1st Premier Member Services Unit. This unit is comprised of 5 member services representatives that are exclusively assigned to our Medicare beneficiaries. In addition to scheduling appointments, they can refer members for case management if they believe they will benefit from

it. As previously stated the Primary Care Physician and relevant specialists are part of the ICT, and therefore all medical records of these physicians become part of the overall care plan for each beneficiary. It is the responsibility of the Medical Group to ensure that all relevant information is integrated and available to all ICT members so care plans can be modified as needed.

- The primary care provider is the gatekeeper and responsible for identifying the needs of the beneficiary. The Interdisciplinary Care Team (ICT) resides at the Medical Group level, with Care1st representation. The composition of the ICT consist of all CMS required participants such as:
  - Primary Care Physician
  - Specialists
  - Case Managers
  - Social Workers
  - Care Navigators
  - Mid Level Providers such as Nurse Practitioners
  - Pharmacists
  - Health educators
  - Behavioral Health Providers
  - IHSS worker
  - CBAS provider
  - HCBS provider

  Care1st provides the Health Risk Assessment and Individualized Care Plan to the PCP, ICT, and member. Any specialized needs the member has will be identified and addressed by the Case Manager. The PCP is responsible to complete a comprehensive physical examination as described above. The PCP will identify additional specialized needs the member may have and will arrange these services through the ICT at the Medical Group level.

- Care1st assures that specialized services are delivered to the member in a timely and quality way through multiple checks and balances.
  - First when a member in newly enrolled Care1st conducts the Health Risk Assessment within 90 days of enrollment. The importance of this HRA is it gives Care1st the opportunity to identify the members' complex needs very early and work proactively to arrange the specialized services, including LTSS

and HCBS. During these HRA contact calls the member in encouraged to schedule the comprehensive physical with their PCP right away and we offer assistance in scheduling for them and providing free transportation. A summary of the HRA and an Individualized Care Plan is developed and sent to the PCP for the record.

- Care1st Quality Improvement department conducts access to care studies annually to monitor timeliness with appointment availability (PCP and specialists), after hours coverage, geographical distribution (done every six months) of PCP, specialist, hospitals and ancillary services.
- Care1st Quality Improvement department continuously monitors member grievances, potential quality issues (delay in auth, services etc.), and satisfaction surveys to identify breakdowns and opportunities for improvement that effect access and timeliness of care.
- Every SNP member is assigned a Care Navigator representative, which allows the member to have a specific person to develop a relationship with that is trained to resolve any issue the member may have with the care system. If the member was to have any problem with access to care or untimely services they have a person to contact to get their issue resolved immediately.
- The ICT is responsible for closely monitoring the member needs, care, and services. Care1st provides oversight of the ICT to assure member care and transitions are timely and that there is no breakdown in the quality of care and services.
- Members with specific conditions are identified and enrolled into Disease State Management programs, where member with these conditions are monitored and care is fast tracked with close communication with the ICT.
- Members with very serious and complex needs are referred to Complex Case Management programs, where specialized case managers work with the ICT to assure all care is fast tracked and member need are met.

- Care1st assures that reports on services are disseminated to PCP, ICT and any case or disease management case manager. In addition to providing the care team with the HRA and POC, Care1st routinely provides the care team with updated pharmacy utilization and diagnosis history reports. Providers can access this information

through the web portal. Care1st does this to assure continuity and coordination of care because a specialist might have prescribed a medication the PCP might not know about or the member might have a condition the PCP was not aware of.

- Care1st has implemented specific processes to assure continuity and coordination of care across care settings and providers.
  - With every admission Care1st completes a full medication reconciliation with the member upon discharge. The Inpatient Case manager is responsible to provide the medication reconciliation to the PCP, with a copy of the discharge summary. The case Manager also contacts the member to assure the discharge medication were filled and picked up and that the member is being compliant with the treatment plan.
  - All newly enrolled SNP members have a complete HRA done with the development of an POC, which is provided to the PCP and the ICT.
  - Care1st monitors the functions of the ICT to assure continuity and coordination of care is being met.
  - The provider web portal was developed to provide the PCP with information about the member medical conditions, results and diagnosis and treatment history that the PCP can utilize and provide updates to the plan.

- Care1st's Medical Management decisions are based on the Milliman Care Guidelines, which are nationally recognized evidence-based clinical practice guidelines. The members and providers have the ability to appeal any organizational determination to Care1st. Care1st adopts nationally recognized Clinical Practice Guidelines (CPGs), which are taken through our committees for discussion and recommendations. Our committees are comprised of network physicians, medical directors and QI staff but only physicians have voting rights. We assure that all clinical practice guidelines are approved through these committees annually. These CPGs include but are not limited to Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Coronary Artery Disease (CAD). In addition, the Behavioral Health CPG will include Depression. In addition to the Utilization Management Department using Milliman Care Guidelines, they also use nationally recognized clinical practice guidelines such as National Heart, Lung and Blood Institute, American Diabetic Association and U. S. Preventive

Services Task Force Standards. Review criteria are updated on an ongoing basis. For nationally recognized criteria sets they will be renewed at least every two years.

Describe how the Plan determined that their facilities and providers were actively licensed and competent;

Practitioner Initial and Recredentialing Process and Ongoing Monitoring

- All Care1st contracted practitioners, including but not limited to medical doctors, osteopathic doctors, podiatrists, dentists, optometrists, chiropractors, audiologists and psychologists are reviewed and evaluated against credentialing criteria and performance standards established by the Credentialing Committee prior to entering the Care1st network.
  - **Review process.** The Credentialing Committee is responsible for making decisions regarding initial credentialing of practitioners. The Credentialing Committee's decision will not be based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or payor sources. However, this will not preclude Care1st from including in its network practitioners who meet certain demographic or specialty needs.
  - **Initial application.** Care1st uses the *California Participating Physician Application* ("CPPA") and Addendum A, B, and C (Appendix A). The application will include an Attestation Questionnaire and Release, both must be signed (stamped signature is not accepted) and dated; the Attestation and Release must be no more than 180 calendar days old at the time of the Credentialing Committee's review and approval. This Attestation will require the applicant to provide information on:
    a) Reasons for inability to perform the essential functions as a practitioner, with or without accommodation;
    b) Lack of present substance abuse, including illegal drug use;
    c) History of loss of license and felony convictions;
    d) History of loss or limitations of privileges or disciplinary activities;
    e) Current malpractice insurance coverage; and
    f) Attestation by the applicant of the correctness and completeness of the application.

- **Completed initial application.** Each applicant will be required to submit a completed CPPA or similar application (dated no more than three (3) months) along with the following required supporting documentation:
  a) A copy of a current and unrestricted California medical or professional license, certificate or registration to practice or a Physician's Certificate of Registration while practicing medicine within the constraints of Section 2113 of the California Business and Professions Code;
  b) A copy of a valid DEA certificate (if applicable) with a California address. If the applicant has not been granted a DEA or if it is in the process of renewal, the applicant will need to provide written documentation that another practitioner with a valid DEA certificate is willing to write all prescriptions requiring a DEA number for the prescribing practitioner until he/she has a valid DEA certificate;
  c) A copy of a current malpractice liability insurance certificate, in the minimum amounts of $1 million per occurrence and $3 million aggregate ($1 million and $2 million for optometrists and audiologists);
  d) A current curriculum vitae ("CV") or documentation of at least the last 5 years of work history on the application. Any discrepancy or gap of six months or more in work history must be explained in writing;
  e) A copy of ECFMG (if applicable); and
  f) Written explanations regarding any sanction activity, pending malpractice suits, malpractice judgments/settlements in the last five years, restriction of privileges, etc

- **Incomplete application.** If the application received is deemed incomplete by the credentialing staff, the applicant will be notified by facsimile, letter, email or telephone of any incomplete (e.g. application which is incomplete, is not accompanied by all supporting documentation, is dated more than three months prior to receipt, etc.). The Credentialing Department will make three (3) attempts over a 60-day period to obtain the information. Failure to submit the information after the third attempt will be considered a voluntary withdrawal of the application and will result in the applicant not being added to the Care1st network. This information

will be forwarded to the Provider Network Operations ("PNO") Department.

- **Recredentialing date.** All practitioners will be recredentialed no more than every three (3) years from their Credentialing Committee approval date.

- **Recredentialing packets and initial notification.** The Credentialing Department mails recredentialing packets to the practitioners six (6) months prior to the end of their three (3) years appointment period. Each recredentialing packet includes a California Participating Physician Reapplication ("CPPR") (Appendix D) pre-populated with the practitioner's data stored in the credentialing database, Addenda A, B and C, a list of currently contracted hospitals, a stamped self-addressed return envelope, and a cover letter that specifies the supporting documents to be returned with the application and that the application is due back to the Credentialing Department within thirty (30) calendar days. The CPPR will include an Attestation Questionnaire and a Release; the practitioner will be instructed to answer all questions on the Attestation and to sign and date both the Attestation and Release. Both the Attestation and Release must be no more than 180 calendar days old at the time of the Credentialing Committee's review and decision. The Provider Network Operations ("PNO") Department is given a list of practitioners who are sent recredentialing packets.

- **Second notification.** If the recredentialing packet is not received after 35 calendar days, the Credentialing Department sends a second notice to the practitioner requesting the recredentialing application be submitted within fifteen (15) calendar days. PNO is given a list of practitioners who are sent the second notice for recredentialing packets.

- **Final notification.** If the recredentialing packet is not received after twenty (20) calendar days of the second notice, the Credentialing Department sends a third and final notice by certified mail requesting the recredentialing application be submitted within ten (10) business days. The practitioner will be informed via the final notice that failure to submit the recredentialing application by

the deadline will be considered a voluntary resignation from the Care1st network and will be forwarded to the Credentialing Committee for "Administrative Termination" effective the last day of the month of the Committee review. A list of these non-compliant practitioners, along with a copy of the final notice, is forwarded to PNO to assist in follow-ups with the requests for recredentialing.

- **Non-compliance with recredentialing.** If the recredentialing packet is not received after fifteen (15) days after the final notice, the Credentialing Department sends a list of the practitioners who have not returned their recredentialing packets to PNO. PNO will administratively terminate the practitioner from the network for being non-compliant with recredentialing pursuant to Policy 70.1.3.4.

- **Credentialing file.** The Credentialing staff will set up a confidential credentialing file for each applicant and initiate a credentialing checklist, which is used as a worksheet to track verification process. The file will include the application, all the supporting documentation received, all the verifications, and facility site review (if applicable).

- **Verification Sources.** Care1st will verify the above information from one of the following sources:
  a. The primary source, the entity that originally conferred or issued the credential;
  b. A contracted agent of the primary source. If the agent is used, Care1st will obtain documentation from the agent indicating that there is a contractual relationship between it and the approved source, entitling it to provide verification of specific credentials on behalf of the approved source (e.g., licensure verification by an agent on behalf of the state licensing board, education verification by an agent on behalf of a medical school); or
  c. Another NCQA-accepted source listed for the credential (e.g., AMA, AOA, CertiFacts).

- **Primary source verification and timeframe.** Upon receipt of a completed application, the Credentialing Department will verify, through the most effective methods (e.g. online, in writing or verbally) the information below with the listed sources. The

Credentialing Department will obtain, additional information or clarification, as needed, to provide the Credentialing Committee with adequate information to make an informed decision regarding the applicant's qualifications. All verifications will be date-stamped, initialed, and will not be more than 180 days old at the time of the credentialing decision. Although work history does not require primary source verification, the Credentialing Department will review, within 180 calendar days of Committee decision, for documentation of a minimum of five years (or since the time of initial licensure, whichever is less) of relevant work history via the practitioner's application or CV; any gap of 6 months or more during the reviewed period must be clarified in writing. The time limit for the application and all credentialing verifications must be no more than 180 calendar days old at the time of the credentialing decision, unless otherwise stated below:

a. A current California license, certificate or registration to practice must be verified with the appropriate board listed:
   - Physicians: Medical Board of California ("MBC") or Osteopathic Medical Board of California ("OMBC");
   - Podiatrists: Board of Podiatric Medicine ("BPM") of California;
   - Dentists: Dental Board of California ("DBC");
   - Optometrists: California Board of Optometry;
   - Psychologists: California Board of Psychology or MBC;
   - Chiropractors: California Board of Chiropractic Examiners; or
   - Speech-Language Pathologists and Audiologists: California Speech-Language Pathology and Audiology Board or MBC.
b. Current and valid DEA, if applicable, can be verified with a legible copy or with the U.S. Drug Enforcement Administration, the National Technical Information Service ("NTIS") website, or the American Medical Association ("AMA").
c. Current and adequate malpractice insurance can be verified with a legible insurance certificate of coverage or directly with the insurance carrier (No verification time limit ("VTL") but must be received prior to Committee decision).
d. Hospital privileges, if applicable, directly from the hospital(s) listed on the application.
e. Current Board certification, if applicable, from:
   - Physicians: American Board of Medical Specialties ("ABMS"), its member boards or through an official ABMS

Display Agent, entry in the AMA Physician Master File, or entry in the American Osteopathic Association ("AOA") Master File;

- Podiatrists: American Board of Podiatric Surgery ("ABPS") or American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM")
- Dentists: Various specialty board – however, board certification is not a substitute for verification of dental education or residency; or
- Non-Physician Medical/Behavioral Professionals: confirmation from the specialty board, state licensing agency, or registry. If the state licensing agency or registry are used, there must be an annual written confirmation from these agencies stating that they conduct primary source verification.

f. If the practitioner is not board certified (except for dentists), the highest level of training or education may be confirmed from one of the following (VTL = none, however, the verification must be received prior to Committee decision):
   - Physicians: from the residency training program, AMA or AOA Physician Master File, confirmation from an association of schools of the health professions or the state licensing. If the association of schools or state licensing agency are used, there must be an annual written confirmation from these agencies stating that they conduct primary source verification;
   - Podiatrists: from the residency training program or podiatry medical school, entry in a podiatry specialty board master file or the state licensing agency. If the specialty board or state licensing agency are used, there must be an annual written confirmation from these agencies stating that they conduct primary source verification;
   - Dentists: confirmation from the dental school, appropriate specialty program of residency training, or the state licensing agency. If the state licensing agency or is used, there must be an annual written confirmation from that they conduct primary source verification; or
   - Non-Physician Medical/Behavioral Professionals: confirmation from the professional school, state licensing agency, or a specialty board or registry. If the state licensing

agency, specialty board or registry is used, there must be an annual written confirmation from these agencies that they conduct primary source verification.

g. Professional liability claims for the last five (5) years can be verified by querying the National Practitioner Data Bank ("NPDB") or the insurance carrier directly.
h. License sanction activities may be verified with the individual licensing board, Federation of State Medical Boards ("FSMB"), NPDB, or Healthcare Integrity and Protection Data Bank ("HIPDB").
i. Medicare or Medicaid sanction activities may be verified from the NPDB-HIPDB, FSMB, Office of Inspector General ("OIG") website, Medicare Exclusion and Reinstatement report, Medi-Cal Suspended and Ineligible Provider List, or AMA Physician Master File.
j. Medicare Opt-Out status from the Palmetto GBA website (http://www.palmettogba.com).

- **Hospital privileges.** The applicant must have unrestricted privileges in the specialty that he/she is practicing. Verifications of hospital privileges must be done no more than 180 calendar days prior to credentialing decision. Primary Care Practitioners ("PCPs") and physicians practicing in specialties that do not typically require hospital privileges (i.e. Allergy & Immunology, Dermatology, Pathology, Radiology, Radiation Oncology, Psychology, Optometry, dental Surgery, Physical Therapy, Audiology, Chiropractic, and Acupuncture) may be exempt from this requirement upon approval by Care1st's Chief Medical Officer ("CMO"). However, the PCPs must arrange with other physicians in the same specialty in the Care1st network to cover inpatient admissions. A letter from the covering physician will be required to verify this arrangement or the PCP may use the Care1st admitting hospitalist panel of physicians to cover for their inpatient admissions. Care1st may also, at its discretion, credential physicians who have privileges at contracted free-standing surgical centers.

- **Facility site/medical record review.** There will be an initial facility site/medical record review of all PCP's offices prior to inclusion in the Care1st network. This will be a structured visit, in accordance

with the Quality Improvement ("QI") facility site review and medical record procedures. The facility site review must be conducted within three (3) years prior to initial credentialing. A PCP who joins the practice or of an existing Care1st PCP, who has passed a facility site review within the previous three (3) years, may be credentialed pending a medical record review within six (6) months of joining the network.

- Once added to the network, all practitioners are subjected to a surprise office site visit each time the QI Department receives a member complaint about the quality, safety or accessibility of the practitioner's site. This type of member-complaint related office site visit will be conducted in accordance to QI P&P 70.1.4.12.

- **File review.** The Credentialing Department will review all documentation for completeness, accuracy, and to ensure that all verifications are still valid and within the specified timeframe. When the file is complete, the credentialing staff will sign and date the credentialing checklist and forward this information to the Credentialing Committee in a summarized credentialing report that will include, but not limited, to board certification status, training, hospital affiliations, and facility site review status (if applicable). The applicant's license number will be used as the identifier on the credentialing report; no names will be used.

- **Negative information.** If the Credentialing Department identifies any negative data during the credentialing process, this information will be flagged and forwarded to the CMO and Credentialing Committee for review. Negative data includes but is not limited to:
  a. Any state medical or professional license disciplinary action, 805 reports or state hearing procedures or sanctions;
  b. Any information was reported by the NPDB/HIPDB;
  c. Training not commensurate with requested status;
  d. Any reported death involving the applicant;
  e. Medicare/Medicaid sanction activity;
  f. Any discrepancies on the applicant's attestation questions;
  g. Any issues involving lack of or restriction of hospital privileges;
  h. Any issues involving malpractice insurance coverage; and

i. Any malpractice claims, either open or closed with payment, in the last 5 years.

- **Applicants with no negative information.** A list of applicants for initial credentialing with no negative information is presented to the CMO for "clean" file review or the Credentialing Committee for review and approval. The Committee/CMO is provided sufficient information to adequately assess the applicant's qualifications.

- **Applicants with negative information.** All applicants identified with negative data as defined above are reviewed by the CMO, then forwarded to the Credentialing Committee to review the issues and to recommend action. If the Committee recommends denial of membership (Initial Credentialing), termination or restriction of privileges (if currently credentialed) based on a medical disciplinary cause or reason, the applicant will be afforded fair hearing rights in accordance with Credentialing P&P 70.1.3.10. Negative information fond through hot sheets or ongoing monitoring activities will be added to the practitioner file between credentialing cycles.

- **Report to Board of Directors.** A report of the decisions of the Credentialing Committee is forwarded to the Board of Directors for final approval. The Credentialing Committee approval date is considered the approval date for determining that the individual credentials verifications meet the established time limits.

- **Performance monitoring**. Care1st incorporates data from the following sources in the recredentialing decision-making:
  a) Quality Improvement ("QI") Activities (all practitioners);
  b) Utilization Management ("UM") Data (all practitioners);
  c) Member Grievances (all practitioners);
  d) Facility Site Review within 3 years (Medi-Cal PCPs only); and/or
  e) Medical Record Review within 3 years (Medi-Cal PCPs only).

Facilities Initial and Reassessment Process and Ongoing Monitoring

Prior to contracting with the HDO, Care1st assess the HDO to ensure they are able to provide quality care and service to Care1st. Re-

evaluation of the HDO will be performed every three (3) years thereafter. The assessment includes:

- Confirmation that the HDO is in good standing with state and federal regulatory bodies;
- Confirmation that the HDO has been reviewed and approved by an accrediting body; and
- If the HDO is not accredited, conducts an onsite quality assessment.

Care1st will include the following HDO in its assessment:

- Medical providers:
  a) Hospitals
  b) Home health agencies ("HHA")
  c) Skilled nursing facilities ("SNF")Freestanding surgical centers
  d) Hospices
  e) Clinical laboratories
  f) Comprehensive outpatient rehabilitation facilities ("CORF")
  g) Outpatient physical therapy and speech pathology providers
  h) Providers of end-stage renal disease services ("ESRD")
  i) Providers of outpatient diabetes self-management training
  j) Portable x-ray suppliers
  k) Rural health clinics ("RHC")
  l) Federally qualified health centers ("FQHC")
- Behavioral healthcare providers:
  a) Inpatient
  b) Residential
  c) Ambulatory
- Durable Medical Equipment
- And other HDO as deemed necessary.
- Care1st will not contract with HDO, as described above, that have not been approved either by a recognized accrediting body or been through a Centers for Medicare & Medicaid Services ("CMS"), Department of Health Care Services ("DHCS") or Care1st site review.

- As part of the initial contract/application package, HDO providers must submit the following documentation PNO:
  a) Proof of current good standing with applicable state and federal regulatory bodies; and
  b) Proof of current accreditation by an approved accrediting body;
  c) If not accredited, evidence of review and approval by CMS or DHCS within the previous three (3) years; and

d) Proof of current malpractice liability insurance. The minimum required coverage for hospitals, home health agencies, skilled nursing facilities, and freestanding surgical centers is $1 million per occurrence and $3 million annual aggregate.

- The Credentialing Department perform the following:
  a) Confirms the HDO is in good standing with state and federal regulatory bodies:
     - State licensing agency (i.e. DHCS)
     - Physician-owned surgical clinics are not required to be licensed by the California Department of Public Health ("CDPH") but must be accredited by an agency approved by the Medical Board of California ("MBC")
       a) Federal regulatory bodies will be accomplished by query of the Office of Inspector General ("OIG") online exclusion database to ascertain whether the provider has been excluded from participation in Medicare
       a. Confirms HDO is accredited by one of the following accepted accrediting bodies:

Provider	Approved Accrediting Bodies
Hospitals	• The Joint Commission ("TJC") • Healthcare Facilities Accreditation Program ("HFAP"), the accrediting program approved by the American Osteopathic Association ("AOA") • Det Norske Veritas National Integrated Accreditation for Healthcare Organization ("DNVNIAHO")
Home Health Agencies	• TJC • Community Health Accreditation Program ("CHAP") • Accreditation Commision for Health Care Inc. ("ACHC")
Skilled Nursing Facilities	• TJC • Commission on Accreditation of Rehabilitation Facilities ("CARF") • Continuing Care Accreditation Commission ("CCAC")
Free Standing Surgical Centers	• TJC • American Accreditation Association for

Provider	Approved Accrediting Bodies
	Accreditation for Ambulatory Surgery Facilities ("AAAASF") • Accreditation Association for Ambulatory Health Care ("AAAHC")
Hospices	• TJC • CHAP
Clinical Laboratories	• Clinical Laboratory Association Improvement Amendments ("CLIA") Certificate • CLIA Waiver • Commision on Office Laboratory Accreditation "COLA")
Comprehensive Outpatient Rehabilitation Facilities ("CORF")	• TJC • CARF
Outpatient Physical Therapy and Speech Pathology Providers	• No accreditation, but must be certified by Medicare
Providers of End-Stage Renal Disease Services ("ESRD")	• No accreditation, but must be certified by Medicare
Providers of Outpatient Diabetes Self-Management Training	• American Association of Diabetes Educators ("AADE") • Indian Health Service ("IHS")
Portable X-Ray Suppliers	• Federal Drug Administration ("FDA") Certification
Rural Health Clinics ("RHC")	• No accreditation, but must be certified by Medicare
Federally Qualified Health Centers ("FQHC")	• No accreditation, but must be certified by Medicare
Behavioral Health Care Providers (inpatient, residential, and ambulatory)	• TJC • CARF • HFAP • Council on Accreditation for Children and Family Services ("COA")
Durable Medical	• No accreditation, but must be certified by

Provider	Approved Accrediting Bodies
Equipment ("DME")	Medicare

c. Conducts an on-site quality assessment, if the HDO is not accredited. The criteria for site audit may vary, according to the type, size and complexity of the HDO under review. The criteria may include, but not be limited to, verifying that the HDO had credentialed their practitioners, interviews with senior management, chiefs of major services, and key personnel in nursing, Quality Improvement ("QI") and Utilization Management ("UM"). Care1st may, at its discretion, decide to conduct an onsite audit for accredited HDO as well.
   i) Although CMS or state review or certification does not serve as accreditation of the facility, in the case of non-accredited facilities, Care1st may substitute a CMS or state review (i.e. DHCS) in lieu of the required site visit. In this case, the Credentialing Department must obtain the report from the HDO to verify that the review has been performed and that the report meets Care1st standards.
   ii) Care1st may contract with a non-accredited HDO that has not been audited by CMS or the state **if** the HDO is located in a rural area; evidence of the HDO meeting this requirement will be included in the HDO file.

2. The Credentialing Department will maintain a database of all credentialed HDO which will include information on their standing with state and federal regulatory bodies and accreditation status. The required documents will be maintained in the HDO's file which will include a checklist (attached) used to document the receipt of each required documents

3. Once the HDO file is completed, it will be presented to the Credentialing Committee for review and approval. The HDO files may be presented on a list which will include sufficient information for the Committee to adequately assess the HDO's qualifications. If any issues (i.e. malpractice judgment, state disciplinary action or citation) are identified against the HDO, then the issues will be forwarded to the Credentialing Committee for review.

4. HDO's that are identified with negative information are reviewed by the Chief Medical Officer ("CMO") and forwarded to the Credentialing Committee for review and action. Negative information obtained after the

HDO has been actively contracted will be added to the HDO file and forwarded to the CMO and to the Credentialing Committee for review and action.

5. **Notification.** The Credentialing Department notifies the PNO Department of the final credentialing decision. The PNO Department will follow their procedures for executing the contract. After execution, the PNO Department will submit a *Provider Database Maintenance Form* ("PDMF") to the Provider Data Maintenance ("PDM") Department to add the practitioner to the network, in accordance with Credentialing P&P 70.1.3.19. The Credentialing Department provide a list of approved HDO's to the Board of Directors' meeting and after the Board of Directors' final approval of the Credentialing Committee's decision, the Credentialing Department will mail the approval letters to the practitioners notifying them of the Committee's decision. These letters will be mailed within sixty (60) calendar days of the Credentialing Committee's decision.

6. Prior to the expiration of certification, licensing or accreditation, but in any case not less than every three (3) years, the Credentialing Department will require the HDO to submit evidence that they remain in continued good standing with the regulatory body and/or that they have received continued certification or accreditation. HDO's that are not accredited will be required to submit their latest CMS or DHCS site review.

9. The CMO will initiate sanctions, in accordance with the terms of the contract, against any HDO found, during the reassessment or at any time, to no longer be in good standing with a regulatory body or to no longer be accredited. The CMO may also delegate this responsibility to the Credentialing staff.

10. The Credentialing Department will provide reports on the status of HDO to the Credentialing Committee on an as needed basis, but not less than three (3) years since the HDO's last credentialing date.

Describe who determines which services beneficiaries will receive;

The primary care provider functions as the gatekeeper and responsible for identifying the needs of the beneficiary. Care1st in conjunction with its delegated Medical groups and the primary care physician work together to ensure that the beneficiary has access to all medically necessary and appropriate services. Requests for authorizations for services/care are submitted to the Medical Group for review and adjudication within established time frames. The turnaround time is dependent on the clinical urgency of the authorization. Once the services are authorized, the beneficiary is notified in writing.

An example of services the beneficiary will receive is the "Evidence of Coverage" provided to the beneficiary at time of enrollment. Section 1.2 "Basic rules for getting your medical care that is covered by the plan" delineates the "referral" process in detail and provides examples of types of care that would require a referral. The beneficiary can call Member Services for further explanation, clarification, inquiry regarding referral status or assistance with the referral process.

Another example in the "Evidence of Coverage" is section 2.2 "What kinds of medical care you get without getting approval in advance from your PCP" itemizes the services available to the beneficiary, e.g. routine women's health care, preventive health services, flu shots, etc. As example the beneficiary can receive their flu and pneumonia vaccinations from their PCP and a referral is not required to be submitted.

See *attachment Element 5, Factor C*

Another example is the transportation benefit for beneficiaries. Care1st provides unlimited transportation benefits. Therefore any beneficiary may access our free transportation in order to see their Primary care physicians, a specialist, receive dialysis or diagnostic services or to fill medications. In the event that beneficiaries require assistance with scheduling of appointments, they may seek assistance through Care1st Premier Member Services Unit. This unit is comprised of five member services representatives that are exclusively assigned to our Medicare beneficiaries. In addition to scheduling appointments, they can refer members to case management for evaluation and ambulatory management if they believe additional intervention is warranted.

Care1st has a partnership with the AIS, the designated AAA for San Diego County, and its contracted providers, to provide LTSS and HCBS in the home for complex care members with unmet long-term care needs. Members are identified as having potential social services needs through the following: health risk assessments (HRAs), concurrent inpatient rounds, case management, interdisciplinary care team (ICT) referrals, and provider and member referrals. Once a beneficiary is identified as at-risk, the plan will send a Case Manager to the member's home to perform a comprehensive in-home assessment, which looks at financial need, activities of daily living, orientation, behaviors, environmental problems/barriers, medications, medical and behavioral health conditions, nursing services and treatment, risk for falls, assistive devices and nutritional status. The assessment identifies members that may qualify for LTSS and HCBS through including but not limited to: transportation, home care, counseling, legal assistance, home making /chore assistance, home delivered meals, benefits assistance program, and a family caregiver support program. Dual members will be assigned to a Care Navigator, who is responsible to navigate the member throughout the care continuum, including medical, behavioral health, LTSS and HCBS.

Each member who enrolls with Care1st selects their Primary Care Physician (PCP). The PCP is responsible for coordinating the care and has a list of responsibilities to that end outlined below that are incorporated into our provider agreements. However Care1st works closely with the Primary Care Physician in developing a Plan of Care as part of the Model of Care program to ensure dual eligible members are provided access to Medical, Behavioral Health and Social Services.

PCPs provide comprehensive Primary Care services to Plan Members. The PCP or usual practitioner is the Member's gatekeeper. The PCP or usual practitioner, as a key member of the ICT receives and provides information on needed services. The PCP or usual practitioner orders services for the member via the case manager who coordinates the use of participating providers/vendors, etc and reports on any update to the member's care to the members of the ICT via the care plan. The case manager in collaboration with the Utilization Management department reviews the request for service/supplies. The case manager obtains an authorization, reports the approval to the ICT, and coordinates the needs for the member via the network providers/vendors. If the requested service/item is not an authorized member benefit, the case manager and UM employee review

the request with the Medical Director for further determination. Upon review, either a peer to peer consult is conducted, or communication is sent to the requesting provider to inform of the determination. The case manager will also contact the provider to verbally discuss the outcome.

Care1st along with the provider network work in conjunction to ensure that the member has access to the necessary services. The member is notified of the process for obtaining services/referrals through the member information that is distributed upon enrollment, as well as the PCP or gatekeeper and case manager (ICT). Below please find an example of an Evidence of Coverage document which the member receives upon enrollment into the SNP plan.

PCP Responsibilities:

Following is a summary of responsibilities specific to PCPs who render services to Plan Members.

- Coordinate, monitor and supervise the delivery of Primary Care services to each member.
- Ensure the availability of physician services to members in accordance with “Appointment Scheduling”.
- Arrange for on-call and after-hours coverage in accordance with the after-hours service.
- Ensure members are aware of the availability of public transportation, where available, and the medical non-emergency transportation service.
- Provide access to the Plan or its designee to examine thoroughly the Primary Care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as: having influence, ownership or control and either a financial relationship or a relationship for rendering services to the Primary Care office.
- Submit an encounter/claim for each visit where the provider sees the member or the member receives a HEDIS service.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
- See members for an initial office visit and assessment within the first 90 days of enrollment in the Plan.
- Notify patients of authorization decisions when received from the Plan.

The case manager takes an active role in determining additional services such as transportation needs, community resources, etc. Case Managers make determination based on clinical knowledge and understanding of benefits coordination. A case manager may recognize the need and eligibility for certain transportation services and can arrange directly with a transportation provider for the member.

Care1st along with the provider network work in conjunction to ensure that the Member has access to the necessary services. The Member is notified of the process for obtaining services/referrals through the Member information that is distributed upon enrollment, as well as the PCP or gatekeeper and case manager (ICT).

Below please find an example of an Evidence of Coverage document which the Member receives upon enrollment into the SNP plan.

2011 Evidence of Coverage for Care1st Health Plan
Chapter 3: Using the plan's coverage for your medical services 30

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care that is covered by the plan

Care1st Health Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. It needs to be accepted treatment for your medical condition.
- **You have a primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.2 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).

- **You generally must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. We must authorize this care before you receive it. In this situation, you will pay the same as you would pay if you got the care from a network provider.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

Your PCP is a physician who meets state requirements and is trained to give you basic medical care. A PCP can be a Family Practitioner, General Practitioner or Internal Medicine provider. You will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you need. These covered services include:

- x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

Below is an example of the Referral Form utilized by the provider network to request services.

San Miguel IPA

REFERRAL/AUTHORIZATION REPLY [redacted]

Care 1st Health Plan (Medicare) TRACKING # 177879

ATTN UM

OUTPATIENT REFERRAL

Pended

Standard Authorization

PATIENT:	[redacted]	MEMBER ID#:	[redacted]
ADDRESS:		H-PHONE:	
		SEX:	Female
	[redacted]	D.O.B:	[redacted]
REQUESTED DATE:	03/03/2011	ELIGIBLE:	Yes 09/01/2010
REVIEWED DATE:	03/04/2011	RETRO DOS:	
EXPIRATION DATE:	04/03/2011		

REQUESTING PROVIDER/PCP	SPECIALIST	FACILITY
Heltor, Fernanda M.D.	Kayvanfar, John M.D.	
5417 Pacific Blvd	16573 Ventura Blvd.Sre 5	
Huntington Park, CA 90255	Encino, CA 91436	
Tel:(818) 920-0303	Tel:(818) 990-9722	Tel:
Fax:(818) 920-6603	Fax:(661) 947-8665	Fax:

DIAGNOSIS:	714.0	RHEUMATOID ARTHRITIS
	715.00	GENERALIZED OSTEOARTHROSIS UNSPECIFIED SITE

QTY	CPT/SVC	DESCRIPTION	REQUESTED SERVICES
2	99215	OFFICE/OUTPATIENT VISIT, EST	
# OF VISITS:	1		

Response:

1) The member must remain eligible with the health plan/IPA at the time of service for this Authorization to remain valid
2) Authorization for the above services will expire on **04/03/2011**
3) Questions about this referral may be directed to the Utilization Management Department at (323) 923-4160
If you disagree with the findings of this Referral, you may Appeal in writing. You may also request criteria used in this determination. The Medical Director or Physician Review is available to discuss this determination at any time. Please contact the UM Department for further direction.

APPROVED
By LAURA at 4:27 pm, Mar 10, 2011

SAN MIGUEL MEDICAL CLINIC

FAX

FROM: Nana

DATE: 3.3.11

Attn: MSO

COMPANY:

FAX NUMBER: 3239234166

FROM: SENIORS CENTER
PANORAMA CITY
8771 VAN NUYS BLVD.
VAN NUYS, CA. 91402

PHONE: (818) 221-4286

FAX: (818) 221-4287

CC:

NUMBER OF PAGES INCLUDING COVER SHEET: 3

REMARKS:

☐ URGENT ☐ REPLY REQUIRED ☐ OTHER

please refer to 56557

RECEIVED MAR 04 2011 By

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OLYMPIC ORTHO PAGE 01/8

OLYMPIC ORTHOPAEDIC & SPORTS MEDICINE GROUP

JOHN J. KAYVANFAR, M.D.

FAX SHEET

To: Maria

Fax #: 818-221-4287 Phone #:

From: Yesenia

Fax #: (661) 947-8665 Phone #: (661) 947-0078

Date: 3/2/11 Time:

Number of pages to follow: 1

Regarding: Request for 99215 x 2 for Silvia Reyes

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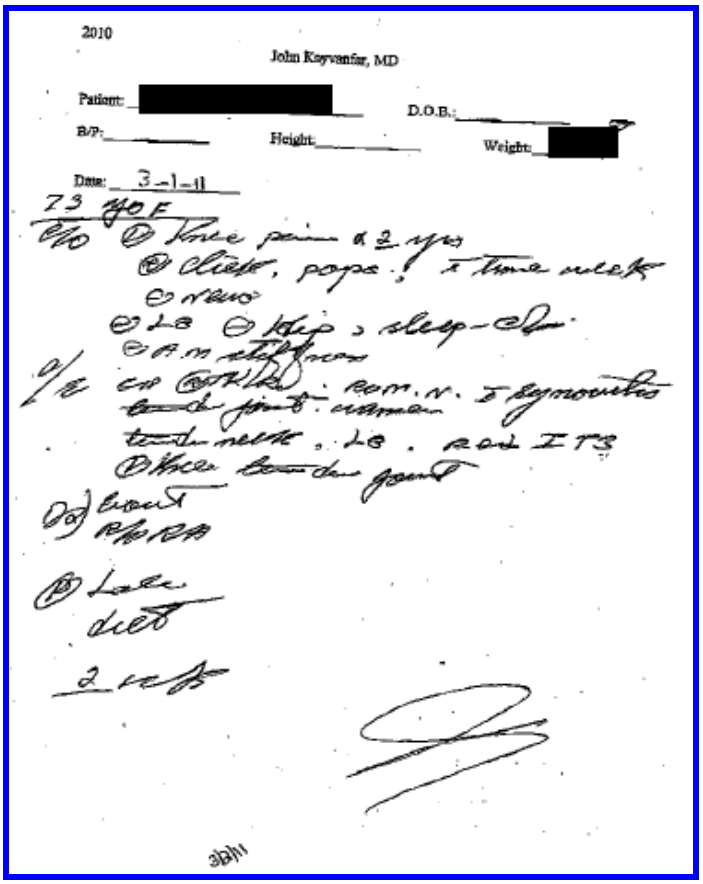
John Kayvanfar, M.D.
40005 10th St. West Suite 213
Palmdale CA 93551

(661) 947-0078 FAX (661) 947-8665



2010

John Kayvanfar, MD

Patient: [redacted] D.O.B.:

B/P: Height: Weight: [redacted]

Date: 3-1-11

Below is an example of submitted authorization data entered into our authorization system to capture all required elements for processing.

```
HC431                    ENTER / UPDATE AUTHORIZATIONS          ENTRY DATE  03-10-11
   AUTH NO. [redacted]          TYPE MD     LOB 2400 REG 310    PCP HEITOR, FERNANDA DE
1. SUBSCRIBER [redacted]        MEM  01   M/R                   NAME [redacted]
   GROUP [redacted]                                                          AGE [redacted] SEX F

2. ADMISSION/SERVICE DATE 03-10-11          9. TRANSPORTATION TYPE R
3. EXPIRATION DATE        04-30-11         10. INTERVIEWER LP       LAURA E PERE
4. REFERRED BY 24481     KAYVANFAR, JOHN   11. INT. DATE    03-10-11   TIME
5. REFERRED TO 24481     KAYVANFAR, JOHN   12. ESTIMATED AMOUNT           0.00
   VENDOR  A1  8336      EHS               13. LIABILITY (Y/N/S/V)  Y    ADJ UM
6. ATT. PROV   45184     HEITOR, FERNAND   14. STATUS
7. DIAGNOSIS                MSO DA  (1)
   714.0     ARTHRITIS, RHEU  N  N         15. COB (W/A/O)
   715.00    OSTEOARTHROSIS,  N  N         16. SSO WAIVE/CONCUR (W/C)
                                               WAIVER CODE
8. PLACE OF SERVICE 11       OFFICE         17. AUTH. PROV/VEND/GLOBAL (P/V/G) P
                                            18. #VISITS ALLOWED

   CHANGE FIELD        F=FILE  DEL=DELETE  I=IN/OUT INFO.  O=OTHER OPTIONS
AUTHORIZATION NEEDS TO BE ADJUDICATED
5/4/2011 5:11:46 PM  HOSTACCESS - Care1st

HC431.PROC                AUTHORIZATION PROCEDURE SUBSCREEN
AUTHORIZATION 573676*MD        ADMISSION/SERVICE DATE 03/10/2011

     FROM DT  PROCEDURE    MOD          QTY   DAYS     COPAY      COINS AMB AR SSO
(1)  THRU DT  DESCRIPTION               TOS          BENEFIT    EST AMT G/L CODE
 1.  03/10/11 99215                      1      1      0.00       0.00 N   N  N
     04/30/11 OFFICE OR OTHER OUTP      OS            9SSPC02      0.00 630020

 2.

 3.

 4.

 5.

CHANGE FIELD          S=SAVE   X=EXIT   R=REDISPLAY   O=OTHER OPTIONS
AUTHORIZATION NEEDS TO BE ADJUDICATED
5/4/2011 5:11:56 PM  HOSTACCESS - Care1st
```

Below is the notification document mailed to member to describe services requested and approved with all required information.

Date 03/11/2011

Member: [redacted]

Patient DOB: [redacted]

Rel to Sub: Subscriber

ID#: [redacted]

Health Plan: **Care 1st Health Plan**

PCP: [redacted]

Patient Phone: [redacted]

Re: [redacted]

Referring Physician (*Referido por Doctor*): [redacted]

Request for services have been authorized as follows (*El siguiente servicio a sido autorizado*):

Service (*servicio*):

99215 QTY: 1 OFFICE VISIT EST. LEVEL 5

Refer to (*referido a*): [redacted]

Specialty (*Especialidad*): ORTHOPAEDIC SURGERY

Your authorization number is (*Su numero de autorizacion es*): [redacted]*MD Expiration:04/10/2011

You may call for an appointment at your convenience. If you cannot make your appointment within 30 days, please notify your Primary Care Physician so an extension can be generated.

If you have any questions regarding this authorization, please phone us at 1-800-468-9935.

Puede llamar al especialista para hacer una cita. Si no puede asistir a su cita en los proximos 30 dias, notifiquele a su medico primario para que se le pueda hacer una extension.

Si tiene algun pregunta sobre esta carta, comuniquese con nosotros al telefono 1-800-468-9935.

Care 1st Health Plan (Utilization Management Department)

NOTICE TO PROVIDER SERVICES

This authorization certifies medical necessity only. Payment is guaranteed only if the Member is eligible at the time the services are rendered. DO NOT BILL THE PATIENT.

This authorization is valid for the month it is authorized. Request for continuation of services or additional services should be directed to the Care 1st Utilization Management Department.

Send claims to Care 1st Health Plan: 601 Potrero Grande Drive
Monterey Park, CA 91755 1-800-468-9935

Interpreter services for Care1st members are available at no cost, and can be scheduled by calling Care1st member services department at 1-800-605-2556.

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Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services;

As previously stated the Primary Care Physician and relevant specialists are part of the ICT, and therefore all medical records of these physicians become part of the overall care plan for each beneficiary. It is the responsibility of the Medical Group to ensure that all relevant information is integrated and available to all ICT members so care plans can be modified as needed.

It is the responsibility of the Case Managers and Care Navigators to ensure that all health care needs such as specialty referrals, durable medical equipment or medications authorizations are submitted and processed timely. It is also the Case Manager's responsibility to ensure that appointments are made and kept and that transportation if needed be provided. Based on results of consultations or diagnostic testing the Case

Manager is responsible for updating the POC and communicating the changes to the PCP or other relevant ICT members either in writing or telephonically. In addition, any changes to the POC must be communicated to the member telephonically and encouraged to discuss them with the provider in the next office visit.

Example: New beneficiary completes the HRA answers question # 16 which asks "Are you currently being treated for any of the following health conditions" "Yes" to "Congestive Heart Failure" and "Yes" to "If you have Congestive Heart Failure, have you been hospitalized for it in the last 12 months. This response generates the POC identifying this as a "Problem" requiring "Intervention" by a Case Manager and the beneficiary's PCP. In reviewing this beneficiary's clinical history it is established that there was no prior evaluation by a Cardiologist to determine severity or classification of CHF. All available clinical data is presented to the ICT with the cardiology and case management present. The recommendation is for a cardiology referral, and an echocardiogram to determine ejection fraction. The member will be enrolled in Care1st CHF Disease Management Program. The Case Manager will ensure all referrals completed, member notifications, appointments scheduled, transportation arranged. The interventions are documented in the ICT minutes, POC updated and communicated to the beneficiary and their PCP.

HB 02/2011 – 03/2011

The Care1st member was admitted to a skilled nursing facility for skilled rehabilitation following her admission to the local emergency room for status post-fall with hip fracture. The member was previously independent with all activities of daily living and lived with a son who worked erratic hours. The Care1st Social Worker contacted the member's two sons to coordinate the member's care and discharge plan. It was reported that the two sons would not be able to provide consistent care if the member were to discharge home. The Care1st Social Worker discussed alternative placement and care giving options with the member and her sons. Discussion included admission to an RCFE, ALF, long term skilled nursing facility, or an additional caregiver, either through IHSS or privately. Member expressed strong preference to return home. Following approximately three weeks of rehabilitation, the Care1st Inpatient Case Manager discussed with the Care1st Social Worker regarding the member's anticipated Last Covered Day. Concerns persisted regarding the member's care giving coverage at home. The Care1st Social Worker then contacted the social

services team at the nursing facility and requested their assistance to also discuss the concerns and to present a temporary RCFE/ALF placement. The nursing facility social worker followed up with the member but the member declined all alternative options. She maintained preference to return home. Member returned home and reported that she tolerated the transition well. Case was then referred to Care1st Home Health Case Manager and home health services were initiated. Care1st Social Worker explored the IHSS program with the member again but she expressed reluctance to pay her Medi-Cal share of cost for the care giving services. Care1st Social Worker then conference-called Department of Social Services as well as Social Security Administration with the member to clarify her share of cost. Member declined changes they proposed for $0 SOC eligibility. The home health agency skilled nurse visited the member and reported back to the Care1st Home Health Case Manager that an Adult Protective Services referral is not necessary at this time, although some concerns were noted. Member also reported to the Care1st Social Worker that she has been coping adequately with her transition home. With the member's permission, a referral was made to the local Aging Agency and application was submitted for SOAR, a county program which seeks to track and assist frail seniors choosing to remain in the home. The Care1st Social Worker coordinated the case with the Aging Agency Case Intake Worker and then updated the Care1st Home Health Case Manager regarding the referral. All information was updated in the Case Management system, the POC was updated and PCP was notified.

Network provider selection to participate in the ICT is based on the individual needs of the members being discussed during the calls. Notification to network providers is communicated via phone or fax prior to the ICT. Notification to the member is communicated telephonically. In an instance when the case manager needs to communicate to several of the ICT members at once, notification is sent to the ICT participating members including the member's gatekeeper with two to three days' notice including a time and dial-in information. Attendance records of all communication meeting participants are kept on file.

The case manager with the available direction of the Director/Manager and/or Medical Director ensures that the ICT has the appropriate clinical

and psychosocial participants with the required level of authority and resources to execute ICT recommended interventions that meet the needs of the SNP member.

Member's pertinent current clinical information as well as medical/psychosocial history, including the developed individualized care plan is shared and discussed with the ICT for comments and input from participants. ICT recommendations to current care plan information or new goals/interventions are documented by the case manager during the call and are maintained within the Cre1st Case Management System, called CCMS. The CCMS system generated care plan is a communication tool for all stakeholders. Updated care plans are sent to all members of the ICT. Follow-up with the member takes place to discuss the care plan in depth. The member is encouraged to discuss their care plan with their gatekeeper and specialists during office visits.

Services ordered for members who have had a transition may be ordered by someone other than a member of the ICT such as a Hospitalist, these orders are collected and shared with the ICT by the Case Manager who follows up with members who have any change in level of care, change in condition or caregiver when applicable.

Case Study below illustrates interventions with member for follow-up care and coordination by Care1st Health Plan Complex Case Management:

Member Name/	Call type:	Person Calling: (to or	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes

ID		from)				
xxxxxx	☒ **CCM** ☐ Routine ☐ Care Conference ☒ Outlier ☐ **DM** ☐ Routine ☐ Care Conference ☐ Outlier ☐ **SW** ☐ Routine ☐ Care Conference ☐ Outlier ☐ CT ☐ Routine ☐ Care Conference	☒ Member ☐ Provider ☐ Family ☐ Other	CCM contact member regarding HH and appt w/ MD. Mbr. stated no way of getting to doctor's office.	S/w member who confirm HH-PT coming 3 times a week. Has appt with PCP and needs assistance w/ transportation. Informed CT-Case Manager of HH-PT.	☒ Member ☒ Family: Sister – ☐ Caregiver: ☒ CCM: S. Fields, LVN ☒ DM: V. Silla, LVN ☒ SW: B. Quinonez, MSW ☒ CT: M. Rodriguez, LVN ☒ MD: Dr. Nguyen ☒ BH: CompCare_ ☐ Other: _____ Frequency: ☒ Tier 1 q 6 months ☐ Tier 2 q 3 months ☐ Tier 3 q month	☐ Ed. Materials sent: ☒ Referrals: HH-PT ☒ Transportation: Schedule for appt. ☒ F/U 2 weeks w/ CCM-mbr. agreed Documentation: ☒ CCMS - records attached ☐ MHC ☐ POC sent to Mbr. ☐ POC sent to PCP: ☒ Other: Letter sent to external ICT members, internal via IDCP meeting.

	☐ Outlier ☐ Premier Member Service ☐ Routine ☐ Outlier					

Below is a sample letter as reference above in the Case Study, Outcomes, sent to member for notification regarding Case Management and SNP information.

DATE

PT Name
Address
City, State Zip

Patient Name
Patient DOB
Client Name

Member Name
Care1st Member ID #

Thank you for the recent opportunity to speak with you about Case Management services. As I explained to you, I am a nurse working as a Case Manager for Care1st Health Plan. Case Management is a benefit offered to you through Care1st Health Plan at no cost to you.

My job as a Case Manager is to assist you in obtaining quality cost-effective medical services. I do not make medical decisions, nor interfere with treatment plans, but am available to assist you in making decisions about your health care and benefits and as we discussed, to coordinate and facilitate the Interdisciplinary Care Team (ICT) and meeting.

As an enrollee in our Special Needs Program (SNP) you are entitled to participate in our case management program and access any information obtained during the case management process. You will be receiving written documentation of services authorized and will receive written notification at the time of case management closure. If you wish to obtain copies of any of these documents, please contact me directly and I will be happy to assist you.

Enclosed please find an Authorization for Release of Medical Information/Consent for Case Management. Please sign and return this form in the enclosed self-addressed stamped envelope. I will need this consent to assist you with planning for your health care needs.

If you would like additional information on why you were chosen for case management services, have any concerns, or to precertify any services, please contact me at (800) 468-9935 (TTY users call 800-735-3069) from 8:00 a.m. to 8:00 p.m., seven days a week. I will be in touch with you soon.

Sincerely,

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

Care1st through its delegated process requires all Medical Groups to utilize nationally approved clinical practice guidelines to make utilization decisions. In addition, any denial of services is reviewed by Care1st on a quarterly basis to ensure that guidelines are properly applied on all instances. Care1st's Medical Management decisions are based on the Milliman Care Guidelines Edition 15. Ultimately beneficiaries and providers have the ability to appeal any organizational determination to Care1st. This is another way to ensure prompt review of any denial made.

Examples of Clinical Practice Guidelines used by Care1st Health Plan includes but not limited to: National Heart, Lung, and Blood Institute (NHLBI) National Education and Prevention Program (NAEPP), Expert

Panel Report 3 (EPR3): American Diabetes Association Guidelines, Guidelines for Diagnosis and Management of Asthma 2007, Global Initiative for Chronic Obstructive Lung Disease, 2007, Heart Failure Society of America Comprehensive Heart Failure Practice Guideline, 2006 ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults 2009. All Clinical Guidelines are presented annually to the Medical Services Committee for review, discussion, recommendations and approval. Providers are notified annually via Provider Newsletter of approved Clinical Practice Guidelines. The guidelines are also available on the Care1st Provider Web Site.

HEDIS Measures are an example of nationally recognized preventive guidelines. Through our Quality Improvement Department we monitor the performance of preventive measures throughout the year. The PCP has access to real time data through a secure portal. Therefore when a member is seen, the PCP can identify what preventive measures are missing for that member during the year. (see *attachment Element 5, Factor E, 1*)

In addition all PCPs are provided on an annual basis with a Performance Report that compares their HEDIS performance with that of their peers. (see *attachment Element 5, Factor E, 2)*

Another example of how the Plan ensures the use of evidence based guidelines is through our Medication Therapy Management Program (MTM). In this program a clinical pharmacist will perform regularly scheduled review of pharmacy profiles for members that meet certain pre established parameters such as taking a certain number of medications per month, or exceeding a certain cost per month. Under these circumstances, the pharmacist will review the profile for safety, duplication and guideline adherence. So if a member is diabetic, and the member is not filling a ACE or ARB(Recommended by ADA for all diabetics) the pharmacist will notify the prescribing physician in writing of this gap in care and recommend appropriate treatment. (see *attachment Element 5, Factor E, 3)*

Based on the health care needs of the member population and opportunities for improvement, clinical practice guidelines are adopted by the Plan. These guidelines are reviewed, revised and approved on an annual basis, using nationally-recognized evidenced-based literature. The

guidelines are developed with input from community physicians via the Care1st Medical Services Committee and approved by the Medical Services Committee. Member education material, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. Annually, a random sample of provider records is reviewed for compliance with one or more clinical practice guidelines. The guidelines are disseminated annually to providers (changes are also communicated as they occur) via the handbook and the Plan's website as well as to members upon request.

Case Study below illustrates the application of clinical practice guidelines address to the PCP from the Care1st Pharmacy Department.

PHARMACY DEPARTMENT 601 Potrero Grande Dr. Monterey Park, CA 91755
Phone: (877) 792-2731 Fax: (323) 889-6254

Fax: 619/263-9601

From:	Nora Tomassian, R.Ph.	**Date:**	4/7/2011
Re:	Care1st MTMP (Medication Therapy Management Program) - Clinical Pharmacist Review		
	(Quarter: 2011-Q1)		

Your patient has filled 45 prescriptions during the following period: (10/1/2010 - 12/31/2010)

Member name: [redacted] Member ID #:

CLINICAL RECOMMENDATIONS

Dear Doctor,

A Medication Review was conducted by Care1st clinical pharmacy department for your patient, using member's medication fill data. A copy of the medication profile is attached for your review. Please see following recommendations.

1. Drug –Age Precaution: the patient is over 70 years of age and has filled metformin. Since the risk of lactic acidosis increases in this age group, please monitor patient's serum creatinine and liver function as drug clearance is reduced in renal and hepatic insufficiency situations.

2. Potential Drug-Drug Interaction: The patient has filled gemfibrozil and a statin: the risk of myopathy and rhabdomyolysis may be increased by co-administration of a statin and gemfibrozil. Please consider alternative fenofibrate (generic Lofibra) less likely to interact with a statin

3. The patient has filled antihyperglycemic medications and no ACE inhibitors. The American Diabetes Association guidelines recommend ACE inhibitors for all diabetic patients with HTN, known CVD, or any degree of proteinuria. Please assess whether the addition of ACE inhibitor therapy would be appropriate for your patient. Titration should be based on BP response (goal <130/80), serum creatinine, potassium level, and proteinuria.

4. Please indicate by faxing back this form if:

*Clinical recommendation is accepted: YES NO

*If YES, please indicate action taken

_____

*If NO, please indicate medical justification for not accepting_____

*If the alternative medication is accepted, please provide a new prescription to the patient's pharmacy

Please review the above suggestions and feel free to give me a call for any further discussion or questions at
(877) RXCARE1 or (877) 792-2731. Thank you!

CONFIDENTIALITY NOTICE: This document and any attachments are confidential and may be protected by legal privilege. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of this information or any attachment is prohibited. If you have received this information in error, please notify the original sender immediately by telephone or return this package, along with any attachments, to sender at the address provided below. Thank you for your cooperation.

Element 6 – Model of Care Training for Personnel and Provider Network

Element 6, Factor A

Describe how the Plan for initial and annual MOC training including training strategies and content;

Care1st Health Plan Care Management staff has an in-depth orientation in regards to all aspects of case management, clinical guidelines and disease management in order to assure quality services to our enrollees. Written Policies and Procedures and clinical guidelines are reviewed annually by the Medical Services Committee and available to internal staff and external contracted providers. This training includes, but not limited to, in the SNP MOC training: Health Risk Assessment (HRA), Interdisciplinary Care Team, Enrollee participation, etc. as seen in training materials. The training is required to be taken yearly for all staff involved in MOC. Any new employees, who are involved in MOC will receive training within 30 days of the start date of their employment. Employees have access to the SNP policies and procedures that support the MOC.Policies and procedures are updated annually and approved by the Medical Services Committee and the Board.

In services are scheduled at least quarterly to educate staff on best practices and outcomes data as it relates to the MOC.

Example of primary training material is the *Model of Care and Quality Improvement Program Training May 27, 2009_Powerpoint presentation from CMS Division of Special Programs* which was presented in face to face meetings to 23 Plan staff. In addition the training materials were provided to all Medical Groups and providers. *(Attachment Element 6, Factor A, 1)*

Example used in training staff includes the SNP-MOC Responsibility Matrix that delineates Care1st and the IPA Responsibilities. *(Attachment Element 6, Factor A, 2)*

Provider Network Training:

Prior to the annual enrollment period the Care1st Provider Network Operations Department and Medical Services Management Department develop a training schedule and list of internal and external required participants. Special emphasis in training materials is placed on Model of Care and changes from prior year's plan benefits, if applicable. Training materials for the providers are posted on the Care1st provider portal. All providers are notified in writing regarding the annual training and how to access the information on the Care1st website.

Example of Care1st training approaches, described below:

In order to identify relevant SNP providers, the Healthcare Informatics Department runs a report listing SNP providers (i.e., any PCP assigned a SNP member and any specialist who has submitted two or more claims in a six-month timeframe for services rendered to a Care1st SNP member). Using that list, the SNP providers are sent written notification via blast fax.

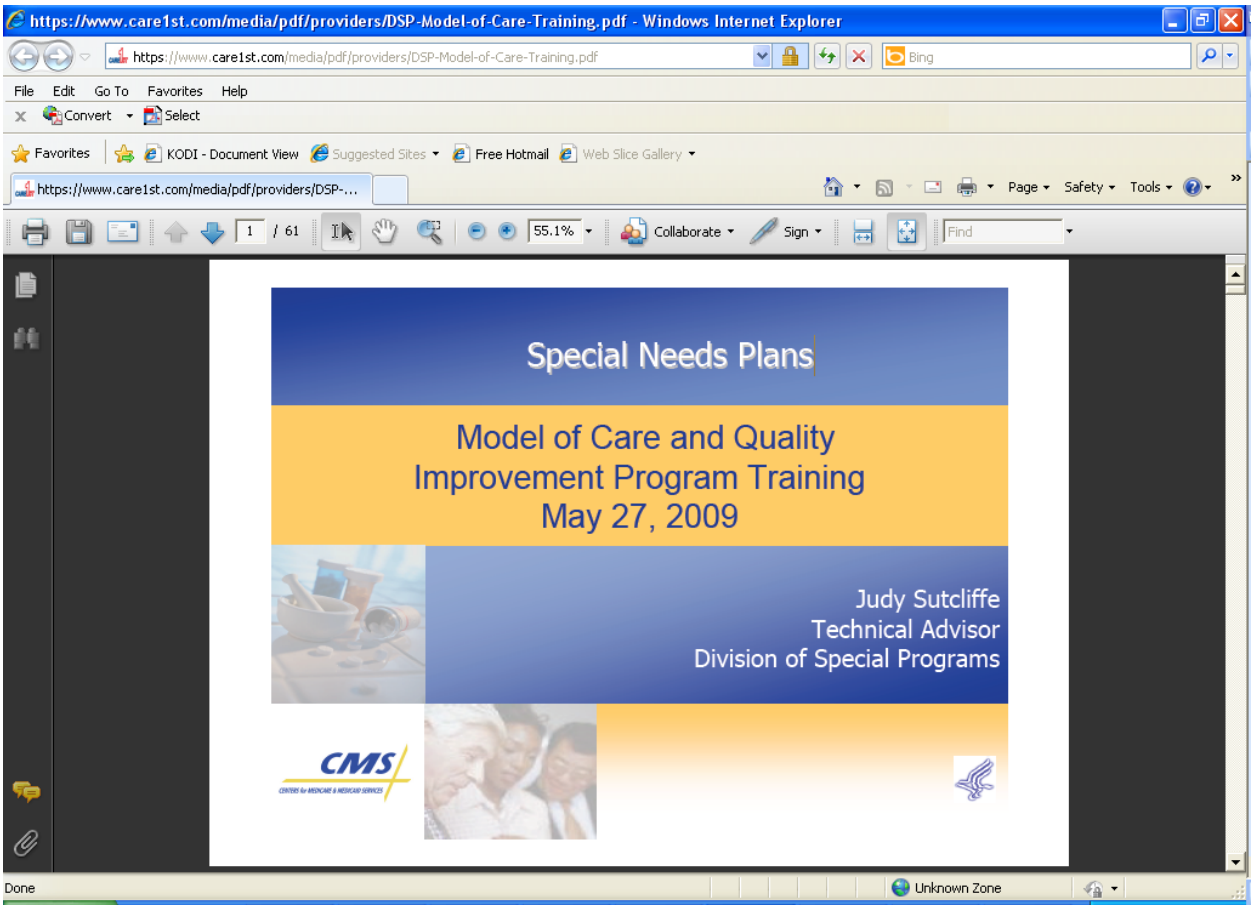
For SNP providers for which the initial fax failed or for whom Care1st did not have a valid facsimile number, Care1st identifies them for a subsequent mailing list and provide this mailing list to the Provider Network Operations (PNO) Department. For returned mail, the PNO Department will call the provider and attempt to obtain accurate mailing addresses.

For all providers who are unreachable via fax or mail, Care1st will conduct a phone campaign. The PNO Department will call providers to obtain current fax and mailing address information. The MOC training program information will then be faxed, or, if no fax number is available, mailed to the identified providers. For those providers who remain unreachable despite the efforts described, Care1st will conduct face-to-face training.

Additionally, the MOC training materials are available on Care1st provider web portal (https://www.care1st.com/media/pdf/providers/DSP-Model-of-Care-Training.pdf). Care1st advertises the availability of the web-based MOC training through written letter, provider newsletter and a banner message to all registered web portal users. (Care1st encourages all participating providers to register with Care1st's provider web portal to take advantage of self service functionality including claims look-up, eligibility authorization status, as well as a multitude of trainings and other resources.) Providers may also contact Care1st to request additional training.

Example:

Below is screen shots illustrating the SNP-MOC PowerPoint Presentation training tool posted on the Care1st website provider portal:



Personnel Training:

Care1st delivers annual specialized SNP-related training to those associates whose job responsibilities include substantive SNP-related activities. Attendee lists for all trainings are maintained by Medical Services Department.

Employees have access to the policies and procedure manuals (electronic and hard copy) that support the SNP Model of Care. Policies and Procedures are reviewed and updated annually. Quarterly staff audits are conducted by the Manager, Medical Services to ensure adherence to Model of Care policies and procedures. Deficiencies that are identified during the audit process are documented and addressed one on one with

the staff. In-services are scheduled as needed to educate the entire staff on best practices and aggregate findings from the staff audits, as well as improved outcomes in support of the Model of Care. Attendance is documented in the form of a sign in sheet and kept by the Manager in departmental record.

Employees are encouraged to meet the Model of Care standards through training, one-on-one and the audit process. In the event that an employee is unable to meet department standards they are placed on a Performance Improvement Plan developed by their Manager.

Example: Upon hire, a new SNP Case Manager will receive training on Care1st's SNP-MOC. During the course of his or her employment, the associate will receive ongoing training updates in regular staff meetings. Annually, the associate will be required to successfully complete a MOC training.

Personnel Training Contents:

Example of MOC Training Topics:

- **SNP Case Manager New Hire and Annual Trainings**
  - *SNP* Overview– characteristics of a SNP plan, Types of dual eligible members by qualification level, how member eligibility is determined *Member Identification and Communication* – how to identify eligible dual members, criteria for case management enrollment, MOC Program overview, goals
  - *Member Assessment and Monitoring* –review HRA questions and information captured, stratification levels comparison, participants in the ICT, explanation of POC, and reporting requirements

- **SNP Case Manager Ad Hoc Trainings**
  - Transition of Care overview and specific components
  - Transition of Care requirements and data capture
  - Referring and Utilizing Community Resources
  - Risk/Fall Prevention Program

- **Member Service Department Training**

- *Overview of Dual Special Needs Plans*- Overview of Dual Special Needs Plans
- *Serving Dual Special Needs Plan Members* – Key terms, benefits, Member Service Representatives role, identifying SNP Member calls, tracking calls

Element 6, Factor B

Describe method for assuring and documenting completion of training by the employed and contracted personnel;

Care1st Health Plan conducts initial training of the Model of Care for all relevant Health Plan employees to include but not limited to; Case Managers (licensed), Care Coordinators (non-license), Social Service (credentialed) and administrative support for the SNP program. The materials used (as stated above) were the CMS Model of Care Training slides and any relevant policies and procedures. Attendance was documented through minutes of the meeting. Annual training will be performed in a similar fashion for all new and existing employees prior to the annual enrollment period.

Example: Complex Case Management Meeting 10/12/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 6, Factor B, 1)*

Example: Disease Management Meeting 11/3/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 6, Factor B, 2)*
Example: For internal staff the Medicare Operations Department prior to annual enrollment conducts an inservice for benefits which includes SNP benefit changes, the attendance is mandatory, including telecommuting staff in face-to-face meeting. *(Attachment Element 6, Factor B, 3)* (*Attachment Element 6, Factor B, 5*)

Example: SNP Model of Care (MOC) training is conducted for delegated entities. The plan's Health Education Department in collaboration with IPA Compliance Department presented an in-service on March 18, 2011 – Included agenda IPA/Medical Group Seminar 2011, agenda IPA Compliance Update, *(Attachment Element 6, Factor B, 4)*

Provider Network Training:

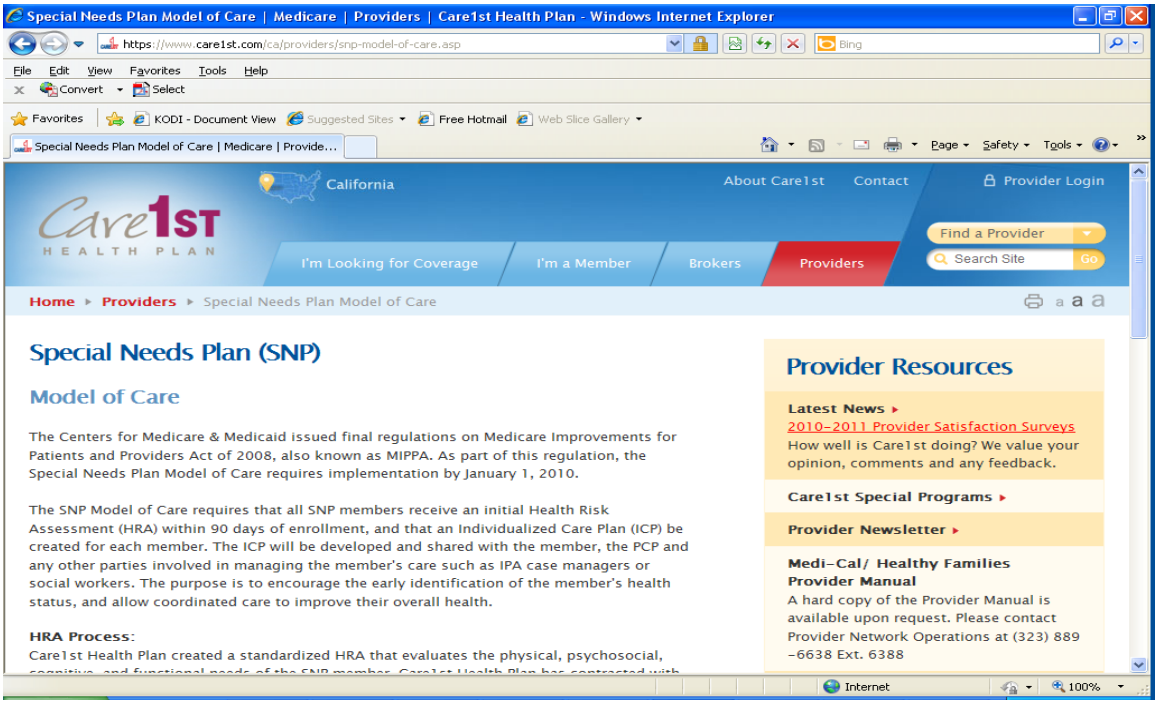
All Care1st providers are notified in writing annually regarding SNP-MOC information and training available on the Care1st provider web-site. This includes an explanation of the MOC and a link to the Special Needs Plan – Model of Care and Quality Improvement Program Training CMS PowerPoint presentation.

Care1st is in the process of including an evaluation form on our website requiring providers to complete and return to Care1st when they complete the training presentation. We will also provide the evaluation online. Specifically, when providers complete the online training, they can attest to completion through the online website.

Care1st will track which providers return the MOC training attestation, identifying those that do as complete. For providers who do not return an attestation by one of the methods previously mentioned, Care1st will attempt to call or visit each provider in order to obtain attestations.

This process will be repeated annual for all identified SNP providers.

Below are screen shots illustrating the SNP-MOC information and training tools posted on the Care1st website provider portal



Special Needs Plan Model of Care | Medicare | Providers | Care1st Health Plan - Windows Internet Explorer

https://www.care1st.com/ca/providers/snp-model-of-care.asp

HRA Process:
Care1st Health Plan created a standardized HRA that evaluates the physical, psychosocial, cognitive, and functional needs of the SNP member. Care1st Health Plan has contracted with a vendor to perform the telephonic HRA. The process is as follows:

- All HRAs will be conducted telephonically from vendor's centralized call center.
- All calls, successful and unsuccessful attempts will be documented and reported to Care1st on a weekly basis.

Care Plan Process:
Depending on the answers to specific HRA questions an Individualized Care Plan is generated. The Care Plan is comprised of problems, interventions and goals. The problem is specific to the identified issue based on the member's answer to the particular question. The intervention is targeted to address the associated problem and either a short term or long term goal is triggered.

The member and member's PCP receives a cover letter explaining the HRA process and the Individual Care Plan. The PCP also receives a summary of the member's responses to the HRA.

- SNP Guidance Model of Care
- Special Needs Plan – CMS Presentation
- HRA Questionnaire – English
- HRA Questionnaire – Spanish

Care1st Programs

Provider Network Operations at (323) 889 -6638 Ext. 6388

Provider Disputes
Providers can communicate questions and concerns to Care 1st Provider Network Operations Department by telephone, e-mails, in writing or in person.

The Providers' Guide to Detect and Report Fraud
The Government Accounting Office estimates that more than 10% of the healthcare budget is lost to fraud and abuse.

Quality Improvement Incentive Program (Q.I.I.P)

Cultural & Linguistics
To ensure that all members have access to health care providers and services in their language of choice

Got Questions?
1-323-889-6638

https://www.care1st.com/media/pdf/providers/SNP-Guidance-Model-of-Care.pdf - Windows Internet Explorer

https://www.care1st.com/media/pdf/providers/SNP-Guidance-Model-of-Care.pdf

II. SNP Guidance

A. Model of Care

42 CFR 422.101(f) - CMS 4138-IFC
Effective date: January 1, 2010

In the 2009 Call Letter, CMS discussed its requirement that Special Needs Plans (SNP) have a model of care (MOC), namely, a structure and process by which they delivered healthcare services and benefits to the special needs individuals they elected to target. We emphasized that, as MA plans, we expected all SNPs to offer coordinated care delivered by a network of providers who had the clinical expertise to meet the target population's specialized needs, and who did not discriminate against its most vulnerable beneficiaries. The Call Letter guidance substantively fleshed out the SNP MOC architecture by describing eight components designed to support service delivery for special needs individuals. These components included:

1) Goals and objectives pertinent to the plan's targeted special needs beneficiaries

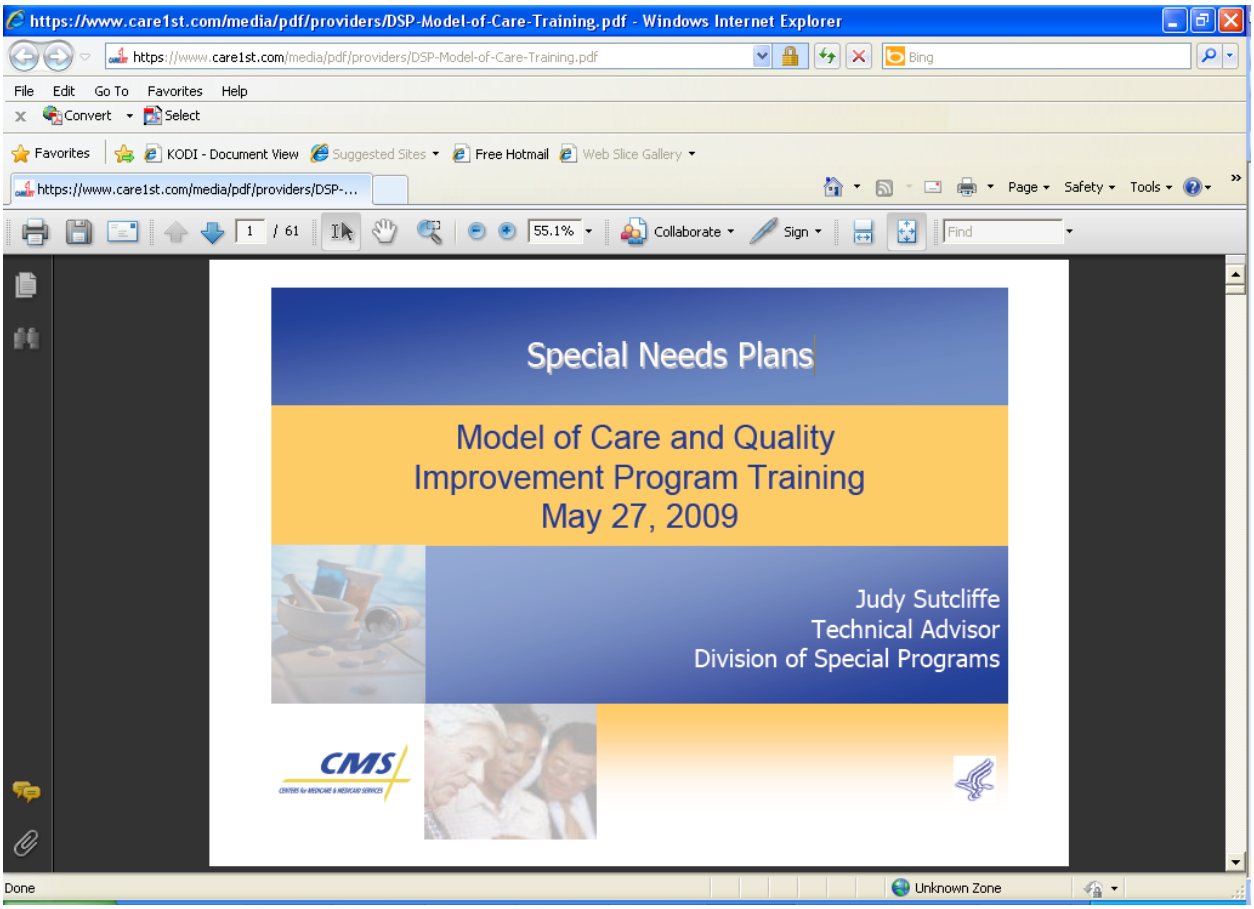
2) Comprehensive risk assessment using a risk assessment tool

3) Specialized provider network

4) Care coordination

5) Service delivery system including protocols and out-of-network specialists

6) Communication and accountability system



Element 6, Factor C

Describe identified personnel responsible for oversight of the MOC training;

The Director and Manager of Medical Services is responsible for internal clinical staff training for SNP – MOC that is annually conducted and is also available on an ad hoc basis for new employees or those that unable to attend. The instructors are licensed nursing personnel with experience in CMS compliance, either by extensive background development or subject matter expertise.

Example: Complex Case Management Meeting 10/12/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 6, Factor C, 1)*

Example: Disease Management Meeting 11/3/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 6, Factor C, 2)*

The V.P of Medicare Operations is responsible for oversight training for all internal staff on new benefits prior to open enrollment. This position is a licensed Pharmacist with expertise in Medicare operations, regulatory requirements, policies and benefits.

Example: Annual mandatory Medicare benefit training including SNP benefits. *(Attachment Element 6, Factor C, 3)*

The V.P. Medical Services is responsible for oversight training for delegated IPA/Medical Groups for SNP – MOC requirements. This training is on a minimum of an annual basis and is conducted at the Joint Operations Committee (JOC) Meetings. The IPA Compliance Department will be disseminating the IPA Compliance Bulleting to all Care1st Medicare contracted delegates. This will include information on the SNP-MOC. Medical Services has a yearly mandatory meeting for all department employees regarding Medicare benefits. This includes, but not limited to: Plan Name requirement for SNP plan type, Call Center hours, Enrollment periods, Medicare Advantage Disenrollment Period (MAPD), 2011 renewal plans, any new or revisions to benefits, etc. This meeting also addresses any changes to Inpatient and Outpatient services, Medical Supplies, Preventive Care/Health and Wellness and Transportation.

Example: JOC Agenda, meeting minutes, attendance sheet. *(Attachment Element 6, Factor C, 4)*

Example: IPA Compliance Bulleting Volume 3 Issue 2 April 2011 *(Attachment Element 6, Factor C, 5)*

The V.P of Medicare Operations is responsible for oversight training for all internal staff on new benefits prior to open enrollment. This position is a licensed Pharmacist with expertise in Medicare operations, regulatory requirements, policies and benefits. Annually the Member Service Department conducts the same meeting (w/ some modifications) that is mandatory for their department employees to update on any changes to enrollees benefits.

See below title page of PowerPoint Presentation mandatory meeting for Utilization Management, Member Services and Medicare Operations.

Provider Network Training:

The Medical Services Management team in conjunction with Healthcare Informatics and Provider Network Operations is responsible for conducting the data analysis and identifying the universe of SNP providers who require MOC training. This Care1st team is also responsible for collecting evaluation forms received by providers to ensure completion.

Healthcare Informatics and Provider Network Operations will provide data to the Medical Services Management team indicating (a) which providers require telephonic outreach, and (b) which providers completed the training online. Medical Services Management and Healthcare Informatics and Provider Network Operations teams therefore jointly share responsibility for MOC training oversight.

Example: Medical Services Management team create/review/revise the model of care training materials. Medical Services Management team, with the assistance of Healthcare Informatics analytics identifies all providers (PCP/Specialists) who treat SNP members; Provider Network Operations

completes a fax blast containing the information directing the providers to the MOC Training available on the Care1st website. Medical Services Management team keeps a log of all providers who have completed the training and the evaluation of the training. Medical Services Management team Management and Provider Network collaborate on all aspects of model of care training for providers.

Element 6, Factor D

Describe actions to take when the required MOC training has not been completed;

Staff not performing to meet the requirements set forth by the MOC training policies and procedures may be remediated by a corrective action plan (CAP). These include re-education and training or one-on-one instruction. The Director of Medical Service (or designee) will develop oversight for SNP internal staff through random audit, inter-rater reliability studies and/or case conferences. If an identified deficiency is trended a focus audit will be administered.

Example: The SNP MOC description and additional website links for training are available to employees, external providers, member and public via the Care1st website at https://www.care1st.com/ca/providers/snp-model-of-care.asp . *(Attachment Element 6, Factor D, 1)*

Care1st's IPA Compliance Department is responsible for oversight of the Model of Care training for our contracted medical groups. They will effectuate oversight by conducting routine audits and impose CAP for outcomes not meeting goals.

Example: IPA oversight audit tool documents compliance to SNP MOC requirements. Medicare Advantage Addendum and UM Case Management Audit Tool *(Attachment Element 6, Factor D, 2)*

The materials used internally by Care1st staff were provided to all delegated Medical Groups and instructed to perform initial and annual training to relevant employees and contracted providers. Documentation of performance and MOC implementation for this requirement will be completed through an annual audit that is conducted by our IPA

Compliance Auditors who are licensed nurses specializing in auditing/monitoring of our contracted medical groups. Care1st Health Plan will work with the delegated entities to ensure that proper training and implementation is conducted as required. In the event that training does not take place or is determined to be inadequate or the medical group does not comply with their delegated functions, Care1st will notify the delegated entity and. will be required to submit a CAP that addresses all deficiencies. Care1st will review the CAP, if it is not satisfactory, Care1st will assist the delegated group with implementation of a CAP that will correct and adhere to all requirements. Care1st IPA Compliance Auditors will then re-audit to ensure compliance. If the delegated entity has not met the mandated standards, this may include de-delegation of this function by the Health Plan.

Provider Network Training:

Care1st's goal for delivery of training materials to SNP providers is 100%, using all methods of delivery. Care1st's goal for provider completion of MOC training is 80%. Care1st's goal for return of evaluations or attestations from providers is 80%.

As described above, Care1st has adopted an electronic approach to following up on both delivery of MOC training material and subsequent evaluation or attestation by providers. If providers have not completed the training on the Care1st website and completed/returned the attestation then the following steps will occur:

- Fax SNP MOC materials to identified providers
- Mail materials to providers with no or failed fax
- Repeat the above steps to providers who do not return attestation
- Telephonic outreach to non-responding providers
- Outreach and/or conduct face to face visit with unreachable providers

Personnel Training:

All Care1st personnel with SNP-MOC responsibilities are required to participate in SNP training. All trainings are given with a specified date of completion. Manager(s) will be notified of staff members who have failed to complete SNP training in a timely fashion. Managers are held accountable

for their staff's timely completion of all mandatory training. If an employee does not complete training as required, disciplinary action will be taken, up to and including termination of employment.

Case Study: Care1st initiates an annual notice to a case manager instructing her that she must complete the Annual SNP Model of Care Training. This case manager sees the email, but neglects to schedule time to complete the training promptly. As the completion date for the training approaches, they will be sent a second email reminding the case manager of the required training. The case manager again neglects to complete the training and the due date passes. The Director of Medical Service (or designee) then sends an email to the case manager's manager requesting that the manager direct the associate to complete the training. The manager officially discusses the situation with the case manager who completes the training forthwith.

Element 7 – Health Risk Assessment

Element 7, Factor A

Describe the health risk assessment (HRA) tool used to identify the specialized needs of its beneficiaries;

Care1st Health Plan created a standardized Health Risk Assessment questionnaire that evaluates the physical, psychosocial, cognitive, and functional needs of the SNP member. The questionnaire is designed to help identify key care needs. It does not replace the need for a comprehensive physical exam conducted by the primary care practitioner. The HRA survey tool is included with file name *H5928_Dual_HRAT_Exhibit A*.

The assessment includes but is not limited to:

- Health history
- Special care needs (DME, home health, social worker, etc.)
- Specialty care needs
- Living situation
- Activities of daily living (ADLs)
- Safety issues
- Mental status
- Behavioral conditions
- Substance Use
- Functional assessment
- Pain assessment
- Medication history
- Health educational needs

An example of the tool capturing the specialized need of a SNP member occurs when the HRA indicates that a member needs help at home but is unable to get any. This answer indicates that the member is at risk for falls, dehydration and nonadherence to medications. Therefore there will be an automatic trigger for a social worker to call the member and asses needs and coordinate with state Medicaid benefits such as home care worker.

Another example is question # 23 which asks”Have you completed an advance directive?” If they answer “no” there is a follow up question which

asks them if they wish to receive information about Advance Directives. Those that answer yes are referred to our Social Services Department. They are provided with a sample Advance Directive and a letter that explains to them how to complete it, or how to reach a Social Worker at the Plan if they need assistance.

There are a number of questions that deal with mental health issues such as depression, and substance abuse. For those members that answer affirmatively about having a mental health or substance abuse issue, they are contacted in order to asses their neeed for behavioral care. They are instructed how to self refer to our Behavioral Health Provider.

In addition to the above examples, based on the unique combination of answers to the HRA, the tool stratifies the member into 3 different tiers.. Those members with the highest acuity level are automatically referred to our Complex Case Management department for further assessment.

Care1st Health Plan has contracted with a vendor who will contact newly enrolled and current Care1st dual-eligible beneficiaries. The HRA is performed either telephonically or by mail. The HRA is completed for all new beneficiaries within 90 days of enrollment. All beneficiaries will be reassessed annually. The vendor will initiate the survey calls based on a list of new enrollees provided by Care1st Health Plan shortly after the beneficiaries enrollment transaction is confirmed by CMS. If the vendor is unable to contact the beneficiary by phone, the survey will be mailed to the beneficiary. All calls, successful and unsuccessful will be documented and reported to Care1st on a monthly basis. Beneficiary responses to the survey calls and responses to mailed surveys will be forwarded to Care1st Health Plan and entered into the Care Enhance Clinical Management Software (CCMS). Care1st will monitor adherence to conducting all initial assessments within 90 days of enrollment. An annual assessment will be conducted within one year of the last assessment for all dual-eligible SNP beneficiaries.

Based on programmed logic established by physicians and nurses with expertise in the care of SNP beneficiaries, the answers to the HRA generate an acuity score which stratifies members according to their acuity score.

The HRA tool was designed to identify key SNP Member risk and needs related to medical/physical, psychosocial, cognitive and functional areas. The tool is conducted telephonically or if requested by the Member, the HRA survey can be mailed.

The HRA tool uniquely stratifies the Member using the combined data elements. Care plan interventions will be appropriate to the member's risk.

HRAs are conducted within 90 days of enrollment and an annual re-assessment of the individual's medical, physical, cognitive, psychosocial and functional need. An example of a 2011 completed HRA is below:

HEALTH RISK ASSESSMENT **HRA Score:** 3.00 **HRA Tier:** 1.00

ReferenceID: [redacted]*01 **Agency:** CARE1ST HEALTH PLAN

Member Name: [redacted] **HRA status:** COMPLETED

Member Phone: [redacted]

1. DEMOGRAPHICS

1. Assessment Date: 4/11/2011

2. Name:

First: JOSE P Middle: Last: [redacted]

3. Physical Address:

Street:

City: ANAHEIM State: CA Zip: [redacted] County:

4. Day Phone: [redacted]

5. Email:

6. Date of Birth: [redacted]

7. Sex:

☑ Male ☐ Female

CAREGIVER INFORMATION.

8. Is there any Primary Caregiver? ☐ Yes ☑ No ☐ Decline

If No or Decline, IGNORE THE REMAINING QUESTIONS FOR THIS SECTION.

9. Name: First: Middle: Last:

10. Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Grandchild ☐ Friend ☐ Other Relative ☐ Other ☐ Decline

11. Telephone:

12. Primary Language:

2. ASSESSMENT QUESTIONNAIRE

1. Did you receive your Care1st ID card?

☑ Yes ☐ No

2. What is your primary language?

☐ English ☐ Spanish ☑ Other *if Other, specify:* FILIPINO

3. Where do you currently live?

☑ Live in an independent house, apartment, mobile home.

☐ Live in an assisted living apartment, or board & care. *(Specify Name below).*

https://ecarecentral.com/HRA/HRACare1stPrintableVersion.aspx?AssessmentID=4259 5/9/2011

☐ Live in a nursing home. *(Specify Name below).*
☐ Other. *(Describe below).*
Specify if required:

4. What is your current living arrangement? (Check each that applies)

☐ Live Alone ☑ With spouse/significant other ☐ With child(ren)
☐ With other relative(s) ☐ With non-relative(s) ☐ With paid caregiver

5. Do you plan on changing your present living arrangements in the next 6 months?

☐ Yes ☑ No *If yes, describe:*

6. Do you know the name of your current Primary Care Physician (PCP)?

☑ Yes ☐ No *If yes, Name:* SAMSON MERCEDES BLASCO

7. Have you seen your current PCP in the last 3 months?

☑ Yes ☐ No

7a. If No to question 7, do you have a scheduled PCP appointment?

☐ Yes ☐ No

8. Are you under the care of a Specialist?

☐ Yes ☑ No *If yes, Name and Specialty:*

9. Have you been to the Emergency Room in the past 6 months?

☐ Yes ☑ No *If yes, How many times:* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10+

10. Have you stayed overnight in a hospital in the past 12 months?

☐ Yes ☑ No *If yes, How many times:* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10+

11. Have you been in a Skilled Nursing Facility in the past 12 months?

☐ Yes ☑ No *If yes, How many times:* ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10+

12. In general, would you say your health is:

☑ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

13. Are you able to perform the following activities without help or do you need some help?

☐ Some help ☑ No help ----- *Using the toilet*
☐ Some help ☑ No help ----- *Bathing*
☐ Some help ☑ No help ----- *Dressing*
☐ Some help ☑ No help ----- *Eating*
☐ Some help ☑ No help ----- *Getting in/out of bed or chairs*
☐ Some help ☑ No help ----- *Walking*
☐ Some help ☑ No help ----- *Managing Money*
☐ Some help ☑ No help ----- *Taking Medications*
☐ Some help ☑ No help ----- *Preparing Meals*

☐ Some help ☑ No help ----- *Shopping and Errands*

☐ Some help ☑ No help ----- *Housekeeping Chores*

☐ Some help ☑ No help ----- *Using the Telephone*

14. If you receive help with any of the activities selected in above question, who is the helper? (Name, relationship and phone number if we may contact your helper)

Name: Relationship:

Phone Number:

15. Do you use any of the following special equipment because of a disability or health problem?

☐ Yes ☑ No ----- *Walker*

☐ Yes ☑ No ----- *Bedside Commode*

☐ Yes ☑ No ----- *Wheelchair*

☐ Yes ☑ No ----- *Hoyer Lift*

☐ Yes ☐ No ----- *Cane*

☐ Yes ☐ No ----- *Grab Bars*

☐ Yes ☐ No ----- *Bath Bench*

☐ Yes ☐ No ----- *Hospital Bed*

☐ Yes ☑ No ----- *Ramps*

☐ Yes ☐ No ----- *Raised Toilet Seat*

16. Are you currently being treated for any of the following health conditions?. If yes, please describe.

Dialysis

☐ Yes ☑ No

Memory Loss

☐ Yes ☑ No

Arthritis

☑ Yes ☐ No

Urinary Problems

☐ Yes ☑ No

Breathing Problems

☐ Yes ☑ No

High Blood Pressure

☐ ☐
Yes No

Cancer

☐ ☑
Yes No

Circulation Problems

☐ ☑
Yes No

Osteoporosis

☐ ☑
Yes No

Stomach/Bowel Problems

☐ ☑
Yes No

Recent Fracture (last 12 months)

☐ ☑
Yes No

Parkinson's

☐ ☐
Yes No

Ankle/Leg Swelling

☐ ☑
Yes No

Uncorrected Hearing Loss

☐ ☑
Yes No

Congestive Heart Failure

☐ ☑
Yes No

If you have Congestive Heart Failure, have you been hospitalized for it in the past 12 months?

☐ Yes ☐ No

Other Health Conditions (Describe)

16a. Have you ever being treated for any of the following health conditions?. If yes, please describe.

Stroke

☐ ☑
Yes No

Heart Attack

Yes No

Chest Pain

☐ ☑
Yes No

17. Do you have Diabetes?

☐ Yes ☑ No

17a. If Yes, have you had a Diabetic Eye Exam done in the past year?

☐ Yes ☐ No ☐ Don't know

17b. If No, have you had a Glaucoma (Eye Pressure) Screen done in the past year?

☐ Yes ☑ No ☐ Don't know

18. How is your eyesight? (While wearing glasses or contacts, if applicable)

☐ Excellent ☑ Good ☐ Fair ☐ Poor ☐ Blind

19. Are you currently receiving any of the following services from an agency?

☐ Yes ☑ No ----- *Home Health Nurse*

☐ Yes ☑ No ----- *Physical, Occupational, Speech Therapy at Home*

Yes No ----- *Home Health Aide*

☐ Yes ☐ No ----- *Social Worker*

☐ Yes ☑ No ----- *Adult Day Care Center*

☐ Yes ☑ No ----- *Assistance with Transportation*

Other:

20. Do you currently use or receive any of the following?

☐ Yes ☐ No ----- *Feeding Tube*

Yes ☑ No ----- *Oxygen*

☐ Yes ☑ No ----- *Colostomy Care*

☐ Yes ☑ No ----- *Catheter Care*

Other:

21. Which of the following statements fits you best in terms of health? Check all that apply.

☐ Must stay in bed all or most of the time because of physical limitations.

☐ Must stay in the house all or most of the time because of physical limitations.

☐ Need the help of another person in getting around inside or outside the house.

☐ Need the help of some special aid, like a cane/wheelchair to get around inside or outside the house.

☐ Do not need the help of another person or a special aid but have trouble getting around freely.

☑ Not limited in any of these ways.

22. Do you need help at home because of health problems and are unable to get help?

☐ Yes ☑ No

23. Have you completed an Advance Directive?
(A document that directs your health care wishes in the event you become ill.)

☐ Yes ☑ No

23a. If Yes to #23, is it on file with your PCP?

☐ Yes ☐ No

23b. If No to #23, are you interested in receiving information on Advance Directive?

☑ Yes ☐ No

24. Have you fallen in the last 12 months?

☐ Yes ☑ No

25. Do you have any wounds, sores or skin breakdown?

☐ Yes ☑ No

If yes, please describe:

26. Do you currently have any pain? If No, go to question 27.

☐ Yes ☐ No *If Yes, describe:* SHOULDER, KNEE

26a. Pain Severity Scale 1-10, 10 being the most severe.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☑ 8 ☐ 9 ☐ 10

26b. Do you take medication for pain?

☐ Yes ☐ No *If Yes, name of medicine(s):* IBUPROFEN 250MG AS NEEDED

26c. Does the pain medicine provide adequate relief of your pain?

☑ All the time ☐ Most of the time ☐ Some of the time ☐ None of the time

27. Do you feel depressed?

☐ Yes ☑ No

27a. If Yes, are you currently being treated for depression?

☐ Yes ☐ No

28. Do you feel you have a problem with:

Alcohol Abuse ☐ Yes ☑ No

Drug Abuse ☐ Yes ☑ No

29. Do you smoke?

☐ Yes ☑ No

29a. If Yes, are you interested in a Smoking Cessation Program?

☐ Yes ☐ No

30. Do you routinely get a flu shot every year?

☑ Yes ☐ No ☐ Don't know

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31. Have you had a pneumonia shot in the past?

Yes No Don't know

32. Have you had a Zostavax shot in the past?

Yes ☑ No Don't know

33. Have you had a test to screen for colon cancer done with one of the following?

FOTB (Fecal Occult Blood Test), testing the stool for presence of blood this year?

Yes ☑ No Don't know

DCBE (Double Contrast Barium Enema) X-Ray procedure any time last 4 years?

Yes ☑ No Don't know

Flexible sigmoidoscopy any time in the last 4 years?

Yes ☑ No Don't know

Colonoscopy anytime in the last 10 years?

Yes ☑ No Don't know

34. Are you a caregiver? (for a spouse or someone else.)

Yes No

35. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?

Yes No

If Yes, name, relationship, and day-phone of the person who could take care of you?

Name: REBECCA [redacted] Relationship: WIFE

Phone Number: [redacted]

36. Is there anything else you would like us to know about you?

EVERYTHING IS OK

Based on the responses from the HRA the following issues have been identified:

- The member has both hypertension and arthritis which is causing knee and shoulder pain. The case manager will asses in further detail how this limits member's mobility and addresses findings with the PCP. Also because the member uses a cane, will asses home safety evaluation.
- The member does not have advance directives and is interested in having them. The Social Services department gets an automatic request to mail member all necessary materials including contact information for the member to call if necessary.
- There are three preventive measures the member has not received.
    - Colorectal Screening
    - Glaucoma Screening
    - Zostavax

The case manager will address these with the member and explain the importance in getting them done and assisting the member with authorization, scheduling and transportation if necessary.

Element 7, Factor B

Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary;

The reassessment will consist of the same process as the initial or previous HRA. The responses of the last HRA will be compared with those of the previous HRA. This will create a gap report that will illustrate the positive and negative changes to the member's health status and will further update the POC. Based on the positive and negative changes it will be possible to provide reports to the physicians, and the ICT, that quantify objectively the trends and changes that individual, SNP members are experiencing.

The aggregated responses from the HRA are then analyzed by our Quality Improvement Department. (see *attachment Element 7, Factor B, 1*)

The following table identifies all HRA activity for 2010 and the year to date status for 2011.
The last column is the 2010 activity. It shows that there were a total of 4104 eligible SNP members for an HRA. Of these 4104 members:

- 263 (6.4%) disenrolled from the Plan before the HRA could be done
- 1300(31.6%) Did not complete the survey despite all good faith efforts including multiple phone calls and mailings.
- 2141(52%) completed the HRA
- 400(9.7%) are pending completion of the HRA

The second to last column shows the same data for YTD 2011.
The column labeled "due for re-survey" identifies the SNP members that are still eligible with the Plan in 2011 and are due for re survey in the first quarter of 2011 and the status of the surveys.

HRA Status 01 - Year Enrolled by Survey Status					
Plan_Type	**Survey_Status**	**Due for Re-Survey**	**Row Total**	**2011**	**Before 2011**

HRA Status 01 - Year Enrolled by Survey Status					
Plan_Type	Survey_Status	Due for Re-Survey	Row Total	2011	Before 2011
SNP	Member_Disenrolled_B4_Survey_Done	0	369	106	263
SNP	Survey_Abandoned	413	1308	8	1300
SNP	Survey_Completed	685	2197	56	2141
SNP	Survey_Pending	29	1699	1299	400
SNP	Z_Sub-Total	1127	5573	1469	4104
Z_Total		0	5573	1469	4104

The initial comprehensive HRA is conducted within ninety days of enrollment to the health plan. The HRA is conducted telephonically. All new Members enrolled in the health plan are outreached for the completion of the HRA and are encouraged to participate in the case management program. The HRA is completed with the Member and the data is applied to an algorithm system that stratifies all Members into levels 1-3. The case manager reviews the HRA and begins the case management process with the Member. The case manager assesses the Member with a medical status assessment in order to obtain additional information. An individualized care plan (POC) is generated as a result of the initial comprehensive HRA data and medical status assessment and is shared with all known Members of the ICT. The Member remains in case management until needs are met or Member chooses to opt out of the program. Annual reassessment of the Member takes place between 9-12 months of the initial comprehensive HRA.

Example: A member who was enrolled in February 2010 had an HRA completed in March of 2010 and was enrolled in Case Management in March of 2010. This member had outreach for completion of a reassessment starting December 2010 and completed the reassessment in

January of 2011. Each member has outreach for reassessment starting 9 months after initial assessment and goes to 12 months after the initial assessment, in the previous example outreach started in December of 2010.

Element 7, Factor C

Describe the personnel who review, analyze, and stratify health care needs

The HRA tool is the basis from which the Individualized Care Plan (POC) is developed. The POC are reviewed initially by the. Clinical Case Managers. The Clinical Case Managers are either LVNs or RNs with extensive experience in Case Management. Based on their assessment of the member or interaction with the caregiver, they will review the initial POC and make any changes that are necessary. They may at that time stratify the member to a higher acuity level which will lead to a more frequent follow up call schedule. An example of this can be a member who answers the HRA stating that he/she does not have gastrointestinal problems, but during the medication reconciliation it is established that he/she is taking a PPI for a chronic duodenal ulcer.

A primary care physician or a specialist who have been fully credentialed in the network evaluates the member is at liberty of modifying or restratifying a member. As noted below, the HRA answers and POC is sent to the primary care physician. After the member's evaluation, it is possible that the physician will make changes to the POC. An example of this would be a member who answers the HRA saying that he/she does not have depression. After the evaluation the primary care physician may disagree with this answer and identify the member as being depressed. He may at that time elect to treat the member or make a referral to the Behavioral Health Provider and inform the Case Manager that the member requires closer follow up.

Another example of how a member's health care needs may be modified is through our Clinical Pharmacist. S part of the Medication Therapy Management Program (MTM) the clinical pharmacist will review the member's medication profile. There are certain classes of drugs such as sleeping medications or anxiolytics that can place elderly or fragile

members at risk. It is not unusual to find different physicians prescribing the same or similar medications. Under these circumstances, the member, Primary Care Physician and Case Manager will be informed of the findings and the need to modify the medications the member is taking. These findings would modify the care the member needs by ensuring proper education regarding the risks of certain medications when they are taken in combination.

Care1st Health Plan will provide the HRA response to the beneficiaries' primary care providers using written notification. Additionally, Care1st will provide the HRA response to the associated delegated medical group also indicating the stratification level via secure electronic medical record transfer protocols. The beneficiaries are notified in writing with a copy of their Individualized Care Plan. Refer to Exhibit B Policy & Procedure – Special Needs Plan Model of Care and MAPD Health Risk Assessment Process.

Case Manager (*reviews and analyzes*) - Coordinate care and services across continuum of illness, promotes effective utilization and monitors healthcare resources. Review, analyze and stratify Member healthcare needs based on HRA data and Case Management activities/communication with Member and ICT. Provides Member education on self-management plans, consults with pharmacy on Member medications, refers to Behavioral Health vendor. Assumes a leadership role within the ICT to achieve optimal clinical and resource outcomes. Assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Member.

Director Medical Services (*analyzes, reports, implements*) - Oversight of Case Management team operations and implementation of processes to meet all regulations related to SNP.

Medical Director or Chief Medical Officer (*reviews, analyzes, implements*) - Oversight and guidance to Case Managers and conduct peer to peer interventions as needed.

BH Care Manager (*collects*) - Provide Behavioral Health coordination, collaboration and assistance (resources) to the Member.

Senior Data Quality Analyst (*collects and reports*) - Responsible for enrollment file to HRA vendor, receives Member HRA files from vendor and uploads to Care1st CM system, and maintains and updates CM database, ensures Member re-assessment files are processed timely. Runs algorithm to provide HRA with a stratification level for CM review.

VP Quality Improvement (analyzes and implements) -Has overall accountability for the day- to-day operations of the QI Program.
He and his staff serve as the resource for quality references, clinical indicators, etc. Plan QI Department personnel collaborate with personnel in each clinical and administrative department to evaluate quality of care to identify opportunities and implement interventions to improve the healthcare and service delivered to members. Functions of these staff include, but are not limited to, prioritizing problem areas for resolution, designing strategies for change, implementing improvement activities and measuring the success of interventions. .

Medical Director, Medical Informatics (analyzes and implements) - The Medical Director of Medical Informatics oversees all data reporting including HEDIS reporting. He ensures that data sources are of the highest quality by working with staff members from other departments.

An example of collaboration between the Case Manager and any or all of the above personnel is as follows:

The HRA is received and the stratification is reviewed by the Case Manager after the HRA information is through an algorithm that determines Member stratification level based on utilization, medical, psychosocial, function and cognitive needs. The Case Manager initiates contact with the Member to gather additional information. Once all the information is collected the Case Manager analyzes all the data received and after consulting with the Primary Care Physician may refer the Member to Behavioral Health or other specialists as needed.

In addition the Case Manager may review the information with the Medical Director for additional guidance. Based on the HRA information and specific Member need the Case Manager may also refer to the Clinical Pharmacist for medication review and consultation.

Element 7, Factor D

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

This is an example showing how the aggregated HRA data is shared with our Medical Groups. This information is sent electronically to the FTP site therefore complying with all HIPAA requirements. This information is then available for all ICT members and pertinent network providers. (see *attachment Element 7, Factor D, 1*)

This is an example of the HRA answers and the POC that is mailed to the primary Care Physician. (see *attachment Element 7, Factor D, 2)*

This report shows an aggregated analysis of all HRAs and POC sent to the Primary Care Physician

HRA Status 03 - SNP 2010 by Survey Status								
Year Enrolled	Plan_Type	Survey_Status	Due for Re-Survey	Row Total	Member Care Plans Total Sent	Member Care Plans English Sent	Member Care Plans Spanish Sent	PCP HRA and Care Plans Sent
Before 2011	SNP	Member_Disenrolled_B4_Survey_Done	0	260	0	0	0	0
2Before 2011	SNP	Survey_Abandoned	413	1334	0	0	0	0
Before 2011	SNP	Survey_Completed	685	2137	2061	1122	939	2061
Befor	SNP	Survey_Pending	29	36	0	0	0	0

HRA Status 03 - SNP 2010 by Survey Status								
Year Enrolled	Plan_Type	Survey_Status	Due for Re-Survey	Row Total	Member Care Plans Total Sent	Member Care Plans English Sent	Member Care Plans Spanish Sent	PCP HRA and Care Plans Sent
e 2011				9				
Z_Total			0	4100	2061	1122	939	2061

2061 Care Plans generated, 1122 in English, 939 in spanish to members
2061 Care Plans and HRA sent to PCP.

The communication mechanism to notify the ICT, provider network, beneficiary on the HRA and Member stratification results is as follows:

Upon completion of the HRA, the Case Manager communicates with the Member, obtains additional information and discusses the results of the HRA including stratification level and meaning of stratification, and utilizes all information available to finalize the POC. The HRA and the POC are incorporated into the member record within CCMS. This POC is then shared with the ICT (including the member)via mail and oftentimes discussed telephonically. The Case Manager utilizes the POC as the tool for communication with the ICT.

Case Study: Case Manager contacts the member to discuss outcome of HRA who was stratified @ Tier 3 level. Member was admitted thru the emergency room; this is her second acute admission in 2 months and has multiple ER visits in the last month for same symptoms. She also has multiple co-morbidities (including type 2 Diabetes) and per HRA does not "always take" medication. The Case Manager completes a medical assessment and confirms the member is a Tier 3 level and completes an

POC in collaboration with the member. Both entities agreed on set goals and the participation of ICT membership is discussed and determined. She is primary caregiver but has family support. The Case Manager informs and member agrees upon participation in ICT and recommendations that may ensue. The Case Manager informs the member that she will receive a copy of the POC.

Case Study below is to illustrate interventions with Initial call by Complex Care Manager after identification as a Tier 3 level for stratification and the subsequent notification to ICT members:

Member Name/ID	Call type:	Person Calling: (to or from)	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes
XXXXXXXXX	☒ **CCM** ☒ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **DM** ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **SW** ☐	☒ Member ☐ Provider ☐ Family ☐ Other	Initial call to regarding HRA, (stratification for Tier 3 CM), recently discharged from hospital w/ CHF. Comorbidities: 13. IDDM 14. Diabetic Retinopathy-mild 15. Chronic Renal Failure (non dialysis) 16. Depression Mbr. Agreed to participate	S/W her PCP who confirmed her new diagnosis of CHF will forward test results and notes. Asked if he or designee would participate in ICT, was in agreement. S/w DM case manager she will assess member and participate in ICT. CTCM will participate for any transition	☒ Member ☒ Family ☐ Caregiver: ☒ CT: M. Rodriguez, LVN ☒ CCM: N. Cabaccang, LVN ☒ DM: V. Silla, LVN ☒ SW: S. Chang, MSW ☒ MD: Dr. Peters ☒ Specialist: Cardiology ☐ Rx: ☒ BH: CompCare	ICT via teleconference; all in agreement for POC: ☒ Ed. Materials sent: CHF Management Brochure ☒ Referrals: ☒ DM educ. Classes @ CA Hospital MC ☒ Adult Yoga ☐ Depressi

Member Name/ID	Call type:	Person Calling: (to or from)	Problem/ Concerns	Interventions	Interdisciplinary Care Team	Outcomes
	Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ CT: ☐ Initial ☐ Routine ☐ Care Conference ☐ Outlier ☐ **Premier Member Service** ☐ Initial ☐ Routine ☐ Outlier		in ICT and understand need for being compliant with all meds and appts.	needs. S/w Cardiologist nurse made arrangement for f/u appt, will participate in ICT S/w member about transportation, no needs for transportation to be arranged.	☐ Other: _____ Frequency: ☐ Tier 1 q 6 months ☐ Tier 2 q 3 months ☒ Tier 3 q month	on (mbr declined) ☒ F/U 2 weeks w/ MSW and 1 week w/ DM ☒ Prevent Care: Podiatrist visits within 6 months Documentation: ☒ CCMS-records attached ☐ MHC ☒ POC sent to Mbr. 4/29/11 ☒ POC sent to PCP 4/29/11 ☒ Other: POC to Cardio 4/29

Element 8 – Individualized Care Plan

Element 8, Factor A

Describe which personnel develops the individualized plan of care (POC) and how the beneficiary is involved in its development as feasible

Care1st Health Plan's Medical Management team which is comprised of physicians, nurses, social workers and pharmacists identified individual questions from the HRA that have significant importance as it pertains to the care management of the beneficiaries. Based on these unique questions, a series of Problems, Interventions and Goals (PIGS) were created. Once the beneficiary completes the HRA, the responses are entered into our Care Management Software. The unique combination of answers for each member generates an POC.

The POC reflects stratified needs that are matched to services and benefits so that the vulnerable and sickest members receive care proportionate to their needs.

The Care Management model ensures care plan interventions are designed to educate, empower and facilitate the member to exercise her/her rights and responsibilities. The POC identifies member specific services and benefits to be provided that have measurable outcomes. The Case Manager discusses the POC with the member/Caregiver and ensures that information and support is rendered to the member to make choices regarding his/her health whenever feasible. Members are encouraged to take a copy of their care plan to their provider at each scheduled appointment to review and update goals and/or interventions as needed. Members are mailed a copy of their POC and are advised to review it and if there are any discrepancies or inaccurate statements, they are asked to discuss them with their Primary Care Physician or call the Plan, so their Case Manager can address any issues and make modifications to the POC based on the member's input. The care plan is revised when appropriate to reflect the member's current needs, based on evaluation of new clinical data, progress towards goals, response to care and treatment and/or significant changes in the member's status which can occur after a hospitalization.

The POC will include an itemized list of identified Problems, Interventions and Goals. The POC lists the Problems, Interventions and Goals into distinct categories that include: Clinical, Functional, Preventive Measures, Psychosocial, and Compliance. (Exhibit C-Sample POC)

The Case Manager with the active involvement of the Member and his/her closest caregivers/member representatives works with the Member's primary care physicians (PCP), and a variety of specialist (s) as well as ancillary care providers to identify and prioritize a problem list and comprehensive treatment plan.

The Model of Care is a Member centered approach that emphasizes Member engagement and in depth understanding of the Member's strengths and vulnerabilities.

The Case Manager develops the POC with the Member and/or authorized caregiver after review of the initial comprehensive HRA and completion of the medical status assessment.

The Model of Care ensures care plan interventions are designed to educate, empower and facilitate the Member to exercise his/her rights and responsibilities. The Care Plan identifies Member specific services and benefits to be provided that have measurable outcomes, including LTSS and HCBS.

The Case Manager discusses the Care Plan with the Member/Caregiver and ensures that information and support is rendered to the Member to make choices regarding his/her health whenever feasible.

Case Managers will provide fax or send electronic copies of Member's individualized care plan when facilitating appointments to encourage member/PCP involvement. This ensures that the case management model represents the Member's point of view, even when the member is unable to participate in decisions.

The Case Manager places special emphasis on assisting the member in recognizing his/her role as the daily self-manager and family/caregiver's engagement in the member's overall self-management.

The POC is developed with the Member after completion of the medical status assessment and goals are agreed upon with the Member at that time. If a member is not available to participate or cannot participate, an authorized member representative can participate on behalf of the Member in the creation of the care plan with the case manager. If the Member is unable to contact or refuses to participate in the case management program, an initial communication plan is developed without the Member's input and is shared with the PCP or usual practitioner. The goal is to communicate with the provider and obtain Member information for the case manager to create an individualized care plan. When information is received from the provider the case manager adds this information to customize the care plan to the specific Member.

The case manager is assisted by social workers, discharge planners, case coordinators, Care Navigators, and other staff who support Members and providers through all phases of care. The case manager is assigned the singular responsibility for assembling an POC for each Member who expresses a willingness to collaborate on a plan. The case managers are highly trained to develop POCs that are realistic, practical, and yet have a high probability of leading to a successful outcome.

Example: A Member completes an HRA and is contacted by a Case Manager who completes the medical status assessment, the Member and Case Manager review possible problems and goals, and priority of each goal. Member is reminded to discuss the care plan goals with their provider(s) during visits. The Case Manager assists the Member and provides education on preparing for future provider visits (i.e. questions they should ask, biometric measurements they have collected and wish to report, areas of concern, etc.)

Element 8, Factor B

Describe the essential elements incorporated in the POC;

As an example , there are a series of questions in the HRA that are related to whether or not the member has obtained preventive services such as colon cancer screening, glaucoma screening and diabetic eye screening. Any member that answers these questions in the negative generates a specific Problem, Intervention and Goal (PIG). It also generates an

automatic reminder to our Quality Improvement Department which will then outreach to the member and the physician in order to schedule the specific preventive service that is needed.
If a member is identified as having had a fall, it would generate a PIG that would expedite an assessment of the member to ensure that the home is safe. In most instances a Home Safety Evaluation will take place, and the member will be educated in appropriate Fall Prevention Issues.

The initial POC is developed by Care1st and shared with the member/caregiver, PCP and medical group. The primary care physician will review the POC with the beneficiary at the time of the patient visit and will revise as agreed upon by the provider and beneficiary. Additionally, the medical group will review the POC and communicate with the primary care provider and member to revise and update the action items. Frequency of these reviews will be determined based on the beneficiaries' needs, but at a minimum, twice yearly.

The POC is developed by the case manager with the Member using information collected during the initial comprehensive health risk assessment (HRA) conducted with the Member and/or caregiver by our contracted vendor. The case manager identifies problems, reviews the problems with the Member and the Member and case manager agree upon problems, goals, and interventions. Interventions for the care plan are varied and individualized based on Member input, need and available benefits to the Member. All areas of the Member health and social status are taken into consideration while building the care plan; community resources and benefits available, as well as those services that are not covered that the plan takes into consideration to expand as add-on benefits.

Individual Member care and treatment goals are incorporated in to the POC. Each member's care plan identifies goals that reflect the Member's unique needs, are realistic and measurable, include a time frame for achievement, when appropriate, identifies services and care to meet Member's goals and connects the Member/caregiver with add-on benefits and services such as community resources.

An example of a completed care plan is hereby included:

CARE LIST HEALTHPLAN

Individualized Care Plan

Member: [redacted], Jose P Member#: [redacted]*01

Date of Birth: 1/24/[redacted] Sex: M

PCP Name: Dr. Mercedes [redacted] IPA: Quality Care Medical Group

The following Individualized Care Plan was created for the above referenced member based on responses to the Health Risk Assessment Survey that was completed on 4/11/2011.

Problems	Interventions	Goals	Notes
Clinical			
Being Treated For: Arthritis	PCP/Case Manager to evaluate Arthritis	PCP to optimize treatment of Arthritis	
Being Treated For: High Blood Pressure	PCP/Case Manager to evaulate High Blood Pressure	PCP to optimize treatment of High Blood Pressure	
Functional			
Member states has Pain	PCP/Case Manager to evaluate members Pain	PCP/Case Manager to ensure relief of pain	
Preventive Measures			
Member has not had a Glaucoma Screening Exam in past year	Submit referral for Glaucoma Screening Exam	Ensure member receives Glaucoma Screening Exam this year	
Member has not had any Colorectal Screening done	PCP/Case Manager to educate on importance of Colorectal Screening	Member to receive Colorectal Cancer Screening this year	
Member has not received Zostavax in the past	PCP/Case Manager to educate on importance of Zostavax	Member to receive Zostavax unless contraindicated	
Psychosocial			
Member does not have an Advance Directive, wants to complete one	Plan to send Advance Directive information and document	PCP to file completed Advance Directive in medical record	

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Provider: Please file in member's medical records.

Member: Please bring this form to your next doctor's visit. If any of the information in this report is not correct, please discuss it with your doctor so it may be corrected.

The case manager utilizes the care plan as a tool to accomplish set goals, track interventions, and document progress toward set goals. The care plan contains identified problems, interventions and goals. Any changes or progress reported by the member is documented in our case management software, CCMS and the POC is updated. All members of the ICT are notified of the updates.
In this sample POC the member has been identified with the following problems:

- Has arthritis and hypertension.
- Has pain as a result of the arthritis
- Has not received several preventive measures
- Does not have advance directives

Goals for this member would include the following:

- Member will verbalize understanding of condition state
- Member will verbalize understanding of the importance of completing all preventive measures
- Member will complete an advance directive
- PCP will optimize treatment of member's condition

The interventions for this member would be as follows:

- Provide member with written education materials for the case manager and member to review (case manager is accountable for completing this intervention)
- Case manager will evaluate, identify gaps of member's understanding of their condition (case manager is accountable for completing this intervention)

- Continue following up with member to provide ongoing education on arthritis and hypertension (case manager and member are accountable for completing this intervention)
- Discuss with the ICT the need for a rheumatologist (case manager and PCP are accountable for completing this intervention)
- Social Services Department will mail all advance directive information to member. (case manager and member are accountable for completing this intervention
- Case Manager in conjunction with Quality Improvement Department will obtain all necessary authorizations for preventive measures and assist member with scheduling and transportation if needed.

Element 8, Factor C, D, E

Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised.

Describe how the POC is documented and where the documentation is maintained

Describe how the POC and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers

Case Managers and Care Navigators function as the central coordinators of care across all settings and providers. They are responsible for implementing and coordinating all case management activities relating to the special needs population; including advocating and educating members on services and benefits, triaging member's care needs, conducting and analyzing HRA, initializing and implementing the member's POC, ongoing review and updating of the member's POC, coordinating access to LTSS and HCBS and other community resources, as appropriate, and alternative levels of care, coordinating care for beneficiaries across all care settings including provider services, assisting members with scheduling appointments and follow up services. Frequency of reviews is determined based on the beneficiaries' needs, but at a minimum twice yearly and upon change in member's health status. The Case Manager also provides educational opportunities where appropriate including psychosocial

interventions through resource identification, program development and other means. In instances were members are also enrolled in a Disease Management Program; the Disease Manager may obtain information through her interaction with the member that will require the POC to be modified. Since the Disease Managers and Case Managers share the same member centric Case Management System, this information is easily shared between them. Subsequent notification of these changes can be made to the ICT.

The ICT updates the POC as the member's health status changes. Members and their physicians are notified of any changes made to the POC either by written or verbal communication. The POC is available for review and input by the member's Primary Care Physician and specialists, via fax, or written correspondence. All documentation, including changes to the POC, is maintained in the electronic case management system. (see attachment *Element 8, Factor E, 1* and attachment *Element 8, Factor E, 2*)

Primary care physicians are required to incorporate the POC in the beneficiaries' medical record. Likewise, medical groups are provided the beneficiaries POC in a spreadsheet for documentation purposes and they are required to store the POC in a manner that allows access by members of the ICT with safeguards that maintain privacy and confidentiality, e.g. secure database. The beneficiary receives their POC by mail. In addition the POC is downloaded into Care1st Care Management Software. As this software is member centric, all documentation pertaining to that member is stored indefinitely in a secure fashion.

Based on the results of the HRA and the POC, members are risk stratified and various conditions are identified. Beneficiaries can then be enrolled either into Disease Management programs, Case Management, Complex Case Management or Care Transitions. All of these programs interact closely with the beneficiary, Primary Care Physician and specialists. Any changes to the care plan would be documented and relevant ICT members are notified in a secure fashion. The POC is considered a dynamic document which is expected to change and be modified as each beneficiary's clinical condition changes.

Element 8, Factor C

Describe the personnel who review the care plan and how frequently the POC is reviewed and revised;

The personnel utilized to review the Member's POC are at a minimum, the Case Manager, Member/caregiver, and Primary Care Physician (PCP). In addition, all pertinent specialists (if any are identified), social services and community resources are included in the care coordination for the Member.

To illustrate and provide an example of personnel who review the care plan, a member who has been identified as having a PCP, Cardiologist, Rheumatologist and Psychiatrist would have all these providers included in the ICT in addition to the Member/caregiver as well as case manager.

The Case Managers and Care Navigators are responsible for coordinating the input from all members of the ICT and sharing the information with the ICT via the care plan and/or telephonically. The care plan is shared with all Members of the ICT for review and comment/input as needed. This occurs at a minimum, during initiation of the care plan, annually, and at any significant change in the Member's health status. A care plan update can occur at any point along the continuum and is shared with all members of the ICT at any update/change which includes progress and/or regression of goal completion. All Members will have an updated care plan annually with a new comprehensive HRA completed.

Example: Member care plan is shared with the ICT:

a. At initiation,
b. During a hospitalization,
c. When a Member has completed all/any goal (s) established in the care plan,
d. If the Member has a new medical diagnosis, or medications,
e. If the Member is referred for any new services, including LTSS,CBAS and HCBS

The care plan is reviewed with the Member during each scheduled follow up and at any time the Member requests a review. Documentation of review of the Care Plan is maintained in the member's medical record.

<u>Element 8, Factor D</u>

Describe how the plan of care is documented and where the documentation is maintained;

The POC is documented anytime there is a change in the member's condition or whenever the case manager has a discussion with a ICT member. The documentation takes place in CCMS, which is the member centric medical record. All information contained in the member's medical record is accessible to the ICT members, including the member or care giver via fax or mail.
All information in CCMS is secure and HIPAA compliant. All information in CCMS is backed up into a remote server at regularly scheduled intervals and preserved.

The following case study identifies a member's POC and documentation that takes place in CCMS based on the member's change in condition.

CARE 1ST HEALTHPLAN

Individualized Care Plan

Member: [redacted] Member#: [redacted]
Date of Birth: [redacted] Sex: M
PCP Name: Dr. [redacted] IPA: [redacted] - Downey

The following Individualized Care Plan was created for the above referenced member based on responses to the Health Risk Assessment Survey that was completed on 9/3/2010.

Problems	Interventions	Goals	Notes
Clinical			
Being Treated For: High Blood Pressure	PCP/Case Manager to evaulate High Blood Pressure	PCP to optimize treatment of High Blood Pressure	
Has: Diabetes	PCP/Case Manager to evaluate Diabetes	PCP to optimize treatment of Diabetes	
Functional			
Member states has Pain	PCP/Case Manager to evaluate members Pain	PCP/Case Manager to ensure relief of pain	
Needs help with: Preparing Meals	Refer to Case Management to Evaluate Needs of Daily Activities	Use available Plan benefits to meet needs of Daily Activities	
Needs in home assistance due to health problems	PCP/Case Manager to evaluate member needs in home	Use available Plan benefits to assist member with in home needs	
Preventive Measures			
Member has not received Zostavax in the past	PCP/Case Manager to educate on importance of Zostavax	Member to receive Zostavax unless contraindicated	

Provider: Please file in member's medical records.

Member: Please bring this form to your next doctor's visit. If any of the information in this report is not correct, please discuss it with your doctor so it may be corrected.

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Member: [redacted] Date of Birth: [redacted] **Page 1 of 1**
Member #: [redacted] Sex: M

[26 Min] : Care Transition C.M. - SNP - 01/20/2011 : Note - 02/17/11 12:42 PM

Work In Progress

*Member Level Work in Pr...

Member Summary View

To Do List

Note - 02/17/11 12:42 PM

Care Transition C.M. - SNP -...

Note - 02/17/11 12:42 PM

Encounter Date 02/17/11 Time 12:42 PM Entered [redacted]V.N., M

Note

Attachments

Contact

Type

Confidential ☐ Not Accepted

Person

Note Type Care Transition CM

Phone - -

Reason C.T. #5 Member Post D/C - Call

*Event

Appeal

Case 3 Care Transition CM 01/20/11

SNP member identified, attempted several times to reach member was able to contact member today. Reviewed the HRA Summary Responses and the Individual Care Plan generated with member. Talked to member in length about the conditions identified on the Care Plan, HTN and Diabetes. The member states that in the past few months his condition has declined, he is weaker and is now requiring more assistance with ADL's than previously. This information is not reflected in the current ICP. This is a change in his condition. He states he has difficulty preparing meals, bathing regularly, ambulating in the apartment is getting more difficult as he tires quickly. He currently is not using any adaptive devices, walker, etc. Will contact his PCP to updateand discuss regarding the Care Plan change and determine treatment plan. Per member has already applied for IHSS and is aware this process takes time. Member lives only in a senior apartment. Member states some of his friends and neighbors provide some assistance with meals, shopping, however, member understands and agrees he can benefit form additional help. Member has a G-tube in place and is not clear that member understands special diet required.

PLAN: Inform PCP of need to refer member to dietitian and ensure member has a full understanding of diet and due to decline in condition possible referral to higher level of care such as B&C or assisted living. Request home health safety evaluation, possible physical therapy. After HH evaluation will order appropriate DME items. Member will contact social worker for update on IHSS application. Will also refer to Care1st social worker for evaluation, intervention, community resources, etc.

Call placed to member's PCP, left message to return call urgently.

Accept Note

Spellcheck

[34 Min] : Care Transition C.M. - SNP - 01/20/2011 : Note - 03/17/11 1:28 PM

Work In Progress

*Member Level Work in Pr...

Member Summary View

To Do List

Note - 02/17/11 12:42 PM

Care Transition C.M. - SNP -...

Note - 03/17/11 1:28 PM

Encounter Date 02/17/2011 Time 1:28 PM Entered [redacted]V.N., M

Note

Attachments

Contact

Type

Confidential ☐ Not Accepted

Person

Note Type Care Transition CM

Phone - -

Reason Contact Provider

*Event

Appeal

Case 3 Care Transition CM 01/20/11

Member's PCP returned call. I reviewed the care plan and changes in condition, ADL issues, since previous care plan completed. PCP agrees with recommendations for home health, DME and social services and wants to see member urgently for physical exam, medication review. PCP apppointment made and will arrange transportation. Will contact member to update and review plans.

Accept Note

Spellcheck

Element 8, Factor E

Describe how the POC and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers;

After initiation of the care plan and at times of significant health status changes, the POC is updated and shared with the ICT. The Manager or the Care Navigator communicates with the Member and makes changes to the care plan, goals met, interventions, etc. The Member and case manager agree to the changes in the care plan. The Member is informed by the case manager to discuss the care plan and any revisions to the care plan with the provider (s) and request a copy during any PCP/usual practitioner and/or specialist visit, as well as discuss the set goals and ask any related questions they may have. The case manager communicates with the PCP via phone and fax in an effort to collaborate with the network providers and establish communication with the Member.

The Case Managers and Care Navigators are responsible for coordinating the input from all members of the ICT and sharing the information with the ICT via the care plan and/or telephonically. The care plan is shared with all Members of the ICT for review and comment/input as needed. This occurs at a minimum, during initiation of the care plan, annually, and at any significant change in the Member's health status. A care plan update can occur at any point along the continuum and is shared with all members of the ICT at any update/change which includes progress and/or regression of goal completion. All Members will have an updated care plan annually with a new comprehensive HRA completed.

Example: Member care plan is shared with the ICT:

a. At initiation,
b. During a hospitalization,
c. During Member refusal or member self-disenrollment from case management,
d. When a Member has completed all/any goal (s) established in the care plan,
e. If the Member has a new medical diagnosis, or medications,

Members of the ICT review and provide comment/revision as necessary. The revised care plan is updated in the member's individual medical record within CCMS.
The revised care plan is faxed to all members of the ICT
The member receives verbal update from the case manager and update from the usual practitioner during visits (verbally and/or in writing).

CARE 1ST HEALTH PLAN

Individualized Care Plan

Member: [redacted] Member#: [redacted]01
Date of Birth: [redacted] Sex: M
PCP Name: Dr. [redacted]z IPA: [redacted] - Downey

The following Individualized Care Plan was created for the above referenced member based on responses to the Health Risk Assessment Survey that was completed on 11/8/2010.

Problems	Interventions	Goals	Notes
Compliance			
Member has no scheduled appointment with current PCP	PCP/Case Manager to schedule appointment for member ASAP	Ensure member keeps appointment with PCP	
Preventive Measures			
Member does not routinely get a Flu Shot every year	PCP/Case Manager to educate on importance of yearly Flu Shot	Member to receive yearly Flu Shot unless contraindicated	
Member has not had a Glaucoma Screening Exam in past year	Submit referral for Glaucoma Screening Exam	Ensure member receives Glaucoma Screening Exam this year	
Member has not had any Colorectal Screening done	PCP/Case Manager to educate on importance of Colorectal Screening	Member to receive Colorectal Cancer Screening this year	
Member has not received Pneumovax	PCP/Case Manager to educate on importance of Pneumovax	Member to receive Pneumovax unless contraindicated	
Member has not received Zostavax in the past	PCP/Case Manager to educate on importance of Zostavax	Member to receive Zostavax unless contraindicated	

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Member: [redacted] Date of Birth: [redacted]3 Page 1 of 2
Member #[redacted]01 Sex: M

[27 Min] : Care Transition C.M. - SNP - 02/23/2011 : Note - 02/25/11 1:03 PM

Work in Progress

Member Level Work in Pr...

Member Summary View

To Do List

Care Transition C.M. - SNP -...

Note - 02/25/11 1:03 PM

Encounter Date 02/25/11 Time 1:03 PM Entered [redacted]A., M

Note

Attachments

Contact

Type

Confidential ☐ Not Accepted

Person

Note Type Care Transition CM

Phone

Reason Member Follow-up

*Event

Appeal

Case 2 Care Transition CM 02/23/11

SNP member admitted to Long Beach Memorial Hospital with A.Fib., altered mental status, alcohol dementia. Called member at hospital was able to speak with wife who anticipates member will be transferring to SNF for rehab. after discharge. Wife states member has recently declined significantly due to alcohol abuse which has gotten worst and appears depressed and now needs assistance with ambulation as he is not steady on his feet. Per wife member does see PCP but not on a regular basis. Reviewed the HRA Summary and Individualized Care Plan that was completed in November 2010, with wife who is aware of member's condition. Member has not seen PCP recently and is not aware of worsening in condition. The completed ICP does not reflect these current clinical issues. Wife does not believe PCP is aware of the member's worsening condition.

PLAN: Refer to Care1st Social Services to evaluate depression, alcohol abuse and other psychosocial issues. Wife believes that member will agree to assistance with depression and will encourage member to comply with recommendations made by PCP for alcohol abuse. Will contact PCP member to discuss change in care plan regarding decline in clinical conditions and assistance needed with ADL'S. Will continue to f/u and assist as needed post discharge.

Contacted PCP, reviewed current changes in care plan. PCP wants to be kept informed of member's status when transferred to SNF and when discharged, and to schedule urgent post SNF d/c office for evaluation. Will arrange for transportation for PCP visit and home health safety evaluation and ADL needs.

Accept Note

Spellcheck

Element 9 – Communication Network

Element 9, Factor A

Describe the structure for a communication network;

The Health Plan conducts twice weekly case conferences (interdisciplinary) that includes Case Managers, Social Workers, Care Navigators, CMO, Medical Services Management, Health Education, Allied Health professionals (includes Behavioral Health Case Managers) Coordinators and other ad hoc attendees as needed. These meetings are in person and available as teleconference for telecommuters. Shared reports are available and presented at this meeting for review, discussion and intervention. On and ad hoc basis the SNP beneficiary specific Pre-Admission and Discharges Reports are available and reviewed as needed. The minutes are distributed to staff for review and available in department binder as needed. Care1st Health Plan supports telecommunication so meetings or other forms of interaction may be conducted utilizing audio-conferencing, face to face meetings, written communication, and web-based posting of information as a means for communicating information associated with the model of care. On an ad hoc basis ICT members will initiate and communicate with internal and external customers including, case managers, social workers, care navigators, PCP, specialists, beneficiary/caregiver, family members to collaborate on optimizing coordination of care and specific needs addressed.

Example: Medicare Inpatient Census delineating SNP admissions report *(Attachment Element 9, Factor A, 1)*

Example: SNP Member Pre-Admission Report (*Attachment Element 9, Factor A, 2)*

Example: Daily SNP Discharge Report *(Attachment Element 9, Factor A, 3)*

Example: Complex Case Management Meeting 10/12/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 9, Factor A, 4)*

Example: Disease Management Meeting 11/3/10 Agenda, Minutes and signed attendance sheet *(Attachment Element 9, Factor A, 5)*

Example: Case Study Summaries, ad hoc discussions for specific beneficiary needs. *(Attachment Element 9, Factor A, 6)*

Care1st has a comprehensive integrated, diverse communications network that helps all parties remain informed of its services, policies, procedures and reporting. The Company utilizes several avenues including, but not limited to public Web sites; Web portals specific to Members and providers; face-to-face meetings with Members, providers; written correspondence to Members, providers, manuals and newsletters for providers and Members. The provider contract and the provider manual are the foundation for the communication network for participating providers. The provider manual contains information about Care1st practices, policies and procedures of which providers need in order to conduct business with Care1st.

In addition to the provider contract and provider manual, which are both made available to providers upon entry into the Network, Care1st's Provider Network Operations department publishes a quarterly Provider Newsletter to contracted physicians. These newsletters contain articles relative to both clinical and administrative practices such as, but not limited to: HEDIS, Case and Disease Management Programs, self-service options available on the web portal and how to submit claims electronically. Most communication material is also posted on the Care1st Provider portal site on the web. Provider Network Operations staff is also responsible for delivering face-to-face, ongoing training and communication to network providers. These visits often contain information regarding changes in Care1st policies, updates to clinical programs or provider training requirements, information on members who have HEDIS care gaps as well as general information on how to conduct business with Care1st. The Provider Network Operations department in conjunction with feedback from the Marketing Department and Customer/Member Service is accountable for the overall monitoring and evaluation of communication effectiveness to providers.

Care1st maintains a health information system to collect, analyze and integrate the data necessary to implement its quality Case Management programs. In addition, the information entered into the system is reliable, complete and secure, providing the department with reporting capabilities. The system provides the case manager with automated prompts for Member follow-up and Care Plan intervention implementation. Documented

interactions with the Member assist in providing a clear vision of the Members needs, goals, interventions and outcomes. The care plan is generated and shared with members of the ICT via fax.

*The **Medicare Inpatient Census** is used as a tool with indicators, i.e.; hospital, enrollee, diagnosis, Length of Stay (LOS), etc. to assist in identifying members that may require ambulatory post discharge coordination of care/service or transition of care assistance.*

<u>Case Study</u> below sample of the twice weekly IDCP Meeting minutes identifying hospitalized SNP members that represent collaboration and communication with multiple disciplines and with the member:

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up
XXXXXX	☐ MCR ☒ SNP: ☐ Tier 1 ☐ Tier 2 ☒ Tier	Admitted thru ER (identified thru IP census) w/ SOB, to ICU vent. Transfer	Will stay in Rehab until safe with minimum assist will get home PT. 4/21: Per MSW PT progressing, Coumadin level stable, had h/o of bld clot so family	☒ Referral to: Psych Consult 4/12 ☒ Referral to: Home Health SN/PT 4/29 ☒ Referral	G. Hernandez, LVN – IP-CM N. Cabaccang, LVN – CHF CCM -	☒ w/ Cardiologist 5/1 ☒ CCM to discuss classes available: done 4/27 ☒

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up
	3	to Rehab, new diagnosis of CHF. First acute hospitalization	concern, monitoring closely. 4/26 Refer to CCM, member going to live with sister (25 miles from doctors) will set-up transportation to assure visits.	to: CCM 4/26 ☒ Referral to: MSW 1/26 ☒ CT initiated: 4/10/11	Primary V. Silla, LVN - DM	Transportation to MD visits: done 4/27 ☐ None Documentation: ☒ CCMS (records attached) ☐ MHC ☒ Other: Minutes IDCP folder

The **SNP Member Pre-Admission Report** is a daily auto-generated report available to all case managers that identifies all SNP members with an approved referral to a facility for the last 7 days. The primary purpose for this report is to pro-actively identify any SNP member with an authorized facility based service which is considered a **planned transition** from their usual setting of care to another setting. These members/caregiver are contacted telephonically to explain the Care Transition program, conduct an initial assessment to determine the members needs prior to hospitalization and potential plans post discharge. In addition educational material is mailed to these members to provide guidelines to prepare for hospitalization, discharge checklist and Care1st contact information.

Example report below which is referenced above illustrates the process of identifying planned transitions for all SNP members.

CARE 1ST HEALTH PLAN
SNP MEMBERS PRE-ADMISSION REPORT
ADMISSIONS APPROVED IN LAST 7 DAYS
DATE: Thursday, April 07, 2011

MEMBER	MBR #	PHONE	FACILITY	PHONE	AUTH #	APPR DT	DIAG CD	DIAGNOSIS	PROC CD	PROCEDURE
[redacted]	704325*01	[redacted]	51 ST FRANCIS HOSP M	310/900-8900	581613*OH	2011/04/04	235.2	NEOP, UB, STOMACH/IN	45385	LESION REMOVA
						2011/04/04			Z7500	USE OF HOSPEX
[redacted]	1151077*01	[redacted]	51 LAC USC MC,	323/226-2622	581816*OH	2011/04/04	959.01	INJURY NOS, HEAD	Z7500	USE OF HOSPEX
[redacted]	996204*01	[redacted]	51 PACIFIC ALLIANCE M	213/624-8411	582777*OH	2011/04/06	781.3	LACK OF COORDINATIO	Z7500	USE OF HOSPEX
[redacted]	1142929*01	[redacted]	51 ALVARADO HOSPITA	619/229-3172	581205*OH	2011/04/01	787.20	DYSPHAGIA UNSPECIFI	43235	UPPER GASTROI
						2011/04/01			Z7500	USE OF HOSPEX
[redacted]	1191664*01	[redacted]	41 PHAM, NGA VAN	408/532-0105	582369*OH	2011/04/06	366.16	CATARACT, SENILE NUC	66984	EXTRACAPSULA
[redacted]	1216529*01	[redacted]	41 NGUYEN, TAM HOAN	408/258-5083	582372*OH	2011/04/06			66984	EXTRACAPSULA
[redacted]	882084*01	[redacted]	51 ST BERNARDINE MC,	909/883-8711	581660*OH	2011/04/04	569.3	HEMORRHAGE, RECTAL	45378	DIAGNOSTIC COL
[redacted]	1190124*01	[redacted]	51 VALLEY PRESBYTERI	818/782-6600	581761*OH	2011/04/04	715.16	OSTEOARTHROSIS LCL	27447	TOTAL KNEE ART
[redacted]	1161884*01	[redacted]	51 TRI CITY MEDICAL CT	760/724-8411	582351*OH	2011/04/05	414.01	ATHRSCLR, CORONARY	33519	CORONARY ART
						2011/04/05			33533	CORONARY ART
[redacted]	1024494*01	[redacted]	51 PACIFIC ALLIANCE M	213/624-8411	582114*OH	2011/04/05	285.8	ANEMIA NEC	Z7500	USE OF HOSPEX
[redacted]	768184*01	[redacted]	51 ST BERNARDINE MC,	909/883-8711	581731*OH	2011/04/04	787.20	DYSPHAGIA UNSPECIFI	43450	DILATE ESOPHA
						2011/04/04			Z7610	MISC DRUGS AN
						2011/04/04			43235	UPPER GASTROI
[redacted]	861337*01	[redacted]	51 PARADISE VALLEY H	619/470-4321	573819*OH	2011/04/04	627.1	BLEEDING, POSTMENO	58560	HYSTEROSCOPY
						2011/04/04			Z7500	USE OF HOSPEX
[redacted]	867747*01	[redacted]	51 VALLEY PRESBYTERI	818/782-6600	582314*OH	2011/04/05	787.20	DYSPHAGIA UNSPECIFI	45378	DIAGNOSTIC COL
						2011/04/05			43239	UPPER GASTROI
						2011/04/05			Z7500	USE OF HOSPEX

Thursday, April 07, 2011 *Page 1 of 1*

The **Daily SNP Discharge Report** is a daily auto-generated report available to all case managers to track SNP member discharges. This is used to assist the case managers in confirming discharges and tracking the hospitalized SNP members. The SNP Care Transitions and Complex Case Managers are in communication with the Care1st Inpatient Case Managers concurrently to coordinate discharge and post discharge plan of care/service. This report is a tracking mechanism for the case managers. All of these identified members will be contacted telephonically post discharge to conduct a specific assessment to determine their individual needs. This information captured is shared with the members PCP and the case manager communicates telephonically with the PCP to review the care plan and treatment plan.

Example report below which is referenced above illustrates the tracking process for the SNP hospitalized members.

DAILY SNP DISCHARGE REPORT
SORT BY: HOSPITAL
DATA UPDATED: 4/7/2011 2:04:50 AM
REPORT RUN: 4/7/2011 7:32:00 AM

DISCHARGE DATE ON: 4/2/2011

MEMBER	AID	D.O.B.	AUTH #	IPA	ADMIT	HOSPITAL	PHONE	DIAGNOSIS	DAYS	TYPE	CM	CMG	I	S	LOB
[redacted]	501L2LA	7/21/1935	578580*IH	SAN MIGUEL IPA	3/23/2011	GLENDALE MEM	818/502-1900	COMPRESSION, V	15	IH	CT	gh	2		2400
[redacted]	501L2LA	9/14/1940	580549*IH	ANGELES IPA	3/29/2011	MEM HOSP OF G	310/512-6169	DEHYDRATION	9	IH	CT	gh	2	1	2400
[redacted]	501L2LA	12/1/1955	557115*IH	ST FRANCIS IPA MG	4/1/2011	ST FRANCIS HO	310/900-8900	CHLTHIAS W/O CH	6	IH	CT	gh	1		2400
[redacted]	501L2LA	8/4/1949	580943*IH	SAN MIGUEL IPA	3/28/2011	ST JOSEPH HOS	360/735-5400	UNSPEC HEMORR	10	IH			2		2400
[redacted]	501L2LA	3/10/1965	580148*IH	EHS	3/28/2011	WHITE MEMORIA	323/268-5000	SCHIZOPHRENIA	10	IH	CT	ko	3		2400
[redacted]	509L2SD	5/26/1950	581475*IH	SD MULTI CULTURAL	4/1/2011	PARADISE VALL	619/470-4321	DISEASE, ACUTE	6	IH	CCM CT	ko	3	1	2700
[redacted]	509L2SD	10/21/1944	581634*IH	SD MULTI CULTURAL	4/1/2011	SCRIPPS MERCY	619/294-8111	PAIN IN THORACIC	6	IH	CT	ko	2		2700
[redacted]	509L2SD	9/2/1931	578595*IH	VANTAGE	3/24/2011	SCRIPPS MERCY	619/294-8111	SYNDROME, INTE	14	IH	CT	ko	3		2700
[redacted]	509L2SD	7/4/1932	565534*IH	VANTAGE	3/31/2011	SCRIPPS MERCY	619/691-7000	STENOSIS, SPINA	7	IH	CT	ko	1		2700
[redacted]	509L2SD	2/23/1943	569058*IH	VANTAGE	3/31/2011	SHARP CHULA VI	619/502-5800	DYSPLASIA OF CE	7	IH	CT	ko	1		2700
[redacted]	501L2LA	12/8/1953	574602*SNF	PACIFIC ALLIANCE ME	3/23/2011	BRIER OAK ON S	323/663-3951	OSTEOARTHROSI	15	SNF	CT		1	1	2400
								GRAND TOTALS =		11	105				

Page 1 of 1

Element 9, Factor B

Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies.

Communication methods will take into consideration privacy and confidentiality safeguards using secure and encrypted email for interdepartmental exchange and abiding by the Privacy Statement and for the website: https://www.care1st.com/ca/privacy.asp for internal staff and telecommuters. In addition, SNP Care Management (CM) staff contact inpatient and SNF care managers/discharge planners to assure coordinated transitions in care if an inpatient/SNF admission occurs. Contacts from providers or beneficiaries to Care1st Health Plan's Member Services department are documented in the system that is available and accessible to SNP CM personnel. Proactively, SNP CM staff will work with delegated medical group/IPA case managers via outbound calls to identify other needs to refer to community resources or other services. Clinical

pharmacists are available for support medication related issues and Social Workers are obtainable for behavioral health issues via telephone. For behavioral health related issues our contracted mental health vendor is contacted by Care1st staff or by the beneficiary directly through their toll-free phone to assist in care management and coordination of care and services. The communication network connects the plan with the medical groups, primary care providers and beneficiary for the purpose of managing the beneficiary's care. Regulatory agencies may review the model of care processes. Results of the Care1st Model of Care Program will be available for public review at a summary level that safeguards patient-specific information via website: https://www.care1st.com/ca/providers/snp-model-of-care.asp.Other communication methodologies for network provider and beneficiary includes the Provider and Member Newsletters.

Example: Confidentiality Statement Utilization Management *(Attachment Element 9, Factor B, 1)*

Example: Provider Newsletter *(Attachment Element 9, Factor B, 2)*

Example: Member Newsletter *(Attachment Element 9, Factor B, 3)*

Example: Beneficiary Care1st ID Card with Behavioral Health toll free number *(Attachment Element 9, Factor B, 4)*

Example: Care1st Member Website - Behavioral/Mental Health Services page https://www.care1st.com/ca/members/plans-and-benefits/medicareexplore.asp?exploreBehavioralorMentalHealthServices *(Attachment Element 9, Factor B, 5)*

Case Study: This case study illustrates how the communication network connects the key stakeholders when assisting a SNP member through the continuum of care and appropriately documented in our member centric electronic application CCMS.

CareEnhance Care Manager

04/06/11 5:06 PM

Note Summary

ID: CA_[redacted]01

Name: [redacted]

Note Information

Encounter Date Note Type	Case	Note Text	Entered By
02/23/11 Social Services	4	Voice message received from dau Ida Tucker. Discussed case with CM Eduardo[redacted]. He indicated that WTN/HH SN staff expressed concern regarding the member's failure to thrive at home. Recommendation was given for the member's admission to care at a Skilled Nursing Facility. Telephone call with Ida. She expressed frustration with the member's decline since her discharge home. She expressed the strain of being responsible for the member's care and also observing her deterioration at home. She stated that the member requires additional assistance at at Skilled Nursing Facility. She stated intention to admit the member at the hospital in light of her current condition. Discussed case with CM Eduardo[redacted]a, VP Josie[redacted] and CM Kris [redacted]. Prior attending physician Dr. Steven [redacted] was contacted and advised of the member's anticipated admission at Pacifica Alliance UC. Gurney transportation was set up to transport the member to Pacific Alliance UC for evaluation and care direction. Telephone call to Ida to advise her that transportation was set up for the member to be admitted to Pacific Alliance UC and that Dr. Wang has already been advised. Advised her that the transportation company estimated time for arrival to be in 1.5 hours. She verbalized understanding.	[redacted], MSW, Steven
02/08/11 Social Services	4	Voice message received from dau [redacted]er.	[redacted]g, MSW, Steven
02/07/11 Social Services	4	T/c to Tina 323-[redacted]o provide her with the phone to Tender Care 626-943-8988.	[redacted]s, MSW, Beatriz
02/07/11 Social Services	4	T/c from Ida [redacted] 323-[redacted] and 323-[redacted] stating that home health has not gone out to the home yet. social worker advised that if member went home on a Sunday HHA do not work on Sundays so someone should be coming out today.DTR states that her mother has wound care that needs to be managed daily and no one has gone out. DTR further states she was reported to APS and she needs there right equipment at home and the right HH wound care so that this does not happen again. DTR states she is a senior citizen herself and the hospital bed she received is the type that has to be cracked and she cannot do this as she has her own health conditions. Social worker will speak with nurse Geraldine [redacted] adn call DTR back.	[redacted], MSW, Beatriz

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Note Summary

ID: CA_[redacted]01

Name: [redacted]

Note Information

Encounter Date Note Type	Case	Note Text	Entered By
02/01/11 Social Services	4	Discussed member's care plan in rounds. Telephone calls with member's daughter Ida [redacted] to coordinate the member's anticipated LCD and discharge plan. Ida stated that the plan is still for the member to transition home upon discharge from skilled level of care. Discussed the member's discharge plan, including wound care and DME. Explained the attending physician will order the HH and DME, as appropriate. Ida verbalized confidence that the member would receive adequate care from her family at home. She requested recommendation for a new PCP. Discussed case with CCM Shelli [redacted] and received recommendation for a Healthcare Partners physician as well as their home visit physician's program. Telephone call to Ida to discuss possible transition of PCP and explained full-risk nature of the IPA and the changes involved. She verbalized understanding and preference for the home physician visit program. Explained that the transition will not take place until the following month. Discussed case with MS Lead Gabriela [redacted]. A representative will be calling Ida to coordinate the change.	[redacted], MSW, Steven
12/16/10 Social Services	4	Social worker with member at the SNF to deliver Holiday Gift Baskets with MS representatives Marcy [redacted] and Mary [redacted]. Member was being bathed by SNF staff and then was attended to by the SNF treatement nurse. Waited until the member was done and resting again in her bed. Member was awake and responsive to touch and simple greetings. She appeared very lethargic/weak, but was able to respond appropriately to conversational cues.	[redacted], MSW, Steven
12/15/10 Social Services	4	Social worker visit with member at the SNF to coordinate care. Member was resting in hospital bed. She appeared very lethargic and weak. Member appeared to be sleeping and did not noticeaby respond to this social worker's presence or attempts to wake her. She was sucking on her hand, and did not respond to social cues. Coordinated care with SNF social worker Lolita. She stated that the member is often in the state observed now, whenever she becomes tired. However, at other times, the member is much more awake and is able to respond to questions and visually track. Dau is very involved and visits the member almost everyday. She stated that the memberis observably more engaged when her daughter is present.	[redacted], MSW, Steven

Note Summary

ID: CA_[redacted]01

Name: [redacted]

Note Information

Encounter Date Note Type	Case	Note Text	Entered By
12/14/10 Social Services	4	Member has MEDI-CAL coverage with $0 SOC, per AEVS: Eligibility ResponseEligibility transaction performed by provider: PHP00[redacted] on Tuesday, December 14, 2010 at 1:12:47 PM Name: [redacted] Subscriber ID: 91365[redacted]1 Submitted ID: 545[redacted] Subscriber ID Updated Service Date: 12/14/2010 Subscriber Birth Date: 04/01/1924 Issue Date: 12/14/2010 Primary Aid Code: 1H First Special Aid Code: 80 Second Special Aid Code: Third Special Aid Code: Subscriber County: 19 - Los Angeles HIC Number: 545328352A Primary Care Physician Phone #: Service Type: OIM R Trace Number (Eligibility Verification Confirmation (EVC) Number): 8968[redacted] Eligibility Message: SUBSCRIBER LAST NAME: [redacted] EVC #: 8968M1XRQB. CNTY CODE: 19. PRMY AID CODE: 1H. 1ST SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. PART A, B AND D MEDICARE COV W/HIC #545328352A . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER MEDICARE RISK HMO. CARRIER NAME: CARE1ST HEALTH PLAN. COV: OIM R.	[redacted], MSW, Steven
12/03/10 Social Services	4	Telephone call received from dau Ida [redacted]. Discussed the member's case and her refusal for the member to be transferred to a Skilled Nursing Facility. Ida stated that in 1998-1999, the member was admitted to a Country Villa where blatant abuses of the member occurred and reports were made to the Department of Health Services. The member was already suffering from dementia and was unable to defend and articulate the events herself. Due to the very difficult experience, Ida feels very apprehensive towards Skilled Nursing Facilities in general. Processed her feelings. Explained that, as per rounds and discussion with CM Geraldine [redacted] the attending physician as well as the medical team strongly advises that the member undergo rehab and treatment at a SNF admission. She verbalized understanding and sounded reluctant but was verbalized agreement with plan, should it be presented with the physician's order and recommendation again. Discussed the member's wounds. Ida stated that she was caring for the member, but was improperly dressing the wounds. Voice message left for Geraldine updating her of development.	[redacted], MSW, Steven

CareEnhance Care Manager 04/06/11 5:06 PM

Note Summary

ID: CA_[redacted]01

Name: [redacted]

Note Information

Encounter Date Note Type	Case	Note Text	Entered By
12/02/10 Social Services	4	Referral received from CM Geraldine[redacted]z. Telephone call to FS Primary/dau Ida[redacted]r – not available. Left voice message. Telephone call to residence -- niece Carrie answered and stated that Ida likely will not be home until tomorrow. She stated that she does not have an alternate contact number for Ida. Left message with Carrie for Ida to call this social worker back to coordinate the member's care.	[redacted], MSW, Steven

Page 4 of 4

Care1st' Health Education and Culturally Linguistic Department also performs outreach to local Community Based Organizations (CBOs) such as Black Women for Wellness, Chinese American Association, National Health Foundation, and United Cambodian Community, Inc. to ensure the company's services, policies and initiatives are effectively communicated to advocates assisting and working with our membership and markets. Care1st staff, including Health Education and C&L, Community Outreach, Legal & Regulatory Affairs, and Medical Services meet face-to-face with these organizations to communicate current regulatory activity impacting health plan procedures, as well as provide resources for member issue resolution to ensure advocates always have current and accurate information related to the Plan and issues affecting beneficiaries overall. The department also collects feedback from advocates in these meetings to better understand the needs of our partners and enhance our communications.

The below is an **example** of CLAS Community Advisory Committee Meeting Minutes and Agenda:

CARE 1ST HEALTH PLAN

COMMUNITY ADVISORY COMMITTEE (CAC) MEETING

Monday, December 6, 2010
9:30 am to 11:30 am
Main Training Room

AGENDA

I.	Welcome and Introduction	Therese Chung
II.	Committee Business: ▪ Review of Minutes & Action Items ▪ Approval of Minutes ▪ Review Agenda	All
III.	CLAS Updates: ▪ Interpreting Services (Face-to-face & Over the Phone) ▪ Translation Services	Therese Chung
IV.	n-Action Family Network ▪ Overview ▪ Programs	Kay W. Coulson
V.	Community-Based Organization Updates	All
VI.	Health Education Updates	Linda Fleischman
VII.	Announcement: ▪ Next CAC meeting will be held on Monday, June 6, 2011	Therese Chung
VIII.	Adjournment	

Element 9, Factor C

Describe how to preserves aspects of communication as evidence of care

The Health Plan has available to beneficiaries, providers, employees and public via Care1st Health Plan website Evidence of Coverage, Provider Manual, Health Education materials, Language assistance, etc.

Care1st Health Plan website also has available: Community Resources Directory, Disease Management Programs and education, Frequently Asked Question (FAQs), Preventive Health services, Member Service link, etc. The plan has also identified that not all beneficiaries either have access to, or are familiar with, navigating or searching websites for information. Last year, Care1st Health Plan sent newsletters to the beneficiary informing of our website and all of the valuable information available to them. The plan also understands that not all beneficiaries have computers so the plan's Member Services toll-free line was identified in bold print with available hours to assist their needs.

Care1st has a quarterly Public Policy Meeting, with beneficiary representation conducted by the Member Services Department. Medicare benefits/SNP –MOC requirements are discussed in this forum. This committee is chaired by the Manager of the Member Services.Department.
http://www.care1st.com/
https://www.care1st.com/ca/providers/provider-manual.asp
https://www.care1st.com/ca/members/plans-and-benefits/medicare-explore.asp
https://www.care1st.com/ca/guests/language-services.asp
https://www.care1st.com/ca/members/health-education/health-education-materials.asp

Example: Healthy Living newsletter Spring/Summer 2010 *(Attachment Element 9, Factor C, 1)*

Example: Health Risk Assessment PCP Letter *(Attachment Element 9, Factor C, 2)*

Care1st uses electronic databases and other tracking methods including, but not limited to, paper archival services; newsletters; and Web sites to preserve aspects of communication as evidence of care. Care1st

preserves communications of meetings in minutes both in hard copy and electronically. .

When communication occurs with a specific provider and/or Member, the case manager documents this information in the case notes to include the content of the communication in CCMS. The information documented includes documentation of the name of the person, type of contact (care plan, ICT meeting) and the date and time of the contact. The information documented in the case notes includes content of any information shared with the Member, any requests made and any follow up that needs to be completed.

Additional aspects of communication as evidence of care include IDCP minutes documenting SNP member specific issues, interventions, plan of care.

Case Study:
Case Study below sample of the twice weekly IDCP Meeting minutes identifying hospitalized SNP members that represent collaboration and communication with multiple disciplines:

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up
XXXXXXX	☐ MCR ☒ SNP: ☐ Tier 1 ☐ Tier 2 ☒ Tier 3	Admitted thru ER (identified thru IP census) w/ SOB, to ICU vent. Transfer to Rehab, new diagnosis of CHF. First acute hospitalization	Will stay in Rehab until safe with minimum assist will get home PT. 4/21: Per MSW PT progressing, Coumadin level stable, had h/o of bld clot so family concern, monitoring closely. 4/26 Refer to CCM, member going to live with sister (25 miles from doctors) will set-up transportation to assure visits.	☒ Referral to: Psych Consult 4/12 ☒ Referral to: Home Health SN/PT 4/29 ☒ Referral to: CCM 4/26 ☒ Referral to: MSW 1/26 ☒ CT initiated: 4/10/11	G. Hernandez, LVN – IP-CM N. Cabaccang, LVN – CHF CCM - Primary V. Silla, LVN - DM	☒ w/ Cardiologist 5/1 ☒ CCM to discuss classes available: done 4/27 ☒ Transportation to MD visits: done 4/27 ☐ None Documentation: ☒ CCMS (records attached) ☐ MHC ☒ Other: <u>Minutes IDCP folder</u>

<u>Element 9, Factor D</u>

Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness

The Vice President (VP) of Medical Services has reporting responsibilities for Care1st Special Needs Program (SNP) along with the Director of Medical Services, a licensed registered nurse, who has overall operational accountability. The Director is responsible for accurate and current policy and procedures for SNP with overseeing implementation and evaluation of the program. On at least an annual basis the Director will assess the SNP effectiveness through multiple avenues such as, to include but not limited to; SNP staff feedback,inter rater reliability audit of Plan ICT staff, beneficiary's survey, provider satisfaction surveys UM reports, etc.

The primary oversight responsibility for monitoring and evaluating communication effectiveness as described above is Care1st Health Plan Medical Service Committee. The Medical Service Committee is chaired by the Chief Medical Officer and meets on quarterly basis Committee members include network physicians, VP of Quality Improvement, VP of Medical Services, Director of Health Education, Director of Medical Services, and Clinical Pharmacy Program Manager.

The VP of Medical Services is responsible for reporting to the committee all the reports that address the evaluation of communication effectiveness. Based on these reports, the committee is responsible for establishing corrective action plans to address any deficiencies. The Chief Medical Officer reports all Medical Services findings to the Board of Directors who ultimate authority for accepting or modifying the recommendations of the Medical Services Committee.

Example: IPA Letter-SNP Model of Care 12/23/09 *(Attachment Element 9, Factor D, 1)*

Example: Delegated UM Reporting Requirements Utilization Management SNP 2011 *(Attachment Element 9, Factor D, 2)*

Example: Sample of Quarterly Report for Multiculteral Primary Care Medical Group UMQM Report summary March 2010 *(Attachment Element 9, Factor D, 3)*

Example: Medical Services Quarterly Committee Meeting Minutes *(Attachment Element 9, Factor D, 4)*

Example: Board of Directors Meeting UM SNP Reports *(Attachment Element 9, Factor D, 5)*

VP of Medical Services has overall responsibility for day to day operations of the internal SNP program as well as the IPA compliance Department. Care1st Health Plan internally has a designated Care Transition Case Manager (CTCM) and Care Navigator dedicated to identifying, collaborating and communicating with the SNP enrollees. The IPA Compliance department is comprised of three (3) IPA Compliance Auditors which are Registered Nurses and 2 IPA Compliance Analysts which have the responsibility to monitor and evaluate the communication effectiveness and overall Model of Care compliance for each delegated Medical Group/IPA. The plan is responsible for Health Risk Assessment (HRA) and Individual Care Plan (POC), this function is not delegated to the medical groups/IPAs. In 2009, an IPA Letter was mailed and electronically sent to all delegated entities which addressed Care1st Health Plan SNP MOC requirements and the collaboration with delineation of responsibility between the plan and IPA. This year all delegated groups were sent an email describing the SNP reporting requirements for quarterly submission. In 2011, the IPA Compliance Team will be providing on-site/office training for the IPA delegates who need assistance with meeting the SNP–MOC requirements. Documents associated with the Model of Care Program and communication effectiveness will be retained in the findings of each Medical Group's annual audit. Any deficiencies found require a corrective action plan (CAP). All audit findings are presented to the Medical Service Committee. Meeting minutes, are kept for documentation purpose. The VP and Director of Medical Services oversee the development, implementation, and evaluation of policies and procedures that are related to the SNP Model of Care. The VP along w/ the Director also have responsibility for evaluating the SNP Model of Care and determining its effectiveness. Care1st Health Plan Medical Director (s) share in the responsibilities as it relates to the clinical overview of the program. Inpatient and Outpatient Case Managers are assigned to the membership work with the CTCM to coordinate care and develop the Member's individualized care plan. Care Navigators and Social Work staff are available to assist with the Members' psychosocial needs identified within the Member's individualized plan of care, e.g. assistance with obtaining meals.

Care1st Health Plan Case Management Department within Medical Services collaborates with Marketing Communications to provide quality information about dual special needs plans to both Members and providers.

Case Study below sample of the twice weekly IDCP Meeting minutes identifying hospitalized SNP members that represent collaboration and communication with multiple disciplines:

Auth #	LOB	Issue	Discussion	Interventions	Responsible Person(s)	Follow-up
XXXXXX	☐ MCR ☒ SNP: ☐ Tier 1 ☐ Tier 2 ☒ Tier 3	Admitted thru ER (identified thru IP census) w/ SOB, to ICU vent. Transfer to Rehab, new diagnosis of CHF. First acute hospitalization	Will stay in Rehab until safe with minimum assist will get home PT. 4/21: Per MSW PT progressing, Coumadin level stable, had h/o of bld clot so family concern, monitoring closely. 4/26 Refer to CCM, member going to live with sister (25 miles from doctors) will set-up transportation to assure visits.	☒ Referral to: Psych Consult 4/12 ☒ Referral to: Home Health SN/PT 4/29 ☒ Referral to: CCM 4/26 ☒ Referral to: MSW 1/26 ☒ CT initiated: 4/10/11	G. Hernandez, LVN – IP-CM N. Cabaccang, LVN – CHF CCM - Primary V. Silla, LVN - DM	☒ w/ Cardiologist 5/1 ☒ CCM to discuss classes available: done 4/27 ☒ Transportation to MD visits: done 4/27 ☐ None Documentation: ☒ CCMS (records attached) ☐ MHC ☒ Other: <u>Minutes IDCP folder</u>

Example: Below is a sample of the IPA Letter-SNP Model of Care 12/23/09

IPA LETTER - SNP MODEL OF CARE

December 23, 2009

Med Director
Name of IPA
Address

Re : Special Needs Plan (SNP) Model of Care

Dear

The Centers for Medicare & Medicaid issued final regulations on Medicare Improvements for Patients and Providers Act of 2008, also known as MIPPA. As part of this regulation, the Special Needs Plan Model of Care requires implementation by January 1, 2010.

The SNP Model of Care requires that all SNP members receive an initial Health Risk Assessment (HRA) within 90 days of enrollment, and that an Individualized Care Plan be created for each member. Care1st will be responsible for having the members complete the HRA. Care1st will then create an Individualized Care Plan for each member that completes the assessment.

We have enclosed the following additional documents for your review:

- SNP Model of Care - Responsibility Matrix
- Sample Member Summary Report (answers to completed HRA questionnaire)
- Sample Individualized Care Plan

A comprehensive presentation by CMS on SNP Model of Care and additional pertinent documents, including our survey tool can be found on our website with the following link: https://www.care1st.com/ca/providers/snp-model-of-care.asp

Please take the time to review all of the details and requirements of this important new legislation.

Care1st Health Plan will work collaboratively with its contracted Medical Groups and IPAs in order to meet the SNP Model of Care requirements. If you have any questions you may call Robert Feldman, RN, Director of Medical Services at (323) 889 6638 x 6298.

Sincerely;

Jorge Weingarten, MD
Chief Medical Officer

Cc: UM Director, Administrator

CARE1ST HEALTH PLAN

Special Needs Plan (SNP) - Model of Care

Responsibility Matrix

Activities	Care1st Responsibilities	IPA/MG Responsibilities
Care Management Plan	Care1st Health Plan will develop and implement a Care Management Plan that describes the Model of Care and documents how it will coordinate its efforts with those of the IPA/MG in order to meet all CMS requirements.	IPA/MG will develop and implement a Care Management Plan that describes the Model of Care and meets all CMS requirements.
Health Risk Assessment (HRA)	• Conduct within 90 days of enrollment an initial Health Risk Assessment (HRA) of physical, psychosocial, cognitive, and functional needs. • Use a standardized tool to perform the health risk assessment. • Share the results of the health risk assessment with the delegated IPA/MG member or care giver and member's PCP.	Utilize the results of the initial HRA in order to analyze member health care needs and communicate plan to interdisciplinary care team, and pertinent providers.
Individualized Care Plan	• Create an Individualized Care Plan (ICP) based on the member specific responses to the HRA which will be risk stratified. • The ICP will include an itemized list of identified Problems, Interventions and Goals. • The ICP will be shared with the member/care giver, PCP and IPA/MG	The IPA/MG will provide coordinated care and services proportionate to the member needs and stratification level. • Involve beneficiaries and/or caregivers whenever feasible, through various ways of communication • Reviewed and revised annually or when health status changes • Maintain care plan records to assure access, and in accordance with HIPAA and professional standards
Staff Structure and Care Management Roles	Care1st will employ or contract all necessary staff to meet Administrative Roles such as: • Enrollment processing • Eligibility verification • Grievance resolution • Conducting quality improvement activities and meeting all data analysis and reporting requirements to CMS Also will provide oversight of Model of Care implementation, auditing of all delegated functions and effectiveness of Model of Care	IPA/MG must employ or contract all necessary staff to provide Service Delivery Roles such as: • Member education and advocacy • Triage • Authorization and timely provision of medical and behavioral services consistent with established clinical guidelines, • Healthcare information management functions such as maintenance and sharing of records and reports in HIPAA compliant manner.
Interdisciplinary Care Team	Ensure through annual audit that interdisciplinary care team requirements are met.	IPA/MG must assign each member to an interdisciplinary care team which will analyze and update annually or as needed the ICP in order to manage the medical, cognitive, psychosocial and functional needs of the members. The interdisciplinary care team should consist of at least a medical, behavioral and social services expert.
Provider Network	• Care1st must have an adequate network of acute, long term and rehabilitation care facilities. • Ensure that delegated functions such as credentialing of the provider network are performed to meet NCQA standards.	IPA/MG must have a network of medical, behavioral , nursing and allied health professionals that will collaborate with the interdisciplinary care team and provide clinical expertise based on nationally recognized guidelines and assist in the updating of the ICP

Activities	Care1st Responsibilities	IPA/MG Responsibilities
Model of Care Training for Plan Personnel and Provider Network	Ensure initial and annual training is conducted for all Health Plan employees and network providers. Methodology may be: • Face-to-face • Interactive (web-based, audio/video conference) • Self-study (printed materials, electronic media)	IPA/MG must conduct and document initial and annual training on the SNP Model of Care for all employed, and contracted personnel including network providers. Methodology may be: • Face-to-face • Interactive (web-based, audio/video conference) • Self-study (printed materials, electronic media)
Performance and Health Outcomes Measurement	Health Plan will collect, analyze and report data to measure health outcomes and indices of quality	• IPA/MG will submit all necessary data in order for Plan to be able to perform adequate analysis and report outcomes. • Specific detail of data submission requirements will be made through the Delegated UM Reporting Requirements submission.

Example: Delegated UM Reporting Requirements Utilization Management SNP 2011

Care 1st Health Plan
Delegated UM Reporting Requirements
Utilization Management
Special Needs Plan (SNP)

MONTHLY

Submit concurrently:

- **Denial Files** – all denial letters, with attached referral request, notification confirmation, supporting documentations -

Due to Care1st by the 10th business day of the following month:

- Denial Logs
- Attestation Form (if no ER Denial or Denial cases reported)
- Attestation statement for any log reported (if none were reported for the month)

Due to Care1st by the 10th business day of the following month:

- EIOD Log

QUARTERLY or SEMI-ANNUAL REPORT

- Semi-Annual UM Report in ICE Format (applicable if you only have Medicare LOB with Care1st- **due on Feb. 25 and August 25) OR**

- **Quarterly Report:**
  Submit UM Report in ICE Format Section F (Reporting Statistics)

SNP Metrics
cases identified for case management
cases enrolled in case management
of cases refusing case management/Opt-out
# of identified Moderate acuity SNP members
# of identified Low acuity SNP members
Data Element
# of SNP Hospital admission (census report) **(Full-Risk)**
# of SNP member SNF/LTC facility admission **(Full-Risk)**
# of cases admitted through ER **(depends on DOFR)**
# of SNP ER visits **(depends on DOFR)**

- **Transition of Care Logs** (For Full-Risk groups: include care plan transition timeframe; practitioner notification timeframe; member/caregiver communication timeframe
- **Minutes of Interdisciplinary Care Team (ICT) meetings**

ANNUAL – Submit to Care1st by Feb. 25th

- Annual UM Evaluation
- Annual UM Program Description (Model of Care)
- Annual UM SNP Work Plan

** **All logs must be submitted electronically** **

Zeus Quality Management IPA Oversight UM Reporting Requirements 2011 SNP 2011 Reporting Requriements_SNP.doc

Example: Sample of Quarterly Report for Multicultural Primary Care Medical Group UMQM Report summary March 2010

MULTICULTURAL PRIMARY CARE MEDICAL GROUP
CARE 1ST - MEDI-MEDI
UMQM REPORT SUMMARY
for the month of
MARCH 2010

REPORT	TOTAL	REPORT	TOTAL
ADULT FLU LOG	1	FAMILY PLANNING	0
ADULT PHEUMOCCAL	0	HEALTH EDUCATION	1
AUTHORIZATIONS - APPROVED	194	HOSPICE CARE	0
AUTHORIZATIONS - MODIFIED	0	LONG TERM CARE	0
AUTHORIZATIONS - DEFFERRED	0	MAJOR ORGAN TRANSPLANT	0
AUTHORIZATIONS - DENIED	4	OB CARE	0
AUTHORIZATIONS - CCS	0	RETINAL LOG	1
ADMISSIONS	13	PSA	4
BEHAVIORAL HEALTH	0	PSYCH FACILITY (INPATIENT)	0
BREAST CANCER SCREENING	0	SECOND OPINION	0
CHDP LOG	0	SNF	2
CERVICAL CANCER SCREENING	0	STD LOG	1
CPSP LOG	0	TB LOG	0
C SECTION DELIVERIES	0	VACCINATION LOG (AGE 0-2)	0
DENTAL EXAM	0	VACCINATION LOG (AGE 3-18)	0
AIDS/HIV	0	VISION CARE	45
ER ADMISSIONS	16	WIC LOG	0
ESRD/DIALYSIS LOG	0	DDS (Early Interventions) Regional Center	0

BED DAYS = 79 * AVERAGE LOS = 6.08**

CCS BED DAYS= * AVERAGE LOS =**

***** This summary page is intended to be used for verifying the monthly Health Plan Reporting Package. Any report with a count greater than zero will have a corresponding report with it. Conversely, any report shown with a "zero" next to it will not generate a report due to our reporting system. Therefore our healthplan partners will only get reports that have data for the specific report for each given month.**

* Authorization data is based on Date Authorized, Claim data based on Date PAID, Case data based on Date of Service

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Example: Medical Services Quarterly Committee Meeting Minutes

Care 1st Health Plan
Medical Services Quarterly Committee Meeting Minutes (Los Angeles)
September 14, 2010
(Training Room)

Committee Members Present:	Not Present:
Physician Members: Jorge Weingarten, *M.D., Care1st Chief Medical Officer* Harry Brenner, *M.D., Internal Medicine* Maria Khalatian, *M.D., Pediatrics* Weiguo Li, M.D., *Family Practice* Gow-Nan, Ling., *Family Practice* Richard Powell, *M.D. Medical Director MedPoint* Nora Tee, *MD., Internal Medicine* Kevin Thomas, *M.D., General Practice* Hemant Upadhyaya, MD., *Pediatrics* Jeffrey C.Young, *D.O., Family Practice* **Management /Staff :** *David Wedemeyer, RN, Associate, VP, Quality Improvement* *Josie Wong, RN, VP of Medical Services* *Robert Feldman, R.N. Director, Medical Services* *Linda Fleischman, MPH, Health Ed Manager* *Rebecca Romo, QI Project Manager*	Lukchai Bhavabhtanon, *MD., Internal Medicine* Robert Chan, *MD, Internal Medicine* Luning Chen, *MD, Internal Medicine* David Gu, *D.O., Internal Medicine* Anita Mercado, *M.D., Family Practice* Maureen Tyson, MD *Internal Medicine* Albert Young, *MD, Internal Medicine*

Confidentiality Statement: All committee attendees/participants agree to respect and maintain the confidentiality of all discussions, reports and information generated in connection with this meeting and agrees not to make any voluntary disclosure of such information except to persons authorized to receive such information.

TOPIC	DISCUSSON	ACTION RESPONSIBLE PARTY	DATE COMPLETED
	Project Updates 1. Aware URI Collaborative: • San Diego PCPs that have 250 or more Medi-Cal members meeting the minimum performance level (MPL) of HEDIS rates representing the 25% of the national rates. • There was a significant improvement when comparing 2009 to baseline • The State should be starting a new collaborative project next year. 2. ER Inappropriate Use: • A QIA Analysis is due 10/31/10 for the project. • Based on results, there was no improvement noted. 3. COPD Collaboratives and Vaccination Reminder Program • No activity to report for the second quarter. 4. CMS Requirements • An update to be provided at next meeting.		
5. **2ND QUARTER QI REPORT/POLICIES AND QI SUB-COMMITTEE MINUTES APPROVAL**	D. Wedemeyer requested approvals for the Second Quarter QI Report, Policy Approvals and QI Sub-Committee minutes (.for Peer Review and Credentialing)	A motion was made, Seconded to approve. Approved 1st – Dr. Thomas 2nd – Dr. Powell	9/14/10
UTILIZATION MANAGEMENT			
6. **UM SPECIAL PROGRAMS -** A. **CARE TRANSITIONS**	R. Feldman provided an extensive update on the Care Transitions: • The Care Transitions for Special needs Plan involves the coordination of care for planned and unplanned transitions. • Overview of Managing Care Transitions Policy was presented. • Care Transition Program Post –Hospital Discharge Assessment reviewed • Hospital/Skilled Nursing Facility Post-Discharge Medication Reconciliation Form (MRP) was reviewed. It was noted, that the PCP is to receive a copy of the form, after member has been discharged. • The MRP to include up the 60 days of prescriptions that have been filled for member. Additionally, the Top 5 Diagnoses were reviewed with the committee: 1. Cardiac/Cardiovascular	A motion was made, Seconded to approve. Approved 1st – Dr. Thomas 2nd – Dr. Khalatian	9/14/10
	2. Neurologic Disorders 3. Respiratory 4. Diabetes 5. Renal/GI There was an overview of the process in place and member efforts: • The goal is to train the member to be engage in the process. • Member will be encouraged take a copy of the MRP form to their PCP • Within 48 hours of discharge to home either (Hospital to Home or SNF to Home), a call to be made to member. Additionally, there was consensus that having all the related CCM forms uploaded to the website, would be beneficial to the providers.	Old Business/ R. Feldman	
B. **DISEASE MANAGEMENT)**	R. Feldman presented an overview of the Disease Management – Asthma report for the last quarter **Asthma Cases (Open/Closed Status)** Adult 169 – Open 338 – Closed Child (Pediatric < 12 years old) 161 – Open 431 – Closed The following was noted/discussed: • The report reviewed includes a 12-month period and for the next committee meeting, will plan to present a quarter by quarter comparison. • A full time analyst will be hired to assist with analyses. **Closed Cases (Adults by Reason for Closure)** R. Feldman shared the following regarding this report: • Described the efforts made to contact members that includes 3 calls prior to dis-enrolling members from program. • A question was raised if a member is admitted to the hospital if they would automatically enrolled into program. It was clarified that a member is not enrolled, but he/she. Would receive an educational newsletter as part of the program.	A motion was made, Seconded to approve. Approved 1st – Dr. Thomas 2nd – Dr. Khalatian Old Business/ R. Feldman	9/14/10

Element 10 – Care Management for the Most Vulnerable Subpopulations

Element 10, Factor A

Describe how the MAO identifies its most vulnerable beneficiaries

The Care1st Complex Case Management Program identifies members at risk for changes in health status and provides continuous clinical and psychosocial monitoring in an effort to prevent unexpected transitions in care. Refer to Care1st's Complex Case Management P&P (Exhibit-D) for methods used to identify at risk individuals. In addition, other sources of identifying members at risk include, but are not limited to the following:

- Initial and annual health risk assessment
- Information obtained by Care1st Case Managers and Care1st Social Workers through direct member interaction
- Information obtained from Primary Care Physician and Specialty Providers
- Information obtained from calls documented by Care1st Premier Member Services Unit
- Information obtained through the Care1st Disease Management Programs
- Information obtained from the Care1st Pharmacy Department, including the Care1st Medication Therapy Management Program (MTMP)
- Weekly hospital admission and readmission reports
- Referrals from medical groups
- Member transportation requests
- Member requests for LTSS and/or HCBS
- Monthly review of encounter data

Care1st uses the definition of the American Geriatric Society when defining frail or vulnerable members:

- A state of reduced physiologic reserve associated with increased susceptibility to disability
- Individuals who have severe disability in two or more of the following domains or moderate disability in at least three or more

of these domains: physical health, mental status, functional status, socio-economic status and residential environment; or
- Individuals aged 85 years or older; or
- Individuals who depend on others for the activities of daily living; or
- Who are at high risk of becoming dependent; or
- Older individuals who are homebound; or
- Older individuals with mental disorders such as dementia; or
- Older individuals with communication disorders; or
- Individual with significant multiple chronic conditions such as arthritis, hypertension, heart disease, diabetes, osteoporosis, fracture, stroke, cancer (currently active), dementia, Parkinson's disease; or
- Individuals who would qualify for long-term care services. These individuals are usually defined based on severe chronic disease or disability involving substantial functional impairment

A frequent source of vulnerable members is identified through either readmission reports or weekly in patient reports.

Example 1 Member W.R.
He was referred to Complex CM in November 2010 after having been readmitted to the hospital with dehydration, cellulitis due to radiation for head and neck cancer. He had a new G Tube.

Challenges were coordinating appointments, authorizations, pain control, and pharmacy prior authorizations. Social Services support for the member was obtained and completed application for disability and assistance with Advance Directive.

Member is now stable; has some residual complications from radiation, chronic otitis media, decreased hearing, He continues to need periodic laryngoscopies and physician follow up visits. Transportation is provided for these visits. His weight is stable, continues to depend on liquid supplement; and still has problems swallowing some food Overall; he is much improved and stable.

Example #2 Member M.A.
Member identified after admission to hospital for dyspnea and respiratory distress. Member arrived to USA day prior to admission from Mexico where he was vacationing with wife who recently retired. Per wife member was

hospitalized in Mexico and received dialysis treatment for five days and had chest tube inserted to drain fluid from lungs. At this time member continues to require dialysis.

Member was diagnosed with mesothelioma After a 10 day hospitalization member was transferred to a skilled nursing facility for physical therapy and IV antibiotic treatment. Dialysis treatment was no longer needed at his time. Follow up with Oncologist was arranged after discharge.

A home health nursing evaluation for safety and medication review and physical therapy was completed. Necessary equipment including a wheelchair and 3in1 commode were provided. Follow up appointments with the oncologist have been kept and round trip transportation has been provided.

We have attached an example of our most recent Complex Case Management analysis (Exhibit -E) which details specific measurements that demonstrate a complete process of continuous improvement and monitoring efforts.

Element 10, Factor B

Describe the add-on services and benefits the MAO delivers to its most vulnerable beneficiaries

Examples of additional services and benefits provided by Care1st include:

- Transportation services: All SNP members have access to unlimited round trip transportation for doctor appointments, going to the pharmacy to pick up medications, or for other medical related appointments like dialysis, physical therapy or diagnostic testing. The type of transportation provided depends on the needs of the member. It can range from a private taxi, to a wheelchair van or gurney transport. Members or their providers can request transportation by calling the Member Services department. Otherwise, the member or provider can call the member's assigned Case Manager and she will make the necessary arrangements. The main purpose of providing this service is to

ensure adequate access for our members and therefore eliminate barriers of care.

- Social service support: Our Social Services Department not only provides telephonic support for our member's social needs. Complex care dual members will be assigned to a Care Navigator, who is responsible to navigate the member throughout the care continuum, including coordinating LTSS and HCBS. A Case Manager may go to the member's home to conduct a comprehensive in-home assessment to determine the support structure, unmet long-term care needs. If the duals member could benefit from CBAS or in-home supportive services, the Care Navigator will contact LTSS and HCBS provider and make arrangements for services to be provided in the home, as appropriate. A Case Manager may also go to the skilled nursing facility or hospital to meet with not only the member, but also family, caregivers and physicians. This is most commonly used with our most vulnerable members who may be at the end of life or not have adequate family support to assist them with important decisions such as long term care placement, or nutritional support. The social worker will evaluate each individual situation and after conferring with all involved parties may make referrals to other agencies such as Adult Protective Services, coordinate community support services with appropriate LTSS and HCBS, or with the state Medicaid agency to increase the number of hours for In Home Support Services. NP members are often referred to the Social Worker by the Case Manager who is actively managing the member's care. But members can also access the social worker directly, or by any physician or outside agency referral by calling our toll free number. Having this kind of service can assist the member in remaining in the least restrictive setting possible and maintain a higher quality of life.
- Access to dental services: Dental health can often not be properly addressed and can lead to exacerbations of other medical co morbidities. Recent changes in Medi-Cal coverage for dental care have left this population with gaps in coverage. Care1st provides an additional dental benefit that included cleaning and x-rays. In addition all SNP members have an allowance of $500.00 per year that can be used towards payment of comprehensive dental benefits through our preferred dental network at reduced rates. Members can self refer to any dental network provider. If they

need assistance they can ask their Case Manager or a Member Services representative to assist them. Having adequate access to dental services and maintaining good oral health is extremely important towards maintaining overall health and adequate nutrition.

- Access to specialized wound technology network: Wounds are a significant problem in the frail population where poor nutritional support and lack of ambulatory capacity can lead to development of wounds that can significantly impair the member's health. Based on this, Care1st provides state of the art wound care with a specialized network of physicians and Nurse Practitioners who are fully trained as wound care specialists. The care is provided at the member's home. All evaluations are documented in a electronic medical record which includes photographs of the wounds that are taken throughout the course of treatment to document the improvement. The Care1st Case Managers and physicians have access to these records via a secure and password protected web site. In addition to providing the wound care, they will provide recommendations regarding nutritional and durable medical equipment needs. Members are typically referred for this service by their Case Manager or physician. All the referrals are approved by the Plan. Chronic wounds are a significant co-morbid condition that can impact the overall health status and if not properly treated can lead to loss of limbs, chronic infection and even death.
- Hearing aid benefit: All SNP members have access to a generous $1,000 per year allowance that can be used towards the purchase of a hearing aid. The members can self-refer or be referred by their physician or Case Manager to our audiology network. The initial visit does not require an authorization and there are no applicable co-pays.
- Enhanced vision benefit: All SNP members have an enhanced vision benefit that consists of $200.00 per year allowance that can be used towards the purchase of eye wear. The members can access a number of Optometry providers in the network by referral from the Primary Care Physician or Case Manager.

Element 11 – Performance and Health Outcome Measurement

Element 11, Factor A

Describe how the MAO will collect, analyze, report and act on to evaluate the MOC ((at a minimum includes: specific data sources, specific performance and outcome measures, etc.)

- **HEDIS Measures:**
  - HEDIS data is collected through encounter data, claims data, pharmacy data, lab repositories and direct medical record reviews. Care1st proactively monitors HEDIS measures and actively contacts members and providers in attempts to get member scheduled for these services. The Quality Improvement department has outreach coordinators and nurses who visit providers continuously throughout the year to educate physicians and office staff on details about these measures. The QI department provides physicians with incentives for completing these specific services and the office staff small incentives for using our web portal and filing the reminders in the charts. The outreach staff collect gap data when out in the physicians offices (they are equipped with secure laptops and scanners). Physician offices are educated about encounter submission processes and Care1st has a process for submission of encounter data through the web portal (See *attachment Element 11, Factor A, 1*).
  - HEDIS data is analyzed annually through the NCQA HEDIS Technical Specifications process. Care1st utilizes NCQA Certified HEDIS software programs to produce samples and enter medical record abstraction data. All HEDIS measures are compared against National benchmarks distributed by NCQA. All HEDIS measures are also compared to previous results to document statistical significance of rate changes (See *attachment Element 11, Factor A, 2*). All HEDIS data has a quantitative and qualitative analysis completed and documented through the QI process. Providers are provided individual profile reports every six months that detail their HEDIS rates compared to their peers, Care1st overall and

National benchmarks (See *attachment Element 11, Factor A, 3*). Ongoing analysis and monitoring is done to track each measure proactively and interventions are done to encourage member to complete specific services.

- HEDIS analysis results are compared to national benchmarks and previous rates to establish statistical significance of changes. These results are submitted through the NCQA web site and an NCQA HEDIS Auditor who audits the results. The auditor performs an on-site audit of how data is used, an audit of the medical record abstraction process and the HEDIS result submission to NCQA. When the auditor signs-off on the results they are considered official results. When results are official the QI department summarizes all results, details statistical changes, completes a report of the quantitative and qualitative analysis, establishes new goals, and they are reported to the Medical Services Committee for recommendations. The QI department will recommend specific interventions and goals aimed to improve rates and through this committee these results are reported to the Board of Directors.
- Care1st acts upon these results through the same process. Each measure is reported with key findings, quantitative and qualitative analysis, goals and benchmarking, interventions and follow-up actions.

Specific Examples:

- Care1st had a low baseline result for the Medication Reconciliation Post Discharge (MRP) measure with all SNP product lines. Our initial interventions were aimed at educating physicians about the requirements of the measure and specifics about how the documentation needed to be in the record. Our second year results revealed improvement but the rates revealed a huge opportunity for improvement. Through the QI process we developed new interventions where each admission is case managed and post discharge medication reconciliation are done by the RN Case Manager and is discussed, disseminated and filed in the member's medical record.

- Care1st had a low baseline results for the Care for Older Adults (COA) measure with all SNP product lines. Our initial interventions were aimed at reminding physicians of the required services, providing them with a list of their member needing the service and reminding the member to schedule the appointment. The second year results revealed improvement but there was still a huge opportunity for further improvement. The results were analyzed and reported through the committee and new interventions were developed using the Health Risk Assessment process. The HRAs were summarized and these were provided to the PCP for follow-up action and documentation. We focused questions on the four specific COA Measures and instruct the PCP to evaluate the member and use this information in the evaluation. This has significantly improved our COA measure results for reporting year 2011. This has improved member access to information about advanced directives and end of life care.

- **Access to affordable health care services and essential services such as medical, behavioral health, drug and alcohol rehabilitation, and social services:**
  - Care1st collects data to evaluate access to care for appointment availability, after hours availability, geographical distribution and coverage (for PCPs, specialist, hospitals and ancillary services), and physical site accommodations for members with disabilities. Care1st also monitors the drug and alcohol rehabilitation access and monitors this through HEDIS measures. Data for appointment availability and after hours availability is collected through provider survey and secret shopper contact calls. Data for the geographical distribution and coverage analysis is collected from our provider directory and is matched with our members home addresses to map out coverage within 15 miles of each member home. Physical site accommodations data is collected through on-site audits by our FSR Nurse. Drug and alcohol rehabilitation data is collected through encounter and claims data. The Care1st Quality Improvement department also reviews member grievance and CAHPS data as it relates to access to care issues, which gives validity to our

access to care results. Behavioral Health access to care data is collected by our NCQA Accredited MBHO and distributed to QI for reporting to the Medical Services Committee.

- Care1st analyzes all the data collected from surveys and secret shopper contact calls and calculates each provider compliance rate. These rates are compared to overall averages and prior year rates to document improvements or changes. Care1st analyzes geographical mapping studies to document and establish specific geographical areas where additional coverage is needed. The geographical studies are completed fro all PCPs, specialist, hospitals and ancillary services. We also conduct language mapping to assure we have enough providers who speak specific languages that our members need. These results are compared to previous results to document improvements, which are completed every six months. Data is supplied in writing to our Provider network Operations (PNO) department to work on contracting additional providers in coverage gap areas. Physical Site Accommodations data is not scored and a CAP is not done but data is analyzed and placed in the provider directory for members to use when selecting provider who best meet their needs. The Care1st Quality Improvement department also analyzes member grievance and CAHPS data as it relates to access to care issues, which gives validity to our access to care results. The MBHO is delegated the responsibility to analyzes and provide interventions and follow-up for access to care as it relates to behavioral health providers.
- Care1st reports all the data and analysis to our Medical Services Committee for recommendations and through this committee to the Board of Directors. Physicians who fall below the benchmark goals are given results and are required to submit a written CAP. PNO department obtains report of coverage gaps to work on contacting additional providers. Physical accessibility reports are used for provider directories so members can be better informed about the sites ability to meet their needs. Behavioral health access to care reports are supplied by our NCQA Accredited MBHO and are reported through our Medical Services Committee.

- Care1st acts on all the access to care related studies and reports by first reporting all analysis to our Medical Services Committee for recommendations and through this committee to the Board of Directors. All providers who fall below the 95% compliance rate for appointment availability and after hours are required to submit a written CAP and follow-up evaluation is planned to document improvements. Geographical mapping is acted upon through contracting additional providers need to cover any identified gap areas. If a gap area cannot be covered we have a written plan to address the issue. An example; we have a rural area where specific specialty types are not available within the required distance. Care1st addresses this issue by providing these member free transportation to out of area specialists.

- **Member satisfaction, grievances and potential quality issue reviews:**
  - Care1st collects data to evaluate member satisfaction through the CAHPS and a Proactive CAHPS process. The Quality Improvement department conducts a proactive member satisfaction survey mid-year where every SNP member gets a survey form to complete. The Member Services department also offers the survey to member when they contact us. At the beginning of each year Care1st will conduct an official CAHPS survey through an NCQA Certified CAHPS vendor. Care1st does not delegate any QI activities to any entity (with exception for the MBHO) so all member grievances and PQIs are reviewed and processed at Care1st. We keep a centralized database giving us ability to track and trend this data multiple ways.
  - Care1st analyzes proactive member satisfaction data through calculating each question rates, which are compared to previous studies for improvement. Actual CAHPS studies will be completed by an NCQA certified vendor and analysis and benchmarking will be report to us in summary reports. Member grievances and PQIs are annualized per 1000 members and the QI department profiles providers and medical groups to identify trends. Each individual grievance is investigated and if a quality issue is identified an individual corrective action plan will be written and completed. The

contracted MBHO collect, analyzes and reports behavioral health related grievances.

- Care1st reports all data collected and analyzed for member satisfaction, grievances and potential quality issues to the Medical Services Committee for recommendations. Individual grievances or PQIs where an actual quality issue is identified are reported through the Peer Review Committee for corrective actions prior to the Medical Services Committee. From the Medical Services Committee all reports are then supplied to the Board of Directors.
- Care1st acts upon these reports in various ways. Individual grievance or PQI issues are addressed directly with the physician or medical group and all documentation and corrections are documented. Trending reports are supplied to the medical groups during Joint Operation Meetings (done at least annually). CAHPS reports are distributed to internal departments and interventions are developed. The Quality Improvement Activity Steering Committee (QIASC) has developed internal action teams to identify additional opportunities for improvements. An example of this process is as follows: We had lower CAHPS scores two years ago and brought the issues to the QIASC for discussion and action. The committee agreed to establish a post grievance survey to document if the member was satisfied with our resolution of their grievance issue. Through this committee the Primer Member Services department was recommended so we had the ability to personalize our services to our members. The proactive CAHPS survey process was also recommended and established. Quality issues identified from grievances and PQIs are reported through the Peer Review Committee (PRC). The PRC takes specific actions to address the issues identified and can range from education, proctoring, to termination of contractual agreement.

Element 11, Factor B

Describe who will collect, analyze, report and act on data to evaluate the MOC (at a minimum includes: internal quality specialists, contracted consultants, etc.)

Data is collected, processed and monitored through several various sources and processes.

- **Claims Data**
  Claims data is submitted directly to Care1st Claims department for processing. Our Claims department adheres to all regulatory requirements for timeliness and confidentiality. Care1st has a staff of claims examiners that adjudicate the claim and enter all data into our system. Claims department is headed by the Chief Financial Officer (CFO), who has been with Care1st Health Plan in this position for over 10 years *(see attachment Element 3).*

- **Encounter Data**
  Encounter data is submitted directly to Care1st Informatics department and this data is housed in a main repository. The Informatics department has an encounter data staff responsible to entering encounter data, data analyst who are responsible to development of databases and providing specific data for specialized reporting needs (i.e. they submit data files to our HEDIS software vendor for import). The Informatics department is headed by a physician with vast greater than 10 years experience in data management *(see attachment Element 3).*

- **Grievance Data**
  The Member Services department receives a majority of the grievances through members contacting Care1st. Care1st has a Grievance department that works with Member Services to resolve the members issue the same day. The Grievance Department is staffed by nurses and coordinators (*attachment Element 3).* When a potential quality issue (PQI) is identified the grievance is forwarded to the Quality Improvement department for investigation into the quality issue. The Quality Improvement department is staffed by RNs, who review and investigate all PQIs.

- **HEDIS Data**
  The Quality Improvement department works closely with Claims, Encounter, Informatics, our NCQA HEDIS software vendor and our own internal staff to process HEDIS related data. Electronic files are supplied to our HEDIS vendor to be imported into the software program. The Care1st Quality Improvement department has a sub-department called the Quality Outreach department. This

department is staffed by seven nurses and eight coordinators who visit providers' offices and collect and abstract data during the HEDIS cycle. This staff also proactively visits provider offices pushing the use of the provider web portal and HEDIS interventions programs. Medical record abstraction data is entered into certified software systems and is used for HEDIS rates. The Chief Medical Officer (CMO) oversees the Quality Improvement department and has greater than 15 years experience in this position. The Vice President of Quality Improvement (BSN) directly oversees the day to day operations and has over 13 years with Care1st in this capacity and has the help of an RN Manager and two Supervisors. The Quality Outreach staff has a lead nurse and coordinator and six nurse coordinator teams out in the field visiting provider offices. The clinical review team (investigates PQIs) has four RNs and a coordinator responsible for the investigation of quality related issues. The Facility Site Review sub-department of QI has two full time RN reviewers and two coordinators. They have responsibility to perform the physical accessibility audits. The Credentialing department has a supervisor with 13 years credentialing experience and three credentialing coordinators. The medical groups are delegated credentialing function and Care1st also has direct contracted provider so we do primary credentialing functions also *(see attachment Element 3).*

- **Pharmacy Data**
  Care1st contracts with a Pharmacy Benefit Manager (PBM) that is responsible to adjudicating pharmacy claims. This allows Care1st to have access to 100% of pharmacy data for quality purposes. The Pharmacy department has several PharmD that monitor the process and review care. The Pharmacy department works with the Quality department on several quality improvement interventions *(see attachment Element 3).*

The Care1st Informatics Department is responsible for administrative data collection through claims and encounter submissions. Analysis of data takes place within the Quality Improvement Department with oversight by the Chief Medical Officer. Informatics supports the Quality Improvement, Utilization, Case Management and Disease Management Departments with data analysts that help to provide specific reports and data to support their needs. The Medical Services Committee is responsible for monitoring and

evaluating the model of care including analysis of barriers, root cause analysis and interventions. Although all improvement projects will be reported through the committee during the year the QI Department provides an annual evaluation of all quality improvement activity each year.

Examples of data that are collected, processed and monitored through various sources, and the departments responsible.

- **Claims Data**
  Claims data is submitted directly to Care1st Claims department for processing. Our Claims department adheres to all regulatory requirements for timeliness and confidentiality. Care1st has a staff of claims examiners that adjudicate the claim and enter all data into our system. Claims department is headed by the Chief Financial Officer (CFO), who has been with Care1st Health Plan in this position for over 10 years All claims data is captured by our Informatics Department for use with Quality Improvement projects.

- **Encounter Data**
  Encounter data is submitted directly to Care1st Informatics department and this data is housed in a main repository. The Informatics department has an encounter data staff responsible to entering encounter data, data analyst who are responsible to development of databases and providing specific data for specialized reporting needs (i.e. they submit data files to our HEDIS software vendor for import). The Informatics department is headed by a physician with vast greater than 10 years experience in data management

- **Grievance Data**
  The Member Services department receives a majority of the grievances through members contacting Care1st. Care1st has a Grievance department that works with Member Services to resolve the members issue the same day. The Grievance Department is staffed by nurses and coordinators When a potential quality issue (PQI) is identified the grievance is forwarded to the Quality Improvement department for investigation into the quality issue. The Quality Improvement department is staffed by RNs, who review and investigate all PQIs.

- **HEDIS Data**

The Quality Improvement department works closely with Claims, Encounter, Informatics, our NCQA HEDIS software vendor and our own internal staff to process HEDIS related data. Electronic files are supplied to our HEDIS vendor to be imported into the software program. The Care1st Quality Improvement department has a sub-department called the Quality Outreach department. This department is staffed by seven nurses and eight coordinators who visit providers' offices and collect and abstract data during the HEDIS cycle. This staff also proactively visits provider offices pushing the use of the provider web portal and HEDIS interventions programs. Medical record abstraction data is entered into certified software systems and is used for HEDIS rates. The Chief Medical Officer (CMO) oversees the Quality Improvement department and has greater than 15 years experience in this position. The Vice President of Quality Improvement (BSN) directly oversees the day to day operations and has over 13 years with Care1st in this capacity and has the help of an RN Manager and two Supervisors. The Quality Outreach staff has a lead nurse and coordinator and six nurse coordinator teams out in the field visiting provider offices. The clinical review team (investigates PQIs) has four RNs and a coordinator responsible for the investigation of quality related issues. The Facility Site Review sub-department of QI has two full time RN reviewers and two coordinators. They have responsibility to perform the physical accessibility audits. The Credentialing department has a supervisor with 13 years credentialing experience and three credentialing coordinators.

- **Pharmacy Data**
  Care1st contracts with a Pharmacy Benefit Manager (PBM) that is responsible to adjudicating pharmacy claims. This allows Care1st to have access to 100% of pharmacy data for quality purposes. The Pharmacy department has several PharmD that monitor the process and review care. The Pharmacy department works with the Quality department on several quality improvement interventions
- **Quality Improvement Department**
  Care1st Quality Improvement department has primary responsibility in analyzing data from all of the above mention sources and provides comprehensive quantitative and qualitative analysis reports, including a barrier analysis and recommended interventions.

Description of the staff responsible for the collection, processing, analyzing, reporting and acting upon data to evaluate the model of care.

- **Chief Medical Officer**
  Board Certified Physician that provides oversight and guidance to all of Medical Services, which includes Case Management, Utilization Management, Disease Management, Quality Improvement, Credentialing and Peer Review.

- **Informatics Medical Officer**
  Physician that provides oversight and guidance for all data collected through the above described sources. Oversight responsibility in assuring completeness and accuracy of data and providing specialized reports to specific departments responsible for performing the functions of the model of care.

- **Vice President of Medical Services**
  Registered Nurse that provides oversight and guidance for all Utilization Management, Case Management, Complex Case Management, and Disease Management programs. Provides oversight of the NCQA Accredited Managed Behavioral Health Organization (MBHO), which includes analyzing and reporting to the Medical Services Committee. Analyzes reports and makes policy decisions

- **Director of Medical Services**
  Registered Nurse that provides day to day direction of the Case Management, Complex Case Management, Disease Management programs, and Health Risk Assessments Staff involved in providing the day to day functions include but are not limited to:
  - **Case Management Nurses**
  - **Case Management Coordinators**
  - **Complex Case Management Nurses**
  - **Complex Case Management Coordinators**
  - **Disease Management Nurses and Coordinators**
  - **Social Workers**

- **Vice President of Quality Improvement**

Registered Nurse that provides oversight and guidance for all day to day functions of the Quality Improvement department, including but not limited to: HEDIS, CAHPS, Access to Care, Potential Quality Issue reviews, Credentialing, Quality Outreach, NCQA Accreditation, Quality Improvement Activities, Peer Review, Facility Site Review and metric related to the model of care

Staff involved in providing the day to day functions include but are not limited to:

- **QI Manager**
- **Clinical Review Nurses (3)**
- **HEDIS Review and Outreach Field Nurses (6)**
- **HEDIS Review and Outreach Field Coordinators (12)**
- **Credentialing Supervisor (1) and Specialists (3)**
- **Facility Site Review Nurses (2 employed and 2 contracted)**

- **Associate Vice President of Pharmacy**
  PharmD that provides oversight and guidance for all day to day functions of the Pharmacy department, including but not limited to: monitoring persistent medication, high risk medication reviews, and medication adherence programs. Also provides day to day guidance and oversight of the Pharmacy Benefit Manager (PBM) including prior authorization process.**.** Staff involved in providing the day to day functions include but are not limited to:
  - **Clinical Pharmacists**
  - **Pharmacy Coordinators**

Element 11, Factor C

Describe how the MAO will use the analyzed results of the performance measures to improve the MOC ((at a minimum includes: internal committee, other structured mechanism, etc.)

- The Medical Services Committee is established by the authority of the Care1st Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all Medical Services and Model of Care activities, including Quality Improvement and Utilization Management. The

Medical Services Committee has a specific sub-committees charged with more focused responsibilities. The sub-committees are; Credentialing, Peer Review and Quality Improvement Activity Steering Committee *(see attachment Element 11, Factor C, 1).*

The scope of the Medical Services Committee responsibilities include but are not limited to:

- Directing all Quality Improvement activity
- Recommending policy decisions
- Reviewing, analyzing and evaluating Quality Improvement activity
- Ensuring practitioner participation in the QI program through planning, design, implementation and review
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or QIASC)
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program and MOC
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, SDHCS, DMHC, and NCQA
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria
- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term project
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events

- Reviewing and evaluating reports submitted by the Plan's counsel
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff
- Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies
- Responsibility for evaluating and giving recommendations from monitoring and tracking reports
- Ensuring follow-up, as appropriate

Medical Services Committee Reporting

The Medical Services Committee shall submit a summary report of quality activities and actions for review and approval to the Care1st Board of Directors on a quarterly basis. This is completed by the approval of the Quality Improvement quarterly report.

Medical Services Committee Composition

- **Chairperson**

  The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
  - Directing the Medical Services Committee meetings
  - Reporting Medical Services Committee activities to the Board
  - Acting on behalf of the committee for issues that arise between meetings
  - Ensuring all appropriate QI activity and reports are presented to the committee
  - Ensuring there is a separation between medical and financial decision making

- **Membership**

  Membership is assigned and will include representatives from the following disciplines:
  - Primary Care Practitioners
  - Specialty Care Practitioners
  - IPA/PMG Medical Directors

- Utilization Management Director
- Associate Vice President , Quality Improvement
- Quality Improvement Manager
- Q.I. Project Manager
- Member Services
- Health Education
- Provider Relations
- Behavioral Health Practitioner
- Other members appointed at the discretion of the Chairperson

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of CMS, SDHCS and DMHC may attend upon request.

- **Quorum and Voting**
  Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Medical Services Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Medical Services Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

- The analysis reports provided to committee members always detail the key findings, comparison to set goals, description of all interventions, quantitative analysis, qualitative analysis and recommendations for additional interventions and actions.
- The Quality Improvement department takes a leading role in implementing interventions aimed at improving MOC deficiencies.

The Quality Improvement department establishes and documents the methodology planned or used to monitor and measure the MOC. The Quality Improvement department analyzes the measures and reports the analysis to specific stakeholders and through the committee process.

- The Quality Improvement department is responsible for running the Quality Improvement Activity Steering Committee (QIASC). The QIASC has a representative from every Care1st department. The QIASC is charged with the responsibility to remove interdepartmental barriers to getting specific interventions accomplished. This committee strives to work collaboratively across departments to provide strong process flows aimed at improving MOC measures.

Element 11, Factor D

Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the MOC (at a minimum includes: electronic print copies of its evaluation process, etc.)

- **Effectiveness of the Model of Care and Quality Improvement Program**
  - **Quality Improvement Work Plans**
    Quality Improvement Work Plan is developed annually outlining Quality Improvement and Model of Care activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment. The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement *(see attachment Element 11, Factor D, 1).*

  - **Measuring Effectiveness of Care Management Programs**

Care Management Programs, such as Model of Care, QIPs, CCIP, Disease Management Programs, Complex case Management, HEDIS, CAHPS, HOS, grievances and PQIs, are measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the QIA Steering Committee and Medical Services Committee and specific timeframes for re-measurement and methodology vary. All measurements and studies are presented to the Medical Services Committee and summarized on the annual evaluations, which are available for regulatory agency review. Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter *(see attachment Element 11, Factor D, 2).*

- **Quarterly Reports**
  Quarterly reports are an evaluation of the progress of the Quality Improvement and Model of Care activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter.

- **Annual Plan Evaluation**
  Quality Improvement and Model of Care activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the Quality Improvement Program and preparing the following year's Work Plan. The Evaluations are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and approval *(See attachment Element 11, Factor D, 3).*

- **Recording of Meeting and Dissemination of Action**
  - All Medical Services Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.

- Meeting minutes and all documentation used by the Medical Services Committee are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are be maintained in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings/Quality Outreach Visits
- Formal medical educational meetings
- Care1st Newsletters or Web Portal
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

Care1st Quality Improvement department utilizes continuous quality improvement processes and is primarily responsible for documenting specific functions of the model of care in the QI Program Description, Work Plan and Annual Evaluation. Other specific day to day operations of the Model of Care are also reported in the Utilization Management and Case Management Program Descriptions, Work Plans and Annual Evaluations.

Effectiveness of the Model of Care and Quality Improvement Program

- **Work Plans**
  - **Quality Improvement Work Plans**
    Quality Improvement Work Plan is developed annually outlining Quality Improvement and Model of Care activities for the year.

The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment. The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement

- **Utilization and Case Management Work Plans**
  Utilization and Case Management departments develop annual Work Plans that outline all Utilization, Case Management, and Model of Care activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment. These Work Plans are fluid documents and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement

- **Measuring Effectiveness of Care Management Programs**
  Care Management Programs, such as Model of Care, QIPs, CCIP, Disease Management Programs, Complex Case Management, HEDIS, CAHPS, HOS, grievances and PQIs, are measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the QIA Steering Committee and Medical Services Committee and specific timeframes for re-measurement and methodology vary. All measurements and studies are presented to the Medical Services Committee and summarized on the annual evaluations, which are available for regulatory agency review. Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter

- **Quarterly Reports**
  Quarterly reports are an evaluation of the progress of the Quality Improvement and Model of Care activities, as outlined

in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter.

- **Annual Plan Evaluation**
  Quality Improvement and Model of Care activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the Quality Improvement Program and preparing the following year's Work Plan. The Evaluations are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and approval
- **Recording of Meeting and Dissemination of Action**
  - All Medical Services Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
  - Meeting minutes and all documentation used by the Medical Services Committee are the sole property of Care1st Health Plan and are strictly confidential.
  - A written agenda will be used for each meeting.
  - Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
  - The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
  - The minutes and all case related correspondence are be maintained in the Quality Improvement Department.
  - The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

  The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:
  - Informal one-on-one meetings/Quality Outreach Visits
  - Formal medical educational meetings
  - Care1st Newsletters or Web Portal

- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

Element 11, Factor E

Describe the personnel having oversight responsibility for monitoring and evaluating the MOC effectiveness ((at a minimum includes: quality assurance specialist, consultant with quality expertise, etc.)

- **Committee Level Oversight Responsibility**
  - **Governing Body**
    The Plan's Governing Body is the Care1st Board of Directors. The Board of Directors is responsible for the establishment and implementation of the Plan's Quality Improvement Program. The Board of Directors appoints the Chief Medical Officer and Medical Services Committee as accountable entities for oversight of the Quality Improvement Program. The Chief Medical Officer reports all Quality Improvement activities monthly and the Medical Services Committee reports all Quality Improvement activities to the Board every quarter. The Board of Directors formally reviews and approves all Quality Improvement activities quarterly and directs these operations on an ongoing basis.

  - **Medical Services Committee**
    The Medical Services Committee is established by the authority of the Care1st Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all Medical Services and Model of Care activities, including Quality Improvement and Utilization Management. The Medical Services Committee has a specific sub-committees charged with more focused responsibilities. The sub-committees are; Credentialing, Peer Review and Quality Improvement Activity Steering Committee.

- **Personnel Level Oversight Responsibility**

  - **Chief Medical Officer**

The Chief Medical Officer is a physician who holds a current license to practice medicine with the Medical Board of California. The Chief Medical Officer is the Board of Directors designee responsible for implementation of Quality Improvement Program and Model of Care activities. The Chief Medical Officer works in conjunction with the Vice President of Quality Improvement to develop, implement and evaluate the Quality Improvement Program and Model of Care Activities. The Chief Medical Officer is Chairperson of the Medical Services, Credentials/Peer Review and Pharmacy & Therapeutics Committees. Responsibilities include but not limited to:

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Developing and implementing medical policy.
- Actively participating in the functioning and resolution of the grievance procedures.
- Providing support and clinical guidance to the program and to all physicians in the network.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, SDHCS, DMHC, and NCQA.
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities.
- Directing the implementation of the Quality Improvement and Model of Care process.
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement and Model of Care operations.
- Analyzing Quality Improvement and Model of Care data.
- Reviewing all clinical grievances, PQIs, QCIs; assign severity levels; and direct corrective actions to be taken, including peer review, if required.

- Reviewing Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports.
- Directing Health Education and Credentialing activities.
- Assisting with the development, conduct, review and analysis of HEDIS and IQIP studies.

- **Vice President, Quality Improvement**
  The Associate Vice President, Quality Improvement is a Bachelors Degree in Registered Nursing with a current California licensure, oversees the operations of the, Quality Improvement Department, and responsible for the execution, coordination, and monitoring effectiveness of all Quality Improvement and Model of Care activities. The Vice President Quality Improvement reports to the Chief Medical Officer (CMO). The Vice President helps to plan, develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement and Model of Care Programs and all QI policies and procedures. It is the Vice President of Quality Improvement's responsibility to interface with other departments on Quality Improvement and Model of Care issues. The Vice President reports any areas of concern to the CMO and/or the Medical Services Committee. Additional responsibilities include but not limited to:
  - Performing statistical analysis relevant to quality improvement functions and goals.
  - Developing and/or revising annually the Quality Improvement Annual Evaluation and Work Plan and presenting for review and approval.
  - Developing quarterly Quality Improvement activity progress reports.
  - Developing and/or revising annually Quality Improvement policies and procedures.
  - Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
  - Monitoring and reporting to the Medical Services Committee the resolution of quality improvement activities in accordance with the Quality Improvement Program.
  - Overseeing compliance required by regulatory agencies.

- Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
- Acting as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding Quality Improvement issues.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, SDHCS, DMHC, and NCQA.
- Serving as liaison with Regulatory Agencies for Quality Improvement activities.
- Monitoring and follow up with all applicable Quality Improvement activities.
- Ensuring that staff collects and monitors data and reports identified trends to the CMO and Medical Services Committee.
- Ensuring that HEDIS and IQIP studies are conducted appropriately.
- Overseeing the Facility Site Review Program.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Managing the Credentials process.
- Managing the Practitioner database modification process.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the Chief Medical Officer for clinical quality of care and service issues.
- Maintaining a comprehensive PQI/QCI database to track pertinent case data that facilitates capturing, tracking and trending of this data.
- Assuring the department adheres to HIPAA compliance standards.
- Overseeing member clinical grievance case files and the process for the Chief Medical Officer's action.
- Preparing peer review case files for the Chief Medical Officer's action.
- Reviewing potential risk management issues and reporting them to the Chief Medical Officer.

- Serving as liaison with CMS, SDHCS, DMHC and other regulatory agencies for investigation, collaboration and resolution of clinical grievances
- Developing policies and procedures in conjunction with the Chief Medical Officer
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Preparing PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings.
- Collaborating with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Overseeing the pre-contractual and annual Due Diligence audit process.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Submitting a written report summarizing each pre-contractual or annual review.
- Tracking compliance with reporting requirements and provide reports for Delegated Oversight Committee and Joint Operating Committee meetings.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
- Reporting IPA/PMG findings of non-compliance to the CMO and Delegated Oversight Committee.

- **Quality Improvement Manager**
  The Quality Improvement Manager manages the administrative day to day operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement and Model of Care activities. The Quality Improvement Manager reports to the Vice President of Quality Improvement. It is the Quality Improvement Manager's responsibility to interface with other departments on day to day Quality Improvement and Model of

Care processes and issues. Additional responsibilities include but not limited to:

- Assisting the Vice President in developing and/or revise annually the Quality Improvement Annual Evaluation and Work Plan and presenting for review and approval.
- Assisting in collecting information for quarterly Quality Improvement activity progress reports.
- Assuring that all staff members are adhering to company standards of conduct
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Associate Vice President the resolution of quality improvement activities in accordance with the Quality Improvement Program.
- Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures.
- Acting as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding Quality Improvement issues.
- Serving as liaison with Regulatory Agencies for Quality Improvement activities.
- Monitoring and follow up with all applicable Quality Improvement activities.
- Ensuring that staff collects and monitor data and report identified trends to the CMO and Medical Services Committee.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, SDHCS, DMHC, and NCQA.
- Assisting in all HEDIS and IQIP studies.
- Ensuring appropriate resources and materials are available and ordered to meet the department's needs.
- Reviewing the daily staff time clock logs and ensuring compliance with company standards.
- Assisting in the development of Focused Review Studies.
- Interfacing with the Associate Vice President, Quality Improvement and Chief Medical Officer for clinical quality of care and service issues.

- Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
- Overseeing member clinical grievance case files and the process for the Associate Vice President, Quality Improvement and Chief Medical Officer.
- Preparing peer review case files for the Chief Medical Officer's action.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Preparing PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings.
- Collaborating with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Tracking compliance with reporting requirements and provide reports for Joint Operating Committee meetings.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
- Reporting IPA/PMG findings of non-compliance to the Associate Vice President, Quality Improvement and CMO.

- **Other Quality Improvement Staff and Resources**
  The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but not limited to:

- Clinical Quality Review RNs
- Data Analysts
- Credentialing Coordinators
- HEDIS Coordinators and Nurses
- Facility Site Review RNs
- Disease Management/Chronic Care Improvement Program RNs
- Q.I. Project Manager
- Other supporting administrative staff

Element 11, Factor F

Describe how the MAO will communicate improvements in the MOC to all stakeholders ((at a minimum includes: a webpage for announcements, printed newsletters, bulletins, announcements, etc.)

- **Dissemination of QI and Model of Care Program, Activities and Outcomes to Network Practitioners**
  All network Practitioners will be informed of the Quality Improvement and Model of Care Program, activities and outcomes in accordance with DHCS, CMS, and NCQA, and DMHC requirements. Care1st Health Plan will update Practitioners on any revisions or changes to the QI program. The QI Department will disseminate information on its activities and outcomes from studies or surveys.
  - All Care1st Network Practitioners will be given a Practitioner Manual, which describes in detail the Quality Improvement and Model of Care standards, goals, objectives and guidelines.
  - Periodically the Quality Improvement Department will write articles in the Practitioner newsletter highlighting specific standards and guidelines (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).
  - Any immediate change in standards the Practitioner network will be notified in writing and via broadcast fax. This will be followed up with newsletter articles and revisions to the Practitioner Manual.
  - Practitioners will be mailed at least every six months a profile report, which details their compliance with several QI and Model of Care indicators.
  - These indicators include but are not limited to:

- Encounter data submission
- Compliance rates of Access to Care studies, FSR.
- Current HEDIS rates

- Practitioners are provided through the web portal monthly a list of their assigned members needing preventive care services (i.e., Colorectal cancer Screening, Mammograms, medication reconciliation, functional assessments, etc.)
- Practitioners will be notified of any grievance issue and they are required to respond in writing. They will be notified of all determinations in writing.
- Study outcomes are disseminated to Practitioners through the Practitioner Newsletter, direct mailings and our web site.

- **Dissemination of QI and Model of Care Program, Activities and Outcomes to Members**

  All members will be informed of the Quality Improvement and Model of Care Program, activities and outcomes. Care1st Quality Improvement department will disseminate information on its activities and outcomes from studies or surveys.

  - All Care1st members will be mailed at least two times a year a member newsletter that details Quality Improvement and Model of Care activities and where to find additional details and analysis on the web site (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).
  - Members will have access to the provider directory on line, which will detail physical accessibility information.
  - Members will be mailed reminders for services they are due to complete
  - Member Service screens are populated with HEDIS reminder data so when they contact Care1st they will be reminded.
  - Members will be mailed and informed of the contact information if they wish to request a hard copy of specific study results or information.
  - Members will be mailed an acknowledgement of any grievance issue within 5 days of receipt and a closure letter within 30 days of receipt.

- **Dissemination of QI and Model of Care Program, Activities and Outcomes to Network Practitioners**

All network Practitioners will be informed of the Quality Improvement and Model of Care Program, activities and outcomes in accordance with DHCS, CMS, and NCQA, and DMHC requirements. Care1st Health Plan will update Practitioners on any revisions or changes to the QI program. The QI Department will disseminate information on its activities and outcomes from studies or surveys.

- All Care1st Network Practitioners will be given a Practitioner Manual, which describes in detail the Quality Improvement and Model of Care standards, goals, objectives and guidelines.
- Periodically the Quality Improvement Department will write articles in the Practitioner newsletter highlighting specific standards and guidelines (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).

SUMMER '10

CARE1ST HEALTHPLAN
www.care1st.com

PROVIDER Newsletter

WE WELCOME CARE1ST PROVIDERS TO OUR QUALITY OUTREACH PARTNERSHIP

Our Quality Outreach Department is delighted to partner with providers by giving you educational tools to use at the point of care. Our Quality Outreach Tool-Kit has essential tools that will improve our HEDIS rates and continually improve the quality of care to our members.

This coming fall, our Quality Outreach Teams will be visiting your offices and a priority item will be to provide extensive education regarding Hierarchal Condition Category (HCC). Why is it important? The HCC process consists of collecting accurate diagnosis codes on all our members and we submit this data directly to the Centers for Medicaid and Medicare Services (CMS). This data is used by CMS to determine the cost of care for our members.

Our goal during our visits will be to assist you and your office staff in understanding how specific diagnosis must be documented and submitted to assure we have accurate accounting of our member's conditions. We will also be addressing Healthcare Effectiveness Data and Information Sets (HEDIS), which are annual sets of quality measures. We have developed specific tools that will help in meeting all of these goals that we would like to share with you.

Welcome to our Quality Outreach Partnership, we look forward to seeing you soon and being a permanent resource to better meet your needs.

If you have any questions, please contact the Quality Outreach staff at (877) 472-4332.

At Care1st, our Providers and Members come first!

in this *issue*

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Care1st Community Health Event "Celebrate Good Health"

Care1st and HealthCare Partners proudly sponsored the "Celebrate Good Health" community event at the Watts Senior Center on February 26th. Guests included members of the Watts Senior Center, parishioners from St. Lawrence Church, and neighborhood residents. The event's Mardi gras theme greeted attendees with masks, beads, and a tote bag full of information and giveaways. Plenty of healthy refreshments were available through the generous participation of Care1st Health Plan, Costco, and Starbucks.

Care1st hosted a hospitality suite to introduce members to Dr. Malone and Dr. Deorosan who are active Care1st / HealthCare Partners providers within the community. Linda Fleischman and Rosa Hernández, from Care1st's Education Department, provided body fat analysis, educational displays, and pamphlets. Dr. Fitzgerald, DDS, Care1st Health Plan's Dental Director of Quality Improvement, furnished a booth presenting the importance of dental hygiene to personal health.

A variety of health screenings were offered to guests. Screenings included stroke, glucose, bone density, and blood pressure. Carrie Anne, from SilverSneakers, demonstrated an aerobics workout to inspire seniors to "get up and get moving". The event included the participation of a Massage Therapy school who donated their time and skills by providing relaxing and soothing massages.

This event was a successful collaboration between Care1st Health Plan and HealthCare Partners. Two organizations dedicated and committed to improving quality of care and healthy living.

If you have any questions regarding participation in future educational events, please contact the marketing department at Care1st Health Plan at (800) 605-2556.

Health Information Technology for Economic and Clinical Health Act (HITECH) – part of the American Recovery and Reinvestment Act of 2009 (ARRA)[1]

Chief Privacy Officers are very busy implementing the federal data breach notification requirements spelled out in the new HITECH law. Simply put, HITECH requires health care providers to notify individuals whose data has been breached. The Breach Notice Rule is an interim final regulation issued on August 24, 2009 by the US Department of Health & Human Services (DHHS). It provides guidance on how to comply with HITECH. Details and exclusions of the Breach Notice Rule can be accessed on the Internet at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/breachnotificationrlt.html

Breach Notice Requirement

Under the new law, when a breach[2] has been identified, a covered entity is to notify each individual whose unsecured protected health information (PHI) has been, or reasonably believed to have been, accessed, acquired, disclosed, or compromised. PHI is compromised when it poses a significant risk of financial, reputational, or other harm to the individual. It does not matter if the breach occurred through the covered entity or a business associate. Business associates must notify the covered entity of the breach.

Discovery constitutes the first day the covered entity or business associate knows, or has reason to suspect, that a breach has occurred. Once discovered, any required notifications must occur without unreasonable delay (i.e. no later than 60 calendar days after discovery). If notification is delayed, proper evidence should be prepared to demonstrate the necessity of the delay.

Prompt notification to an individual should be written and sent via first class mail unless the individual requests electronic mail delivery. If the individual's contact information is out of date or insufficient, a substitute form of notice should be used. Substitute forms of notice include posting on the covered entity's website, or public notice in major print or broadcast media in the geographic area where the individual most likely resides.

Breaches involving 500 or more individuals in State or jurisdiction require the use of State media outlets. Further, when a breach involves 500 or more, the HHS should be immediately notified by visiting the HHS website by filling out and electronically submitting a breach report form. The HHS Breach Reporting Form can be found at: http://transparency.cit.nih.gov/breach/index.cfm. Otherwise (less than 500), a covered entity should maintain a log of breaches and submit it annually to HHS using the breach form and electronic submission to HHS.

No matter how a covered entity notifies an individual of a breach, the notification must include:

- How the breach occurred;
- Date(s) of breach/discovery;
- Description of the PHI involved;
- Description of investigation and mitigation process and future prevention plans;
- Contact procedures in order to get more information; and
- How individuals can be protected against potential harm.

Examples

1) The Billing Department mistakenly sends the Explanation of Benefits (EOB) notice of a patient who received behavioral health services to the individual's employer. Does this require breach notification? Yes. The Privacy Rule was violated, and there could be substantial reputational or financial harm caused when accidentally disclosing PHI to someone's employer.
2) A hospital laptop was stolen and it contained the medical records information of 30 people. However, the laptop was encrypted. Is breach notification required? No. The PHI was "secured" by encryption.
3) A hospital discloses PHI that contains the name of patient and the fact that the patient received treatment in the hospital's substance abuse treatment program. Does this require breach notification? Yes. The Privacy Rule was violated, and there could be significant risk of reputational or financial harm to the individual when disclosing treatment at specialized facilities (e.g., oncology, substance abuse, etc.).
4) A laptop was stolen and it contained the medical records information of 30 patients. The laptop was recovered and a forensic analysis shows the laptop was not opened, altered, or accessed. Is breach notification required? No. The Privacy Rule was violated, but the PHI was not compromised, and thus, there is no significant risk of reputational or financial harm to the patients.
5) A provider discloses PHI that contains the name of the patient and the fact that the patient received services (but not what the specific services were) at a hospital or the provider's office. Does this require breach notification? No. Although the Privacy Rule was violated, it is not likely there would be significant risk of reputational or financial harm to the individual.

[1] *"A Quick Guide To Investigating Data Breaches", Frank Riccardi, JD, CHC, CFE, CPHRM Compliance Today, January 2010; and http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html*

[2] A breach is an unauthorized acquisition, access, use, or disclosure of unsecured PHI which compromises the privacy, security, or integrity of the PHI.

To report suspected and/or actual breaches of Care1st members' protected health information, call Care1st's Hotline at 1-877-837-6057 or call Care1st's Compliance Officer, Brooks Jones at 323-889-6638.

Care1stCARES "Is In The House"

Beginning April 1, 2010, all Disease Management Programs under Care1stCARES have been transitioned from Healthways to Care1st Health Plan.

The administration of all Disease Management Programs by Care1st staff allows for improved comprehensive care coordination between our PPGs, physicians, home health agencies, and Care1st internal departments such as Complex Case Management, Transitional Care Case Management, Inpatient Case Management, Social Services and Pharmacy.

The current Disease Management Programs include:

Medi-Cal	Medicare
Asthma	COPD
CHF	CHF

You can obtain more information about these programs, including how to refer your Care1st patients to Care1stCARES on our website. The link for Care1stCARES site is: http://www.care1st.com/ca/members/quality-improvement/care1st-cares.asp

The purpose of the Care1stCARES programs is to oversee and manage a defined member population with chronic conditions. To achieve ultimate outcomes, the program consistently applies approved guidelines and criteria and focuses on member self-care efforts.

The goals of the Care1stCARES programs include:

- To reduce the members incidence of condition exacerbation
- Improve medication adherence and compliance to prescribed medication therapy
- To improve overall quality of life
- To improve member's knowledge/understanding of their condition
- To improve member's self-management skills
- To improve practitioner adherence to approved treatment guidelines
- To decrease hospital admissions
- To decrease Emergency Room visits

We look forward to working closely with you in delivering high quality care and improving the quality of life for our members.

If you would like to discuss these programs with our Disease Managers, please contact Care1st Health Plan at 877-702-5566.

Care1stCARES Disease Management Practice Guidelines

Practice guidelines provide evidence-based recommendations for the assessment and treatment of various disorders. All guidelines used for the Care1stCARES Disease Management Program are nationally recognized and represent appropriate standards of care for each condition.

Below are the guidelines utilized by the Care1stCARES programs.

Asthma	• National Heart, Lung, and Blood Institute (NHLBI) National Education and Prevention Program (NAEPP), Expert Panel Report 3 (EPR3): Guidelines for Diagnosis and Management of Asthma 2007. • Complete guidelines are accessible at: www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf.
COPD	• Global Initiative for Chronic Obstructive Lung Disease, 2007. • Complete guidelines are accessible at: http://www.goldcopd.com
CHF	• Heart Failure Society of America Comprehensive Heart Failure Practice Guideline, 2006 • ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults 2009 • Complete guidelines are accessible at: http://www.hfsa.org/hf_guidelines.asp

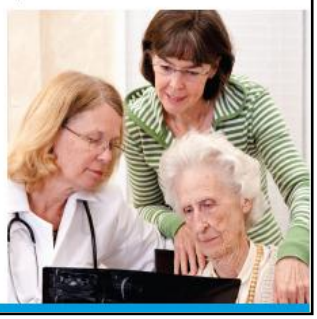
Sensitivity Critical to the Care of Female Patients

In a recent focus group study conducted by the health plans that provide services to Medi-Cal Managed Care members in Los Angeles County, female members gave feedback on ways to increase breast and cervical cancer screenings.

The following were their suggestions:

- Provide educational materials and videos in the waiting room explaining what women may expect during the exams and provide materials following the screenings as well.
- Remind women about the importance and intervals for breast and cervical cancer screenings.
- Show greater sensitivity about how difficult these screenings can be for women.
- Refrain from making comments about a woman's body.
- Inform women how to receive their screening results within a reasonable time frame.

Please contact Rosa Hemández at 323-889-6638 ext. 6282 or at rhemandez@care1st.com to request a full copy of this report.



Care1st Health Plan's website, www.care1st.com, offers member materials on a variety of topics, including mammograms and cervical cancer screenings. We encourage you to follow the preventive health care guidelines also available on this site.

Language Rights for Care1st Health Plan Members

Care1st Health Plan members have the right to:

- Request interpreting services (telephonic, face-to-face & American Sign Language) from Care1st or their PCP at no cost.
- Receive interpreting services 24 hours a day / 7 days a week (includes after hours)
- Receive health education brochures and materials in their primary language and /or alternative formats (i.e. Audio, Braille & Large Print etc.)
- Participate in community programs and services that offer culturally and linguistically appropriate social services.
- File a grievance if the services provided do not meet their cultural and language needs.

Care1st Health Plan provides at NO COST:

- Interpreting services 24 hours a day / 7 days a week by calling Care1st Member Services at 1-800-605-2556.
- Live Interpreter Services prior to scheduled appointments 24 hours in advance by calling Care1st Member Services at 1-800-605-2556.
- Educational materials and forms in various languages (i.e. Member's Rights, Request or Refusal of Interpreting services forms, IHEBA, etc.), including alternative formats (i.e. audio, Braille, Large Print, etc.).
- Educational opportunities & resources for providers and staff; including on-site trainings.
- Referrals to Community Programs and Services
- Interpreting Services Poster

To Contact a Member with Hearing/Speech Impairment:

- Call California Relay Service at **1-888-877-5379**

The California Relay Service is a FREE service available 24 hours a day / 365 days a year with no restrictions on call length or number of calls.

Interpreting Services Poster:
The poster must be placed in visible areas within your office (i.e. reception desk, waiting room, or exam room). It is translated into LA County's ten threshold languages and will inform patients of the availability of interpretation services at no cost. You may obtain free copies of the poster by contacting the Cultural and Linguistic Department.

Cultural & Language Related Complaints & Grievances:
Provider offices should establish a policy for their office that will assist staff in handling cultural & language related complaints. Grievance forms are available in English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Tagalog, and Vietnamese. Please contact the Cultural and Linguistics department to request a copy.

You can also visit the Care1st website to access most of the materials available in various languages at www.care1st.com. If you need any additional information, please contact Therese Horth at (323) 889-6638 ext. 6538. We also welcome you to send your request via e-mail to thorth@care1st.com.

Bilingual Providers & Staff:
The most current ICE Provider & Staff language capability self-assessment tool has recently been distributed via Fax to providers and facility site review nurses. If you have not received a copy in the last couple of months, please request a copy via e-mail to Therese Horth at thorth@care1st.com, or download

a copy from the Care1st Health Plan website at www.care1st.com.

Furthermore, please maintain certification of language proficiency certifications or interpretive trainings on file for each provider and office staff. Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency to determine if they are qualified for medical interpreting. Bilingual staff, with limited bilingual capabilities, should not provide interpreting service to members.

Other Resources:

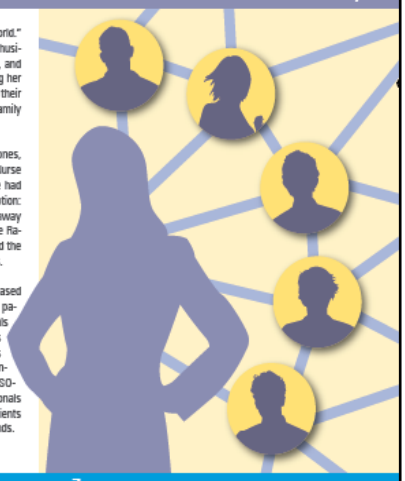
- On-line Cultural Competence Training from DHS Office of Minority at www.thinkculturalhealth.org
- Health Care Interpreting: A short Course for Bilingual Health Care Workers Who Interpreter for Patients www.lacare.org
- Resource-materials such as videos on how-to work with interpreters and cultural resources at www.diversityrx.org , www.xculture.org (CCHCP), www.nationaltbcenter.edu (Francis Curry TB Center)
- TCE publications such as "How to Choose and Use a Language Agency and Health Care Interpreter Training in California at www.calendow.org
- Ensuring Linguistic Access in Health Care Settings and Language Services Action Kit available from National Health Law Program at www.healthlaw.org
- Department of Health And Human Services-The Office of Minority Health: www.omhrc.gov

Nurse Rachel Is Too Friendly

Nurse Rachel is "the friendliest person in the world." She greets patients to Dr. Tran's office with enthusiasm, always asks after their family members, and proudly shows off the treats her patients bring her to thank her for her kindness as they deal with their own medical problems and those of their family members.

One of nurse Rachel's favorite patients, Mary Jones, passed away recently from breast cancer. Nurse Rachel posted on her Facebook a picture she had taken of Mary just before she died with the caption: "Mary Jones, a grand lady to end, passed away today. Another victim of breast cancer." Nurse Rachel violated the law in posting the picture and the caption without the permission of Mary Jones.

Protected Health Information is not to be released even on a Facebook page paying tribute to a patient. Motive is irrelevant. All health professionals must avoid posting online pictures and names of patients, mentions of the health conditions of patients, and any mention of health status including death. Social networking is just that, SOCIAL. It is not to be used by friendly professionals to share information about patients, even patients who bring them treats and treat them like friends.



Health Care Fraud & Abuse

Common Managed Care Fraud Schemes

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medi-Cal and/or Private Insurers, increases everyone's health care costs. If we are to maintain and sustain our current health care system, we must work together to reduce unnecessary costs.

I. Administrative/Financial

- Falsifying credentials.
- Billing fee-for-service [FFS] for capitated services.
- Double-billing for health care services or goods that were provided.
- Accepting kickbacks for referring sicker patients to FFS specialists.
- Conducting improper dis-/enrollment practices.
- Attracting healthy patients or refusing sicker patients.
- Persuading sicker patients to dis-enroll.
- Falsifying medical exemptions.
- Use of telemarketing/selling as marketing tools.

II. Services/Encounter

- Falsifying encounter data.
- Misrepresenting services to meet quality of care standards.
- Billing for "phantom patients" who did not receive services.
- Billing for services/supplies not provided.
- Upcoding charges and unbundling services.
- Excluding distinct groups of beneficiaries (e.g. patients with chronic conditions).
- Engaging in under-utilization.
- Regularly denying treatment requests and specialist referrals without regard to proper medical evaluation.
- Concealing ownership in a related company.

III. Member Issues

- Falsifying eligibility applications.
- Using another person's health plan identification card to obtain medical care.
- Doctor shopping to obtain multiple prescriptions for controlled substances/ prescriptions drugs.
- Misrepresenting medical conditions.
- Failing to report third party liability.

WHAT CAN YOU DO?

- Review Care1st Provider Manuals.
- Report potential fraud to the Department of Health Services for Medi-Cal.
- Report potential fraud to the HHS Office Inspector General for Medicare.
- Contact Care1st Health Plan's Special Investigations Unit and make aware of potential fraud issue.
- Establish office policies and procedures to address fraud and abuse issues.
- Share this important information with your staff.

Department Contact Information

Provider Relations
P: (323) 889-6638 Ext. 6388
F: (323) 889-6212

Member Services
P: (800) 605-2556
F: (323) 889-6289

Authorizations
P: (800) 605-2556
F: (323) 889-6577

Pharmacy
P: (877) 792-2731
F: (877) RX-CARE1

P: (866) 712-2731
F: (866) R1-CARE1

Claims
P: (800) 605-2556 Ext. 6335
Ext. 6234

CARE 1ST HEALTH PLAN On-line: www.care1st.com

CONTACT INFORMATION BY COUNTY:

LOS ANGELES
ORANGE
SAN BERNARDINO
RIVERSIDE

Care1st Health Plan
601 Potrero Grande Drive
Monterey Park, CA 91755

Phone
(323) 889-6638

Main Fax
(323) 889-6255

SAN DIEGO
Care1st Health Plan
3131 Camino del Rio North
Suite 350
San Diego, CA 92108

Phone
(619) 498-8228

Main Fax
(619) 498-8237

Report potential fraud by calling:

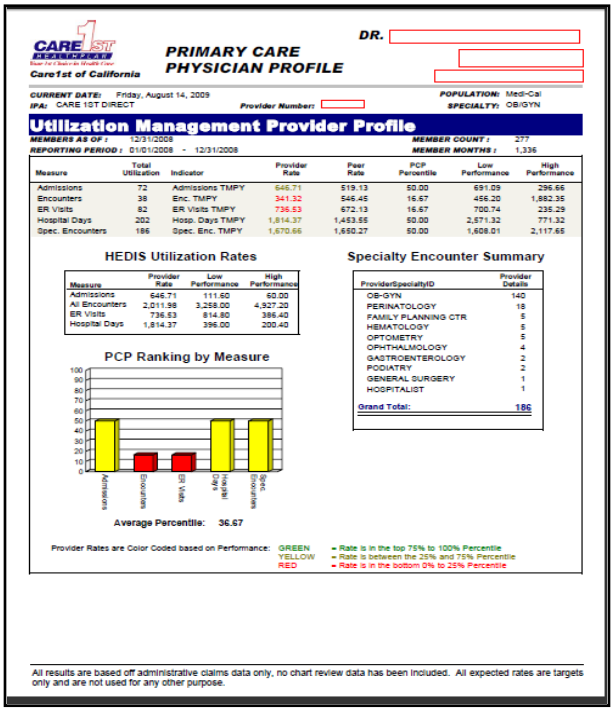
Medicare Fraud Hotline of the HHS office Inspector General
(800) 447-8477

Medi-Cal Fraud Hotline Department of Health Services
(800) 822-6222

Care1st Health Plan Compliance Hotline
(877) 837-6057

- In the event of any immediate change in standards the Practitioner network will be notified in writing and via broadcast fax. This will be followed up with newsletter articles and revisions to the Practitioner Manual.

- Practitioners will be mailed at least every six months a profile report, which details their compliance with several QI and Model of Care indicators.



CARE 1ST HEALTHPLAN
Your 1st Choice for Health Care
Care1st of California

PRIMARY CARE PHYSICIAN PROFILE

DR.

CURRENT DATE: Friday, August 14, 2009
IPA: CARE 1ST DIRECT
Provider Number:
POPULATION: Medi-Cal
SPECIALTY: OB/GYN

Utilization Management Provider Profile

MEMBERS AS OF : 12/31/2008
REPORTING PERIOD : 01/01/2008 - 12/31/2008
MEMBER COUNT : 277
MEMBER MONTHS : 1,336

Measure	Total Utilization	Indicator	Provider Rate	Peer Rate	PCP Percentile	Low Performance	High Performance
Admissions	72	Admissions TMPY	646.71	519.13	50.00	691.09	296.66
Encounters	38	Enc. TMPY	341.32	546.45	16.67	456.20	1,882.35
ER Visits	82	ER Visits TMPY	736.53	672.13	16.67	700.74	235.29
Hospital Days	202	Hosp. Days TMPY	1,814.37	1,453.66	50.00	2,671.32	771.32
Spec. Encounters	186	Spec. Enc. TMPY	1,670.66	1,650.27	50.00	1,608.01	2,117.65

HEDIS Utilization Rates

Measure	Provider Rate	Low Performance	High Performance
Admissions	646.71	111.60	60.00
All Encounters	2,011.98	3,268.00	4,927.20
ER Visits	736.53	814.80	386.40
Hospital Days	1,814.37	396.00	200.40

Specialty Encounter Summary

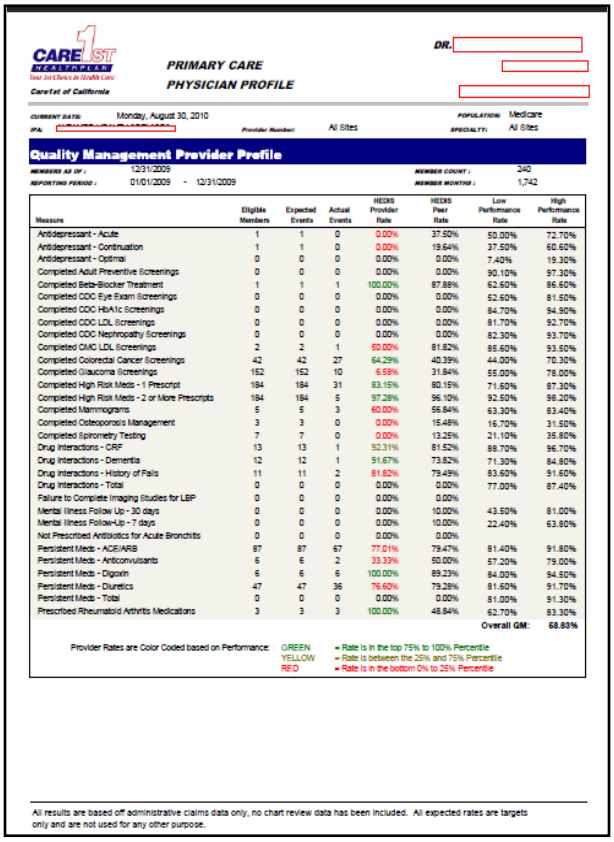
ProviderSpecialtyID	Provider Details
OB-GYN	140
PERINATOLOGY	18
FAMILY PLANNING CTR	5
HEMATOLOGY	5
OPTOMETRY	5
OPHTHALMOLOGY	4
GASTROENTEROLOGY	2
PODIATRY	2
GENERAL SURGERY	1
HOSPITALIST	1
Grand Total:	186

PCP Ranking by Measure

Average Percentile: 36.67

Provider Rates are Color Coded based on Performance:
GREEN = Rate is in the top 75% to 100% Percentile
YELLOW = Rate is between the 25% and 75% Percentile
RED = Rate is in the bottom 0% to 25% Percentile

All results are based off administrative claims data only, no chart review data has been included. All expected rates are targets only and are not used for any other purpose.



CARE 1ST HEALTHPLAN
Your 1st Choice for Health Care
Care1st of California

PRIMARY CARE PHYSICIAN PROFILE

DR.

CURRENT DATE: Monday, August 30, 2010
IPA:
Provider Number: All Sites
POPULATION: Medicare
SPECIALTY: All Sites

Quality Management Provider Profile

MEMBERS AS OF : 12/31/2009
REPORTING PERIOD : 01/01/2009 - 12/31/2009
MEMBER COUNT : 240
MEMBER MONTHS : 1,742

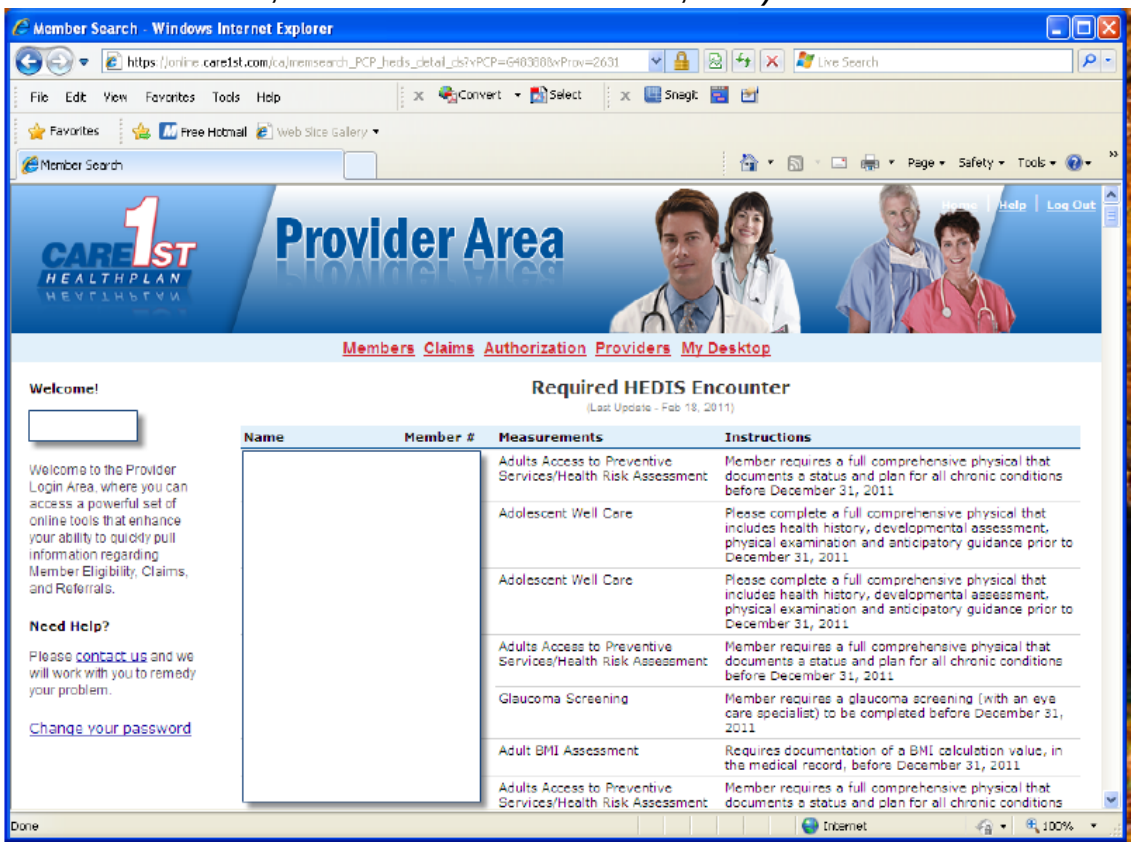
Measure	Eligible Members	Expected Events	Actual Events	HEDIS Provider Rate	HEDIS Peer Rate	Low Performance Rate	High Performance Rate
Antidepressant - Acute	1	1	0	0.00%	37.50%	50.00%	72.70%
Antidepressant - Continuation	1	1	0	0.00%	19.64%	37.50%	60.60%
Antidepressant - Optimal	0	0	0	0.00%	0.00%	7.40%	19.30%
Completed Adult Preventive Screenings	0	0	0	0.00%	0.00%	90.10%	97.30%
Completed Beta-Blocker Treatment	1	1	1	100.00%	87.88%	62.60%	86.60%
Completed CDC Eye Exam Screenings	0	0	0	0.00%	0.00%	52.60%	81.50%
Completed CDC HbA1c Screenings	0	0	0	0.00%	0.00%	84.70%	94.90%
Completed CDC LDL Screenings	0	0	0	0.00%	0.00%	81.70%	92.70%
Completed CDC Nephropathy Screenings	0	0	0	0.00%	0.00%	82.30%	93.70%
Completed CMC LDL Screenings	2	2	1	50.00%	81.82%	85.60%	93.50%
Completed Colorectal Cancer Screenings	42	42	27	64.29%	40.39%	44.00%	70.30%
Completed Glaucoma Screenings	152	152	10	6.58%	31.84%	55.00%	78.00%
Completed High Risk Meds - 1 Prescript	184	184	31	83.15%	80.15%	71.60%	87.30%
Completed High Risk Meds - 2 or More Prescripts	184	184	5	97.28%	96.10%	92.50%	98.20%
Completed Mammograms	5	5	3	60.00%	56.84%	63.30%	83.40%
Completed Osteoporosis Management	3	3	0	0.00%	15.48%	16.70%	31.50%
Completed Spirometry Testing	7	7	0	0.00%	13.25%	21.10%	35.80%
Drug Interactions - CRF	13	13	1	92.31%	81.52%	88.70%	96.70%
Drug Interactions - Dementia	12	12	1	91.67%	73.82%	71.30%	84.80%
Drug Interactions - History of Falls	11	11	2	81.82%	79.49%	83.60%	91.60%
Drug Interactions - Total	0	0	0	0.00%	0.00%	77.00%	87.40%
Failure to Complete Imaging Studies for LBP	0	0	0	0.00%	0.00%		
Mental Illness Follow Up - 30 days	0	0	0	0.00%	10.00%	43.50%	81.00%
Mental Illness Follow-Up - 7 days	0	0	0	0.00%	10.00%	22.40%	63.80%
Not Prescribed Antibiotics for Acute Bronchitis	0	0	0	0.00%	0.00%		
Persistent Meds - ACE/ARB	87	87	67	77.01%	79.47%	81.40%	91.80%
Persistent Meds - Anticonvulsants	6	6	2	33.33%	50.00%	57.20%	79.00%
Persistent Meds - Digoxin	6	6	6	100.00%	89.23%	84.00%	94.50%
Persistent Meds - Diuretics	47	47	36	76.60%	79.28%	81.60%	91.70%
Persistent Meds - Total	0	0	0	0.00%	0.00%	81.00%	91.30%
Prescribed Rheumatoid Arthritis Medications	3	3	3	100.00%	48.84%	62.70%	83.30%
						Overall GM:	68.83%

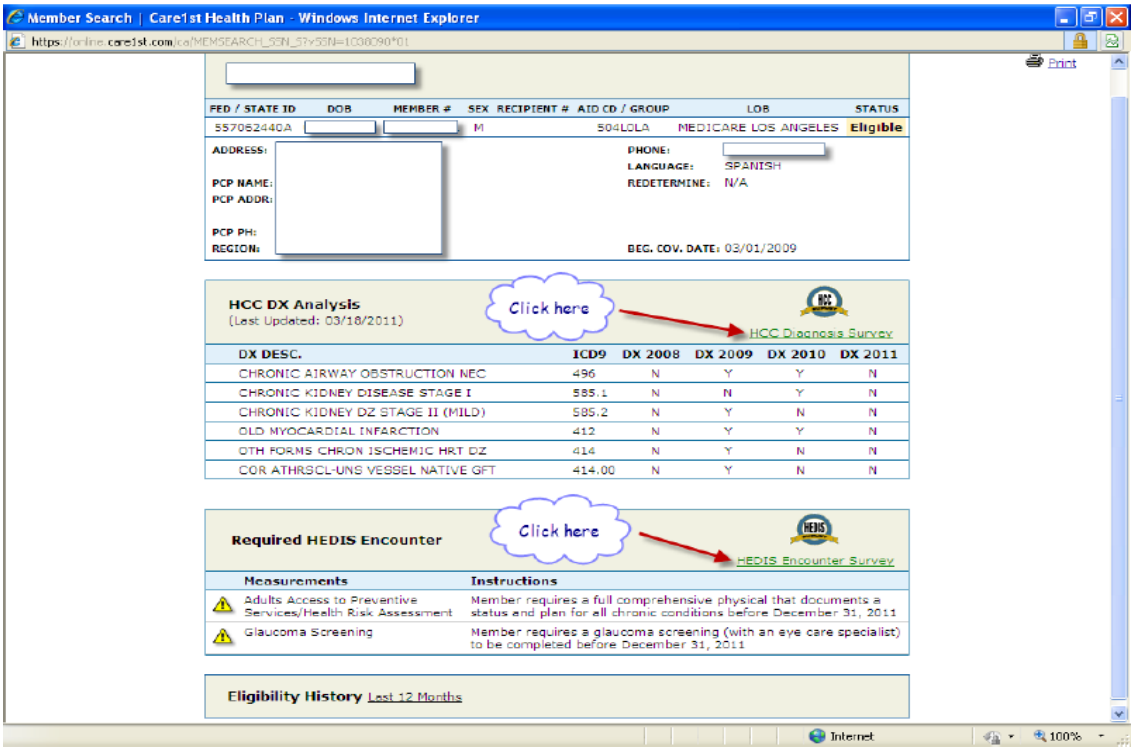
Provider Rates are Color Coded based on Performance:
GREEN = Rate is in the top 75% to 100% Percentile
YELLOW = Rate is between the 25% and 75% Percentile
RED = Rate is in the bottom 0% to 25% Percentile

All results are based off administrative claims data only, no chart review data has been included. All expected rates are targets only and are not used for any other purpose.

- These indicators include but are not limited to:
  - Encounter data submission
  - Compliance rates of Access to Care studies, FSR.
  - Current HEDIS rates
- Practitioners are provided through the web portal monthly a list of their assigned members needing preventive care services (i.e.,

Colorectal cancer Screening, Mammograms, medication reconciliation, functional assessments, etc.)





- Practitioners will be notified of any grievance issue and they are required to respond in writing. They will be notified of all determinations in writing.
- Study outcomes are disseminated to Practitioners through the Practitioner Newsletter, direct mailings and our web site.

- **Dissemination of QI and Model of Care Program, Activities and Outcomes to Members**
  All members will be informed of the Quality Improvement and Model of Care Program, activities and outcomes. Care1st Quality Improvement department will disseminate information on its activities and outcomes from studies or surveys.
  - All Care1st members will be mailed at least two times a year a member newsletter that details Quality Improvement and Model of Care activities and where to find additional details and analysis on the web site (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).

healthy living

CARE 1ST HEALTH PLAN
Your 1st Choice in Health Care

Spring/Summer 2010

Find what you need on our website

Care1st Health Plan encourages appropriate use of benefits and services and discourages underuse of them. Care1st does not reward staff or doctors for keeping members from getting care.

You can visit our website, *www.care1st.com*, to learn more about the following topics:

- Disease management and programs available.
- Member rights and responsibilities.
- Access to care standards.
- Specialist access to care standards.
- Language help.
- Grievance process.
- Appeal process.
- New technology.
- Professional qualifications (providers).
- Communication services (how to access staff to discuss utilization management issues).
- Information on incentive use.
- Preventive health guidelines.
- Provider and hospital directory.
- Communication of protected health information use and disclosure.
- Pharmaceutical management procedures and patient safety.
- Marketing information.

Member Services

Call 800-544-0088 or 800-735-2929 (TTY users) from 8 a.m. to 8 p.m., seven days a week.
www.care1st.com

Things to Know

Resources for members

We offer our members a directory of community resources and agencies. It has information about organizations near you that can help you with issues such as domestic violence and elder care. The directory also lists organizations that offer counseling services, social services and interpreter services.

If you would like a directory, please call the Care1st Member Services Cultural and Linguistics Department at **800-544-0088, extension 6538** (TTY 800-735-2929).

Health Care Plan of California
601 Potrero Grande Drive
Monterey Park, CA 91755

Health Care Plan of California
Plan Information Bulletin

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staying healthy

Health screenings

Know your numbers

Health screenings (tests) can tell you how your body is doing. Knowing and understanding your results can help you prevent heart disease, stroke and kidney problems.

Check your blood pressure

Blood pressure is the force of blood against the walls of your arteries when your heart beats and when it rests. Normal blood pressure is 120/80 or lower.

When you have high blood pressure, or hypertension, your heart works harder. Over time that can lead to heart attack, stroke and kidney failure.

Have your blood pressure checked regularly. If it is high, talk to your doctor about diet and exercise changes. If you need to take medicine for it, take it as prescribed.

Control cholesterol

Cholesterol is a type of fat. Your body needs a certain amount of it. When you have too much of it, it clogs your arteries and makes it harder for blood to reach your heart.

Ask your doctor about when you should have your cholesterol checked. Your total cholesterol should be less than 200. Your LDL (bad) cholesterol should be less than 130. However, if you have heart disease or other risk factors, your LDL cholesterol should be less than 100. HDL (good) cholesterol should be more than 40 for men and more than 50 for women.

If you have high cholesterol, talk to your doctor about diet and exercise changes. If you need to take medicine to lower your cholesterol, take it regularly. The medicine works better when you follow a healthy diet that is low in saturated fat, trans fat and cholesterol. Avoid foods like fatty red meat, whole-milk dairy products, eggs and processed foods.

To keep your numbers looking good, exercise regularly and eat a healthy diet.

Keep an eye on blood sugar

Your doctor will check for diabetes by giving you a blood glucose (sugar) test. If you have diabetes, check your blood glucose levels regularly with a glucose meter. Before a meal, your plasma glucose should be less than 100 mg/dL. After a meal, it should be less than 140 mg/dL.

You also need an A1C test. This test tells you your average glucose level in the past three months. Your goal should be less than 6 percent. Have an A1C test at least once a year. If you are not at your goal, have the test every four months.

Take your diabetes medicines as prescribed. Keeping your glucose at a healthy level will help prevent future health problems.

Remember, you can help prevent diabetes by exercising for 30 minutes, 5 times a week, and by eating a healthy diet. If you are overweight, losing 10 percent of your body weight can also help.

Care1st Health Plan is a Medicare-approved HMO.

MMC.Ch3.Sect90.20-healthed-33
Approval date: 09/2010

CARE1ST HEALTH PLAN, 601 Potrero Grande Drive, Monterey Park, CA 91755, telephone 323-889-6638, 800-544-0088 (TTY 800-735-2929), *www.care1st.com*. Information in HEALTHY LIVING comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider. Models may be used in photos and illustrations.

Chief Medical Officer
Jorge Weingarten, MD

Member Services Director
Tracie Howell

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healthy living

CARE 1ST HEALTH PLAN
Your 1st Choice in Health Care

Fall/Winter 2010

Relief from common bugs

A minor illness can be a major pain. Even a simple cold can have a long list of symptoms.

You might get a stuffy nose and sore throat. You may have a headache all day.

Unfortunately, there's no fast cure for many common bugs. That's because most result from viruses.

Antibiotics can't make a cold virus go away. You just have to wait it out. Usually that means you'll be sick for one or two weeks.

But you can take steps to feel better. Here's how:

- Make sure you get lots of sleep.
- Drink plenty of fluids.
- Stay away from cigarette smoke and other air pollution.

If you have a stuffy nose, try:

- Petroleum jelly to soothe the raw area under your nose.
- Saline nasal spray for congestion.

To cut down on coughing:

- Run a humidifier.
- Inhale steam from a hot shower.

To soothe a sore throat:

- Suck on lozenges. (Don't give these to young kids.) Ice chips can help too.
- Gargle with ½ cup of warm water mixed with ¼ teaspoon of salt.

To ease an earache:

- Cover the sore ear with a warm, damp cloth.
- Try pain-relieving eardrops.

For babies 3 months and younger, call your child's provider at the first sign of illness. For an older child with a cold, see your child's provider if symptoms don't get better.

Sources: Centers for Disease Control and Prevention; National Institute of Allergy and Infectious Diseases

Member Services

Call 800-544-0088 or 800-735-2929 (TTY users) from 8 a.m. to 8 p.m., seven days a week.
www.care1st.com/ca/medicare

Free Classes

Managing your weight

To help you and your family stay healthy, we offer adult, teen and child weight-management classes at our resource center in Huntington Park.

To find out when the next series begins, please call Care1st Member Services.

Health Care Plan of California

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member news

Make your wishes known

An advance health care directive (AHCD) is a written plan that states your health care wishes in the event that you cannot speak or make decisions for yourself.

Having a written plan in place will keep your family from having to guess your wishes or make important medical decisions for you under stress.

In California, an AHCD lets you:

- Choose a health care agent. A health care agent is a person who can legally make medical decisions for you if you are unable to speak for yourself.
- Make your own health care choices in advance. You state the kind of health treatments you want or don't want to receive in any situation when you are unable to make your own decisions.

You can also state your wishes about organ and tissue donation in an AHCD.

Your doctor can give you an AHCD form and instructions.

In California, the AHCD has replaced the living will and the durable power of attorney for health care. It is the legally recognized format for stating your wishes and appointing a health care agent.

Your doctor can give you an AHCD form with instructions on how to complete it.

If you have any questions, please call our Member Services Department at **800-544-0088** (TTY 800-735-2929). Our social workers can help you fill out the form. Your attorney can also make sure your AHCD meets California legal standards.

Source: California Medical Association
H5928_11_042_HE
CMS Approved 11082010

Learn more online

You can get health information, learn more about your member benefits and learn how to file a grievance on our website, *www.care1st.com/ca/medicare*.

Information is available in various languages. Members with vision impairments can use the magnification tool on the website to make the text easier to see.

If you need this information in another format—such as Braille, large print or audio—please call Care1st Member Services at **800-544-0088** (TTY 800-735-2929) and ask for our Cultural and Linguistics Department at extension **6538**. You can also send an e-mail to thorth@care1st.com.

Care1st Health Plan is a Medicare-approved HMO.

H5928_11_062_HE
File & Use 11282010

CARE1ST HEALTH PLAN, 601 Potrero Grande Drive, Monterey Park, CA 91755, telephone 323-889-6638, 800-544-0088 (TTY 800-735-2929), *www.care1st.com/ca/medicare*.

Chief Medical Officer
Jorge Weingarten, MD

Member Services Director
Tracie Howell

Information in HEALTHY LIVING comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider. Models may be used in photos and illustrations.

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- Members will have access to the provider directory on line, which will detail physical accessibility information.
- Members will be mailed reminders for services they are due to complete

CARE1ST HEALTHPLAN

A Medicare Advantage organization with a Medicare contract

Care1st Health Plan
601 Potrero Grande Dr.
Monterey Park CA 91755
Tel 1-800-544-0088 (TTY 1-800-735-2929)
8:00 a.m. to 8:00 p.m., seven days a week

<date>

<First Name><Last Name>
<Street Address>
<City, State, Zip>
<Member ID#>

RE: Important Reminder - Preventive Screening

Dear <Member First Name> <Member Last Name>:

Care1st Health Plan wants you to have the best healthcare. Our records show that you may be missing one or more preventive screenings this year.

We have sent your PCP a complete list of the screenings or tests, which based on our records you have not had this year.

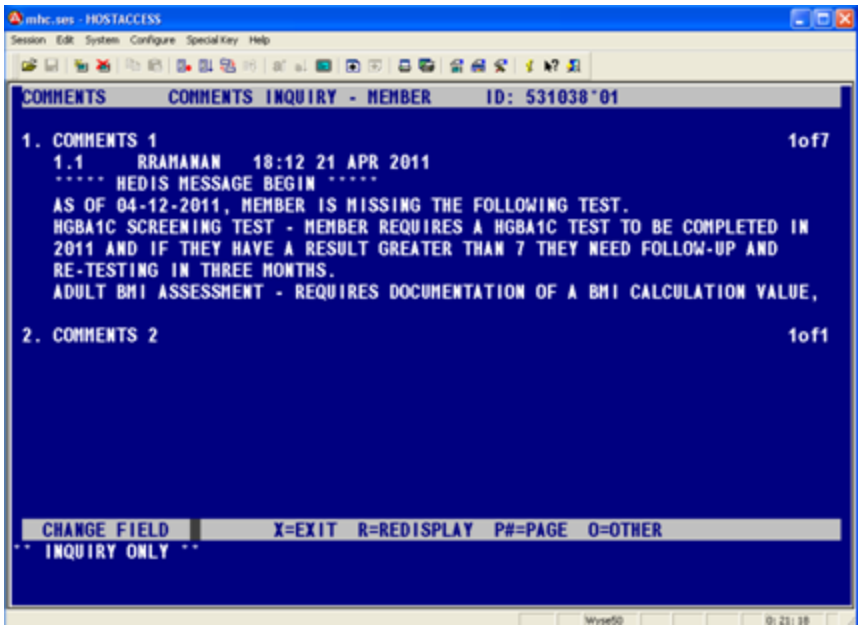
Please make an appointment with your Primary Care Physician <PCP Name> at <PCP Phone>, so you can have your screenings completed as soon as possible. Take this letter with you when you go to your PCP.

If you have any questions or need help, call Care1st Health Plan at (877) 472-4332 (TTY 1-800-735-2929).

Sincerely,

Jorge Weingarten, MD
Chief Medical Officer
Care1st Health Plan

- Member Service screens are populated with HEDIS reminder data so when they contact Care1st they will be reminded.



- Members will be mailed and informed of the contact information if they wish to request a hard copy of specific study results or information.
- Members will be mailed an acknowledgement of any grievance issue within 5 days of receipt and a closure letter within 30 days of receipt.