

**State of California
Health and Human Services Agency
Department of Health Care Services**

California's Dual Eligible Demonstration Request for Solutions Response

Submitted by



**L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, California 90017**

February 24, 2012

February 22, 2012

Toby Douglas
Director
California Department of Health Care Services
1501 Capitol Ave., 6th Fl., MS 0002
Sacramento, CA 95814



Howard A. Kahn
Chief Executive Officer

Dear Mr. Douglas,

L.A. Care is pleased to present our response to California's Dual Eligible Demonstration Request for Solutions. We are excited about the potential to deepen our 15 year partnership with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) through this opportunity to improve the quality of life and beneficiary experience for Dual Eligibles in Los Angeles County.

L.A. Care and Health Net are both submitting proposals to offer a collaborative Two-Plan Model solution for dual eligibles throughout all of Los Angeles County. The Two-Plan model has operated in Los Angeles County for nearly 15 years and provides a strong platform upon which to build a seamless, person-centered experience for dual eligibles.

The attached response is presented with the understanding that the rate development process is underway by both CMS and DHCS and that the rates paid to participating plans need to be sufficient to run the pilot as outlined. We recognize the requirement of initial savings from the demonstration but urge both CMS and DHCS to balance that need with the reality of unmet (and often unknown) need in this population especially in the area of home and community based services.

L.A. Care requests that DHCS continue to actively pursue financial risk sharing arrangements with pilot plans. Viable financial risk corridors that align the interests of the entities, coupled with adequate rates, are two factors necessary to impact the success of long term care integration and the entire demonstration more than any others.

CMS and DHCS should be commended for their interest and leadership in developing and implementing these pilots, however, we must also recognize the massive change that will be rapidly implemented in a program with a spend of over \$10 billion in Los Angeles County alone. That magnitude of change will likely result in unintended consequences. Some of these consequences can be anticipated in the structure of program participation to prevent the shift of financial risk in such a way as to undermine the stability of the participating pilot plans. We urge an incremental approach to implementation of related issues such as shifting responsibility for long term care to the plans for the population that opts out of the pilot. Further, we urge you to develop a plan for existing D-SNPs without a Medi-Cal contract (or subcontract) to enroll that population into the pilot so that their medical care is not segregated from their long term supports and services benefits.



A public entity serving Los Angeles County • 1055 West 7th Street, 10th floor, • Los Angeles, California 90017
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Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

For a Healthy Life

In closing, thank you for this opportunity to submit L.A. Care's application and we look forward to continuing our work with you on this important project.

Sincerely,

A handwritten signature in blue ink, appearing to read "Howard A. Kahn".

Howard A. Kahn



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For a Healthy Life

Applicant Name:

L.A. Care Health Plan

Date:

2/22/12

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.	X	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	X (see Att 1)	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	X	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	X	
4	Applicant has a current Medi-Cal contract with DHCS.	X	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	X	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	X	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.	X (see Att 2)	
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	X	

Signature:



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	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
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 Att 3)	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	X (see Att 4)	
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	X	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	X	
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	X	

Signature: _____



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	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	do the same, and provide an operational approach to accomplish this as part of the Readiness Review.		
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	X (see Att 5)	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	X	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.		
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	X	
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	X	

Signature:



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	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
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:

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	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	4 years	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	No	
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes (See Att 3)	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes (See Att 6)	
5	Has the Plan received NCQA certification for its D-SNP Product?	No	L.A. Care will work in good faith to seek NCQA accreditation for its D-SNP product by the end of the 3 rd year of the pilot.
6	How long has the Plan had a Medi-Cal contract?	15 years	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	dental, transportation, vision, world wide coverage
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 Att 7)	DHS, DPH, DPSS, DMH, Community and Senior Services
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	Yes (See Att 8)	Attached is a draft agreement with DPSS related to

Signature: _____



Applicant Name:

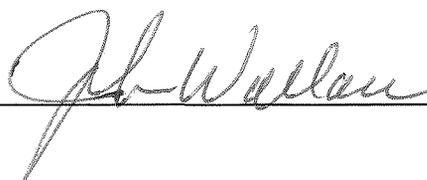
L.A. Care Health Plan

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	Criteria for Additional Consideration	Answer	Additional explanation, if needed
			provisions of health care coverage for IHSS workers
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes (See Att 9)	Attached is an MOU outlining the coordination of health and mental health services and also, an MOU for the provision of data sharing for SPD members
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	HealthCare Partners, CareMore, AltaMed, Heritage, SCAN, Kaiser, Apple Care, Facey, LA County, others

Signature: _____



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L.A. Care Health Plan

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#	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	<p>Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review.</p> <ul style="list-style-type: none"> ○ A detailed operational plan for beneficiary outreach and communication. ○ An explanation of the different modes of communication for beneficiaries' visual, audio, and 	X	

Signature:



Applicant Name:

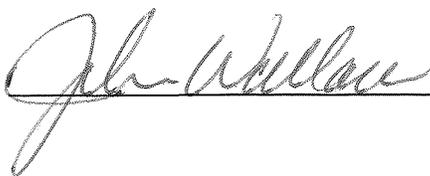
L.A. Care Health Plan

Date:

2/22/12

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
	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.		
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	

Signature:



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L.A. Care Health Plan

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#	Project Narrative Criteria	Check Box to certify YES	If no, explain
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	X	

List of Attachments:

- Attachment 1** Letter from DMHC indicating financial standing
- Attachment 2** List of sanctions and penalties taken by Medicare or CA government entity
- Attachment 3** Medi-Cal quality performance indicators (3 year trend)
- Attachment 4** SNP quality performance indicators
- Attachment 5** Stakeholder involvement and letters of community support
- Attachment 6** NCQA certificate for Medi-Cal line of business
- Attachment 7** Letter of support from the LA County Chief Executive Office
- Attachment 8** Draft agreement of County IHSS agency
- Attachment 9** MOUs with LA County Dept. of Mental Health
- Attachment 10** Duals model of care
- Attachment 11** Organizational chart
- Attachment 12** Duals Project Manager Resume
- Attachment 13** Operational workplan including timeline

Points of Contact:

John Wallace	Phinney Ahn
Chief of Staff	Special Projects Manager
L.A. Care Health Plan	L.A. Care Health Plan
1055 W. 7 th Street, 10 th Floor	1055 W. 7 th Street, 10 th Floor

Signature: 

Applicant Name:

L.A. Care Health Plan

Date:

2/22/12

Los Angeles, CA 90017

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pahn@lacare.org

Signature: _____



Executive Summary

L.A. Care has been serving Los Angeles (L.A.) County's Medi-Cal population since 1997 through a contract with the Department of Health Care Services (DHCS) to operate a Medi-Cal managed care program. With over 1 million members enrolled, L.A. Care is the largest not-for-profit Medicaid health plan in the nation and is accredited by the National Committee for Quality Assurance (NCQA). As a leader in developing new programs to improve access to and quality of care for underserved populations and to support the safety net, L.A. Care has been an advocate, and innovator, and a collaborator on behalf of low income residents in L.A. County.

L.A. Care and Health Net are both submitting proposals to offer a collaborative Two-Plan Model solution for dual eligibles throughout all of Los Angeles County. The Two-Plan model has operated in Los Angeles County for nearly 15 years and provides a strong platform upon which to build a seamless, person-centered experience for dual eligibles. L.A. Care and Health Net will build on our extensive Medi-Cal and Medicare networks and local stakeholder relationships to coordinate and streamline the full range of primary, acute, behavioral and long term services and supports needed by dual eligibles. We will build on L.A. Care's historic ties to Los Angeles County to coordinate in home supportive services (IHSS), Specialty Mental Health Services, Older Americans Act services and Adult Protective services with physical and mental health services provided through our vast and diverse network of safety net providers, health systems and specialized health plans.

Goals:

The goals of the Dual Eligibility Demonstration are:

- Improve the care experience and outcomes for dual eligibles by providing a seamless, person-centered plan of care that integrates physical health, mental health and long-term services and supports;

- Reduce the total cost of care by preventing hospital and nursing home admissions and expanding the use of home and community-based services (HCBS); and
- Integrate and improve the health system in Los Angeles County through continuous engagement with stakeholders, including members, advocates, County departments, community organizations and providers.

Integration through Care Coordination

In our model, one entity will be accountable for developing and overseeing a plan of care with a team that includes the member, primary care physician (PCP) and others based on the needs and preferences of the member, which may include family members, medical specialists, personal care workers, and social workers. Members will have one place they can call for assistance. The locus of coordination will be based on the needs of members, and the choices they make.

Projected Enrollment

L.A. County has approximately 374,000 adult dual eligibles. By the end of 2013, L.A. Care expects to have between 100,000 and 170,000 dual eligibles as members, based on our assumptions about market share and retention, given passive enrollment with an opt-out provision.

Key Partners

L.A. Care is in potential partnership discussions with a number of plans and provider organizations, including Kaiser Permanente, SCAN, AltaMed, HealthCare Partners, CareMore, and others. The County of Los Angeles is a key partner in coordinating IHSS, behavioral health, Older Americans Act services, Adult Protective services and an array of other social supports. CompCare, our NCQA-accredited behavioral health partner for our existing D-SNP members, will play an expanded role in the Demonstration. We are also actively working to build on relationships with several community-based organizations, including Multipurpose Senior Services Program (MSSP) providers, Independent Living Centers, Community-Based Adult Services (CBAS) providers,

housing organizations and Regional Centers. Finally, we are engaging advocacy and other community organizations to advise us now and throughout implementation.

Section 1 - Program Design

Section 1.1 - Program Vision and Goals

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

L.A. Care has been serving Los Angeles (L.A.) County's Medi-Cal population since 1997 through a contract with the Department of Health Care Services (DHCS) to operate a Medi-Cal managed care program. With over 1 million members enrolled, L.A. Care is the largest not-for-profit Medicaid health plan in the nation and is accredited by the National Committee for Quality Assurance (NCQA). As a leader in developing new programs to improve access to and quality of care for underserved populations and to support the safety net, L.A. Care has been an advocate, and innovator, and a collaborator on behalf of low income residents in L.A. County.

L.A. Care has operated its Medicare Advantage D-SNP program in L.A. County since January 2008 and currently has over 2,500 members enrolled, many of whom have complex, chronic health conditions and social support needs. The D-SNP is designed to coordinate all Medicare and most Medi-Cal benefits in one easy-to-use plan. The D-SNP offers a foundation to create an integrated care program for duals with one set of comprehensive benefits. L.A. Care has specially trained multilingual staff, called Health Navigators, who are dedicated to providing personalized, one-on-one services to D-SNP members, scheduling appointments, answering questions, and ensuring care is coordinated between Medi-Cal and Medicare.

L.A. Care has significant experience in managing the care of other medically and socially complex populations, such as Seniors and People with Disabilities (SPDs). The SPD and dual eligible populations largely overlap. Both have high incidences of co-morbidity, chronic conditions and social support needs. We estimate that about 30% of Medi-Cal-only SPDs transition to dual eligibility within 24 months of enrollment in Medi-Cal.

L.A. Care has enrolled over 90,000 SPDs in nine months. In the process, we have gained critical experience in coordinating care for a complex population on a large scale. L.A. Care has critical infrastructure including risk stratification and assessment processes, care management capacity, outreach and enrollment strategies for hard-to-reach populations, a large and diverse network of public and private providers, and health information technologies. We also have existing relationships with the County of Los Angeles, Regional Centers, Independent Living Centers, Area Agency on Aging, health advocacy organizations and other community-based organizations that serve dual eligibles. As we enroll an estimated 100,000 to 170,000 dual eligibles, we will need to expand our infrastructure, but will be able to build on existing capacity, relationships and knowledge to provide dual eligibles with the full continuum of medical care and social supports and services needed to maintain good health and remain in the community with a high quality of life.

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

The Dual Demonstration will enable us to strengthen and expand our service to the community that created us. L.A. Care is Los Angeles County's local initiative health plan. Its mission is to provide access to quality health care for L.A. County's vulnerable and low income communities and residents and to support the safety net required to achieve that purpose. For the last 15 years, L.A. Care has been dedicated to delivering patient-centered care and adding value to

the health care delivery system by containing costs, increasing quality of care, and maintaining stable Medi-Cal provider networks. After serving low-income parents and children (including duals who enrolled voluntarily) for nearly 15 years, we responded to the State's policy decision in 2010 to add SPDs to the mandatory managed care population. Dual eligibles are the last significant low-income population to remain largely outside our system.

As a community accountable health plan, L.A. Care has made community involvement a priority. Member advocates serve as advisors at all levels of the organization, including the Board of Governors, to which they nominate two members. We work closely with the County and will take the opportunity presented by the Duals Demonstration to more closely align our incentives with those of the County, provider systems and other stakeholders to create a more integrated and accountable system for the entire County of Los Angeles.

L.A. County is home to approximately 374,000 Duals, with an annual combined Medi-Cal and Medicare expense of over \$10 billion in 2009, or almost \$30,000 per beneficiary. L.A. County presents a tremendous opportunity to test comprehensive and accountable care at a scale sufficient to yield timely and generalizable findings on experience, quality and costs, while enabling L.A. Care to fulfill its mission and strategic vision.

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

An L.A. County pilot offers a large-scale opportunity to meet the goals of the Duals Demonstration. Our strategies for achieving each goal are summarized here.

1. Coordinating benefits and access to care, improving continuity of care and services.

In our model, care coordination will vary depending on the member's needs and the affiliation of the member's PCP, but responsibility will be clearly assigned for every member. For example, a

member whose PCP belongs to a large IPA and is medically stable will receive care coordination directly from the IPA as part of a delegated provider agreement with L.A. Care. Another member with more complex needs will receive care coordination from a care manager at L.A. Care, who will ensure communication and collaboration across physical and mental health providers and services provided through the community and County, such as Meals on Wheels and IHSS. Tiers of providers will be established based on their ability to manage care and long term support services (LTSS).

As the entity that pays for hospital and nursing home services, L.A. Care will receive notification of planned and emergency admissions to hospitals and facilities, and will immediately engage providers and family members in planning effective transitions back home and into the community whenever appropriate.

Members will receive one membership card and handbook, simplifying and consolidating their Medicare and Medi-Cal benefits. Providers will be paid by one source, eliminating the need for balance billing.

2. Maximize the ability of duals to remain in their homes with appropriate services and supports in lieu of institutional care.

Our proposed model will support beneficiaries to remain in their homes for as long as medically possible and assist them to return to their homes after an acute episode of care, or a stay in a nursing home. Our person-centered care planning process includes early detection of risks, including the risk of institutionalization. Directly or through contractors, we will conduct in-home assessments when indicated. We are considering enhancing the availability of home modification as a value-added benefit, to ensure that the need for relatively simple modifications, such as the installation of grab bars, do not become obstacles to remaining home. Our network will include an array of community organizations with experience providing in home supports, including modifications,

meals, personal care and homemaker services. We also will work with organizations that specialize in transitions out of nursing homes, both for short-stay and long-stay patients.

3. Increasing availability and access to home and community-based alternatives.

L.A. Care plans to offer value-added services that help keep people at home, such as home health visits and home-delivered meals. In addition, we plan to work collaboratively with Health Net on focused efforts to stimulate and develop the HCBS sector. Given long wait lists for MSSP and other HCBS programs, we believe that health risk assessments will identify HCBS needs that are not reflected in historical claims, and that may outstrip the capacity of existing HCBS providers. Our goal will be to reinvest savings from prevented admissions to hospitals and nursing homes into expanding the availability of HCBS.

4. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.

We will work closely with the IHSS program to assure that members are aware of self-directed LTSS options and have access to those options. We will work with the County and SEIU to develop a training and certification program for IHSS workers that strengthens the program by investing in the work force, enabling them to contribute to the integration of IHSS and medical care.

5. Improve health processes and satisfaction with care.

L.A. Care engages in continuous quality improvement processes, collecting and analyzing data from multiple sources, including claims, incident reports, member and provider satisfaction surveys and from our 11 Regional Community Advisory Committees. These are analyzed to detect systemic issues from which improvements are developed and implemented.

6. Improve coordination of and timely access to care

(Please see #1, above)

7. Optimize the use of Medicare, Medi-Cal and other State/County resources:

L.A. Care believes that the proposed model will slow the Medicare and Medi-Cal expenditure growth rate by preventing avoidable admissions to hospitals and nursing homes through the early identification of needs and delivery of low-cost community supports and services. Also care coordination that results in a reduction of duplicative testing and diagnostics will reduce costs. L.A. Care shares risk with its providers whenever possible, in the belief that care is most cost effective when plan and provider incentives are aligned.

Section 1.2 - Comprehensive Program Description

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

Two-Plan Model Countywide

The State of California will build on L.A. County's successful two-plan managed care infrastructure to offer comprehensive and coordinated Medicare and Medi-Cal services to all adult¹ dual eligibles throughout the County. Dual eligibles will have a choice of two organized, comprehensive, and accountable care delivery systems, L.A. Care and Health Net, each of which includes subcontracted health plans and risk-bearing provider groups.

Substantial Enrollment

L.A. County has approximately 374,000 adult dual eligibles. By the end of 2013, L.A. Care expects to serve between 100,000 and 170,000 of them as members, based on our assumptions about market share and retention, given passive enrollment with an opt-out provision.

¹ Los Angeles County is a California Children's Services pilot site. Therefore children will not be enrolled in the Dual Demonstration.

Key Partners

Prospective members will be attracted to our brand name and to those of our subcontracted plans and provider organizations, which may include AltaMed, HealthCare Partners, CareMore, Kaiser Permanente, SCAN and others.² The County of Los Angeles will be a key partner in coordinating IHSS, behavioral health, Older Americans Act services, Adult Protective services and an array of other social supports. CompCare, our NCQA-accredited behavioral health partner for our current D-SNP members, will play an expanded role in the Demonstration. We are also working to expand relationships with several community-based organizations, including Multipurpose Senior Service Program (MSSP) providers, Independent Living Centers, Community-Based Adult Services (CBAS) providers, housing organizations and Regional Centers.

Benefits

All existing Medicare and Medi-Cal services will be unified into a seamless benefit package for beneficiaries.³ Subject to the rates set by the Centers for Medicare and Medicaid Services (CMS) and the State, and our analysis of fee-for-service utilization data, L.A. Care is considering several possible value-added services, including dental, vision and non-emergency transportation, which we currently offer in our D-SNP. We are also considering services that will help keep people in their homes, such as home modifications (e.g., installation of ramps, grab bars, air conditioners, etc.) and home-delivered meals.

Integration through Care Coordination – A Tiered Approach

Our vision is that every dually eligible beneficiary will receive a seamless, person-centered plan of care that integrates physical health, mental health and long-term services and supports as needed. In our model, a single entity will be accountable for developing and overseeing a plan of

² We are in discussions with all of these organizations.

³ For the first year, the IHSS program will continue to be administered as it is today, while we work with stakeholders to design greater integration of the program with physical and mental health services.

care with a team that includes the member, PCP and others based on the needs and preferences of the member, which may include family members, medical specialists, personal care workers, social workers, etc.

The locus of care coordination will flow from a member's needs and choice of a PCP (or assignment, if no choice is made). In the first 18 months of the Demonstration, we expect a small percentage of our delegated plans and provider groups to meet a "Tier 1" delegation standard, which means they have capacity and experience to coordinate all services for their patients, including physical health, mental health and LTSS. A member who chooses or is assigned a PCP within a Tier 1 plan or provider group will receive all care coordination through that plan or group. For those members, L.A. Care will provide enrollment, member services, member rights oversight, provider and plan oversight, and quality improvement activities, and will manage complaints, grievances and appeals. L.A. Care will also serve as a single point of information and problem solving for any member or provider that needs information or is having difficulty accessing benefits for any reason. L.A. Care will also be a resource to delegated plans and provider groups for purposes of coordinating with IHSS and other County-administered services as the County's role in the Demonstration evolves. L.A. Care has over 15 years of experience as the responsible oversight agency.

For members who choose other plans or provider groups that do not meet Tier 1 standards, L.A. Care will play a more direct role in care coordination. These members will be assigned health navigators at L.A. Care, who will connect interdisciplinary teams and coordinate across providers of physical health, mental health, and LTSS, including the County and community-based organizations as needed. The health navigator will be the point of contact for the member, addressing any issues that arise.

L.A. Care / Health Net Collaboration

L.A. Care and Health Net will approach the Dual Eligible Demonstration in that spirit wherever it maximizes value for beneficiaries. We will maintain a healthy competition where doing so results in more choices and better value. To date, L.A. Care and Health Net have collaborated in proposing L.A. County as a two-plan county demonstration site. We have also collaborated on stakeholder engagement, holding joint meetings with the County, consumer and advocacy organizations and community-based organizations, and historically collaborated on conducting facility site reviews of provider practices.

If selected for the Demonstration, L.A. Care and Health Net will seek the Department's approval to explore opportunities to share infrastructure, where doing so will facilitate cost effective development and streamline the interface for the County, providers and community-based organizations. For example, we will collaborate on stimulating and coordinating HCBS resources. Both plans believe that HCBS, well coordinated with health services, will prevent admissions and readmissions to hospitals and nursing homes, but they are in short supply, and a collaborative effort will allow more rapid development of the sector.

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

We anticipate that capitated payments will continue to be paid by Medicare and Medicaid. However, to the extent that Demonstration rules allow, we intend to integrate financing at the health plan level. Funds will be integrated internally and L.A. Care will pay for all necessary care from a blended funding stream. Delegated plans, medical groups, and IPAs that receive risk-based payments from L.A. Care will receive a single payment, not two.

L.A. Care expects to maintain a single financial statement for the Demonstration, and to report total combined revenue and expenses for duals without regard to Medicare or Medicaid. The

Dual Eligible Demonstration will be treated as one line of business. To the extent that we require prior authorization of certain services, they will not be “Medicare” or “Medi-Cal” services, but rather “Demonstration” services, authorized based on member need, without regard to funding source.

This approach assumes that normal Medicare Advantage financial reporting rules will be waived by CMS. If L.A. Care is required to meet all existing Medicare Advantage reporting requirements, we will need to track Medicare expenditures separately, and will not be able to achieve integrated financing.

QUESTION 1.2.3 - Describe how the program is evidence-based.

The proposed model will use best practices from successful dual eligible programs nationwide to tailor the model of care to the population. Care management practices studied in the Massachusetts Senior Care Options Program and the Arizona Long Term Care System have, for example, helped L.A. Care better understand the challenges and best practices of integrating care for a population that uses a broad range of services across multiple providers.

L.A. Care will determine the needs of patients through evidence-based risk stratification and assessment tools designed for SPDs and other complex populations. Our care management model will utilize evidence-based self-management and goal setting health education curricula. For example “*Living Well with a Disability*,” is a health education workshop developed by the University of Montana and launched in L.A. County by L.A. Care in 2009, and “*Healthier Living*” based on the Stanford University/Kate Lorig self-management curriculum for people with chronic conditions that L.A. Care has offered for the last two years.

L.A. Care adopts evidence-based clinical practice guidelines promulgated by recognized sources for selected conditions identified as relevant to its membership for the provision of non-

preventive health, acute and chronic medical conditions, and for preventive and non-preventive behavioral health services. Clinical Practice Guidelines are presented for review and approval to the Physician Quality Committee (PQC), are reviewed at least every two (2) years and updated as needed. Clinical practice guidelines are disseminated to practitioners via the L.A. Care website and on a regular basis via Physician Quality Improvement Liaison Nurse (PQIL) visits. Practitioners are also informed through a practitioner newsletter when clinical practice guidelines or updates are available.

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

L.A. Care has been addressing the health care needs of underserved and culturally diverse populations for nearly 15 years. We regularly analyze and report health care outcomes by race, ethnicity and primary language spoken to identify health disparities and report results to our Quality Oversight Committee, the primary vehicle by which targeted quality initiatives and interventions are developed. In 2009, L.A. Care received the NCQA Recognizing Innovation in Multicultural Health Care Award for our program to improve health care screenings among African American women. Our efforts have increased collaboration in L.A. County by engaging the community and increasing awareness.

L.A. Care will address co-morbidities at both a population and individual level. At the population level, L.A. Care will regularly analyze the health outcomes data for our members with co-morbidities and develop systemic strategies for improvement. At the individual level, L.A. Care will convene interdisciplinary teams that have the expertise to address all facets of members' multiple conditions.

L.A. Care will provide a culturally sensitive continuum of care for diverse populations that will ensure timely access to care across cultures, thereby minimizing some disparities. L.A. Care's

call center has the capacity to handle member calls in over 100 different languages. L.A. Care also makes telephonic interpretation available to all providers. Member informing and health education materials are produced in English and Spanish and are available in other threshold languages upon request.

QUESTION 1.2.5 - Explain whether/how the program could include a component that qualifies under the federal Health Home Plans State Plan Amendment (SPA).

Given the profile of the target population, the Demonstration could incorporate one or more types of health homes under Section 2703 of the Affordable Care Act. To be eligible for the enhanced federal Medicaid match, a member would need to: a) have at least two chronic conditions; b) have one chronic condition and be at risk for another; or c) have one serious and persistent mental health condition. Nationally, the health home model of comprehensive, person-centered care coordination has been embraced as a vehicle for integrating primary and mental health care for persons with serious mental illness, and we believe this approach has promise in Los Angeles County. A growing body of research finds that persons with serious mental illness have a significantly shorter life expectancy, due in part to poor management of their co-occurring physical health conditions. The health home model could be used to test multiple approaches to integrating physical and mental health services, including providing primary care on site at mental health centers, and providing mental health services on site at primary care practices.

Although the enhanced federal matching funds would clearly benefit California, we encourage the Department to consider carefully the costs and benefits of drawing down the enhanced Medicaid match for a narrowly defined service received by a subset of Demonstration enrollees. The administrative costs of separately accounting for health home services and beneficiaries may outweigh the benefit of enhanced federal funding, and may undermine the

Demonstration's efforts to integrate funding streams, since certain services would need to be tracked specifically as Medicaid-reimbursable health home services.

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

Challenges to successful implementation include the following.

- **Integration of mental health.** Integration of mental health benefits into the Demonstration poses a particular challenge because of the historical separation of specialty mental health services (carved-out and administered by the County in accordance with State policy), other mental health services administered by health plans, and Medicare mental health services, which are limited to a more highly credentialed group of providers. For persons with serious mental illness, current structures offer little care coordination between mental and physical health providers. This area will require concentrated attention by plans, consumers, providers, the County and other stakeholders to develop integration strategies that improve coordination while being inclusive of the very broad range of providers who treat dual eligibles today. In the previous section, we suggested that the development of health home models for persons with serious mental illness could be an effective approach for pulling together a badly fragmented service delivery system. Whether through health homes or some other model, L.A. Care will convene a Mental Health Services Work Group with stakeholder representation to identify strategies for improving coordination across mental health services, and between mental and physical health services.
- **Provision of home and community-based services.** HCBS waiver programs serving the target population, including the Multipurpose Senior Services Program (MSSP), assisted living, and acute hospital waiver programs, are slated for inclusion in the Demonstration.

Given existing wait lists and the likely undetected need that exists for HCBS, a challenge will be how to expand HCBS services in the short run, before the program has had time to generate savings from administrative efficiencies, avoidable nursing home and hospital admissions. This challenge may be exacerbated by any changes that result from the Department's expected adoption of a standardized LTSS assessment process. L.A. Care strongly supports early and consistent identification of HCBS needs as a matter of equity, and as a strategy for avoiding institutional admissions whenever possible. The challenge is managing a risk that is not fully represented in historical claims. As noted earlier L.A. Care and Health Net plan to collaborate to expand and coordinate the HCBS sector. To address this problem, we urge the Department to consider pent-up, unmet need for HCBS as it develops its MediCal rates, particularly in the first year, and redirect some projected program savings into additional resources for HCBS. Also, in developing the standardized assessment process, we strongly encourage the use of an objective instrument based on activities of daily living (ADLs) and health conditions that is valid and reliable, which will make HCBS needs more predictable going forward.

- **Coordinating closely with the County without over-loading capacity.** Closer coordination among health plans, providers and County (including IHSS, Public Health, the Area Agency on Aging, Mental Health, and Adult Protective Services) promises to yield improvements in health and quality of life for dual eligibles. The challenge, especially in the first year, is to develop protocols that facilitate timely communication without overtaxing capacity. We will explore the feasibility of inter-operable electronic records for future years, and as an interim measure, L.A. Care will create a Demonstration portal to enhance communication, including referrals back and forth, and to provide a destination where a central member record can be maintained

- **Implementation timeline.** The aggressive timeline put forward by CMS and the State poses a challenge. However, L.A. Care has begun its internal planning efforts and is actively engaging stakeholders (e.g., provider groups, hospitals, advocates, etc). If pilot sites are selected no later than March 2012 as anticipated, we can build on existing relationships and expand infrastructure to successfully begin enrolling dual eligibles on January 1, 2013.
- **Timing of rate setting.** It is clearly a challenge to respond to the RFS with no indication of rates. Expectations are building in the community about value-added benefits, enhanced care coordination, provider rates, expanded HCBS and other items that will depend ultimately on the rates paid to Demonstration plans. To address this challenge, L.A. Care must be tentative in aspects of this proposal that have significant resource implications, and will recalibrate its plans as needed once rates are known.
- **Access to beneficiary data prior to enrollment.** Utilization and provider data for current dual eligibles is critical for timely health risk assessment, and for ensuring that members are linked to providers with whom they have a history. L.A. Care would like to address this issue by meeting with the Department and other health plans as soon as pilot sites are selected to review the recent experience with SPD data and develop a more effective process for receiving data on dual eligibles.
- **Maintaining a low opt out rate.** It will be challenging for the State and health plans to keep prospective members from opting out of the Demonstration. Fears about managed care are great, often fueled by providers fearful of losing patients, and the benefits of care coordination and quality oversight may not be compelling enough for some. To achieve high penetration rates, subject to adequacy of rates, L.A. Care will offer value-added benefits that consumers have consistently identified as important in their selection of Medicare

Advantage plans. These include dental, vision, and non-medical transportation. We are also

considering home modification and other services that would help people stay in their homes.

Section 2 - Coordination and Integration of LTSS

Section 2.1 - LTSS Capacity

QUESTION 2.1.1 - Describe how 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 primary goal of the Demonstration is to help members stay in their homes and communities, maximizing their autonomy and quality of life. In the current system, the medical and LTSS systems operate separately from one another. In the Demonstration, L.A. Care will be the agent that unites these two systems to produce better health outcomes and a more positive experience for members who use both. L.A. Care will use multiple strategies to achieve this.

We will employ non-clinical health navigators to serve as a single point of contact for members with LTSS needs. The navigators will be responsible for coordinating health and functional assessments, connecting with actual and virtual interdisciplinary teams based on the needs of members, and developing comprehensive, person-centered plans of care. The navigator will serve as a bridge among the PCP's practice, LTSS providers of Community Based Adult Services and HCBS waiver services, and the County, which administers IHSS, Older Americans Act services, Adult Protective Services and other LTSS. The navigator will be empowered to make referrals for in-home assessments, authorize certain home modifications (if available) such as the installation of accessibility ramps, and coordinate transitions out of hospitals and nursing homes.

The L.A. Care Member Services department will also play a key role in the coordination and provision of LTSS, as they are the primary point of contact for members and caregivers. Currently L.A. Care has a team of member services representatives with additional experience in serving seniors and people with disabilities and additional training on the specific needs of this population. They are able to handle complex questions and concerns from members, caregivers, advocates, and providers. This personalized, concierge-style service has been effective in connecting members and their agents to needed care and services.

Key to the coordination of LTSS is the ability to exchange information among plans, healthcare providers, contractors, and community agencies. As described in Sections 7.2.1 and 7.2.3., L.A. Care has been a leader in working with safety net providers to achieve meaningful use of electronic health records and information exchange. However, LTSS providers are generally not eligible for meaningful use incentives, and despite great progress, Los Angeles County may not enjoy widespread health information exchange for some time. As an interim strategy, L.A. Care will develop a portal through which all Demonstration providers will be able to contribute to a central electronic health record for each member.

Finally, L.A. Care will ensure that its provider contracts include incentives to participate in care coordination, share information, participate in transition planning to help members successfully return home, and otherwise contribute to integrated care.

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

Potential contracting relationships include:

- PASC, the Personal Assistance Services Council, the public authority that oversees IHSS in L.A. County, to support IHSS worker training and education, background checks and registry functions, and other functions as warranted;
- The IHSS program administered by the County;⁴
- The DIAL program, a program of the Westside Center for Independent Living that helps consumers return to the community after a short-term stay in a skilled nursing facility;
- Six agencies in L.A. County that have received “Money Follows the Person” funding to operate California Community Transitions programs, which help long-term residents of nursing homes return safely to the community and provides one year of support following discharge;
- Community Based Adult Services providers, that support independent living and delay or deter long term care placements; and
- The six Multipurpose Senior Services Program (MSSP) providers in L.A. County that have the experience, expertise and relationships needed to connect members to the appropriate community-based resources.

L.A. Care uses multiple reimbursement arrangements, depending on the capacity and preferences of providers. As a general principle, we strive for shared risk and other arrangements that align plan and provider incentives. However, because of the relatively small size of LTSS providers and their limited ability to share risk, a more traditional approach is often required. We use the following methods:

- A case rate, whereby the agency is paid a fee for a defined suite of services;
- A fee-for-service rate, whereby the entity submits a claim for a service provided; and

⁴ We support the State’s plan to keep the IHSS program operating as is for the first year of the Demonstration, and expect our contracting relationship to reflect that.

- A per-member per-month capitation, to include any and all services members need within a defined scope.

We will include performance incentives to the extent permitted under CMS and State rules. For example, incentives will be developed to reward agencies for helping members stay healthy and safe in their own homes, avoiding preventable hospital and nursing home admissions.

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

We currently use four steps to identify members' needs through a Health Risk Assessment process:

Step One: Stratify. We will use 12 months of paid fee-for-service claims (both Medi-Cal and Medicare) to stratify members into risk categories and prioritize those who may need intervention and support soonest. Predictive modeling programs are already in place and being utilized for SPDs. These programs use an algorithm to examine ER and hospital utilization, pharmacy utilization, and diagnosis codes to determine who is at greatest immediate risk. The effectiveness of these processes is dependent upon our receipt of complete and accurate claims records as early as possible, prior to enrollment.

Step Two: Streamline. Some dual eligibles are assessed frequently: by DPSS for IHSS hours annually, by CBAS provider sites, by MSSP providers, by physicians, by social workers at other agencies providing care and service. The multiple tools used are often duplicative and beneficiaries are subjected to repetitive and time consuming processes. For members determined by predictive modeling to be at the highest risk of adverse health outcomes, the interdisciplinary team will conduct a Health Risk Assessment using an integrated tool that assesses health, function and

psycho-social risks. The HRA will be integrated into the care management process and will be performed in the most appropriate setting and format. For example, an assessment might be completed at the member's home, in a doctor's office, at a CBAS site, or telephonically, whichever will produce the highest quality, most effective result. The tool will draw on national, standardized assessment tools and best practices for determining risk levels for dual eligibles.

Step Three: Connect. Refer and connect members to the intervention and supports that match their identified needs. For LTSS, this will often involve making referrals to County offices. We will develop communication protocols to ensure that referrals are streamlined to avoid overwhelming county capacity, and to receive information back from the County for purposes of monitoring the plan of care.

Step Four: Re-assess. Re-assess periodically, based on needs and risk profile, but at least annually or when an event such as a fall or hospital admission warrants a re-assessment. Review assessment tools and processes periodically to ensure they are responsive to changes in the health care and social service landscape, and that they incorporate new evidence-based guidelines.

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

L.A. Care has experience with a broad range of LTSS providers, including contracting and coordinating care with skilled nursing facilities; working with Intermediate Care Facilities (ICFs) and Institutes for Mental Disease (IMDs) when members transition in or out of those facilities; contracting with MSSP providers for a variety of services including care coordination; collaborating with the Personal Assistance Services Council (PASC) on several initiatives and projects, including the joint offering of health education training workshops for IHSS providers and consumers at the

L.A. Care Family Resource Center; funding and jointly offering “Living Well With a Disability” workshops with Independent Living Centers (ILCs) around L.A. County; training staff at all seven ILCs on how to navigate managed care; strong collaboration with all seven L.A. County Regional Centers, including developing models of care and coordination of services for members with intellectual and developmental disabilities and training their staff on navigating managed care.

QUESTION 2.1.5 - Describe your plans for delivering integrated care to individuals living in institutional settings. Institutional settings are appropriate settings 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?

L.A. Care intends to create a pod of LTSS expertise within its Medical Management department. Among other functions, the LTSS pod will monitor the progress of members in institutional settings, communicating closely with the member, staff at the facilities, and coordinating transitions out of facilities with family and friends, PCPs, home health and home care agencies and others as needed. The LTSS pod will also coordinate physician support, deploying contracted physicians and physician extenders to bring primary care to members in long term facilities. The LTSS pod will include a utilization management nurse, care management nurse, health navigators, and an authorization technician to facilitate DME, and will be supported by a social worker and pharmacist as needed.

The LTSS pod will also coordinate with two innovative programs here in L.A. County to ensure that short-term stays do not become long-term stays, and to help long-term residents move out. The DIAL (Deinstitutionalization Is About Living) program, run by the Westside Center for Independent Living, works with consumers as soon as they enter hospitals or skilled nursing facilities to develop and implement a plan for transitioning the individuals safely back into the community. DIAL looks at the consumer holistically, addressing needs such as housing, IHSS,

mental health and transportation, and puts the supports and services into place that enable people to leave institutional settings and return to the community. The second innovative program is California Community Transitions (CCT) which identifies consumers who have been in skilled nursing facilities for longer than 90 days but could, with the right services and support, transition back to community-based living. CCT agencies develop and implement individualized transition plans and continue to support individuals for one year after discharge. Identifying appropriate housing is a major component of CCT agencies' scope of work. The six agencies in L.A. County that operate CCT programs have extensive relationships with organizations and agencies that support independent living. L.A. Care has worked with most of the CCT agencies and will partner with them to develop effective transitions for dual eligibles.

Section 2.2 - IHSS

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

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

L.A. Care certifies the intent as described.

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

Our discussions with the IHSS program and its stakeholders will be guided by two goals: 1) Ensure that IHSS remains a strong LTSS option for persons who choose to direct their services; and 2) strengthen coordination of health and IHSS services for people who need both. We believe there are many possible models for achieving these goals and expect to engage in a robust conversation leading up to Year 2 of the Demonstration. That said, we offer the following preliminary responses to the question.

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

In the course of the Health Risk Assessment and care coordination processes, an interdisciplinary care team will identify members who could benefit from new or increased IHSS hours and will refer them to the County IHSS program for further assessment (the role of the interdisciplinary care team is described in further detail in question 3.3). A County social worker will conduct an in-home assessment and authorize IHSS services within established parameters, consistent with current practice. Unusual situations, in which needs far exceed the norm, would be brought to the interdisciplinary team for discussion and approval.

An IHSS provider is often the person who knows the member's current status, home situation and preferences better than other, more distant providers, and is often the first responder in an emergency, a co-decision maker when it comes to seeking routine or urgent care, and a person with enormous opportunity to encourage consumers to live healthy lives and participate in improving their own health. To support true person-centered care, IHSS providers will be integrated into the

members' interdisciplinary teams, with the consent and support of the members. This integration offers an opportunity to bring the social model of supports and medical care delivery system closer together. Willing IHSS providers will be trained to communicate clearly, effectively, and assertively with members of the care team regarding the member's health status. IHSS providers can help manage acute conditions prevalent in the duals population and prevent others through ensuring good nutrition, encouraging exercise, helping members manage their medication, and becoming more knowledgeable about their employers' conditions through training.

- ***A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease.***

Training will improve and expand the role of IHSS workers and teach workers how to assume health and social support roles. Training curriculum will be developed jointly by SEIU and L.A. Care and provided at the appropriate level and language of providers. Training modalities may include synchronous online, moderated training; DVD series; and standard classroom training.

The goals of the training will be two-fold. First, the training will help IHSS workers interface with the health system, thereby facilitating integration of care. Second, the training will enable IHSS workers to advance in their professions through a certification process tied to greater pay. Topics could include the following.

- *Basic Caregiving Skills:* IHSS providers will learn CPR/First Aid, IHSS system, activities of daily living (ADL), and mobility. Training will include a career advancement workshop where participants will gain a clear picture of their values, interests, and skills, and relate these to a future career goal.
- *Advanced Caregiving Skills:* Modules will include infection control, paramedical services (i.e., care of foley catheters, skin care, glucose monitoring), nutrition (i.e., diabetes diets, cultural

issues around food, food safety practices); Alzheimer’s and dementia; quality of life issues; and data collection. Training will review the most common chronic illnesses that workers are likely to encounter, including diabetes, hypertension, heart disease, depression, dementia, Alzheimer’s and asthma, and common symptoms to watch for with suggested responses for each; how to watch for changes in cognitive function and symptoms of mental health problems that might otherwise go undetected or not get addressed until advanced; how to identify and address any physical barriers in the household that may impede patients’ mobility or ability to comply with preventive measures or medication compliance (e.g., maintenance of stairs or ramps, home safety to prevent falls, working appliances).

Successful completion of this level will lead to certification.

IHSS providers are currently paid the same wage regardless of their level of expertise, the type of services they are providing, or their qualifications. L.A. Care would like to explore the feasibility of a tiered wage scale for IHSS providers who take an expanded care role by completing training and participating in interdisciplinary care teams.

- ***A plan for coordinating emergency systems for personal attendant coverage.***

L.A. Care intends to utilize the existing L.A. County substitute, short-notice/short-term coverage system. The Personal Assistance Services Council (PASC) manages a Back-Up Attendant Program (BUAP), a pool of providers identified by PASC who are experienced IHSS providers, may also be Home Health Aides (HHAs), and work on a long-term part-time basis to be on call for temporary work. PASC recruits providers for this, so any provider who wants to participate can apply, but must meet skills and experience criteria.

Section 2.3 - Social Support Coordination
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QUESTION 2.3.1 - Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

L.A. Care certifies the above.

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

As described in Section 2.1.3, member needs will be identified initially through a Health Risk Assessment that addresses health, function and psycho-social needs. The interdisciplinary care team (described in section 3) will include staff with experience and expertise in community-based services such as home-delivered meals and socialization programs. The team will track the types and number of referrals made, will follow up with members, caregivers, and agencies to ensure services are being provided, and will communicate with all stakeholders as warranted to determine if members' needs have changed or if different services are required. The interdisciplinary care team will also receive referrals from others identifying a need for social programs. These may come from PCPs, other providers, family members, and friends. The team will act on such referrals as appropriate, including making or arranging for home visits to assess the need in the person's own environment.

As noted previously, L.A. Care is considering offering home delivered meals as a value-added service. We anticipate that the undetected need for such services may outstrip the funding provided by Older Americans Act and other sources, and we believe it will be cost effective to purchase meals when they are not otherwise available. However, the determination of value-added services will be dependent on the development of State rates.

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

L.A. Care already partners with senior centers, the City and County AAAs, and all seven ILCs in L.A. County. For example, L.A. Care presents “Health in Motion” nutrition and fitness classes, free of charge, at senior centers throughout the County. We also funded “Living Well with a Disability” workshops at the ILCs, and have worked with them on multiple other projects and initiatives. While there are no formal ADRC partnerships currently in L.A. County (according to the California Community Choices program of the CA Health and Human Services Agency), the AAAs and ILCs will be instrumental in developing ADRC initiatives in the future, and we will partner with them in those efforts.

We have also coordinated with ILCs providing transition services to SPD members moving out of nursing homes, and would expect that relationship to expand as we assume responsibility for LTSS.

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

Our intent is to partner with a variety of housing related agencies, both those that provide housing services and those that engage in developing housing policy and advocacy. Partnerships with the Corporation for Supportive Housing and JWCH, Inc., a major provider of clinical and other services to homeless individuals, are well underway, and L.A. Care is looking at innovative and cost effective models of coordinating services with housing, such as locating health navigators in high-density Section 8 buildings where several members live. As mentioned previously, several

programs in L.A. County work with duals in inpatient or long-term care settings to address their housing needs. L.A. Care will also work with agencies that manage recuperative care centers to ensure that members who do not have a home to which they can be safely discharged post-hospitalization do not end up unnecessarily institutionalized. We are specifically investigating the development of transitional beds that our members could use when they are able to leave a rehab center, but not yet ready to return home.

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

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

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

L.A. Care contracts with Comprehensive Behavioral Health Care (CompCare) to provide all Behavioral Health Services to our D-SNP members and we plan to extend that relationship for the Dual Eligible Demonstration. CompCare and L.A. Care are seeking to expand the behavioral health network to include L.A. County Department of Mental Health Providers. This will expand capacity and provide access and coordination with County providers likely to be important to certain dual eligibles, including persons with serious mental illness and homeless persons.

CompCare offers high-quality behavioral health management for members. Clinicians are available via a toll-free hotline 24 hours a day, 7 days a week to assist members with accessing treatment and with setting up appointments. The Behavioral Health provider network includes qualified specialists, including board-certified geriatric practitioners. Providers are available to see

members in a timely fashion and many of the psychiatrists are available to provide consultation in nursing homes and inpatient settings within 4 hours of the request.

Since a large proportion of our current D-SNP members have co-occurring behavioral and other chronic conditions, CompCare has developed recovery-oriented programs built around effective care management and coordination between physical health and behavioral health services. CompCare operates two clinical tracts; one to address the behavioral health needs associated with older persons through an integrated treatment approach and the other a very different and intensive program for persons under 65 with major mental illness and co-occurring conditions.

L.A. Care works closely with CompCare to ensure that the behavioral health needs (including mental health and substance use treatment) of its members are met. When a behavioral health need is identified by L.A. Care in the course of a Health Risk Assessment, other care planning process, or as a result of a referral from a provider or family member, L.A. Care makes a referral to CompCare, and receives communication back from CompCare as to the status of the referral. We do not currently have “warm hand off” protocols but will develop and implement such processes with CompCare in the Dual Eligible Demonstration.

Behavioral Health Collaborative Committee (BHCC)

We collect and analyze data on the following as part of our ongoing Quality Improvement process:

- Exchange of information between PCPs and Behavioral Health Specialists;
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
- Appropriate uses of psychopharmacological medications; and
- Treatment and follow-up of members with coexisting medical and behavioral disorders.

The Behavioral Health Collaborative Committee (BHCC) is responsible for collecting and reviewing the data, and developing, implementing, and monitoring interventions to improve continuity and coordination of medical and behavioral care. The Behavioral Health Collaborative Committee includes Medical Directors from L.A. Care and CompCare in addition to clinical and non-clinical multi-disciplinary staff from both organizations. We plan to invite representatives from the County Department of Mental Health to participate on the BHCC.

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

Currently our program uses the expertise of CompCare's Medical Director, Ramsey Kiriakos. Dr. Kiriakos is a psychiatrist and well experienced in managed Behavioral Health Care. Dr. Kiriakos is available to L.A. Care and provides guidance on Quality Improvement and Medical Management issues. He is a key member of the Behavioral Health Collaborative Committee mentioned above. Dr. Kiriakos is also a member of L.A. Care's Pharmacy and Therapeutics Committee and provides formulary guidance for Behavioral Health Drugs.

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

Multidisciplinary Team Based Coordination

L.A. Care's Model of Care includes a team-based approach to care coordination through an Interdisciplinary Care Team (ICT) that meets weekly. The ICT consists of Medical Directors, Registered Nurse Care Managers, Nurse Practitioners, Clinical Pharmacists, Social Workers, Health Educators, health navigators and others, depending on the needs of the member. PCPs participate

by phone as needed. Behavioral health experts from CompCare participate for members who use or need behavioral health services. ICT meetings serve as an avenue to discuss complex needs, linkages to home and community based services for members who are high risk or whose health status has changed and require follow-up on other concerns related to utilization, level of care or other specialized services (such as members who are frail, have disabilities, have multiple chronic illnesses, may be near or receiving end of life care).

Co-location of Services

Our provider network includes various community and public health clinic sites that include co-location of physical and behavioral health services. L.A. Care is exploring an expansion of the number of sites that include co-located services, perhaps using the Medicaid health home option as a vehicle. The expansion may include additional community and public health clinics, and medical group clinics.

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

As noted in Section 1.2.6, integration of physical and behavioral health is a primary challenge of the Demonstration. If selected as a Demonstration site, L.A. Care will consider convening a Mental Health Services Work Group with stakeholder representation to identify strategies for improving coordination across mental health services, and between mental and physical health services. The Work Group will include advocates, consumers, representatives from the County Department of Mental Health, providers and others. L.A. Care will ask the Work Group for advice on identifying and prioritizing steps toward integration. Note that in addition to this Work Group dedicated to Mental Health, members and member advocates serve on 11 Regional Community Advisory Committees for L.A. Care, described in detail in Section 5.4.

Section 3.2: County Partnerships

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

As described in the previous section, L.A. Care's Behavioral Health services are provided through our partner, CompCare an NCQA-accredited Behavioral Health Plan. CompCare provides and supports benefits for individuals affected by mental illness and chronic substance abuse disorders, including those with serious conditions.

We plan to expand and strengthen the partnership among the County Department of Mental Health, CompCare and L.A. Care by including more County providers in CompCare's network, adding County representatives to our standing Behavioral Health Collaborative Committee, and convening a Mental Health Services Work Group to solicit advice from the County, consumers and advocates on improvements to the behavioral health system.

Our network currently includes community and public health clinics where behavioral health services are co-located. We see this as a promising model for integration, in that it facilitates engagement of patients at the moment of opportunity, and at a location comfortable for the patient.

We believe it is more important to engage key stakeholders in this evolution than it is to create large changes immediately. To ensure continuity of care, changes must be made with wide participation so members, advocates, families and providers are prepared for them.

QUESTION 3.2.2 - Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services

to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.

- **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.**

L.A. Care and the County of Los Angeles Departments of Mental Health (DMH) and Public Health (DPH) will continue to advance their efforts to develop systems of integration collaboratively to meet the behavioral health needs of the Duals population. Specialty Mental Health Services for the Medi-Cal population within the two plan model counties are “carved out” and in Los Angeles, are administered by DMH. While DMH is responsible for the specialty mental health benefit, L.A. Care is responsible for the basic mental health benefit (mental health conditions which are in the Primary Care Physicians’ scope of practice) for its members.

The two entities are mandated to collaborate on providing care to Medi-Cal members. A Memorandum of Understanding between L.A. Care and DMH was initiated at the outset of the licensing of L.A. Care in the 1990’s. Referral of beneficiaries between L.A. Care to DMH and from DMH to L.A. Care is common. The State of California Department of Health Care Services, responsible for overseeing the activities of the Medi-Cal Plans, mandates a functional interface between the two entities (Health Plan and DMH) for improved patient care and coordination. Medi-Cal members may also receive mental healthcare by going directly to DMH clinics throughout Los Angeles County or call the access line for triage to a mental health therapist. A similar MOU arrangement exists with the County Department of Public Health (DPH) for managing patients with substance use. L.A. Care and DMH and DPH have maintained a close working relationship, and we expect the relationship to grow in the Demonstration.

Special Collaborative Projects Between L.A. Care, County Department of Mental Health and Department of Public Health (for substance use services). In 2011, when SPDs were enrolled into managed care, L.A. Care, the County Department of Mental Health and the County Department of Public Health convened meetings with a subcommittee to develop a system for improving coordination of care between PCPs and Behavioral Health Specialists. The subcommittee discussed potential strategies to share information on the SPD population transitioning from fee-for-service to managed care with the goal of better coordinating care between physical health and mental health and ensuring continuity of care. The importance of ensuring continuity of care for transitioning SPD beneficiaries who were receiving behavioral health services was emphasized. The subcommittee developed strategies to overcome barriers to exchange information across systems:

- **Development of Information Exchange Forms:** Two separate Physical and Behavioral Health Care Coordination –Exchange of Information Forms were developed by the subcommittee. These forms are utilized by physical and behavioral health providers for the purpose of exchanging provider and beneficiary information and enhancing coordination of care for the SPD population. These forms can also be used for the Dual Eligible Demonstration.
- **Member Data Matching:** In order to ensure that the care provided to SPD enrollees of L.A. Care and DMH Medi-Cal clients is coordinated, it is necessary for L.A. Care and DMH to identify mutual clients. To that end L.A. Care and DMH have developed a Memorandum of Understanding (MOU) and process to exchange and match member data between the two entities (see Attachment 9). This matching will be expanded to include participants of the Dual Eligible Demonstration.
- **Telehealth Technology eConsult:** L.A. Care proposes to scale a proven telehealth technology, eConsult. This web-based application allows PCPs and specialists, including

behavioral health specialists, to securely share clinical information and discuss patient cases. Electronic consultation between PCPs and specialists offers improved collaboration, expands the scope of the PCP, increases efficiency of specialty care visits, and speeds resolution of patient cases. eConsult is transforming how specialty care is accessed and coordinated in Los Angeles County.

eConsult addresses gaps in specialty care by enabling PCPs and specialists to dialog, share clinical data, and coordinate care for their patients. eConsult pilot projects have shown significant reduction in unnecessary specialist face-to face visits, improved access and quality of care, and better care coordination with sustainable lower costs. L.A. Care has partnered with the L.A. County Department of Health Services (DHS) - the second largest public healthcare delivery system in the nation, HealthCare LA Independent Physician Association (HCLA), MedPOINT Management Inc. (MPM) - a management services organization, the Community Clinic Association of L.A. County (CCALAC), and L.A. County Department of Mental Health Services (DMH). L.A. Care is collaborating with its partners to implement and launch eConsult in April 2012.

Section 4 – Person-Centered Care Coordination

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

The Institute of Medicine has identified 5 elements of a person-centered approach:⁵

- Individualized service planning and delivery;

⁵ Wunderlick and Kohler, eds. *Improving the Quality of Long-Term Care*. Institute on Medicine Committee on Improving Quality in Long-Term Care. Washington, D.C.: National Academy Press, 2001.

- Participation of the person and, as appropriate, family members and others chosen by the person in service planning and delivery;
- Consideration of the person's values, culture, traditions, experiences and preferences in the definition of quality;
- Recognition and support of a person's self-care capabilities; and
- Integration of formal and informal supports.

L.A. Care believes these elements are relevant and appropriate across the broad range of health, functional and psycho-social needs represented in the dual eligible population. Our approach to care coordination incorporates these elements, beginning with development of a person-centered plan of care. The care plan incorporates the member's short- and long-term goals, diagnosis, prognosis, care needs, and barriers to attaining goals. It is developed by the care manager, in collaboration with the member, PCP, family, specialists and care-givers as appropriate. The member is involved in the development of the care plan whenever feasible. Family members, friends and/or caregivers may participate along with members, or be designated to represent members who are not able, due to conditions such as advanced Alzheimer's disease or dementia. Staff obtains consent for such representation from the member or legal representative when one exists.

Care Managers develop the initial person-centered plan of care from information provided by the member and/or the member's family member, caregiver or representative through the health risk assessment, quality of life assessment and follow-up telephone calls. Care managers must develop an initial care plan within 90 days of the initial referral and enrollment of the member into the care management program. Assessments may be completed in multiple visits with the factors of care management criteria addressed. Components of the assessment may be completed by other members of the care team and with the assistance of the member's family member or caregiver. Home visits may be conducted as needed to reach isolated members and assess social and

environmental needs. Visits may also be made to the homes of persons who live in group homes, supported apartments, assisted living and other residential settings, to get a thorough assessment of the supports provided in those settings, and to meet staff who are important to members.

The care plan includes a schedule for follow-up that includes, but is not limited to, counseling, disease management referrals, education and self-management support. Follow-up activities include specific dates on which the care management will follow up with the member. The care plan includes an assessment of the member's progress toward overcoming barriers to care and meeting goals. The care management and coordination process includes reassessing and adjusting the care plan and its goals as needed. The care plan is updated whenever there is a change in the member's major goals, level of health, formal or informal supports, or major life change, such as the death of a spouse or caregiver. To summarize, the care planning/care coordination process uses a person-centered approach by including:

- Health care needs assessment and quality of life assessment that includes information received from the member or the member's representatives;
- Individualized goals set with input from the member, care manager, participating physician(s), inter-disciplinary team, and family, friends or caregivers, as appropriate;
- Assessment of the care setting (including home) appropriate to goals, and the education and training, and community supports required to achieve the desired level of functioning/independence;
- Home visits to fully assess the member's social and environmental needs;
- Educational and other supports necessary to reach self-management goals;
- The broad range of services and supports needed to keep people out of institutional settings whenever possible, including rehabilitation, home health, home care, DME, nutritional support, psychosocial support, financial support, legal interventions and other supports; and

- Problem identification that is specific to the member's individual needs, preferences and circumstances.

L.A. Care supports self-direction of LTSS when a member wishes to self-direct and can meet the responsibilities associated with self direction. When certain long term services and supports are identified, including the need for personal care and homemaker services, development of the person-centered plan of care will include discussion of self-directed service options, including the IHSS program. When applicable, self-directed services will be included in the plan of care.

QUESTION 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 Attachment 10.

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

Primary Care Providers participate in care coordination in several ways. L.A. Care shares care plans that result from health risk assessments and results of the Patient Health Questionnaire 9 (PHQ-9) Depression Screen with medical groups, IPAs, and/or PCPs and follows up with them on any treatment or referrals that are needed as a result. PCPs participate by phone in multidisciplinary case conferences as needed.

In regard to care transitions, including admissions, discharges, or any changes in health status, L.A. Care actively engage providers by sharing the transition/treatment plan with the provider and the medical group.

Providers are contacted directly by case managers and care coordinators to collaborate on resolving any health care issues that arise.

As we expand our responsibility to include LTSS and a broader range of specialty mental health providers, we will include provisions in our contracts to ensure that providers participate in care coordination as needed, and in a manner appropriate to their level of involvement with the member. For some providers, this may mean agreeing to spend time on the phone with our care managers, while for others, it may mean participation in multidisciplinary case conferences. At a minimum, it must include sharing critical information to keep member records up to date.

Incentives will vary by provider. Many of our large provider groups have risk contracts with that already include care coordination in capitated payments. We will review those contracts to ensure they are explicit about the level of participation we expect. Many of the smaller provider groups expected to join the network lack the scale or experience to take risk. As we structure those contracts, we will explore various ways of compensating for care coordination activities. This may include hourly rates for participating in defined activities, case rates that pay a per member per month amount for a range of coordination activities, or other approaches.

IHSS workers may have no experience participating in care coordination, yet are a key link to integrating medical services with LTSS. Working collaboratively with the SEIU and the County, we would like to explore a worker training and certification program that would include participation in care coordination. (We have described this in more detail in Section 2.2.2.)

Section 5 - Consumer Protections

QUESTION 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.

L.A. Care Health Plan certifies the above.

Section 5.1 – Consumer Choice

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

Beneficiaries may choose their current doctors or clinics if the doctors or clinics participate with L.A. Care’s network. Beneficiaries may choose a new doctor from L.A. Care’s *Provider Directory*, which gives beneficiaries a listing of all medical groups, PCPs, specialists and hospitals contracted with L.A. Care, and has helpful information about each doctor and clinic. Beneficiaries may change their PCP at any time by calling Member Services.

When a beneficiary chooses a PCP, the beneficiary also selects that PCP’s medical group so it is important to know with which set or group of providers, specialists and hospitals with whom the PCP is affiliated.

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

L.A. Care believes beneficiaries who qualify for certain supports and services, such as household chores, personal care services, and accompaniment to medical appointments, should have the option of self-directing those services. Any member identified as needing such services in the course of the individualized care planning process will be informed of self-directed options and how those options may help advance the member’s life goals.

Some beneficiaries may desire to exercise the choice and control associated with self-direction, but shy away from the option because of the employer-related responsibilities, such as

confirming employment eligibility. To support members in meeting their self-direction responsibilities, L.A. Care will contract for Financial Management Services, which CMS defines as a service that assists the family or participant to: (a) manage and direct the distribution of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant by performing, as the participant's agent, such employer responsibilities as processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and (c) perform fiscal accounting and making expenditure reports to the participant and/or family and state authorities.

With regard to the IHSS program, the State currently performs some financial management services. Whether and how financial management services will change as IHSS transitions into the Demonstration will be addressed as part of the transition process.

L.A. Care believes that effective care coordination is a core service valuable to members and enables L.A. Care to improve health outcomes and quality of life. However, in the rare instance that a member wishes to waive care coordination, L.A. Care will ensure that the member is fully informed and understands the implications of such a decision.

Section 5.2 – Access

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

L.A. Care certifies the above.

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

L. A. Care proactively ensures provider compliance with access and availability standards as established by the Department of Health Care Services, Department of Managed Health Care, CMS, and other regulatory agencies. The organization conducts ongoing educational forums with providers and staff to review expectations as they relate to the timely provision of services for members. Additionally, any modifications to regulatory standards are promptly communicated to providers. Current access requirements are continually communicated by all business units who interact with providers thereby increasing opportunities for providers to maintain compliance.

L.A. Care also solicits and receives patient feedback on the accessibility, quality and timeliness of care through member satisfaction surveys and ongoing interactions with Regional Community Advisory Committee members. The data are used as a foundation for developing training programs that increase office/clinic accessibility, support provider development and ensure ability to sustain best practices in meeting access standards. L.A. Care will continue to monitor and measure the impact of provider training programs on maintaining acceptable standards of accessibility and availability for dually eligible patients.

To determine the degree to which providers are compliant with access standards, L.A. Care conducts and will continue to conduct an annual Access to Care Survey.

Every three (3) years a Facility Site Review is conducted by health plans at each PCP office site using the Physical Accessibility Review Survey provided by the DHCS. This is a process we conduct collaboratively with Health Net and other plan partners for practices in common, minimizing the burden on providers and ensuring a consistent standard of accessibility across plans. There are several critical elements which must be met for each Accessibility Indicator in order for the office to be identified as meeting the standard.

L.A. Care maintains a member page on its website to house member documents and information. Members can access current provider directory information, summary of benefits,

evidence of coverage, and pharmacy benefit information as well as other helpful information and forms.

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

L.A. Care publishes accessibility levels for each contracted provider in the L.A. Care Provider Directory. Provider Directories are sent to all new members upon enrollment with the “New Member Welcome Kit” and then annually thereafter based on member eligibility. Provider Directories are also posted on the L.A. Care website for members to access electronically. Members and prospective members can also look up individual providers on the L.A. Care website and check the accessibility of their offices. Accessibility levels are obtained through the Facility Site Review process which is completed every three (3) years.

Section 5.3 – Education and Outreach

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

L.A. Care converts written member informing and health education materials in up to ten threshold languages and alternative formats including audio, Braille, large print, web-accessible and electronic text files. For Medi-Cal and Medicare, L.A. Care sends the member handbook and accompanying documents in the member’s preferred format on an annual basis. L.A. Care provides additional materials upon request, and in a timely fashion appropriate for the format being requested. The right to receive member materials in alternative formats is incorporated into the Member Rights and Responsibilities statement.

L.A. Care will also explore holding new member orientation classes at our two Family Resource Centers, located in Lynwood and Inglewood, California. These two centers are located in communities where a high volume of L.A. Care members reside and can serve as an additional venue for effective communication. Additionally, L.A. Care has experienced success in communicating health education messages in non-traditional formats, including fotonovelas, and will continue utilizing these best practices to ensure effective communication.

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

L.A. Care uses multiple methods to meet the cultural and linguistic needs of members and to communicate with members in their own language, including translation of member informing documents into threshold languages, referral to physicians able to provide services in the member’s preferred language, use of qualified⁶ bilingual staff, vendor contracts for telephonic and face-to-face interpreting services, including American Sign Language (ASL) at medical and non-medical points of contact, and use of the California Relay Service and Plan teletypewriter (TTY) system. L.A. Care’s Member Services call center has the capability to communicate in over 100 languages.

Improvements underway include the use of translation tools such as glossaries and translation memory to improve consistency and quality of translations, ongoing promotion of interpreting services through use of translated signage and “I Speak” cards in multiple languages, and pilot testing of American Sign Language video interpreting services.

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

⁶ Qualifications of bilingual staff providing interpreting services may include, but are not limited to: written or oral assessment of bilingual skills, documentation of the number of years of employment the individual has as an interpreter, and/or documentation of completion of interpreter training and education program(s).

- **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.**

L.A. Care Health Plan certifies the above.

Section 5.4 – Stakeholder Input
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QUESTION 5.4.1 – Discuss the local stakeholder engagement plan and timeline during 2012 project development/implementation phase, including any stakeholder meetings that have been held during development of the Application.

We have engaged numerous stakeholders as we developed this application. In a collaborative process with Health Net, we reached out in a series of conference calls to consumer, advocacy, and service organizations including Neighborhood Legal Services, LA Gay and Lesbian Health Center, National Health Law Program (NHELP), Maternal and Child Health (MHC) Access, Community Clinic Association of Los Angeles County (CCALAC), Center for Health Care Rights, Armenian Social Services, Corporation for Supportive Housing, Community Health Councils, Legal Services Foundation, Independent Living Centers and MSSP programs. Discussions with these groups were held on February 10, February 14, February 17 and February 21 and included the topics of continuity of care, case management and care coordination, network adequacy and the provider network, behavioral health integration, home and community based services, IHSS, and discussions about developing a process for on-going and meaningful stakeholder and beneficiary participation throughout the demonstration project. In these calls, we shared our plans to apply as a two-plan pilot site, outlined our preliminary approach to key issues, and requested feedback.

We have also been working closely with the County of Los Angeles to design a model that achieves integration over time with County-managed services. In January, we held a full-day

collaborative kick-off meeting (L.A. Care, Health Net and several County agencies, including the Chief Executive Office, IHSS, Mental Health, Community and Senior Services, Health Services, Adult Protective and Public Health) to learn more about the array of services offered through the County and discuss how we will partner to provide comprehensive, person-centered care to L.A. County's residents. On February 9, Howard Kahn, CEO, L.A. Care, and Jay Gellert, CEO, Health Net, met with Los Angeles County CEO, Bill Fujioka, and senior staff, including Sheila Shima, Deputy CEO for Health and Mental Health, and Antonia Jiminez, Deputy CEO of Social Services, to explain the RFS and discuss ways to collaborate on LTSS and mental health services delivered by the County. In Los Angeles County, the CEO exercises executive authority over most County departments and operations, including Health Services, Mental Health, Public Social Services and Community and Senior Services. As a result of the meeting, several senior County staff was assigned to develop an approach that meets the goals of the Dual Eligible Demonstration with L.A. Care and Health Net. The County's DPSS Director and two senior executives within the County's health department serve on the L.A. Care Board of Governors, providing an ongoing avenue for close communication at the governance level.

L.A. Care met with AARP, who expressed a willingness to continue working together to ensure beneficiaries are protected during the pilot. Additionally, L.A. Care participated in a meeting with the California Association of Public Hospitals, LA County, and other health plans to discuss possible collaborative areas to better serve the duals population.

L.A. Care has also met with numerous health plans, provider systems and provider associations. Some of these meetings have been initiated by the plans and providers, seeking participation in the Demonstration network. Others have been initiated by L.A. Care in an effort to communicate its plans to key provider constituencies.

Going forward in 2012, we will continue to garner stakeholder input from Regional Centers, other community based organizations that have already been engaged during the proposal process, and other groups identified during the development process. We are specifically asking these groups for ideas on effective stakeholder processes and incorporating their feedback. Pending more input, we plan to create a joint Dual Demonstration Advisory Committee that will meet at least monthly throughout 2012 and advise both L.A. Care and Health Net on implementation of the Demonstration.

In addition, L.A. Care has eleven existing Regional Community Advisory Committees throughout the County comprised of health plan members and member advocates who serve as conduits for input on health plan operations and program design. Members of these committees today include seniors, people with disabilities, and parents and caregivers of children and adults with disabilities. As part of our development process for the Demonstration, we will continue to engage these Committee members to discuss what worked well in prior implementations and what could be improved as we implement the Dual Demonstration.

We will also continue engaging existing and prospective providers in 2012. Relative to SPD implementation, we maintain ongoing communication with providers regarding their capacity to continue accepting new members and any issues they have experienced in absorbing significant numbers of new patients into their practices. We will also be reaching out to new providers to ensure adequate network capacity in 2013. Finally, we will continue to meet with any requesting provider organization regarding capacity or any other issues.

QUESTION 5.4.2 – Discuss the stakeholder engagement plan throughout the three-year Demonstration.

We will review the membership of our 11 Regional Community Advisory Committees (RCAC) to ensure that the needs of dual eligibles are well represented and use that structure to garner ongoing input from the community. In addition, we will build on our current outreach and education efforts related to the SPD enrollment which include:

- One-on-one and group educational sessions with providers including physicians, hospitals, medical groups and IPAs, office staff, and ancillary providers currently contracted and participating in the FFS system;
- Presentations at CBOs and advocacy organizations serving dual eligibles;
- On-site health plan support at all seven Regional Centers by the L.A. Care Regional Center Liaison;
- Customized education for administrators of residential facilities (group homes) for people with developmental disabilities who are critical to the success of a coordinated care system as they make the decisions about how to seek healthcare for the people living in their facilities;
- Stakeholder meetings to ensure input from consumers and advocates;
- Contract with reputable CBOs to do additional consumer and stakeholder outreach;
- Webinars and community forums.

We expect that specific issues will be identified by L.A. Care, the RCACs, members, and others during the demonstration and will convene ad hoc work groups to address them.

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

L.A. Care will use the existing Regional Community Advisory Committee (RCAC) structure to involve external stakeholders in the development and ongoing operations of the program. We will review the membership of our 11 RCACs to ensure that dual eligible issues are well represented.

The RCACs are made up of consumers, members, and advocacy groups across Los Angeles County. RCACs were established to comply with L.A. Care's State enabling legislation and regulations governing L.A. Care. The organizational structure and procedures for the RCACs are subject to the L.A. Care bylaws. The L.A. Care Board of Governors approves RCAC membership, criteria for membership in a RCAC, and reviews feedback from the RCACs. The RCACs elect two consumer advocate representatives to the L.A. Care Board of Governors.

Function and Role: Areas where input on the may be requested include but are not limited to:

1. Improving member satisfaction with L.A. Care's provision of services;
2. Improving access to care;
3. Ensuring the provision of culturally and linguistically appropriate services and programs;
4. Identifying emerging needs in the community and establishing programmatic responses;
5. Determining and prioritizing health education and outreach programs;
6. Addressing community health concerns collaboratively; and
7. Gathering information about issues and concerns that are pertinent to the health and well-being of L.A. Care members in the region.

Membership: RCAC members consist of consumer members (including SPDs and will include dual eligibles) who get healthcare from L.A. Care or care for someone who does and consumer advocates who represent community based organizations interested in improving access and the quality of healthcare.

RCACs elect two volunteer leaders, a Chairperson and a Vice-Chairperson. In partnership with L.A. Care staff, elected RCAC leaders lead discussions, preside over business meetings and represent the RCAC at other meetings.

RCACs meet every other month on a schedule and location to be determined jointly by L.A. Care staff and the RCAC members. With guidance from the assigned Community Outreach & Education staff person, RCAC members set the date and time of each meeting.

Section 5.5 – Enrollment Process

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

We envision a passive enrollment process through which dual eligibles will be informed of their impending enrollment in the Demonstration and of their right to opt out. Similar to the transition of Medi-Cal Seniors and People with Disabilities (SPD) into managed care, we envision phasing in dual eligibles over 12 months according to birth month. Persons who first become dually eligible during 2013 and in subsequent years will be passively enrolled at the point of eligibility. L.A. Care understands CMS' preference for a uniform enrollment process coinciding with the Medicare annual enrollment process, however, the large numbers of potential enrollees in Los Angeles County may overwhelm the service delivery system if all are enrolled on January 1, 2013. Beneficiaries could still receive their notice of open enrollment in early October, but the message to dual eligibles could be tailored to explain the passive enrollment that will occur during their birth month.

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

The greatest concern with SPD implementation has been the high no choice of health plan or provider and issues associated with default enrollment. More than two-thirds of new members were not aware that they had been assigned by the State to L.A. Care nor were they necessarily aware of the mandatory transition to managed care. Improvements could also be made to informational materials sent to impacted members to ensure they are clearly identified and contain easy to understand instructions.

Members default assigned to L.A. Care phoned to complain that they had in fact completed an enrollment form. This should be addressed by ensuring adequate enrollment processing capacity. L.A. Care received thousands of default members during the last week of each month, too close to the effective date for proper member outreach. Default assignments should be provided to plans over the entire month.

Initial efforts to reach each prospective member by phone proved to be too resource intensive. Calls were lasting more than one hour and members were confused, as they were also getting calls from HCO. Anticipating this going forward, greater resources will need to be allocated to welcome calls.

Plans did not receive historical claims information prior to the effective date of enrollment. Having this information in hand for dual eligibles will facilitate member assignment and continuity of care, and should be a priority. Contact information provided was out-of-date for a significant number of new members. It is unclear what can be done to avoid this with dual eligibles, though perhaps Medicare contact information will prove to be more current than Medi-Cal information.

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

Based on L.A. Care’s recent experience with the SPD and CBAS transitions, L.A. Care seeks clarification on several processes before the pilot commences: process and timing to notify plans of enrollment whereby plans have adequate advance notice of new member assignment; process by which DHCS will identify Duals in data files; DHCS data and information provided subsequent to enrollment (claims, TARS, evaluation and assessment data, plans of care); and anticipated enrollment process, including timing of advance notices, member communications, and contact information; network adequacy standards. L.A. Care will also need historical claims data on dual eligibles in order to determine which providers to bring into our network. This data will be needed as soon as possible so that an appropriate provider network can be established.

Section 5.6 – Appeals and Grievances

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

L.A. Care Health Plan certifies the above.

Section 6 - Organizational Capacity

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

L.A. Care’s vision, mission, and values serve as our organization’s guiding principles.

- **Vision-** A healthy community in which all have access to the health care they need.

- **Mission-** To provide access to quality health care for Los Angeles County’s vulnerable and low income communities and residents and to support the safety net required to achieve that purpose.
- **Values-** We are committed to the promotion of accessible, high quality health care that:
 - Is accountable and responsive to the communities we serve and focuses on making a difference;
 - Fosters and honors strong relationships with our health care providers and the safety net;
 - Is driven by continuous improvement and innovation and aims for excellence and integrity;
 - Reflects a commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence;
 - Empowers our members, by providing health care choices and education and by encouraging their input as partners in improving their health;
 - Demonstrates L.A. Care’s leadership by active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families; and
 - Puts people first, recognizing the centrality of our members and the staff who serve them.

With over one million enrolled members, L.A. Care is the largest public health plan in America. L.A. Care has significant experience in managing the care of dual eligibles and other high-need populations, such as SPDs. As the local initiative plan, L.A. Care is committed to meeting the needs of low-income and difficult to reach populations. This Demonstration allows us to further meet our mission by adding a large, high-needs group to our membership.

QUESTION 6.2 - Provide a current organizational chart with names of key leaders.

Please see Attachment 11.

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

L.A. Care's management team has decades of combined experience in health care management and is dedicated to the project's successful implementation. Most recently, the management team led the transition of SPD members to managed care.

Howard A. Kahn, Chief Executive Officer, L.A. Care Health Plan

Howard A. Kahn is Chief Executive Officer of L.A. Care Health Plan, a position he has held since 2001. In his position as CEO, Mr. Kahn leads a coalition of over 50 community organizations that have joined together to create the Children's Health Initiative of Greater Los Angeles, an effort to provide health insurance to every low-income child in Los Angeles County. Launched in June 2004, the Initiative has successfully raised over \$100 million through a public/private partnership, and is actively enrolling children in health coverage programs. Mr. Kahn has also led efforts by L.A. Care to reinvest millions of dollars into the community, with a special emphasis on strengthening the safety net.

Mr. Kahn has more than 25 years of experience in healthcare, leading for-profit, not-for-profit and public organizations, with an emphasis on serving diverse and vulnerable populations. He served as Senior Vice President for Latin America and Global Health at CIGNA International. Mr. Kahn has also served in several capacities at Aetna, notably as a Vice President responsible for the company's global health business, and as Vice President and General Manager for Aetna's nationwide governmental managed care and managed health operations.

Mr. Kahn was Founding President and Chief Executive Officer of The California Wellness Foundation, a \$1 billion foundation whose mission is to promote health and prevent disease in underserved communities. He was also the Founding Chief Executive Officer of the Health Plan of San Mateo, a public non-profit HMO, which since 1987, has enrolled dual eligibles. Mr. Kahn serves on the boards of Charles Drew University, Cal eConnect, the Association for Community Affiliated Plans, The Good Hope Foundation, Insure the Uninsured Project, Latino Coalition for a Healthy California, Local Health Plans of California and the School of Community and Global Health at the Claremont Graduate School.

John Wallace, Chief of Staff, L.A. Care Health Plan

As Chief of Staff, Mr. Wallace is responsible for the following operating units: Administration & Strategies, which includes Communications & Marketing, Government Relations, Plan Partner Relations and Regulatory Affairs & Compliance. Additionally, Managed Care Services, which includes Member Services, Provider Network Operations, Strategic Initiatives Department, Product Operations and Claims; and Information Services report to Wallace. Prior to L.A. Care Health Plan, Mr. Wallace held a number of positions with the Los Angeles County Department of Health Services including responsibility for Communications, Government Relations, Public Policy, 1115 Waiver Office and the Public Private Partnership Program. Mr. Wallace also worked in the Administrations of Governor Pete Wilson and Los Angeles County Supervisor Don Knabe.

Elaine Batchlor, Chief Medical Officer, L.A. Care Health Plan

As Chief Medical Officer, Dr. Batchlor is responsible for the medical leadership of L.A. Care Health Plan, including the assurance of quality health care delivery to all of L.A. Care's one million plus members. She serves as chair of several groups of the organization, including the Quality Assurance and Quality Improvement Committee. She also oversees the community investment program as well as culture and linguistic services for the organization.

Dr. Batchlor is Chair of the Integrated Healthcare Association, a statewide organization that promotes the continuing evolution of managed health care under integrated systems. She is an advisory board member for the California HealthCare Foundation Leadership program, and a leader of the e-Clinic Initiative, a partnership with Kaiser Permanente and the UniHealth Foundation to integrate e-health technology into the practice of health care at community clinics. She serves on the State of California's Olmstead Advisory Committee, which advises the Secretary of Health and Human Services on the implementation of principles designed to allow people with disabilities to live in the community.

Prior to her affiliation with L.A. Care, Dr. Batchlor developed and oversaw research, policy analysis and programs aimed at improving health care financing and delivery for the California HealthCare Foundation. She was the Chief Medical Officer for Prudential Health Care of California with responsibility for all aspects of medical management for that company's managed care products in the "five states" western region. She served briefly as the Medical Director for Community Health Plan, the health maintenance organization operated by the Los Angeles County Department of Health Services. She was Service Area Medical Director for CIGNA Health Plan of California, and was also a clinical instructor at the UCLA School of Medicine.

Tim Reilly, Chief Financial Officer, L.A. Care Health Plan

Tim Reilly is Chief Financial Officer at L.A. Care Health Plan. In this role, he oversees the financial operations of the organization. He leads the strategic financial direction at L.A. Care to achieve success for its key initiatives, goals and mission. Mr. Reilly has extensive experience in both the public and private sectors, and is the industry leader in developing managed care programs for publicly funded populations.

Mr. Reilly brings to L.A. Care over 30 years of managed care administration and consulting experience. In his previous position, Mr. Reilly was a Partner and Founder of Pacific Health

Consulting Group for 22 years in Sacramento, California. He also served as Chief Financial Officer and Treasurer for four years at Health Plan of San Mateo in San Mateo, California.

He has the unique experience of being a principal in the development of all the County Organized Health Systems in California (COHSs). He was also a member of the policy team that developed and implemented the Children's Health Initiative (CHI) to provide health insurance to every child in the Santa Clara County which was then replicated in 28 other California counties.

QUESTION 6.4 - Provide a resume of the Duals Demonstration Project Manager.

Please see Attachment 12.

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

L.A. Care is governed by a 13-member board, of which two are elected by L.A. Care members. Representatives include community clinics, physicians, federally qualified health centers, hospitals, Los Angeles County and its Department of Health Services. L.A. Care's governance model is community-accountable, transparent and subject to all applicable government open-meeting requirements.

L.A. Care currently has more than one million members and a solid infrastructure to coordinate and provide quality to care to our members enrolled in Medi-Cal, Healthy Families (CHIP) and IHSS Homecare Workers coverage.

L.A. Care employs more than 600 people and intends to minimize administrative costs for this pilot by building upon existing infrastructure. Information systems, legal services, credentialing, facility site review, member communications, project management, and regulatory, contractual and financial oversight and compliance for the pilot will be performed by augmenting the existing

corporate structures with additional resources. Additionally, L.A. Care plans to build a new dedicated member services call center for the pilot. A team of specially trained representatives and health navigators, experienced call center employees serving our current members, will closely interact with pilot participants.

Section 6.2 – Operational Plan

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

Please see Attachment 13.

QUESTION 6.2.2 - Provide roles and responsibilities of key partners.

L.A. Care's key partnerships for the Demonstration reflect the rich and diverse delivery systems that exist in Los Angeles County.

Providers (including subcontracting health plans, hospitals, and medical groups)

L.A. Care has subcontracted arrangements that include other major Knox-Keene licensed health plans. L.A. Care has a comprehensive provider network that includes high quality medical groups and IPAs with advanced infrastructure for progressive care management. We are also in conversations with specialized health plans and provider groups that are not currently part of L.A. Care's network, but would like to participate in the Demonstration. Because of the size and complexity of Los Angeles County, and to promote as much integration as possible at the provider level, L.A. Care delegates care management to provider groups that are able to meet our standards. We anticipate that incorporation of LTSS will be difficult for many of our delegated provider

groups, requiring L.A. Care to play a direct role in coordinating LTSS and other social services with the medical services managed by the provider groups.

PACE

Dual eligibles enrolled in the Program of All-Inclusive Care for the Elderly (PACE) will remain enrolled in PACE unless they actively seek enrollment with L.A. Care or Health Net or choose FFS. Going forward, duals that meet the PACE enrollment requirements will still be able to join a PACE program during the pilot. In addition, L.A. Care will explore partnership opportunities with PACE sites, in which L.A. Care might purchase day center services or delegate care management to a PACE site for members who meet nursing home level of care requirements.

SCAN and Other Specialized Health Plans

We are actively exploring partnerships with SCAN, other Dual SNPs and Chronic Care SNPs operating in Los Angeles County to serve subsets of dual eligibles with specialized needs.

L.A. County

L.A. County provides several critical services used by dual eligibles and is a key partner in the Demonstration. In particular, coordination with the County's specialty mental health services and IHSS program will be critical to success. The County also administers programs funded through the Older American's Act, such as home-delivered meals, that are vital to the population. Strong links to the County's Adult Protective Services will also be important. Finally, the County maintains a network of safety net providers that are key components of L.A. Care's network.

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

Please see Attachment 13.

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

L.A. Care Health Plan certifies the above.

Section 7: Network Adequacy

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

L.A. Care has a *comprehensive* network that includes 72 hospitals and over 40 IPAs that are recognized as having advanced infrastructure for progressive care management. Within the network we maintain a roster of approximately 3,800 PCPs and 5,900 specialists. Specific to our SNP we maintain contracts with 32 IPAs and 42 hospitals within L.A. County. In addition, L.A. Care has subcontracted arrangements to serve Medi-Cal patients that include other major Knox-Keene licensed health plans. We bring an inclusive and collaborative model which we can build to even greater effectiveness, while minimizing beneficiary disruption.

In preparation for the transition of seniors and persons with disabilities (SPD), we utilized the data provided by DHCS to identify high volume providers of all specialty types, ancillary providers and facilities. Using this data, L.A. Care developed education and outreach strategies to inform providers of the transition of seniors and persons with disabilities into Medi-Cal managed care to encourage their participation. L.A. Care expanded its network of providers, with particular focus on specialty providers, tertiary care centers, DME, transportation and home health to provide for continuity of care and ensure beneficiary access. L.A. Care also expanded its skilled nursing facility network to accommodate the increased level of SNF care need by the beneficiaries. Specifically, L.A. Care's Direct Medi-Cal network expanded to include over 340 dialysis, home health, hospice, SNF, specialty pharmacy and surgery centers.

L.A. Care anticipates receiving claims data on the providers serving the dual eligible beneficiaries, and will employ similar strategies to educate providers about the Demonstration Project and encourage their participation. Some of the lessons learned from the SPD outreach include the timing of data and the importance of getting as much information to the providers in advance. Also direct face-to-face outreach to high volume providers, specifically those who have not been exposed to managed care, is critical. We also expect that frequently used ancillary providers will require orientation on understanding the impact of the Demonstration Project to their existing Medicare FFS clients and assistance in determining how they can participate. L.A. Care is prepared with provider relations and contracting staff to conduct intense outreach and recruitment to all provider types.

Dually eligible beneficiaries are similar to the SPD population in regard to their specialty needs and chronic conditions. A large proportion of dual eligibles has disabilities and lives with cognitive and mental health conditions. L.A. Care has extensive experience managing the mental health needs of beneficiaries. Through our behavioral health vendor we are able to closely coordinate the mental health and substance abuse needs of our members with their physical health needs.

Working closely with the County, we will access the network of vendors and providers used by the County for the IHSS program, specialty mental health services, Older Americans Act services and other LTSS and social supports. Over time, we will work with the County to expand the supply of needed services, particularly HCBS options for members who need LTSS.

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

L.A. Care currently uses mixed reimbursement methodologies across its Medi-Cal and D-SNP networks. L.A. Care will work with provider groups, specialized health plans and the hospitals to determine the most efficient and appropriate reimbursement methodologies for the Demonstration Project, including shared risk and full risk models. Per diem and case rates are also utilized in many of our facility agreements. L.A. Care will develop a risk stratified payment process that accounts for the acuity of the beneficiaries.

In short, L.A. Care favors payment methods that align the interests of the patients with incentives or the payers, plans and providers, but recognizes that not all providers are financially able or willing to share risk. We anticipate that as we expand our network to include HCBS and other providers used by dual eligibles, we will need to remain flexible regarding payment methods, since many will be relatively small volume providers.

L.A. Care also intends to pursue enhanced payments to providers based on performance measures that include participation in the care transitions process.

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

L.A. Care exists to serve low-income populations and has a robust network of providers who participate in the Medi-Cal managed care program. Some who have not participated in the past have been reluctant to participate based on reimbursement rates and the significant number of service and program carve-outs, such as dental, specialty mental health, CCS, Genetically Handicapped Persons Program (GHPP), and certain disease states.

The Demonstration will give L.A. Care the ability to coordinate a comprehensive continuum of services. Providers will have access to a broader set of supports for their patients, coordinated through L.A. Care. For dual eligibles, providers will also benefit from having only one payer to deal

with (L.A. Care), rather than two (Medicare as primary and Medi-Cal as secondary payer). These Demonstration benefits will make it easier to recruit providers who have previously resisted participation with Medi-Cal.

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

Every three (3) years a Facility Site Review is conducted by the Health Plan at each Primary Care Physician office site using the Physical Accessibility Review Survey provided by the Department of Health Care Services. This is a process we conduct collaboratively with Health Net and other plan partners for practices in common, minimizing the burden on providers and ensuring a consistent standard of accessibility across plans. There are several critical elements which must be met for each Accessibility Indicator in order for the office to be identified as meeting the standard.

L.A. Care has developed contractual relationships with highly experienced providers and plans that have experience treating seniors and persons with disabilities and chronic conditions. To enhance access to persons with serious mental illness, L.A. Care is working with provider groups to explore co-location of physical and mental health services in settings conducive to patient engagement.

For persons whose disabilities make it difficult to leave their homes, L.A. Care is developing a network of primary care providers capable of conducting home visits.

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

L.A. Care recognizes that a significant number of Medicare fee-for-service providers do not participate in either commercial or Medicare managed care. We will identify high volume Medicare

FFS providers from claims data provided by the DHCS and/or CMS and work jointly with our network partners to encourage participation based upon geography and capacity. We understand the importance of working with the data immediately to conduct outreach as soon as possible. Several of L.A. Care's cornerstone provider groups have already begun identifying target providers and developing recruitment strategies. We strongly believe that the foundational premise of integrating care across the continuum of health care services will offer a powerful incentive to participate. Also, clearly defining and expanding the role of the PCP as providing a medical home will drive interest in participation. We intend on developing FAQs for potential new providers and will propose a time for orientation/briefing from our provider relations staff.

L.A. Care will encourage provider participation through the promotion of a delivery system where the provider becomes an integral and significant team member in the complete health care delivery of the patient. As a result of integrating both programs, L.A. Care intends to adjust provider payments to account for the coordination of all dual benefits through one composite rate, although different negotiations will be required for certain providers. L.A. Care will make a single risk adjusted payment tailed to the unique tier of the provider.

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

L.A. Care has subcontracted arrangements that include other major Knox-Keene licensed health plans, as well as high quality medical groups and IPAs with advanced infrastructure for progressive care management. To promote as much integration as possible at the provider level, L.A. Care delegates care management to qualified provider groups that meet our standards. We anticipate that the incorporation of LTSS will be difficult for many of our delegated provider groups, requiring L.A. Care to play a direct role in coordinating LTSS and other social services with

the medical services managed by the provider groups. We also anticipate modifying our contracts to ensure that delegated provider groups have incentives to coordinate closely with L.A. Care on complex cases, including all members who use LTSS.

As previously described, L.A. Care subcontracts with CompCare to integrate behavioral and medical care. We will extend this relationship to include dual eligibles. Behavioral health services are particularly fragmented in Los Angeles County and while it has a strong potential to add value, it remains an area needing much attention. If selected as a pilot site, we plan to convene a Mental Health Services Work Group to identify key strategies for integrating physical and mental health services.

L.A. Care uses a contracted PBM, MedImpact, for the following pharmacy management functions: a broad pharmacy network to meet CMS Medicare Part D requirements, pharmacy claims payment, generation/correction of L.A. Care Prescription Drug Events (PDEs), provision of Plan Finder data for posting on the www.medicare.gov website, provision of patient-specific prescription eligibility, medication history and formulary information for e-prescriptions, implementation and maintenance of the Part D formulary that meets both CMS and state dual eligible requirements, and other tasks associated with the maintenance of our Medicare Part D program.

L.A. Care uses both concurrent and retrospective drug utilization review to identify potential pharmacy issues. Concurrent drug utilization review occurs at the point-of-sale/point-of-distribution to inform the pharmacist of potential therapeutic duplication, over-utilization, under-utilization, interactions, incorrect dosage, allergies, or clinical abuse. Retrospective drug utilization review is an ongoing periodic examination of drug claims to identify patterns of inappropriate or medically unnecessary care that may be associated with specific drugs or groups of drugs, including controlled substances, antibiotics, polypharmacy, high risk medications, and drug interactions. L.A. Care notifies prescribing providers who will evaluate members for additional medically appropriate

interventions. L.A. Care’s Pharmacy department is also expanding the retrospective review process to include the oversight of members’ adherence and persistence to select chronic medications, including diabetes, asthma, ADHD, and atypical antipsychotic medication.

L.A. Care’s clinical pharmacist is a member of interdisciplinary care team (ICT). The ICT provides guidance and support to other team members including care managers and discharge planners for medication reconciliations during members’ transitions to different levels of care. Prescribing conflicts between the PCP and psychiatrist may be identified and addressed in the weekly ICT meetings. PCPs may be called upon to attend these meetings by phone. CompCare behavioral health staff is part of the ICT and assist in addressing prescribing conflicts.

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

L.A. Care Health Plan certifies the above.

QUESTION 7.8 - Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long term care networks and readiness review and 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.

L.A. Care Health Plan certifies the above.

QUESTION 7.9 - Certify that the Plan will meet Medicare Part D. Requirements (e.g. benefits, network adequacy), and submit formularies and prescription drug event data.

L.A. Care Health Plan certifies the above.

Section 7.2 – Technology

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

Over the past five years, L.A. Care has helped providers purchase and implement a variety of health information technologies to improve efficiency and quality of care. These technologies include disease and immunization registries, e-prescribing and electronic health records. Through two previous HIT grant initiatives, L.A. Care has provided over \$4 million to help 20 community clinics implement 25 HIT projects, including ePrescribing, chronic disease management, and health information exchange systems.

HITEC-LA is a federally designated grantee operating as an L.A. Care project that serves solo, small practices, clinics and public hospitals throughout Los Angeles County in achieving meaningful use. Specifically, HITEC-LA projects assisting 3,000 priority primary care providers in achieving meaningful use of a certified EHR by April 2014. HITEC-LA seeks to transform Los Angeles County’s health delivery system to effectively use health information technology while supporting the achievement of national and local quality initiatives including the National Quality Strategy, Patient Centered Medical Homes, Accountable Care Organizations, Partnership for Patients, and Pay-for-Performance initiatives. L.A. Care was the first health plan in the nation to be designated as a regional extension center.

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

Currently, primary care and specialty physicians largely rely on paper and patients to communicate important clinical information. This inefficient system limits communication and

produces delays in specialty referrals, duplication of diagnostic testing, lack of follow-up and overall poor coordination of care. We have successfully piloted eConsult, a telecommunication process allowing physician to physician consultations. Though it will be applicable to all duals, eConsult is particularly beneficial for persons with multiple chronic conditions, including many who are at risk for nursing home admission.

An eConsult system replaces paper communication processes with a Health Insurance Portability and Accountability Act secure application through which primary care and specialty physicians can share clinical information and coordinate care for their patients. Primary care physicians use the system to transmit patient-specific clinical information and care questions to specialists. Specialists use the system to review the clinical information and provide “electronic consultations” back to the primary care physicians. When a patient needs a face-to-face specialist visit, the system can be used to process the referral request and authorization. Since the project launched in summer 2011, we have successfully tested the system with over 45 providers conducting over 1,000 eConsults and are now expanding the roll out of eConsult to other safety net providers. To date, 18 community clinics representing 48 clinic sites have expressed interest in participation.

We would also like to explore the use of in-home telehealth technologies more specifically targeted to persons at risk for nursing home admission, possibly in conjunction with a training program for IHSS workers. Working with SEIU and the County, we will explore the feasibility of certifying workers to assist in monitoring members’ health, (i.e. performing medication reconciliation, providing clinical support, monitoring key vital signs that can be transmitted remotely to PCPs).

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

L.A. Care has helped lead the development of a health information exchange in Los Angeles County and for California. L.A. Care was a founding member of Health-e-LA, the first Los Angeles area group to convene local stakeholders to promote health information exchange, and has supported a number of other efforts to develop and promote health information exchange, including the Long Beach Network for Health (now known as Western Health Information Network), Cal eConnect, California’s statewide health information exchange organization, and most recently, LANES, a regional health information exchange effort initiated by the Los Angeles County Board of Supervisors. L.A. Care also provided financial support for the State’s health information exchange planning effort which allowed the State to access \$38.8 million in federal funding for health information exchange.

L.A. Care has supported provider adoption and use of health information technology fundamental to our belief that health information technology and health information exchange are important tools for improving access, quality, and cost of health care for the communities we serve. We recognize that providers, especially safety net providers, need financial and technical support to implement and use these technologies effectively. L.A. Care’s HIT III Grant Initiative will continue critical support for important local HIT projects.

Section 8 - Monitoring and Evaluation

QUESTION 8.1 – Describe your organization’s capacity for tracking and reporting on:

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

Enrollee satisfaction is measured in several ways. An annual Consumer Assessment of Healthcare and Providers and Systems (CAHPS) survey is completed and analyzed in various committees in the quality improvement (QI) program. In addition, a complete member satisfaction

analysis is conducted annually using CAHPS results as well as grievance and appeals data compiled by issue code to provide a comprehensive picture. The member satisfaction analysis is included in the annual QI program evaluation which tracks up to 3 years of data on any given measure as standard operating procedure. Grievance and appeals data are collected and reported on by issue code quarterly as well in QI Committees.

Self-reported health status is monitored through the Health Outcome Survey conducted once a year in accordance with CMS guidelines. Some of these measures are included in the QI work plan and reported in QI committees. Additionally self-reported health status is collected during the CMS annual survey and the initial and annual care management health assessment process.

Access to care is reported and tracked quarterly through reports that are reviewed at the Quality Oversight Committee and other QI committees. In addition, an extensive annual analysis is completed and included in the annual QI program evaluation. The QI program evaluation tracks up to 3 years of data on any given measure as standard operating procedure. The access to care analysis includes member to PCP ratios, specialty care providers (SCP) to member ratios for high volume SCPs, travel distance to PCP and high volume SCPs, appointment wait times for urgent, nonurgent, preventive and routine care, access and availability of behavioral health providers and care, and access to member services.

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

L.A. Care has established processes to track encounter data collected from contracted providers for all covered services for dual eligible members. Behavioral health encounter data for duals and Medicare members is received from CompCare, our contracted behavioral health vendor. Due to the specialty mental health carve out for Medi-Cal members, and IHSS and other HCBS

provided through the County, we are working with the County to establish processes for sharing those encounters.

- **Condition-specific quality measures**

Condition specific quality measures are reported and tracked through the Healthcare Effectiveness Data and Information Set (HEDIS) measures. For example, there are multiple measures for persons with diabetes such as A1c screenings and levels, eye exams LDL screenings and levels and medical attention for nephropathy. Hypertension management and cholesterol screenings and levels are monitored through HEDIS for the population with cardiovascular diseases. Another measure is the osteoporosis management in older women. These measures and more are reported and analyzed in various QI committees. In addition, an extensive annual analysis is completed and included in the annual QI program evaluation. The QI program evaluation tracks up to 3 years of data on any given measure as standard operating procedure.

QUESTION 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):

L.A. Care is able to track and report beneficiary outcome by age, disability, ethnicity, race, gender, and English proficiency (preferred language) to the extent the information is provided in member files. However, we currently do not collect sexual identity information.

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

L.A. Care certifies the above.

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

We do not currently exchange clinical information electronically with County departments and see the need to develop capacity with them to share information efficiently and effectively. Because mental health and LTSS providers do not qualify for meaningful use incentives, federal health information technology grants will not help with this issue.

We are also interested in working with the State, SEIU, and County on the development of a voluntary training and certification program that could result in higher wages for IHSS workers who acquire skills that will enable them to assist with care integration. While L.A. Care is open to paying higher rates for more highly skilled workers, investments would need to be made in developing and implementing a training program and purchasing home technologies.

Finally, as we have noted elsewhere, we believe there are undetected HCBS needs that will overwhelm the community infrastructure once we identify those needs through the health risk assessment process. We intend to work collaboratively with the State and Health Net on a plan to make new investments in the County's HCBS sector.



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

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February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Augustavia J. Haydel
 General Counsel
 L.A. Care Health Plan
 1055 W. 7th Street
 Los Angeles, CA 90017

Re: Letter of Standing – Local Initiative Health Authority For L.A. County

Dear Mr. Haydel:

On February 7, 2012, you requested a letter regarding Local Initiative Health Authority For L.A. County's ("LIHA") standing as licensee under the Knox-Keene Health Care Service Plan Act.¹ LIHA 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, LIHA 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 3 enforcement actions involving LIHA. Of those, 2 involve grievance system violations; 1 regards compliance with the financial requirements of the Knox-Keene Act and related regulations; and zero are complaints regarding health care standards. The plan is not currently under supervision, a corrective action plan or special monitoring by the Office of Enforcement. The Office of Enforcement does not comment on past, pending, or anticipated Enforcement actions against any plan that might potentially impact its licensing with the State.

The Division of Financial Oversight ("DFO") has reviewed LIHA and LIHA 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 LIHA was issued on December 22, 2009. There were no identified deficiencies from this Routine Medical Survey. The next Routine Medical Survey is scheduled to begin May 1, 2012.

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

Please contact me with any questions or concerns.

Sincerely,



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

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Melissa Moon, Division of Licensing
Tracy Chen, Division of Financial Oversight

ATTACHMENT 2 – Sanctions and Penalties taken by Medicare or a State of California Government Entity

2011 CMS Monitoring Review (corrective action notice received February 1, 2012 and due March 31, 2012):

- ***Enrollment & Disenrollment.*** 7 elements
 - Completed Enrollment - L.A. Care did not have approved acknowledgement and confirmation letters that are consistent with current CMS models and the Medicare Marketing Guidelines.
 - Denial of Enrollment - L.A. Care did not fully and appropriately process enrollment applications, including making every effort to obtain missing information to make the request complete; must enroll beneficiaries who are eligible for enrollment and must not deny enrollment to otherwise eligible individuals.
 - Denial of Enrollment – L.A. Care must update all of its notices so that they are compliant with current CMS model notices and that it meets the timeframes for mailing of communications to beneficiaries.
 - Involuntary Disenrollment for Move Out of Service Area (Correct Identification and Appropriate Processing) – L.A. Care did not adhere to CMS requirements relating to involuntary disenrollments, as a result of the beneficiary’s move out of the plan’s service area.
 - Involuntary Disenrollment for Move Out of Service Area (Correct and Timely Processing of Transmission) - L.A. Care did not adhere to CMS requirements relating to involuntary disenrollments, as a result of the beneficiary’s move out of the plan’s service area.

- Involuntary Disenrollment for Move Out of Service Area (Appropriate and Timely Communication) - L.A. Care did not adhere to timeframes for the mailing of communications to beneficiaries.
- Involuntary Disenrollment for Loss of Special Needs Status (Appropriate and Timely Communication) - L.A. Care must update all notices to be compliant with current CMS model notices and revise its policies and procedures regarding involuntary disenrollment, as a result of loss of special needs status to provide the correct timeframe for mailing these communications to beneficiaries.
- **Marketing/Surveillance:** 1 element
 - Outbound Enrollment Verification (OEV) calls were not following the CMS approved scripts.
- **Claims:** 2 elements
 - Timely Payment of Non-Contracting Provider Clean Claims - L.A. Care did not meet the CMS compliance standard for timely payment of non-contracted provider clean claims, due in part by ineligible receipt dates.
 - Interest on Clean Claims Paid late – L.A. Care did not meet the CMS compliance standard for interest on late payments to non-contracted provider clean claims.
- **Part C Appeals and Grievances:** 5 elements
 - Adverse Standard Pre-Service Organization Determinations (Notice Content) – L.A. Care’s Notice of Denial of Medical Coverage (NDMC) was non-compliant because it included denial reasons that were too technical and the members’ Health Information Claim Number (HICN) or Social Security Number.
 - Adverse Expedited Organization Determinations (Notice Content) – L.A. Care’s NDMC contained information that is not part of the standardized notice.

- Correctly Distinguishes Between Organization Determinations and Reconsiderations – L.A. Care did not categorize cases appropriately.
- Adverse Standard Pre-Service Reconsiderations (Timeliness) – L.A. Care did not timely notify member.
- Organization Determinations and Reconsiderations Not Categorized as Grievances – L.A. Care did not categorize cases appropriately.
- ***Compliance Program:*** 2 elements
 - Written Policies, Procedures and Standards of Conduct – L.A. Care had insufficient policies and procedures for training programs.
 - Effective Lines of Communication - L.A. Care failed to take timely action upon receipt of a compliance complaint.

A copy of the full 2011 CMS Monitoring Review report can be provided upon request.

State of California Department of Managed Health Care Enforcement Actions

- **May 17, 2007 – Penalty \$2,500**
 - Violation #1368.01(a) – Failure to resolve enrollee grievance within 30 days
 - Violation #1300.68(d)(3) – Failure to resolve enrollee grievance within 30 days
- **June 16, 2009 – Penalty \$15,000**
 - Violation #1371 – Failure to pay claims timely/to pay interest on late claims/to include fee for failing to include interest
 - Violation #1371.35 – Time limits for reimbursement, contest, or denial of certain claims

- Violation #1300.71(b)(2)(A) – Failure to forward provider claim involving emergency service to capitated provider within 10 working days

- **May 2, 2011 – Penalty \$2,500**
 - Violation #1300.67.04©(F)(v) – Failure to provide notice of availability of interpretation and translation services

- **June 7, 2011 – Penalty \$1,250**
 - Violation #1367.01(h)(4) – Failure to give clear and concise explanation, criteria or guideline used, and/or clinical reasons for the Plan’s initial decision

- **June 10, 2011 – Penalty \$25,000**
 - Violation #1371 – Failure to pay claims timely/to pay interest on late claims/ to include fee for failing to include interest
 - Violation #1300.71 – Claims settlement practices
 - Violation #1300.71(a)(8)(B) – Failure to timely forward at least 95% of misdirected claims over a three month period
 - Violation #1300.71(b)(2)(A) – Failure to forward provider claim involving emergency service to capitated provider within 10 working days

L.A. Care Health Plan HEDIS 2011 Summary

A t t a

Category: Women's Health

MEASURES:

Breast Cancer Screening (BCS)
 Cervical Cancer Screening (CCS)
 Chlamydia Screening (ChI)
 Prenatal Visits
 Postpartum Screening

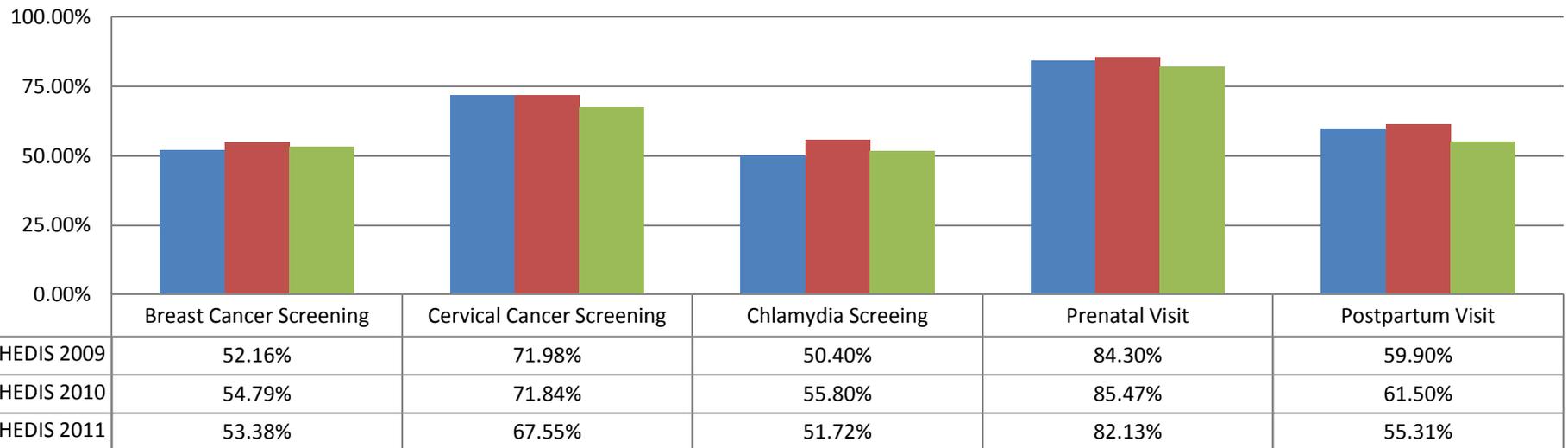
BARRIERS:

Availability of mammography screening centers
 Cultural or personal beliefs that preventive care or follow up visits are not necessary or harmful
 Too busy to go for postop check ups
 Parental disapproval of screenings for teenage daughters
 Long wait time to get screenings
 Pregnant teens are unaware of the need for prenatal visits
 Data is unavailable to the health plan because services were sought out of plan

INTERVENTIONS

Reminder calls to members and postcards
 Contracting with mobile mammography units
 Member preventive health guidelines
 Chlamydia Toolkit for providers
 Text 4baby
 Member and provider education
 Missed opportunities reports sent to providers
 Outreach for laboratory data and medical records
 RCAC CHIP program
 L.A. P4P Program
 Encounter data incentive

Trend Analysis No significant changes were noted for cervical cancer screening, prenatal visits and postpartum check-ups in 2011. Breast cancer screening dropped significantly from 2010 to 2011 because of changes in the recommendations to the US Preventive Task Force. Chlamydia screening showed a significant improvement in 2010, then returned back to the 2009 levels in 2011.



Category: Children's Health

MEASURES:

Childhood Immunization (CIS)
Well Care Visit 3-6 Yrs (W34)
Adolescent Well Care (AWC)
Weight Assessment and Counseling of Nutrition and Physical Activity for Children and Adolescents(WCC)

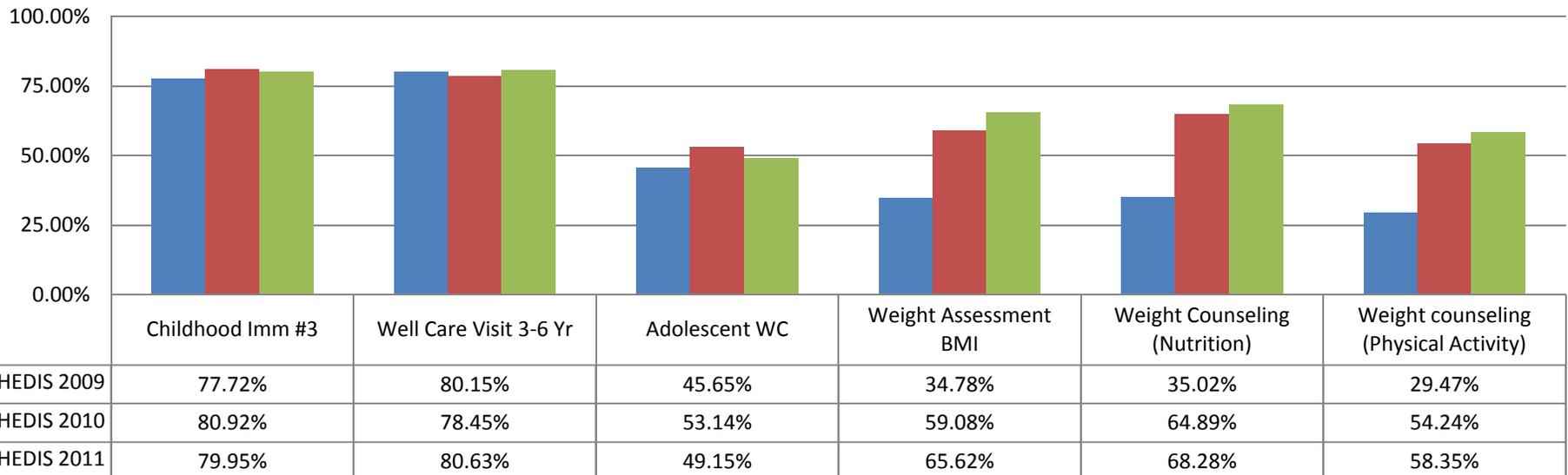
BARRIERS:

Cultural or personal beliefs that preventive care is not necessary
Misconceptions regarding immunizations
Provider documentation did not meet the HEDIS specifications for well care visits or weight assessment
CHDP program recommendations differ from American Pediatric Association requirements for well care visits

INTERVENTIONS

Member Preventive Health Guideline
Missed Opportunities Report
Provider and member education programs
L.A. P4P Program
RCAC CHIP Program
Encounter data incentive
Improved data capture through PM 160 forms and supplemental data
Physician Incentive Program

Trend Analysis No significant changes were noted for the well care visit measures and childhood immunizations between 2010 and 2011. Significant improvement was noted for the weight assessment and counseling measures from 2009 to 2010 and 2010 to 2011.



Category: Diabetic Care

MEASURES:

Retinal Eye Exam
 LDL Screening
 HbA1C Test
 Poor HbA1C Control
 Good HbA1C Control
 Medical Attention for Nephropathy (Nph)

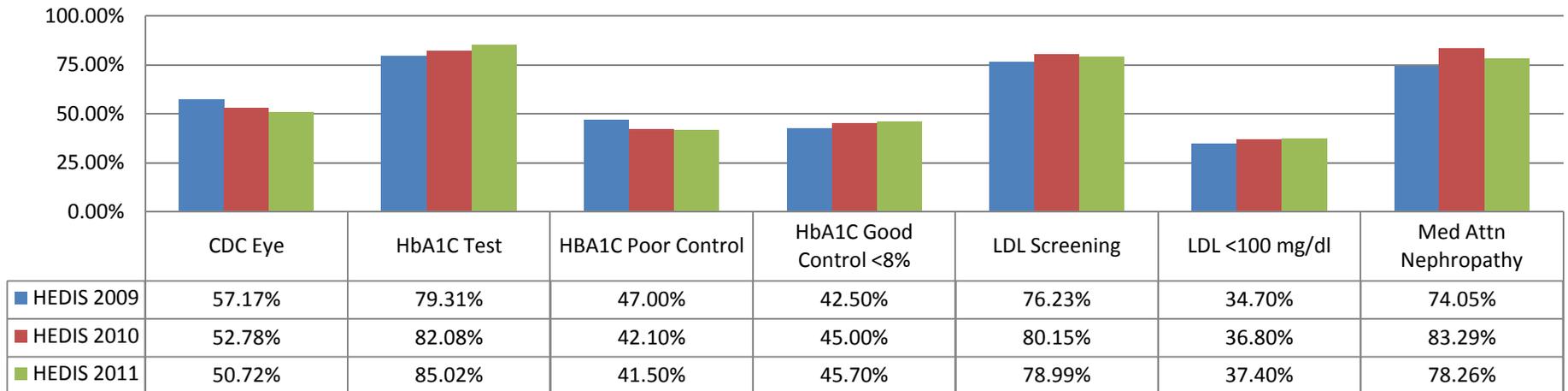
BARRIERS:

Data from specialists and eye care professional are not available
 Laboratory data is not available directly to L.A. Care because contracts are through the provider groups
 Member compliance

INTERVENTIONS:

Disease management program
 Complex case management
 Provider and Patient Education
 Missed Opportunities Report
 L.A. P4P Program
 Provider Incentive
 Data analysis
 Supplemental Lab data request from provider groups

Trend Analysis No significant changes were noted between 2010 and 2011. The HbA1C good control (<8%) results between 2009 and 2011 show significant improvement over the three-year period.



Category: Antibiotic Use

MEASURES:

Avoidance of Antibiotic Therapy for Adults with Acute Bronchitis
 Appropriate Treatment for Children with Upper Respiratory Infection
 Appropriate Testing for Children with Pharyngitis

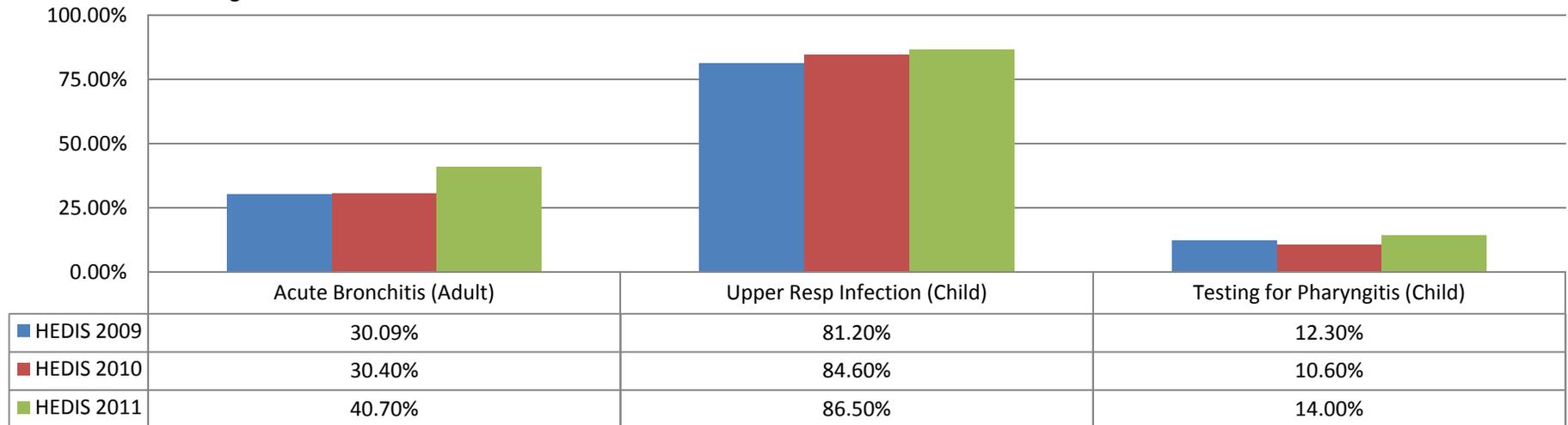
BARRIERS:

Provider practice
 Member expectation
 Payment issues for lab tests (testing for streptococcus)
 Incomplete diagnosis code list

INTERVENTIONS:

Provider education
 RCAC CHIP program
 Monitoring of antibiotic use
 L.A. P4P
 Provider incentives
 Supplemental lab and pharmacy data
 Medical record analysis (to identify a more comprehensive list of diagnosis)

Trend Analysis: All three antibiotic related measures show significant improvements between 2010 and 2011. The acute bronchitis measure reached the 90th percentile. In spite of the gains made with the pharyngitis measure, results are still below average



Category: Chronic Conditions

MEASURES:

Cholesterol Management
 Control of High Blood Pressure
 Use of Appropriate Medications for People with Asthma
 Use of Imaging Studies for Low Back Pain

BARRIERS:

Member non-compliance
 Provider practice
 Emergency room use

INTERVENTIONS:

Disease management (Asthma)
 Provider and Member Education
 L.A. P4P
 Provider Incentives
 Complex Case Management

Trend Analysis: Trends indicate a steady three-year trend for cholesterol management, high blood pressure and low back pain management. A significant drop was noted for use of appropriate medications for people with asthma from 2009 to 2011.



	Cholesterol Management	High Blood Pressure	Asthma Medications	Low Back Pain
■ HEDIS 2009	85.30%	58.25%	87.96%	78.80%
■ HEDIS 2010	88.83%	62.17%	86.12%	79.60%
■ HEDIS 2011	85.99%	62.56%	84.88%	80.20%

Summary

- **Significant improvement for 3 Indicators:**
 - Avoidance of Inappropriate Use of Antibiotics in Adults with Acute Bronchitis
 - Appropriate Testing for Pharyngitis
 - Appropriate Treatment for Children with URI
- **High performance level (HPL) or 90th Percentile for 5 Indicators:**
 - WCC (BMI)
 - WCC (Nutrition)
 - WCC (Physical)
 - Avoidance of Inappropriate Use of Antibiotics in Adults with Acute Bronchitis
 - Beta Blocker Treatment after a Heart Attack
- **Significant decline for 3 indicators:**
 - Breast Cancer Screening
 - Appropriate Medications for People with Asthma
 - Chlamydia Screening
- **Low performance level (MPL) or Below the 25th Percentile for 4 Indicators:**
 - Postpartum Screening
 - Appropriate Medications for People with Asthma
 - Use of Spirometry Testing and Diagnosis of COPD
 - Appropriate Testing for Pharyngitis



HEDIS 2011

MEDICARE – SNP PERFORMANCE RESULTS

For a Healthy Life

HEDIS 2011 Medicare Highlights for L.A. Care



- The majority of Medicare measures could not be reported due to small sample size (less than 30 eligible members)
- 2011 is the first HEDIS reporting year for the SNP program due to membership
-

SNP-Medicare Results



Care for Older Adults (coa)	
Advance Care Planning	12.17%
Medication Review	66.91%
Functional Status Assessment	27.49%
Pain Screening	1.22%

- Comprehensive management of pain screening was not well documented

SNP-Medicare Results



Effectiveness of Care: Prevention and Screening	
<i>Adult BMI Assessment (aba)</i>	1.89%
<i>Breast Cancer Screening (bcs)</i>	37.35%
<i>Colorectal Cancer Screening (col)</i>	34.42%
<i>Glaucoma Screening in Older Adults (gso)</i>	24.05%

- Results were based on administrative results

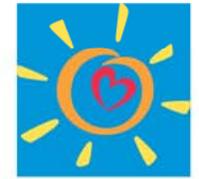
SNP-Medicare Results



Effectiveness of Care: Diabetes	
Comprehensive Diabetes Care (cdc)	
<i>Hemoglobin A1c (HbA1c) testing</i>	63.64%
<i>HbA1c Poor Control (>9.0%)</i>	71.29%
<i>HbA1c Control (<8.0%)</i>	19.14%
<i>Eye Exam (Retinal) Performed</i>	25.36%
<i>LDL-C Screening Performed</i>	64.11%
<i>LDL-C Control (<100 mg/dL)</i>	21.05%
<i>Medical Attention for Nephropathy</i>	87.56%

- Results were based on administrative results
- Blood pressure results were not reported for diabetes

SNP-Medicare Results



L.A. Care
HEALTH PLAN®

Effectiveness of Care: Medication Management	
Annual Monitoring for Patients on Persistent Medications (mpm)	
<i>ACE Inhibitors or ARBs</i>	55.75%
<i>Digoxin</i>	NR<30
<i>Diuretics</i>	55.74%
<i>Anticonvulsants</i>	NR<30

- Results were based on administrative results

ATTACHMENT 5 - Stakeholder Involvement

Applicants 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, Applicants must certify that 3 of the following 5 are true:

1. The Applicant has at least one dual eligible individual on the board of directors of its parent entity or company.
2. 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).
3. 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.
4. 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.
5. The Applicant has conducted a program of stakeholder involvement (with the Applicant providing a narrative of all activities designed to obtain community input.)

L.A. Care certifies that numbers 2, 3, and 5, as mentioned above, are true.

(2) Advisory board of dually eligible consumers

L.A. Care will set up a consumer advocate committee/advisory board made up of dually eligible consumers reporting to the Board of Governors. This committee/Board will oversee and provide guidance for the coordination partnership and progress toward integration amongst other relevant issues.

(3) Letters of support

Letters of support from the community are attached.

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

L.A. Care has engaged many stakeholders as we developed this application. In a collaborative process with Health Net, we reached out with a series of conference calls to consumer, advocacy, and service organizations including Neighborhood Legal Services, LA Gay and Lesbian Health Center, NHELP – National Health Law Program, MCH Access, CCALAC – Community Clinic Association of Los Angeles County, Center for Health Care Rights, Armenian Social Services, Corporation for Supportive Housing, Community Health Councils, Legal Services Foundation and the Independent Living Centers. Discussions with these groups were held on February 10, February 17 and February 21 and included the topics of continuity of care, case management and care coordination, network adequacy and the provider network, behavioral health integration, home and community based services, IHSS as well as how to develop a process for on-going and meaningful stakeholder and beneficiary participation throughout the demonstration project. In these calls, we shared our plans to apply as a two-plan pilot site, outlined our preliminary approach to key issues, and requested feedback.

We have also been working closely with the County of Los Angeles to design a model that achieves integration over time with County-managed services. In January, we held a full-day collaborative kick-off meeting (L.A. Care, Health Net and several County agencies, including the Executive Office, IHSS, Mental Health, Community and Senior Services, Health Services, Adult Protective and Public Health), in which we learned more about the array of services offered through the County and began discussing how we will partner to provide comprehensive, person-centered care to L.A. County's residents. On February 9, Howard Kahn and Jay Gellert met with Los Angeles County CEO Bill Fujioka and senior staff, including Sheila Shima, Deputy CEO for Health and Mental Health, and Antonia Jiminez, Deputy CEO of Social Services, to explain the RFS and discuss ways to collaborate on LTSS and mental health services delivered by the County. In Los Angeles County,

the CEO exercises executive authority over most County departments and operations, including Health Services, Mental Health, Public Social Services and Community and Senior Services. As a result of the meeting, several senior County staff was assigned to develop an approach that meets the goals of the Duals pilot with L.A. Care and Health Net. The County's Health Director serves on the L.A. Care Board of Governors, providing an ongoing avenue for close communication at the governance level.

L.A. Care met with AARP, who expressed a willingness to continue working together to ensure beneficiaries are protected during the pilot. Additionally, L.A. Care participated in a meeting with the California Association of Public Hospitals, LA County, and other health plans to discuss possible collaborative areas to better serve the duals population.

L.A. Care has also met with numerous plans, provider systems and provider associations. Some of these meetings have been initiated by the plans and providers, seeking participation in the Demonstration network. Others have been initiated by L.A. Care in an effort to communicate its plans to key provider constituencies.

Going forward in 2012, we will continue to garner stakeholder input from Regional Centers, other community based organizations that have already been engaged during the proposal process, and other groups identified during the development process. We are specifically asking these groups for their ideas on what makes an effective stakeholder process, and are open to their suggestions.

Pending more input from them, we plan to create a joint Dual Demonstration Advisory Committee that will meet at least monthly throughout 2012 and advise both L.A. Care and Health Net on implementation of the Demonstration.

In addition, L.A. Care has 11 existing Regional Community Advisory Committees throughout the County, comprised of health plan members and member advocates, that serve as conduits for input on health plan operations and program design. Members of these committees today include seniors, people with disabilities, and parents and caregivers of children and adults with disabilities. As part of our development process for the Demonstration, we will engage these members to learn what worked well in prior implementations, and what could be improved as we implement the Dual Demonstration.

We will also continue engaging existing and prospective providers in 2012 and are committed to using the stakeholder feedback received to guide future program design. Relative to SPD implementation, we maintain continuous communication with providers regarding their capacity to continue accepting new members, and any issues they have experienced in absorbing significant numbers of new patients into their practices. We will also be reaching out to new providers to ensure adequate network capacity in 2013. Finally, we will continue to meet with any provider organization that initiates contact with us to hear about their capacity and let them know what capacity we believe is needed to serve dual eligibles effectively.



February 17, 2012

Mr. John Wallace
L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear John:

On behalf of CareMore, I am expressing our interest and willingness to join with L.A. Care Health Plan in the planning of the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). While there are many details of our participation to be worked out, we are committed to collaborating with L.A. Care in this new endeavor.

CareMore has made significant advances in medical, social, functional, and psychological care of chronically ill and frail population. We are extremely enthusiastic about bringing these capabilities to our partnership to improve care and for the dual eligible population in Los Angeles County and protect precious financial resources of California and the federal government. We look forward to working closely with L.A. Care on the Dual Eligible Demonstration Pilot to achieve greater coordination of benefits, access to care and improved health outcomes for our clients and the many other dual eligibles in Los Angeles County.

Please feel free to contact me at (562) 622-2813 regarding this letter of support.

Sincerely,

Leeba Lessin
President
CareMore Health Plan



Dedicated to the well-being and the respectful, compassionate healing of our patients and our communities

February 14, 2012

Mr. John Wallace
Chief of Staff
LA Care
1055 W. 7th St., 10th floor
Los Angeles, CA. 90017

Re: Letter of Commitment for Dual Eligible Demonstration Pilot – Los Angeles County

Dear Mr. Wallace:

On behalf of HealthCare Partners Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with LA Care. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with LA Care toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible Pilot Program, as a provider in the LA Care network, will require that we comply with all of the requirements and regulations established by DHCS and CMS specifically for this pilot program.

HealthCare Partners is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with LA Care on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (310) 354-4221 regarding this letter of commitment and support.

Sincerely,

A handwritten signature in black ink, which appears to read "Robert Margolis, MD". The signature is fluid and cursive.

Robert Margolis, MD
CEO
HealthCare Partners, LLC



1055 Wilshire Blvd., Suite 1400
Los Angeles, CA 90017
(213) 201-6500
(213) 250-2525 FAX
www.ccalac.org

MEMBER CLINICS:

All for Health, Health for All, Inc.
AltaMed Health Services Corporation
American Indian Healing Center, Inc.
Arroyo Vista Family Health Center
Asian Pacific Health Care Venture
Central City Community Health Center
Chinatown Service Center Family Health Clinic
City Help Wellness Center
Clinica Mr. Oscar Romero
Community Health Alliance of Pasadena
Comprehensive Community Health Centers, Inc.
East Valley Community Health Center, Inc.
Eisner Pediatric & Family Medical Center
El Proyecto del Barrio Family Health Care Clinic
Family Healthcare Centers of Greater LA
Garfield Health Center, Inc.
Harbor Community Clinic
Herald Christian Health Center
Jeffrey Goodman Special Care Clinic
JWCH Institute, Inc.
Korean Health, Education, Info & Research Cntr
Los Angeles Christian Health Centers
Meet Each Need with Dignity (MEND)
Mission City Community Network, Inc.
Northeast Community Clinic
Northeast Valley Health Corporation
Our Saviour Center/Cleaver Family Wellness Clinic
Planned Parenthood Los Angeles
QueensCare Family Clinics
St. John's Well Child & Family Center
South Bay Family Healthcare Center
South Central Family Health Center
Saint Anthony Medical Centers
Tarzana Treatment Center, Inc.
T.H.E. Clinic, Inc.
The Children's Clinic, Serving Children & Their Families
The Saban Free Clinic
UMMA Community Clinic
URDC/Bill Moore Community Health Clinic
Valley Community Clinic
Venice Family Clinic
Watts Healthcare Corporation
Westside Family Health Center
Westside Neighborhood Clinic
Wilmington Community Clinic

The Voice For Access To Quality Health Care

February 22, 2012

Mr. Howard Kahn
CEO
L.A. Care
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

RE: *Dual Eligible Demonstration Pilot Program – Letter of Support*

Dear Howard:

On behalf of the community health center members of the Community Clinic Association of Los Angeles County (CCALAC), I am excited about the opportunity to support L.A. Care Health Plan in the planning and implementation of the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS).

Our members have worked hard to successfully implement the transition of Seniors and People with Disabilities into managed care over the last several months. We have learned so much that will be useful as the dual eligibles transition into managed care during this demonstration project. We believe that our comprehensive primary care services coupled with our collaboration with L.A. Care will only strengthen services to these additional individuals.

We look forward to working in close partnership with L.A. Care on the Dual Eligible Demonstration Pilot to achieve greater coordination of benefits, access to care and improved health outcomes for our clients and the many other dual eligibles in Los Angeles County.

Please feel free to contact me regarding this letter of support. I can be reached via email at lmccarthy@ccalac.org or by calling (213) 201-6500.

Sincerely,

Louise McCarthy, MPP
President & CEO



Heritage Provider Network

February 22, 2012

Mr. Howard Kahn
Chief Executive Officer
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, California 90017

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Mr. Kahn:

On behalf of Heritage Provider Network, Inc. (HPN), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with LA Care to provide services on a full-risk basis. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with LA Care toward a successful conclusion. This commitment does not preclude HPN from seeking direct participation in Dual Eligible Demonstration Pilots or partnering with other organizations selected to participate in the Pilot.

HPN is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with LA Care on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (916) 295-4069 regarding this letter of commitment and support.

Sincerely,

Richard Martin
Vice President
Heritage Provider Network, Inc.
(916) 295-4069
rmartin@heriatgemed.com



Services Center for Independent Living

www.scil-ilc.org

February 17, 2012

Howard Kahn, CEO,
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

Dear Mr. Kahn,

I am pleased to add this letter of support to the others expressing interest and willingness to join with L.A. Care Health Plan in the planning of the Dual Eligible Demonstration Pilot for Los Angeles County. These are challenging times and, as one of the agencies in L.A. County mandated to keep persons with disability connected with programs and services, partnering with L.A. Care serves the best interests of all the involved parties. While there are many details of our participation to be worked out, I and my staff are committed to collaborating with L.A. Care in this new endeavor.

We look forward to working closely with L.A. Care on the Dual Eligible Demonstration Pilot as a community partner to achieve greater coordination of benefits, access to care, and improved health outcomes for our consumers and the many other dual eligibles in Los Angeles County.

Please feel free to contact me at (909) 645-6298 regarding our commitment to this project.

Sincerely,

LeRoy Wm. Nattress, Jr., Ph.D.
Executive Director and Chair
The San Gabriel Valley Disabilities Collaborative

107 South Spring Street
Claremont, California 91711
(909) 621-6722
VP: (909) 962-7035
FAX: (909) 445-0727

1520 West Cameron Avenue
Suite 160
West Covina, California 91790
(626) 337-8868
FAX: (626) 337-1835

Advocating for Inclusion, Access, and Self-Determination, on behalf of Persons with Disability



{ A family of services.
A family that serves.

February 17, 2012

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

Dear Mr. Douglas:

Jewish Family Service of Los Angeles (JFS) would like to offer our support for LA Care's proposal to DHCS to participate in California's Dual Eligibles Demonstration Program in partnership with HealthNet. As the largest Los Angeles County Medi-Cal Managed Care providers, their participation will help ensure the pilot's successful demonstration of how to improve outcomes and care coordination for California's frail and vulnerable populations while reducing unnecessary costs.

LA Care has a longstanding commitment to provide access to quality health care for Los Angeles County's vulnerable and low income communities and residents and to support the safety net required to achieve that purpose. Their active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families well positions them for this project.

JFS was one of the original pilot sites for the groundbreaking Multipurpose Senior Services Program (MSSP) which provides comprehensive, professional nursing, social work, and clinically driven direct services to the frailest elderly so they may remain safely at home. Through a statewide network of providers, MSSP has reduced overall health services costs while enhancing quality of life for medically fragile, nursing home-eligible seniors for more than 30 years. For more than 157 years, JFS has provided compassionate social services to all in need regardless of age, ethnicity, religion or ability to pay. JFS counsels families, supports the elderly, houses the homeless, feeds the hungry, assists the disabled and empowers survivors of violence.

We are hopeful that LA Care and HealthNet will be selected to participate and look forward to partnering with them in California's Dual Eligibles Demonstration Program. If you have any further questions, please contact me at 323-761-8800 and pscastro@jfsla.org.

Sincerely

Paul S. Castro

Chief Executive Officer



NORTH LOS ANGELES COUNTY REGIONAL CENTER

15400 Sherman Way, Suite 170 • Van Nuys, CA 91406-4211
Main Office 818/778-1900 • Fax 818/756-6140

February 14, 2012

Mr. Howard Kahn
Chief Executive Officer
L.A. Care Health Plan
1055 W. 7th. St. 10th floor
Los Angeles, CA 90013

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Mr. Kahn:

On behalf of the North Los Angeles County Regional Center (NLACRC), I am expressing our interest and willingness to join with L.A. Care Health Plan in the planning of the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services in their recently released Request for Solution. While there are many details of our participation to be worked out, we are committed to collaborating with L.A. Care in this new endeavor.

NLACRC is a private, non-profit organization funded by the State of California, Department of Developmental Services to provide services and supports to infants, children and adults with developmental disabilities. We currently serve approximately 18,000 persons in the San Fernando, Santa Clarita and Antelope Valleys of Los Angeles County.

We look forward to working closely with L.A. Care on the Dual Eligible Demonstration Pilot as a community health partner to achieve greater coordination of benefits, access to care and improved health outcomes for the individuals we serve as well as the many other dual eligible in Los Angeles County.

If you have any questions, please feel free to contact Dr. Carlo DeAntonio, Clinical Services Director, at (818) 756-6379 regarding this letter of support.

Sincerely,

George Stevens
Executive Director



732 Mott Street
Suite 150
San Fernando, CA 91340
Phone 818-837-3775
Fax 818-837-3799
www.picf.org

February 17, 2012

Howard Kahn, CEO
L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Mr. Kahn:

On behalf of Partners in Care Foundation, I am expressing our interest and willingness to join with L.A. Care Health Plan in the planning of the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). While there are many details of our participation to be worked out, we are committed to collaborating with L.A. Care in this new endeavor.

We look forward to working closely with L.A. Care on the Dual Eligible Demonstration Pilot as a community health partner to achieve greater coordination of benefits, access to care and improved health outcomes for our clients and the many other dual eligibles in Los Angeles County.

Please feel free to contact me at (818) 837-3775 regarding this letter of support.

Sincerely,

W. June Simmons, CEO



February 16, 2012

Howard Kahn, CEO
L.A. Care Health Plan
1055 W. 7th St. 10th Floor
Los Angeles, CA 90017

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Mr. Kahn:

On behalf of Harris Family Center for Disability and Health Policy (HFCDHP), I am expressing our interest and willingness to join with L.A. Care Health Plan in the planning of the Dual Eligible Demonstration Pilot for Los Angeles County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). While there are many details of our participation to be worked out, we are committed to collaborating with L.A. Care in this new endeavor.

HFCDHP worked with L.A. Care to prepare for the Seniors and Persons with Disabilities transition to Managed Care, and L.A. Care took a leadership role in the development and training for the Access Tool which is now used throughout California.

We look forward to working closely with L.A. Care on the Dual Eligible Demonstration Pilot as a community health partner to achieve greater coordination of benefits, access to care and improved health outcomes for our clients and the many other dual eligibles in Los Angeles County.

Please feel free to contact me at (909-469-5385) regarding this letter of support.

Sincerely,

Brenda Premo

Brenda Premo, Director
Harris Family Center for Disability and Health Policy





National Committee for Quality Assurance

has awarded

Local Initiative Health Authority, dba L.A Care 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.



John Fisher

CHAIR, BOARD OF DIRECTORS

July 13, 2011

Margaret Eck

PRESIDENT

July 13, 2014

Duane E Davis MD.

CHAIR, REVIEW OVERSIGHT COMMITTEE

DATE GRANTED

EXPIRATION DATE



County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
<http://ceo.lacounty.gov>

WILLIAM T FUJIOKA
Chief Executive Officer

February 21, 2012

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

Board of Supervisors
GLORIA MOLINA
First District

MARK RIDLEY-THOMAS
Second District

ZEV YAROSLAVSKY
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

Dear Mr. Douglas:

I am writing to express our intended involvement in the L.A. Care Health Plan proposal for California's Dual Eligible Demonstration Request for Solutions, submitted in conjunction with Health Net of California. As Chief Executive Officer of the County of Los Angeles, I have executive authority over most County departments and operations, including the Departments of Health Services, Public Social Services, which administers the In-Home Supportive Services (IHSS) program, Mental Health, and Community and Senior Services, which includes the Area Agency on Aging.

County of Los Angeles is home to approximately 374,000 Duals, with an annual combined Medi-Cal and Medicare expense of over \$10 billion in 2009, which is almost \$30,000 per beneficiary. County of Los Angeles presents a tremendous opportunity to test comprehensive and accountable care at a scale sufficient to yield timely and generalized findings on quality and costs prior to statewide implementation.

We believe L.A. Care and Health Net have developed a comprehensive and fully integrated proposal that not only meets the demonstration goals, but will fundamentally change the delivery of care in the County of Los Angeles, improve quality of life for some of the County's most vulnerable citizens, and reduce health care costs.

Integral to L.A. Care and Health Net's proposal is leveraging existing organized systems in the County of Los Angeles. While the details of our participation continue to be developed, the County of Los Angeles is committed to collaborating with L.A. Care and Health Net toward a successful Implementation.

Thank you for your time and consideration.

Sincerely,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SAS:hd

022112_HMHS_LACountyCEOLetterofSupportLACareHealthNet(2)_L

"To Enrich Lives Through Effective And Caring Service"

**Please Conserve Paper – This Document and Copies are Two-Sided
Intra-County Correspondence Sent Electronically Only**

DEPARTMENT OF

PUBLIC SOCIAL SERVICES



CONTRACT BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

L. A. CARE HEALTH PLAN

FOR

HEMOCARE WORKERS HEALTHCARE SERVICES

FINANCIAL AGREEMENT

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DRAFT



CONTRACT BETWEEN
COUNTY OF LOS ANGELES
AND
L. A. CARE HEALTH PLAN
FOR
HEMECARE WORKERS HEALTHCARE SERVICES
FINANCIAL AGREEMENT

This Contract is made and entered into this ____ day of _____, 2012, effective February 1, 2012, by and between the County of Los Angeles, hereinafter referred to as County and The Local Initiative Health Authority for Los Angeles County, an independent government agency, dba L.A. Care Health Plan. L. A. Care Health Plan, hereinafter referred to as Contractor, or L. A. Care. L. A. Care is located at 1055 West 7th Street, 10th Floor, Los Angeles, CA 90017. The County and L.A. Care Health Plan are sometimes referred to herein as the "Parties."

RECITALS

WHEREAS, under State, federal and local law, County is charged with administering programs that provide services to individuals and families in financial need; and

WHEREAS, a program administered by County is the In-Home Supportive Services ("IHSS") program, which helps pay for services provided to aged, blind or

disabled individuals so that they may remain safely at home. Services are provided by IHSS Workers; and

WHEREAS, pursuant to Welfare and Institutions Code Section 12301.6, the County Board of Supervisors has created a public authority, known as the Personal Assistance Services Council ("PASC"), to provide the delivery of in-home supportive services to this population; and,

WHEREAS, the PASC exists as an independent public entity, separate and apart from the County and as the employer of record for IHSS Workers in Los Angeles County for purposes of collective bargaining concerning wages and benefits, including but not limited to health benefits; and

WHEREAS, Contractor, a Local Initiative Health Care Service Plan licensed by the California Department of Managed Health Care, is an independent public agency , established by ordinance by the Board of Supervisors in accordance with California Welfare and Institutions Code Section 14087.38 and, 14087.96 – 14087.9725

WHEREAS, Contractor and PASC have entered into a separate contract entered into in January 2012 entitled "In-Home Supportive Services Homecare Workers Benefit Agreement" (hereinafter "PASC/L.A. Care Contract") for L.A. Care to provide or arrange for the provision of health care benefits to Eligible Enrolled IHSS Workers; and,

WHEREAS, the parties agree County, on behalf of PASC, shall provide payment up to the amount stated herein for the IHSS Health Care Plan to L.A. Care. In return,

pursuant to its separate contract with PASC, L.A. Care agrees to provide health care services to eligible IHSS Workers.

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1.0 APPLICABLE DOCUMENTS

Exhibits A, B, C, D, E, F, G, H, I, and J are attached to and form a part of this Contract. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, schedule, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the base Contract and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the Contract and then to the Exhibits according to the following priority.

This Contract and its Exhibits hereto constitute the complete and exclusive statement of understanding between the parties, and supersedes all previous contracts, written and oral, and all communications between the parties relating to the subject matter of this Contract. No change to this Contract shall be valid unless prepared pursuant to Subparagraph 8.1 - Amendments and signed by both parties.

2.0 DEFINITIONS

The headings herein contained are for convenience and reference only and are not intended to define the scope of any provision thereof. The following words as

used herein shall be construed to have the following meaning, unless otherwise apparent from the context in which they are used.

- 2.1 **Business Days:** Monday through Friday, excluding County holidays.
- 2.2 **Capitation Payments:** This is the maximum not to exceed amount that County agrees to pay L.A. Care on behalf of PASC based on the Capitation Payment Rate under the Department of Public Social Services (DPSS)-PASC Contract. The Capitation Payment is calculated by multiplying the Capitation Payment Rate by the number of Eligible Enrolled In-Home Supportive Services (IHSS) Workers each month.
- 2.4 **Contract:** This Agreement executed between County and Contractor, including all of its Exhibits and Attachments thereof. It sets forth the terms and conditions for the issuance and performance of Exhibit A, Statement of Work.
- 2.5 **Contract Management Division:** The Department of Public Social Services' division responsible for this Contract.
- 2.6 **Contractor or L.A. Care Health Plan ("L.A. Care"):** The entity that has entered into this Contract with the County to perform or execute the work covered by the Statement of Work. It is a community-accountable health plan that serves over 900,000 Los Angeles County Residents through low-cost health coverage programs.
- 2.7 **Contractor Program Manager:** The individual designated by the Contractor to administer the Contract operations after the Contract award.

- 2.8 **County Contract Program Monitor:** Person with responsibility to oversee the day to day activities of this Contract for the County. Such responsibilities include inspections of any and all tasks, deliverables, goods, services and other work provided by the Contractor.
- 2.9 **County Contract Director:** Person designated by County Contract Manager with authority for County on contractual or administrative matters relating to this Contract that cannot be resolved by the County's Contract Administrator.
- 2.10 **County Contract Administrator (CCA):** Person designated by County Contract Director to manage the operations under this Contract for County.
- 2.11 **County Contract Manager:** Person designated by County with authority for County on contractual or administrative matters relating to this Contract that cannot be resolved by the County Contract Director.
- 2.12 **Day(s):** Calendar day(s) unless otherwise specified.
- 2.13 **Director:** The Acting Director of DPSS or her designee.
- 2.14 **DPSS:** The County's Department of Public Social Services. It shall be responsible for administering this Contract on behalf of the County.
- 2.15 **Eligible IHSS Worker:** A person who is authorized to work under the IHSS Program and works the minimum established number of hours, as determined by the Board of Supervisors, for two consecutive months

- 2.16 **Eligible Enrolled IHSS Worker:** An Eligible IHSS Worker who is enrolled in L.A. Care Health Plan. This person is referred to as an eligible “IHSS Worker” in the In-Home Supportive Services Home Care Workers Benefit Agreement” between PASC and L.A. Care Health Plan.
- 2.17 **Fiscal Year:** The twelve (12) month period beginning July 1st and ending the following June 30th.
- 2.18 **In-Home Supportive Services (IHSS):** In-Home Supportive Services is a state program administered by DPSS, which helps pay for services provided to eligible individuals so that they may remain safely at home. Services are provided by IHSS Workers.
- 2.19 **IHSS Consumer:** The person who has been determined to be eligible to receive IHSS services.
- 2.20 **IHSS Program:** The section within DPSS responsible for administration of the IHSS Program including developing and issuing policy and procedures related to IHSS in Los Angeles County.
- 2.21 **IHSS Worker:** The person who provides the services to the IHSS consumer. California State Regulations refer to this person as “IHSS Provider”.
- 2.22 **Parties:** The County and L.A. Care Health Plan.
- 2.23 **Personal Assistance Services Council (PASC):** The Personal Assistance Services Council of Los Angeles exists as an independent entity, separate

and apart from the County and serves as the employer of record for IHSS Workers in Los Angeles County for purposes of collective bargaining concerning wages and health benefits.

3.0 WORK

3.1 Contractor, under its PASC/L.A. Care Contract, will be providing the health benefit plan to Eligible Enrolled IHSS Workers. County shall make payments on behalf of the PASC for this benefit up to the amount and in the timeframes set forth in Section 5.0, Contract Rates, Billing, and Payment, of this Contract.

3.2 Pursuant to the provisions of this Contract, the Parties shall fully perform, complete and deliver on time, all tasks, deliverables, services and other work as set forth herein.

3.3 If the Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Contract and other than as specified in the PASC/L.A. Care Contract, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and the Contractor shall have no claim whatsoever against the County.

4.0 TERM OF CONTRACT

4.1 The term of this Contract shall commence on February 1, 2012 and shall expire on January 31, 2013, and shall renew thereafter for successive one (1) year periods, unless sooner terminated or extended, in whole or in part, as provided in this Contract

4.2 !

4.3

5.0 CONTRACT RATES, BILLING, AND PAYMENT

5.1 Contract Rates

5.2 Invoices and Payments

In January 2012, PASC and Contractor shall enter into the PASC/L.A. Care Contract. Under the PASC/L.A. Care Contract, PASC is required to provide an invoice to DPSS, for the Capitation Payments payable to L.A. Care for IHSS Workers who are eligible and enrolled for the health care plan for the following month. Upon receipt of the invoice from PASC, DPSS shall review and, as appropriate, authorize payment to Contractor, on behalf of PASC, in accordance with the terms of this Contract, including but not limited to Exhibit A, Statement of Work. Pursuant to this Contract and the PASC/L.A. Care Contract, , DPSS shall pay Contractor no later than ten (10) business days after receipt of the invoice from PASC.

5.3 Contractor shall provide direct deposit information and complete the applicable forms. Upon approval by the Auditor-Controller direct deposit shall occur. In the absence of direct deposit, Contractor shall make arrangements with the County Contract Administrator (CCA) to pick-up the warrant from the DPSS Financial Management Branch.

5.4 Contractor shall provide direct deposit information and complete the applicable forms. Upon approval by the Auditor-Controller direct deposit shall occur. In the absence of direct deposit, Contractor shall make arrangements with the County Contract Administrator (CCA) to pick-up the warrant from the DPSS Financial Management Branch.

5.5 Upon receipt of payment from County, Contractor shall confirm receipt of payment within two (2) business days. Confirmation shall be made by sending an e-mail message to the County Contract Administrator. Confirmation shall be sent to DPSS by Contractor's bank.

5.6 Contractor shall establish a separate bank account for the sole purpose of receiving Capitation Payments from DPSS. Any interest accrued from this bank account shall be paid to County on the first day of each January, April, July, and October. The interest payments should be remitted to:

Los Angeles County, DPSS

Fiscal Operations Section, attn: Wanda Barbee

P.O. Box 76687

Los Angeles, CA 90078-0687 Los Angeles County, DPSS

Fiscal Operations Section

P. O. Box 76687

Los Angeles, CA 90076-0687

- 5.7 Contractor shall maintain separate accounting records to document receipt and expenditures made in accordance with this Contract.
- 5.8 If any discrepancies should be discovered regarding the payments made to Contractor, including but not limited to, if a person for whom a Capitation Payment was made is not an Enrolled Eligible IHSS Worker, PASC shall provide Contractor in writing a request for repayment for any such ineligible IHSS Worker and Contractor shall provide a refund of the Capitation Payment to DPSS by the fifth (5th) business day following receipt of the PASC's request. Upon notice to Contractor by PASC that a refund is due to DPSS, Contractor shall notify the PASC within three (3) business days that a refund is being processed and the reason for the refund payment. All collected payments should be remitted to Los Angeles County, DPSS, at the same address as stated in Paragraph 5.6 above.
- 5.9 The Contractor shall not be entitled to payment or reimbursement for any tasks or services performed under this Contract, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance under this Contract, except as specified herein. Assumption or takeover of any of the Contractor's duties, responsibilities, or obligations, or performance of same under this Contract by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, shall occur only with the County's express prior written approval

5.10 No Payment for Services Provided Following Expiration/ Termination of Contract

The Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service required under this Contract provided by the Contractor after the expiration or other termination of this Contract. Should the Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services required under this Contract rendered after expiration/termination of this Contract shall not constitute a waiver of County's right to recover such payment from the Contractor. This provision shall survive the expiration or other termination of this Contract.

5.11 Compliance with County Code Section 3.45.140

The Parties understand and acknowledge that Los Angeles County Code Section 3.45.140 prohibits PASC from augmenting health benefits or coverage which have the effect of creating an additional financial obligation of the County, without first obtaining County approval. Accordingly, the Parties understand and acknowledge that the County shall have no financial responsibility to pay for augmented health benefits or coverage in violation of County Code Section 3.45.140. **County understands and acknowledges that Contractor may terminate this Contract pursuant to Section 8.38. should Contractor be required by law or regulation to augment health benefits or health coverage provided to IHSS**

Workers which augmentation has the effect of creating an additional financial obligation for the Contractor and for which Contractor's Capitation Payment Rate is not appropriately adjusted.

6.0 ADMINISTRATION OF CONTRACT - COUNTY

COUNTY ADMINISTRATION

A listing of all County Administration referenced in the following Subparagraphs are designated in Exhibit E, County's Administration. The County shall notify the Contractor in writing of any change in the names or addresses shown.

6.1 County Contract Manager

Responsibilities for the County of the County Contract Manager include:

- ensuring that County's objectives of this Contract are met; and
- providing authority for contractual and administrative matters related to this Contract that cannot be resolved by the County Contract Director.

6.2 County Contract Director

Responsibilities for the County of the County Contract Director include:

- ensuring that the County's objectives of this Contract are met; and
- providing direction to the Contractor in the areas relating to County policy, information requirements, and procedural requirements consistent with the terms of the Contract.

6.3 County Contract Administrator

Responsibilities for the County of the County Contract Administrator include:

- meeting with the Contractor's Program Manager on a regular basis; and
- overseeing the day-to-day administration of this Contract for County.
- acting as liaison with Contractor and be responsible for overall management and coordination of this Contract for County.

The County Contract Administrator is not authorized to make any changes in any of the terms and conditions of this Contract and is not authorized to further obligate County or L.A. Care Health Plan in any respect whatsoever.

6.4 County Contract Program Monitor

Responsibilities for the County of the County Contract Program Monitor include:

- inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of the Contractor under this Contract. Prior to any on site inspection or request for books and records, for this purpose, County shall provide Contractor with reasonable prior written notice, and County and Contractor shall mutually agree upon the

scope and duration of any on site inspection or request for books and records.

The County Contract Program Monitor reports to the County Contract Administrator.

7.0 ADMINISTRATION OF CONTRACT - CONTRACTOR

7.1 Contractor's Authorized Official(s) and Contractor's Contract Manager

7.1.1 Contractor's Authorized Official(s) and Contractor's Manager and alternate are designated in Exhibit F. Contractor shall promptly notify County in writing of any change in the name(s) or address(es) of Contractor's Authorized Official(s)/Contract Manager, and alternate.

7.1.2 Contractor represents and warrants that all requirements of Contractor have been fulfilled to provide actual authority to such officials to execute documents under this Agreement on behalf of Contractor.

7.2 Approval of Contractor's Staff

County has the right to request that Contractor remove from performing work under this Contract any member of the Contractor's staff performing work hereunder and the right to be notified in writing as soon as possible

of any proposed changes in the Contractor's staff, including, but not limited to, a change in the Contractor's Project Manager.

Contractor shall provide, at Contractor's expense, all staff providing services under this Contract with a photo identification badge.

7.3 Background and Security Investigations

7.3.1 Each of Contractor's staff performing services under this Contract, shall have undergone and passed the Contractor's current and usual required background investigation as a condition of beginning and continuing to perform services under this Contract. Such background investigation may include, but shall not be limited to, criminal conviction information obtained through fingerprints submitted to the California Department of Justice. The fees associated with the background investigation shall be at the expense of the Contractor, regardless if the member of Contractor's staff passes or fails the background investigation.

7.3.2 If a member of Contractor's staff does not pass the Contractor's background investigation, County may request that the member of Contractor's staff be immediately removed from performing services under the Contract at any time during the term of the Contract..

7.3.3 County, in its sole discretion, may immediately deny or terminate facility access to any member of Contractor's staff that does not pass Contractor's investigation or whose background or conduct is incompatible with County facility access.

7.3.4 Disqualification of any member of Contractor's staff pursuant to this Paragraph 7.4 shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Contract.

7.4 Confidentiality

7.4.1 Contractor shall maintain the confidentiality of all records and information, including, but not limited to, billings, County records, in accordance with all applicable Federal, State and local laws, including, but not limited to those under the Public Records Act, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

7.4.1.2. County shall maintain the confidentiality of all confidential records and information of Contractor, in accordance with all applicable Federal, State and local laws, including, but not limited to those under the Public Records Act, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, Contractor's policies

concerning information technology security and the protection of confidential records and information.

7.4.2 Contractor shall use its best efforts to inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Contract. Contractor shall ensure that any agreement with subcontractors contains a similar confidentiality provision.

7.4.3 Contractor shall sign and adhere to the provisions of the "Contractor Employee Acknowledgment and Confidentiality Agreement", Exhibit G1, on behalf of its employees.

7.4.4 Contractor shall require that each agreement with non-employees performing services covered by this Contract adhere to the Contractor's confidentiality agreement set forth in each non-employee agreement for services.

8.0 TERMS AND CONDITIONS

8.1 AMENDMENTS

For any change which affects the scope of work, term, Contract Sum, payments, or any term or condition included under this Contract, an Amendment shall be prepared by the County or Contractor and then executed upon mutual agreement of the Contractor and by the County Board of Supervisors.

8.2 ASSIGNMENT AND DELEGATION

8.2.1 Neither Party shall assign its rights or delegate its duties under this Contract, or both, whether in whole or in part, without the prior written consent of the other Party and any attempted assignment or delegation without such consent shall be null and void. For purposes of this Subparagraph, consent shall require a written amendment to the Contract, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Contract shall be deductible, at County's sole discretion, against the claims, which the Contractor may have against the County.

8.2.2 Shareholders, partners, members, or other equity holders of Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Contract, such disposition is an assignment requiring the prior written consent of County in accordance with applicable provisions of this Contract.

8.2.3 Any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of

same by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, shall be a material breach of the Contract which may result in the termination of this Contract. Prior to any termination of the Contract pursuant to this Section 8.2.3., County shall provide notice to Contractor of the alleged breach and Contractor shall have thirty (30) business days to cure any such breach. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

8.3 AUTHORIZATION WARRANTY

The Contractor represents and warrants that the person executing this Contract for the Contractor is an authorized agent who has actual authority to bind the Contractor to each and every term, condition, and obligation of this Contract and that all requirements of the Contractor pursuant to this Contract have been fulfilled to provide such actual authority.

8.4 BUDGET REDUCTIONS

Upon receipt of notice by County of any such reduction, Contractor may terminate this Contract in accordance with Section 8.38 or any other applicable provision.

8.5 COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

8.5.1 In the performance of this Contract, the Parties shall comply with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures, including, but not limited to all applicable standards of The Joint Commission, its National Patient Safety Goals, California Code of Regulations, Title 22, Division 5 regulations and all other applicable industry best practices standards and all provisions required thereby to be included in this Contract are hereby incorporated herein by reference.

8.6 COMPLIANCE WITH CIVIL RIGHTS LAWS

The Contractor hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000 (e) (1) through 2000 (e) (17), the Fair Employment & Housing Act, Government Code Section 12920-12922; and Affirmative Action in County Contracts, Chapter 4.32 of the Los Angeles County Code to the end that no person shall, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project,

program, or activity supported by this Contract. The Contractor shall comply with Exhibit D, Contractor's EEO Certification.

8.7 COMPLIANCE WITH THE COUNTY'S JURY SERVICE PROGRAM

8.7.1 Jury Service Program:

This Contract is subject to the provisions of the County's ordinance entitled Contractor Employee Jury Service ("Jury Service Program") as codified in Sections 2.203.010 through 2.203.090 of the Los Angeles County Code, a copy of which is attached as Exhibit H and incorporated by reference into and made a part of this Contract.

8.7.2 Written Employee Jury Service Policy.

1. Unless the Contractor has demonstrated to the County's satisfaction either that the Contractor is not a "Contractor" as defined under the Jury Service Program (Section 2.203.020 of the County Code) or that the Contractor qualifies for an exception to the Jury Service Program (Section 2.203.070 of the County Code), the Contractor shall have and adhere to a written policy that provides that its Employees shall receive from the Contractor, on an annual basis, no less than five days of regular pay for actual jury service. The policy may provide

that Employees deposit any fees received for such jury service with the Contractor or that the Contractor deduct from the Employee's regular pay the fees received for jury service.

2. If the Contractor is not required to comply with the Jury Service Program when the Contract commences, the Contractor shall have a continuing obligation to review the applicability of its "exception status" from the Jury Service Program, and the Contractor shall immediately notify the County if the Contractor at any time either comes within the Jury Service Program's definition of "Contractor" or if the Contractor no longer qualifies for an exception to the Jury Service Program. In either event, the Contractor shall immediately implement a written policy consistent with the Jury Service Program. The County may also require, at any time during the Contract and at its sole discretion, that the Contractor demonstrate, to the County's satisfaction that the Contractor either continues to remain outside of the Jury Service Program's definition of "Contractor" and/or that the Contractor continues to qualify for an exception to the Program.

3. Contractor's violation of this Subparagraph of the Contract may constitute a material breach of the Contract. In the event of such material breach, County may, in its sole discretion, terminate the Contract and/or bar the Contractor from the

award of future County contracts for a period of time consistent with the seriousness of the breach. Prior to any termination of the Contract pursuant to this Section 8.7.2., County shall provide notice to Contractor of the alleged breach and Contractor shall have thirty (30) business days to cure any such breach.

8.8 CONFLICT OF INTEREST

8.8.1 No County employee whose position with the County enables such employee to influence the award or administration of this Contract or any competing contract, and no spouse or economic dependent of such employee, shall be employed in any capacity by the Contractor or have any other direct or indirect financial interest in this Contract. No officer or employee of the Contractor who may financially benefit from the performance of work hereunder shall in any way participate in the County's approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence the County's approval or ongoing evaluation of such work.

8.8.2 The Contractor shall comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Contract. The Contractor warrants that it is not now aware of any facts that create a conflict of interest. If the Contractor hereafter becomes aware of any facts

that might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to the County. Full written disclosure shall include, but is not limited to, identification of all persons implicated and a complete description of all relevant circumstances. Failure to comply with the provisions of this Subparagraph shall be a material breach of this Contract.

8.9 CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST

Should the Contractor require additional or replacement personnel after the effective date of this Contract to perform the services set forth herein, the Contractor shall give consideration for such employment openings to qualified, permanent County employees who are targeted for layoff or qualified, former County employees who are on a re-employment list during the life of this Contract. For this purpose, consideration shall mean that the Contractor will consider interviewing qualified candidates.

8.10 CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS

8.10.1 Should the Contractor require additional or replacement personnel to perform the services set forth herein after the effective date of this Contract, the Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services Greater Avenues for Independence

(GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Contractor's minimum qualifications for the open position. For this purpose, consideration shall mean that the Contractor will consider interviewing qualified candidates. The County will refer GAIN/GROW participants by job category to the Contractor.

8.10.2 In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority over GAIN/GROW participants.

8.11 CONTRACTOR RESPONSIBILITY AND DEBARMENT

8.11.1 Responsible Contractor

A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County's policy to conduct business only with responsible Contractors.

8.11.2 Chapter 2.202 of the County Code

The Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of the Contractor on this or other contracts which indicates that the Contractor is not responsible, the County may, in addition to other remedies provided in the

Contract, debar the Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five years but may exceed five years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts the Contractor may have with the County.

8.11.3 Non-responsible Contractor

Subject to the provisions in Sections 8.11.4 through 8.11.6, the County may debar a Contractor if the Board of Supervisors finds, in its discretion, that the Contractor has done any of the following: (1) violated a term of a contract with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the Contractor's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

8.11.4 Contractor Hearing Board

1. If there is evidence that the Contractor may be subject to debarment, the Department will notify the Contractor in

writing of the evidence which is the basis for the proposed debarment and will advise the Contractor of the scheduled date for a debarment hearing before the Contractor Hearing Board.

2. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Contractor and/or the Contractor's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Contractor should be debarred, and, if so, the appropriate length of time of the debarment. The Contractor and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.
3. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

4. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County.

5. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the

proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

6. The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

8.11.5 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible, or excluded or whose principals are suspended, debarred, ineligible, or excluded from securing federally funded contracts. By executing this Contract, Contractor certifies that neither it nor any of its owner, officers, partners, or directors or other principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts.

Further, by executing this, Contract Contractor certifies that, to its knowledge, none of its subcontractors, at any tier, or any owner, officer, partner, director, or other principal of any subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Contract, if Contractor knows it or any of its subcontractors, or any principals of either be suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Contract upon which the County may immediately terminate or suspend this Contract.

8.11.6 Subcontractors of Contractor

These terms shall also apply to Subcontractors of County Contractors.

8.12 CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will use its best efforts to also encourage its Subcontractors, if

any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used. Information on how to receive the poster can be found on the Internet at www.babysafela.org.

8.13 CONTRACTOR'S NON EXCLUSION FROM PARTICIPATING IN A FEDERALLY FUNDED PROGRAM

8.13.1 Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director , within ten (10) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Contractor or one or more staff members barring it or the staff members from participating in a Federally funded health care program, whether such bar is direct, or whether such bar is in whole or in part.

8.13.2 Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Contractor or its staff members from such participation in a Federally funded health care program.

8.13.3 Failure by Contractor to knowingly meet the requirements of this Subparagraph shall constitute a material breach of Contract upon which County may immediately terminate or suspend this Agreement.

8.14 CONTRACTOR PERFORMANCE DURING CIVIL UNREST OR DISASTER

The Contractor recognizes that health care facilities maintained by County provide care essential to the residents of the communities they serve, and that these services are of particular importance at the time of a riot, insurrection, civil unrest, natural disaster, or similar event. Notwithstanding any other provision of this Contract, full performance by Contractor during any riot, insurrection, civil unrest, natural disaster or similar event is not excused if such performance remains physically possible and does not pose unreasonable physical harm to Contractor or its staff. Failure to comply with this requirement shall be considered a material breach of Contractor for which County may immediately terminate this Contract.

8.15 CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

8.15.1 The Contractor acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the

County through Contract are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

8.15.2 As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting the Contractor's duty under this Contract to comply with all applicable provisions of law, the Contractor warrants that it is now in compliance and shall during the term of this Contract maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

8.16 COUNTY'S QUALITY ASSURANCE PLAN

The County or its agent will evaluate the Contractor's performance under this Contract on not less than an annual basis. County shall provide Contractor with at least sixty (60) calendar days prior notice of any evaluation to be performed on site at Contractor's facilities. Such evaluation will include assessing the Contractor's compliance with all Contract terms

and conditions and performance standards identified in Exhibit A, Statement of Work. Contractor deficiencies which the County determines are severe or continuing and that may place performance of the Contract in jeopardy if not corrected will be reported to the Board of Supervisors.

The report will include improvement/corrective action measures taken by the County and the Contractor. If improvement does not occur consistent with the corrective action measures, the County may terminate this Contract or impose other penalties as specified in this Contract.

8.17 EMPLOYMENT ELIGIBILITY VERIFICATION

8.17.1 The Contractor warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Contract meet the citizenship or alien status requirements set forth in Federal and State statutes and regulations. The Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by Federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), or as they currently exist and as they may be hereafter amended. The Contractor shall retain all such documentation for all covered employees for the period prescribed by law.

8.17.2 The Contractor shall indemnify, defend, and hold harmless, the

County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Contractor or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Contract.

8.18 FAIR LABOR STANDARDS

The Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by the Contractor's employees for which the County may be found jointly or solely liable.

8.19 FEDERAL ACCESS TO RECORDS

If, and to the extent that, Section 1861(v)(1)(I) of the Social Security Act (42 U.S.C. Section 1395x(v)(1)(I)) is applicable, Contractor agrees that for a period of five (5) years following the termination of services under this Contract, Contractor shall maintain and make available, upon written request, to the Secretary of the United State Department of Health and Human Services or the Controller General of the United States, or to any of their authorize representatives, the Contract, books, documents and

records of Contractor which are necessary to verify the nature and extent of the costs of services provided hereunder. Furthermore, if Contractor carries out any of the services provided hereunder through any subcontract with a value or cost of Ten Thousand Dollars (\$10,000) or more over a twelve (12) month period with a related organization (as that term is defined under Federal law), Contractor agrees that each such subcontract shall provide for such access to the subcontract, books, documents and records of the Subcontractor.

8.20 GOVERNING LAW, JURISDICTION, AND VENUE

This Contract shall be governed by, and construed in accordance with, the laws of the State of California. The Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Contract and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

8.21 INDEPENDENT CONTRACTOR STATUS

8.21.1 This Contract is by and between the County and the Contractor and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and the Contractor. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

8.21.2 The Contractor shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Contract all compensation and benefits. The County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of the Contractor.

8.21.3 The Contractor understands and agrees that all persons performing work pursuant to this Contract are, for purposes of Workers' Compensation liability, solely employees of the Contractor and not employees of the County. The Contractor shall be solely liable and responsible for furnishing any and all Workers' Compensation benefits to any person as a result of any injuries arising from or connected with any work performed by or on behalf of the Contractor pursuant to this Contract.

8.21.4 The Contractor shall adhere to the provisions stated in Subparagraph 7.4 - Confidentiality.

8.22 LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES

Contractor shall obtain and maintain in effect during the term of this Contract, all valid licenses, permits, registrations, accreditations, and

certificates required by law which are applicable to its performance of this Contract, and shall ensure that all of its officers, employees, and agents who perform services hereunder obtain and maintain in effect during the term of this Contract, all licenses, permits, registrations, accreditations, and certificates required by law which are applicable to their performances of **services under this Contract. All such licenses, permits, registrations,** accreditations, and certifications relating to services hereunder shall be made available to County upon request.

8.23 MUTUAL INDEMNIFICATION

8.23.1 The Contractor shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the Contractor's acts and/or omissions arising from and/or relating to this Contract.

8.23.2 The County shall indemnify, defend and hold harmless the Contractor, **members of its Board, its officers, employees and agents from** and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the County's acts and/or omissions arising from and/or relating to this Contract.

8.24 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE

Without limiting Contractor's indemnification of County, and in the performance of this Contract and until all of its obligations pursuant to this Contract have been met, Contractor shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in Sections 8.24 and 8.25 of this Contract. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Contract. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Contract.

8.24.1 Evidence of Insurance Coverage and Notice to County

- Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Contract.

- Renewal Certificates shall be provided to County not less than 10 days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies

of any required Contractor and/or Sub-Contractor insurance policies at any time.

- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Contract by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Contractor identified as the contracting party in this Contract. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand (\$50,000.00) dollars, and list any County required endorsement forms.
- Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be sent to:

County of Los Angeles

Department of Public Social Services
Contract Management Division - Section V
12900 Crossroads Parkway South
City of Industry, CA 91746
Attention: County Contract Administrator

Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to Contractor. Contractor also shall promptly notify County of any third party claim or suit filed against Contractor or any of its Subcontractors which arises from or relates to this Contract, and could result in the filing of a claim or lawsuit against Contractor and/or County.

8.24.2 Additional Insured Status and Scope of Coverage

The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Contractor's General Liability policy with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of the County. County and its Agents additional insured status shall apply with respect to liability and defense of suits

arising out of the Contractor's acts or omissions under this Contract **whether such liability is attributable to the Contractor or to the County.** The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

8.24.3 **Cancellation of or Changes in Insurance**

Contractor shall provide County with, or Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract. **Prior to suspension or termination of this Contract for breach of this Section, County shall provide Contractor with written notice of breach and a reasonable opportunity to cure such breach of not less than thirty (30) days.**

8.24.4 Failure to Maintain Insurance

Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Contract, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. However, prior to withholding payments, suspension or termination of this Contract for breach of this Section, County shall provide Contractor with written notice of breach and a reasonable opportunity to cure such breach of not less than thirty (30) days. County may obtain reasonable damages upon proof of such from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and with prior notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement.

8.24.5 Insurer Financial Ratings

Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

8.24.6 Contractor's Insurance Shall Be Primary

Contractor's insurance policies, with respect to any claims related to this Contract, shall be primary with respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

8.24.7 **Waivers of Subrogation**

To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Contract, **except to the extent such loss is attributable to the County's negligent acts or omissions.** The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

8.24.8 **Subcontractor Insurance Coverage Requirements**

Contractor shall require all Subcontractors as insureds under Contractor's own policies, or shall provide County with each Subcontractor's separate evidence of insurance coverage. Contractor shall be responsible for verifying that each Subcontractor complies with the Required Insurance provisions herein, and shall require that each Subcontractor name the County and Contractor as additional insureds on the Subcontractor's General Liability policy. Contractor shall obtain

County's prior review and approval of any Subcontractor request for modification of the Required Insurance.

8.24.9 **Deductibles and Self-Insured Retentions (SIRs)**

Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

8.24.10 **Claims Made Coverage**

If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Contract. Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Contract expiration, termination or cancellation.

8.24.11 **Application of Excess Liability Coverage**

Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as the underlying primary policies, to satisfy the Required Insurance provisions.

8.24.12 **Separation of Insureds**

All liability policies shall provide cross-liability coverage as would be afforded by, or equivalent to, the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

8.24.13 **Alternative Risk Financing Programs**

The County reserves the right to review, and then approve, Contractor use, if any, of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

8.24.14 **County Review and Approval of Insurance Requirements**

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures and the mutual agreement of Contractor.

8.25 INSURANCE COVERAGE

8.25.1 **Commercial General Liability** insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	\$2 million
Products/Completed Operations Aggregate:	\$1 million
Personal and Advertising Injury:	\$1 million
Each Occurrence:	\$1 million

8.25.2 **Automobile Liability** insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than \$1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Contractor's use of autos pursuant to this Contract, including owned, leased, hired, and/or non-owned autos, as each may be applicable.

8.25.3 **Workers Compensation and Employers' Liability** insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than \$1 million per accident. If Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage

provision. If applicable to Contractor's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

8.25.4 Unique Insurance Coverage

8.25.4.1 Sexual Misconduct Liability

Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than \$2 million per claim and \$2 million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

8.25.4.2 Professional Liability/Errors and Omissions

Insurance covering Contractor's liability arising from or related to this Contract, with limits of not less than \$1 million per claim and \$2 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than

three (3) years following this Agreement's expiration, termination or cancellation.

8.25.4.3 Crime Coverage

A Fidelity Bond or Crime Insurance policy with limits of not less than \$11,000,000.00 per occurrence. Such coverage shall protect against all loss of money, securities, or other valuable property entrusted by County to Contractor, and apply to all of Contractor's directors, officers, agents and employees who regularly handle or have responsibility for such money, securities or property. The County and its Agents shall be named as an Additional Insured and Loss Payee as its interests may appear. This insurance shall include third party fidelity coverage, include coverage for loss due to theft, mysterious disappearance, and computer fraud/theft, and shall not contain a requirement for an arrest and/or conviction.

8.26 NON EXCLUSIVITY

Nothing herein is intended nor shall be construed as creating any exclusive arrangement with the Contractor. This Contract shall not restrict County from acquiring similar, equal or like goods and/or services from other entities or sources.

8.27 NOTICE OF DISPUTES

The Contractor shall bring to the attention of the County's Contract Administrator any dispute between the County and the Contractor regarding the performance of services as stated in this Contract. If the County's Contract Administrator or County's Contract Director is not able to resolve the dispute, the Director shall resolve it.

8.28 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT

The Contractor shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

8.29 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW

The Contractor shall notify and provide to its employees, and shall **use its best efforts to** require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit I of this Contract and is also available on the Internet at www.babysafela.org for printing purposes.

8.30 NOTICES

All notices or demands required or permitted to be given or made under this Contract shall be in writing and shall be e-mailed, hand delivered with signed receipt or mailed by first-class registered or certified mail, postage prepaid, addressed to the parties as identified in Exhibits E - County's Administration and F - Contractor's Administration. Addresses may be changed by either party giving ten (10) days' prior written notice thereof to the other party. The Director shall have the authority to issue all notices or demands required or permitted by the County under this Contract.

8.31 PROHIBITION AGAINST INDUCEMENT OR PERSUASION

Notwithstanding the above, the Contractor and the County agree that, during the term of this Contract and for a period of one year thereafter, neither party shall in any way intentionally induce or persuade any employee of one party to become an employee or agent of the other party. No bar exists against any hiring action initiated through a public announcement.

8.32 RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT

The Contractor shall maintain and provide upon request by County, accurate and complete financial records of its activities and operations relating to this Contract in accordance with generally accepted accounting principles. The Contractor shall also maintain accurate and complete employment and other records relating to its performance of this Contract.

The Contractor agrees that the County, or its authorized representatives, shall have access to and the right to examine, audit, excerpt, copy, or transcribe any pertinent transaction, activity, or record relating to this Contract upon request and reasonable prior notice to Contractor. All such material, including, but not limited to, all financial records, bank statements, cancelled checks or other proof of payment, timecards, sign-in/sign-out sheets and other time and employment records, and proprietary data and information, shall be kept and maintained by the Contractor and shall be made available to the County during the term of this Contract and for a period of five (5) years thereafter unless the County's written permission is given to dispose of any such material prior to such time. All such material shall be maintained by the Contractor at a location in Los Angeles County, provided that if any such material is located outside Los Angeles County, then, at the County's option, the Contractor shall pay the County for travel, per diem, and other costs incurred by the County to examine, audit, excerpt, copy, or transcribe such material at such other location.

8.32.1 In the event that an audit of the Contractor is conducted specifically regarding this Contract by any Federal or State auditor, ~~or by any auditor or accountant employed by the Contractor or otherwise,~~ including audits conducted by the Medicare and Medi-Cal programs, or both then the Contractor shall file a copy of such audit report including Statement of Auditing Standards No. 70 Type 2 Reports with the County's Auditor-Controller within thirty (30) days of the Contractor's receipt thereof, unless otherwise provided by

applicable Federal or State law or under this Contract. Subject to applicable law, the County shall maintain the confidentiality of such audit report(s), unless required by law or court order to disclose such audit report(s). In the event that County is required by law or court order to disclose any such audit report(s), County shall provide Contractor with reasonable prior notice of such disclosure.

8.32.2 Failure on the part of the Contractor to comply with any of the provisions of this Subparagraph 8.32 shall constitute a material breach of this Contract upon which the County may terminate or suspend this Contract. Prior to termination of this Contract for breach of this Section, County shall provide Contractor with written notice of breach and a reasonable opportunity to cure such breach of not less than sixty (60) days.

8.32.3 If, at any time during the term of this Contract or within five (5) years after the expiration or termination of this Contract, representatives of the County conduct an audit of the Contractor regarding the work performed under this Contract, and if such audit finds that the County's dollar liability for any such work is less than payments made by the County to the Contractor, then the difference shall be either: a) repaid by the Contractor to the County by cash payment upon demand or b) at the sole option of the County's Auditor-Controller, deducted from any amounts due to the Contractor from the County, whether under this Contract or otherwise. If such audit finds that the County's dollar liability for

such work is more than the payments made by the County to the Contractor, then the difference shall be paid to the Contractor by the County by cash payment, provided that in no event shall the County's maximum obligation for this Contract exceed the funds appropriated by the County, on behalf of PASC, for the purpose of this Contract.

8.32.4 Audit/Compliance Review

In the event County representatives conduct an audit/ compliance review of Contractor regarding compliance with this Contract, Contractor shall fully cooperate with County's representatives. Contractor shall allow County representatives access to all financial reports, medical records, and reports directly pertaining to this Contract and Contractor's compliance under this Contract, and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractor its customary charge for record copying services, if requested. County Contract Director shall provide Contractor with at least ten (10) working days prior written notice of any audit/compliance review.

An exit conference shall be held following the performance of any such audit/ compliance review at which time the results shall be

discussed with Contractor. Contractor shall be provided with a copy of any resultant written evaluation report(s).

Contractor shall have the opportunity to review County's findings for Contractor, and Contractor shall have thirty (30) calendar days after receipt of County's audit/compliance review results to provide documentation to the County representatives to resolve audit exceptions.

8.33 RECYCLED BOND PAPER

Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at the County landfills, the Contractor agrees to use recycled-content paper to the maximum extent possible on this Contract.

8.34 RESTRICTIONS ON LOBBYING

If any Federal funds are to be used to pay for Contractor's services under this Contract, Contractor shall fully comply with all certification and disclosure requirements prescribed by Section 319 of Public Law 101-121 (31 United States Code Section 1352) and any implementing regulations, and shall ensure that each of its Subcontractors receiving funds provided under this Contract also fully complies with all such certification and disclosure requirements.

8.35 SUBCONTRACTING

8.35.1 Contractor's Responsibilities set forth in Section 1.3. of Exhibit A, may not be subcontracted by the Contractor **without the advance written approval of the County**. Any subcontracting by the Contractor without the prior consent of the County may be deemed a material breach of this Contract.

8.35.2 If the Contractor desires to subcontract its Contractor Responsibilities set forth in Section 1.3. of Exhibit A, the Contractor shall provide the following information promptly at the County's request:

- A description of the work to be performed by the Subcontractor;
- A draft copy of the proposed subcontract; and
- Other pertinent information and/or certifications requested by the County.

8.35.3 The Contractor shall indemnify and hold the County harmless with respect to the activities of each and every Subcontractor

8.35.4 **The Contractor shall remain fully responsible for all responsibilities** required of it under this Contract, including those that the Contractor has determined to subcontract, notwithstanding the County's approval of the Contractor's proposed subcontract.

8.35.5 The County's Contract Director, or his/her designee, is authorized to act for and on behalf of the County with respect to approval of

any subcontract and Subcontractor. After approval of the subcontract by the County, Contractor shall forward a fully executed subcontract to the County for their files.

8.35.6 The Contractor shall be solely liable and responsible for all payments or other compensation to all Subcontractors and their officers, employees, agents, and successors in interest arising through services performed hereunder, notwithstanding the County's consent to subcontract.

8.35.7 The Contractor shall maintain the authority to require from its Subcontractors certificates of insurance, which establish that the Subcontractor maintains all the programs of insurance required by the Contractor from each approved Subcontractor. Upon request of the County, the Contractor shall ensure delivery of all such documents to:

County of Los Angeles
Department of Public Social Services
Contract Management Division - Section V
12900 Crossroads Parkway South
City of Industry, CA 91746
Attention: County Contract Administrator

before any Subcontractor employee may perform any work hereunder.

8.36 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

Failure of the Contractor to maintain compliance with the requirements set forth in Subparagraph 8.15 - Contractor's Warranty of Adherence to County's Child Support Compliance Program, shall constitute default under this Contract. Without limiting the rights and remedies available to the County under any other provision of this Contract, failure of the Contractor to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Contract pursuant to Subparagraph 8.39, Termination for Default and pursue debarment of the Contractor, pursuant to County Code Chapter 2.202.

8.37 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Failure of Contractor to maintain compliance with the requirements set forth in Subparagraph 8.48 - Warranty of Compliance with County's Defaulted Property Tax Reduction Program shall constitute default under this Agreement. Without limiting the rights and remedies available to County under any other provision of this Contract, failure of Contractor to cure such default within 10 days of notice shall be grounds upon which County may terminate this Contract and/or pursue debarment of Contractor, pursuant to County Code Chapter 2.206.

8.38 TERMINATION FOR CONVENIENCE

8.38.1 This Contract may be terminated, in whole or in part, from time to time, when such action is deemed by the County, in its sole discretion, to be in its best interest. Termination of work hereunder shall be effected by notice of termination to the Contractor specifying the extent to which performance of work is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent.

8.38.2 After receipt of a notice of termination and except as otherwise directed by the County, the Contractor shall:

- Stop work under this Contract on the date and to the extent specified in such notice, and
- Complete performance of such part of the work as shall not have been terminated by such notice.

8.38.3 **This** Contract may be terminated when such action is deemed by the Contractor, in its sole discretion, to be in its best interest. Termination of work hereunder shall be effected by notice of termination to the County specifying the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent.

8.38.4 All material including books, records, documents, or other evidence bearing on the costs and expenses of the Contractor under this Contract shall be maintained by the Contractor in accordance with Subparagraph 8.32, Record Retention and Inspection/Audit Settlement.

8.39 TERMINATION FOR DEFAULT

8.39.1 The County may, by written notice to the Contractor, terminate the whole or any part of this Contract, if, in the judgment of County's Contract Manager:

- Contractor has materially breached this Contract; or
- Contractor fails to timely provide and/or satisfactorily perform any task, deliverable, service, or other work required either under this Contract; or
- Contractor fails to demonstrate a high probability of timely fulfillment of performance requirements under this Contract, or of any obligations of this Contract and in either case, fails to demonstrate convincing progress toward a cure within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.

8.39.2 In the event that the County terminates this Contract in whole or in part as provided in Subparagraph 8.39.1, the County may procure,

upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated **as set forth in Section 1.31. of Exhibit A.** The Contractor shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. The Contractor shall continue the performance of this Contract to the extent not terminated under the provisions of this Subparagraph.

8.39.3 The Contractor shall not be liable for any such excess costs of the type identified in Subparagraph 8.39.2 if its failure to perform this Contract arises out of causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the fault or negligence of the Contractor. If the failure to perform is caused by the default of a Subcontractor, and if such default arises out of causes beyond the control of both the Contractor and Subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by

the Subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required performance schedule. As used in this Subparagraph, the term "Subcontractor(s)" means Subcontractor(s) at any tier.

8.39.4 If, after the County has given notice of termination under the provisions of this Subparagraph 8.39.3, it is determined by the County that the Contractor was not in default under the provisions of this Subparagraph 8.39.3, or that the default was excusable under the provisions of Subparagraph 8.39.3, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Subparagraph 8.38 - Termination for Convenience.

8.39.5 The rights and remedies of the County provided in this Subparagraph 8.39.5 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

8.40 TERMINATION FOR IMPROPER CONSIDERATION

8.40.1 The County may, by written notice to the Contractor, immediately terminate the right of the Contractor to proceed under this Contract if it is found that consideration, in any form, was offered or given by the Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing this Contract or securing favorable treatment with respect to the award,

amendment, or extension of this Contract or the making of any determinations with respect to the Contractor's performance pursuant to this Contract. In the event of such termination, the County shall be entitled to pursue the same remedies against the Contractor as it could pursue in the event of default by the Contractor.

8.40.2 The Contractor shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861.

8.40.3 Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

8.41 TERMINATION FOR INSOLVENCY

8.41.1 The County may terminate this Contract forthwith in the event of the occurrence of any of the following:

- Insolvency of the Contractor. The Contractor shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty (60) days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not the

Contractor is insolvent within the meaning of the Federal Bankruptcy Code;

- The filing of a voluntary or involuntary petition regarding the Contractor under the Federal Bankruptcy Code;
- The appointment of a Receiver or Trustee for the Contractor; or
- The execution by the Contractor of a general assignment for the benefit of creditors.

8.41.2 The rights and remedies of the County provided in this Subparagraph 8.41 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

8.42 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE

The Contractor, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by the Contractor, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of the Contractor or any County Lobbyist or County Lobbying firm retained by the Contractor to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Contract, upon which the County may in its sole discretion, immediately terminate or suspend this Contract.

8.43 TERMINATION FOR NON-APPROPRIATION OF FUNDS

Notwithstanding any other provision of this Contract, the County shall not be obligated for the Contractor's performance hereunder or by any provision of this Contract during any of the County's future fiscal years unless and until the County's Board of Supervisors appropriates funds for this Contract in the County's Budget for each such future fiscal year. In the event that funds are not appropriated for this Contract, then this Contract shall terminate as of June 30 of the last fiscal year for which funds were appropriated. The County shall notify the Contractor in writing of any such non-allocation of funds at the earliest possible date.

8.44 TERMINATION DUE TO TERMINATION OF CONTRACT BETWEEN DPSS AND PASC

The County may, by written notice to the Contractor, immediately terminate the right of the Contractor to proceed under this Contract if the contract between DPSS and PASC terminates. In the event of such termination, the County may terminate the whole or any part of this Contract.

8.45 UNLAWFUL SOLICITATION

Contractor shall inform all of its officers and employees performing services hereunder of the provisions of Article 9 of Chapter 4 of Division 3 (commencing with section 6150) of Business and Professions Code of the State of California (i.e. State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no

violation of said provisions by its officers and employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney, it will refer the patient to the attorney referral service of all those bar associations within Los Angeles County that have such a service.

8.46 VALIDITY

If any provision of this Contract or the application thereof to any person or circumstance is held invalid, the remainder of this Contract and the application of such provision to other persons or circumstances shall not be affected thereby.

8.47 WAIVER

No waiver by the County of any breach of any provision of this Contract shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Contract shall not be construed as a waiver thereof. The rights and remedies set forth in this Subparagraph 8.47 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

8.48 WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Contractor acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through contract are current in paying their property tax obligations

(secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

Unless Contractor qualifies for an exemption or exclusion, Contractor warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this contract will maintain compliance, with Los Angeles County Code Chapter 2.206.

8.49 NONDISCRIMINATION AND AFFIRMATIVE ACTION

8.49.1 The Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and shall be treated equally without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations.

8.49.2 The Contractor shall certify to, and comply with, the provisions of Exhibit D - Contractor's EEO Certification.

8.49.3 The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital

status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action shall include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

8.49.4 The Contractor certifies and agrees that it will deal with its Subcontractors, bidders, or vendors without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation.

8.49.5 The Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies shall comply with all applicable Federal and State laws and regulations to the end that no person shall, on the grounds of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Contract or under any project, program, or activity supported by this Contract.

8.49.6 The Contractor shall allow County representatives access to the Contractor's employment records during regular business hours to verify compliance with the provisions of this Subparagraph 8.49

when so requested by the County, and upon reasonable prior notice to Contractor.

8.49.7 If the County finds that any provisions of this Subparagraph 8.49 have been violated, such violation shall constitute a material breach of this Contract upon which the County may terminate or suspend this Contract. While the County reserves the right to determine independently that the anti-discrimination provisions of this Contract have been violated, in addition, a determination by the California Fair Employment and Housing Commission or the Federal Equal Employment Opportunity Commission that the Contractor has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by the County that the Contractor has violated the anti-discrimination provisions of this Contract.

8.49.8 The parties agree that in the event the Contractor violates any of the anti-discrimination provisions of this Contract, the County shall, at its sole option, be entitled to the sum of Five Hundred Dollars (\$500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Contract.

8.50 LOCAL SMALL BUSINESS ENTERPRISE (SBE) PREFERENCE PROGRAM

8.50.1 This Contract is subject to the provisions of the County's ordinance entitled Local Small Business Enterprise Preference Program, as codified in Chapter 2.204 of the Los Angeles County Code.

8.50.2 The Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Local Small Business Enterprise.

8.50.3 The Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Local Small Business Enterprise.

8.50.4 If the Contractor has obtained certification as a Local Small Business Enterprise by reason of having furnished incorrect supporting information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this contract to which it would not otherwise have been entitled, shall:

1. Pay to the County any difference between the contract amount and what the County's costs would have been if the contract had been properly awarded;
2. In addition to the amount described in subdivision (1), be assessed a penalty in an amount of not more than 10 percent of the amount of the contract; and
3. Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any business that has previously obtained proper certification, however, as a result of a change in their status would no longer be eligible for certification, and fails to notify the state and Internal Services Department of this information prior to responding to a solicitation or accepting a contract award.

8.51 CONTRACTOR'S CHARITABLE ACTIVITIES COMPLIANCE

The Supervision of Trustees and Fundraisers for Charitable Purposes Act regulates entities receiving or raising charitable contributions. The "Nonprofit Integrity Act of 2004" (SB 1262, Chapter 919) increased Charitable Purposes Act requirements. By requiring Contractors to complete the Charitable Contributions Certification, Exhibit J, the County seeks to ensure that all County contractors which receive or raise

charitable contributions comply with California law in order to protect the County and its taxpayers. A contractor which receives or raises charitable contributions without complying with its obligations under California law commits a material breach subjecting it to either contract termination or debarment proceedings or both. (County Code Chapter 2.202)

8.52 TRANSITIONAL JOB OPPORTUNITIES PREFERENCE PROGRAM

8.52.1 This Contract is subject to the provisions of the County's ordinance entitles Transitional Job Opportunities Preference Program, as codified in Chapter 2.205 of the Los Angeles County Code.

8.52.2 Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Transitional Job Opportunity vendor.

8.52.3 Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Transitional Job Opportunity vendor.

8.52.4 If Contractor has obtained County certification as a Transitional Job Opportunity vendor by reason of having furnished incorrect supporting information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this contract to which it would not otherwise have been entitled, shall:

1. Pay to the County any difference between the contract amount and what the County's costs would have been if the contract had been properly awarded;
2. In addition to the amount described in subdivision (1), be assessed a penalty in an amount of not more than 10 percent (10%) of the amount of the contract; and
3. Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any entity that has previously obtained proper certification, however, as a result of a change in their status would no longer be eligible for certification, and fails to notify the certifying department of this information prior to responding to a solicitation or accepting a contract award.

8.53 NO INTENT TO CREATE A THIRD PARTY BENEFICIARY CONTRACT

Notwithstanding any other provision of this Contract, the parties do not in any way intend that any person shall acquire any rights as a third party beneficiary under this Contract.

8.54 REPORTING OF CHILD/ELDER AND DEPENDENT ADULT ABUSE

8.54.1 Contractor staff working on this Contract shall comply with California Penal Code (hereinafter "PC") Section 11164 et seq. and shall report all known and suspected instances of child abuse to an appropriate child protective agency, as mandated by these code sections. Child abuse reports shall be made by telephone to the Department of Children and Family Services hotline at (800) 540-4000 within three (3) business days and shall submit all required information, in accordance with the PC Sections 11166 and 11167.

8.54.2 Contractor staff working on this Contract shall comply with California Welfare and Institutions Code (WIC), Section 15600 et seq. and shall report all known or suspected instances of physical abuse of elders and dependent adults either to an appropriate County adult protective services agency or to a local law enforcement agency, as mandated by these code sections. The Contractor staff working on this Contract shall make the report on

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IN WITNESS WHEREOF, Contractor has executed this Contract, or caused it to be duly executed and the County of Los Angeles, by order of its Board of Supervisors has caused this Contract to be executed on its behalf by the Acting Director of the Department of Public Social Services thereof, on the dates indicated below.

COUNTY OF LOS ANGELES

By: _____

Sheryl L. Spiller, Acting Director

Date

Department of Public Social Services

APPROVED AS TO FORM:

ANDREA SHERIDAN ORDIN

COUNTY COUNSEL

By _____

Senior Deputy County Counsel

Date

L. A. CARE HEALTH PLAN

By: _____

(Name of Authorized Signator for Contractor)

Date

L. A. Care Health Plan

By: _____

(Name of Authorized Signator for Contractor)

Date

L. A. Care Health Plan

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MEMORANDUM OF UNDERSTANDING

Between

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH,
LOCAL MENTAL HEALTH PLAN**

And

L.A. CARE

for

Implementation of a Coordinated System
of Health and Mental Health Services
to Medi-Cal Beneficiaries

THIS MEMORANDUM OF UNDERSTANDING ("MOU") IS MADE AND ENTERED INTO ON THE 20th DAY OF JANUARY, 2004 BY AND BETWEEN L.A. CARE, A CALIFORNIA HEALTH PLAN AND THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH AS THE LOCAL MENTAL HEALTH PLAN ("LMHP") IN LOS ANGELES COUNTY.

I. DEFINITIONS, UNDERSTANDINGS, TERMS AND INTENTIONS

Whereas, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provisions of specified Medi-Cal benefits and,

Whereas, pursuant to the State Plan, the State has contracted with the Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan ("L.A. Care") a locally created health plan and designated by the County's Board of Supervisors and,

Whereas, L.A. Care is the Local Initiative designated by the County Board of Supervisors, and as such, is a duly constituted local government agency, created pursuant to Welfare and Institutions Code Sections 14087.38(b) and 14087.9605, and Los Angeles County Ordinance and,

Whereas, L.A. Care is required to provide physical health services to Medi-Cal members through a system of contract providers, and whereas mental health treatment or services are not part of the required or offered health care services benefits to Medi-Cal beneficiaries offered by L.A. Care, except for mental health services within the scope of practice of the primary care physician and,

Whereas, the Los Angeles County Department of Mental Health as the Local Mental Health Plan ("LMHP") is required to provide mental health services to Medi-Cal

MEMORANDUM OF UNDERSTANDING
BETWEEN L.A. CARE AND THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AS THE LOCAL MENTAL HEALTH PLAN

beneficiaries under the authority of the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11, Sections 1810.100 through 1850.505 when Medi-Cal beneficiaries meet the medical necessity criteria of the Department of Mental Health for mental health services, and

Whereas, the LMHP and L.A. Care have agreed on the importance of health care services in the amelioration and/or management of mental health problems, and the importance of mental health services in the well-being of the individual and that coordination, collaboration, consultation and communication are of significant importance in the treatment and/or management of mental health and physical health conditions of members, and

Whereas, the LMHP and L.A. Care have agreed that this MOU will set out (1) the general relationship between the parties, (2) the responsibilities of L.A. Care, (3) the responsibilities of the LMHP, (4) the sharing of medical records, and (5) a dispute resolution between plans and,

Whereas, the services herein described by each party are services required by Federal and State regulations and the contract between L.A. Care Health Plan and the Department of Health Services (DHS) and,

Whereas, agreements in this MOU are not legally binding. Each term is defined by common usage as understood by each party. Disagreements about definitions, programs, missions, goals, or understandings shall be resolved by the general agreement of the parties, and,

Now, therefore, the parties understand as follows:

II. GENERAL RELATIONSHIP BETWEEN THE PARTIES

1. The LMHP and L.A. Care agree that the well-being of Medi-Cal beneficiaries is enhanced when appropriate health and mental health services are provided. Each party agrees to collaborate when physical health/medical matters are related to mental health matters and when mental health matters are related to physical health/medical matters.

Services Provided

2. The LMHP will provide mental health services to beneficiaries who qualify for services as defined by the Department of Mental Health pursuant to State regulations and LMHP contract with the State Department of Mental Health.
3. L.A. Care will provide physical health care services according to L.A. Care's contract with the State Department of Health Services, which includes the evaluation, assessment and treatment of mental health problems within the

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scope and practice of the primary care physician.

Financial Considerations

4. No contractual agreements or monetary obligations for either party are implied by this MOU. The services described by each party are services anticipated by the mission and goals, and the laws, regulations and formal policies and procedures governing the respective services of each party.
5. Monetary obligations are determined by the contracts between each party and the State Department of Mental Health or the State Department of Health Services.

Program Interface

6. Beneficiary confidentiality is to be maintained at all times as established by applicable laws, state and federal.
7. In particular, without intending to limit, the parties each acknowledge their separate and independent obligations with respect to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder ("HIPAA"). The parties understand and agree that HIPAA sets forth standards and imposes requirements upon each of them with respect to the privacy of patient "Protected Health Information" (PHI), and other matters. The parties represent to each other that they have taken steps to implement HIPAA in their respective systems and that they will each be responsible for compliance with HIPAA and other applicable state and/or federal laws with respect to the confidentiality of patient medical information. The parties commit to each other to resolve issues that arise related to PHI and other HIPAA matters (or state law matters) in good faith, consistent with their obligations under the law.
8. Each party to this MOU shall provide the phone number and location of twenty-four (24) hour emergency services of their respective services.
9. Each party to this MOU shall provide to the other the names and phone numbers of appropriate program and administrative liaison staff. Liaison staff shall be sufficiently acquainted with the respective Plan's programs to provide meaningful information and intervention.
10. Each party will provide to the other information sufficient to refer beneficiaries to health or mental health facilities in the beneficiaries' area of residence or geographic area of choice.
11. Culturally sensitive services shall be available for all Medi-Cal beneficiaries

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enrolled in L.A. Care Health Plan and the LMHP.

Data Collection and Information

12. Aggregate data may be shared for purposes of review, evaluation, and accountability.
13. While maintaining authorization by the beneficiary or authorized representative, and as established by applicable laws, information on prescription medication, treatment and diagnoses may be shared for purposes of integrated management of the beneficiary's medical and mental health conditions.

Consultation

14. Each party to this agreement shall develop a process for consultation to the other as necessary and as permitted by applicable law, including clinical consultation on medications in the interests of continuity of care for each Medi-Cal beneficiary.
15. L.A. Care providers will request consultation in those clinical situations deemed necessary to determine whether the beneficiary qualifies for the services of the LMHP.
16. The Department of Mental Health, as the LMHP, may request consultation concerning the medical condition of a beneficiary in those clinical situations deemed necessary to determine the beneficiary's need for physical health care.

III. RESPONSIBILITY OF DEPARTMENT OF MENTAL HEALTH AS THE
LMHP

Responsibilities and considerations of the LMHP are specified in the attached matrix that serves as the central part of the MOU specifically describing each party's responsibilities in the relevant interface areas (see attachment A). In general, the services of the Department of Mental Health, as the LMHP, are described below. It is understood by the parties that the LMHP will provide services only as medically necessary, and as outlined in Sections 1830.205 and 1830.210 of Title IX, Chapter 11 of the California Code of Regulations. The medical necessity criteria require that the beneficiary must meet the following criteria to be eligible for services:

1. Be diagnosed with an included diagnosis (See Section 1830.205(b)(1) for a list of these included diagnoses.)
2. Must have specific impairments as a result of the mental disorder. (see Section 1830.205(b)(2) for specific information on dysfunctions.)

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3. Must meet certain intervention criteria. (See Section 1830.205(b)(3) for the intervention criteria.)

Description of Service:

1. Mental health evaluation and assessment; diagnosis and triage.
2. Access to mental health services with the availability of a 24-hour, 7-day per week toll free telephone number.
3. Determination of qualifications of beneficiaries for services.
4. Medication management.
5. Treatment services which include: mental health inpatient services, case management services, therapy, co-occurring mental health substance abuse and diagnostic services, EPSDT supplementary services.
6. Emergency Services and consultation—24 hours daily.
7. Clinical consultation services.
8. Referral to appropriate services.
9. Pharmaceutical records.
10. Data collection/sharing.
11. Provider credentialing and enrollment of LMHP providers
12. Quality assurance/improvement plan and programs.
13. Dispute resolution processes.

IV. RESPONSIBILITY OF L.A. CARE

The responsibilities and considerations of L.A. Care are specified in the attached matrix that serves as that part of the MOU specifically describing each party's responsibilities in the relevant interface areas (see attachment A). In general, L.A. Care services are described below.

Primary care physicians may provide evaluation and assessment of mental health problems within their scope and practice. The primary care physician scope of practice may include, examination of the beneficiary, discussion of symptoms and problems, appropriate medication which alleviates specific conditions, and referrals for mental health services when such referrals are reasonably believed to be effective in alleviating the mental health symptoms and problems of the beneficiary.

L.A. Care will provide all physical health care services for Medi-Cal beneficiaries enrolled in the plan.

L.A. Care shall be responsible for providing those pharmacy services not carved-out to the State.

V. AREAS OF SHARED RESPONSIBILITY

1. Quality Assurance Program: Each party will maintain a quality assurance system consistent with statutes, regulations, established policies and good clinical

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- practice. Each party will provide information to the other if or as necessary to assist in the establishment, maintenance, review, and implementation of a quality assurance program.
2. Dispute Resolution: A plan shall be developed for resolving disputes between the two parties on the responsibility of care.
 3. Complaint and Grievance Process: Each party will establish a complaint and grievance process for identifying, reviewing and resolving beneficiary disagreements about services rendered. The grievance procedure established by L.A. Care and the grievance procedure established by the LMHP shall not be the same grievance procedure.
 4. Consultation: Each party shall provide consultation as appropriate for the effective management of the care of the beneficiary.
 5. Educational Programs: Educational programs of mutual benefit may be established by the mutual consent of either party.
 6. Beneficiary Referrals: Each party will establish a plan which outlines clearly the steps for referring beneficiaries to the other party on a 24 hour, 7 days per week basis for emergencies. Consultation shall also be available 24 hours per day, 7 days per week for medical or psychiatric emergencies.
 7. Daily Programs: Each party will provide to the other the daily programs (and phone numbers during business hours) designated for emergency, urgent, and ambulatory care.
 8. State Policy and Contractual Requirements: Each party shall follow State policy and contractual requirements specified under pharmacy and laboratory responsibilities and described in the attached matrix.
 9. Relevant Information to Interpret Medi-Cal Regulations: Each party will provide relevant information to inform the other of the nature of the respective programs, and to assist the other in interpreting Medi-Cal regulations, plans, statutes and rules to beneficiaries concerning services and benefits available in each plan.
 10. Confidentiality and Return of Property: Both parties acknowledge that, during the term of this MOU, they may have access to confidential material and information ("Proprietary Information") belonging to the other party or the other party's customers, vendors, or partners. "Proprietary Information" shall be expressly identified in writing as such by the party claiming such, and may include the disclosing party's computer programs and code, business plans, customer/patient lists and information, financial records, partnership arrangements and licensing plans. Proprietary information may include certain

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portions of the network data. Proprietary information does not include information generally available to the public, information the receiving party had in its possession prior to receiving it from or developing it for the disclosing party, information received from a third party, or information independently developed by the receiving party without reference to information received pursuant to this Agreement from the disclosing party. Each party agrees that the disclosing party's expressly identified Proprietary Information will be kept strictly confidential by the receiving party and will not be disclosed to non-employees and agents, unless expressly authorized to do so by the disclosing party. In addition, each party agrees to return all Proprietary Information, including network data, whether in written or other form, to the disclosing party upon termination of this MOU.

11. Notices: Notices hereunder shall be in writing and sent to the parties at the following addresses and the attention of the persons named.

Los Angeles Department of
Mental Health
Local Mental Health Plan

Los Angeles Dept. of Mental Health
Local Mental Health Plan
550 S. Vermont
Los Angeles, CA 90020
Attn: Marvin J. Southard, D.S.W., Director

L.A. Care Health Plan:

L.A. Care Health Plan
555 W. 5th St
Los Angeles, CA 90013
Attn: Howard A. Kahn, CEO

12. Effect of Headings: The titles or headings of the various paragraphs hereof are intended solely for convenience or reference and are not intended and shall not be deemed to modify, explain or place any construction upon any of the provisions of this MOU.

13. Counterparts: This MOU may be executed in one or more counterparts by the parties hereto. All Counterpoints shall be construed together and shall constitute one agreement.

14. Exhibits: All exhibits attached and referred to herein are incorporated.

15. Matrix of Responsibilities: The attached "Matrix of Responsibilities" of this MOU describes in detail the responsibilities and commitments of each party under this MOU. Specific written policies and procedures will be developed to delineate the operational aspects of each of the described areas.

16. Term: This MOU shall be for a term of five years from the date of signature between L.A. Care Health Plan and the L.A. County Local Mental

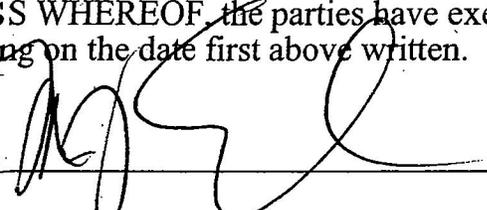
MEMORANDUM OF UNDERSTANDING
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Health Plan, unless earlier terminated as provided in this Agreement. Thereafter, this MOU shall be without further action of the parties, automatically renewed for additional one (1) year terms, unless a party expresses its intent to the contrary. Either party may terminate this MOU without cause upon giving 60 days notice. Either party may terminate this MOU immediately upon a material breach by the other party.

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17. Amendment: The terms and conditions of this MOU shall only be revised through a separate writing of the parties. The terms and conditions of this MOU shall supercede any previous MOU between the parties dealing with the same subject matter.

IN WITNESS WHEREOF, the parties have executed this Memorandum of Understanding on the date first above written.

By  Date: 1/20/04

Marvin J. Southard, D.S.W.
Director
Los Angeles County, Department of Mental Health

By  Date: 5 Dec 03

Howard A. Kahn
Chief Executive Officer
L.A. Care Health Plan

ATTACHMENTS

MEMORANDUM OF UNDERSTANDING

BETWEEN

L.A. CARE

AND

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH REGARDING EXCHANGE OF INFORMATION RELATED TO SENIORS AND PERSONS WITH DISABILITIES

PARTIES

L.A. Care, a California Health Plan, is a locally created health plan and the local initiative designated by the County's Board of Supervisors, which is required to provide physical health services to Medi-Cal members through a system of contract providers.

The County of Los Angeles Department of Mental Health (DMH) is the Local Mental Health Plan (LMHP) responsible for providing medically necessary mental health services to eligible Medi-Cal beneficiaries, and does so both directly through its directly operated programs and through contracts with private mental health providers.

BACKGROUND

On January 20, 2004, L.A. Care and DMH made and entered a Memorandum of Understanding for Implementation of a Coordinated System of Health and Mental Health Services to Medi-Cal Beneficiaries.

Pursuant to a contract with the State of California to provide managed care services for certain categories of Medi-Cal benefits, new members described as "Seniors and Persons with Disabilities" ("SPD enrollees") are being assigned as members of L.A. Care. The new SPD enrollees may also be clients of DMH.

L.A. Care and the County of Los Angeles are "covered entities" under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and L.A. Care and DMH are both subject to the requirements of HIPAA, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations") and the Health Insurance Reform: Security Standards ("the Security Regulations") at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164 (together, the "Privacy and Security Regulations") and also certain provisions of the Health Information Technology for Economic and Clinical Health Act, Title XIII and Title IV of Division B of Public Law 111-005 ("HITECH Act").

HIPAA prohibits a covered entity from using or disclosing protected health information (PHI) except as required or permitted by HIPAA. HIPAA permits a covered entity to use PHI for its own treatment or health care operations, including coordination of care, to disclose PHI for treatment activities of another health care provider and to disclose PHI to another covered entity for certain health care operations activities (such as coordination of care) of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested.

Accordingly, HIPAA permits and does not prohibit the parties from sharing or exchanging PHI of common clients for the purposes of coordinating the care of these common clients. To that end, HIPAA permits and does not prohibit a covered entity from using PHI to identify common clients for purposes of coordinating care.

In order to ensure that the care provided to SPD enrollees of L.A. Care and DMH Medi-Cal clients is coordinated, it is necessary for L.A. Care and DMH to identify their mutual clients. The parties agree that for this purpose, DMH is the entity that should conduct the data match of DMH and L.A. Care's respective clients. This is for the mutual benefit of DMH and L.A. Care. However, doing so will necessarily require L.A. Care to disclose to DMH the name and other limited identifying information of individuals for whom DMH may not in fact presently be providing services or treatment.

Accordingly, the parties agree that DMH shall be a Business Associate of L.A. Care to the extent that for purposes of conducting the match of common clients, it receives PHI from L.A. Care for non-DMH clients.

PURPOSE

Individuals with severe and persistent mental disorders have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their mental health service provider functions as their primary connection to the overall healthcare system. By performing a data match and transmitting the results to the physical healthcare plan providing services to the matched clients, DMH helps achieve two important results for DMH clients.

The match data can potentially help alert healthcare providers to ongoing mental health needs and interventions in individuals served by both systems. These mental health needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and mental health providers that can improve the health status and treatment outcomes of those served.

Results of this match would also provide DMH with information that would allow the Department to more efficiently and effectively facilitate access to much needed physical healthcare services for DMH clients.

OPERATIVE PRINCIPLES

This MOU is solely intended to document the intent of the parties with respect to the sharing of information regarding enrollees of L.A. Care SPD and to document the satisfactory assurances required by paragraph (e) of 45 C.F.R. 164.502.

DEFINITIONS

Attached hereto and incorporated by reference is a list of definitions. Terms used but not otherwise defined in this MOU shall have the same meaning as those terms in the HIPAA Regulations and HITECH Act unless the context clearly demonstrates otherwise.

Now therefore, the parties to this MOU agree as follows:

1. PROTOCOLS GOVERNING THE EXCHANGE OF INFORMATION

- 1.1 L.A. Care shall provide to DMH the information described in the attached Protocol for the Sharing of Enrollee/Client Information (Protocol). The parties agree for purposes of this MOU that this information shall be treated as Protected Health Information (PHI).
- 1.2 L.A. Care and DMH have reviewed the attached Protocol and have jointly determined that the PHI described in section 1.1 meets the minimum necessary standard.
- 1.3 L.A. Care shall transmit the PHI described in section 1.1 in the manner described in the attached Protocol.
- 1.4 L.A. Care is responsible for ensuring that the manner in which the information described in section 1.1 is transmitted to DMH complies with HIPAA.
- 1.5 DMH shall use the PHI described in section 1.1 solely for purposes of determining which L.A. Care enrollees are also LMHP clients and thereafter for purposes of coordinating care.
- 1.6 DMH shall transmit to L.A. Care the PHI of matched individuals, i.e., L.A. Care enrollees who are also LMHP clients, in the manner described in the attached Protocol.
- 1.7 DMH is responsible for ensuring that the manner in which the information described in section 1.1 is transmitted to DMH complies with HIPAA.

2. COORDINATION OF CARE

- 2.1 L.A. Care shall use the information identifying common clients transmitted to it by DMH for purposes of coordinating the L.A. Care enrollee's care.
- 2.2 DMH shall use the information identifying common clients for purposes of coordinating the LMHP client's care.

3. HIPAA OBLIGATIONS OF THE PARTIES

- 3.1 L.A. Care and DMH acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.
- 3.2 Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent the unpermitted uses or disclosures of such PHI.

4. BUSINESS ASSOCIATE OBLIGATIONS

- 4.1 Permitted Uses: DMH may use the PHI regarding non-LMHP clients for the purpose set forth in section 1.5; to provide data aggregation services relating to L.A. Care's health care operations; and, if necessary, for the proper management and administration of DMH.
- 4.2 Prohibited Uses: DMH shall not use or further disclose PHI regarding non-LMHP clients other than as permitted or required by this MOU or as required by law.
- 4.3 Safeguards: DMH shall use appropriate safeguards to prevent the use or disclosure of PHI regarding non-LMHP clients other than as permitted or required by this MOU and shall implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information (EPHI) regarding non-LMHP clients.
- 4.4 Security Requirements: As a Covered Entity, DMH is required to comply with Sections 164.308, 164.310, 164.312, and 164.316 of the Security Rule and shall so comply with respect to its use or disclosure of PHI regarding non-LMHP clients.
- 4.5 Minimum Necessary Standard: DMH agrees to limit the Use and Disclosure of PHI regarding non-LMHP clients to the Minimum Necessary in accordance with the Privacy Regulation's minimum necessary standard as in effect or as amended.

- 4.6 Unauthorized Use/Disclosure or Security Incident: DMH shall promptly and without delay report to L.A. Care any unauthorized use or disclosure of PHI or security incident regarding non-LMHP clients of which DMH becomes aware.
- 4.7 Agents: DMH shall not provide PHI regarding non-LMHP clients to non DMH staff. If DMH does, it shall ensure that any agents, including subcontractors, to whom it provide such information agrees to the same restrictions set forth in this section 4, including section 4.4.
- 4.8 Availability of PHI: L.A. Care and DMH have determined that the PHI transmitted by L.A. Care to DMH does not constitute a “designated record set” as defined by 45 C.F.R. § 164.501. However, DMH shall make available PHI in accordance with 45 C.F.R. § 164.524 and 45 C.F.R. § 164.526.
- 4.9 Accounting of Disclosures: L.A. Care and DMH have determined that the PHI transmitted by L.A. Care to DMH does not constitute a “designated record set” as defined by 45 C.F.R. § 164.501. However, DMH shall within 10 days make available to L.A. Care such information as is in DMH's possession regarding non-LMHP clients and is required for L.A. Care to make the accounting required by 45 C.F.R. § 164.528 and/or the HITECH Act.
- 4.10 Availability of Books and Records: DMH shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by DMH on behalf of, L.A. Care regarding non-LMHP clients available to the Secretary of the Department of Health and Human Services, upon request, for purposes of determining L.A. Care's compliance with the Privacy or Security Standards.
- 4.11 Return/Destruction of PHI: Upon termination of this MOU and following the data match performed by DMH, DMH shall return or destroy the PHI regarding non-LMHP clients provided to it by L.A. Care.
- 4.12 Termination: Either party may terminate this MOU if that party determines that the other party has violated a material term of this MOU.
- 4.13 Breach Notification: DMH shall report to L.A. Care each Breach of PHI regarding non-LMHP clients by DMH, its employees, representatives, agents, or subcontractors of Unsecured Protected Health Information promptly upon discovery, as such terms are defined in HIPAA and the HITECH Act. The parties agree to fully cooperate with each other to ensure timely notification of the Individual and/or Federal Office for Civil Rights. Notification required by this section may be delayed if requested by law enforcement as provided for by HIPAA and the HITECH Act.

- 4.14 Mitigation of Harmful Effect: DMH agrees to mitigate, to the extent practicable, any harmful effect that is known to it of a Use or Disclosure of PHI regarding non-LMPH clients by DMH in violation of the requirements of this MOU.
- 4.15 Survival: DMH's obligations regarding PHI of non-LMHP clients shall survive the termination or expiration of this MOU.
- 4.16 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in this MOU, upon either party's knowledge of a material breach by the other party, the party with knowledge of the other party's breach shall:
- (a) Provide an opportunity for the breaching party to cure the breach or end the violation and terminate this MOU if the breaching party does not cure the breach or end the violation within the time specified by the non-breaching party;
 - (b) Immediately terminate this MOU if a party has breached a material term of this MOU and cure is not possible; or
 - (c) If neither termination nor cure is feasible, report the violation to the Secretary of the Federal Department of Health and Human Services.

5. MISCELLANEOUS PROVISIONS

- 5.1 No Third Party Beneficiaries: Nothing in this MOU shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.
- 5.2 Regulatory References: A reference in this Business Associate Agreement to a section in the Privacy or Security Regulations means the section as in effect or as amended.
- 5.3 Interpretation: Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the Privacy and Security Regulations.
- 5.4 Amendment: The parties agree to take such action as is necessary to amend this MOU from time to time as is necessary for the parties to comply with the requirements of the Privacy and Security Regulations, HITECH, and other privacy laws governing the exchange of PHI.

6. TERM

6.1 This MOU is effective September 1, 2011.

6.2 This MOU shall continue in full force and effect until terminated by the parties.

7. TERMINATION

7.1 This MOU may be terminated at any time by either party upon the giving of 10 days advance written notice to the other party.

7.2 This MOU may be terminated at any time by the mutual agreement of the parties.

8. NOTICES

8.1 L.A. Care: Notices shall be in writing and sent to:

Local Initiative Health Authority for Los Angeles County

1055 West 7th Street, 10th Floor

Los Angeles, California 90017

Attention: Chief Medical Officer

Fax: (213) 438-5749

8.2 DMH: Notices shall be in writing and sent to:

Los Angeles County Department of Mental Health

550 S. Vermont Avenue, 12th Floor

Los Angeles, CA 90005

Attention: Medical Director

9. COUNTERPARTS

9.1 This MOU may be executed in one or more counterparts by the parties hereto. All such Counterparts shall be construed together and shall constitute one agreement.

10. EXHIBITS

10.1 All Exhibits attached and referred to herein are incorporated here by reference.

IN WITNESS WHEREOF, the parties hereto have executed this MOU effective as of February 7, 2012.

L.A. Care:

**Los Angeles County
Department of Mental Health:**

By: Glennie Batts

By: [Signature]

Title: CMO

Title: Director

Dated: 2/8/2012

Dated: 02.07.12

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH/L.A. CARE SENIORS AND PERSONS WITH DISABILITIES DATA EXCHANGE PROTOCOL

Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty mental health care among enrollees of the L.A. Care Health Plan (L.A. Care) who are also clients of the Los Angeles County Department of Mental Health (DMH). In no way should this document supersede or replace the Memorandum of Understanding between the above mentioned parties. This document serves as a protocol for the exchange of protected identifying information between the two parties.

Data Exchange Details

DMH will provide a secured location for L.A. Care to place a data file of beneficiaries identified as Seniors and Persons with Disabilities (SPD), initially in the form of a flat text file, on an interval agreed upon by DMH and L.A. Care. Once both parties are prepared to produce and consume an X12 834 message, the format will be converted from a flat file to the 834 format. The data file, at a minimum, shall contain the following demographic identifying elements:

- **Member First Name**
- **Member Last Name**
- **Member Social Security Number**
- **Member CIN**
- **Member Date of Birth**
- **Member Residence Address**
- **Member Residence City**
- **Member Residence State**
- **Member Residence Zip**
- **Member Gender**
- **Member Ethnicity**
- **Member Race**
- **L.A. Care Internal MHC Member Number**
- **Primary Care Physician Name**
- **Primary Care Physician Contact Phone Number**
- **Primary Care Physician Address**

Match Details

Upon receipt of the SPD file DMH shall load the data to the DMH Enterprise Data Warehouse. DMH shall maintain a historical table of SPD beneficiaries and their respective eligibility information. DMH shall conduct a match of concomitant beneficiaries between L.A. Care and DMH, on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or “match” like clients of DMH and L.A. Care. The match is performed in “tiers” where client data cascades through multiple algorithms to identify like records; when a record does not meet criteria, it is passed to the next algorithm. This process continues until a positive match is found or the record has been passed through all tier criteria. For example, records that do not match on Tier 0 will pass to Tier 1, etc. Each Tier contains unique criteria, which must be met in order to match records. The criteria may contain fuzzy match variables weighted at specified degrees, where a higher weight specifies that the variable must match to a greater precision. The following is a summary of criteria and variable weights:

Tier 0:

- Member CIN weighted at 100%

Tier 1:

- Member Social Security Number weighted at 100%
- Member Date of Birth weighted at 100%

Tier 2:

- Member Social Security Number weighted at 85%
- Member Full Name weighted at 90%

Tier 3:

- Member Social Security Number weighted at 85%
- Member Last Name weighted at 85%

Tier 4:

- Member Social Security Number weighted at 100%
- Member Year of birth weighted at 100%

Tier 5:

- Member Full Name weighted at 90%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Tier 6:

- Member Full Name weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Or

- Member Full Name Order reversal weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

L.A. Care Usage

Upon completion of the match, DMH shall extract and provide (as described below), matched clients who currently have an open and active episode in the DMH Integrated System (IS) or successor DMH electronic health record (EHR) to L.A. Care in the form of a flat text file. Diagnostic and service related data will not be included in the data sent to L.A. Care since the purpose of the exchange is coordination of care. DMH will also not send historical information regarding client contacts with Emergency and/or Acute Psychiatric Services. DMH will, at a minimum, provide the following elements:

- Admission Date of Episode
- Last Mental Health Contact Date
- Mental Health Provider ID
- Mental Health Provider Name
- Mental Health Provider Address
- Mental Health Provider Contact Phone Number
- Mental Health Provider Primary Contact Name

The response data file will be placed on a secured server administered and maintained by the DMH. L.A. Care will retrieve the file and distribute the mental health provider contact information to its Primary Care Providers (PCP) using one of the following methods:

- A list will be generated for the PCP's own assigned members and distributed by mail
- Data will be accessible via a Provider Portal with security controls which limit display to the PCP's assigned members based on user credentials
- A list will be generated to the Participating Provider Group (PPG) via mail for its respective PCPs. The PPG will then forward a list to PCPs of their respective assigned members via mail

DMH Usage

After processing the SPD data, DMH will upload the PCP information for matched clients to the DMH IS or successor DMH EHR. Mental Health treatment providers will then be able to access the data via the IS or successor DMH EHR. The information will be displayed as supplemental detail in order to facilitate coordination of care with Primary Care Providers. Access to the IS or successor DMH EHR is controlled via user credentials.

DEFINITIONS

"Breach" has the same meaning as the term "breach" in 45 C.F.R. § 164.402.

"Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

"Electronic Health Record" has the same meaning as the term "electronic health record" in the HITECH Act, 42 U.S.C. section 17921. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

"Electronic Media" has the same meaning as the term "electronic media" in 45 C.F.R. § 160.103. Electronic Media means (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. The term "Electronic Media" draws no distinction between internal and external data, at rest (that is, in storage) as well as during transmission.

"Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103. Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

"Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

"Minimum Necessary" refers to the minimum necessary standard in 45 C.F.R. § 162.502 (b) as in effect or as amended.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164, also referred to as the Privacy Regulations.

"Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. Protected Health Information includes information that (i) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. "Protected Health Information" includes Electronic Health Information.

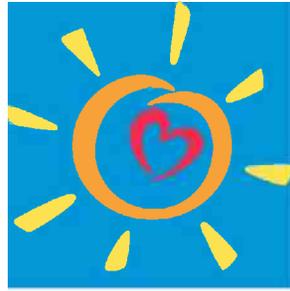
"Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

"Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

"Security Rule" means the Security Standards for the Protection of Electronic Health Information also referred to as the Security Regulations at 45 Code of Federal Regulations (C.F.R.) Part 160 and 164.

"Unsecured Protected Health Information" has the same meaning as the term "unsecured protected health information" in 45 C.F.R. § 164.402.

"Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.



L.A. Care
HEALTH PLAN®

Preface

This document presents L.A. Care's draft SNP Model of Care Elements and Standards for the Dual Eligible Demonstration. This is a modification of the elements and standards implemented in our D-SNP, which has been operating in L.A. County since 2008.

Many details regarding California's Dual Eligible Demonstration were unknown as this document was prepared. Claims data for the target population were not available, and rates had not been set. The extent to which Medicare Advantage rules may be waived or modified was not known. The Legislature was considering LTSS policy with potentially significant implications for the Demonstration. This tentative Model of Care is based on our best assumptions at the time of submission.

Vision

- Every beneficiary experiences a seamless, person-centered plan of care that integrates physical health, mental health and long-term services and supports.
- Integrated systems consistently manage transitions for their members and prevent avoidable hospital and nursing home admissions in real time.

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I. *Description of the Dual Eligible Target Population*

The target population is all adult Medicare-Medicaid dual eligibles in Los Angeles County. This is a diverse group, from young adults to very old persons, who bring with them many distinct cultures and more than 100 languages. Some are homeless. Others live alone, with family or friends, in subsidized housing, in various types of residential care or in nursing homes. It includes some with relatively few health needs, but from our experience to date in our D-SNP, and as reported in national studies, we know that dual eligible beneficiaries have more serious and complex health needs than the broader Medicare or Medicaid populations. They are more likely to live with disability of all types, including intellectual, cognitive, mental and physical; to have multiple chronic conditions and to have difficulty completing three to six activities of daily living.. L.A. Care's dual eligible model of care addresses multiple conditions including, but are not limited to, the following:

- Diabetes
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Depression
- Serious Mental Illness
- Dementia
- Frailty
- Developmental Disability
- Limitations in Activities of Daily Living
- End of Life

II. Measureable Goals and Objectives

Improving access to essential services including medical, mental health, long-term services and supports, and social services:

Access to Medical Services

In order for L.A. Care to ensure an adequate network of primary and specialty care practitioners for members to access medical services, L.A. Care's Provider Network Operations (PNO) has established quantifiable standards for both geographic distribution and numbers (ratio of providers to members) of PCPs¹, and high volume specialists (SCPs). The L.A. Care standards and contractual requirements define the geographic standards and ratios for PCPs.

Access to Mental Health Services

L.A. Care partners with a Managed Behavioral Health Organization (MBHO), CompCare, to integrate medical providers with behavioral health practitioners (BHPs) and use information collected to improve coordination of medical and behavioral health care. CompCare has established quantifiable standards for measuring emergent, urgent, and routine appointment access to mental health services.

Access to Long-term Services and Supports (LTSS)

L.A. Care believes there is significant undetected need for home- and community-based services (HCBS), and that expanding access will improve quality of life and avoid preventable

¹ L.A. Care defines PCPs as physicians in Internal Medicine, Family Practice, Pediatrics, General Practice, and Obstetrics/Gynecology.

admissions to hospitals and nursing homes. Once we are able to establish a robust baseline measurement of need through health risk assessments and other processes, L.A. Care will establish measurable goals for expanding access to HCBS.

Access to Social Services

L.A. Care's goal is to ensure that dual eligible members have access to effective social work services whenever psychosocial or financial needs are barriers to achieving care plan goals. L.A. Care will meet this need directly, through on-staff licensed clinical social workers (LCSW), and also in partnership with the County of Los Angeles and others who will provide social work services on a referral basis. If the social work needs of our dual eligible members cannot be met with existing capacity, we will expand our staff, contractors or both to meet the need.

Access to Cultural & Linguistic Needs

In order to ensure medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and provided in a culturally and linguistically appropriate manner by qualified, competent practitioners and providers committed to L.A. Care's mission, L.A. Care assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of providers if necessary.

L.A. Care uses software to assess availability of PCPs to members for the largest non-English speaking group of members, and establishes network development goals to meet the needs of our members wherever we detect gaps in cultural competency.

Improving access to affordable care

L.A. Care members' access to affordable care is improved by ensuring that every member has a PCP, and through the PCP, gets access to specialty services as needed. Pending analysis of historical costs and receipt of final rates, L.A. Care will enhance access to benefits not otherwise covered by Medicare or Medi-Cal, which may include preventive dental care, eye care, and community based services that make it possible for members to remain in their homes and communities, such as home modifications and home-delivered meals.

Assuring appropriate utilization of services by:

L.A. Care assures appropriate utilization of services by monitoring and measuring hospital-based care goals such as defined:

- Reducing admissions, readmissions and bed-days
- Reducing unplanned re-admission rates
- Reducing preventable hospitalizations
- Decrease inappropriate emergency room utilization
- Reducing institutional care

Improve coordination of care through an identified point of contact:

Our vision is that every member experiences a seamless, person-centered plan of care that integrates physical health, mental health and long-term services and supports. Our immediate goal is for every member to have a clearly identified point of contact for all coordination of care. Depending on the member, the locus of coordination may be a care manager at L.A. Care, or with one of our delegated partners, including health plans and provider groups. Regardless of the locus

on coordination, L.A. Care monitors performance areas affecting and reflecting coordination of care on an annual basis using a coordination of care survey and other data.

L.A. Care uses a standard sliding scale for the short term goals. This is dependent on the prior year's performance rate which will subsequently determine the percentage change expected. This goal will be assessed annually against the performance rate results for specific measures.

Improve seamless transitions of care across healthcare settings, providers, and health services:

Also included in our vision is that systems consistently manage transitions for their members and prevent avoidable hospital and nursing home admissions in real time. L.A. Care improves seamless transitions of care across healthcare settings, providers and health services by coordinating services for members at high risk for a transition and constant communication with the member or responsible party and provider about changes to the member's health status and plan of care throughout the care transition.

- The L.A. Care Care Management Department manages the process of care transitions, identifies problems that could cause transitions, and where possible prevents unplanned transitions and makes a special effort to coordinate care when members move from one care setting to another, such as when they are discharged from a hospital. L.A. Care identifies and measures communication between PCPs and Specialty Care Providers, including hospitalists, (SCPs) by administering surveys for coordination of care to detect and bridge gaps in any continuity of care that may have happened as a result of breakdowns in communication.

L.A. Care focuses on communication between PCPs and SCPs because breakdowns in communication can result in gaps in continuity of care which impact patient safety and member satisfaction with care.

Improving access to preventive health services

Having a PCP greatly increases the likelihood that members will receive preventative services. L.A. Care's goal is to provide an adequate network of primary and specialty care practitioners for members, and to ensure that every member has a PCP. L.A. Care's Provider Network Operations (PNO) has established quantifiable standards for both geographic distribution and numbers (ratio of providers to members) of PCPs², and high volume specialists (SCPs). The L.A. Care standards and contractual requirements define the geographic standards and ratios for PCPs.

Improving beneficiary health outcomes

L.A. Care Health Plan adopts evidence-based clinical practice guidelines promulgated by recognized sources for selected conditions identified as relevant to its membership for the provision of non-preventive health, acute and chronic medical conditions, and for preventive and non-preventive behavioral health services.

L.A. Care annually measures performance of at least two important aspects for each of its clinical practice guideline measures and determines measurable goals for each indicator.

Establishing Measureable Outcomes

² L.A. Care defines PCPs as physicians in Internal Medicine, Family Practice, Pediatrics, General Practice, and Obstetrics/Gynecology.

L.A. Care considers the desired level of achievement that the organization sets for itself as its standard of care as a performance goal. Goals are derived from the baseline year for each specific measure and should be measurable such that an annual data analysis to measure its performance against its goals can be collected and performed. L.A. Care formally adopts and maintains goals against which performance is measured and assessed.

Benchmarks, on the other hand, are taken from the best performance in other organizations, local, State or national norms (external to the organization) as established through comparative data, or reasonable expectations for a specific measure.

The terms benchmark and performance goals are not necessarily one and the same. A recognized benchmark may be a performance goal, but sometimes there is not an established or available benchmark for a particular indicator. If this is the case, L.A. Care may create an internal performance goal based on clear rationale such as a statistically significant increase from the baseline rate.

L.A. Care's Quality Improvement infrastructure includes a comprehensive array of clinical and service performance measurement activities that provide information about the processes and outcomes of clinical services and member services.

When identifying critical performance measures, the demographic characteristics and health risks of the covered population are considered. Key indicators are identified. These indicators are related to structure, process, or outcome of care or service delivery. A sound rigorous measurement methodology is developed and followed for all indicators. Performance is measured and tracked overtime. Most indicators are rate-based indicators or scalar measures. Rate-based indicators describe the percentage or ratio at which a subgroup is evident among a larger group. Scalar measures use a scale such as satisfaction rating (i.e. Likert) scale. Some indicators are sentinel event indicators and require analysis of each and every occurrence.

Corrective Action Plans & Interventions

Performance data for the key indicators are collected, aggregated, and analyzed on a rolling schedule. Multiple data points are displayed together on graphs to show historical performance and facilitate data analysis and trending. Each review includes quantitative and qualitative (causal) analysis. Evaluating the effectiveness of previous interventions is included and influences the next step in planning.

Action is triggered when undesirable sentinel events, patterns and/or trends are identified; comparison with established benchmarking reflects an undesirable level of performance and/or undesirable variance from recognized and accepted standards; improvement is desired, even in the absence of a performance variance; or compliance falls beneath the standard or goal set by L.A. Care and/or a regulatory body.

Interventions are planned and implemented based on the data analysis. When areas for improvement are identified, efforts to develop improvement strategies are prioritized. An in-depth review is conducted on the areas identified as having the greatest potential for improving care, safety, and health status outcomes of members. Continuous quality improvement is realized when data are collected and analyzed, interventions are planned and implemented, measurement is repeated and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the calendar year. Quality improvement is accomplished by using the improvement model described. This process embraces the Plan, Do, Study, and Act (PDSA) model of improvement.

The L.A. Care QI Department works with other departments to address opportunities to improve the delivery of care through the selection, design, and implementation of interventions.

Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, providers, or services.

Interventions to improve performance include health promotion and health education programs, to inform members of ways to improve their health or their use of the health care delivery system, modifications to administrative processes, to improve quality of care, accessibility and service and modifications to the provider network such as additions to improve accessibility and availability. These processes may include customer services, utilization management and case management activities, preventive services and health education. Interventions to improve provider performance include presentation of provider education programs, individual provider feedback on individual and aggregate performance and distribution of best practice material.

III. Staff Structure & Care Management Roles

Administrative Functions

L.A. Care's staff includes specific employed staff who perform administrative functions (e.g., process enrollments verify eligibility, process claims, etc.)

- **Enrollment Specialist(s) and Representative(s) Role**

Enrollment processing and verification of eligibility is performed by Enrollment Specialist(s) and Representative(s) in the Enrollment Unit of L.A. Care. Enrollment applications are reviewed thoroughly to ensure that potential members meet the full dual eligible qualifications, including all Medicare required components (Parts A, B, and D), and L.A. County residence before processing. An outbound enrollment verification call is conducted with the eligible beneficiary to confirm the enrollment, and a letter is sent if the call attempt is not successful. L.A. Care

understands the enrollment process may differ for the Dual Eligible Demonstration than what currently occurs for D-SNP enrollment, where enrollment transactions are submitted to the Centers for Medicare & Medicaid Services (CMS) within 7 days of receipt of application. The Enrollment Unit is also accountable for processing cancellation of enrollment and disenrollment requests.

- **Claims Examiner I; Claims Examiner II Role**

Claims are reviewed, developed and processed by specially trained Claims Examiner I and Claims Examiner II staff in the Claims Department of L.A. Care. Part C claims are reviewed thoroughly to ensure that all required information is available before processing and that the member was eligible on the date of service. If additional information is required from the provider, the claims examiner requests that information via letter; or if there is not sufficient time by phone. If the claims is clean or if any missing information has been obtained from the provider, then the claims examiner determines whether the services require an authorization. If the services require an authorization, the claim and medical records if supplied are forwarded to the Utilization Management (UM) Department for review. If the services are approved by UM or are covered even without an authorization, then the correct level of reimbursement calculated based on bundled payment criteria, the provider contract pricing if applicable, or regulatory non-contracted provider minimum payment rules and released for payment in the next check run. The claims staff is responsible for identifying and coordinating payment with the primary carrier based on Medicare Secondary Payer (MSP) rules, if the member has other health coverage, Workers' Compensation or Third Party Liability (TPL) coverage. If the member is not eligible, or if the services were not eligible for payment, then the claim is denied. If a claim is denied and the member is liable for the expense, an appropriate denial letter is sent to the provider and member. The claims examiner is responsible for ensuring that regulatory requirements for

timeliness of payment are satisfied. If those requirements are not met and the claim was a clean claim from a non-contracted provider, then the examiner must compute and pay interest on the claim.

- **Credentialing Auditor(s) and Specialist(s) Role**

Credentialing staff perform annual oversight of credentialing functions of our IPAs and medical groups to ensure compliance with L.A. Care, state and federal credentialing standards. Oversight includes monitoring delegated plans and provider groups to ensure they maintain current policies and procedures. During the oversight process, L.A. Care validates that the procedures are in place and all reports that are required meet all state and federal regulatory requirements. Additionally, if delegates are not in compliance with a standard or a requirement, L.A. Care issues a Corrective Action Plan and follows it through until it is completely met. These functions are all reported on a monthly basis to the Credentialing Committee. The Credentialing Auditors/Specialists monitor OIG, the Medi-Cal Suspended & Ineligible List, the Medicare Opt-Out, and the Medical Board of California Hot Sheet along with other publications on a monthly basis. Any practitioners or providers identified on these lists are removed from the network and members are reassigned accordingly. L.A. Care also credentials and re-credentials providers and hospitals, and other ancillary facilities. L.A. Care performs primary source verification on all elements as required per our policies and procedures and all state, federal, and accreditation bodies.

- **Encounter Data Manager Role**

The review of encounter data for appropriateness and timeliness of services is performed by the Encounter Data Manager of the Financial Compliance Department of L.A. Care. The Encounter Data Manager is responsible for collecting encounter data from Plan Partners, Preferred Provider Groups (PPGs), the Pharmacy Benefit Manager (PBM), Vision Service Plan (VSP),

CompCare, third party vendors and the internal Claims Department for the Medi-Cal, Healthy Families, and L.A Care Health Plan's Medicare Advantage (D-SNP) lines of business. The Encounter Data Manager ensures that encounter data volume, quality and timeliness are compliant with regulatory and L.A. Care required benchmarks.

Clinical Functions

- **Chief Medical Officer and the Medical Management Medical Director Role**

The clinical functions of the Dual Eligible Demonstration ultimately are under the direction of the Chief Medical Officer and the Medical Management Medical Director. These senior clinicians provide guidance to employed and contracted staff and are responsible for all clinical aspects of the program. Responsibilities include:

- Leadership for assurance of consistent adoption and implementation of all care management strategies, policies and processes
- Clinical leadership for the development and implementation of a consistent care management program based on best practice
- Clinical leadership for care management regulatory and accreditation activities

To effectively achieve the program goals and objectives, licensed health care professionals (including nurses, physicians and other clinical professionals) are responsible and accountable for the clinical functions and activities. These clinical professionals provide oversight and management of the program. Additionally, non-licensed personnel support and facilitate various program functions.

- **Senior Director of Health Services Role**

The Senior Director of Health Services is responsible for the leadership, administration and general management of several key health service operational units: Medical Management, L.A. Care Health Plan

Credentialing, Health Outcomes and Analysis. The Senior Director works in collaboration with the Directors and Managers to develop strategies aligned with L.A. Care's mission and goals/objectives while ensuring compliance with federal, state, and accrediting body standards, requirements and guidelines.

- **Director, Medical Management Role**

A licensed clinical nurse with appropriate health care experience has oversight of day-to-day operations of the utilization management and care management activities performed by designated staff within the department. The Director works in collaboration with the Medical Management Medical Director and is responsible for direct day-to-day supervision of assigned licensed and non-licensed support staff operational oversight of the model of care through utilization and care management activities. The Director is responsible for verifying licensing and competency of clinical staff and ensuring an appropriate level of staffing to effectively carry out program operations. In collaboration with the Medical Director, the Director of Medical Management oversees the activities of the interdisciplinary care team.

The Director of Medical Management is responsible for overseeing the model of care performance measures and evaluating the effectiveness of the care management programs using consistent performance standards and measures related to the care management process, assisting with quality improvement and performance management activities by gathering utilization and pharmacy data for reporting on process measures (including aggregated results of quality care review outcomes) and appropriateness. The Director oversees the performance measures by recommending process indicators and outcome measures to the UM Committee. The Director is responsible for providing performance reports to the appropriate committees, including results of aggregated QI process measures and developing core programs, systems, and performance measures to promote

the delivery of quality care management services for members. The Director is responsible for implementing corrective actions to the model of care as necessary.

- **RN Manager of Medical Management Role**

A licensed clinical nurse with appropriate health care knowledge provides administrative oversight and monitoring of the utilization management (UM) activities. The Manager supervises clinical and non-clinical staff performing utilization management functions, ensuring members receive care and services that meet contractual, state, federal, and accrediting body standards and requirements for quality, timeliness and access. The Manager works with the Medical Director and Director of Medical Management to implement the UM Program and ensure members receive medically appropriate and timely care in the least restrictive setting by overseeing the consistent application of evidence based criteria.

- **RN Manager, Care Manager Role**

A licensed clinical nurse with appropriate health care experience provides administrative oversight and clinical guidance to the Care Management program. The manager of the care management program manages clinical and non-clinical staff performing care management and coordination activities and assures effective implementation and coordination of quality improvement and utilization management activities related to care management of special health care needs, and continuity of care.

- **RN, Lead Care Manager Role**

The Lead Care Manager assists in the management of clinical and non-clinical staff performing care management and coordination activities and assures effective implementation and coordination of quality improvement and utilization management activities related to care management of special health care needs, and continuity of care.

• **RN, Care Manager Role**

Care Managers are registered nurses who are licensed health care professionals who are directly responsible for the actual delivery of care management services to members. The Care Managers consistently perform the activities of assessment, planning, facilitation, and advocacy for members throughout the continuum of care, consistent with state and CMS regulatory requirements, CMS MAPD structure and process measures, accreditations standards, standards of practice and L.A. Care’s Policies and Procedures.

The role of the Care Manager includes the following essential functions and key responsibilities that are consistent with the current standards of practice:

Function	Key Responsibilities
Care Identification	<ul style="list-style-type: none"> • Conduct and document a screener for potential members • Verify and document members acceptance into care management • Obtain and document member or member’s legal representative consent, verbal or written, for participation
Assessment	<ul style="list-style-type: none"> • Conduct and document the initial health risk assessment using the initial assessment tool and any applicable supplemental assessment tools • Conduct medication profile review and medication reconciliation

Function	Key Responsibilities
	<ul style="list-style-type: none"> • Conduct a readiness to change assessment, when applicable • Identify individual needs based on the member’s or caregiver’s understanding of their conditions and any barriers to following the physician’s prescribed treatment
Care Planning	<ul style="list-style-type: none"> • Collect and analyze relevant information, including the member’s goals and preferences, for the purpose of developing a care plan through interaction and communication with the member and/or member’s legal representative • Triage care needs • Responsible for information review, analysis and stratification of member’s health needs. • Evaluate health care delivery of services using evidence based or clinical practice guidelines • Document identified issues, goals (long & short term), target goals, dates, interventions, collaborative approaches and resources, and time frames for follow-up on the care management plan • Incorporate evidence-based interventions and goals into the care management plan • Provide education on self management techniques • Consult with pharmacist/Medical Director for pharmacy issues • Coordinate discussions with Social Worker for identified behavioral

Function	Key Responsibilities
	<p>health issues (mental health or drug rehab strategies)</p> <ul style="list-style-type: none"> • Discuss the care plan with the Care Management Team • Assign a risk acuity level
<p>Coordination and Implementation</p>	<ul style="list-style-type: none"> • Coordinate and implement the interventions specific in the care management plan in order to provide the optimal benefits coverage possible as well as to promote continuity of care and integration of services for the member across a range of settings • Collaborate and communicate with the member, family member, legal representative, physician and/or other health care providers as appropriate to accomplish the identified goals • Identify and facilitate access to community resources
<p>Monitoring and Evaluation</p>	<ul style="list-style-type: none"> • Monitor, reassess, re-evaluate and document the goals and interventions of the care plan to determine if desired outcomes have been met and goals achieved or if revisions or modifications are needed. Evaluation occurs over specific timeframes and is a continuous process • Revise the care plan after all hospitalizations and as needed; document any changes consistent with the member’s needs
<p>Facilitation</p>	<ul style="list-style-type: none"> • Facilitate member/caregiver’s education and understanding to mitigate risk behaviors and to promote and achieve positive health and wellness outcomes

Function	Key Responsibilities
	<ul style="list-style-type: none"> • Actively promote and facilitate communication and collaboration between the member, family, caregivers, physician and other health care providers involved in the member's care
Advocacy	<ul style="list-style-type: none"> • Serve as the member's advocate by providing support and education to empower members and families to become self-reliant in managing their disease processes as well as facilitate life style changes and participation in health care decisions • Protect the privacy and confidentiality of all member information in accordance with the confidentiality policies and applicable laws and regulations • Provide the member with information about specific health care needs to help them participate in their own care • Seek to understand relevant cultural information to work efficiently, respectfully, and sensitively within the member's cultural environment
Utilization Management	<ul style="list-style-type: none"> • Authorize or facilitate access to services by obtaining referrals for appropriate services and benefits utilizing the referral management guidelines defined in the UM program
Documentation and Communication	<ul style="list-style-type: none"> • Conduct verbal and/or written communication with member, physicians and other members of the health care team and provide appropriate documentation of information relevant to care management • Document appropriate clinical information and data in an ongoing

Function	Key Responsibilities
	<p>timely, accurate and concise manner using available tools in the medical management system, which includes documentation of the care manager's name, and the date/time of interaction with the members</p> <ul style="list-style-type: none"> • Obtain consultation and diagnostic reports
Quality Improvement	<ul style="list-style-type: none"> • Participate in quality reporting • Participate in inter-rater reliability reviews • Identify and report potential quality of care concerns • Identify process-oriented opportunities for improvement to promote quality medical care, cost effective delivery and service excellence

- **Care Management Care Coordinator Role**

Health risk assessments (HRAs) will be conducted by appropriate staff. The assessments are electronically submitted to clinical staff to serve as a basis for care plan development. Care coordinators serve as the assistant to care managers to obtain needed health care services and act as a liaison, where appropriate, between the care manager, PCP, member and caregiver. Feedback information from the care coordinator may be used to modify plans of care.

- **Transition of Care Nurse Role**

The Transition of Care Nurse is a licensed registered nurse directly responsible for the actual delivery of clinical services to members in a hospital setting, including:

- Promote effective utilization and monitoring of health care resources while ensuring the services arranged or coordinated are appropriate for the member
- Consistently perform the activities of transition planning between any settings both planned and unplanned , assessment, planning, facilitation, and advocacy for members throughout the continuum of care, consistent with CMS regulatory requirements, CMS MAPD structure and process measures
- Assure seamless transition and timely follow-up, including confirmation of in-home services, medication reconciliation, and communication and follow-up appointment with PCP

- **Social Worker Role**

The Social Worker is a licensed clinical behavioral health specialist (LCSW) providing assistance with referrals for psychosocial or financial needs that are or have become barriers preventing the member from reaching care plan goals. The Social Worker also provides assistance to providers, the member, member’s caregiver and family in navigating the mental health system and accessing community based resources.

- **Physician Role**

Medical Directors and Physician consultants (employed and contracted) are available to staff on an ongoing basis throughout the day and also participate in weekly rounds to discuss cases and interventions.

- **Director, Pharmacy Role**

The Director of Pharmacy is responsible for administrative oversight of L.A. Care's contracted pharmacy benefit management company, MedImpact, to ensure access to drugs and quality pharmacy services. The Director provides clinical guidance to the L.A. Care's pharmacy program. The Director also manages both clinical and non-clinical staff in performing these pharmacy services. The Director is also responsible for the oversight of the Medical Therapy Management Program administered by Outcomes Pharmaceutical Health Care.

- **Clinical Pharmacist Role**

Pharmacists work on referrals from Care Managers after Care Managers and Physicians review Pharmacy data and have identified medication issues, such as poly-pharmacy issues, drug interactions, medication adherence issues, or poor medical management. Pharmacists are asked to review the member pharmacy profile and decide whether to send a Pharmacist for a home visit to assess the member's medication needs or send a letter by mail to the member's PCP to report the member's identified medication issues.

- **Health Education Specialist Role**

Health Education Specialists are professional staff providing specific education for identified member needs, such as preventing falls.

- **Navigator Role**

Navigators are non-licensed staff assigned to each member and assist in navigating members through the health care system by coordinating and facilitating access to both covered and non-

covered services to achieve optimal health outcomes. Health Navigators are trained on Medicare and Medicaid benefits and educate members and member's families on various topics to ensure the member is making active choices on how care is shaped and delivered according to their needs. The Director of Member Services provides oversight to the Health Navigators who work in partnership with the Medical Management/Care Management team

Staff Structure

The staff structure/ roles/activities support the model of care by:

- Coordinating care management - The clinical team assists in the management of the medical, cognitive, psychosocial and functional needs of the members. The social worker provides assistance to member, member's caregiver and family in navigating the mental health system and accessing community based resources. The PCP serves as the gatekeeper for access to necessary services.
- Providing clinical care based on assessed needs and appropriate evidence based interventions. Where necessary, Medical Directors of Medical Management and Clinical Pharmacist are consulted
- Educating members on self management techniques – members can access the disease specific health education materials that are culturally and linguistically appropriate. Member's care plans are designed to include self-management goals. The care management team is trained in empowerment techniques to support the members success in reaching define goals. Care Managers also mail additional educational information to assist in addressing identified self management goals

- Consult on pharmacy issues – identified from monthly reports reviewed for polypharmacy (>10 Rx fills/12 months, poly prescriber > 3/month, high cost drugs > \$500/month) are referred to the care management program and coordinate intervention strategies with the member, member’s family, PCP and Care Manager
- Counsel on drug dependence rehabilitation strategies - members identified during the HRA, care planning process or pharmacy reports as having possible drug dependency issues, the social worker is consulted to coordinate a strategy with the member, member’s family, PCP and Care Manager offering access to available rehabilitation benefits.

Disease Management/ Chronic Care Improvement Program (DM/CCIP) Team

The DM/CCIP team is comprised of clinical and non-clinical staff. Clinical staff include two (2) QI Specialists (Registered Nurses), QI Director (Registered Nurse), Senior Medical Director and Medical Management Medical Director. Non-clinical staff of the DM/CCIP team include the QI Analyst, QI Project Manager, QI Outreach Coordinator, and Health Educator..

L.A. Care currently offers asthma and diabetes disease management programs and will consider adding others when the specific disease burden of the Dual Eligible Demonstration target group has been analyzed. The asthma program is administered internally. The diabetes program has been delegated to an NCQA accredited vendor (Healthways). L.A. Care monitors Healthways’ delegated activities on an annual basis, according to specifications described in a mutually agreed upon delegation agreement and current CMS requirements and NCQA standards. An annual oversight audit of the delegated activities is conducted to monitor and evaluate compliance. L.A. Care evaluates the delegate’s performance against these standards and requirements by reviewing the delegate’s program description, policies and procedures, and/or other documents related to the delegated activity to ensure compliance. Oversight audit results are reviewed, opportunities for

performance improvement are identified and reported to the delegate, and corrective action plans are required to outline the activities planned to bring the delegate's deficiencies back into compliance. As appropriate, follow up to assess compliance occurs following the evaluation. If the delegate does not comply with the corrective action plan, L.A. Care may revoke the delegated function.

- **Senior Medical Director Role**

The L.A. Care Senior Medical Director is a physician, Board Certified in his or her primary care specialty, holding a valid, unrestricted California Physician and Surgeon License. The Senior Medical Director leads staff in achieving performance goals and meeting requirements of the accrediting and regulatory agencies. The Senior Medical Director chairs the Quality Oversight Committee, Physician Quality Committee, Behavioral Health Collaborative Committee, Credentialing Committee, and Peer Review Committee; participates in other committees and task forces as appropriate to assure appropriate management and accountability for all QI activities; develops medical standards/processes and facilitates adoption of medical policies and procedures.

- **Quality Improvement Director Role**

The Director of Quality Improvement is responsible and accountable for all operations conducted in the Quality Improvement Department. The QI Director reports to Senior Medical Director. The QI Director leads staff in the performance of health plan provider quality reviews, establishes and monitors quality improvement goals, and organizes outcome research and appropriate interventions. The QI Director provides oversight to ensure network physicians follow evidence-based guidelines through the monitoring of quarterly medical record reviews and reports to the Quality Oversight Committee.

The overall role of the clinical staff, i.e. the Senior Medical Director and the QI Director are program oversight and monitoring, while the role and responsibilities of the two (2) QI Specialists (RNs) include, but not limited to:

- Ensure compliance with NCQA and CMS guidelines
- Review referrals from Inpatient Post Discharge follow-up calls for possible inclusion into the program
- Review daily “inpatient census report” for possible referrals into the program and which current members are hospitalized and which current members are hospitalized
- Review referrals from New Member Calls performed by Medical Management for possible inclusion into the program
- Review Coordinators logs and tracking spread sheet
- Research, evaluate and update asthma and diabetes programs yearly with the QI Program Director
- Review current existing reports with the QI Director and the Clinical Improvement Committee
- Refer member to the NCQA-accredited vendor for complex cases and Community Based Organizations (home visits) as needed

The role of the non-clinical staff is to support the disease management programs that include, but not limited to:

- Ensure the DM/CCIP programs meet NCQA requirements including new standards as they become available.
- Maintain quality assurance for administration of the DM/CCIP.

- Oversee the completion of all administrative aspects of the asthma (internal) disease management program.
- Respond to provider inquiries about registry reports.
- Create new reports and forms as requested.
- Inform QI Specialists (RNs) of any possible referrals to care management.
- Assist the QI Specialist (RNs) in the operation of the DM/CCIP programs and provides technical support to staff regarding any program issues.
- Assist QI Specialists (RNs) with provider faxes and call primary care physician's office to verify receipt of fax.
- Assess the need for health education materials for members

Administrative & Clinical Oversight Functions

As part of L.A. Care's Compliance Plan, L.A. Care's Compliance Officer has established a Medicare Auditing and Monitoring policy and procedure ("Policy") which requires ongoing auditing and monitoring of delegated entities to ensure compliance with Medicare rules and responsibilities. This Policy will be adapted and extended to ensure compliance with all Dual Eligible Demonstration rules and responsibilities. The Policy identifies key components of the auditing and monitoring process to include, but not limited to, provider network operations, quality improvement, medical management, financial compliance and credentialing. As part of L.A. Care's oversight process, L.A. Care performs an annual on-site audit of delegated provider groups to ensure compliance with Medicare requirements and the delivery of quality healthcare services.

Specifically, administrative and clinical oversight responsibilities are assigned to the following departments:

- Credentialing- Verify licensing and ensure provider is in good standing to participate in federal and state programs
- Financial Compliance- Review encounter data for appropriateness and timeliness of services
- Pharmacy and Regulatory Affairs & Compliance- Review pharmacy claims and Part D utilization data
- Medical Management- Review Part C utilization data and assures provider use of clinical practice guidelines
- Provider Network Operations- Conduct provider training and education.

L.A. Care's audit team consists of a multidisciplinary group of health plan professionals representing the administrative and clinical areas. The audit team is represented by the following professionals:

Credentialing

1. Senior Credentialing Auditor(s)
2. Credentialing Auditor(s)

Financial Compliance

1. Audit Supervisor
2. Senior Financial Compliance Auditor
3. Auditor

Pharmacy

1. Pharmacy Liaison
2. Clinical Pharmacist or Pharmacy Director

Provider Network Operations

1. Provider Relations Specialist

Regulatory Affairs & Compliance

1. Compliance Advisor

Utilization Management (UM)

1. UM Lead Oversight Specialist
2. UM Oversight Specialist
3. UM Liaison

The scope of L.A. Care's administrative and clinical audits, are comprehensive and are based on delegated functions and state and federal regulatory and contractual requirements. L.A. Care uses an audit tool for each specific audit area. The audit tools are updated on an annual basis to capture new regulatory, and contractual requirements. The audit tools for each specific audit area capture, in part, the following audit elements for each of the following audit areas:

Credentialing

- Credentialing policies - The organization has a well-defined credentialing and re-credentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.
- Credentialing Committee - The organization designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions.

- Credentialing Verification - The organization must be able to demonstrate appropriate controls to ensure that only the designated medical director can enter his or her signature in the system.
- Application and Attestation - Practitioners complete an application for network participation that includes a current and signed attestation regarding their health status and any history of loss or limitation of licensure or privileges.
- Sanction Information - The organization receives information on practitioner sanctions before making a credentialing decision.

Financial Compliance

Detailed claims testing for all sampled claims:

- Obtain supporting documentation including the claim form and related attachments, explanation of benefits, denial letter (if applicable), copy of cancelled check or bank statements showing check cleared date
- Calculate the time elapsed from the date of receipt to date of payment or denial to determine if the claim was processed within 30 calendar days for “Clean, Unaffiliated” claims and 60 calendar days for all other claims (“Unclean Unaffiliated”, “Affiliated Paid”, and “Affiliated Member Denied” claims)
- For any “Clean, Unaffiliated” claims processed after 30 calendar days, determine if interest was paid automatically and at the appropriate rate
- Verify to the contract fee schedule for “Affiliated” claims and to the CMS Medicare Providers Fee Schedule (MPFS) for “Unaffiliated” claims to determine if the claims are paid appropriately

- Calculate the time elapsed from the date of receipt of a clean claim to date of payment or denial to determine if the claim was processed within 14 calendar days. (*For incentive purpose only*)
- For denials related to member liability, verify the member's ineligibility at the date of service by performing an eligibility inquiry using L.A. Care's MHC system. Identify any unusual lags or trends by:
 - (1) Comparing the date the claim form was completed (physician signature date) to the date the claim form was received by the PPG (received date stamp)
 - (2) Comparing the date the claim was paid (check date) to the date the check cleared the bank

Pharmacy & Part D Claims

Policies and procedures include the following elements:

- Adoption or creation of a system for point of dispensing communications to identify and classify drug to drug interactions by severity
- Notification to dispensing providers at the point of dispensing of specific interactions when they meet the organizations severity threshold
- Identification and notification of members and prescribing practitioners affected by a Class II or Class III recall or voluntary drug withdrawals from the market within 30 calendar days of the FDA notification
- An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall

- PBM will implement and maintain policies and procedures that delineate pharmacy certification procedures
- PBM will implement and maintain policies and procedures which delineate drug utilization review and drug use evaluation activities
- PBM will implement and maintain policies and procedures, and establish and maintain criteria for the authorization of non-formulary drugs
- PBM will ensure that all PA requests meet turnaround time requirements and appropriate practitioner input and meet all criteria for the authorization of non-formulary drugs
- PBM shall process 98% of clean claims within 15 calendar days of receipt, as indicated in Service Agreement, Performance Guarantee, and Exhibit C. For Medicare Part D claims not to exceed 30 calendar days per the Amendment to the Service Agreement
- PBM and Pharmacy Department manages drug transitions for newly enrolled members (Part D pharmacy requirement)
- The PBM's call-center policies and procedures must meet all contractual and regulatory requirements, and the call-center's performance must comply with CMS required standards.

The Technical Help Call Center must be:

- Available 24 hours a day when the pharmacy network includes pharmacies that are open 24 hours a day
- 80 percent of calls must be answered within 30 seconds
- Abandonment rate of all incoming calls must not exceed 5 percent

Medical Management

1. Appropriate Utilization Management Program

- Follows written policies and procedures that reflect medical coverage rules, practice guidelines, and current standards of medical practice when processing requests for initial or continued authorization of services
- Have in effect mechanisms to detect both underutilization and over utilization of services
- Have in effect mechanisms to ensure consistent application of review criteria and compatible decisions
- Has clinical peers review decisions to deny authorization on grounds of medical appropriateness
- Does not structure utilization management activities so that they provide inappropriate incentives for denial (e.g., no money paid for denial of medically necessary services), limitation, or discontinuation of authorized services
- Does not prohibit providers from advocating on behalf of members within the utilization management process
- Complies with national coverage decisions, general Medicare coverage decisions, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors

2. Adequate and Appropriate Access to Care

- The delegate has written standards for timeliness of access to care and member services that meet or exceed such standards a may be established by CMS, continuously monitors its provider networks' compliance with these standards, and takes corrective action as necessary. The delegate ensures that the hours of operation of its providers are convenient to and do not

discriminate against members. When medically necessary, the delegate makes services available 24 hours a day, 7 days a week

3. Timely Communication of Clinical Information

- Delegates must ensure continuity and coordination of care through procedures for timely communication of clinical information among contracted network providers, with the member, and with his/her designees (if applicable)
- Maintains procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures members may take to promote their own health
- Maintains policies that specify under what circumstances services are coordinated and the methods for coordination
- Maintains procedures to ensure that the Delegate and its provider network have the information required for effective and continuous patient care
- Maintains policies and procedures to ensure that there is appropriate exchange of information among the provider network components

4. No Member Discrimination in Delivery of Health Care

- Has policies and procedures to ensure that the delegate does not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a plan offered by the delegate on the basis of any factor that is related to health status (with certain ESRD exceptions regarding enrollment)

- Ensures that participating providers have practice policies that demonstrate that they accept for treatment any member in need of the health care services they provide
 - Does not refuse care and services to members just because they develop End Stage Renal Disease (ESRD) while enrolled
5. Maintain a complex case management structure to help members with multiple or complex conditions to obtain access to care and services and coordinates their care:
- i. Identifies members for case management using the following data sources to analyze the health status of members: Claims or encounters data
 - ii. Hospital discharge data
 - iii. Pharmacy data
 - iv. Data collected through the UM process
 - v. Lab data
 - vi. other (indicate)

Provider Network Operations

- Preferred provider group (PPG) shall have a developed orientation program for all new physicians and shall orient all physicians within the first ten (10) business days from their affiliation effective date, (including but not limited to, Primary Care Physicians and Affiliated Providers). PPG shall conduct provider orientations as set forth in the Provider Manual

- PPG shall have a developed training and education program for Primary Care Physicians, Affiliated Providers, and office staff. PPG shall conduct on-going provider training and education as set forth in the Provider Manual
- PPG, or its MSO on behalf of the PPG, shall have a call system in place (i.e. call panel, exchange, or answering machine with specific instructions on accessing staff) to ensure a response to after hours, weekend, and holiday calls from Members, Affiliated Providers, and health plan. PPG, or its MSO on behalf of the PPG, shall ensure that staff is available
- PPG must evidence an approved policy and procedure for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services
- The PPG maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services

IV. *L.A. Care Interdisciplinary Care Team*

Composition of the Interdisciplinary Care Team

The model of care assigns each member to an interdisciplinary team that is responsible for:

- Analysis and incorporating the results of the initial and annual health risk assessment into an individualized care plan
- Collaboration to develop and annually update the care plan for each member
- Manage the medical, cognitive, psychosocial and functional needs of the member and communicate

- Assess and address and identified social service barriers or needs
- Assess members for access to longterm services and supports to so members can remain in their homes and communities as long as possible and avoid institutional care
- Coordinate the care plan bringing the medical and social needs together to assist members in remaining in the home and community
- Preserve and enhance the ability of members to self-direct their care
- Provide and support person-centered care coordination and planning
- Identify community based resources as needed and make referral when community resources outside the plan benefits could help members remain in their homes and communities

The Care Management Program uses an interdisciplinary care team (ICT) comprised of contracted and employed staff who are responsible for providing member care management and education through professionally knowledgeable, licensed, and when applicable, credentialed professionals in collaboration with the Primary Care Physician and community-based resources.

ICT Membership and Member Participation

The ICT consists of Medical Directors, Registered Nurse Care Managers, Nurse Practitioners, Clinical Pharmacists, Social Workers, Health Educators and non-clinical support staff (i.e. Care Coordinators and Health Navigators). Additional ad hoc members of the team may include representatives from various operational areas that include palliative care staff, geriatric care specialist, Medicare Operations, Customer Service, Claims and Provider Network Operations, and representatives from community based organizations. The composition of L.A. Care's interdisciplinary team is flexible and can be adjusted as needed, based on the needs of individual

members. A behavioral health expert, social services specialist, and other health care specialists are available when need is identified through the health risk assessment or other information source.

The ICT includes participation of the member and/or caregivers, and the PCP whenever feasible. Members are notified by the Care Manager during the care planning process of the ICT planning discussions, and to encourage participation, are given and the opportunity to participate by phone.

ICT meetings serve as an avenue to discuss complex needs, linkages to home and community based services for members who are high risk or whose health status has changed and require follow-up on other concerns related to utilization, level of care or other specialized services (such as members who are frail, have disabilities, have multiple chronic illnesses, may be near or receiving end of life care).

ICT Care Planning

ICT team members support member-involvement, education, self-management, self-efficacy, knowledge of resource availability, and adherence to the treatment plan. The interdisciplinary team also performs the following roles:

- Analyze and incorporate the results of the initial and annual health risk assessments into the care plan
- Manage the medical, cognitive, psychosocial and functional needs of the members
- Communicate the coordinated care plans across all settings
- Assist in the care plan development and monitoring
- Assist with the measurement of the effectiveness and extent to which each members care is managed

- Assist in identified of long-term services and supports needs

Interdisciplinary Care Team – Operations & Communication

ICT members are responsible for providing input into the review, analysis and stratification of members health needs. Meetings are held weekly to review care plans, resolve barriers to long and short term goals, plan interventions, and update supportive services needed by members.

The ICT works closely with contracted practitioners and agencies in the identification, assessment, referral and implementation of appropriate health care management interventions for eligible adults with special health care needs, including the provision of care coordination, linkages with county resources and access to community and state waiver programs.

ICT members work collaboratively with the PCP, hospital discharge planners, specialty practitioners, ancillary practitioners, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing medical care, rehabilitation services, behavioral health, home health, LTSS and hospice care, including services that may not be covered benefits, such as Meals-On-Wheels, housing services, and services offered through Independent Living Centers, Senior Centers and Area Agencies and Aging.

The Care Manager is responsible for updating the care plan based on the ICT recommendations or whenever there is a change to the member's health status. The revised care plan is communicated with the Member and PCP as needed by letter or telephonically. Care plans are available upon request by the member, the member's legal representative, the PCP or pertinent providers. The care plan will be mailed within 14 calendar days of the request. The care plan is documented electronically and maintained in L.A. Care's secure care management information system. The care management system is accessible to the multidisciplinary team members and is

maintained in accordance with industry practices (e.g., preserved from destruction, and secured for privacy and confidentiality).

The health risk assessment findings, risk stratification results, plan of care and any care plan revisions are available to the ICT members. Care planning discussions and revisions to the care plan are communicated by the Care Manager to the member, PCP and other team members by phone or by mail.

The ICT mode of communication includes regularly scheduled and ad hoc care coordination/case rounds to discuss needs, challenges and successes in implementing care plans. Written minutes of the team meetings are maintained by the Medical Management Director and electronically retained in a HIPAA compliant format within the Information Systems Department for a period of 10 years from the meeting date.

V. ***Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols***

Specialized Expertise in the Provider Network

L.A. Care Health Plan's network is comprised of healthcare providers who provide Medicare and Medicaid services in the following provider types in order to meet the specialized needs of the target population of dually-eligible members who may be affected by multiple chronic conditions:

- Primary Care Physicians
- Geriatricians
- Endocrinologists
- Cardiologists
- Pulmonologists

- Palliative Care Providers
- Specialized Mental Health Network
- Inpatient and Outpatient Facilities
- Skilled Nursing Facilities
- Dialysis Centers
- Home Health Providers
- DME
- Transplant Facilities

The duals pilot requires L.A. Care to enter into contracted relationships with additional entities that provide in-home, and community based services such as IHSS, MSSP Independent Living Centers, and Community-Based Adult Services. L.A. Care, as the local initiative health plan, has a long-standing relationship with community based services and safety net providers such as FQHCs, community clinics, and the county department of health services which it intends to include in its network, and will be providing assistance with meeting the strict quality measures for serving this population. L.A. Care's entire provider network will be subjected to the same quality measures to ensure the members is receiving the highest level of care from provider networks delegated for a specific suite of services.

L.A. Care has already contracted with Medical Groups specifically capable of providing services to dual eligible members who have specific capabilities such as electronic medical records and real time information-exchange throughout their networks to enhance access and quality of care. L.A. Care is in discussions additional specialty plans and medical groups in L.A. County who see a high number of dual eligibles in their practices today to promote having members keep their existing medical homes when feasible.

L.A. Care has initiated discussions with the department of mental health and regional centers to prioritize a comprehensive network of specialized providers of care for dual eligible members across the full continuum of care.

L.A. Care has continued to grow its network of skilled nursing facilities and sub-acute facilities for the seamless transition of lower levels of care with an emphasis on keeping members in the comfort of their homes as an alternative to avoidable institutional care.

In addition to establishing an adequate provider network, L.A. Care actively addresses barriers which people with disabilities and mobility limitations encounter when seeking healthcare services. L.A. Care assesses primary care practice sites for certain physical accessibility requirements and works with safety-net practices to enhance physical access. This has included a grant program that supplied height-adjustable exam tables, wheelchair accessible weight scales, and assistive-listening devices.

Provider Network Credentialing

The Credentialing Department credentials and re-credentials practitioners and facilities every three years. This is consistent with NCQA guidelines, DMHC and DHCS contracts. On an ongoing basis, the Credentialing Department maintains licensure of all providers and certifications which meets the HEDIS requirements as well. On a monthly basis, we monitor all providers for sanctions and limitations on licensures. We take appropriate actions on physician licensures based on the issues identified. In addition to monitoring licensure, we also monitor OIG (Office of Inspector General) lists, which are loaded in our CACTUS database. We monitor the Suspended and Ineligible and Opt Out list, complaints and adverse events.

We also credential and re-credential Health Delivery Organizations (HDOs) and follow the NCQA and CMS guidelines for these types of organizations. The Credentialing Department has a

robust delegation process by which we may delegate credentialing to an IPA (Independent Physician Association) or Medical Group. Prior to contracting with these entities, and every year thereafter, we perform audits to ensure that they meet the strict guidelines that have been set by L.A. Care Health Plan for credentialing and re-credentialing. Some IPAs and Medical Groups may receive a corrective action plan if deficiencies are identified and given the opportunity to correct. This process is strictly monitored and well documented through our Credentialing Committee which meets monthly and ensures that all of our policies and procedures for credentialing, re-credentialing and delegation are adhered to.

Practitioners that fall under the delegated process also go through a stringent quality assurance process. This process encompasses credentialing, facility site review, and provider network operation departments.

L.A. Care uses the CPPA (California Participating Physician Application) for practitioners for our credentialing and re-credentialing process. This application captures required information i.e. education, training, work history, demographic information, liability insurance, hospital privileges, if applicable, and attestation of completeness and accuracy. This information including license, DEA, board certification, contract type, and facility site review, if applicable, are all primary sourced by L.A. Care's Credentialing Department. We do not accept information from any source not approved by NCQA for primary source activities. Practitioners are credentialed and re-credentialed within 180 days from date of attestation signature.

All credentialing and recredentialing activities are populated into our CACTUS database. CACTUS is a credentialing software system designed specifically to meet the needs of the credentialing activities and is the industry leader for credentialing databases. Every credentialing function has a quality assurance review performed prior to Committee review to ensure information is reflected accurately and consistent with the application and information provided. This process

ensures that information, such as board certification, is accurate in our directory for member use. All credentialing activities are presented to the Credentialing Committee to ensure compliance with L.A. Care's requirements.

Our Credentialing Committee is composed of physicians who represent L.A. Care's network. It encompasses external practitioners and employed L.A. Care's physicians. We have a wide range of specialty representation, including Internal Medicine, Pediatrics, General Surgery, Obstetrics-Gynecology, Family Medicine and nursing. This committee has the ability to set policy for L.A. Care and ensure that the current credentialing and re-credentialing policies and procedures are in compliance with our operational processes. This information is well documented with minutes.

L.A. Care has ensured that the Credentialing Committee process has implemented the highest level of confidentiality by using a process call E-Committee whereby each member that attends the committee uses a secure computerized program; hard copies of credentialing documentation are no longer supplied. Once the Credentialing Committee is completed, this information is electronically locked into a secure folder within the data system and warehoused. This process has proven to eliminate error, ensure confidentiality, and ensure efficiencies for the overall credentialing process.

Determining Services & Coordinating Specialized Services between the ICT and the Provider Network

L.A. Care uses the traditional managed care model of assigning a member to a Primary Care Physician (PCP) of their choice to coordinate the entire range of care. PCPs are responsible to directly provide the primary care services and refer members to specialty care through L.A. Care's authorization process. L.A. Care and its contracted provider network must comply with the regulatory time requirements to arrange care.

The specialized needs of dual eligible members are met through a member-centered approach that provides for:

- Systematic identification of members with special needs through several methods at the time of enrollment
- Thorough assessment of member needs during initial outreach
- Coordinating medical care through the PCP (i.e. gatekeeper) and other appropriate providers
- Coordinating all other services and supports identified in the care plan, including long-term services and supports, behavioral health services, disease management programs, and social services.

A health risk assessment (HRA) is conducted for all new members. Special needs may also be identified from other sources, such as member of caregiver information, utilization management, pharmacy or disease management staff, direct provider referrals, predictive modeling, or hospital discharge planners.

Special health care needs may include, but are not limited to:

- Frailty
- Limitations in Activities of Daily Living
- Serious mental illness
- Dementia
- Developmental disability
- Multiple chronic conditions

Triggers indicating a possible special health care need include:

- Home health services more than once per month for three consecutive months
- Out of Area health service/care coordination

- Frequent emergency or urgent care services (more than three visits in a month or two visits in a six month period)
- Hospital admissions (more than three in six months)
- Hospital re-admissions within four weeks of discharge
- Complex social issues that may increase medical complications
- Medication adherence issues
- Symptomatic, chronic complex medical diagnoses
- Pharmacy characteristics, including:
 - Use of atypical psychotics
 - Medications for treatment of HIV/AIDS, hemophilia, multiple sclerosis, renal failure
 - Polypharmacy, chronic (more than 10 current medications for chronic illnesses)
 - Experimental or Investigational Drugs
- Behavioral Health characteristics, including:
 - 2 or more failed chemical dependency episodes
 - 2 or more failed psychiatric hospitalizations in six months
 - History of violence or abuse
 - Deteriorated level of functioning
- Financial needs, including:
 - Drug costs greater than \$500/month
- Social needs, such as:
 - Homelessness/Lives in shelter
 - Lives alone and no caregiver
 - No social support

Service Provider/Delivery of Services

Services for members with targeted special needs identified during the care planning process are communicated and coordinated with the PCP (i.e. gatekeeper) through the standard UM process for referral management identified in the L.A. Care UM Program. The referral management process has employed and contracted administrative staff responsible for the review, approval and coordination of referrals to network or out of network providers with clinical expertise pertinent to the targeted special needs prior to the delivery of services. The UM Departments use the established federal, state and accreditation guidelines for utilization review and use evidence based criteria for decision making.

Referrals identified and processed through the standard UM process are communicated to the assigned care manager. The Care Manager or assigned team member collaborates with providers and shares pertinent member health and health status information with the providers of service. Follow up calls are made within five calendar days by a member of the care management team (i.e. Care Manager, Social Worker, Care Coordinator or Transition of Care Nurse) to ensure members have been linked to the appropriate service and service provider. The identified services and member health care outcomes are shared with the ICT team and the PCP during the ICT planning discussion. For emergency service (triage care needs) (i.e. home safety assessments, medication reconciliation, home oxygen requirements, continuity of care with out-of-network providers, etc) identified prior to the formalized ICT discussions, the Care Manager will coordinate services directly with the PCP or the L.A. Care Medical Director within one business day of identification. Outcomes of the identified services are incorporated into the member's care plan.

Evidence Based Guidelines

The model of care uses best practices from successful dual eligible programs nationwide to tailor the model of care to the population. Care management practices in the Massachusetts Senior Care Options Program and the Arizona Long Term Care system have, for example, been studied to inform L.A. Care's refinement of its care management system to integrate LTSS into the care plan.

L.A. Care will determine the needs of members through evidence-based risk stratification and assessment tools designed for complex populations. All of the care management programs utilize evidence-based self-management and goal setting health education curricula. For example "*Living Well with a Disability*," is a health education workshop developed by the University of Montana and launched in L.A. County by L.A. Care in 2009, and "*Healthier Living*" based on the Stanford University/Kate Lorig self-management curriculum for people with chronic conditions that L.A. Care has offered for the last two years. Additionally, evidence-based clinical guidelines will be utilized for all medical management decisions made by the plan.

L.A. Care adopts evidence-based clinical practice guidelines promulgated by recognized sources for selected conditions identified as relevant to its membership for the provision of non-preventive health, acute and chronic medical conditions, and for preventive and non-preventive behavioral health services. Clinical Practice Guidelines are presented for review and approval to the Physician Quality Committee (PQC), are reviewed at least every two (2) years and updated as needed. Clinical practice guidelines are disseminated to practitioners via the L.A. Care website and on a regular basis via Physician Quality Improvement Liaison Nurse (PQIL) visits. Practitioners are also informed through a practitioner newsletter when clinical practice guidelines or updates are available.

Care Managers utilize evidence based guidelines in the development of care plans and management of the members. L.A. Care's Care Management Care Plus system has algorithmic logic

scripts. The scripts were developed using evidence based guidelines and are supported by prompts to guide Care Managers through the assessment for ongoing management of members.

Additional assessment tools may be utilized to address identified health care needs. These tools were developed using evidence based criteria or national standards of care and include, but are not limited to:

- Chronic Obstructive Pulmonary Disease – Global Initiative for Chronic Obstructive Lung Disease, 2008
- Diabetes – ADA, Standards of Medical Care in Diabetes, 2007
- Congestive Heart Failure – ACC/AHA Evaluation and Management of Chronic Heart Failure in the Adult, 2001
- Milliman Chronic Care Guidelines

Two (2) of L.A. Care’s clinical practice guidelines, Asthma and Diabetes, provide the clinical basis for L.A. Care’s current Chronic Care Improvement Programs, and are used to guide the program interventions. L.A. Care delegates behavioral health services for its Medicare SNP members to an NCQA-accredited behavioral health organization who is responsible for the clinical practice guidelines for behavioral health.

Compliance with these guidelines will be measured using annual HEDIS rates and other measures, such as medical record review. L.A. Care will annually measure performance of at least two important aspects for each of its clinical practice guidelines.

VI. Model of Care Training for Personnel and Provider Network

Personnel Training

L.A. Care Medical Management Department's Director is responsible to oversee training implementation and maintain training records for review upon CMS request. The Medical Director, Director and Training Staff conduct initial and annual model of care training for employed and contracted care management staff and multidisciplinary team members. Training strategies (presentations) and content (e.g., printed instructional materials, face-to-face training, web-based instruction, etc.) are offered in several presentations offered to ensure opportunities for all staff to attend the trainings. Documentation of completion of training is maintained in the department (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.). Staff files are monitored annually to ensure completion of the training. Reminder notifications are sent to employees to ensure participation in the trainings. Staff members that do not participate in the annual trainings are subject to disciplinary actions as defined the organizations Human Resources policies

Provider Network Training

L.A. Care requires contracted Participating Physician Group's (PPG's) to provide training and on-going education to their entire contracted provider network. Initial training to all newly contracted providers must transpire within 10 days of the provider's contract effective date. The ultimate goal of provider training and education is to improve the delivery of services to members by providing appropriate forums for providers to:

- Be better informed and acquire the information needed to comply with L.A. Care Health Plan requirements, policies and procedures and programs
- Understand the needs of L.A. Care members
- Improve clinical, patient interaction, and administrative/management skills

L.A. Care's Provider Relations Specialist with oversight from the Director of Provider Network Operations conducts annual audits on all contracted PPG's to ensure the Provider Training and Education requirements are met. The audit encompasses a complete review of all training activities and documentation of provider participation to ensure compliance with L.A. Care requirements. In the events a PPG does not meet the Provider Training and Education requirements the PPG is provided with the identified deficiencies and requirements for submitting a corrective action plan. The Provider Relations Department will review the corrective action plan to ensure the proposed plan will suffice in meeting the requirements.

L.A. Care provides updated training and education requirements along with plan specific policies and procedures to our contracted PPG's through bi-annual Joint Operations Meetings and Physician Group meetings. These forums provide the opportunity to present updates and impending policies and procedures which need to be communicated to the provider network.

VII. Health Risk Assessment

Initial & Annual Health Risk Assessments - Identifying Specialized Needs of Member's through the Health Risk Assessment Tool

The Health Risk Assessment (HRA) is a standardized self-reported screening tool conducted with all members upon enrollment. The HRA is administered by non-clinical staff members, who conduct telephone interviews with members or caregivers and make follow-up phone calls, when needed, to clarify any questions from previous calls. When staff are unable to reach a member, a written form is mailed with a self-addressed stamped envelope for completion by the member. An annual reassessment is completed within 12 months of the last HRA, or more frequently based on

the needs of the member or changes in health status. L.A. Care will comply with the Medicare HRA requirement but is also exploring other best practices that will optimize results and use of resources.

The HRA tool includes a review of past and current care needs. The HRA tool is automatically scored and a preliminary risk assessment profile is generated based on the responses. Through this process, members are prioritized for additional assessments by a Care Manager or contracted assessment entity as needed.

The HRA identifies medical, psychosocial, functional needs and cognitive needs, documents medical and mental health history, etc. The HRA screens for:

- Home environment/safety concerns
- Caregiver support
- Activities of daily living/Instrumental activities of daily living
- Chronic health conditions/health care needs, including behavioral health needs
- Continuity of care needs
- Medication review
- Cultural and linguistic needs, preferences or limitations
- Visual and health needs, preferences or limitations
- Quality of life
- Life planning needs

Reviewing, Analyzing, & Stratifying, Health Care Needs

HRAs are reviewed, analyzed and health care needs stratified by personnel who are professionally knowledgeable and, when applicable, credentialed professionals such as physicians, registered nurses, pharmacists, social workers, health educators, and biostatisticians.

HRAs stratify the identified risk and are used in the development of care plans.

As depression is very common in late life and in members with chronic health conditions, the HRA also includes the Patient Health Questionnaire (PHQ-2) screening and the Patient Health Questionnaire (PHQ-9) with automated scoring. The PHQ-2 is used as a nationally recognized screening tool assessing frequency of depressed mood over the past two weeks and serves as a screening for potential depression. The PHQ-9 is a brief 9 item self-reported depression assessment and has demonstrated usefulness as an assessment tool for the diagnosis of depression in primary care with acceptable reliability, validity, sensitivity, and specificity. The assessment tool is a diagnostic instrument only to assist the care managers in identifying members who may be depressed and appropriate interventions (i.e. referring members to the Primary Care Physician and the behavioral health provider as needed). For geriatric members, the Care Managers may utilize the Five Item Geriatric Depression Scale to identify members at risk for depression. The GDS is also useful with healthy, medically ill and mild to moderately cognitively impaired older adults.

The HRA tool is evaluated every two years to determine the effectiveness (e.g. specificity and sensitivity) of the tool to identify member's needs.

Communicating the Health Risk Assessment & Stratification Results to the ICT, Provider, & Beneficiary

Results of the HRA are shared with the various stakeholders. Examples of communication include telephonic member outreach, mailing hardcopy of the health risk assessment stratification, care plan and the depression screening results to the Primary Care Physician or pertinent provider after completion, and mailing to the member or the member's representative upon request. For members that screen positive for depression, the Primary Care Physician is expected to corroborate the score and make a clinical determination that a significant depressive syndrome is present.

VIII. *Individualized Care Plan Development*

Development of the Individualized Care Plan

A plan of care is crucial to the success of care management and coordination activities. The care plan incorporates the member's short- and long-term goals, diagnosis, prognosis, care needs, and barriers to attaining goals. It is developed by the care manager, in collaboration with the PCP, member, family, specialists and care-givers as appropriate. The member is involved in the development of care plan whenever feasible. Family members, friends or caregivers may be designated to represent members who are not able to participate directly. This may include, for example, persons with advanced Alzheimer's disease or dementia. Staff obtain consent for such representation from the member or legal representative when one exists.

Care Managers develop the person-centered plan of care from information provided by the member and/or the member's family member, caregiver or representative through the health risk assessment and also through follow-up telephone calls. Care managers must develop an initial care plan within 90 days of the initial referral and enrollment of the member into the care management program. Assessments may be completed in multiple visits with the factors of care management criteria addressed. Components of the assessment may be completed by other members of the care team and with the assistance of the member's family member or caregiver. Home visits may be conducted as needed to reach isolated members and assess social and environmental needs.

The care plan includes a schedule for follow-up that includes, but is not limited to, counseling, disease management referrals, education and self-management support. Follow-up activities include specific dates on which the care management will follow up with the member.

The care plan includes an assessment of the member's progress toward overcoming barriers to care and meeting goals. The care management and coordination process includes reassessing and adjusting the care plan and its goals as needed. The care plan is updated as frequently as the member's level of health and care changes, based on identification of additional needs, barriers, limitations, diagnoses, or other factors that influence the member's health status and the ability to reach established goals. Coordination of planned interventions in the care plan are developed using evidence-based clinical guidelines.

Individualized Care Plan Essential Elements

The essential elements incorporated in the care plan are the results from the health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, barriers identified, and add-on benefits and services for members with disabilities, complex care needs, or other special needs. Each care management plan is a person-centered, interdisciplinary action plan that is reflective of the following:

- Health care needs assessment including the medical, psychosocial and socioeconomic factors relevant to the member's current health care status;
- Problem identification specific to the member's health care needs;
- Measurable Goals, including but not limited to;
 - Individualized goals set by the member, care manager, participating physician(s), inter-disciplinary team, and family, friends or caregivers, as appropriate. Goals must be:
 - Specific - usually defining a maximum of four behaviors or measurable outcomes;
 - Measurable - so that any other care manager could understand and implement the

goals;

- Achievable - it does no good for the patient or for the manager to set unrealistic or unachievable goals;
 - Relevant - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended;
 - Time-dimensioned - Is there a realistic timeframe in which the goal can be achieved?; and
 - Specific, time dimensional interventions assigned to individuals related to accomplishing the pre-set goals.
- Expected outcome of care management interventions;
 - Assessment of level of care settings, i.e. home health, custodial care, adult or child day care, determine the appropriate setting, education and training, and community network resources required to achieve a desired level of functioning/independence;
 - Provide educational support necessary to reach care management goals. This may include a referral to a Disease Management program;
 - Identify needs for ongoing services including, as appropriate, ancillary services such as, rehabilitation, home health, DME, nutritional support, psychosocial support, financial support, legal interventions and long term care needs;
 - Identification of needs based on the Quality of life assessment;
 - Identify needs based on the depression screeners and refer to the PCP and Multi-Disciplinary Team.

The care plan must also reflect a short- and long-term-goals approach to managing the member's care.

- Short term goals are defined as goals that can be accomplished within 3 months of the care plan,
- Long term goals are defined as goals that can be accomplished with 3-6 months of the care plan.
- The care plan includes interventions and actions designed to:
 - Address the barriers and limitations to meeting goals or compliance.
 - Achieve optimally coordinated care.
 - Develop schedules for follow-up and communication with the member.
 - Develop and communicate self-management plans for members.
 - Assess progress against care management plans and goals and implement modifications as needed.
 - Identify and direct the member to the appropriate level and source of care.
 - Meet the member’s outcome goals.

The care plan includes outcomes that are specific, measurable, and goal-oriented. The care manager involves the member, family and care-giver in goal setting while assisting them in understanding the member’s condition so that they may make informed decisions about the care, the alternatives, and the importance of compliance with the recommended treatment.

Services for Members with targeted special needs identified during the care planning process are communicated and coordinated with the PCP (i.e. gatekeeper) through the standard UM process for referral management. The referral management process has employed and contracted administrative staff responsible for the review, approval and coordination of referrals to network or out of network providers with clinical expertise pertinent to the targeted special needs prior to the delivery of services. The Care Manager or assigned team member will share pertinent member health

and health status information with the provider of service. Follow up calls are made within five calendar days by a member of the care management team (i.e. Care Manager, Social Worker, Care Coordinator or Transition of Care Nurse) to ensure members have been linked to the appropriate service and service provider. The identified services and member health care outcomes are shared with the ICT team and the PCP during the ICT planning discussion. For emergency service (triage care needs) (i.e. home safety assessments, medication reconciliation, home oxygen requirements, continuity of care with out-of-network providers, etc) identified prior to the formalized ICT discussions, the Care Manager will coordinate services directly with the PCP or the L.A. Care Medical Director within one business day of identification. Outcomes of the identified services are incorporated into the member's care plan.

In some cases a specialist, or multiple specialists, in lieu of the member's PCP, best provide the most appropriate care. In these situations, the care manager discusses this option with the member's PCP and the specialist(s), and arranges for a standing referral to the specialist(s). The care manager notifies the member that he/she will have direct access to the managing specialist for a specific period of time.

Coordination and Integration of Long-Term Services and Supports (LTSS)

A designated team member will monitor member progress in institutional settings, communicating closely with staff at these facilities, and facilitating transitions of care to the community with the PCP, home health and home care providers, and others as needed).

For members with long-term stays in institutional settings, L.A. Care will provide physician support and care management to ensure member's care needs are met. This will include physician or physician extenders (i.e. Physician Assistants, Nurse Practitioners) overseeing the care of members in compliance with the regulatory requirements.

For members who wish to leave or are able to leave the institutional setting and reside in a community based residence, an LTSS specialist from the L.A. Care team will provide information and options to members/member's representatives/ consumers at the facilities. The goal is to ensure that these members have knowledge about available community and other key resources. The team will facilitate the exchange of necessary clinical and social information between the institutional facility and community residence. The team will provide notifications and transfer clinical information to the Primary Care Provider, the residence administrators and the care management team to ensure a safe transition. After reconciling all medications, including addressing any duplication, discontinuations, new directions, and potential drug-drug or drug-disease interactions, the pharmacist will ensure the member/ member's care givers/PCP are receive the appropriate documentation and instructions. The LTSS clinical team will perform a transitional care management call within 48 hours. The LTSS team member will complete a baseline health risk assessment, provide residential facility with any patient education materials on accessing medical care and services, and assist in the coordination of outpatient follow-up recommendations. Included in this follow-up is a review to determine whether all referrals and orders, including any home health care, have been completed and any durable medical equipment has been delivered. The LTSS team is available to provide support to the residential staff to resolve challenges or concerns after the transition.

For members transitioning from institutional to home, L.A. Care will provide the continued medical and care management support to ensure member's care needs are met. This will include a seamless transition to the LA Care care management team to ensure member's are safely transitioned to home under the medical supervision of their PCP. The team will perform a baseline health risk assessment, care plan, medication reconciliation and provide an initial home safety evaluation. As needed, and based on a defined set of criteria, the team may arrange for an in-home

physician assessment when members are unable to be transported to the assigned medical home. Members will be managed by the care management team and the ICT to ensure care coordination, follow up care and referral management needs are in place in a timely manner.

The care management team will complete the transfer of care documentation containing clinical information and medication needs from the institutional setting to the member's outpatient provider. The care management team will follow member's transition through the L.A. Care high risk care management program to monitor member's safety and avoid any readmissions. The team will discuss members at the monthly interdisciplinary care team meetings. A member of the team will perform a transitional care management call within 48 hours. The CM team member will complete a baseline health risk assessment, provide member/member's caregivers with any patient education materials on accessing medical care and services, and assists in the coordination of outpatient follow-up recommendations. Included in this follow-up is a review to determine whether all referrals and orders, including any home health care, have been completed and any durable medical equipment has been delivered and assess if member's may benefit from additional LTSS services, i.e. additional IHSS hours, supportive services by a certified IHSS worker.

Review, Documentation, Maintenance & Communication of the Individualized Care Plan

Care Managers review/revise the care plan at least annually to determine if changes or updates are necessary.. Revisions to the care plan are performed whenever a change in health status is identified (e.g. following transitions of care, changes in member's home environment, change in diagnosis or medications, end-of-life planning). The care plan is documented electronically and maintained in L.A. Care's Care Management System, Care Plus. Care Plus is accessible to the multidisciplinary team members and is maintained in accordance with industry practices such as preserved from destruction, and secured for privacy and confidentiality.

The plan of care and any care plan revisions are available to the ICT members in the Care Plus System, and are also communicated to team members, communicated by the Care Manager or Care Coordinator to members telephonically and to the PCP telephonically or by letter.

IX. Communication Network

Communication Network Structure – Connecting the Plan, Members, Providers, Public & Regulatory Agencies

Communication within the network is the responsibility of multiple internal departments. The communication structure serves as the communication among plan personnel, providers, ICT, regulatory agencies, and the members. The structure includes: committees, policies and procedures, provider portals, provider manuals, provider newsletters, member handbooks and newsletters which are mailed and posted on the L.A. Care Website. Department specific materials are communicated on a defined timeframe specific to the department's needs, such as the UM Technical Bulletins and updated CMS bulletins are communicated to providers on a quarterly basis. We will explore the feasibility of inter-operable electronic records for future years, and as an interim measure, L.A. Care will create a Demonstration portal to enhance communication, including referrals back and forth, and to provide a destination where a central member record can be maintained

Internal Plan Communication

L.A. Care has various committees across the organization. The committees serve as the primary mechanism for intradepartmental collaboration, strategizing, developing, implementing, monitoring and reporting on organizational initiatives.

Compliance and Quality (C&Q) Committee

The Compliance and Quality Committee (C&Q) is a subcommittee of the Board of Governors (BoG). The C&Q monitors quality activities and reports its findings to the BoG. The Compliance and Quality Committee is charged with reviewing the overall performance of L.A. Care's quality program and providing direction for action based upon findings to the BoG. The Committee also reviewed the QI work plan updates on a quarterly basis.

Quality Oversight Committee

The Quality Oversight Committee (QOC) is a cross functional staff committee of L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care's quality improvement infrastructure. The Quality Oversight Committee conducted the following activities:

- Reviewed current strategic projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Reviewed quantitative and qualitative analysis of performance data of subcommittees through formal reports as needed.
- Identified opportunities for improvement based on analysis of performance data and prioritized these opportunities.
- Tracked and trended quality measures through quarterly updates of the QI work plan.
- Reviewed and made recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis.

- Reviewed, modified, and approved policies and procedures.
- Reviewed and approved the QI and UM program descriptions, QI and UM work plans, quarterly QI work plan reports, and evaluations of the QI and UM programs.

Physician Quality Committee

The Physician Quality Committee's (PQC) primary objective is to ensure practitioner participation in the QI program through planning, design, and review of programs, quality improvement activities, and interventions designed to improve performance. The PQC provides an opportunity for L.A. Care to dialogue with the provider community and gather feedback on clinical and service initiatives. The PQC reports through the Senior Medical Director or designee, to the Quality Oversight Committee. The PQC serves as an advisory group to L.A. Care's Quality Improvement infrastructure for the delivery of health services to the Medicare SNP population. Participation in the PQC, including committee membership, is open to network practitioners representing a broad spectrum of appropriate primary care specialties serving L.A. Care members including but not limited to practitioners who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure).

Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for overall direction and development of strategies to manage the UM Program. The UM Committee assesses the utilization of medical services, reviews and made recommendations regarding utilization management or case management to better reflect its role in the Quality Improvement Program, reviews and makes recommendations regarding UM delegated oversight activities. The UMC is also responsible for the

review, revision and approval of all UM policies and procedures, UM program evaluation, UM program description and the UM Program Work Plan.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee addresses credentialing, recredentialing and peer review activities and demonstrates follow-up on all findings and required actions. The Credentialing/Peer Review Committee reviews L.A. Care's credentialing and recredentialing activities, policies and procedures, made recommendations for each practitioner regarding approval, denial, or suspension of membership in the network, reviews and makes recommendations regarding credentialing delegated oversight activities, reviewed at least the credentials of all practitioners who do not meet L.A. Care's eligibility criteria and makes recommendations regarding credentialing and recredentialing for each practitioner, and coordinated peer review activities including monitoring potential quality issues (PQIs) involving practitioners and adverse events..

Clinical Improvement Committee

The Clinical Improvement Committee is responsible for developing, implementing and monitoring interventions based on analysis of data (primarily HEDIS data) to improve the clinical quality of care L.A. Care members receive throughout the year. The Clinical Improvement Committee identifies strategic areas that result in improvement of clinical quality, develops and manages strategic projects aimed at improving clinical quality and reducing disparities, reviewed HEDIS rates, conducted barrier analyses, prioritized areas and deployment of resources for improvement, monitored the effectiveness of the interventions, and set goals for the measures. Chronic Care Improvement Program reports on Asthma and Diabetes were also presented to this committee.

Service Improvement Committee

The Service Improvement Committee (SIC) is responsible for the development, implementation and monitoring of interventions based on data analysis (primarily complaints and appeals), that result in an improvement in overall member satisfaction with L.A. Care as a health plan. This Committee reviewed and analyzed complaint and appeal results, identified top complaints and appeals, identified interventions to improve identified areas.

Monitoring the Communication Network

As part of L.A. Care's Compliance Plan, the Compliance Officer ensures effective lines of communication are developed and maintained. L.A. Care is committed to fostering dialogue between management and employees through multiple channels. Our goal is that employees should know where to turn when they are seeking answers to questions or reporting potential instances of fraud and abuse, or other potential violations of law, regulations or company policies. Employees also should feel free to make these inquiries or reports without fear of retribution. To facilitate these goals, L.A. Care expects its supervisors to maintain an open door environment which does not tolerate retaliation by any employee against another employee for good faith reports of potential violations of law, regulations or company policies. L.A. Care has established a Compliance Helpline which is available 24 hours a day, 7 days a week through which potential violations of law, regulations and policies may be reported. L.A. Care's Compliance Officer is responsible for communicating the compliance findings to senior management and the Board of Governors.

Monitoring the effectiveness of the communication network are part of the organization's annual satisfaction surveys, such as the annual member and provider satisfaction with the UM and CM process evaluations.

Member & Provider Communication

L.A. Care knows it is important to stay connected to the members we serve. We also want to hear from the doctors, nurses and nonprofit advocates we partner with to provide health care to our members.

L.A. Care communicates with the community and community advocates through the Regional Community Advisory Committees (RCACs). Each RCAC is made up of L.A. Care members, doctors, nurses, nonprofit advocates and other health care providers. They give us advice on how to serve L.A. Care members and their communities.

RCAC members also learn about health care topics such as asthma and diabetes, and they are taught how to make sure they are getting the best health care possible.

L.A. Care's Member Services Call Center, has a Medicare team that is responsible for answering and handling all Medicare inbound calls from members and providers through both the designated toll free # (1-888-522-1298) and the TDD/TTY line (1-866-522-2731). The Call Center assist callers with various issues such as, eligibility, Part C and Part D benefit inquiries, requested materials, transportation requests, and grievances. In addition to members and providers, the Medicare team also receives "secret shopper" calls from CMS. The calls consist of a variety of test questions; such as pharmacy benefits, formulary inquiries, standard benefits, etc. The Medicare team keeps a log of these test questions to review and ensure they are providing accurate information. There are also quarterly revision trainings the team attends, to ensure they are up-to-date with our Medicare benefits (e.g. Part C and Part D benefits, Coverage Determinations, Organization Determinations, Grievances). All Medicare calls are audited at 100% to increase performance, along with member satisfaction.

The Provider Network Operations department conducts bi-annual Joint Operations Meetings and Physician Group meetings. These forums provide the opportunity to present updates and impending policies and procedures which need to be communicated to the provider network.

In addition, L.A. Care sends a hard copy provider newsletter “Progress Notes” to all contracted providers three times a year. This newsletter is a venue to disseminate educational and training information out to each and every contracted provider (PCP, Specialist & Hospital).

In addition to Progress Notes, L.A. Care’s Provider Relations Department publishes an electronic newsletter “the PULSE” on a quarterly basis. This electronic news brief provides contracted providers with real time information on critical updates and issues. The electronic medium also provides the opportunity to send relevant announcements to individual and group practice contracted physicians.

Regulatory Agency Communication

Additionally, effective lines of communication between L.A. Care and our subcontractors, and the regulatory agencies are a significant component of the Compliance Plan. The Regulatory Affairs & Compliance Department is a key contributor in regards to communicating L.A. Care’s concerns with rules, regulations or compliance matters with the regulatory agencies. In the role of liaison between L.A. Care and the regulatory agencies, Regulatory Affairs & Compliance staff ensure both parties have a common understanding of L.A. Care operations, regulatory agency requirements, and required deliverables. Communication between L.A. Care the regulatory agencies routinely occur via regularly scheduled meetings, ad hoc meetings, and written correspondence.

Preserving Aspects of Communication

Documents shared among stakeholders as part of the communication mechanism are maintained in the relative departments electronically on a secured server or via hardcopy and in a manner compliant with the HIPAA and privacy laws. Non-member specific materials are accessible on the L.A. Care Website, made available to the public upon request, available to regulatory agencies during audits and upon request.

Every inbound call into the Call Center is recorded through the Cactus system and also documented in our Member Eligibility Information System (MEIS) using specific codes, thus allowing various reports to be generated to capture particular types of calls.

The activities of the committees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. Draft minutes of the prior meeting are reviewed and approved at the next meeting. Minutes are then signed and dated. Minutes are also reported to their respective Committee as required. All activities and associated discussion and documentation by the committee participants are considered confidential and shall abide with L.A. Care policies and procedures for written, verbal, and electronic communications.

Oversight & Responsibility for Monitoring and Evaluating Communication Effectiveness

As part of L.A. Care's Compliance Plan, L.A. Care's Compliance Officer has established a Medicare Auditing and Monitoring policy and procedure ("Policy") which requires ongoing auditing and monitoring of delegated entities to ensure compliance with Medicare rules and responsibilities. The Policy identifies key components of the auditing and monitoring process to include, but not limited to, provider network operations, quality improvement, medical management, and credentialing. These areas are also responsible for oversight of the Communication Network. As part of L.A. Care's oversight process, L.A. Care performs an annual on-site audit of delegated

provider groups to ensure compliance with Medicare requirements and the delivery of quality healthcare services.

L.A. Care's Regulatory Affairs and Compliance Department is responsible for coordinating these audits. Subject matter experts from each operational area (i.e., provider network, utilization management, credentialing, etc.) are responsible for ensuring compliance for their specific area of expertise. In addition to the annual on-site visits, the L.A. Care operational areas are responsible for on-going compliance oversight of the Communication Network and the delegated provider group. On-going monitoring is accomplished via a variety of mechanisms including, but not limited to, monthly reporting/data analysis, Joint Operations Meetings between L.A. Care and the delegated entity, and peer review activities.

The Regulatory Affairs and Compliance Department has oversight responsibility of published member marketing materials and ensuring the connection between L.A. Care and the regulatory agencies is clear and solid. In accordance with the Marketing Guidelines, Chapter 3 of the Medicare Managed Care Manual, the Regulatory Affairs and Compliance Department ensures all marketing materials such as the Evidence of Coverage, Summary of Benefits, Provider Directory, and Detail Explanation of Non-Coverage and Denial notices are submitted to the appropriate regulatory agencies for approval. Once approved, L.A. Care uses marketing materials to inform beneficiaries of benefits, rights, and process to navigate through the Plan's health care delivery system.

X. Care Management for the most Vulnerable Subpopulations

Identifying the most Vulnerable Members & Providing Add-On Services and Benefits

L.A. Care's most vulnerable population (e.g. those who are frail, have special health care needs, multiple chronic illnesses and/or immediate medical needs, are homeless , etc.) are identified through the HRA process described in Section VII, the Individualized Care Planning process described in Section VIII, internal and external referrals from UM staff, discharge planners, physicians, predictive modeling tools, and assessments from various sources. As needed, these members receive more intensive care management services with add-on services and benefits.

These services include, but not limited to,

- Complex case management,
- Non-emergency transportation for medically necessary services
- Post-hospital discharge follow up program Home visits for medication reconciliation performed by a Nurse or Pharmacist through the Medical Therapeutics Management (MTM) Program
- More frequent case reviews

XI. Performance and Health Outcome Measurements

Methodologies Used to Collect, Analyze, and Act on the Results to Evaluate the Model of Care

L.A. Care uses many different sources to obtain performance data. The data sources include information such as: HEDIS results, quality report cards, complaints, grievances, appeals, member and provider satisfaction survey results, network access and availability reports, encounter data, utilization data and medical record review results.

The model of care ensures that information from all parts of the organization are routinely collected (i.e., monthly, quarterly, semi-annually, and annually) and interpreted to identify issues in the areas of clinical services, access to care and member services. Types of information to be reviewed include:

- Population Information – data on enrollee characteristic relevant to health risks or utilization of clinical and non-clinical services, including age, sex race, ethnicity, language and disability or functional status.
- Performance Measures – data on the organization’s performance as reflected in standardized measures, including when possible Local, State or national information on performance of comparable organizations.
- Other utilization, diagnosis and outcome information - Data on utilization of services, procedures medications and devices; admitting and encounter diagnoses, adverse incidents (such as death, avoidable admission or readmission and patterns of referrals or authorizations requests.
- Data from results of HEDIS and Structure and Process measures.
- External data sources – data from outside organization, including Medicare or Medicaid fee-for-service data, data from other managed care organizations and local national public health reports on condition or risks for specified populations.
- Enrollee Information on their experiences with Care: Data from surveys (such as, Health Outcomes Survey (HOS), the Consumer Assessment of Health Plans and Provider Systems or CAHPS), information from the grievance and appeals processes, and information on disenrollments and requests to change providers. (Note that general population surveys may under-represent populations who may have special needs, such as linguistic minorities or

persons with disabilities. Assessment of satisfaction for these groups may require over sampling or other methods, such as focus groups or member interviews). In addition to information generated with the organization, the QI Program assesses information supplied by purchasers, such as data on complaints.

- Data elements from CMS Part C reporting.

The annual model of care evaluation measures the effectiveness of improvement to member's health outcomes by reviewing self reported member data and encounter data. The methodology for this includes claims encounter data which is reviewed for emergency room and hospital utilization to evaluate for a reduction in hospitalizations which may result in improved access to care; self reported information will be collected telephonically during a survey of members enrolled in the program for more than six months to assess member satisfaction with the program. The data collected and methodologies include:

Description of the Personnel Involved in the Collection, Analysis, and Reporting and Evaluation of the Model of Care

Staff throughout L.A. Care is responsible for collecting, analyzing, reporting, and acting on data to evaluate the effectiveness of the model of care which includes an aggregate data review of the measurable goals and program satisfaction results. Most activities are coordinated and/or carried out by staff in two main service areas: Health Services and Managed Care Operations. Staff leading the efforts include but are not limited to:

- L.A. Care Medical Management Medical Director
- L.A. Care Senior Medical Director
- L.A. Care Senior Director, Health Services

- L.A. Care Director, Medical Management
- L.A. Care Director, Quality Improvement
- L.A. Care Manager, Quality Improvement
- L.A. Care Director, Health Outcomes & Analysis
- L.A. Care Biostatistician, Health Outcomes & Analysis
- L.A. Care Manager, UM/CM
- L.A. Care Lead Management Specialist
- L.A. Care UM Oversight and Compliance Specialist
- L.A. Care UM Oversight Specialist

Identifying Opportunities for Improvement

The analyzed results of the performance measures may be used to improve the model of care by identifying gaps in services, identify possible member benefit needs, staff and provider trainings, improve care transitions and improve member health outcomes. At least annually, qualitative and quantitative analysis of data collected is used to prioritize opportunities to improve service delivery. Based on the results of the measurements and analysis, if goals are not met or not met within the expected timeframe, actions are taken which may include strategic training for staff both employed or contracted staff, institution of corrective action plans across the network for employed or contracted staff, revisit the defined benchmarks for validation, etc. Opportunities for improvement will be re-measured in a pre-determined timeframe using methods consistent with the initial measurement (i.e. within six months of the initial measure).

Interventions are planned and implemented based on the data analysis. When areas for improvement are identified, efforts to develop improvement strategies are prioritized. An in-depth

review is conducted on the areas identified as having the greatest potential for improving care, safety, and health status outcomes of members. Continuous quality improvement is realized when data are collected and analyzed, interventions are planned and implemented, measurement is repeated and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the calendar year. Quality improvement is accomplished by using the improvement model described. This process embraces the Plan, Do, Study, and Act (PDSA) model of improvement.

The L.A. Care QI Department works with other departments to address opportunities to improve the delivery of care through the selection, design, and implementation of interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, providers, or services.

Interventions to improve performance include health promotion and health education programs, to inform members of ways to improve their health or their use of the health care delivery system, modifications to administrative processes, to improve quality of care, accessibility and service and modifications to the provider network such as additions to improve accessibility and availability. These processes may include customer services, utilization management and case management activities, preventive services and health education. Interventions to improve provider performance include presentation of provider education programs, individual provider feedback on individual and aggregate performance and distribution of best practice material.

Documentation & Preservation of the Model of Care

Documentation on model of care evaluation is maintained electronically within the Medical Management Department and preserved as evidence of the effectiveness of the model of care. The document is made available to CMS upon request and during onsite audits.

Oversight – Monitoring & Evaluating the Effectiveness of the Model of Care

The Quality Oversight Committee is an internal committee of LA Care which reports to the Board of Gov through the Compliance and Quality Committee. The QOC is charged with aligning organize-wide goals with the needs of the population served. The QOC also monitors and evaluates the effectiveness of the overall performance of LA. Care activities including the model of care. The QOC is responsible for reviewing and reporting data.

Communicating Improvements in the Model of Care to all Stakeholders

Annually, improvements in the model of care are communicated to all stakeholders (e.g., by webpage for announcements, printed member and provider newsletters, bulletins, announcements, etc.).

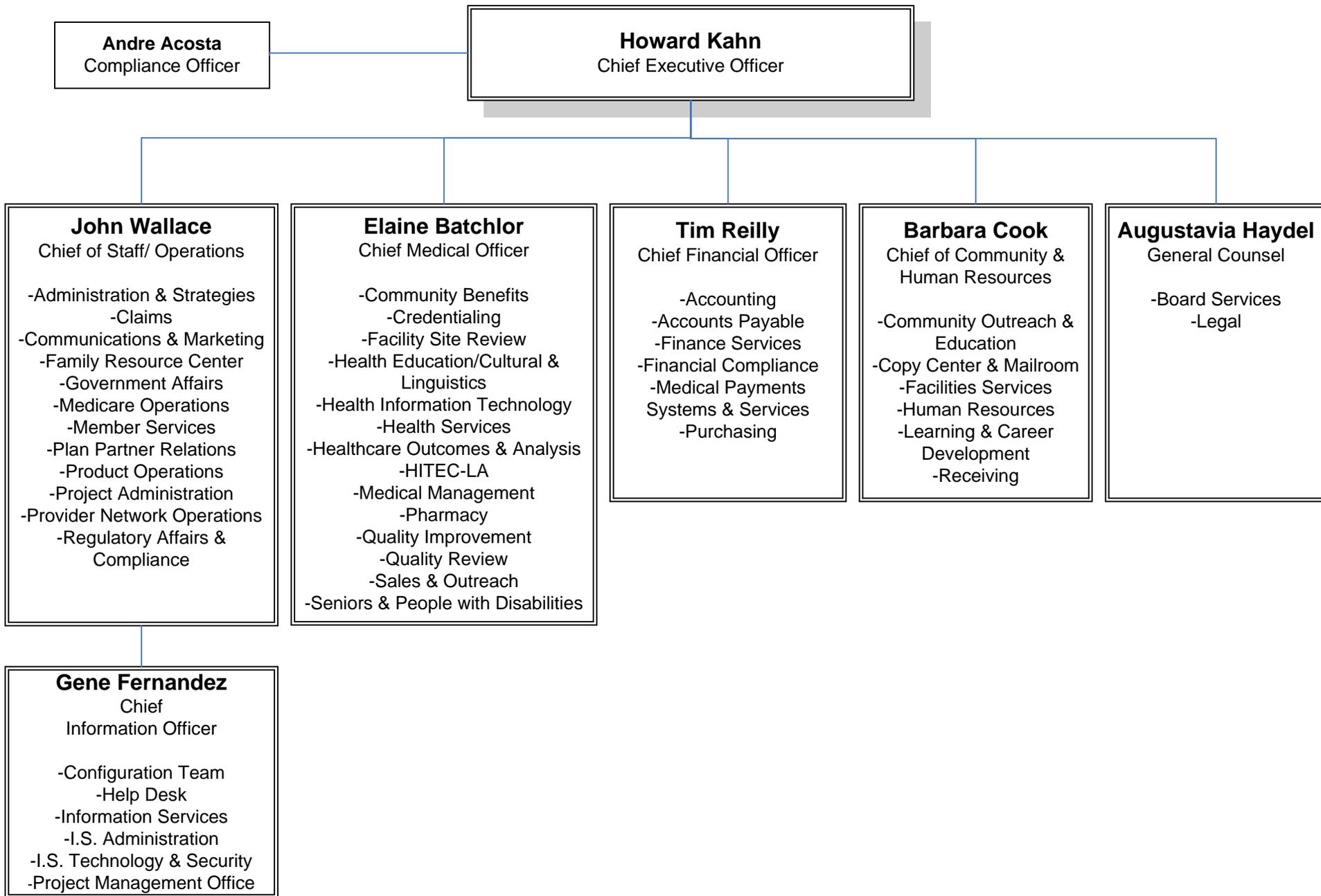
Performance Measures

Purpose	Indicator	Measure	Methodology	Sampling
Improvement in health status;	Quality of Life Survey– SF12 Mental Health Components	Percentage of respondents rating their health as excellent, very good and good	All patient in complex care management for 6 months after enrollment or upon discharge from the program	All patient responding with self-reported health rating as “excellent, very good or good”/Total number of

				respondents
Improvement with mobility and functional status	Quality of Life Survey– SF12 Physical Health Components	Percentage of respondents rating their functional and mobility status as “not at all”	All patient in complex care management for 6 months after enrollment or upon discharge from the program	All patients responding” not limited at all”/Total number of respondents All patients responding “no” to mental health response/Total number of respondents
Improvement with self management and independence)	Medication compliance	Percent of patients achieving medication compliance	Patients on chronic medications filling chronic medication prescriptions every month	All patient filling prescription every month /All patients in CCM identified as being on chronic medications/
Improve satisfaction with health services	Patient satisfaction	Percentage of patients responses for the overall	All patient in complex care management after	Total number of “very satisfied” respondents/Total

		satisfaction with the care management	45 days or upon discharge from the program	number of respondents
Improvement of beneficiary health outcomes	Avoidance of hosp admissions for ambulatory care sensitive conditions (ACSC)	Total admissions and bed days for patient admitted with ACSC	All patients in CCM who are admitted for ACSC are included	Total number of bed day reduced for patient with ACSC after enrollment/ Total number of bed day days for patient with ACSC prior to enrollment

L.A. Care Organizational Chart



*John Roger Wallace****Experience***

L.A. CARE HEALTH PLAN, Los Angeles California **2005 to Present**
One of the nation's largest Medicaid health plans also operating Medicare Advantage and other public insurance products.

Chief of Staff (2007 to Present)

Promoted to this key management position and maintained responsibilities of Senior Director. In this capacity as lead operational and strategy executive, oversaw the Chief of Operations and CIO. Functional areas include: Provider Network Operations, Member Services, Claims, Information Systems, and Delegated Plan Services.

- Provide managed care services to more than 1,000,000 members through delegated plan services and direct operations.
- Manage contract plan relationships with national, regional and local health plans, including Blue Cross, Kaiser, and CareFirst.

Selected Achievements

- Lead successful negotiations and transition of more than 180,000 members from Community Health Plan to L.A. Care.
- Designed and implemented new Project Management Office to oversee all major operational projects impacting cross-functional areas organization-wide.

Senior Director, Administration and Strategy (2005 to 2007)

Key executive reporting to the CEO. Responsible for Communications and Marketing, Government Affairs, Strategic Planning, Regulatory Affairs and Compliance, and Plan Partner Accounts.

Selected Achievements

- Developed key elements of business plan – marketing plan, compliance plan, enrollment metrics – when LA Care launched its first direct managed care product line.
- Tripled L.A. Care's brand awareness through the company's first significant branding campaign using media and community outreach strategies.
- Conceptualized and developed Family Resource Center (FRC) program to boost member outreach and community awareness. The effort included the establishment of two satellite offices offering health education, enrollment and other services to targeted members and local residents interested in available health education resources.

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES (2001 to 2005)
A public healthcare system, with a \$3 billion annual budget, providing healthcare to 700,000 individuals through an integrated network of hospitals and clinics.

Director of Policy and External Relations (2004 to 2005)

Executive manager for corporate units of Communications, Intergovernmental Relations, Office of Ambulatory Care, and 1115 Waiver Office. The 1115 Waiver Office is responsible for regulatory compliance reporting for the \$1.2 billion Federal Medicaid Waiver and oversight of various operational improvement plans.

Selected Achievements

- Achieved objectives of federal waiver to refocus delivery system from inpatient care to an integrated delivery system with an increase in ambulatory care.
- Managed strategic initiative, Private Partnership Program, focused on \$50 million contract agreements with private community clinics and other community providers to provide primary and specialty care for County responsible patients.

Director of External Relations (2001 to 2003)

Promoted to executive manager and reported to the Director and Chief Medical Officer and the Chief Operating Officer. In addition to the responsibilities of Director of Communications, and Intergovernmental Relations, I also recommended and implemented legislative priorities and strategy.

Selected Achievements

- Implemented key parts of the Department's Strategic and Operational Plan.
- Played a key role in the 2002 negotiations with State and Federal officials that brought an additional \$250 million in revenue to the Department.

Director of Communications (2000 to 2001)

Reported to the Director of Health Services. Managed the Health Services Public Information Office and provided oversight to public information staff at the major medical facilities. Developed strategy and policy for all of the agency's internal and external communications

Selected Achievements

- Successfully communicated strategies and objectives of complex Five-Year Strategic Plan to press.
- Developed first executive level working groups with key stakeholders such as labor organizations.

LOS ANGELES COUNTY FOURTH SUPERVISORIAL DISTRICT (1995 to 2000)

Senior Deputy to Supervisor Don Knabe (1996 to 2000)

County-wide policy development including planning, organization and making recommendations on all aspects of Los Angeles County's \$15 billion budget. Also responsible for development and implementation of media strategy and press relations serving as the Supervisor's spokesman on all issues, serving as the Supervisor's lead staff in Sacramento and Washington, DC, working with elected officials and their staffs, and coordination of Supervisor Knabe's participation in the National and California Associations of Counties

Campaign Manager, Don Knabe for County Supervisor (1995 to 1996)

Duties included strategy development, budgeting, fund-raising, media production and placement, mail development, supervision of field staff operations including management of all employees and

contractors, press relations, and contracting for polling and opposition research.

Selected Achievements

- Supervisor Knabe won his election with a 24% margin.
- Campaign raised \$2.6 million.

OFFICE OF GOVERNOR PETE WILSON

1990 to 1995

Staff Assistant, Los Angeles Office

Daily responsibilities included management of subordinates, press relations, working with local elected officials, community groups, business organizations and industry representatives.

Served as lead field staff on many of the Governor's major public Southern California appearances.

Selected Achievements

- Developed and implemented media strategies for the Governor's response to the Southern California Firestorms (January and February 1993), Northridge Earthquake (January and February 1994) and the California Economic Comeback Tour (April thru July 1994).
- Played a major role in developing, coordinating and executing the California Crime Summit (February 1994).
- Served as Summit Director for the "California Focus on Fathers Conference" (June 1995).

Education

B.A. Political Science, May 1992
University of Southern California

Related Activities

Member, 2008 Committee on Waiver Development and Medi-Cal Expansion

Sponsored by the Blue Shield Foundation, the Working Committee on Waiver Development and Medi-Cal Expansion is a non-partisan group set up to probe how California can more effectively draw down federal dollars to help support expansion of healthcare coverage to more Californians.

<http://caworkingcommittee.org/>

Lead, Los Angeles County CHP membership transition project

Lead negotiator with Los Angeles County on transitioning membership from Community Health Plan, its Knox-Keene licensed plan, to L.A. Care consistent with the April 2010 report to the Los Angeles County Board of Supervisors from Health Management Associates.

http://file.lacounty.gov/bc/q2_2010/cms1_147252.pdf

Participant, Forces of Change, Health care leadership program at Harvard School of Public Health

Program addresses critical success factors at the intersection of health care and business management, mindful of emerging issues in health care reform and focused on "things you don't already know." The program offers an overview of the challenges facing health care leader and also powerful tips, tools, and techniques for overcoming these challenges

ID	Task Name	2012				2013				2014		
		Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2
1	Program Design											
2	Develop Program Vision and Goals Refinement											
3	Comprehensive Program Description											
4	Overall design of the program											
5	Develop how the program will be managed with an integrated financing model											
6	Determine whether/ how the program could include a Health Home Plans SPA component											
7	Coordination and Integration of LTSS											
8	LTSS Capacity											
9	Develop Coordination between medical care and LTSS											
10	Develop Contracting Relationships with LTSS providers											
11	Establish process on the use of HRA screenings to identify enrollees in need of medical care and LTSS											
12	Develop an integrated care model for individuals in an institutional setting											
13	IHSS											
14	Contract with County to administer IHSS services											
15	Design a model for interacting with IHSS through years 2 and 3 (including care coordination, training program, and coordinating emergency systems)											
16	Social Support Coordination											
17	Develop operational plan for connecting beneficiaries with social supports											
18	Establish partnerships with AAA, ADRC, and/ or ILC											
19	Establish partnerships with housing providers											
20	Coordination and Integration of Mental Health and Substance Use Services											
21	Design a model for coordinating access to the Medicare and Medi-Cal mental health and substance abuse benefits											
22	Develop a plan for working with a dedicated Mental Health Director and/ or psychiatrist quality assurance											
23	Develop a plan for supporting co-location of services and/ or multidisciplinary, team-based care coordination											
24	Establish a plan to include consumers and advocates on a local advisory for the oversight of the care coordination partnerships and integration progress											
25	County Partnerships											
26	Develop a plan for supporting integrated benefits for individuals affected by mental illness and chronic substance use disorders											
27	Establish Partnership with the County provision of mental health and substance use services to the seriously ill											
28	Person-Centered Care Coordination											
29	Design the model (patient-centered care coordination for the Duals)											

Project: Duals Demonstration Project - Date: 2/10/12	Task		Milestone		External Tasks	
	Split		Summary		External Milestone	
	Progress		Project Summary		Deadline	

ID	Task Name	2012				2013				2014			
		Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3
30	Create a plan for engaging providers in the network to participate in care coordination												
31	Consumer Protections												
32	Demonstrate compliance with all consumer protections in the Demonstration Proposal and Federal-State MOU												
33	Consumer Choice												
34	Establish process for allowing beneficiaries to choose their primary care provider, specialists, and care team												
35	Access												
36	Demonstrate compliance with DHCS accessibility standards												
37	Communication plan for beneficiaries on the accessibility levels of providers in the network												
38	Education and Outreach												
39	Ensure communications will be in a range of formats with beneficiaries												
40	Create an operating plan, communication plan, and education approach to meet DHCS requirements												
41	Stakeholder Input												
42	Create a stakeholder engagement plan and timeline for the 2012 project development/ implementation phase												
43	Create a stakeholder engagement plan for the three year demonstration												
44	Establish a process for involving external stakeholders in the development and ongoing operations of the program												
45	Enrollment Process												
46	Develop internal enrollment process starting 2013 and be phased in over the year												
47	Analyze utilization data and use data to appropriately assign members												
48	Identify administrative and network issues that DHCS should address prior to enrollment												
49	Appeals and Grievances												
50	Demonstrate compliance with the appeals and grievances processes for beneficiaries and providers according to the Demonstration Proposal and Federal-State MOU												
51	Organizational Capacity												
52	Consider new organizational structure to serve duals												
53	Establish a plan for the governance, organizational and structural functions that will need to be in place to implement, monitor, and operate the demonstration												
54	Operational Plan												
55	Refine an operational plan including a draft work plan preparing for implementation in 2013 and ramp up in the first year												
56	Create call center												
57	Hire navigators, nurses, other team members												

Project: Duals Demonstration Project - Date: 2/10/12	Task		Milestone		External Tasks	
	Split		Summary		External Milestone	
	Progress		Project Summary		Deadline	

ID	Task Name	2012				2013				2014			
		Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3
58	Define roles and responsibilities of key partners												
59	Define a timeline of major milestones and dates for execution of the operational plan												
60	Create a plan for monthly reporting on progress made toward implementation of the timeline												
61	Network Adequacy												
62	Develop on provider payment methodologies												
63	Create a strategy for encouraging providers who do not accept Medi-Cal to participate in the demonstration pilot												
64	Create a strategy for working with providers to ensure accessibility for beneficiaries with disabilities												
65	Create a strategy for encouraging providers working with the demonstration population to join our care network												
66	Develop subcontract arrangements in support of integrated delivery												
67	Demonstrate compliance with Medicare standards for medical services and prescription drugs and Medi-Cal standards for LTC networks												
68	Technology												
69	Develop a plan for utilizing care technology for beneficiaries at very high-risk of nursing home admission												
70	Monitoring and Evaluation												
71	Ensure on the organization's capacity for tracking and reporting enrollee satisfaction, self-reported health status, access to care, encounter data for all covered services, and condition-specific quality measures												
72	Ensure on the organization's capacity for reporting beneficiary outcomes by demographic characteristics												
73	Budget												
74	Develop and improve internal infrastructure support that could help facilitate integration of LTSS and behavioral health services												

Project: Duals Demonstration Project - Date: 2/10/12	Task		Milestone		External Tasks	
	Split		Summary		External Milestone	
	Progress		Project Summary		Deadline	