SCAN Health Plan
Response to California's Dual Eligible Demonstration Request for Solutions
(California Department of Health Care Services)

February 24, 2012

San Bernardino County

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Chris Wing, C.E.O.

February 24, 2012

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

Dear Mr. Douglas:

SCAN Health Plan (SCAN) is pleased to submit the enclosed proposal to the State of California's Request for Solutions regarding the Dual Eligible Demonstration Project for San Bernardino County. SCAN commends the State's intention to enroll dual eligibles into high quality, integrated health plans, beginning in 2013.

For more than three decades, SCAN has provided high-quality, integrated, person-centered care to dual eligibles. Your current goal crystallizes our long-held mission.

We are ready and willing to help the State and CMS integrate care and improve overall health while promoting individuals' independence and control over how that care is delivered.

Sincerely,

Chris Wing
Chief Executive Officer
SCAN Health Plan

Applicant Name: SCAN Health Plan – San Bernardino County Date: February 24, 2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.	x	See Appendix 1 for supporting documentation.
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	x	See Appendix 2, Financial Statement ending 12/31/11 from DMHC website in lieu of letter.
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	x	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.		n/a
4	Applicant has a current Medi-Cal contract with DHCS.	x	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	x	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	x	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.	x	See Appendix 3 for supporting documentation.
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	x	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	x	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.	x	See Appendix 4 for supporting documentation.
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	x	See Appendix 4 for supporting documentation.

Signature: _____

Applicant Name: SCAN Health Plan – San Bernardino County Date: February 24, 2012

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
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 do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	x	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	x	See Appendix 5 for supporting documentation.
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	x	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	x	
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.		n/a
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	Applicant certifies that it has a history of business integrity. With respect to the "history of being responsive to past contractual obligations," Applicant certifies that it has been responsive to

Signature: _____

Applicant Name: SCAN Health Plan – San Bernardino County Date: February 24, 2012

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
			contractual obligations of which it was affirmatively aware and/or of which it was capable of fulfilling. Applicant has recently become aware of historical contractual provisions included in standard managed care contracts between the State of California and Applicant, which either were not enforced as to Applicant by DHCS or which were impossible for Applicant to fulfill, either because of conflicts between State and Federal Law or because of other factual impediments. Applicant has long ago remedied any defects in contractual compliance and certifies that it is currently responsive to any/all contractual obligations.
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	x	

Signature: _____

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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?	28 yrs	Contract has been in place since 1984.
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	Yes, 2 CAPs	See Appendix 6 for supporting documentation.
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	No	
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	
6	How long has the Plan had a Medi-Cal contract?	Since 1984	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	Vision, Dental, Hearing Aids and Transportation, dependent on reimbursement rates.
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	San Diego County Dept of Health and Human Services, San Diego Public Authority, City of Los Angeles Area Agency on Aging, Los Angeles County Office of the Chief Executive Office. See Appendix 7 for supporting documentation.
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	No	
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	SCAN has a comprehensive provider network experienced at providing innovative and high value care to dual eligibles. SCAN will work with its contracted provider network to assess

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			continuity of care needs and would supplement the provider network as appropriate.

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Applicant Name: SCAN Health Plan – San Bernardino County Date: February 24, 2012

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

Signature: _____

Applicant Name: SCAN Health Plan – San Bernardino County Date: February 24, 2012

Point of Contact for SCAN Health Plans' California Dual Eligible Demonstration Request for Solutions Proposal Checklist:

Douglas Jaques
Senior Vice President, General Counsel
SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
Long Beach, CA 90806
562-989-5100

Signature: _____

Executive Summary

The Applicant must provide a two-page executive summary of the Demonstration project. This should serve as a succinct description of the proposed project, including the goals of the project, the proposed geographic coverage area, number of projected dual eligibles to be enrolled, and list of strategic partnerships that will be developed to carry out the project. Write the executive summary so that it is clear, accurate, concise, and without reference to other parts of the Application.

SCAN Health Plan (SCAN) commends the State of California's proposal to enroll all Californians who are dually eligible for Medicare and Medi-Cal ("dual eligibles" or "duals") in high-quality, integrated health plans, beginning in 2013. Dual eligible patients deserve seamless access to the care and social supports and services that will help them maintain good health and a high quality of life in the setting of their choice. SCAN has provided high-quality, integrated, person-centered care to dual eligibles since shortly after our founding by community activists nearly 35 years ago. SCAN has extensive experience in coordinating Medicare, Medicaid, and home- and community-based services (HCBS) benefits, as well as supplemental services, making SCAN one of only a few health plans nationwide capable of executing on the State's integrated care model immediately. Today, SCAN is the nation's fourth largest not-for-profit Medicare Advantage plan, serving nearly 130,000 individuals, and is the only fully-integrated dual eligible special needs plan (FIDE SNP) in California. Throughout that significant expansion, SCAN's mission has stayed and will remain the same: the pursuit of

innovative ways to enhance our members' ability to manage their health and control where and how they live.

Through California's Dual Eligible Demonstration (the "Dual's Demonstration"), SCAN proposes to transition duals from the current disjointed fee-for-service system to a fully integrated system of care delivery under SCAN's person-centered Model of Care. In doing so, we will improve health outcomes, increase the quality of and members' satisfaction with care, and optimize the use of Federal and State resources, all while maximizing our members' ability to continue living in the community. SCAN's Model of Care has already proven successful for our enrolled duals, in terms of quality of care, outcomes, and costs. For example:

- Ninety-eight (98) percent of SCAN's nursing facility level of care (NFLOC) duals in California are able to reside in the community instead of in long-term care institutions.
- A recent study revealed that SCAN's HEDIS 30-day All-Cause Readmission Rate for dual eligible members in 2010 was 23 percent lower than that of a similar cohort of fee-for-service enrolled duals in California, and 24 percent lower than expected based on enrollees' average adjusted probability.
- In 2011, 97 percent of SCAN dual eligible members said they were satisfied with SCAN, and 94 percent said that SCAN helped them live independently.

SCAN proposes to expand our dual eligible enrollment to serve an additional 5,000 dua ls throughout San Bernardi no County. SCAN will provide seam less access to the full array of Medicare, M edi-Cal and LTSS benefits, as well as a range of important supplemental benefits, such as dental care and transportation, in a culturally sensitive and clinically appropriate manner. We will structure financial incentives to encourage medical providers to meet quality benchmarks. In addition, we will enhance our already robust partne rships in the local comm unity, including with the Departments of Mental Health and Public Soc ial Services, Public Guardian, HCBS providers such as Co mmunity-Based Adult Services (CBAS) centers, and community resources such as Meals on Wheels and independent living centers.

SCAN is deeply invested in the goals of the Duals Demonstration. We are ready and willing to help the State and CMS integrate care and improve overall health outcomes while promoting individuals' independence and control over how that care is delivered.

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.

SCAN Health Plan (SCAN) has a long history of serving dually eligible, dually enrolled beneficiaries and combining Federal and State funding to deliver comprehensive, coordinated, person-centered care. SCAN was founded in 1977 by a group of seniors who were frustrated by their lack of access to services and who sought an organization that addressed their specific needs. These forward-thinking individuals formed the Senior Care Action Network, now known as SCAN Health Plan. SCAN's goal then was the same as it is today: to find innovative ways to promote our members' ability to manage their health and control where and how they live.

In pursuit of this mission, SCAN was an original participant in California's Multi-Purpose Senior Services Program (MSSP). Today SCAN operates the largest MSSP site in the State through SCAN's home and community-based services (HCBS) division, Independence at Home™ (IAH). SCAN also participated for more than two decades in Medicare's Social HMO Demonstration, incorporating HCBS benefits into a comprehensive assessment and care management program. Since 1985, SCAN has used Medicare and Medi-Cal funding to provide a fully

integrated array of Medicare, Medi-Cal, and HCBS benefits to dually eligible enrollees under contracts with Medicare and Medi-Cal.

Under the Social HMO Demonstration, SCAN managed a population that met nursing facility level of care (NFLOC) criteria. Case managers conducted comprehensive assessments in the home to qualify the beneficiary for participation, to ascertain the level of impairment, and to identify which community resources could successfully address these deficits. SCAN provided personal care, homemaking (including meal preparation and maintaining sanitary living conditions), home-delivered meals, nutritional supplies, incontinence supplies, a telephone emergency response system, adult day care services, bath equipment, and limited inpatient respite. SCAN's current care management model evolved from our experience as a Social HMO. It emphasizes prevention and early intervention, spans the continuum of a beneficiary's health status, and provides the right care at the right time. Our early experience in managing frail, NFLOC beneficiaries has directly informed the design of our current case management services, our investment in training a highly competent field staff, and our dedication to building deep relationships with community agencies. Since 1985,

SCAN's program of specialized services is estimated to have delayed or prevented 100,000 nursing home admissions in California.[1]

As the Social HMO demonstration ended, SCAN became a Special Needs Plan (SNP) when that program was created as an offering in Medicare Advantage. Today, as the nation's fourth largest not-for-profit Medicare Advantage plan and the only CMS-approved Fully-Integrated Dual Eligible SNP in California, SCAN provides comprehensive, coordinated care to nearly 130,000 individuals in Medicare Advantage, including approximately 8,000 dually enrolled dual eligibles in California. SCAN has served dual eligibles in dual eligible Special Needs Plans (D-SNPs) since 2006. In addition, dual eligibles make up about 85 percent of SCAN's chronic condition Special Needs Plan (C-SNP) enrollment. SCAN maintains a contract with the State of California for D-SNPs in Los Angeles, Riverside, and San Bernardino Counties. Although we do not have a contract with the State for San Joaquin County, SCAN nevertheless provides care coordination services to dual eligible members residing there. SCAN has also served as a contractor for the Arizona Long Term Care System (ALTCS) since 2006, enrolling both disabled and older adults who are low-income, meet NFLOC criteria, and suffer from physical, functional, or behavioral impairments. In Arizona, SCAN

[1] Internal calculation based on the number of NFLOC-qualified enrollees since 1985 who have remained in their homes instead of residing in an institutional setting.

deploys 50 case managers to provide care management, comprehensive medical care, and supportive in-home services to a membership of 2,700. Across all of SCAN's product lines, including MSSP and our Arizona plans, we currently serve approximately 12,000 duals.

SCAN has an extensive and successful track record serving dual eligibles with complex health needs, both elderly and non-elderly. SCAN's dual eligibles assessed at NFLOC have, on average, three to four severe chronic conditions and take more than four prescription medications. More than 70 percent have hypertension and nearly 40 percent are overweight, putting them at high risk for diabetic and cardiovascular conditions. Indeed, more than one-third of SCAN beneficiaries have diabetes, and another quarter have vascular disease. Despite the complexity of this population, however, recent analyses of SCAN's dual eligibles reveal that SCAN successfully keeps NFLOC members in the community, improves health and reduces utilization of expensive services such as inpatient and skilled nursing facility (SNF) stays, and performs very well on a range of process, outcomes, and quality measures. For example:

- Ninety-eight (98) percent of SCAN's NFLOC dual eligibles in California are able to reside in the community instead of in long-term care institutions.[2]

[2] Internal reports by SCAN Health Plan.

- Within the first six months after enrollment in our Geriatric Health Management program, the percentage of members with an inpatient admission was reduced by 45.6 percent and the percentage of members who had an emergency room visit was reduced by 22.7 percent.[3]
- Participating in SCAN's Congestive Heart Failure (CHF) Disease Management program reduced inpatient bed days by 25.4 percent and SNF bed days by 39 percent as compared with members who were not enrolled in the program (adjusting for medical group variation).[4]
- In 2011, 97 percent of SCAN dual eligible members said they were satisfied with SCAN and responded that SCAN helped manage their health, and 94 percent said that SCAN helped them live independently.[5]
- A recent study conducted by Avalere Health comparing HEDIS 30-day All-Cause Readmission Rates between dual eligibles enrolled in SCAN Health Plan versus Medicare FFS dual eligibles found that SCAN's dual eligibles had a readmission rate that was 23 percent lower than a similar

[3] Ibid.
[4] Ibid.
[5] Ibid.

cohort of California FFS dual eligible beneficiaries (15 percent and 19. 5 percent respectively).[6]

- The Avalere Health study also found that SCAN Health Plan scored better than Medicare FFS on ARHQ's Prevention Quality Indicators (PQI) Overall Composite, demonstrating a 15 percent lower inpatient admission rate for conditions that compose the composite measure, including COPD, CHF, and bacterial pneumonia.[7]
- In 2011, SCAN performed in the 90th percentile among Medicare D-SNPs on a wide range of quality measures, including colorectal cancer screenings, glaucoma screenings, and on a number of comprehensive diabetes care measures.
- A 2010 study by the University of Southern California found that if a beneficiary admitted to a skilled nursing facility received SCAN HCBS and case management services, there was a 26 percent greater likelihood

[6] The Avalere Health study compared outcomes on the AHRQ Prevention Quality Indicators (PQI) Overall Composite and the HEDIS 30-day All-Cause Readmission Rate between Medicare FFS dual eligibles in California and dual eligibles enrolled in SCAN Health plan. The PQI Overall Composite measures potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs), which are intended to reflect issues of access to, and quality of, ambulatory care in a given geographic area. The analysis was conducted on a sample of SCAN Health Plan duals enrolled in SCAN's Medi-Medi plan for at least one month in 2010, but were continuously enrolled in SCAN Health Plan for all of 2009 and 2010. Similarly, Medicare FFS duals were identified as beneficiaries who were enrolled in Medi-Cal for at least one month in 2010. (See data table at Appendix 9.)
[7] Ibid.

of discharge to a home setting as compared with FFS beneficiaries who did not receive these services, helping to minimize conversions from short term to long term institutional stays.[8]

In addition, SCAN maintains a 4-star overall quality rating based on a range of process, access, and outcome measures under the Medicare Advantage quality rating program. This high performance rating earns SCAN quality bonus payments from CMS.

In sum, our experience and history of high performance in caring for the dual eligible population make SCAN one of only a very few plans nationwide that have the expertise and capability to deliver comprehensive, person-centered care under the Duals Demonstration.

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

The California Dual Eligible Demonstration and SCAN share a common mission: to provide high-quality, coordinated, continuous, self-directed care that enables at-risk patients to live where and how they choose. For nearly 35 years, SCAN has developed innovative ways to help individuals manage their health and maintain their independence. We are pleased that the State of California is leading

[8] Thomas K, Gassoumis Z, and Wilber K. (2010) Conversion diversion: Participation in a social HMO reduces the likelihood of converting from short-stay to long stay nursing facility placement. Journal of the American Medical Directors Association, 11, 333–337.

the movement to make integrated care the standard for dual eligibles. No group is more deserving of the wrap-around services and integrated health care envisioned by the State's Demonstration. That is why SCAN, in its health plan model and as a home and community-based care management organization, sees the Duals Demonstration as a tremendous opportunity to fulfill our mission. On the broadest scale to date, we will be able to provide culturally and economically diverse seniors and disabled adults with patient-centered health care and HCBS that will allow them to maintain their independence and to lead healthy lives in their homes. SCAN is committed to working with both the Federal government and the State of California in this important endeavor to integrate all health care services for duals in a logical, comprehensive manner that improves the quality and lowers the cost of health care. This commitment, our mission, and our experience make SCAN uniquely suited to participate in the Duals Demonstration.

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

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

SCAN maintains a coordinated care management model that is distinctly designed for the dual eligible population, who, in addition to having low incomes, may also be frail and disabled, and are likely to suffer from complex chronic conditions. Upon a member's enrollment, SCAN engages in individual assessment

to determine the member's overall needs, followed by care coordination for all dual eligible members, and targeted care management services for those with chronic conditions and/or identified psychosocial needs. SCAN has a dedicated team that works to achieve continuity of care, regardless of payer (e.g., a member receiving skilled nursing facility services who exhausts the Medicare benefit and continues receiving care under the Medi-Cal benefit). To ensure continuity of non-medical services, SCAN's specially-trained staff link members to the services and supports they need and monitor their use. In addition, dual eligible members can always contact a member of the Personal Assistance Line (PAL) Unit for live, one-on-one telephonic assistance with understanding and accessing all the benefits to which they are entitled. Thus, through our person-centered approach, SCAN supports dual eligible members in a comprehensive way, providing members with the information, support, and assistance necessary to actively manage their own care.

b. Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care; and Increasing availability and access to home-and community-based alternatives.

SCAN has more than 30 years of experience in coordinating HCBS for our members. Our experience has proven that members who receive the appropriate HCBS stay healthier and able to remain in the community, rather than requiring institutional care. As a result, we provide HCBS benefits not only for our own plan

members, but also for other plans' members and for FFS beneficiaries through our IAH division. Under the Demonstration, SCAN will leverage and build upon our existing partnerships with community health care and service organizations to improve our new members' access to HCBS relative to FFS. Our links to these organizations are strong and will be further enhanced under the Duals Demonstration. For example, we have collaborated with other non-profits in the community to host events benefiting sensitive populations, participated in fundraising activities, and conducted cross-training of our staffs to work together more effectively. Under the Demonstration, we will work with agencies including ADHC/CBAS centers, Meals on Wheels, Independent Living Centers, Disability Rights Centers, caregiver agencies, senior centers that offer chronic disease support services, and housing providers—many of which are already strong partners of SCAN. Through our ongoing partnerships, these agencies also have the benefit of maintaining their client base and their ability to continue providing services even when fluctuations in the economy or State funding occur.

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

At SCAN, a patient's choice is firmly respected. Whether it involves primary care physicians (PCPs), medical groups, social workers, care navigators, or telephonic assistants, our patients have the right to choose care that satisfies them. The patient is at the center of the SCAN Model of Care. Indeed, patient

needs and preferences drive the flow of care. Every dual eligible plan member participates in the development of an Individualized Care Plan based on identified needs and the member's input on the Health Risk Assessment (HRA). If a member has identified needs, a SCAN case manager will contact the member by phone to collaboratively develop his or her care plan. The member's finalized care plan is documented in SCAN's software platform, the McKesson CareEnhanced Clinical Management System (CCMS), and mailed to the member along with information about who to call for help in managing his or her conditions or to discuss changes in his or her health status. Members are encouraged to review their care plan with their physician. Specifically for dual eligible members meeting NFLOC criteria, a SCAN field specialist meets face-to-face or by phone with the SCAN RN and the member and his or her caregiver to develop a care plan. The care plan includes an HCBS plan, identifying additional services that would assist the member, such as personal care services and Meals on Wheels. The member is given a copy of the care plan and another copy is mailed to the PCP. Through these processes, dual eligible members actively direct their care and SCAN ensures that they receive high quality care to meet their individual needs.

d. Improve health processes and satisfaction with care.

SCAN is committed to continually improving the quality of care our members receive. For 2012, SCAN's Medicare Advantage plans received a CMS

rating of 4 stars overall, including high marks on process measures and beneficiary satisfaction. In particular, SCAN significantly exceeded the national average performance on HEDIS measures of comprehensive diabetes care, glaucoma screening, and colorectal cancer screening. To ensure that our members are receiving the right care at the right time, and that they have high levels of satisfaction with the care they receive from our contracted providers, SCAN engages in ongoing evaluation and monitoring (see Section 8). At the time of contracting, SCAN conducts a Medical Management Infrastructure Assessment of our provider groups to identify any gaps in care processes and to develop and implement action plans to bring all providers into alignment with best practices. SCAN tracks the results of our oversight and monitoring activities in our Quality Committee Structure. We also routinely survey members and their caregivers, as well as providers, to identify any gaps in care, quality or access, and we make adjustments to remedy them.

e. Improve coordination of and timely access to care.

SCAN aims to deliver the right care at the right time to our members. Through SCAN's individualized care management model, our care coordinators ensure that members are accessing the services they need in a timely way, ranging from preventive services for healthier members, to ongoing case management for members with more complex needs, to care transition services for members

discharged from acute or post-acute care facilities. We share timely patient information with providers to ensure efficient utilization and coordination among medical services, as well as track members' use of non-medical supports and services.

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

By integrating medical care and non- medical supports and services under a single umbrella, SCAN will optimize the use of all the benefits for which dual eligibles qualify, along with additional community-based services that will allow them to remain independent. The current FFS system, financed through Federal, State, and local sources of funding, is disjointed and inefficient. This often leads to beneficiary confusion and frustration, with many forgoing care that can prevent the need for more intensive service use later. Additionally, the current system fosters the perverse incentive to avoid providing Medicaid-paid services that can actually prevent the need for more intensive use of Medicare-covered services. Under the Duals Demonstration, SCAN will continue our current holistic approach to assessing needs and delivering care that optimizes resources and improves quality and the members' experience. Using our efficient systems of care delivery and coordination, SCAN is confident we can reduce cost under the Duals Demonstration as compared to the current bifurcated FFS system.

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.)

Under the Duals Demonstration, SCAN will apply our time-tested, team-based care management model to transition duals from Medicare and Medi-Cal FFS in a way that improves health outcomes, increases quality of care, and reduces overall costs. SCAN's model will address the needs of dual eligibles in a comprehensive and integrated manner, combining culturally sensitive and clinically appropriate medical care with the social supports and services that allow them to remain living in the community. SCAN currently serves 1,241 duals throughout San Bernardino County and proposes to expand to serve an additional 5,000 duals. The enrollee population would include all full benefit duals, aged 21 and older, for which SCAN would provide the full array of benefits to which they are entitled under Medicare and Medi-Cal, as well as supplemental services including dental care, vision care, transportation, hearing aids and other items and services (subject to reimbursement levels).

To assist in the delivery of the Medicare, Medi-Cal, and supplemental services, SCAN will partner with the County Departments of Mental Health/Substance Abuse and Public Social Services, Public Guardian, the Area

Agency on Aging, Local Public Authorities, Independent Living Centers, CBAS, MSSP, and Rehabilitation Department offices. We will also engage in sub-contracting discussions with other health plans that have appropriate expertise in managing duals.

The SCAN Model of Care, included as Appendix 10, is a coordinated care management model distinctly designed for the dual eligible population. The Model of Care begins with risk stratification to identify members at the highest risk, and individualized assessment and team-based care planning to determine how best to meet members' clinical and social support needs. SCAN's model includes a suite of programs designed to tailor a member's care to his or her unique needs, from healthy through end of life. Our person-centered care management approach is described in more detail below:

Risk Stratification and Comprehensive Assessment: SCAN uses a sophisticated risk-stratification algorithm to identify members at highest risk, based on diagnoses, utilization patterns, medications, and responses to the bi-annual HRA. SCAN's model also relies on comprehensive assessment instruments that consider the multiple factors that can impact the whole person—physical, functional, social, and behavioral. Assessments are based on validated instruments, including the SF-36, PHQ-9, and a variety of specialized screening tools.

Individualized, Team-Based Care: Based on the comprehensive assessment, SCAN designs a plan of care around the individual, including targeted case management as needed, with active involvement of the member, family, and PCP as part of the Interdisciplinary Care Team. All members, regardless of health status, benefit from preventive strategies. More at-risk members, with chronic conditions such as diabetes, hypertension, dementia, CHF, or Chronic Obstructive Pulmonary Disease (COPD), and those suffering from disabilities (e.g., traumatic brain injury, amputations, mobility impairments, multiple sclerosis, and behavioral health/substance use diagnoses) are managed through our Geriatric Health Management & Monitoring (GHM) and Disease and Disability Support programs. Hospitalized members and their caregivers receive coaching and inpatient case management, while members leaving the hospital or nursing home are guided by the Care Transitions Program. For members with memory impairments, specially trained case managers work with family caregivers to coach them about disease course and behavioral modifications. Proactive referral processes have been established with caregiver agencies so members are more likely to get the services they need. Thus, our multifaceted care management approach is tailored to each individual's unique needs and health conditions.

SCAN's case management programs are integrated by a common software platform and supported by nurse and social work staff trained in geriatrics and

complex care management. SCAN emphasizes tested approaches, such as motivational interviewing, coaching for self-management, caregiver support, and behavioral health coordination to help the patient receive the best support possible for their care. A key element is the Interdisciplinary Care Team case conference with a SCAN physician and subsequent communication with the member's PCP. The PCP plays an integral role, including reviewing care plans, communicating with case managers, and participating in case conferences.

Disease Management and Disability Support: SCAN's disease management programs are specific to the chronic care needs of dual eligibles. Case managers educate members about their disease process and management, recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, medication management, nutrition, self-management and healthy behaviors and advance care planning. The key disease states are CHF and COPD, but we also routinely help members manage multiple, co-morbid conditions, such as diabetes. These are telephonic educational programs that follow guidelines established by the American College of Cardiology/American Heart Association (ACC/AHA) and the Global Initiative for Chronic Obstructive Lung Disease (GOLD).

Disability Support focuses on individuals with mobility challenges, amputations, traumatic brain injuries, depression, serious mental illness, and other

disabling conditions. Case managers address the whole spectrum of needs with the goals of helping individuals live as independently as possible.

Care Transitions: A master's level social worker ensures that members being discharged from the hospital or skilled nursing facility transition home safely and avoid unnecessary readmissions. Care Transitions follows the Coleman Model, based on Four Pillars:

1. Use of a Personal Health Record to communicate information to primary and specialist physicians;
2. Reconciliation of pre- and post-hospital medications;
3. Knowledge of warning signs and symptoms; and
4. Understanding of appropriate follow-up care post-discharge.[9]

Recognizing the age and vulnerability of SCAN's membership, SCAN added a Fifth Pillar regarding advance-care planning. Often, a hospitalization or change in condition signals a time when members and their families are open to discussing their preferences with regard to end-of-life care.

Medication Therapy Management: Managing complex medication regimens is a primary focus across the case management spectrum. SCAN provides members at high risk for medication issues (those taking 8 or more medications)

[9] Parry C., Coleman E.A., Smith J.D., Frank J.C., Kramer A.M. The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers between Sites of Geriatric Care. Home Health Services Quarterly. 2003: 22(3): 1-18.

with skilled medication management in a similar format to those members that participate in the CMS Medication Therapy Management Program. Such medication issues may include problems with health literacy, making it difficult for some members to manage their medications; mismatches between drugs and diagnoses; and use of non-recommended medications. In cases where a medication issue is anticipated, the member's case manager alerts the member to medication issues that should be raised with the treating physician. An IAH pharmacist who specializes in substance use and behavioral health will work in tandem with SCAN's pharmacists and will employ our PharmMD MedPro pharmacy software to identify potentially problematic risk profiles.

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.)

SCAN currently aggregates Medicare and Medicaid payments to provide the comprehensive, integrated model of care through our D-SNPs. We will continue to do so through the Duals Demonstration plan in San Bernardino County. SCAN does not treat the full complement of services as Medicare- or Medicaid-paid; rather, care is individualized without regard to the original source of funding. Our 20 years' experience as a Social HMO makes SCAN uniquely qualified to operate under an integrated financing model. We look forward to learning more about the financing structure to be used in the Demonstration.

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

SCAN has developed and adopted Clinical Practice Guidelines and corresponding Case Management Guidelines that are designed to assist practitioners and case managers in the management of specific conditions that are prevalent in the geriatric and disabled populations. Examples of SCAN's Clinical Practice Guidelines include practitioner guidelines for the treatment of diabetes, COPD, and depression. Case Management Guidelines include guidelines for managing diabetes, substance use, chronic pain, and screening and prevention. These guidelines provide a roadmap for assessing needs and taking corresponding actions. The guidelines are based on nationally-accepted medical evidence and best practices derived from clinical literature and expert consensus. The Clinical Practice Guidelines are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee, and the evidenced-based guidelines for case managers are reviewed annually and processed through SCAN's Quality Management Committee. A list of SCAN's Clinical Practice and Case Management Guidelines is attached at Appendix 11.

To ensure consistent understanding among SCAN staff members, we train staff annually on these tools. In addition, the guidelines are communicated to our provider organizations in the following ways:

- Evidence-Based Continuing Medical Education (CME) Programs. SCAN sponsors a robust performance improvement education program for our medical provider partners and community physicians. SCAN is an accredited continuing education provider for physicians, nurses, licensed social workers, and pharmacists. Web-based modules, each with an interactive case study, are created by expert university faculty, who incorporate the latest research data into their presentations. The goal is to enhance practicing physician performance in caring for SCAN's older, complex, and disabled population, as many providers have not received formal training in geriatrics or care of the disabled. Current topics include Diabetes Management, Stroke Prevention, CHF, Depression Care, and Office-Based Assessment, with additional modules in development.
- SCAN Provider Webpage. SCAN's website offers additional information and tools, including a training course on Hierarchical Condition Categories (called "HCC University"), tools such as the PHQ-9 for depression screening and the Six-Item Screener for cognitive screening, provider updates, formulary information, and multi-cultural resources.
- Clinical Collaboration. Providers are an integral part of the SCAN Pharmacy & Therapeutics Committee, participate on planning committees for SCAN-sponsored CME, and are included in SCAN's annual Geriatric Advisory

Board (GAB) meetings. The GAB is composed of national experts in aging and health care that advise SCAN about incorporating new evidence-based models and best practices into the delivery of care.

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.

SCAN has developed culturally sensitive approaches to address our population's complex health and social needs. Demographically, nearly half of SCAN's dual eligibles are Hispanic, approximately 25 percent are White, and an additional 11 percent and 9 percent are African American and Asian/Pacific Islanders, respectively. Additionally, about 40 percent of members report not speaking English well or at all, and 22 percent believe that their health beliefs conflict with their doctor's advice.[10]

Under the Duals Demonstration, SCAN will identify members with the highest health risks, who are often the same ones who have been underserved by the disjointed FFS system. They may have not had a medical home or continuous relationship with a primary care provider, or access to necessary preventive tests and screenings. Contrary to their experience under FFS, these beneficiaries will receive care that meets their unique needs, including their cultural and linguistic needs. For example, we translate our printed materials into the threshold languages

[10] SCAN Health Plan (2010). Internal analyses and survey.

(English and Spanish throughout California, and additionally Vietnamese and Chinese in Northern California) languages; many of our ambulatory and disease management case managers are bilingual; and we inform members about free interpreter services that are available to them and to providers. SCAN's case managers are sensitive to members' cultural preferences (including dietary preferences) in developing care plans.

Perhaps most important, SCAN's Patient Assistance Line (PAL) is dedicated to assisting dual eligible members. Each member has their own "PAL" who they can call for information about benefits, how to change doctors, transportation referrals, or help getting used to the new procedures of managed care. PAL staff work to develop relationships with their assigned members, so that they can understand their preferences for care and communication. All PAL staff are bilingual (English/Spanish), and new bilingual staff will be added as new threshold languages are identified.

SCAN's program will also reduce the impact of multiple co-morbidities and will modify members' health risk factors. Beneficiaries with complex health needs—those with CHF, COPD, and/or multiple co-morbidities—will receive targeted disease management services to help them manage their chronic conditions and lower their risk factors over time. For example, the CHF Disease Management Program targets members with CHF who have been identified as

high-risk through SCAN risk stratification algorithm. Nurse case managers guide the member through educational pathways focused on understanding their disease, communicating with their doctors, identifying warning signs and symptoms, and adhering to their medication, diet, and exercise regimens. Staff maintains strong connections with the member's doctor and medical group, so that if any concerning change is identified (e.g., if a member reports a weight (fluid) gain) care can be escalated.

Furthermore, case managers are well-trained to work with members with diabetes, a prevalent condition in the dual eligible population. Case managers follow a specially-designed set of diabetes clinical guidelines and educate members about the importance of diabetic tests, including foot, eye, and kidney screening; modifying their diet; and incorporating exercise into their lifestyle. Self-management skills also focus on regularly checking blood sugars, effectively communicating with doctors, wearing proper footwear, and attending to foot problems before they become serious. SCAN has submitted a SNP application to add a Diabetes Disease Management Program in 2013.

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

SCAN uses a patient-centered, targeted, team-based care management model for individuals with chronic illnesses, consistent with the health homes envisioned by the Affordable Care Act (ACA) and California's 1115 waiver. SCAN currently

has a sizeable population of patients that will be eligible for health home services based on the proposed eligibility criteria (e.g., asthma, diabetes, heart disease, obesity, mental condition, and substance use disorder, one serious and persistent mental health condition).

For years, SCAN has been providing team-based health care and care coordination services to our members using an evidence-based chronic disease model. The case management program has an Interdisciplinary Care Team consisting of physicians, nurse case managers (RNs), social workers, dieticians, pharmacists, and behavioral health workers. The team meets weekly to discuss patient management using a "holistic" or "whole person" approach covering the clinical, pharmacological, behavioral, cultural, health literacy, economic, and psychosocial aspects of the member's health. An individualized care plan is developed for each of our members and is communicated to the full team and the member's physicians (primary care and specialists). Effective feedback is solicited from the physicians involved in the care, and all aspects of care are planned to be patient-centric, taking into account cost effectiveness, quality, evidence-based medicine, and patient preferences.

The care management provided by the Interdisciplinary Care Team includes risk stratification to identify high risk members; comprehensive care management; individual and family support; member education on disease self-management; and

support through motivational interviewing leading to patient empowerment. The model also includes care coordination, health promotion, comprehensive transitional care between settings, and referral to appropriate community and social support services. SCAN effectively uses health IT tools to gather and analyze data, which is then used to link these members to the appropriate care management programs to fill any potential "gaps" in care.

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

SCAN anticipates several significant challenges to the successful implementation of the program:

- The large number of dual eligibles the State intends to move into managed care;
- The expedited timeline for the Demonstration;
- The unknown level of patient need and demand for health services and supports;
- The reorganization of the current system to become a "one door entry" for duals to access health care and social services providers;
- The impact of reimbursement reductions; and
- Uncertainty surrounding beneficiaries' acceptance of the transition into a managed care model.

Many of these challenges can be mitigated by using a phased approach to enrollment. Specifically, enrolling beneficiaries in the month of their birth, as was done with the SPD population, will allow plans to make the most efficient use of their enrollment staff. In addition, establishing clear timelines will help plans allocate sufficient resources and staff for the Annual Enrollment Period. However, if the expedited process becomes too burdensome, the State may want to follow the lead of Arizona and postpone implementation until 2014 to assure a successful transition.

To mitigate the uncertainty surrounding the potential health needs of newly enrolled dual eligible members, SCAN intends to use our HRA instruments to accurately gauge members' condition upon enrollment and the projected level of demand for services. We will use risk stratification to ensure that each member receives the appropriate level of services. Our PAL Unit and case management staff will be key resources for determining the best way to manage each member's care. In addition, CMS and the State should make available as much historical claims data and health status information about newly enrolled duals as possible to help the selected Demonstration plans understand their expected health care needs and service utilization.

Based on our experience with IAH and as a Social HMO, SCAN is well positioned to merge the health care and social services elements to facilitate the

transition to a "one door entry" system for duals. Promoting communication among all stakeholders regarding the best ways to service the patient will help to ensure a successful transition, after a period of adjustment.

As for the reduction in reimbursement, managed care plans can successfully deliver better care and reduced costs if plans are paid based on a reasonable discount off of historical FFS costs, and if the payments for individual beneficiaries are risk-adjusted going forward.

Finally, beneficiaries will support the State's proposal only if they truly believe that the care they will receive going forward will be at least as good as what they currently receive. Plans must produce a network of high-quality practitioners augmented by support services that help patients live the life they want to live. Through our extensive contracting and quality assurance processes, SCAN is prepared to deliver an integrated set of benefits of the highest caliber.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

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

The cornerstone of SCAN's mission is caring for our members in a way that allows them to continue living as independently as possible in the setting of their choice. Thus, it is critically important that members' medical care services be complemented by and coordinated with community-based LTSS, including Adult

Day Health Care (ADHC)/Community-Based Adult Services (CBAS) Center, In-Home Support ive Services (IHSS), and the HCBS waiver programs including MSSP, In-Hom e Operation waivers, Devel opmentally Disabled Services waivers, AIDS waivers, and the Assisted Living waiver.

SCAN h as extensive experience work ing collaboratively with LTSS providers, seamlessly linking members with wrap-around services in our history as a Social HMO and within the IAH program . Based on our experience, we have in-house experts who work closely with a wide range of L TSS providers and programs. SCAN is prepared to broa den the reach of these services in a coordinated and unified m anner, ensuring the developm ent of a seam less process that will consist of open communication a nd include the m ember and their support network each step of the way. SCAN will continue to work collaboratively with County and City Area Agencies on Aging; Public Authority; individual providers; professional organizations, including a ll MSSP sites that serve the county; CBAS providers; and comm unity services and cont racted providers. The result will be a process that ensures our mem bers' need s are appropriately addressed through a system of care that accounts for all of the components found in the "Framework for Understanding Long-Term Car e Coordination" (Appendix E to the RFS). SCAN will facilitate additional collaborative wor kgroups as needed, and will enhance our existing Mem ber and Community Advisory Committ ees to include representation

from involved organizations. This collaborative approach will ensure that there is representation and input from the members and their family and caregivers, PCPs, LTSS programs in the community, faith-based entities, and other resources that make up the system of care.

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

SCAN will develop additional contract relationships with LTSS service and other community based service providers, similar to those currently in place with our HCBS vendors, to deliver LTSS-type services as part of the Duals Demonstration. SCAN, both as a Knox-Keene-licensed health plan and through our IAH division, has significant experience in delivering LTSS-type services. This experience has allowed SCAN to develop effective methods for contracting with these vendors, including incentivizing superior performance and implementing controls that guard against poor performance. Potential payment methodologies could include setting a per-case rate or a per-member per-month rate, depending on the service, the frequency of use, and the breadth of expected use across the population.

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

SCAN has a validated HRA instrument that identifies member needs, particularly those in need of medical care and LTSS. For members of SCAN's D-SNP who are identified as needing HCBS that are covered by the State contract, an initial HRA is conducted in the member's home by a field specialist and a corresponding telephonic assessment is conducted by an RN. The assessment tool and processes have been approved by DHCS and meet the requirements of the State contract.

SCAN's HRA is a 28-question instrument that is based on validated instruments such as the SF-36 and PHQ-9 (for depression). It includes questions on the critical assessment domains: physical and mental health, functional, social, and environmental. SCAN annually mails the assessment in English or Spanish (depending on the member's language preference). SCAN is prepared to expand the available languages to the other threshold languages so that it may be completed in the member's chosen language. Members and caregivers can also complete the questionnaire online. If members do not respond, a follow-up mailing is sent, followed by a reminder call with a request to call the SCAN case management department. Our overall response rate is high—approximately 60 to 70 percent—with dual eligibles only slightly less responsive. Once the HRA is

completed, the data is incorporated into SCAN's risk stratification software that determines members' overall risk based on utilization, pharmacy, cost of care, and HRA data. Based on the HRA, a summary of actionable items is compiled and sent to the member's PCP.

Under the Duals Demonstration, SCAN will expand the current HRA process to incorporate any universal assessment tool provided by DHCS as well as additional screening information needed to appropriately assess members for all LTSS services. Once a consolidated tool is in place, each completed assessment will be reviewed. As under our current process, if a member responds to certain trigger questions, he or she will be automatically referred to the appropriate care management program or LTSS service for further needs assessment. An interdisciplinary team will review the case, and the care planning process and service implementation will begin. High-risk cases will be reviewed by the SCAN Interdisciplinary Care Team, which includes a nationally recognized geriatrician, a nurse, a social worker, a clinical pharmacist, a behavioral health specialist, and a dietician.

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.

SCAN has extensive experience working with a wide range of LTSS providers based on our 30-plus years as an MSSP provider and our experience as a

Social HMO. Both the health plan and IAH have a long history of providing HCBS to NFLOC and dual eligible individuals, and coordinating with the network of care of each individual. Examples of services provided have included ADHC, MSSP, behavioral health, personal care, homemaking, transportation, transportation escort, respite care, home-delivered meals, telephone emergency response services, housing support and minor home repairs, nutrition supplements, incontinence supplies, and durable medical equipment (DME).

In working with LTSS providers, we have engaged in ongoing collaboration, communication, and maintenance of our contractual and reimbursement arrangements, ensuring high quality care delivery. SCAN and IAH have collaborated with and trained both the LTSS providers and health plan/IAH staff, and have worked together on procedures for monitoring compliance and quality, ensuring appropriate delivery of services to the member. SCAN has partnered with both for-profit and not-for-profit agencies through direct collaboration, community workgroups, and contracts. Providers' services must cover the entire SCAN service area (encompassing several counties), and they must provide evidence of standards of care that meet State and Federal specifications.

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

SCAN has well-developed protocols and Policies and Procedures for delivering care to members residing in institutional settings. SCAN provides institutional Long Term Care (LTC) to dual eligible members who require more care than can safely be provided through home and community-based programs. SCAN's Utilization Management (UM)/Complex Case Management (CCM) Department works with the facility and providers of care to ensure that members meet criteria for placement, and that they are receiving comprehensive quality care in the most appropriate and least restrictive setting. SCAN clinical staff also identify and refer members who require additional case management services. SCAN RNs review the MDS 3.0 form completed upon admission and quarterly thereafter. SCAN requires that contracted nursing facilities respond to changes in a member's health status (e.g., falls, emergency department visits, significant weight loss, pressure ulcers, unexpected change in mental status) by notifying the treating practitioner within 48 hours. SCAN case managers then follow up with the delegated provider organization, make any necessary referrals, and work with the facility to adjust the care plan.

SCAN has extensive experience with transitioning individuals who wish to leave an institutional setting back into the community. SCAN's IAH division is an original and current contractor under the Money Follows the Person California Community Transitions (CCT) project. Through this program, IAH has worked with DHCS staff and other contractors across the State to help Medi-Cal recipients aged 18 years and older return to the community living setting of their choice after residing in a nursing facility. Through State-validated assessment tools and qualitative measures, this program performs a comprehensive assessment, designs a complex care plan, and begins the implementation on behalf of the patient while they are still living in a nursing facility. Services that may be performed during this period include finding and setting up housing; home modification to ensure accessibility; arranging for IHSS services; linking the member to other waiver programs, such as MSSP and the In-Home Operations waiver program; medication management training; transfer of benefits for institutional setting to community dwelling; re-establishing SSI payments; and obtaining DME. The work of transitioning long-term members from a nursing home requires creativity and intensive effort to marshal varied community resources to provide "wrap" support as the individual returns to the community. Quality assurance is provided through case conferencing with the direct care team on a monthly basis, and with the extended team quarterly and as needed. Social workers also participate in the

nursing facility interdisciplinary team meetings to ensure the necessary collaboration to prepare for the individual's return to the community.

Section 2.2: IHSS

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

- *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.*

SCAN Health Plan certifies that we will comply with all above requirements.

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. Specifically address:

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

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

SCAN and IAH have a long history of coordinating care for the frail population with IHSS. Currently, we collaborate with IHSS case workers to ensure that members are receiving appropriate care. If, for example, a sudden change in the member's condition occurs or the current IHSS hours are not adequate, SCAN will use contracted agencies to provide supplemental care so the member's care needs are met. SCAN and IAH staff will then help the member communicate with IHSS to ensure that the appropriate services are in place.

Most recently, SCAN hosted a coordinating meeting with IHSS Public Authority Representatives in November 2011 to learn about how the IHSS programs function in Los Angeles, Riverside, San Bernardino, and San Diego Counties, and to explain how SCAN's D-SNP operates. Our goal was to pursue opportunities to cooperate going forward in light of anticipated Duals Demonstration activities. Additional meetings and conversations have occurred to continue this progress. SCAN has received letters of agreement from the Los Angeles County Public Authority and the San Diego County HHS Agency and the Public Authority to work in good faith on the Duals Demonstration project (see Appendix 7).

During Year 1 of the Duals Demonstration, SCAN will continue discussions with the County and/or local IHSS offices and Public Authorities. The "Framework for Understanding Long-Term Care Coordination" (Appendix E to the RFS) will serve as the foundation for discussion with IHSS to develop a plan toward full contractual relationships that:

- Establish a care coordination model including the referral, assessment, and care coordination process;
- Ensure member choice of caregiver;
- Ensure appropriate training, supervision, and payment of caregivers;
- Extend and incorporate evidence-based disease- and disability-specific education and training for the IHSS worker and member/caregiver, building on those interventions mentioned in section 1.2.3; and
- Provide continuous care for members when an IHSS worker is not available, including the use of agency care in emergency situations.

As more details become available on how the IHSS program will interact with managed care plans within the Demonstration, SCAN will continue these discussions in pursuit of contractual relationships with the public authorities.

Section 2.3: Social Support Coordination

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

SCAN Health Plan certifies that we will comply with the above requirement.

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.

A key part of the HRA and assessment process evaluates how members self-manage in their homes. This includes ADL and IADL functional ability, home setup, access to food and other basic needs, social support, and financial resources. Where there are deficits that could put members at risk, SCAN will coordinate the necessary array of services. For example, a member who cannot transport himself to a doctor's appointment for monitoring of his chronic health conditions would receive both transportation and transportation escort services to help him get out of the house and return safely to home. A member who needs help shopping and preparing meals and who, without proper nutrition, would be at risk of poor health and having to enter an institutional setting, would be linked to home-delivered meals, congregate meal sites, and other food assistance programs. If a person is isolated and lacking social support, SCAN staff would link them to a friendly visitor program or senior center for regular social interaction and visits. SCAN's long experience as a Social HMO and MSSP participant shows that using these types of community linkages assists us in enabling our members to avoid

unnecessary institutionalization. By assessing each member's needs and matching those needs with the right services, we keep our members living independently in their own homes, in furtherance of the SCAN mission.

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).

SCAN will engage existing partnerships in each county and will develop new relationships with county and private aging and disability services to coordinate support efforts for our members. The goal of this collaboration will be to establish seamless transitions and facilitate access for members in need of community services. SCAN will look at strategically staffing case managers on-site at some program locations to help bridge gaps, as well as to build relationships and familiarity with the agency and population while ensuring seamless care. We will establish two-way communication with the Area Agency on Aging, Independent Living Centers (ILCs), and Aging and Disability Resource Centers, where applicable. For example, SCAN is already an established partner with LA County Community and Senior Services/Area Agency on Aging. For more than 13 years, SCAN's IAH division has provided Linkages, as well as Title IIIB and IIIE care management and support services, to the southern Los Angeles County region on behalf of the AAA. Linkages is designed to prevent the premature or inappropriate institutionalization of frail, at-risk elderly and functionally impaired

adults, aged 18 and older, by providing care management and comprehensive information and assistance services. IAH and SCAN also work collaboratively with the Los Angeles City Department of Aging on several community workgroups and in community and senior centers to ensure that the needs of this population are met through outreach, education, and coordination. IAH also currently collaborates with ILCs and other community resources through the CCT Program.

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.

Both SCAN and IAH serve members who reside in senior and low-income housing, as well as in assisted living facilities and retirement communities. Care management staff have established relationships with resident coordinators and with on-site support staff in these communities. The nature of these partnerships includes collaboration in meeting the needs of individual members (where applicable consents for disclosure have been signed by the client), as well as providing group wellness and education services to residents that support healthy living and home safety.

SCAN's networked relationships provide us with an awareness of housing availability, allowing SCAN to support the member through the application process as well as to assist with home setup and monitoring with the support of

existing building requirements. Existing relationships will prove essential where housing management or staff can alert SCAN in the event of an emergency or when a change in functional status is noted, provided that proper consents are in place. This will enable interventions before a person loses his or her housing for failing to pay rent, or becomes at risk of a medical event that may impact his or her safety or ability to live in the community, such as a fall.

In addition, SCAN is partnering with United Cerebral Palsy (UCP) to help manage the care of beneficiaries with complex social needs. Currently, UCP assists beneficiaries with disabilities by providing them with independent, "smart" housing options that include remote monitoring capabilities, oversight of daily needs such as nutrition, and access to direct care workers.

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.*

SCAN will leverage our existing robust medical care management infrastructure to incorporate and provide mental health and substance use treatment benefits in accordance with Medicare and Medi-Cal coverage requirements. Having reviewed the Framework for Understanding Mental Health and Substance

Use and the related Technical Assistance document (Appendices F and G to the RFS), SCAN understands that moving into this new service delivery model will require carefully thought-out and coordinated screening, assessment, and treatment that supports the member through the system of care. To establish the seamless coordination of access to mental health and substance use care that includes warm hand-offs of the member, SCAN will work with county and community providers and use our own experience with delivering these services to create an implementation plan.

SCAN will bring our current knowledge and experience with providing behavioral health and substance use services to this conversation. We recognize that treatment and management of behavioral health issues and inappropriate substance use is an important component of stability and wellness. Currently, all of SCAN's contracted medical groups are required to provide both inpatient and outpatient behavioral health services, including detox and substance use treatment. Treatment for medication misuse, a common problem in older adults, is included in the scope of assessment and treatment. How the medical groups provide this varies—some groups contract with large behavioral health providers, such as Value Options and Windstone, while other groups hire their own co-located behavioral health staff. In addition, there are areas where members have been using the County Mental Health system, coupled with provider involvement.

Furthermore, SCAN has experience coordinating behavioral health services through IAH's in-home mental health services program, Innerlinks Advantage. This program offers in-home mental health services to Spanish- and English-speaking NFLOC clients of the MSSP and Linkages programs. This program fills a unique niche for members who either cannot or will not leave their homes due to mobility, agoraphobia, or other behavioral diagnoses, or when county mental health providers for that area are not available. At present, IAH has relationships in place with LA County Mental Health through membership on the Older Adult System of Care Committee. We also have referral-based and collaborative relationships with Heritage Clinics, Pacific Clinics, and LA County's FACTS Program, all of which are contracted county mental health providers. We expect to form similar partnerships in the other counties in which we participate in the Duals Demonstration.

To provide seamless access, SCAN will work with both county departments of mental health and alcohol and drug programs to establish a service delivery plan and contracts to prevent the interruption of services for existing patients in Year 1. SCAN will initiate an interdisciplinary review team with county providers to ensure a shared care plan and continued continuity of care. SCAN will also add an additional component in Year 1 using IAH's Innerlinks Advantage services to wrap around and reach those in the home who, due to their medical condition,

cannot reach traditional mental health settings but still need these critical services for their stability and wellbeing.

SCAN will also create a "no wrong door" access point for newly identified members who are in need of either mental health and/or substance use treatment. As a part of the assessment process, SCAN will utilize the following mental health and substance use assessments to identify needs and facilitate referral to one of the contracted or in-house services for all dual eligible members. These tools include:

- PHQ-9: Depression Screen
- Six Item Screener: For Cognition
- DASS: for Depression, Anxiety, and Stress
- CAGE 1: For Alcoholism and Drug Abuse
- Bipolar Diagnostic Criteria
- For further assessment and diagnosing:
    - Geriatric Depression Scale (GDS) (short version)
    - St. Louis University Mental Health Status (SLUMS) examination: For Cognition

When a member's screening or assessment indicates evidence of risk based on standardized criteria included with each tool, the case will be referred to the behavioral health specialist for review and referral to the appropriate subcontractor for a full evaluation. The behavioral health specialist will contact the member to

discuss and explain the referral. If the member accepts, the member will be linked with a contract agency through a conference call between the behavioral health specialist, member and agency staff to facilitate a warm handoff. Once the evaluation is complete, a treatment plan will be developed and services will begin. Interdisciplinary case conferences will be held on an as-needed basis, but beginning on a monthly basis. These will be coordinated by the medical health director and the behavioral health specialist to ensure care coordination, track outcomes, and identify the need for ongoing services.

Throughout Year 1, SCAN will engage in strategic planning with our partners to enhance the service delivery model for Years 2 and 3 of the Demonstration, including co-location in physician offices to increase access to assessment and care.

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).

The Mental Health Director's role will be to oversee all services and contractors through an interdisciplinary team review and quality assurance process, including collecting care plan outcomes data to identify program improvement opportunities. Key members of the interdisciplinary team will include a geriatric pharmacist specializing in mental health and substance use issues, a consultant psychiatrist, and a behavioral health specialist or mental health clinician. This team

will be responsible for quarterly case review (more frequently if there is a significant change in the member's needs), including review of care plan outcomes, changes in condition, and ensuring that all disciplines involved in the member's care are informed. The Mental Health Director will oversee the use of evidence-based practices in all treatment modalities and will also create and deliver subject specific trainings to enhance the clinical and assessment practice skills of SCAN staff.

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

Many of SCAN's contracted providers already co-locate behavioral health services with primary care. For members who may be reticent to seek behavioral health care, having the two services in one place facilitates access. SCAN's contracted providers have offices throughout the region, making community access readily available as soon as the Demonstration begins. In addition, the use of Innerlinks Advantage will bring access to treatment to those who are unable to go to a clinic setting due to behavioral and physical limitations.

All SCAN and IAH programs function around the use of multidisciplinary teams to support the member. IAH teams have a public health nurse, social worker, geriatric pharmacist, and where they will be involved, a physician. SCAN's Interdisciplinary Care Teams have a membership of physicians, nurses, LCSW behavioral health specialists, geriatricians, pharmacists and dieticians, as well as

other disciplines as needed. This approach is an integral part of the SCAN Model of Care and will continue when expanding to bring these services to our members. In this new model, we will also bring all involved contactors and family supports to the dialogue to ensure the goals set are being met.

In Years 2 and 3 of the Demonstration, SCAN will work to further co-location of services in medical offices and clinics throughout the county and the provider network.

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.

SCAN has an established and growing Member and Community Advisory Committee in place to support the enhancement of SCAN's Model of Care. This committee includes strategic representation from different constituencies, including mental health, community services, long-term care, caregiver services, cultural needs, and consultation from the Area Agency on Aging, as well as dual eligible members and family members. This committee will be expanded to include substance use services, independent living center services, as well as CBAS and additional health plan members and consumers to help us strengthen, monitor and improve care coordination as this new system of care is formalized and launched. In counties outside of LA, an area-specific Member and Community Advisory Committee will be established to provide county-level input and

evaluation. The county committees will meet quarterly, will review quality assurance metrics, and will help ensure the delivery of patient-centered care in which both medical and behavioral health services are delivered in an increasingly integrated manner.

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.)

SCAN will build on the existing foundation of coordinated services to further integrate health care services with mental health, substance use treatment and LTSS services for all, including those affected by co-occuring disorders. Individuals who are severely impacted by mental illness and substance use are in greater need of wrap-around supportive services so that interventions and assistance can occur expeditiously when a member is experiencing stressors in order to maintain stability and prevent a psychiatric or medical emergency.

As noted in section 3.1, SCAN will build upon our comprehensive medical care management model and will bring county departments together with contract providers to create an individualized delivery plan. The plan will provide for seamless entry and continuation of county services for Year 1, coordinated with the members entire care team. SCAN will take the lead by using the expertise of its

own Interdisciplinary Care Team, which has membership of physicians, nurses, a LCSW behavioral health specialist, a geriatrician, a pharmacist and a dietician, and adding the county partners to review complex cases and establish treatment recommendations and measureable care plan goals. This will also include the potential full array of LTSS programs as involved to ensure all services further the progress towards stability and meeting goals that will help the member and his or her support system manage the member's health more effectively so that he or she can remain in the community.

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.*

SCAN and IAH currently work with county mental health and substance use services in a number of ways, ranging from collaboration on service area planning activities such as the Older Adult System of Care workgroups (to implement funding and service strategy resulting from the Mental Health Services Act (MHSA)) to coordination with county providers for individual service provision to members. SCAN and IAH staff also serve on joint public health taskforces with local providers and community services to inform our delivery of mental health

services. These relationships are a natural point of entry to bring together the county and key stakeholders to develop a service delivery plan that includes specific responsibilities, quality assurance and monitoring, and a payment structure and responsibility for risk. We also have received some letters of intent to collaborate in good faith with County departments responsible for mental health and substance use services (see Appendix 7).

We envision a phased plan that will include the county, its contractors, SCAN's interdisciplinary team, and experts in the field of mental health and substance use to establish evidence-based standardized criteria for identifying members through screening and outreach, and develop treatment approaches techniques to target and coordinate care for these individuals. This will build on SCAN and IAH's existing criteria for case management and referrals to ensure that all members potentially impacted by mental health and substance use issues have full access to services and are not lost in the transition.

Key findings of the California Mental Health and Substance Use Needs Assessment include that the exchange of information and data is currently a barrier in the care system and should be addressed. SCAN will work to overcome this challenge by partnering with contractors to bring current technology systems to improve the sharing of information in additional to traditional telephonic

interactions. The planning group will also use existing protocols and develop new ones as needed to exchange information.

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 complex health and social needs of the dual eligible population makes person-centered care essential. Under the SCAN model, each participating dual eligible member will designate a physician or clinic as his or her PCP. The patient-centered care delivery model functions as a member's health home, focusing on care improvement and enhancement through the member's dedicated PCP, an interdisciplinary team, member (and caregiver or family member) education, physician education and support, and use of information technology to communicate and support the provision of care.

As described in section 1.2.1, individual assessment and care planning are central to integrating the range of services required by dual eligibles. SCAN implements specific assessment tools in conjunction with the expertise of our Interdisciplinary Care Teams to focus on patients who are at greatest risk for worsening conditions and hospital utilization. SCAN uses individual assessment tools and techniques to stratify members based on their specific needs and/or risk.

These tools and techniques are best practices that are successful in identifying and/or predicting risk for chronic conditions and disabilities based on past medical claims data, pharmacy data and laboratory results, diagnosis information, and information from beneficiary-completed surveys including disability level (i.e., limitations in activities of daily living).

SCAN will place particular emphasis on the management of mental and cognitive diseases and conditions, which will require additional mental and behavioral health services that coordinate with the patient's primary care health home and are part of the interdisciplinary team. The behavioral health interdisciplinary team will be comprised of a pharmacist, licensed behavioral health providers such as Licensed Clinical Social Workers (LCSW), marriage/family therapists or psychologists, registered nurses, and care coordinators. For behavioral health services that are not delivered at the patient's primary care location, alternative treatment sites will meet the beneficiary's medical, psychological, and functional status needs and preferences, and may include a medical office where medical and psychiatric care are co-located, or in the member's home (which includes a nursing home, assisted living facility, private residence, or telephonically).

Once members are determined to be eligible for disease management, disability support or case management, care teams work with them to understand

their needs and selectively target the type and level of services called for. A plan of care will then be developed and executed in collaboration with the patient's PCP and the patient (and his or her caregiver, if appropriate). The focus of this treatment plan will be to care for the entire patient, including health goals and cultural preferences, communication, coordination, and access.

SCAN's care planning process will incorporate:

- Input from the patient regarding personal health goals, preferences regarding care, understanding of health status, language and cultural preferences;
- Assessment tools to identify patient needs, goals, and readiness/motivation for change, and to track changes in the patient's health status on an ongoing and regular basis;
- Review of the patient's encounter and utilization data, pharmacy utilization data, and assessment questions across multiple domains (i.e., chronic illness, medication, cognitive, social-psychological, spiritual, self-management skills, community resource needs, preventive services, and access to care); and
- Data from assessment informs the care plan and interventions designed specific to the patient.

Care management programs will work with patients to ensure care plan adherence, timely access to primary care, preventive health referrals, improved

self-management of chronic conditions, and medication reconciliation. Case managers help members manage their care by recognizing symptoms and actions to take, when to call a doctor or to seek emergency care, medication management, nutrition, self-management and healthy behaviors, and advance care planning. Given the need for strong coordination and successful transitions between providers, several disease management and disability support programs will be a major focus under the Duals Demonstration:

- Complex Care and Disease Management including:
  - CHF
  - Diabetes
  - COPD
  - Chronic Kidney Disease (CKD)
  - Depression
- Disability support
- Behavioral health care coordination, including dementia care
- Medication therapy management

SCAN's experience serving the Arizona ALTCS disabled and aged population have resulted in considerable expertise in serving a range of disabilities including behavioral (schizoaffective and anxiety disorders, substance use,

schizophrenia), mobility, visual and hearing impairments, multiple sclerosis, and traumatic brain and spinal cord injuries.

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 attached Appendix 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.

SCAN's contracted provider groups are actively engaged in care coordination efforts and we work with these groups to emphasize the importance of continuity of care. Under a delegated model, SCAN contracts with provider groups to take on care coordination activities. Through our initial contracting process and ongoing monitoring and oversight activities, SCAN ensures that delegated provider organizations are performing all delegated responsibilities, including care coordination, to meet Medicare and Medi-Cal standards. In addition, providers are a key member of the patient's Interdisciplinary Care Team, which meets regularly to discuss the patient's condition and interventions that have been undertaken.

Under the Demonstration, SCAN will continue to engage with our provider groups to ensure appropriate care coordination for dual eligibles. In light of the additional services that will be brought under the SCAN umbrella, it is even more critical that providers are consulted regularly, whether in person, by phone, or

virtually, to ensure that members are receiving the right care and social services at the right time. We will continue to monitor provider performance in this regard and will continue to provide regular CME and training to teach best practices for patient care.

In SCAN's experience, performance-based incentives shared with providers lead to higher-quality care for beneficiaries. For example, structuring provider payments in line with the CMS 5-Star System for Medicare Advantage plans incents our providers to strive for the highest performance on quality measures. Depending on the payment structure determined for the Duals Demonstration, SCAN will consider ways to incentivize our provider groups to ensure seamless care coordination.

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.

SCAN Health Plan certifies that we will comply with the above requirements.

Section 5.1: Consumer Choice

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

SCAN supports control and choice for the individual, from the enrollment process to the choice of provider to the manner in which services are received. Upon enrollment, SCAN members receive a list of PCPs that participate in the

SCAN network. This expansive network assures wide-ranging consumer choice. Patients receive information regarding location of physician offices and language spoken, and every effort is made to match patients to appropriate caregivers based on the patient's age, functional abilities, and health status. Patients also have access to SCAN's robust panel of specialists. PCPs and members work together to find the specialist that meets the member's needs. Should a member question a provider's diagnosis, treatment plan or recommendation for surgery, for example, SCAN upholds the member's right to a second opinion. Finally, SCAN acknowledges that fee-for-service members who enroll into the Demonstration have a right to keep their current providers for up to a year, even if the provider does not join the SCAN network. For payment purposes, we would treat those providers as we do today, on a fee-for-service, out-of-network basis.

SCAN believes strongly in the importance of effective patient-provider communication. If a member believes that he or she cannot communicate effectively with his or her PCP, a specialist or a case manager, he or she can request a change. Specifically, members may change their PCP and/or medical group once per month, and can request a second opinion from a different specialist if they are facing surgery or a serious illness. If a member feels he or she cannot communicate easily with his or her case manager or any other member of the care

team, his or her Personal Assistance Line "PAL" can make alternative arrangements for them.

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.

Members always retain their ability to make choices about their providers and their desired level of care coordination. SCAN is committed to working with each member and his or her selected home care assistant to create the right care management plan for the patient. SCAN's self-directed attendant care model (SDAC) in Arizona has helped members learn about their options and achieve their goal of self-directing care. The program offers patients tips on how to select and manage a caregiver when they enroll. Along the way, patients receive ongoing education and support to help them be successful. Ensuring that care is provided in a member-centric manner is central to SCAN's mission, and our experience shows that patient outcomes and satisfaction are improved when patients and their caregivers play an active role in the assessment process, in care planning, and in making choices that best meet the individual's unique needs. The individual stands at the core of the development and operation of our care management model—the member's needs, goals and desires are at the center of all care planning activities. Therefore, under the Duals Demonstration, SCAN will provide members opportunities to self-direct their care, along with caregivers and family members.

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.

SCAN Health Plan certifies that we will comply with the above requirement.

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

Physical Accessibility: SCAN's Quality Management Department completes pre-operational Facility Site Reviews (FSRs) that assess the physical accessibility of all contracted entities, including the accessibility of stairs and elevators, wheelchair accessibility including ramps, wide doors, handicapped-accessible bathrooms, electric exam tables, imaging equipment such as X-rays being accessible and comfortable, and signs and orientation for those with visual impairments. SCAN's entire network of facilities providing care, and high volume provider offices, have passed the FSRs. All FSR findings are reported to the Delegation Oversight Review Committee for approval or development of a corrective action plan. Should the provider not meet the standards identified, the committee will make recommendations up to and including termination of the provider site from the SCAN network. Subsequent site reviews are scheduled every 3 years for PCPs that provide care to SCAN dual eligible members.

Community Accessibility : Community and geographic accessibility are evaluated by our Network Management Department prior to contracting with

provider groups and facilities. SCAN currently meets the DHCS standards for location and network accessibility. SCAN uses network provider data, enrollee residence data, Quest Analytics software, and CMS criteria that include county level minimum numbers of providers and time/distance standards to ensure our provider networks are adequate to meet the needs of current and future enrollees. Ninety (90) percent of enrollees must have access to at least one provider within the time/distance standard for that provider type and county. These criteria can be modified to meet DHCS requirements, including but not limited to adding provider types such as long-term care facilities and adding Medi-Cal eligible and enrollee residence data. Facilities must also be in locations accessible by public transportation and free of hazardous access barriers.

Document/Information Accessibility: SCAN is in compliance with Section 508 of the Rehabilitation Act and is committed to ensuring that all our written communications are easy to read and navigate. For example, the SCAN website is designed for ease of reading and navigation and allows for enlarging of font size. Alternative types of materials are available: print and telephonic communication, including TDY lines and face to face and telephonic interpreters. SCAN is committed to senior and disabled-friendly communications which reflect considerable research of the required standards and published research about older and disabled individual's perceptual abilities and the adaptive mechanisms that can

assist. As an example, SCAN uses high contrast primary colors in all of our printed materials and on the website, since older and disabled individuals may have more difficulty with muted colors and low contrast. Communications are in a 14-point, sans serif font called Futura, which is easier to read than letters with a serif. All written communications are checked for readability at a 6th grade reading level. Incoming member telephone calls are always answered by a live person; we do not use automated systems or telephone trees for incoming calls, as members have indicated they are difficult to use. We have dedicated 1-800 numbers set up for members, as well.

Doctor/Provider Accessibility: As described in Section 7, Network Adequacy, SCAN is compliant with the geographical and physician type accessibility requirements. SCAN ensures that enrollee linguistic needs are met by comparing enrollee and PCP languages and taking appropriate action, including but not limited to offering translation services that are available 24 hours a day, seven days a week; working with delegated provider groups to contract providers who speak and write the required languages; and reaching out to enrollees to assist them with finding PCPs in their areas who speak their language. In addition, offices and facilities are required to provide service during normal business hours, and many providers offer urgent care centers with extended night and weekend hours. In an emergency, members can access any hospital worldwide at any time.

If members report a lack of access, SCAN investigates the complaints with the provider group, tracks complaints, and reviews trends. If necessary, Corrective Action Plans are structured and monitored.

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

SCAN communicates the accessibility levels of providers to patients in a variety of ways. The Evidence of Coverage document, the provider directory, benefits highlights, the SCAN website and the PAL Unit all serve as prime sources of information for members about the accessibility of their providers. For instance, the Evidence of Coverage document, which is mailed annually to members and is on the SCAN website, contains essential information about using the SCAN health care system. It includes information regarding how to change doctors, get a referral to a specialist, how to get care if the member is out of area and needs emergency help, and what services can be accessed without a referral. The Provider Directory, which is mailed to every SCAN member and is on our website, contains information on languages other than English, spoken by providers in the SCAN network.

SCAN's Personal Assistance Line (PAL) is a concierge-like service that SCAN offers to help dual eligible patients navigate provider networks. Members are paired up with own "PAL", who understands their unique needs for language, types of communication medical care, and services. PAL staff reaches out to

members to assist them in finding physicians in their area who speak their preferred language and educates dual eligible members about the free language interpreter benefit. The PAL staff is available 8am-8pm, 7 days per week to answer questions or help members navigate their benefits. For after-hours, non-urgent health care questions, members can call our Nurse Advice line, SCAN On-Call, which is available 24 hours a day, 7 days a week and has staff that speak multiple languages. Registered nurses help members decide if and where to seek care, answer routine questions about symptoms, medications and prevention, and send a report to SCAN of any patient that was advised to go to an Emergency room so that we can follow up.

Section 5.3: Education and Outreach

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

SCAN has a strong history of communicating with members who are frail and disabled and who have limited health literacy, and we tailor our communications to meet our members' needs. The types of communications include (1) telephone contact with the PAL Unit, (2) letters, (3) the SCAN Club Newsletter and other informational materials directed to members and their families, (4) the SCAN website, and (5) audio formats.

For telephone contact, call waiting times are monitored and SCAN specifically avoids the use of automated response or telephone trees for incoming

calls, as members have indicated these mechanisms are difficult for them to use, due to hearing, dexterity, and audio processing impairments.

As discussed in above sections, SCAN's printed material standards have been designed to ensure ease of reading. For example, the use of contrasting colors, sans serif font type, and increased use of white space in the page layout have been shown to assist readers. All written communications meet CMS standards of 6th grade reading level and 14-point font size. These standards apply to letters and printed materials and newsletters.

SCAN has also developed an extensive website, for members or family who use computers. The website contains useful resources, such as community resource information, information about advance care planning, and tools to make doctor visits more successful. The extensive Healthwise® Knowledgebase is a compendium of healthcare topics to help members understand their conditions, know when to seek care, and preventive care tips. All content is in English and Spanish.

If members prefer not to use written materials, audio materials can be prepared by the PAL Unit. As an example, a member who speaks a non-threshold language, such as Armenian, and doesn't want printed materials, can have a translator in person at a medical site, or by telephone, or have a translator record a response to a question, which is then sent to the member on a tape or CD.

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

Member-informing documents, including Evidence of Coverage documents, provider directories, and letters required by CMS or by regulation, are provided for 2012 in English and Spanish throughout California, and additionally Chinese and Vietnamese in Northern California. On an annual basis, per CMS regulations, SCAN determines its language threshold by reviewing census data. If more than 5 percent of the population that resides in a service area speaks a language other than English, materials will be translated into that language. For languages that do not meet the threshold, SCAN is able to respond to a specific member question through the use of interpreter services.

SCAN also provides free medical translation services to members and providers, in the office or by phone 24 hours a day, seven days per week. SCAN contracts with several large translation services to translate materials, and provide translation services, including "Translation Plus" and other vendors. Sign language interpretation is also provided at no cost. Arrangements for all these types of translations are made by the PAL Unit. SCAN has developed a pocket-sized "I SPEAK" interpreter card that advises members and providers about the availability of free language interpretation services. This year, additional education efforts are planned to remind members of the availability of these services.

SCAN annually conducts a Dual Eligible Group Needs Assessment (GNA), in accordance with DHCS contract requirements. The scope of the GNA is to identify needs of dual eligible members, availability of health education materials, cultural and linguistic programs, and any gaps in service, towards the goal of improving health outcomes in this population. The GNA includes a demographic profile of the population, and reviews the disease prevalence, health status and utilization of health care and health education. The study also assesses the cultural and linguistic needs of the members, identified health disparities, and any gaps in services. Recommendations are made based on each year's GNA results.

The 2011 GNA findings indicated that dual eligible members were not broadly aware of the interpreter services available to them, and were also not as familiar with health education materials. Moreover, many of the members preferred to have a conversation about healthy behaviors as opposed to receiving printed materials. As a result, we enhanced our efforts to let members know about the interpreter services, including sending a mailing to all dual eligible members of the "I SPEAK" wallet card, reminders at the end of each member call and articles in the SCAN Club Newsletter to members. More research will be undertaken about how to make members aware of health education materials, and to develop alternate channels for disseminating health education verbally.

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:

- *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.*

SCAN Health Plan certifies that we will comply with all of the above requirements.

Section 5.4: Stakeholder Input

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

SCAN developed a stakeholder engagement strategy in preparation for the 2012 annual election period. Stakeholders participating in these discussions include dual eligible members, family and caregivers, community agencies, contractors, LTSS providers, and contracted medical and behavioral health providers. Planning and preparation for this State contract have been taking place since 2011. As part of this process, SCAN has communicated with several health plans to assess their capabilities to serve dually eligible aged and disabled members and whether a partnership might be feasible. We have also reached out to all the MSSP providers in each county in which SCAN is applying for the Demonstration to discuss coordination of the LTSS benefit. We have received numerous letters of support for working together to ensure continuity of care and a

seamless transition as the Demonstration goes into effect. See letters attached at Appendix 8.

SCAN has also sought input from our members in these discussions. In addition to engaging our Community Advisory Committee and conducting member forums (described below), SCAN is convening focus groups of FFS dual eligibles. These groups will play an integral role in gauging beneficiary preferences regarding the network and location of providers, determining which benefits this population believes are most important, customer service, and preferred communication methods.

SCAN intends to employ our regular means of stakeholder engagement, which have proven effective in assessing members' needs and preferences. We also plan to engage additional focus groups as the need arises. The key means of stakeholder engagement are:

- Community Advisory Committee
- Senior Advisory Committee
- Member and Community Advisory Committee
- Member Straight Talks

<u>Community Advisory Committee</u>: The Community Advisory Committee is comprised of dual eligible members and one provider from SCAN's in-home and community-based services network. The Committee meets quarterly, with two

meetings held in English, and two meetings held in Spanish. Members play an integral role in developing and improving upon different programs. For example, the Committee is often asked to review articles and brochures for readability, clarity of message, and appearance. In another meeting, member feedback was solicited on how SCAN could improve quality by assuring that members get necessary tests and screenings. When SCAN rolled out our Care Transitions program—which assists members in successfully transferring from hospital to home or from hospital to skilled nursing facility—Committee members provided important suggestions about how to explain and present the program.

Senior Advisory Committee: The Senior Advisory Committee, also composed of SCAN members, includes both Medicare-only members and dual eligible members, and a contracted provider. SCAN's CEO serves as an ex officio Committee member. Similar to the Community Advisory Committee, this Committee provides feedback on member needs, communication vehicles, programs, and benefits.

Member and Community Advisory Committee: In 2011, SCAN convened a Member and Community Advisory Committee to strengthen, monitor, and improve care coordination as this new system of care for duals is launched. This group has strategic representation from diverse constituency areas, including mental health, community services, long-term care, caregiver services, and cultural needs. Area

Agencies on Aging, dual eligible members and family members are also represented on the board and participate in these discussions. Going forward, the Committee will be expanded to include substance use services, independent living center services, CBAS centers, and additional health plan members and consumers.

Member Forums: Each fall, SCAN executives travel throughout SCAN's service area to meet with members, their caregivers, and potential members at "Straight Talk" events. During these meetings, the executives explain new benefits, provide attendees with an understanding of the direction of the organization, and answer questions. Straight Talks serve as an important forum for SCAN to better understand members' needs, and for members to ask any questions about SCAN or about their health care in general. In 2011, over 11,000 members attended a total of 29 sessions, hosted in 21 locations in 9 counties in California and Arizona.

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

During the three-year demonstration, SCAN leadership will consult regularly with key stockholders to seek continuous quality improvement in the program for the duals. We will establish regular face-to-face quarterly meetings with our stakeholder advisory committees, augmented by teleconferences as the need arises. Meetings with SCAN contracted providers will occur on average twice each year through the format of our Joint Operating Committees (JOCs). In addition, when a unique need is identified, SCAN will conduct targeted outreach to

additional community agencies and advocacy organizations to seek their insight on the needs of a particular population. These entities include the Center for Health Care Rights, the Disability Rights Legal Center at Loyola Law School, and the Health Insurance Counseling and Advocacy Program.

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.

SCAN is actively working in the community to solicit meaningful input from key external stakeholders. Since the announcement of the Duals Demonstration, SCAN has organized and held several critical meetings with our Member and Community Advisory Committee to solicit advice on the program's direction. That input has figured prominently in our comments on the Framework and the RFS. The Advisory Committee includes members representing specific stakeholder areas including City/County Senior Services (AAA), Mental Health, Disability Services-Independent Living, Long-term Care Caregiver Services, Community Service, Cultural Needs, Dual Members and Dual Family members. SCAN is committing to a quarterly schedule of face-to-face Advisory Committee meetings, augmented by phone conferences.

Another example of meaningfully seeking community input has occurred in San Diego. SCAN is a member of the Duals Demonstration Stakeholder Advisory

Committee organized by San Diego County's Healthy San Diego stakeholders and the Aging and Independent Services Department (AIS). The group held its first organizational meeting in February. The committee includes all of the San Diego County Managed Care plans responding to the RFS and all of the local LTSS providers. Also participating are consumer representatives including the Consumer Center for Health Education and Advocacy, County In-Home Supportive Services (IHSS), County Behavioral Health Services, Program of All-Inclusive Care for the Elderly (PACE), Community Based Adult Services (CBAS), Senior Alliance, United Domestic Workers (UDW), Hospital Association of San Diego and Imperial County, Community Clinics, AIS Aging Services (ADRC), a SNF representative, at least three dual eligible beneficiaries, the San Diego Regional Center, Access to Independence, and the IHSS Public Authority. In counties where similar county-inspired stakeholder involvement groups are available, SCAN will be an active and willing participant. In counties where this structure does not develop, we will create county-specific Advisory Committees following our Advisory Committee model.

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.

SCAN supports the Department's proposal to use an opt-out or "passive" enrollment process coordinated with Medicare's Annul Enrollment Period,

beginning in October 2012. SCAN expects that beneficiaries will be assigned to a Duals Demonstration plan containing both Medicare and Medi-Cal benefits plan in their county of residence. The State might consider "intelligent assignment" of individuals based on the level of additional benefits that plans offer. However, this will work only if payments for individual patients are risk-adjusted to avoid adverse selection. Individuals will then have the opportunity to opt out of the Medicare portion of their assignment and instead choose a Medicare Advantage plan or traditional Medicare.

If the Duals Demonstration follows the example of the SPD program, the State would wait to enroll individual beneficiaries until the month of their birth, thereby providing a natural phase-in period that will be more efficient than requiring a general January 1 start date for all duals. SCAN has automated enrollment capability that is scalable in order to accommodate numerous transactions at once, and so we do not anticipate problems connected with the first time enrollment of a population this size; however, phasing the enrollment will help to ensure that plans can properly coordinate care for all newly-enrolled duals from the start.

SCAN is encouraged that the State is pursuing an enrollment lock-in, in which beneficiaries must remain enrolled with their selected health plan for at least six months in order to bring stability to the new program. However, the State and

health plans must be prepared for the possibility that CMS may reject the lock-in proposal as being too restrictive of patient choice.

In terms of enrollment process, SCAN envisions communication of enrollment eligibility data from DHCS to SCAN via daily HIPAA 834 files, as well as monthly reconciliation files.

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

Important lessons learned from the SPD transition are the need for improved communication with potential enrollees and more thorough preparation and information regarding the enrollees' current health condition—including pending critical medical procedures that could be interrupted by a hasty transition to a new plan or network. Following the SPD transition, legislative hearings highlighted cases of individuals who were scheduled for transplants or who needed highly critical services, such as insulin, whose care was interrupted by a switch to a Medi-Cal managed care plan. While these individuals represent a small percentage of the target population, special attention must be focused on identifying critical cases early in the transition process and delaying such transitions until the receiving plan is prepared to immediately and seamlessly deliver the needed care.

In addition, the SPD transition experience showed that the information provided to those individuals being transitioned must be far more user-friendly. SCAN has standing review panels composed of plan members to make sure that

published materials are appropriate for the plan membership. A similar system should be used to develop the materials that will be provided to potential Demonstration plan enrollees.

Finally, enrolling individuals based on their birth month was a wise choice for the SPD population and we believe it would also work well for the Duals Demonstration.

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.

The following issues must be addressed prior to the start of the Duals Demonstration:

- How will reimbursement levels be set?
- What will be the LTSS network adequacy standards?
- How will issues in the readiness review be resolved?
- How will data be formatted and transferred?
- Will there be "intelligent assignment" of beneficiaries and, if so, what form will it take?

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.

SCAN has experience and is currently in compliance with both Medicare and Medi-Cal provider appeals and grievance processes (see Appendix 12 for the list of appeals and grievances policies currently in force). SCAN Health Plan certifies that we will comply with the appeals and grievances processes established under the Federal-State MOU.

Section 6: Organizational Capacity

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

SCAN is guided by our mission to find innovative ways to enhance our members' ability to manage their health and to continue to control where and how they live. SCAN's philosophy of care emphasizes a holistic approach to meeting members' physical, mental, social, and spiritual needs. SCAN has 35 years of experience developing processes and protocols and maintaining an organizational structure that furthers the goals of managing appropriate utilization of services and improving clinical and quality of life outcomes.

Since our founding, we have worked to understand the unique needs of the duals population. We have established strong community partnerships, such as with Meals on Wheels, ADHC/CBAS centers, and other agencies, and over the

years we have learned from these community-level organizations and applied knowledge of the dual eligible population to enhance our person-centered care management model. As described in Section 1, SCAN has a strong record of performance in working with the duals population, including high quality and patient satisfaction ratings, and a very high percentage of NFLOC-qualified individuals who have been able to remain in their homes rather than residing in an institutional setting.

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

See attached Appendix 13.

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

Collectively, SCAN's key staff members have hundreds of years of experience managing the health and well-being of at-risk populations. SCAN's Chief Medical Officer, Dr. Tim Schwab, has been with SCAN for 24 years and is recognized nationally as an expert on geriatric medicine and the establishment of integrated care systems. Other members of SCAN's leadership team are masters-level social workers or hold doctorate degrees in public health and health informatics. Staff members' breadth of experience makes them keenly aware of the challenges facing the duals population and adept at dealing with issues related to patient-centric, integrated care. We have attached additional details on our team's skills and expertise at Appendix 14.

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

Up to this point, Dr. Schwab has spearheaded the Duals Demonstration project. SCAN will create a new senior-level management position to assume the new duals business unit described in section 6.5. See Dr. Schwab's resume attached at Appendix 15.

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

To facilitate the creation and growth of the structure needed to operate the Duals Demonstration, SCAN will create a new business unit within the organization. This "Duals Operations Unit" will be solely responsible for program implementation and for ongoing management and oversight. The unit will be led by a direct report of the Chief Operating Officer. The Unit's responsibilities will include ensuring a smooth, successful implementation of the program, as well as its ongoing management.

To ensure that SCAN's duals membership is managed appropriately and effectively, there will be direct responsibility within the Duals Operations Unit for several key functions. These include: Utilization Management, Quality Management, Medical Management, Grievances and Appeals, Case Management, Member Services/PAL Services, Behavioral Health, and community-based member advocates (staff in the community who will assist beneficiaries with membership, benefits and enrollment support, and provide ongoing member

support). In addition, SCAN will deploy a dedicated compliance specialist responsible for overseeing all regulations and compliance activity related to the Duals Demonstration.

There are several departments within SCAN that will provide shared services to the Duals Operations Unit. These departments include: Enrollment and Reconciliation, Claims, and Provider Services. While we intend to use the infrastructure, processes, and some staff members within these departments, there will also be dedicated resources specifically assigned to the Duals Operations Unit.

The Duals Operations manager will have oversight responsibility for shared services, and will work closely with the management team of each department to ensure that all activities related to the Demonstration are being executed according to all applicable protocols and regulations. In addition, a number of corporate departments will provide administrative support to the Duals Operations Unit. These include: Marketing, Compliance, Finance, HR/Payroll, Facilities, and Network/Provider Management. These departments have existing administrative support protocols in place with other business units to provide the needed supplemental support. These procedures will be deployed for the Duals Operations Unit.

In addition to monitoring the progress of implementation, the Chief Operating Officer will also provide frequent status updates to the SCAN Executive Team, Board of Directions, and Quality Committee.

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.

In anticipation of a January 1, 2013 implementation start date, SCAN has begun developing an implementation work plan in accordance with CMS guidance and the DHCS RFS timelines (see draft work plan, Appendix 16). SCAN has well-established, scalable systems and processes in place to accommodate membership growth and to continue to provide exceptional service to our members. We also have extensive experience with incorporating new product lines into our existing organization. SCAN will be creating ongoing structure, support, and accountability for the Duals Demonstration business model, and will be leveraging our knowledge and processes for a successful deployment of the Duals Demonstration. In addition, we will consider utilizing external expertise and resources to assist with the implementation.

Key components of the proposed operational plan include:

- Impact Assessment: One of the first activities in the work plan will be to conduct a detailed business impact assessment to identify additional needs and requirements to support the Duals Demonstration. This assessment will

review logistical components such as IT infrastructure, staffing models and staffing ratios, and facility space. In addition, shared and administrative services that will be provided by SCAN's central departments will be assessed, including Enrollment and Reconciliation, Claims, and Provider Services. Anticipated transaction volume in these departments will be carefully analyzed and staffing and workflow projections will be developed to coincide with the membership increase expected throughout 2013 and beyond.

- Business Requirements: Another critical activity within the implementation work plan will be to finalize the complete set of business requirements needed to support the expanded duals population, from IT systems to staff training to business process enhancements. The results of this activity will determine how SCAN can expand current capabilities to address all current and expected needs of the Duals Demonstration business.
- Staffing: In conjunction with the Duals Operations unit, SCAN is developing a staffing plan. Within this plan, we have developed staffing requirements based on our preliminary estimates of membership, as well as on the expected increase in membership volume over the course of 2013 and beyond. Once SCAN receives notification of our participation in the Duals Demonstration project, we will begin staffing the unit with its leadership

positions. It is expected that we will begin hiring for the Duals Operations Unit support personnel in May 2012, and will continue to add staff as membership increases.

- Contracting: SCAN will begin meeting with HCBS and county agencies to discuss partnerships, operational procedures, and contract negotiations.
- Training: SCAN will provide multi-layered training for its staff, including education on the Duals Demonstration, the special needs of these members, and how we can best care for them. Training curricula will be developed and will be targeted based on the employees' level of participation in the Demonstration.
- Education and Outreach: SCAN has a successful track record with outreach activities that provide health information and benefit updates to our members, their families, and community and county partners. As part of the implementation work plan, staff will structure a calendar of community events. For providers, communications regarding the Duals Demonstration will be communicated via bi-annual Joint Operations Committees (JOCs).
- Enrollment: The work plan aligns Medicare Advantage enrollment period activities with the Duals Demonstration activities to be as effective and efficient as possible. This includes developing plan benefit packages and

consistent brand marketing materials that will be used during enrollment periods.

- Beneficiary On-boarding: SCAN intends to provide an exceptional, personal beneficiary on-boarding experience, similar to the process currently in place. We will conduct beneficiary meetings in the community to introduce them to their member advocates, as well as to provide assistance and education on topics. The on-boarding will also include providing guidance on PCP and group selections, conducting health assessments, identifying special needs, coordinating special case management requirements, and providing ongoing education for such topics as Part D benefits, formularies, and provider networks.

All of the work plan activity prepares SCAN for the site readiness reviews. During and after the site readiness reviews with CMS and the State of California, SCAN will assess the findings of the reviews in an effort to continuously improve. SCAN intends to work very closely with the State to propose additional solutions that will be advantageous for our beneficiaries, the State of California, CMS, and SCAN.

Question 6.2.2: Provide roles and responsibilities of key partners.

SCAN's partners in implementation of the Demonstration include (1) health care providers, (2) county departments, and (3) home and community-based

services agencies . SCAN's contracted health care providers carry out the comprehensive medical care described under Network Adequacy in Section 7. County departments—specifically, Area Agencies on Aging, Departments of Mental Health, and the State Department of Rehabilitation offices—partner with SCAN to provide HCBS, mental health services, and rehabilitation services for individuals who may seek retraining for work. These relationships and responsibilities, including scope of service, use of common assessment forms, referral methods and payment, will be codified in Memoranda of Understanding (MOUs).

A wide array of HCBS providers in each county will partner with SCAN to serve the dual eligible population. Some of these providers will be accessed by referral (e.g., caregiver agencies, housing facilities, Meals on Wheels), while others will be based on contracts (e.g., transportation, personal care, telephone emergency response systems).

These various types of partners will meet at least quarterly with SCAN Dual Demonstration leadership through channels that include JOCs, Member and Community Advisory Committees, and as small group meetings for planning and monitoring.

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

Please see Appendix 16.

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.

SCAN Health Plan certifies that we will comply with the above requirement.

Section 7: Network Adequacy

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

To ensure our provider networks are adequate to meet the needs of current and future enrollees, SCAN uses network provider data, enrollee residence data, Quest Analytics software, and CMS criteria that include county level minimum numbers of providers and time/distance standards. Ninety percent of enrollees must have access to at least one provider within the time/distance standard for that provider type and county. These criteria can be modified to meet DHCS requirements, including but not limited to adding provider types such as long-term care facilities and adding Medi-Cal eligible and enrollee residence data.

SCAN reports and analyzes network adequacy for all counties and product lines at least semi-annually. If deficiencies are identified, remediation includes but is not limited to contracting directly with appropriate providers, working with delegated provider groups to contract with or add appropriate providers, and ensuring accuracy of provider types and addresses in our system. SCAN also works with provider groups to arrange for specialty care outside of our provider network when network providers are unavailable or inadequate to meet enrollees' medical needs.

In addition, SCAN ensures enrollee linguistic needs are met by comparing enrollee and PCP languages and taking appropriate action, including but not limited to offering translation services 24 hours a day, 7 days a week, working with delegated provider groups to contract providers who speak and/or write the required languages, and reaching out to enrollees to assist them with finding PCPs in their area who speak their native language.

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

For the Duals Demonstration, SCAN will continue to use our contracted provider network that serves our existing duals population. These providers are paid based on a mix of capitation, Medicare rates, and case rates. All of our organized medical groups are paid on a capitation basis to coordinate care and act as the medical home in concert with SCAN's care management programs. Most of our hospitals and ancillary providers are paid on an FFS basis at Medicare-allowable rates and, in some instances, case rates for common procedures such as open heart surgery or transplants. Some provider contracts contain additional funding for care coordination in support of demonstrated quality care outcomes. In addition, SCAN offers incentive programs for all interested providers, which offer higher compensation for demonstrated quality outcomes (i.e., HEDIS measures) and could be adjusted to meet the specific goals of the Duals Demonstration. For example, as part of our End Stage Renal Disease (ESRD) C-SNP, we established a

revenue sharing program to incentivize nephrologists to meet the quality measures established for the program, whereby they demonstrate adherence to quality protocols. All such incentives would depend on the rates to be paid under the Demonstration.

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

Many providers do not accept Medi-Cal because they are frustrated by the disjointed nature of Medi-Cal benefits and covered services. To encourage participation, SCAN will educate providers about the benefits of participating in the Duals Demonstration, including:

- The streamlining that would come with participation in the Duals Demonstration, minimizing the administrative burden on their practice as compared with traditional Medi-Cal, and minimizing coverage issues for beneficiaries (e.g., carrying two membership cards, being referred to a non-participating provider);
- The ability of non-Medi-Cal providers to increase their current patient base under the Demonstration;
- The real opportunities to improve patients' overall health afforded by the Demonstration's coordinated approach;

Some providers may choose not to participate because of the rates paid by Medi-Cal. To encourage participation in the Demonstration by these providers,

SCAN will educate them about SCAN's D-SNP experience, demonstrating reasonable payment levels when coordinating care under Medicare and Medi-Cal funding. While we cannot assure or guarantee that the rates under the Demonstration will exceed Medi-Cal rates, since the financing of the Demonstration is to be finalized, we can say that our current experience in the D-SNP space proves that revenue is higher and is "prepaid", with no billing required.

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

SCAN performs pre-contractual and ongoing Facility Site Reviews for PCPs serving dual eligibles, in accordance with the DHMC-approved tool to assure access for those with disabilities. Through these reviews, SCAN educates providers about accessibility requirements and then ensures that providers are maintaining these standards through additional visits. Under the Duals Demonstration, SCAN will expand these site visits to include ancillary providers beyond PCPs.

In addition, SCAN believes it is very important to ensure that our providers understand the accessibility challenges faced by the elderly and the disabled. To educate providers and their staff about these challenges, SCAN provides a program called "Trading Ages" in which participants experience the onset of disabilities and diminished faculties and learn first-hand what it is like to feel like the patients they

treat. Additional ways that SCAN promotes patient accessibility with providers include:

- Through providers, SCAN distributes appropriate, easy-to-understand patient information in formats that include Braille, large-print, and audio.
- SCAN provides transportation to provider offices for our frail and disabled members, as well as a personal care escort for NFLOC-qualified members
- SCAN provides a TTY telephone line and sign language services on-site at the physician office for members who are hearing-impaired.

SCAN will continue these efforts under the Duals Demonstration.

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.

SCAN will work with our contracted provider groups in the local communities to assess continuity of care needs and will expand our provider network as appropriate. To encourage providers to join our network, SCAN will educate providers about the importance of continuity of care for the member to ensure high quality care and the best possible outcomes, as well as the importance of maintaining the member's relationship with their current care providers. SCAN will educate providers about the support that they would have from SCAN in caring for these patients through the coordinated care approach under the Demonstration and the benefit to patients inherent in receiving coordinated care.

Finally, we will emphasize the ease of administration that comes with joining our provider network, particularly as compared to navigating both the Medicare and Medi-Cal payment systems.

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

Under the Duals Demonstration, SCAN will continue to work with our contracted provider network that currently serves our dual eligible beneficiaries. SCAN's contracts with these provider groups are in full compliance with Federal and State requirements. To support the care needs of an expanded duals membership, we will expand our existing contractual relationships and develop new ones to the extent needed to meet demand for medical care, behavioral health and LTSS. SCAN also intends to continue working with our currently-contracted pharmacy benefits manager, ExpressScripts, to deliver pharmacy management services to our current duals and the expanded duals population under the Demonstration.

As payment rates are published, subcontracting arrangements with ancillary providers will be negotiated. These contractors may include vision, dental, hearing aids and transportation.

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

SCAN Health Plan certifies to 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 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.

SCAN Health Plan certifies that we will comply with the above requirements.

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

SCAN Health Plan certifies that we will comply with the above requirements.

Section 7.2: Technology

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

SCAN's contracted provider network of medical groups has been focused on the importance of moving their physician offices toward meeting meaningful use requirements. Despite encountering challenges with the process and obtaining incentive payments, the provider network has not been deterred from such efforts. Virtually all of SCAN's providers have either implemented electronic health record (EHR) systems or are in the process of implementing them. As a health plan, SCAN seeks to support our providers in EHR adoption.

Whenever feasible, providers and SCAN share data through secure portals, electronic data interface (EDI), and direct shared access of systems. For example, SCAN staff are users of certain provider systems through which SCAN case managers have access to real-time patient care information, which supports case management and utilization management activities. The shared data enables seamless quality care.

In addition, all SCAN case management programs use the same software, McKesson's CareEnhanced Clinical Management Software (CCMS), to assess, monitor, and report on case management activities. The system can be used on a laptop when visits to the member's home are made and it can generate care plans, member letters and assessment summaries that are sent to providers. SCAN leverages Pharm MD's MedPro software platform for its MTM Program, which reviews member medication profiles and identifies drug therapy problems (i.e. therapeutic duplication, gaps in therapy, drug-drug interactions) by utilizing evidence-based medicine, national guideline standards and proprietary rule sets to identify potential interventions and reduces the time to impact by a SCAN pharmacist to intervene on issues.

SCAN has experience with several member monitoring devices. SCAN participated in a test of an Intel touch screen product that allowed member/case manager communication. Currently, members in the CHF Disease Management

program are testing the utility of Bluetooth scales that report their daily weights to their case management. Since weight gain often signals dangerous fluid retention in CHF patients, the alert can trigger a quick response by the case manager and physician.

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.)

SCAN uses a broad set of technology tools throughout the care delivery process to ensure quality, identify individuals for intervention, trend and identify opportunities for quality improvement, perform case management, and apply clinical criteria to ensure appropriate utilization. Due in no small part to our use of health IT tools, SCAN has successfully kept 98 percent of NFLOC members in their own homes and out of institutional care. We intend to continue to enhance our care management processes by leveraging our staff and technology to keep our members independent and healthy.

SCAN's proprietary risk stratification model identifies high-risk members by analyzing both the typical data elements (e.g., diagnoses, medications, demographics), and data regarding functional and health status. Once identified as a high-risk member, SCAN uses sophisticated care management and medication therapy management software to consistently and appropriately manage the member's care. SCAN's case management software—McKesson's CareEnhanced

Clinical Management Software (CCMS)—facilitates communication across case management programs and medical offices, and newly developed interfaces collect data in the field via mobile technologies. These robust capabilities have been built, tested, and revised over the last 10 years and offer a scalable platform to serve SCAN's current members, as well as large numbers of potential newly enrolled duals. Our ultimate objective is to expand this set of systems to aggregate the combined information across the spectrum of care for our members.

SCAN currently uses telemonitoring to support quality care and intends to expand the use of such remote tools under the Duals Demonstration. Our telemonitoring scale program provides remote monitoring scales to members, which interface with the case management software to provide alerts to disease management nurses that enable them to support members' self-management. In addition, SCAN has developed a user interface, currently being piloted in our Arizona plan, to collect data during in-home visits, and intends to use this technology under the Duals Demonstration. SCAN will deploy in-home monitoring technologies, such as blood pressure cuffs, glucose monitoring systems, medication adherence alerts and Bluetooth scales that transmit weight daily. SCAN will leverage these mobile technologies to collect real-time, actionable data on beneficiary health status in order to support our goal of keeping our members out of institutional care.

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

SCAN supports national and local efforts to adopt health information exchanges (HIEs) and device protocol interoperability standards and believes that standardizing the exchange of health information will help streamline care delivery. SCAN intends to continue moving towards the adoption of software and devices that meet interoperability standards in order to support providers' use of EHRs and our intended use of in-home remote monitoring technologies. In addition, SCAN is developing a systems architecture that will ensure maximum system flexibility by being easily adaptable to the interoperability standards as they evolve and by accommodating unanticipated requirements or changes in the protocols.

Section 8: Monitoring and Evaluation

The evaluation will examine the quality and cost impacts on specific vital Medicare and Medicaid services, including the integration on IHSS and other home-and community-based LTSS. Therefore, the Applicant must:

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

- *Enrollee satisfaction, self-reported health status, and access to care,*
- *Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied), and*
- *Condition-specific quality measures.*

SCAN currently tracks and reports on numerous quality and performance metrics, including the following:

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

SCAN conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to ask our members to report on and evaluate their experiences with SCAN and their health care services. The CAHPS survey covers topics that are important to members and focuses on aspects of quality that members are best qualified to assess, such as the communication skills of providers and ease of access to health care services. Members are asked to report their overall ratings of all health care, personal doctor, specialist, and health plan. Information about members' self-rated health status is included in the survey. SCAN annually submits results from the CAHPS survey to CMS and uses the results to direct ongoing improvements in SCAN's member-focused operations.

SCAN also administers its own Health Questionnaire (HQ) annually to all SCAN members to gather data on service quality towards the improvement of members' health. The HQ collects information on members' self-rated health status and on members' history of access to care. Reports based on the responses are generated regularly to identify any issues that require attention. Information is used internally to guide the disease management and complex case management programs, and is also shared with members' PCPs to continually improve the quality of care they are delivering to our members.

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

SCAN has extensive experience collecting data from providers and submitting process and outcomes data, including aggregated results, regularly to the State and Federal governments and their contractors. SCAN has existing protocols and an infrastructure to collect, analyze, and report on uniform encounter data for all covered services, including HCBS, behavioral health services, and Medicare Part D pharmacy data. SCAN accepts and submits encounter data in standard HIPAA mandated formats, as well as industry and regulator required formats.

SCAN has built and actively maintains a state-of-the-art encounter data system that automates data processing, thereby enabling encounter data staff to actively analyze, research, and monitor data submission rates, quality, and completeness from providers and to regulators. This analysis and monitoring is driven by operational system reporting as well as specifically developed reports. All data received into the encounter data system is stored within one schema, ensuring consistency for various submission and research efforts. SCAN utilizes an enterprise-wide Data Warehouse (DW). The DW is a secure and reliable integrated repository of corporate information, organized to support analysis and reporting.

Value is added by calculating and providing common business measures. The DW is a "single source of truth" for corporate information. Executives, operations personnel and analysts leverage the DW through Business Intelligence tools such as: direct queries, ad-hoc and standardized reports, dashboards, Executive Information Systems, etc.

c. Condition-specific quality measures

SCAN uses the Healthcare Effectiveness Data and Information Set (HEDIS) tool to measure our performance on important dimensions of care and service. HEDIS includes many condition-specific quality measures, such as quality of antidepressant medication management. SCAN annually reports results from the HEDIS to CMS. In addition, SCAN continues to have a successful track record improving quality of care and quality of life for frail elderly Medicare beneficiaries. For example, in 2011, SCAN performed in 90th percentile among Medicare D-SNPs on a wide range of HEDIS quality measures, including colorectal cancer screenings, glaucoma screening, and a number of comprehensive diabetes care measures.

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).

SCAN is experienced in reporting beneficiary outcomes by demographic characteristics. Many of the health outcome measures in SCAN's annual HEDIS

report are age- or gender-specific. In addition, the Health Questionnaire described above includes members' demographic characteristics, such as age, gender, race/ethnicity, English proficiency, and disability measures, such as difficulties in Activities of Daily Living (ADLs). The data SCAN collects through the various surveys and data sets can be sorted and reported based on most of these demographic characteristics, including age, gender, race, ethnicity and disability. In addition, SCAN recently conducted a group needs assessment, which identified the ability to sort data based on other demographic characteristics (e.g., English proficiency and sexual identity) as a needed process improvement.

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

SCAN Health Plan certifies that we will comply with the above requirement.

Section 9: Budget

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

SCAN has submitted an application for a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Challenge Grant worth $11.212 million. The goal is to add community health workers and mobile and remote technologies to our current robust model of care to build a paradigm for the care of dual eligibles nationwide. If CMMI accepts our application, SCAN will incorporate the proposal into the California Duals Demonstration project.

SCAN's proposal creates the technological and human infrastructure to surround high-need patients with services that attend to their medical needs and preserve their independence. Specifically, SCAN's proposed Enhanced Care Management Model will improve care for the target population by:

- Expanding the effectiveness of current medical and support services by adding culturally-competent community health workers to our current comprehensive care team of physicians, nurse practitioners, case managers, and telephonic assistants;
- Enhancing beneficiary communication across the care continuum—from the home to all clinical settings—through the use of cutting-edge technology to improve the breadth and timeliness of collected data and ensure that the right care is delivered at the right time with high beneficiary satisfaction;
- With this human and technological infrastructure in place, engaging beneficiaries to assume a greater role in their own health by promoting the use of primary and out-patient care in the community, and through preventive, behavioral health, and community-based social services and supports; and

- Lowering costs through a reduction in inpatient admissions and readmissions, inpatient length of stay, emergency department visits, and skilled nursing facility stays, when clinically appropriate.

The proposed Enhanced Care Management Model is projected to serve 12,100 dual eligible beneficiaries and result in $170,581,379 of savings over three years—a 4.73:1 return on investment relative to FFS costs for dual eligible beneficiaries.

In short, SCAN will lower costs for dual eligible beneficiaries relative to FFS through better care coordination that looks at each individual's level of need and unique situation. Moreover, this model will allay patient advocate concern about moving dual eligibles to health plans with little experience in caring for this complex population.

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Appendix 1

THIS LICENSE IS NOT TRANSFERABLE OR ASSIGNABLE

Department of Corporations

State of California

License

HEALTH CARE SERVICE PLAN

SCAN HEALTH PLAN

File No. 933 0212

IS HEREBY LICENSED AS A HEALTH CARE SERVICE PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975, AS AMENDED, AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A HEALTH CARE SERVICE PLAN WITHIN THE STATE OF CALIFORNIA SUBJECT TO THE PROVISIONS OF SAID ACT AND THE RULES OF THE COMMISSIONER OF CORPORATIONS ADOPTED PURSUANT THERETO, UNTIL SUCH TIME AS THIS LICENSE IS SUSPENDED OR REVOKED BY ORDER OF THE COMMISSIONER, OR IS SURRENDERED.

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

AJO:ijh

Date: 11-30-84

(SEAL)

FRANKLIN TOM
Commissioner of Corporations

By Richard L. Camilli

RICHARD L. CAMILLI
Assistant Commissioner

CORP LC

Appendix 2

SCAN HEALTH PLAN

NOTES TO FINANCIAL STATEMENTS
AS OF AND FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2011

1. ORGANIZATION

SCAN Health Plan (the "Company"), a California nonprofit public benefit corporation, is a health maintenance organization providing comprehensive medical care and specialized social services to seniors and other Medicare eligible beneficiaries in California through the use of managed care arrangements. On November 30, 1984, the Company was licensed by the State of California as a Health Care Service Plan pursuant to the Knox-Keene Act of 1975, as amended. Enrollment of participants in the Company's managed care plan began on March 1, 1985. Prior to December 31, 2007, the Company operated as a Medicare Advantage Organization ("MAO") as mentioned below, with a special waiver as a Social Health Maintenance Organization ("Social HMO") under a national demonstration program administered by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the federal government, in four counties: Los Angeles, Orange, Riverside, and San Bernardino. The waiver expired on December 31, 2007. With the expiration of the aforementioned waiver, the Company continues to operate as a MAO. The Company receives substantially all of its revenue from CMS. In addition, the Company has a contract with the California Department of Health Care Services ("DHCS") to serve dually eligible and dually enrolled beneficiaries in the Medicare and Medi-Cal programs. Furthermore, the Company expanded its Medicare Advantage offerings to beneficiaries in Ventura, Kern, and San Diego counties in 2006 and 2007; San Joaquin County in 2009; and Contra Costa, Santa Clara, and San Francisco in 2010. The Company also receives grants from the State of California, local governments, and private foundations to provide in-home services for those individuals who are at risk of being institutionalized.

SCAN Group is the sole corporate member of the Company, The SCAN Foundation (through December 31, 2009), and SCAN Health Plan Arizona. SCAN Health Plan Arizona is an Arizona nonprofit corporation, which in turn, is the sole corporate member of SCAN Long Term Care, an Arizona nonprofit corporation.

The Company is exempt from federal and California income taxes in accordance with Internal Revenue Code ("IRC") Section 501(c)(3) and California Revenue and Taxation Code Section 23701(d), respectively.

2. REGULATORY REQUIREMENTS AND OPERATIONS

Under the Knox-Keene Health Care Services Plan Act, the Company must comply with various rules and regulations, including certain tangible net equity requirements. In addition, the Company is subject to regulatory oversight by CMS, the California Department of Managed Health Care (the "Department"), and DHCS, among others. The Company is required to periodically file financial statements with regulatory agencies in accordance with various statutory accounting and reporting practices. At December 31, 2011, the Company is in compliance with the tangible net equity requirement of the Department, as the Company's required tangible net equity was $23,721 as compared to actual tangible net equity of $674,023.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying financial statements include the accounts of the Company and have been prepared in accordance with accounting principles generally accepted in the United States of America ("generally accepted accounting principles" or "GAAP"), including Financial Accounting

Standards Board ("FASB") Accounting Standards Codification ("ASC") 958, *Not-for-Profit Entities*. FASB ASC 958 establishes standardized external financial reporting by not-for-profit organizations.

Generally accepted accounting principles require not-for-profit organizations to report information regarding their financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets based on the existence or absence of donor-imposed restrictions. As of December 31, 2011, the Company had no temporarily or permanently restricted net assets.

Use of Estimates — Management uses estimates and assumptions in preparing the financial statements in accordance with generally accepted accounting principles. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities, and the reported revenues and expenses. Actual results could vary from the estimates that were assumed in preparing the accompanying financial statements.

Cash and Cash Equivalents — Cash and cash equivalents primarily include highly liquid debt instruments purchased with a remaining maturity of three months or less, as well as cash on hand and on-demand bank deposits.

Investments — Investments are accounted for in accordance with FASB ASC 958-320, *Not-for-Profit Entities-Investments-Debt and Equity Securities*. Under FASB ASC 958-320, equity securities with readily determinable fair values and all investments in debt securities are reported at fair value with realized gains and losses included in Report #2: Revenue, Expenses and Net Worth. Unrealized gains and losses are included in Report #2: Revenue, Expenses and Net Worth unless the unrealized losses are deemed to be other than temporary, in which case, the losses are recorded as realized. During the twelve months ended December 31, 2011, the Company did not record any realized losses for investments deemed to be other-than-temporarily impaired.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts in Report #1-Part A: Assets.

Premiums and Other Receivables — Receivables include amounts due from third-party payors, such as government-sponsored health care programs ("Medicare" and "Medi-Cal"), premiums from employers, and amounts due from members.

The Company establishes an allowance for those accounts that are estimated to have credit risk. The Company does not believe that there are significant credit risks associated with reimbursement from government-sponsored health care programs.

Policies for recording receivables relating to changes in risk adjustment factors are discussed in the revenue recognition and unearned premiums section.

Property and Equipment — Property and equipment are recorded at cost. Depreciation is provided on the straight-line method over the estimated useful lives of the assets as follows:

Computer equipment and software	3–10 years
Office furniture and equipment	3–10 years
Leasehold improvements	3–12 years
Vehicles	5 years

Assets purchased with the use of government grant funds are considered to be the property of the government agency in accordance with the contracts between the Company and the government agency. Accordingly, these assets are expensed when purchased, and no provision for depreciation of these assets is made. For the twelve months ended December 31, 2011, the Company did not purchase any assets with government grant funds.

Impairment of Long-Lived Assets — Management reviews long-lived assets to be held and used in the Company's operations for impairment at least annually, or more frequently if circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets are deemed to be impaired if estimated undiscounted future cash flows are less than the carrying amount of the assets. Estimates of expected future cash flows are based on management's best estimates of anticipated operating results over the remaining useful lives of the assets. The Company measures the impairment as the amount by which the carrying amount of the asset exceeds the fair value of the asset. Management does not believe any impairment of its long-lived assets existed at December 31, 2011.

Revenue Recognition and Unearned Premiums — Generally, Medicare Advantage organizations' membership contracts with individuals are subject to an annual election period after which members are locked into the contract and can only disenroll in limited circumstances. Dually eligible and dually enrolled individuals (Medicare and Medi-Cal eligible and enrolled), however, may disenroll monthly. Employer group retiree plan membership contracts are renewed on an annual basis. Certain optional membership contracts are on a monthly basis, subject to cancellation by the individual upon 30 days' written notice. Under each of these types of membership contracts, revenues are recognized based on the estimated number of eligible members per month multiplied by the contracted monthly capitation rate, which is adjusted for member health status. Revenue is recorded in the month in which eligible members are entitled to health care services. Premiums received prior to the month earned are reported as unearned premiums in the financial statements.

Certain estimates are required to record revenues and accounts receivable at net realizable value due to the nature of the membership contracts, specifically eligibility changes in the membership base. These estimates are based on actual historical adjustments to monthly capitation premiums. Inherent in these estimates is the risk that they will have to be adjusted as additional information becomes available. Such adjustments are typically identified and recorded at the point of cash application or account review. Medicare and Medi-Cal revenues are potentially subject to audit and retroactive adjustment by the respective regulatory agencies responsible for those programs. Laws and regulations governing these programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount.

The Company has an arrangement with CMS for certain Medicare products, whereby periodic changes in its risk factor adjustment scores for hierarchical condition category codes ("HCC risk scores") result in changes to health plan services premium revenues. CMS uses a risk-adjustment model to determine the premium amount it pays for each member. The CMS risk-adjustment model allocates premiums paid to all MAO plans according to the health status of each beneficiary enrolled and pays more for Medicare members with higher HCC risk scores.

The Company recognizes changes in receivables previously accrued when the amounts to be received become determinable, supportable, and collectibility is reasonably assured. Because the recorded revenue is based on the best estimate at the time, the actual payment received from CMS for risk adjustment reimbursement settlements may be different than the amounts initially recognized in the financial statements.

Hospital, Physicians, and Other Services — Health care costs are recorded in the period when members are entitled to services. Substantially, all physician services and a majority of hospital services are provided under capitated contractual agreements, some of which include the establishment of a risk-sharing fund. The Company establishes the risk-sharing fund by retaining a portion of the providers' monthly capitation payments. Providers bear the level of financial risk specified in their respective contractual agreements if mutually agreed-upon hospital utilization goals are not achieved.

The Company runs the risk with capitated contracts of delegated administrators ("DA") being unable to meet their financial obligations. The liability for certain delegated claims may be transferred to the Company in the event of DA insolvency or termination of a DA agreement. To manage this risk, the Company monitors the financial status of the DA network via analysis of the DA's quarterly financial statements, annual audited financial statements, and by conducting on-site audits. The Company has the contractual right to withhold a portion of capitation otherwise payable to the DA in the event that a DA becomes insolvent or terminates an agreement. This withhold is held in reserve by the Company to cover any potential transfer of delegated liabilities and is included in medical claims payable in Report #1- Part B: Liabilities and Net Worth.

The Company also accepts hospital risk through contractual agreements other than capitation. The cost of health care services is recognized in the period in which services are provided and includes an estimate of the cost of services that have been incurred but not yet reported. The Company estimates the amount of the provision for service costs incurred but not reported ("IBNR") using standard actuarial methodologies based upon historical data, including the period between the date services are rendered and the date claims are received and paid, denied claim activity, expected medical cost inflation, seasonality patterns, and changes in membership. The estimates for service costs IBNR are made on an accrual basis and adjusted in future periods as required. Any adjustments to the prior period estimates are included in the current period. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The Company assesses the profitability of its Medicare and Medi-Cal contracts for providing health care services when operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contract. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with its method of acquiring, servicing, and measuring the profitability of such contracts. The Company did not record any premium deficiency reserves as of December 31, 2011.

While the ultimate amount of claims and expenses is dependent on future developments, the Company believes the liability for medical claims payable, shared risk settlements, and other reserves included in medical claims payable in Report #1- Part B: Liabilities and Net Worth are reasonable estimates to cover such costs.

Medical Administration Expenses — Medical administration expenses include care management for Medicare and Medi-Cal members who meet specified criteria, quality assurance, utilization management, compliance, member services, grievances and appeals, and geriatric practice innovation.

Deferred Compensation — The Company maintains various nonqualified retirement plans that cover certain key executives. The Company accrues expenses related to these plans over the applicable vesting periods.

Income Taxes — The Company is recognized as a tax-exempt entity under IRC Section 501(c)(3) and California Revenue Code Section 23701(d).

Fair Value of Financial Instruments — The carrying amounts of cash and cash equivalents, restricted cash, premiums and other receivables, and accounts payable and accrued expenses at December 31, 2011 approximate fair value because of the relatively short period of time between origination of the instruments and their expected liquidation. The fair value of investments is presented in Note 8.

Recent Accounting Pronouncements — In September 2009, the FASB amended ASC 820, *Fair Value Measurements and Disclosures*, for measuring the fair value of investments in certain entities that do not have a quoted market price but calculate net asset value per share or its equivalent. Equivalents to net asset value per share include net asset value per member unit or per an ownership interest in partners' capital that is entitled to a proportionate share of net assets. Such investments, sometimes referred to as alternative investments, include certain hedge funds, private equity funds, real estate funds, venture capital funds, and offshore funds. The new accounting guidance is effective for annual periods ending after December 31, 2009. The Company adopted this standard, as amended, as of December 31, 2010, noting no additional disclosure deemed necessary.

In January 2010, the FASB amended ASC 820 to require new disclosures related to transfers in and out of Level I and Level II, including reasons for the transfers, and to require new disclosures related to Level III fair value measurements. In addition, the new guidance clarifies existing disclosure requirements related to the level of disaggregation of classes of assets and liabilities and provides further detail about inputs and valuation techniques used for fair value measurement. The new guidance for Level I and Level II is effective for the Company beginning January 1, 2010 and the new disclosures related to Level III fair value measurements are effective for the Company beginning January 1, 2011. See Note 8 for information on the Company's fair value measurements and disclosures required by the adoption of these amendments.

In August 2010, the FASB issued Accounting Standards Update ("ASU") No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*, which clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. The adoption of ASU No. 2010-24 is effective for the Company beginning January 1, 2011. The adoption of ASU No. 2010-24 is not expected to have a material impact on the Company's financial statements.

4. MEDICARE PART D

On January 1, 2006, the Company began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with CMS. Under the Medicare Part D program, there are six separate elements of payment received by the Company during the plan year. These payment elements are as follows:

CMS Premium — CMS pays a fixed monthly premium per member to the Company for the entire plan year.

Member Premium — Certain members pay a fixed monthly premium to the Company for the entire plan year in addition to the CMS premium for expanded insurance coverage.

Low-Income Premium Subsidy — For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.

Catastrophic Reinsurance Subsidy — CMS pays the Company a cost reimbursement amount monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum of four thousand five hundred fifty dollars.

Low-Income Member Cost-Sharing Subsidy ("LICS") — For qualifying low-income members, CMS pays some or all of a member's cost-sharing amounts, such as deductibles and coinsurance on the member's behalf. The cost-sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims experience, subsequent to the end of the plan year.

CMS Risk Share — If the ultimate per member per month benefit cost of any Medicare Part D plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS, there is a risk-share settlement with CMS that is settled subsequent to the end of the plan year. The risk-share adjustment, if any, is recorded as an adjustment to premium revenues and other receivables or liabilities.

The CMS premium, the member premium, the low-income subsidy, and the catastrophic reinsurance subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded in Medicare premium revenues in Report #2: Revenue, Expenses and Net Worth. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. Premium payments received in advance of the applicable service period are recorded as unearned premiums in Report #1- Part B: Liabilities and Net Worth.

The LICS represents cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in medical and hospital expenses in Report #2: Revenue, Expenses and Net Worth.

The Company's Medicare Part D benefit design includes both the basic Medicare Part D benefit ("Defined Standard benefit") and a supplemental benefit. For the basic Medicare Part D benefit, the Company is responsible for approximately 66% of the Medicare beneficiary's drug costs up to the initial coverage limit of two thousand eight hundred forty dollars, while the beneficiary is responsible for 100% of the drugs costs, from two thousand eight hundred forty dollars to six thousand four hundred forty seven dollars and fifty cents. The supplemental benefit, for which the Company receives no Medicare Part D reimbursement, fills in the gap between two thousand eight hundred forty dollars, and six thousand four hundred forty seven dollars and fifty cents with generic drug coverage. The Company's supplemental coverage also raises the initial coverage limit above two thousand eight hundred forty dollars.

5. INVESTMENTS

Investments restricted for use in the Company's various nonqualified deferred retirement plans amounted to $2,572 at December 31, 2011.

The gross unrealized losses on the Company's investments were caused by interest rate increases and general downturn in market conditions.

Restricted Cash — Pursuant to requirements of the Knox-Keene Health Care Services Plan Act, $300 has been deposited and assigned to the Department as of December 31, 2011. Interest income accrues to the Company.

Effective May 26, 2004, the Company changed from a guaranteed cost workers' compensation insurance program to a large deductible program. Effective May 26, 2006, the Company changed back to a guaranteed cost workers' compensation insurance program.

6. PROPERTY AND EQUIPMENT

Property and equipment as of December 31, 2011 consist of the following:

Computer equipment and software	$ 13,102
Office furniture and equipment	11,061
Leasehold improvements	14,730
Vehicles	414
	39,307
Less accumulated depreciation and amortization	(22,042)
	17,265
Construction in progress — leasehold improvements	418
Total	$ 17,683

7. MEDICAL CLAIMS PAYABLE

Liabilities for unpaid claims and claim expenses are estimates of payments to be made under health coverage for reported but unpaid claims and for IBNR claims. Management develops these estimates using actuarial methods based upon historical data for payment patterns, cost trends, product mix, seasonality, utilization of health care services, and other relevant factors.

8. FAIR VALUE MEASUREMENTS

FASB ASC 820 defines fair value, establishes a framework for measuring fair value in accordance with existing GAAP, and expands disclosures about fair value measurements. Assets and liabilities recorded at fair value in Report #1- Part A: Assets and Part B: Liabilities and Net Worth are categorized based upon the level of judgment associated with the inputs used to measure their fair value and the level of market price observability.

Investments measured and reported at fair value using level inputs, as defined by FASB ASC 820, are classified and disclosed in one of the following categories:

Level 1 — Quoted prices are available in active markets for identical investments as of the reporting date. The types of investments included in Level 1 include equities and mutual funds. As required by FASB ASC 820, the quoted price for these investments is not adjusted, even in situations where the Company holds a large position and a sale could reasonably impact the quoted price.

Level 2 — Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the reporting date, and fair value is determined through the use of models or other valuation methodologies. Investments that are generally included in this category include U.S. government and agency obligations, mortgage-backed securities, asset-backed securities, corporate bonds, and commingled funds.

Level 3 — Pricing inputs are unobservable for the investment and include situations where there is little, if any, market activity for the investment. The inputs used in the determination of fair value require significant management judgment or estimation. Management's estimates are based on information provided by fund managers, the general partners, or third-party service providers using methods and significant assumptions the Company considers appropriate based on its understanding of the characteristics of the investments.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an investment's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement. Management's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the investment.

9. EMPLOYEE BENEFITS

The Company provides a defined contribution retirement plan ("retirement plan") organized under IRC Section 403(b) for its employees. The Company makes discretionary contributions of approximately 5% of gross salaries on behalf of all eligible employees with a minimum of one year of service and one thousand hours worked. Employees are immediately vested in the 5% contribution.

Effective January 1, 2006, the Company began to match employee's contributions. The retirement plan provides for an employer-matching contribution of an amount equal to 50% of the first 4% of pay an employee's contributes as salary deferral contributions. Employees are eligible after twelve months of service and one thousand hours worked for the employer match. The matching contribution is vested after three years of service. The employee's maximum contribution limit is sixteen thousand five hundred dollars for the year; employees over age fifty may contribute up to twenty two thousand dollars for the year; based on the Internal Revenue Service ("IRS") annual compensation limit of two hundred forty five thousand dollars for the year. Employees are immediately 100% vested.

The Company also sponsors a 457(b) deferred compensation plan to benefit certain management employees. Participants are eligible to defer from 1% to 100% of their compensation for the year up to the IRS dollar limit of sixteen thousand dollars for the year, adjusted in future years for cost of living increases in accordance with Section 457(e) (15) of the IRC. The Company also contributes 5% of a participants' earnings to the 457(b) plan on a quarterly basis. The employer contribution is also included in the IRS dollar limit.

Effective January 1, 2006, the Company established a 457(f) executive nonqualified retirement plan that covers certain key executives. This plan is maintained for the purpose of providing retirement benefits for a select group of management. The Company credits the employer account of each active participant on a quarterly basis. A participant becomes vested in the employer contribution account upon completion of their chosen vesting option while the participant is an employee.

The Company has established a Key Employee Share Option Plan ("KEYSOP") that covers certain key executives. The KEYSOP provides for incentive payments that will be made upon completion of a

specified vesting period and are generally dependent upon continued employment of the participants. The plan has been frozen since May 2002. The Company no longer makes contributions to this plan.

10. RELATED-PARTY TRANSACTIONS

The Company provides administrative services in support of the operations of SCAN Health Plan Arizona, SCAN Long Term Care, The SCAN Foundation, and SCAN Group. These affiliates have agreed to reimburse the Company for providing and arranging accounting, financial, and other services. The amount of the expenses to be reimbursed is allocated based on time allocations provided by each department of the Company or as a percentage of SCAN membership or headcount. The amount of the expenses is reported in Report #2: Revenue, Expenses and Net Worth and the amount reimbursed to the Company for the services provided by the Company were recorded as reductions of affiliate receivables in Report #1-Part A: Assets.

SCAN Group assumed direct responsibility for providing certain administrative services in support of the operations of the Company. The Company has agreed to reimburse SCAN Group for providing and arranging internal audit, legal, information technology, human resources, facilities, and other services. The amount of expenses to be reimbursed is allocated based on time allocations provided by each department of SCAN Group or as a percentage of SCAN membership or headcount. The charges for these services to the Company were recorded in Report #2 Revenue, Expenses and Net Worth.

Intercompany transactions between the Company and affiliates represent costs incurred in the ordinary course of business by, or on behalf of, the Company. Intercompany receivable and payable amounts are settled through intercompany cash settlements within 30 days of year-end.

On March 28, 2011, the Company issued a $50,000 note receivable to SCAN Health Plan Arizona with no stated interest rate (the "Note"). The Note was approved by the Department on March 22, 2011. The Note is due in full within 90 days of the ending date of the financial statements filed with the Arizona Department of Insurance ("DOI") in which SCAN Health Plan Arizona reports risk-based capital, as if the Note has been paid, of 300% of the authorized control level. Repayment is subject to the approval of the DOI. As of December 31, 2011, there is an allowance provision of $14,843 on the $50,000 note receivable resulting in a net book value for the note receivable of $35,157.0

11. COMMITMENTS AND CONTINGENCIES

Cash Concentration — The Company maintains the majority of its cash and cash equivalents in one financial institution, which subjects the Company to concentrations of credit risk related to temporary cash investments.

Credit Concentration — A substantial portion of operating revenues for the twelve months ended December 31, 2011 result from contracts with CMS. CMS cancellation or nonrenewal of its contracts with the Company or nonpayment of amounts due to the Company would have a material adverse effect on the Company's Net Worth.

Medical Claims Risk — The Company is exposed to certain medical claims risk due to the nature of its operations. The major portion of medical services provided for the Company's members is performed under contract; however, the Company regularly incurs costs for noncontracted services from providers. In addition, in the event of default or financial difficulties with certain providers, the Company could be liable for outstanding claims, which, if substantial, could have a material adverse effect on the Company's Net Worth.

Cost Containment Measures — Both government and private pay sources have instituted cost containment measures designed to limit payments made to providers of health care services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect the Company's Net Worth.

Regulatory Changes — As discussed in Note 1 above, prior to January 1, 2008, the Company operated as a MAO with a special waiver as a Social HMO under a national demonstration program administered by CMS in four counties: Los Angeles, Orange, Riverside, and San Bernardino. The Company commenced operations as a MAO without the special waiver beginning in 2008. As a MAO without the special waiver, revenue per member has been reduced as compared to the levels when the waiver was in place; however, other additional medical services offered to its members as a Social HMO have been reduced as well.

Professional Liability Insurance — The Company carries managed care errors and omissions liability coverage with limits of five million dollars per claim and five million dollars in aggregate in any one year. In the ordinary course of business, the Company is subject to the claims of its members arising out of treatment authorization decisions and other managed health care operations.

Regulatory Proceedings and Litigation — In the ordinary course of its business operations, the Company is subject to periodic reviews by various regulatory agencies with respect to the Company's compliance with a wide variety of rules and regulations applicable to its business, which may result in the assessment of regulatory fines or penalties. Additionally, the Company is also party to various legal actions arising in the normal course of business. These other regulatory and legal proceedings are subject to many uncertainties, and, given their complexity and scope, their final outcome cannot be predicted at this time. However, after taking into consideration legal counsel's evaluation of such legal and regulatory actions, and except as described in Note 14, management believes the outcome of these matters will not have a material adverse effect on the Company's Net Worth or Cash Flows.

Health Reform — On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act into law, and then, on March 30, 2010, President Obama signed into law the Health Care and Education Affordability Reconciliation Act of 2010 (collectively, "health insurance reform"). Health insurance reform provisions include limiting Medicare Advantage payment rates, mandatory issuance of insurance coverage, requirements that would limit the ability of health plans and insurers to vary premiums based on assessments of underlying risk, and stipulating annual rebates to enrollees if the amount of premium revenues expended on medical costs falls below prescribed ratios for group and individual health insurance coverage. The Company is evaluating the effect that health insurance reform may have on its financial position and currently expects that the health insurance reform provisions would reduce its premium rates and revenues beginning in calendar year 2012.

Guarantees and Indemnities — From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily relate to (i) certain real estate leases, under which the Company may be required to indemnify property owners for environmental or other liabilities and other claims arising from the Company's use of the applicable premises and (ii) certain agreements with the Company's officers, directors, and employees, under which the Company may be required to indemnify such persons for liabilities arising out of their employment relationship.

The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, obligation amounts under these contracts can not be reasonably estimated until a specific claim is asserted. No claims have been asserted as of December 31, 2011. Consequently, no liabilities have been recorded for these obligations on the Company's Report #1: - Liabilities and Net Worth.

12. INVESTIGATIONS AND EXAMINATIONS

Investigation — In March 2010, the Company received a subpoena for documents from the Office of Inspector General (the "OIG"), U.S. Department of Health and Human Services. The Company thereafter was notified of parallel investigations being conducted by the California Attorney General (criminal and civil) (the "Cal AG") and the United States Attorney's Office for the Central District of California (civil) (the "DOJ"). The parallel investigations focus on the Company's receipt of program funds under various contracts with CMS and the DHCS during the period 2001 to 2009. In particular, the parallel investigations focus on whether the Company was overpaid on any contract in place with CMS and DHCS during any of the years in question and whether any current or former Company employee knowingly sought to obtain money for the Company that the Company allegedly was not entitled to receive. In addition, OIG and DOJ are investigating whether the Company allegedly received excess payments from CMS by failing to submit proper HCC risk scores for certain beneficiaries.

The Company is cooperating with these investigations and has voluntarily produced records and made witnesses available for interview by investigators. The State and Federal investigations are ongoing.

Promptly after learning of the existence of the investigations, the SCAN Group Board of Directors appointed a special committee (the "Special Committee") consisting solely of independent directors to address issues arising out of the investigations. The Special Committee engaged independent counsel and outside forensic accountants to assist in conducting an internal investigation. To date, the Special Committee has not received any evidence suggesting intentional misconduct on the part of the Company or any of its current or former employees.

At the Board of Directors' direction, in October 2010, Independent counsel shared the evidence adduced as part of the independent investigation with investigators from the Cal AG, the OIG, and DOJ. In March 2011, Independent counsel made a separate presentation regarding the HCC risk score issue to Investigators from OIG and DOJ.

Notwithstanding the evidence adduced during the internal investigation, and the various defenses the Company could mount to any potential claims brought by the State and/or Federal government, in December 2010, the Company entered into global settlement negotiations with the State and Federal governments in an attempt to resolve any potential claims and to avoid the costs and uncertainty of litigation. The Company offered to pay $125 million to resolve any and all claims associated with the contracts at issue with CMS and DHCS. In December 2010, the Company recorded a provision of $125 million to accounts payable and accrued expenses liabilities to record the proposed settlement offer.

Settlement discussions are ongoing, and the Company cannot predict whether or when a settlement will occur or whether criminal or civil court proceedings might be initiated against the Company or any of its current or former employees or officers. The Cal AG and the DOJ have indicated that a counter-offer is forthcoming to resolve any and all civil claims but, to date, no counter has been received. The Company has entered into tolling agreements with both the Cal AG and the DOJ while settlement negotiations continue. It is reasonably possible that a change in the estimated liability may occur in subsequent periods to resolve this matter in amounts not currently determinable by the Company.

An adverse resolution of any of these investigations could have a material adverse effect on the Company's business, including substantial financial payments and potential exclusion from participation in State or Federal health care programs.

Examination — CMS has been performing Risk Adjustment Data Validation ("RADV") audits of selected MAO plans to validate provider coding practices under the risk adjustment model used to

calculate the premium paid for each MAO member. One of the Company's contracts in California, which serves Los Angeles, Orange, San Bernardino and Riverside counties, has been selected by CMS for audit for the 2007 contract year ("2007 RADV audit") as part of this broad CMS audit program. The Company is cooperating with the audit. This coding audit may result in prospective or retrospective adjustments to payments made to the Company pursuant to its CMS Medicare contract.

In December 2010, CMS published a proposed methodology for payment adjustments determined as a result of its various RADV audits, including its methods for sampling, payment error calculation, and extrapolation of the error rate across the relevant plan population. In January 2011, CMS announced that this draft methodology would be revised to reflect public comments. CMS has not disclosed a specific timetable for finalizing its RADV audit sampling and payment error calculation methodology.

Because the RADV audit methodology is not final and is subject to modification, there is significant uncertainty as to how CMS will determine payments adjustments to the Company arising out of the 2007 RADV audit. Accordingly, management cannot estimate the likelihood or amount of any possible financial impact that may result from the 2007 RADV audit and, therefore, has not recorded any related accruals. However, an adverse resolution of this audit, could, if substantial, have a material adverse effect on the Company's business and net assets.

* * * * * *

Appendix 3

Search Enforcement Actions \ Search Results

There are **2** enforcement actions that meet your search criteria.

Scan Health Plan

Org. Type	Action Date	Penalty
Health Plan	11/16/2009	--

Violation #	
1375.4	Failure to comply with Plan/RBO contractual requirements.
1300.75.4.5	Failure to have adequate procedures for review of Solvency Reg reports and to take appropriate action when RBOs fail to comply with the specified Regs.

Scan Health Plan

Org. Type	Action Date	Penalty
Health Plan	07/03/2008	--

Violation #	
1375.4	Failure to comply with Plan/RBO contractual requirements.
1300.75.4.5	Failure to have adequate procedures for review of Solvency Reg reports and to take appropriate action when RBOs fail to comply with the specified Regs.

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Appendix 4

DHCS Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

		2009		2010		2011	
MEASURE		DHCS H5425	DHCS H9104	DHCS H5425	DHCS H9104	DHCS H5425	DHCS H9104
	PBP						
Breast Cancer Screening - non SNP Measure						73.08%	76.17%
Colorectal Cancer Screening							
Glaucoma Screening in Older Adults		65.08%	72.80%	63.67%	75.79%		
Care for Older Adults - New for 2009 Rpt Yr							
	Advance Care Planning						
	Medication Review						
	Functional Status Assessment						
	Pain Screening						
Spirometry Testing for COPD							
Pharmacotherapy Mgmt of COPD Exacerbations							
Controlling Blood Pressure							
Persistence of BB Use After a Heart Attack		NA	NA	NA	NA	NA	NA
Osteoporosis Management After a Fracture							
Antidepressant Medication Mgmt							
Follow Up After Hospitalization							
Annual Monitoring for Patients of Persistent Medications (total)							
Medication Reconciliation Post Discharge							
Potentially Harmful Drug-Ds Interaction in the Elderly (total)							
Use of High Risk Medications in the Elderly							
	One Prescription						
	Two Prescriptions						
Board Certification							
	Family Medicine						
	Internal Medicine						
	Geriatrics						

DHCS Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

		2009		2010		2011	
MEASURE		DHCS H5425	DHCS H9104	DHCS H5425	DHCS H9104	DHCS H5425	DHCS H9104
	PBP						
	Other Specialties						
Plan All Cause Readmission Avg Adj Prob - new for 2011 Rept Yr							
Quality Improvement Projects for CA Dept Healthcare Services							
Stroke	Mortality Rates						
	All	**NR**	**8.66%**	**7.87%**	**7.94%**	**5.63%**	**7.20%**
	Cohort1 (hypertension+diabetes+dyslipidemia) Only	NR	7.69%	7.48%	7.12%	4.70%	6.21%
	Cohort2 Afib Only	NR	10.54%	NR	9.20%	NR	8.76%
	Cohort3 (hypertension+diabetes+dyslipidemia) +Afib	NR	10.83%	NR	10.99%	NR	10.61%
COPD	Spirometry and Bronchodilator						
	SPIROMETRY	NR	17.49%	NR	20.42%	27.14%	19.07%
	BRONCHO (PCE) - 30 Days	77.27%	60.44%	NR	66.52%	69.81%	68.26%
	BRONCHO (PCE) - 6 Months	84.09%	74.68%	NR	76.02%	92.45%	81.44%

California DHCS Selected Measure

SNP Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

		2009		2010					
MEASURE		H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP SB	H9104 DSNP LA	H9104 DSNP RV	H9104 DSNP SB
	PBP	10	11	10	11	12	6	8	9
Breast Cancer Screening - non SNP Measure									
Colorectal Cancer Screening		54.84%	NA	61.40%	43.33%	NA	NA	NA	NA
Glaucoma Screening in Older Adults		62.75%	NA	68.00%	51.22%	NA	83.95%	NA	NA
Care for Older Adults - New for 2009 Rpt Yr									
	Advance Care Planning	NR	NR	7.54%	8.72%	18.00%	15.47%	18.69%	18.75%
	Medication Review	NR	NR	48.42%	45.64%	48.67%	58.27%	52.34%	56.25%
	Functional Status Assessment	NR	NR	15.57%	22.56%	20.00%	42.09%	34.58%	48.44%
	Pain Screening	NR	NR	18.00%	23.08%	25.33%	27.70%	24.30%	42.19%
Spirometry Testing for COPD		NA	NA	NA	NA	NA	NA	NA	NA
Pharmacotherapy Mgmt of COPD Exacerbations		NA	NA	NA	NA	NA	NA	NA	NA
Controlling Blood Pressure		53.70%	NA	52.47%	51.19%	55.70%	57.26%	63.41%	63.33%
Persistence of BB Use After a Heart Attack		NA	NA	NA	NA	NA	NA	NA	NA
Osteoporosis Management After a Fracture		NA	NA	NA	NA	NA	NA	NA	NA
Antidepressant Medication Mgmt		NA	NA	NA	NA	NA	NA	NA	NA
Follow Up After Hospitalization		NA	NA	NA	NA	NA	NA	NA	NA
Annual Monitoring for Patients of Persistent Medications (total)		86.29%	NA	85.74%	86.72%	84.11%	92.89%	93.83%	100.00%
Medication Reconciliation Post Discharge		NR	NR	21.26%	14.29%	7.89%	23.38%	21.88%	NA
Potentially Harmful Drug-Ds Interaction in the Elderly (total)		NA	NA	NA	NA	NA	26.47%	NA	NA
Use of High Risk Medications in the Elderly									
	One Prescription	41.86%	36.36%	39.09%	32.32%	35.95%	49.10%	42.99%	49.23%
	Two Prescriptions	10.70%	4.55%	13.85%	9.60%	12.42%	15.77%	14.02%	21.54%
Board Certification									
	Family Medicine	NR	NR	NR	NR	NR	NR	NR	NR
	Internal Medicine	NR	NR	NR	NR	NR	NR	NR	NR
	Geriatrics	NR	NR	NR	NR	NR	NR	NR	NR

SNP Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

		2009		2010					
MEASURE		H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP SB	H9104 DSNP LA	H9104 DSNP RV	H9104 DSNP SB
	PBP	10	11	10	11	12	6	8	9
	Other Specialties	NR	NR	NR	NR	NR	NR	NR	NR
Plan All Cause Readmission Avg Adj Prob - new for 2011 Rept Yr									
Quality Improvement Projects for CA Dept Healthcare Services									
Stroke	Mortality Rates								
	All	**NR**	**NR**	**7.29%**	**9.68%**	**NR**	**7.82%**	**7.91%**	**7.79%**
	Cohort1 (hypertension+diabetes+dyslipidemia) Only	NR	NR	7.23%	8.00%	NR	6.93%	7.63%	6.78%
	Cohort2 Afib Only	NR	NR	NR	NR	NR	9.49%	8.36%	9.79%
	Cohort3 (hypertension+diabetes+dyslipidemia) +Afib	NR	NR	NR	NR	NR	11.11%	8.96%	12.39%
COPD	Spirometry and Bronchodilator								
	SPIROMETRY	NR	NR	NR	NR	NR	24.02%	13.65%	16.19%
	BRONCHO (PCE) - 30 Days	NR	NR	NR	NR	NR	69.61%	65.00%	NR
	BRONCHO (PCE) - 6 Months	NR	NR	NR	NR	NR	80.39%	70.00%	NR

SNP Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

MEASURE		2011		
		H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP SB
	PBP	10	11	12
Breast Cancer Screening - non SNP Measure				
Colorectal Cancer Screening		59.44%	56.12%	55.43%
Glaucoma Screening in Older Adults		72.97%	72.85%	74.67%
Care for Older Adults - New for 2009 Rpt Yr				
	Advance Care Planning	46.47%	51.09%	54.46%
	Medication Review	58.88%	67.15%	66.77%
	Functional Status Assessment	48.66%	58.15%	56.62%
	Pain Screening	24.09%	27.01%	29.54%
Spirometry Testing for COPD		NA	NA	NA
Pharmacotherapy Mgmt of COPD Exacerbations		NA	NA	NA
Controlling Blood Pressure		54.15%	62.50%	69.32%
Persistence of BB Use After a Heart Attack		NA	NA	NA
Osteoporosis Management After a Fracture		NA	NA	NA
Antidepressant Medication Mgmt		NA	NA	NA
Follow Up After Hospitalization		NA	NA	NA
Annual Monitoring for Patients of Persistent Medications (total)		92.69%	93.54%	93.63%
Medication Reconciliation Post Discharge		25.31%	27.37%	22.95%
Potentially Harmful Drug-Ds Interaction in the Elderly (total)		34.00%	NA	NA
Use of High Risk Medications in the Elderly				
	One Prescription	35.45%	34.43%	41.28%
	Two Prescriptions	11.42%	8.96%	14.68%
Board Certification				
	Family Medicine	NR	NR	NR
	Internal Medicine	NR	NR	NR
	Geriatrics	NR	NR	NR

SNP Quality Performance Indicators including HEDIS
for SCAN Health Plan's senior members

		2011		
MEASURE		H5425 DSNP LA	H5425 DSNP RV	H5425 DSNP SB
	PBP	10	11	12
	Other Specialties	NR	NR	NR
Plan All Cause Readmission Avg Adj Prob - new for 2011 Rept Yr		14.45%	14.12%	19.55%
Quality Improvement Projects for CA Dept Healthcare Service				
Stroke	Mortality Rates			
	All	**5.37%**	**4.84%**	**7.84%**
	Cohort1 (hypertension+diabetes+dyslipidemia) Only	4.81%	3.92%	5.13%
	Cohort2 Afib Only	NR	NR	NR
	Cohort3 (hypertension+diabetes+dyslipidemia) +Afib	NR	NR	NR
COPD	Spirometry and Bronchodilator			
	SPIROMETRY	27.14%	NR	NR
	BRONCHO (PCE) - 30 Days	NR	NR	NR
	BRONCHO (PCE) - 6 Months	NR	NR	NR

Appendix 5

Response to Mandatory Qualifications #12

SCAN Health Plan meets the following three of five criteria for demonstrating local stakeholder involvement:

The Applicant has provided at least 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.

Letters from agencies are included in appendix #8.

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.

SCAN Health Plan approached the design and development of this Application through the development of the Member and Community Advisory Committee. Our inaugural meeting took place October 2011. During this meeting, committee members collaborated to establish a committee charter and mission statement as well as review SCAN's submission regarding the DHCS request for comment on draft frameworks. The Committee also met via conference call in January to discuss SCAN's response to the Draft RFS and proposal to submit a response to CMS regarding the CCMI Challenge Grant, included in Section 9. The group met again in person on January 27, 2012 to further discuss these initiatives and provide suggestions which SCAN has included in the final conceptualizing of this proposal.

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

SCAN Health Plan currently has several ways in which stakeholders are engaged to provide input regarding benefits and future planning for enhancing the model of care. Section 5.4 of the RFS details current and future engagement. This includes:

- SCAN developed a stakeholder engagement strategy in preparation for the 2012 annual election period. Stakeholders participating in these discussions include dual eligible members, family/caregivers, community agencies, contractors, LTSS providers, and contracted medical and behavioral health providers. Planning and preparation for this state contract have been taking place since 2011. As part of this process, SCAN has communicated with several health plans to assess their capabilities to serve dually eligible aged and disabled members and whether a partnership might be feasible. We have also reached out to all the MSSP providers in each county in which SCAN is applying for the Demonstration to discuss coordination of the LTSS benefit.

- SCAN has also sought input from our members in these discussions. In addition to engaging our Community Advisory Committee and conducting member forums (described below), SCAN is convening focus groups of FFS dual eligibles. These groups will play an integral role in gauging beneficiary preferences regarding the network and

location of providers, determining which benefits this population believes are most important, customer service, and preferred communication methods.

- SCAN intends to employ our regular means of stakeholder engagement, which have proven effective in assessing members' needs and preferences:

Community Advisory Committee: The Community Advisory Committee is comprised of dual eligible members and one provider from SCAN's in-home and community-based services network. The Committee meets quarterly, with two meetings held in English, and two meetings held in Spanish. Members play an integral role in developing and improving upon different programs. For example, the Committee is often asked to review articles and brochures for readability, clarity of message, and appearance. In another meeting, member feedback was solicited on how SCAN could improve quality by assuring that members get necessary tests and screenings. When SCAN rolled out our Care Transitions program—which assists members in successfully transferring from hospital to home or from hospital to skilled nursing facility—Committee members provided important suggestions about how to explain and present the program.

Senior Advisory Committee: The Senior Advisory Committee, also composed of SCAN members, includes both Medicare-only members and dual eligible members, and a contracted provider. SCAN's CEO serves as an ex officio Committee member. Similar to the Community Advisory Committee, this Committee provides feedback on member needs, communication vehicles, programs, and benefits.

Member and Community Advisory Committee: In 2011, SCAN convened a Member and Community Advisory Committee to strengthen, monitor, and improve care coordination as this new system of care is launched. This group has strategic representation from diverse constituency areas, including mental health, community services, long-term care, caregiver services, and cultural needs. Area Agencies on Aging, dual eligible members and family members are also represented on the board and participate in these discussions. Going forward, the Committee will be expanded to include substance use services, independent living center services, CBAS centers, and additional health plan members and consumers.

Member Forums: Each fall, SCAN executives travel throughout SCAN's service area to meet with members, their caregivers, and potential members at "Straight Talk" events. During these meetings, the executives explain new benefits, provide attendees with an understanding of the direction of the organization, and answer questions. Straight Talks serve as an important forum for SCAN to better understand members' needs, and for members to ask any questions about SCAN or about their health care in general. In 2011, over 11,000 members attended a total of 29 sessions, hosted in 21 locations in 9 counties in California and Arizona.

Another example of meaningfully seeking community input has occurred in San Diego. SCAN is a member of the Duals Demonstration Stakeholder Advisory Committee organized by San Diego County's Healthy San Diego stakeholders and the Aging and Independent Services Department (AIS). The group held its first organizational meeting in February. The committee includes all of the San Diego County Managed Care plans responding to the RFS and all of the local LTSS providers. Also participating are consumer representatives including the Consumer Center for Health Education and Advocacy, County In-Home Supportive Services (IHSS),

County Behavioral Health Services, Program of All-Inclusive Care for the Elderly (PACE), Community Based Adult Services (CBAS), Senior Alliance, United Domestic Workers (UDW), Hospital Association of San Diego and Imperial County, Community Clinics, AIS Aging Services (ADRC), a SNF representative, at least three dual eligible beneficiaries, the San Diego Regional Center, Access to Independence, and the IHSS Public Authority. In counties where similar county-inspired stakeholder involvement groups are available, SCAN will be an active and willing participant. In counties where this structure does not exist, we will create county specific Advisory Committees following our Advisory Committee model.

SCAN Health Plan

MEMBER/COMMUNITY ADVISORY COMMITTEE

CHARTER

October 21, 2011

Introduction

SCAN Health Plan (SCAN) will establish and maintain a Member/Community Advisory Committee (Committee) to support SCAN's mission to continue to find innovative ways to enhance seniors' and disabled individuals' ability to manage their health and to control where and how they live. The Committee will provide insight and feedback on issues that affect those served by SCAN, with the dual objectives of improving SCAN's delivery of care to its members and increasing awareness of SCAN in the community.

Section I: Committee Roles and Objectives

The Member/Community Advisory Committee will serve in an advisory capacity and provide insight and feedback to SCAN regarding public policy, SCAN programs and community issues, and promote a collaborative effort to enhance healthcare services delivered to SCAN members. Key objectives may include, but are not limited to:

A. Discuss public policy including proposed federal/state/local legislative/regulatory changes and provide insight and feedback with respect to the effect of such policy and changes on SCAN members for the purpose of informing SCAN leadership regarding planning considerations.
B. Review and provide comments regarding ongoing and/or proposed Community Outreach activities to ensure that community needs are being addressed.
C. Bring current topics and issues from the Committee members' respective areas of expertise to the Committee for discussion to facilitate planning by SCAN to meet current and emerging member needs.
D. Review and provide comments regarding SCAN member communication materials, education, and assessment methods.
E. Recruit additional members for the Committee from constituencies/stakeholders that are not then represented (e.g., nursing facility, alternative residential setting, and behavioral health services).

One Committee meeting will be held each calendar quarter.

Section II: Committee Composition and Membership

Once fully established, the Committee will have fourteen (14) members. The Committee will select members from various constituency/stakeholder groups and/or service/setting types so as to reflect the diversity and complexity of those served by SCAN. Those constituencies are as follows:

- City/County Social Services
- Mental Health
- Disability Services/Independent Living
- Long-term Care
- Caregivers
- Community Services
- Cultural Needs

- SCAN Health Plan Member (3)
- SCAN Health Plan Family Member (2)
- Member At Large (2)

All committee members will serve a two (2) year term with term limit of two (2) consecutive terms with the exception of Mental Health and City/County Social Services positions which members, once appointed, may be reappointed to unlimited two (2) year terms at the discretion of the SCAN Health Plan Chief Executive Officer. Positions as members of the Committee will be offered by SCAN Health Plan through appointment by the SCAN Health Plan Chief Executive Officer except with respect to seats held by a SCAN Health Plan Member (3), SCAN Health Plan Family Member (2) and Member at Large (2) which may be determined through an appointment or application process, at the discretion of SCAN Health Plan.

All members of the Committee must satisfy the following minimum criteria:

- Work or reside in Los Angeles County.
- Able to serve a two year term.

Section III: Committee Functions

Leadership: The Committee will have a Committee Chair who will be elected by the members. The Committee Chair will facilitate Committee meetings. The Committee Chair will also work together with representatives of SCAN Health Plan, as designated by the SCAN Health Plan Chief Executive Officer, to set each meeting's agenda. The term of the Committee Chair as Chair will be one year with the option of re-election with a term limit of two (2) consecutive terms.

Compensation: Participation in the Committee is voluntary. SCAN Members who have difficulty attending the meeting due to lack of transportation, may be offered transportation assistance so as to facilitate their participation on the Committee.

Resignations/Vacancies: In the event of resignations or vacancies, the SCAN Health Plan Chief Executive Officer or his designee will work with the Committee and identify candidates to invite for appointed positions or will begin an open application process.

Section IV: Meeting Schedule and Process

The Committee will meet four times per year, once each calendar quarter. These meetings will be set at the beginning of each year and this schedule will be made public. All meetings will be in person at the SCAN Health Plan's corporate office in Long Beach, California. The Committee Chair will facilitate the meeting and all discussions.

Designated SCAN Health Plan staff will be present at each meeting to:

- Present an update regarding SCAN Health Plan
- Answer questions as needed.
- Be responsible for relaying information to other SCAN Health Plan staff/departments.
- Report on any follow up.

Appendix 6

SCAN Health Plan History of Corrective Action Plans in last five years

In 2009, the DHCS Audits and Investigations Division (A & I) conducted a medical review for the audit period February 1, 2008 through January 31, 2009. Certain deficiencies were identified within the following areas: Utilization Management, Continuity of Care, Availability and Accessibility, Member's Rights, and Administrative and Organizational Capacity. The Plan's corrective action was accepted and closed out by DHCS in 2010.

In 2010, the DHCS conducted a Nursing Facility Level of Care (NFLOC) review for the audit period March 1, 2010 through May 31, 2010. The audit was conducted over the course of three separate visits which occurred at SCAN offices on the following days: September 28, 2010 through September 29, 2010; September 13, 2011 through September 15, 2011, and October 25, 2011 through October 27, 2011. A fourth and final review occurred at DHCS offices on November 4, 2011. Deficiencies were identified within the following areas: capitation recovery, DHCS Pre-approval of all Initial NFLOC Assessments, Annual Re-Certification of all Existing Members, and capitation rate setting. The Plan received the final audit report from DHCS on December 27, 2011. The Plan's corrective action is currently under development.

Appendix 7

NICK MACCHIONE, FACHE
DIRECTOR

DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

County of San Diego

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

February 8, 2012

Letter of Agreement to Work in Good Faith:

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

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

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

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

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

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

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

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

Sincerely,

NICK MACCHIONE, MS, MPH, FACHE
Director

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

PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
SAN DIEGO COUNTY

February 15, 2012

Letter of Agreement to Work in Good Faith:

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

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

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

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

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

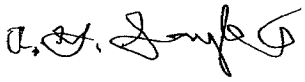
As the Executive Director of the IHSS Public Authority, I commit our organization to continue working in good faith with health plans to develop an integrated system of care for the dual eligibles in our community. We will coordinate our efforts with those of the County to ensure that we take a consistent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

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

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

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

Sincerely,



Albert G. "Bud" Sayles
Executive Director

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

LAURA TREJO
GENERAL MANAGER

CITY OF LOS ANGELES

CALIFORNIA

DEPARTMENT OF AGING
AN AREA AGENCY ON AGING
3580 WILSHIRE BLVD., STE. 300
LOS ANGELES, CA 90010
(213) 252-4000

ANTONIO R. VILLARAIGOSA
MAYOR

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,

The City of Los Angeles Department of Aging - *Area Agency on Aging* (LADOA) believes that greater care coordination for Medicare and Medicaid "dual eligible" seniors and disabled will help improve beneficiaries' quality of life and potentially yield savings. Dual eligible seniors have unique needs that can be best met by tested and experienced plans. LADOA is supportive of the State of California"s plan to partner with managed care plans that have demonstrated success in caring for dual eligibles, such as SCAN Health Plan. Serving Southern California seniors, SCAN Health Plan's model of care combines vital medical services with home and community-based services that help keep members/patients in their own homes and out of institutions.

The mission of the Los Angeles Department of Aging is to improve the quality of life, independence, health and dignity of the City's older population by managing community based senior programs that are comprehensive, coordinated and accessible. Serving the Nation's second largest concentration of persons sixty years and older, among the state's most diverse within a geographic area the size Boston, Cleveland, St. Louis, Pittsburgh, Minneapolis, Milwaukee, San Francisco, and Manhattan combined.

LADOA has a long standing partnership and is well acquainted with SCAN's commitment to California's seniors and adults with disabilities. Because of this, the Los Angeles Department of Aging supports their inclusion in California's Dual Eligibles Demonstration Program.

If you need any additional information, please do not hesitate to contact me.

Sincerely,

Laura Trejo, Manager
Los Angeles City Area Agency on Aging

LT:mn:z\SCAN plan ltr

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

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

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

Dear Mr. Douglas:

I am writing to express our commitment to collaborating with SCAN Health Plan if they are successful in their bid for California's Dual Eligible Demonstration Request for Solutions. 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 (DHS), Mental Health (DMH), Public Social Services (DPSS), which administers the In-Home Supportive Services (IHSS) program, and Community and Senior Services (CSS), which includes the Area Agency on Aging.

We understand that the goal of the Dual Eligible Demonstration is to develop a model which provides greater care coordination for Medicare and Medicaid "dual eligible" seniors and disabled that will help improve beneficiaries' quality of life and potentially yield savings. Dual eligible seniors have specific needs that can only be met by tested and experienced plans. The best way to approach success in each county is through collaboration. As a current contractor with CSS, SCAN currently administers the Older American Act, Title IIIB and IIIE programs, as well as Los Angeles County's Linkages Program demonstrating home and community-based experience that has been vital to our County.

In addition to collaboration by CSS, the participation by DHS, DMH and DPSS will ensure that the medical, mental health, and supportive services provided by those respective agencies will be appropriately integrated into the planned implementation of the SCAN proposal for integrated services to the Dual Eligible population.

Through CSS involvement with SCAN, we are well acquainted with their s commitment to California's seniors and disabled individuals. Because of this, we look forward to collaboration if they are selected as a California's Dual Eligibles Demonstration Program.

If you have any questions regarding this letter of support, please contact Sheila Shima, at (213) 974-1160 or at sshima@ceo.lacounty.gov.

Sincerely,

WILLIAM T FUJIOKA
Chief Executive Officer

WTF:SAS:hd

022112_HMHS_LosAngelesCountyLetterScan_L

Appendix 8

www.alz.org/californiasouthland

California Southland Chapter
Los Angeles Office
5900 Wilshire Blvd., Ste. 1100
Los Angeles, CA 90036

24/7 Helpline: (800) 272-3900
323 938 3379 **p**
323 938 1036 **f**

alzheimer's association®

February 13, 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,

As the state of California seeks to enhance the care coordination provided to Medicare and Medicaid "dual eligible" seniors through enrollment in managed care plans, SCAN Health Plan's distinguished record and commitment to California's disabled and seniors make it an exemplary candidate. The Alzheimer's Association, California Southland Chapter currently serves on SCAN's Member & Community Advisory Committee and is the Caregiver Services Representative. Our participation on this Committee, as well as our cooperation with SCAN on case management, community outreach, and educational projects, give us a unique insight into how SCAN's involvement in the demonstration program could benefit dual eligibles and potentially yield savings.

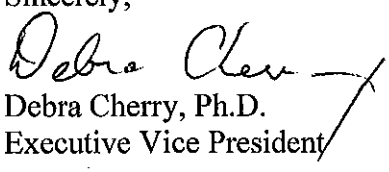
SCAN Health Plan plays a critical role in caring for Californians living with Alzheimer's disease. Its model of care extends far beyond medical coverage and encompasses vital home and community-based services that help both patients and their caregivers. SCAN's broad-based services recognize that individuals living with Alzheimer's span the continuum, with some patients needing only periodic services while others require intensive and constant care. We are deeply gratified by SCAN's commitment to helping seniors live with independence and dignity in their local communities and are very pleased to offer our unconditional support for SCAN Health Plan's inclusion in California's Dual Eligibles Demonstration Program.

The California Southland chapter of the Alzheimer's Association serves people with dementia, their family caregivers, and professionals in Los Angeles, Riverside, and San Bernardino Counties. Some of our key programs designed for family caregivers are: the website at www.alz.org/californiasouthland, with educational materials in both English and Spanish; the 24/7 telephone information and referral service known as Helpline; professional care consultants who assist caregivers by providing support, counseling and help connecting with needed services; caregiver and community education programs offered in a variety of languages and locations and to many different audiences; over 140 affiliated support groups conducted in five languages; the Medic Alert+Safe Return identification program for individuals with memory loss; ComfortZone™ a GPS-based program for patients at-risk for wandering; and community

service development projects that targets under-served communities. Over 2,000 professionals access our programs for training on Alzheimer's disease and its care each year.

SCAN Health Plan's experience providing a range of services for seniors make them an excellent candidate for your California's Dual Eligibles Demonstration Program. If you have any questions regarding this letter of support, feel free to contact me at 323-930-6225 or debra.cherry@alz.org.

Sincerely,



Debra Cherry, Ph.D.
Executive Vice President

WISE & Healthy Aging

February 15, 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,

WISE & Healthy Aging highly recommends SCAN's participation in California's Dual Eligibles Demonstration Program as they have evidenced their ability to provide an array of services that allow seniors to remain independent in their homes and communities.

As California prepares to shift Medicare and Medicaid "dual eligibles" into managed care plans, WISE & Healthy Aging urges the State to partner with health plans with a documented record of success in California. One such plan is SCAN Health Plan, which has served Southern Californians since 1977. Its model of care provides seniors with a full menu of valued services, including medical, home, and community-based services. Taken together, these services allow individuals to continue to lead vibrant lives in their local communities and stay out of nursing homes, if possible. As a Member of SCAN's Member & Community Advisory Board and the Long-Term Care Representative, WISE & Healthy Aging has seen first-hand that SCAN's model of care is well-suited to meet the aims of the demonstration project. We are very supportive of SCAN's application and look forward to their involvement in California's Dual Eligibles Demonstration Program.

With a 43-year history of serving the seniors in Los Angeles County, WISE & Healthy Aging understands the needs of older adults and their families, and is committed to working with colleagues such as SCAN to build a stronger network of support services to meet the needs of our communities.

Should you have any questions regarding this letter of support, do not hesitate to contact me at (310) 394-9871, ext. 440 or at gchengbraun@wiseandhealthyaging.org.

Sincerely,

Grace Cheng Braun
President and CEO

1527 4th Street, 2nd Floor Santa Monica, CA 90401 310.394.9871 Fax 310.395.0863
www.wiseandhealthyaging.org

SBSS
St. Barnabas Senior Services
Live Well • Feel Well • Age Well

February 10, 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,

St. Barnabas Senior Services supports providing California's low-income and disabled seniors with greater care coordination through well-designed, patient-centered managed care plans. As a Member of SCAN's Member & Community Advisory Committee, we have an understanding and appreciation for SCAN's model of care.

For more than three decades, SCAN Health Plan has worked collaboratively with community-based organizations such as St. Barnabas to strengthen the safety net for Southern California's most vulnerable populations. Such efforts include community outreach and educational projects for low-income populations. We also recently partnered with SCAN to coordinate services for disabled adults and seniors transitioning from Adult Day Health Centers to Community-Based Adult Services.

SCAN's model of care overlays comprehensive medical care with home and community-based services that allow seniors to remain in their local communities and out of institutional settings. Assistance with activities that fully functioning adults may take for granted – including bathing, meal preparation, and household chores – can mean the difference for some seniors between living independently or moving to an institution. Given SCAN's impressive track record in California, St. Barnabas Senior Services strongly supports SCAN's application to participate in California's Dual Eligibles Demonstration Program.

675 S. Carondelet Street Los Angeles • California 90057-3309
telephone (213) 388-4444 fax (213) 739-2972

St. Barnabas Senior Services (SBSS) is a dynamic nonsectarian senior service agency that believes older adults have the right to age with dignity. For over 100 years, they have been serving aging and impoverished people residing in Los Angeles. Their comprehensive nutritional, medical, and social services programs promote healthy aging, prolong independence, and enhance dignity for over 8,000 seniors annually. Typically, SBSS clients are in their mid-70s, live alone, depend on Social Security of $800 monthly, have few relatives or friends to provide assistance, and speak minimal English. As a model agency widely recognized for their innovative programs, SBSS is making positive impactful change in the life of vulnerable seniors, and continues to be a leader in health services of high integrity and value in Los Angeles.

I strongly support SCAN's participation in California's Dual Eligibles Demonstration Program as their proven ability to provide comprehensive medical care and community-based services has allowed seniors to remain independent in their homes. With any questions regarding this letter of support, please contact me at 213.388.4444 ext. 220 or at RSaborio@sbssla.org.

Sincerely,

Rigo Saborio
President and CEO
St. Barnabas Senior Services

Heritage Clinic

447 N. El Molino Ave.
Pasadena, CA 91101
(626) 577 - 8480
Fax (626) 577- 8978

301 N. Prairie Ave.
Suite 612
Inglewood, CA 90301
(310) 673-8402
Fax (310) 673-8407

155 N. Occidental Blvd.
Suite 243
Los Angeles, CA 90026
(213) 382-4400
Fax (213) 382-4494

1037 West Avenue N
Suite 205
Palmdale, CA 93551
(661) 575-9365
Fax (661) 575-9502

1940 Market Street
San Diego, CA 92102
(619) 233-3381
Fax (619) 236-8240

6160 Mission Gorge Rd.
Suite 120
San Diego, CA 92120
(619) 282-2232
Fax (619) 282-2992

200 E. Washington Ave.
Escondido, CA 92025
(760) 737-8642
Fax (760) 737-8918

The Community Assistance
Program for Seniors
Alzheimer's Day Care Centers

3740 E. Sierra Madre Blvd.
Pasadena, CA 91107
(626) 351-5427
Fax (626) 351-2308

520 South Lark Ellen Ave.
West Covina, CA 91791
(626) 917-4484
Fax (626) 917-4475

Website
www.centerforagingresources.org

The Center for Aging Resources

February 15, 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,

Heritage Clinic, the mental health division of The Center for Aging Resources, supports the state of California's efforts to advance care coordination to better meet the complex needs of older and disabled adults who are dually eligible for Medicare and Medicaid.

For more than 30 years, Heritage Clinic, based in Los Angeles County, has provided mental health services to diverse older adults with limited resources. Based on its substantial experience with elders who experience symptoms of mental illness, often complicated by chronic factors such as diabetes, pain, substance abuse and dementia, Heritage Clinic believes it is critical that the state partner with managed care plans that have demonstrated experience in working alongside elders whose needs are complex, such as dually eligible older adults. The SCAN Health Plan is one such plan.

In addition to partnering with SCAN's Independence at Home division to coordinate elders' care management and mental health services in Los Angeles and San Diego Counties, Heritage Clinic also partners with SCAN as a member of its Member and Community Advisory Committee. Through these partnerships with SCAN, Heritage Clinic has found SCAN's model of care to be collaborative and responsive in providing thousands of seniors with much-needed medical care and essential home- and community-based services, services that are key to keeping seniors in their own homes and communities and out of institutions. As a step toward California successfully increasing care coordination for dually eligible elders, Heritage Clinic strongly supports the inclusion of SCAN Health Plan in California's Dual Eligibles Demonstration Program.

As a private nonprofit agency that provides public mental health services for older adults in Los Angeles and San Diego Counties, The Center for Aging Resources' Heritage Clinic values SCAN Health Plan's geriatric-focused, innovative and collaborative approach. The SCAN Health Plan's approach complements Heritage Clinic's in-home delivery of the following mental health services: psychotherapy, clinical rehabilitative services, and

outreach and engagement; care coordination; psychiatric assessment and prescriptions for medication; psychological assessment and assessment of clinical capacities (to inform decisions such as representative payee and daily money management); group therapy and support groups; peer support; community outreach and education; and professional training activities and education. In addition, SCAN Health Plan's demonstrated history of serving culturally and economically diverse older and disabled adults with personalized home- and community-based services (e.g., Independence at Home, Multi-purpose Senior Service Project [MSSP]) fits well with Heritage Clinic's long-standing commitment to assist elders with symptoms of mental illness to overcome barriers (e.g., economic, cultural, physical, cognitive, emotional) to services. In Los Angeles County, Heritage Clinic's clientele is comprised of diverse elders (e.g., Caucasian, 34%; Latino, 31%; African American, 17% and Asian, 2%), of whom more than 75 percent have low incomes.

As Chief Executive Officer of Heritage Clinic, I am pleased to strongly recommend SCAN Health Plan's participation in California's Dual Eligibles Demonstration Program. The SCAN Health Plan's breadth of knowledge addressing the complex needs of older and disabled adults, and demonstrated history of community partnerships, qualify SCAN for inclusion in the program. If I may provide additional information, please contact me at 626-577-8480, extension 119, or at vkelartinian@heritageclinic.org.

Sincerely,

Vatche Kelartinian, MBA
Chief Executive Officer
The Center for Aging Resources

MEXICAN AMERICAN OPPORTUNITY FOUNDATION
Senior Services Program
972 S. Goodrich Blvd. • City of Commerce, CA 90022
(323) 890-1555 • Fax (323) 890-1648

February 15, 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,

The Mexican American Opportunity Foundation believes that all Californians deserve access to high-quality, affordable health care. For Medicare and Medicaid "dual eligible" seniors and disabled, it is critical that the State ensure that participating plans have the experience and cultural sensitivity to serve all Californians, including the Latino community.

We believe that SCAN Health Plan should be included in California's Dual Eligibles Demonstration Program. As a Member of SCAN's Member & Community Advisory Committee and, specifically, the Committee's Cultural Needs Representative, the Mexican American Opportunity Foundation knows that SCAN's model of care serves the needs of elderly and disabled Latinos very well. SCAN provides not only much-needed medical care, but also important home and community-based services that help seniors stay in their own homes or with their families and not be forced into an institution. Such services include SCAN's "Classroom in the Community", a health education program tailored to help seniors control and improve their health. The Mexican American Opportunity Foundation has partnered with SCAN to bring this program to Spanish-speaking low income areas of Los Angeles County with hopes of better addressing the health needs of the Latino community. These services are critical to Latinos as they help individuals stay healthy and keep families intact. All seniors and disabled individuals deserve a caring and

compassionate health care system and that is what SCAN Health Plan helps to advance.

The Mexican American Opportunity Foundation (MAOF) is a non-profit, community based organization that was established in 1963 in order to serve disadvantaged individuals and families in the Los Angeles area. MAOF is the largest Latino-oriented, family service organization in the United States, and has achieved this status by providing high quality social services and programs to those communities where the need is greatest.

MAOF service programs include, but are not limited to: Senior and disabled services (Handyworker, Home Secure, Senior Hispanic Information and Assistance Services), Family Caregiver Support Services, Child Care and Development Programs, Child Care Centers, state preschools, Head Start Centers and a network of child care providers Resource and Referrals, a Food Bank, Financial Literacy and computer literacy education.

I strongly support SCAN Health Plan's participation in California's Dual Eligibles Demonstration Program as their comprehensive services have helped seniors remain healthy in their homes and communities. With any questions regarding this letter of support, please contact me at (323) 313-1605 or at ejimenez@maof.org.

Sincerely,

Elizabeth Jimenez
Program Director
Mexican American Opportunity Foundation (MAOF)

HSA
Human Services Association

6800 Florence Ave.
Bell Gardens, CA 90201

Where Caring Becomes Doing

Tel (562) 806.5400
Fax (562) 806.5394
www.hsala.org
agency@hsala.org

February 15, 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,

As California works to increase the quality of care provided to Medicare and Medicaid "dual eligibles" through better care coordination, the Human Services Association is pleased to support SCAN Health Plan's proposal to participate in the demonstration program. The success of this demonstration project rests with health plans that have the demonstrated expertise to care for complex populations such as duals and to work with a wide range of community-based organizations.

Through my role as MSSP Site Director, I have seen first hand how expert care coordination and medical care can promote home and community based living for our most frail and vulnerable seniors. SCAN's model of care spans the continuum and provides not only medical care, but essential home and community-based services that allow individuals to live independently within their communities.

Human Services Association has been providing comprehensive home and community based services for over 40 years. HSA's services span the aging spectrum and provide meals at senior centers, meals at home, care management, home based care, Alzheimer's Day Care, caregiver services, and general advocacy. We are proud to partner with SCAN as we share a vision to provide quality long term support services for vulnerable senior citizens.

SCAN Health Plan experience providing an adequate range of services for seniors make them an excellent candidate for your California's Dual Eligibles Demonstration Program. I strongly support their inclusion in the program and am eager to partner with

HSA
Human Services Association

6800 Florence Ave.
Bell Gardens, CA 90201

Where Caring Becomes Doing

Tel (562) 806.5400
Fax (562) 806.5394
www.hsala.org
agency@hsala.org

them to help improve the net for the Los Angeles-area's frail and vulnerable seniors. With any questions regarding this letter of support, please contact me at 562-806-5400, or at Darren.dunaway@hsala.org.

Sincerely,

Darren Dunaway
Associate Director
Multipurpose Senior Services Program (MSSP)
Human Services Association

Huntington Hospital

Huntington Memorial Hospital
100 W. California Boulevard
P.O. Box 7013
Pasadena, California 91109-7013
(626) 397-3241

Jane Haderlein
Senior Vice President
Development and Public Affairs

February 15, 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:

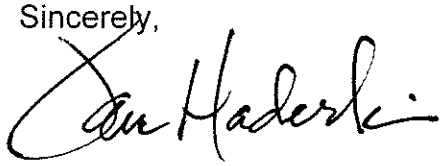
As California seeks better care coordination for Medicare and Medicaid "dual eligibles" through its new demonstration project, Huntington Hospital Senior Care Network urges that you ensure contracts are awarded to proven, experienced health plans. With that in mind, and given the challenges in caring for dual eligibles, we are pleased to support SCAN Health Plan's application to be selected as a demonstration health plan provider.

Huntington Hospital Senior Care Network (HSCN) provides an array of home and community based services for adults and older adults in the San Gabriel Valley of Los Angeles County. Since our beginning nearly 30 years ago, HSCN has gained experience and a strong reputation as a leader in providing home and community-based services including care management/care coordination, care transitions, community resource information, health education, caregiver supports and services and comprehensive geriatric assessment services.

Our team of social work and nursing professionals works closely with patients and their families, health care providers, community agencies, and staff of our own and other area hospitals in fulfilling our mission to maximize wellness and independence. We have many years experience as a Medi-Cal HCBS waiver provider of both the MSSP (site 16) and Assisted Living Waiver services.

SCAN's model of care shares the same vision and goals as our organization, as well as the demonstration project; we look forward to partnering with them to improve the access to high quality care integrated health and long term services and supports for California's population of dual eligibles. Feel free to call me with any questions you may have regarding this letter of support or you may contact Eileen Koons, Director of Senior Care Network, at (626) 397-2011.

Sincerely,



JANE HADERLEIN
Senior Vice President

C: Chris Wing, Chief Executive Officer, SCAN Health Plan
Timothy Schwab, Chief Medical Officer, SCAN Health Plan
Eileen Koons, Director, Senior Care Network

JEWISH FAMILY SERVICE OF LOS ANGELES

A family of services.
A family that serves.

February 16, 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 SCAN Health Plan's participation in California's Dual Eligibles Demonstration Program. SCAN's mission and the program's stated goals are well-aligned. SCAN's participation will help ensure the demonstration's success by improving care coordination for California's frail and vulnerable populations.

Jewish Family Service of Los Angeles is a non-sectarian organization that has a long and continuous history of providing services to families and individuals in need. Since its inception in 1854, the agency has evolved into a multi-faceted, multi-service organization. Our mission is to strengthen and enhance individual, family, and community life by providing a wide range of services at every stage of the life cycle, especially to those who are poor and disadvantaged.

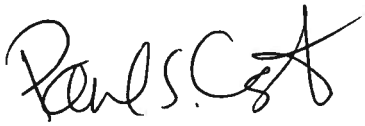
JFS was one of the original pilot sites for the groundbreaking Multipurpose Senior Services Program (MSSP) which provides comprehensive, professional nursing, social work, and clinically driven direct services to the frailest elderly so they may remain safely at home. Through a statewide network of providers, 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 over three decades, SCAN Health Plan has played a key role in helping to strengthen the safety net for Southern California's seniors and disabled. Working with frail and homebound seniors as an MSSP Site has allowed us to see the vital role expert care coordination plays in helping seniors live safely and with dignity in their own homes. With a model of care focused on meeting the individual's comprehensive needs – not only medical, but also vital home and community-based services – SCAN will help individuals live independently within their local communities.

Phone: 323.761.8800 | Fax: 323.761.8801 | 3580 Wilshire Blvd. Ste. 700 | Los Angeles, California 90010 | www.jfsla.org
Jewish Family Service is a beneficiary of The Jewish Federation of Greater Los Angeles

SCAN's approach has helped seniors live richer and fuller lives with the quiet dignity that all individuals deserve, especially in the twilight of their lives. We are hopeful that SCAN will be selected to participate and look forward to partnering with them in California's Dual Eligibles Demonstration Program. If you have any question regarding this letter of support, please contact me at 323-761-8800 and pscastro@jfsla.org.

Sincerely,



Paul S. Castro
Chief Executive Officer

February 20, 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,

The Partners in Care Foundation support the SCAN Health Plan playing an important role in California's Dual-Eligibles Demonstration Program. With more than three decades of experience providing medical and care coordination services for Southern California's seniors, SCAN Health Plan brings a unique depth of experience to caring for dual-eligibles. Their proven commitment to meeting the comprehensive needs of seniors includes medical and behavioral care as well as important personal care services like assistance with bathing, cooking, and cleaning.

As the provider of three MSSP Sites, I understand well the role proper care coordination can play in fostering independent living and preventing the inappropriate placement of older adults in nursing facilities. SCAN's model of care fits MSSP's purpose well as it combines comprehensive medical services with home and community-based care that enable seniors to live safely in their own homes.

We have two sites in Los Angeles County – covering from Long Beach north to the northern boundary of the County, and up through Antelope Valley. We operate a third site in Kern County. Our populations are very diverse and very frail. We are the largest provider of MSSP services in California, customizing care to a wide range of specific local communities and needs.

I strongly support SCAN's participation in California's Dual Eligibles Demonstration Program and look forward to partnering with them to help strengthen the safety net for our most frail and vulnerable seniors. If you have any questions regarding this letter of support, please contact me at (818) 837-3775 or my email: jsimmons@picf.org.

Sincerely,

W. June Simmons, CEO

University of Colorado
Anschutz Medical Campus

February 14, 2012

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

Re: SCAN Health Plan Response to California's Dual Eligible Demonstration Request for Solutions

Dear Mr. Douglas,

I am pleased to offer my perspective about SCAN Health Plan's application to participate in California's Dual Eligibles Demonstration Program. Better care coordination of California's Medicare and Medicaid "dual eligibles" is a worthy public policy goal and one that should be advanced only with capable and expert partners. SCAN Health Plan would be one such partner.

As the founding director of the Care Transitions Program and the developer of our evidence-based Care Transitions Intervention, I have worked with SCAN for nearly a decade to help adapt and tailor this model to meet the complex care needs of its patient population. SCAN has proven to be a very innovative and dedicated organization seeking to help address patient care at every point on the health care continuum. SCAN's implementation of both the Care Transitions Intervention and its own model of care have provided better care coordination for its seniors, their family caregivers, and clinicians. In turn, these tools have enabled SCAN's enrollees to live independently within their local communities and help avoid costly institutional care. SCAN's model of care complements the demonstration's goals and I am enthusiastic about their participation.

I would be more than willing to further elaborate on SCAN's commitment and innovation and hope you will favorably evaluate this application.

Respectfully,

Eric A. Coleman, MD, MPH
Professor of Medicine
Head, Division of Health Care Policy and Research
Director, Care Transitions Program
Eric.Coleman@ucdenver.edu

THE FLORIDA STATE UNIVERSITY
College of Medicine
Department of Geriatrics
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Web Site: http://www.med.fsu.edu/geriatrics

2/22/2012

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

Regarding: SCAN Health Plan Response to California's Dual Eligible Demonstration Request for Solutions

Dear Mr. Douglas,

As a physician specializing in geriatrics, and a former president of the American Geriatric Society, I am pleased to share my thoughts about SCAN Health Plan's application to participate in California's Dual Eligibles Demonstration Program. I have been a member of the Geriatric Advisory Board for SCAN for nearly ten years and have assisted them in using motivational interviewing to help their members think about advance care planning, including end-of-life care.

I believe that SCAN would be an ideal partner for the demonstration program. With more than three decades of service to seniors in Southern California, SCAN has the requisite expertise to care for complex and vulnerable populations. I have been very impressed by SCAN's commitment to quality and innovation. The American health care system does a fairly good job of providing acute care, but too often fails to address seniors' expectations about chronic and long-term care and especially in end-of-life care. SCAN's participation in the program would help seniors address these inevitable questions. Further, given SCAN's record of helping seniors live independently in their local communities, SCAN would be well positioned to address advance care planning in a home or community-based setting.

I urge you to consider their application positively and invite them to participate

Sincerely,

Karita Bonnel-Gal MD

Kenneth Brummel-Smith, MD, ABFP, AGSF
Charlotte Edwards Maguire Professor & Chair, Department of Geriatrics

JOHNS HOPKINS
UNIVERSITY

Bloomberg School of Public Health
Department of Health Policy and Management
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www.jhsph.edu/LipitzCenter

Guided Care

February 15, 2012

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

Regarding: SCAN Health Plan Response to California's Dual Eligible Demonstration Request for Solutions

Dear Toby,
As an expert in caring for seniors living with and managing chronic conditions, I have worked closely with SCAN Health Plan for nearly five years to help it design and implement effective health programs for this population. Based on my experience and given its record of performance, SCAN would be an ideal candidate for participation in California's Dual Eligibles Demonstration Program.

My care management program, Guided Care, is a nationally recognized leader in providing health plans and other providers with comprehensive care tools and techniques for managing chronically ill seniors. SCAN's staff has participated in our educational programs and has incorporated important lessons into their own care management programs. SCAN's model of care builds on these lessons by helping to address the comprehensive needs of vulnerable populations. In doing so, SCAN helps its members live independently within their own communities and enjoy fuller and richer lives with their loved ones. I have no doubt SCAN would be an outstanding partner for this demonstration project, and I encourage you to select SCAN for your demonstration program.

Sincerely,

Chad Boult, MD, MPH, MBA
Professor
Johns Hopkins Bloomberg School of Public Health

2/22/2012

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

Regarding: SCAN Health Plan Response to California's Dual Eligible Demonstration Request for Solutions

Dear Toby,

As California seeks to expand the coordinated care options available to Medicare and Medicaid "dual eligibles," SCAN Health Plan has the expertise to play a pivotal role in advancing the goals of the demonstration project. With a complex population such as the dual eligibles, it is essential that the project only select those plans with the experience and know-how to care for low-income, frail seniors.

As an outside expert advisor to SCAN, I have seen first-hand how SCAN's innovative model of care advances quality patient care, especially with the PACE program. SCAN has long incorporated evidence-based data into its programs and is open and willing to learning how new practices can work for its case management programs. After having worked with SCAN for nearly 10 years, I am confident that they would be an outstanding partner for the demonstration project and I urge their inclusion in the program.

Sincerely,

Cheryl Phillips, MD

Cheryl Phillips, M.D.
Senior VP Advocacy and Policy
LeadingAge
cphillips@leadingage.org

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February 15, 2012

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

Regarding: SCAN Health Plan Response to California's Dual Eligible Demonstration Request for Solutions

Dear Mr. Douglas:

I would like to offer my perspective on SCAN Health Plan's participation in California's Dual Eligibles Demonstration Program. As a physician with expertise in long-term care and aging issues who has advised SCAN for nearly ten years and who has studied care for dual eligibles for more than two decades, I am well positioned to offer guidance about SCAN's ability to serve California's dual eligibles. I strongly recommend SCAN Health Plan for approval in the Demonstration Program. They have a strong commitment to this area of care and a long record of creative and effective services for this population.

SCAN's participation in the program would benefit California's duals on multiple fronts. SCAN has a long history of case management, comprehensive geriatric assessment, and integration of home and community-based services and partnerships with community agencies. These integrated services meet the individual's needs across the care spectrum, well beyond just medical services. SCAN's model of care helps enable seniors to remain living in their own communities surrounded by loved ones and to avoid costly institutional care. By helping seniors to live with dignity, SCAN is fulfilling its mission and is poised to help the demonstration project succeed.

Sincerely,

Robert L. Kane, MD
Professor

Appendix 9

Comparison of SCAN Dual Eligibles versus California Fee-For-Service Dual Eligibles

Preliminary Results from a study by Avalere Health, February 2012 (1)

Patient Characteristic	SCAN Health Plan Duals	Medicare FFS Duals (CA only)
Total Sample	5,584	48,994
Dual Eligibility		
Duals Months 2009 & Dual Months 2010		
Zero Months & 1-6 Months	109	1,143
Zero Months & 7-12 Months	66	844
1-6 Months & 1-6 Months	14	385
1-6 Months & 7-12 Months	87	1,049
7-12 Months & 1-6 Months	242	2,125
7-12 Months & 7-12 Months	5,066	43,448
Mortality		
Number of enrollees who died in 2010	327	2,565
Mortality Rate	5.9%	5.2%
Gender		
Female	3,858	28,443
Male	1,726	20,551
Age Groups		
18-64	4	15,813
65-74	2,372	14,990
75-84	2,388	12,530
85+	820	5,661
Condition Groups *(Percent of Enrollees)*		
Bacterial infections	58.3%	49.5%
Behavioral health and substance abuse disorders	45.5%	35.6%
Congestive Heart Failure (CHF)	19.7%	12.5%
Chronic Obstructive Pulmonary Disease (COPD)	26.5%	17.4%
Cancer	25.7%	18.4%
Diabetes	47.4%	35.7%
Gastrointestinal disorders	48.9%	42.2%
Hematologic disorders	30.6%	30.0%
Major acute coronary events	3.7%	2.8%
Musculoskeletal disorders	75.9%	57.7%
Neurological disorders	78.0%	56.0%
Other cardiovascular disorders	89.7%	64.6%
Other conditions and factors influencing health care	69.1%	41.6%
Other endocrine, immunity, and metabolic disorders	78.4%	60.1%
Other ill-defined conditions and factors influencing health care	79.6%	57.8%

Patient Characteristic	SCAN Health Plan Duals	Medicare FFS Duals (CA only)
Other injuries and poisoning	34.7%	29.3%
Other respiratory disorders	52.2%	46.0%
Other urinary disorders	56.7%	42.9%
Pneumonia	8.9%	8.7%
Renal failure	31.9%	12.5%
Skin disorders	33.9%	29.9%
Stroke and TIA	12.4%	9.6%
Traumatic injury	5.4%	5.1%
HEDIS 30-day All-Cause Readmissions Rate		
2010 Observed Readmission Rate ("Observed Rate")	15.0%	19.5%
2010 HEDIS Average Adjusted Probability ("Expected Rate")	19.6%	22.2%
Ratio of Observed Rate to Expected Rate	0.76	0.88
Prevention Quality Indicators (PQI) ***(Per 100,000 enrollees)***		
Prevention Quality Indicator (PQI) Overall Composite	4,996.4	5,908.9
Angina Without Procedure (PQI 13)	429.8	83.7
Congestive Heart Failure (CHF) (PQI 8)	1,325.2	1,539.0
Hypertension (PQI 7)	250.7	128.6
Chronic Obstructive Pulmonary Disease (COPD) (PQI 5)	734.2	832.8
Uncontrolled Diabetes (PQI 14)	0.0	51.0
Diabetes Short-Term Complications (PQI 1)	0.0	112.3
Diabetes Long-Term Complications (PQI 3)	197.0	555.2
Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)	0.0	110.2
Dehydration (PQI 10)	232.8	228.6
Bacterial Pneumonia (PQI 11)	1,056.6	1,081.8
Urinary Tract Infection (PQI 12)	644.7	826.6
Adult Asthma (PQI 15)	125.4	359.2

(1) The Avalere Health study compared outcomes on the AHRQ Prevention Quality Indicators (PQI) Overall Composite and the HEDIS 30-day All-Cause Readmission Rate between Medicare FFS dual eligibles in California and dual eligibles enrolled in SCAN Health plan. The PQI Overall Composite measures potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs), which are intended to reflect issues of access to, and quality of, ambulatory care in a given geographic area. The analysis was conducted on a sample of SCAN Health Plan duals enrolled in SCAN's D-SNP plan for at least one month in 2010, but were continuously enrolled in SCAN Health Plan for all of 2009 and 2010. Similarly, Medicare FFS duals were identified as beneficiaries who were enrolled in Medi-Cal for at least one month in 2010.

Appendix 10

scan HEALTH PLAN®

3800 Kilroy Airport Way
Suite 100, P.O. Box 22616
Long Beach, CA 90801-5616

TEL 562 989.5100
FAX 562 989.5200

February 22, 2012

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

VIA E-MAIL

Dear Mr. Douglas:

This is a formal request for the State to keep confidential SCAN's Model of Care, submitted in full in Appendix 10 of our Request for Solutions filing for the Dual Eligible Demonstration.

SCAN's Model of Care is described fully in the Project Narrative section, and examples of our methodology are included in other areas of the Appendix. However, it is our strong position that the entire Model of Care is proprietary and confidential, and should be redacted when the entire submission is made public.

As you are aware, our Model of Care submitted for the Demonstration is based largely on SCAN's Dual Eligible Special Needs Plan Model of Care. SCAN participates in a bidding process with other D-SNP applicants in the Medicare Advantage program, and publication of our Model of Care through the Demonstration could raise competitiveness concerns.

Thank you for consideration of this request. If you have any questions, please contact me directly at 562-989-5166.

Sincerely,

Douglas Jaques
Sr. Vice President, General Counsel

cc: Chris Wing
Peter Harbage

Appendix 11

Case Management Guideline

Screening and Prevention

Name

Brief Description of Guideline:

Case mangers have an influential role in preventing disease and improving the health of the members. The preventive care guidelines presented here, are designed to assist care managers in coaching members and caregivers on the importance and recommended frequency of needed preventive services. This information may be of further assistance in the coordination of preventive care and health care decision-making with the primary care physician, and in achieving quality standards.

The guidelines incorporate evidence based medicine (EBM), and clinical experience. Recommendations come primarily from two sources, the US Preventive Services Task Force (USPSTF), which is supported by the Agency for Healthcare Research and Quality (AHRQ), and the Assessing Care of Vulnerable Elders (ACOVE) project. USPSTF represents an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The ACOVE project, conducted by RAND Health and Pfizer, Inc., developed a set of quality indicators for medical care of the elderly.

Clinicians caring for older people face a number of barriers in implementing clinical guidelines. These barriers may include co-morbidities, frailty, dementia, end-of-life, and lack of social support. The guidelines also acknowledge the need to individualize evaluation and treatment approaches, taking into account the health status and preferences of older patients. For individuals who are severely demented or at end of life, most preventive screening should be suspended.

Special Instructions on How to Use:

The focus of this guideline is to identify the minimum standards for basic tests and screenings to promote health.

.* *Asterisks indicate that these are HEDIS, CAHPS, HOS measures.*

Definitions:

ROBUST - Strong, healthy, functionally independent, no cognitive impairment.

FRAILTY - Presence of under-nutrition, functional dependence, prolonged bed rest, pressure sores, gait disorders, generalized weakness, age > 90 years, weight loss, anorexia, fear of falling, dementia, hip fracture, delirium, confusion, going outdoors infrequently (homebound) and poly-pharmacy. Frailty significantly predicts disability and other adverse outcomes in older adults.

END-OF-LIFE - May indicate multi-organ failure, functional dependence, hospice criteria met.

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- Cholesterol screening
- Colorectal cancer screening
- Elder Abuse Monitoring
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  - shingles
  - tetanus
- Medication monitoring for long-term meds
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II. Managing Chronic Conditions

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- Diabetes care
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  - I. Controlling BP
  - II. Aspirin
  - III. Beta Blocker
- Osteoporosis management
  - IV. Screening
  - V. Treatment

Guideline Content:

	Robust	*Frail*
Office Visits	At least annually	As needed (1-4 times/yr)
Medication Monitoring for Chronic Medications *HEDIS: –Annual Monitoring for Patients on Persistent Medications *HEDIS: –Care of Older Adults (SNP)-Medication review	At least annual evaluation for: • Geriatric non-recommended drugs (see attachment). • Specific drugs: ACE/ARB, digoxin, diuretic, anticonvulsants that require ongoing lab assessment. • Therapeutic duplication. • Potential drug/drug or drug/disease interactions.	With each visit
Colorectal Cancer Screening *HEDIS : Colorectal Cancer Screening	One or more of the following screenings: • Annual Fecal Occult Blood Test. • Flexible sigmoidoscopy every 5 yrs. • Colonoscopy every 10 years (exclusion: colorectal cancer or total colectomy.	Consider every 1 – 2 years. Not recommended for 85+.
Cognitive Screening	At least annually. Consider with evidence of cognitive impairment.	Same
Depression Screening PHQ-2, PHQ-9 *HEDIS: Anti-depressant medication management	At least annually, more frequently if symptomatic with or without treatment.	Same
Diabetes – *HEDIS: Comprehensive Diabetes Care2 *See Diabetes Guideline if current diabetic Dx*	Annual until age 75 with risk factors (hypertension, dyslipidemia, obesity): • HbA1c • Cholesterol • Blood Pressure	Annual until age 75, with risk factors. Relaxed HbA1c - <9.0=good control
Hearing Impairment	Consider every 2 years	Annual evaluation as part of initial visit.
Weight *HEDIS-Adult BMI Assessment	BMI should be measured every 2 years until age 75. • Weight taken with each visit. If unintentional loss >5 –10 lbs./year, discuss eating pattern • Normal BMI-. BMI: 18.5 – 24.9;> 25 is obese: >30 is morbidly obese.	Each visit, if able to weigh.

	Robust	*Frail*
	Cardio-Vascular Risk	
Prescribing Aspirin as Primary Prevention of CV Events	• If a history of MI or >2 cardio-vascular risk factors including HTN, DM, dyslipidemia, obesity, or smoking.	Same
BP and Orthostatistic BP: Orthostatic BP measures the change of BP with change in body position from lying to sitting to standing *HEDIS: BP Control	At least annual • BP target <140/90 or <130/90 with dx of diabetes, heart and renal disease. • Orthostatic BP if: symptomatic with dizziness or on antihypertensive or diuretic.	With each visit.
Cholesterol Screening *HEDIS-Cholesterol management for patient w/ cardiovascular conditions.	• Annual, if diabetic, cardiovascular disease or other risk factors (smoking, obesity, dyslipidemia). • All others every 1-2 years up to age 75.	Consider at least every 2 years.
Post MI treatment *HEDIS: Beta Blocker (BB) after MI	After acute MI: Treatment with BB for six months except if contraindicated or history of adverse reaction to BB therapy.	Same
	Immunizations	
Influenza *CAHPS: Annual Flu Shot	Annual	Annual
Pneumococcal *CAHPS: Pneumonia Shot	Once; may repeat every 5 years for individuals with chronic diseases.	Once; may repeat if greater than 5 years.
Shingles	Shingles-> 60 years of age, one time.	Same
Pertussis *CAHPS: Annual flu shot, *CAHPS: Pneumonia shot	Pertussis tetanus-diphtheria booster after age 49, Booster every 10 yrs. Primary series if has not received.	Same
	Lifestyle Education: Exercise, Smoking Cessation, Alcohol & Injury Prevention	
Exercise/Activity *HOS: Physical Activity	Assessment at least annually. Recommendation: 30 minutes per day 5 times/week or 45 min every other day.	Assessment at least annually. Encourage up to 30 minutes per day or as tolerated.
Smoking Cessation *CAHPS: Smoking Cessation	Assessment at least annually. If current smoker : • Advise to quit • Medication to support cessation Recommend methods (i.e. website, support groups, medicines).	Same
Alcohol Misuse	Assess for misuse annually. Target alcohol use at maximum: • Men - 2 drinks/day • Women – 1 /day (1-beer or 5	Screen for any problem (abuse or safety concerns).

	Robust	*Frail*
	oz wine or 1.5 oz per ETOH = a drink)	
Functional Assessment - ADLs and IADLs *HEDIS: Care of Older Adults	Annually	Quarterly
Elder Abuse	Each visit	Each visit
Thyroid Stimulating Hormone- (TSH)	Annually	Annually
Urinary Incontinence *HOS measure: UI *See Urinary Incontinence Guideline*	Assess every 2 years unless symptomatic.	Same
Visual Acuity and Glaucoma Testing *HEDIS: Glaucoma Screening	Assess every 2 years Glaucoma screening at least annually for > 65 yrs	Same
Advance Care Planning *HEDIS: Care of Older Adults	Annual	Annual and as needed POLST if advanced illness or expected to die within 2 years.
Osteoporosis Screening- Baseline bone density testing *HEDIS: Osteoporosis, within 6 months of fracture, bone density testing and Rx *See Osteoporosis Guideline*	All post-menopausal women, with any risk factor: Prior fracture after age 50, Family Hx Fracture, Hx Hip/Spine, low BMI, current smoking, glucocorticoid/steroid use > 3 months, Alcohol >2 drinks/day, Chronic Kidney Disease.	Same, not necessary after age 85.
	Women Only	
Breast Exam	Controversial, discuss with PCP.	Same
Breast Cancer Screening – Mammography **HEDIS: Mammography*	Every 2 years up to 74 years, unless at high risk. Not recommend for 75 years or older.	Same, not recommended if less than 5 year life expectancy.
Cervical cancer screening – Pap smear	If no cervix, no Pap necessary, (except if removed for malignant or premalignant condition). Stop screening at age 65 with 3 previous normal/negative Pap tests and no abnormal/positive cytology tests within last ten years.	

	Robust	*Frail*
	If under 65, every 3 yrs if with 3 previous normal/negative Pap tests and no abnormal/positive cytology tests within last ten years.	
Pelvic Only	No standard	
Hormone Replacement – Hormone Replacement Therapy	Controversial discuss due to increased risk of breast CA. Encourage to discuss with MD.	Same
	Men Only	
Prostate Cancer Screening Digital Rectal Exam	Annual	Annual
Prostate Specific Antigen (PSA) – Lab	<75 yrs: Controversial: Encourage member to discuss with MD 75+. Do not screen.	Same
Abdominal Aortic Aneurysm (AAA)	One time ultrasound screening in men 65-75, with history of smoking.	Consider one time ultrasound screening in men 65-75 with history of smoking.

References:

US Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/

Wenger et al, *Introduction to the Assessing Care of Vulnerable Elders-3 Quality Indicator Measurement Set, (2007). Journal of the American Geriatrics Society 55¨S247-S252.*

Case Management Guideline

Depression

Name

DESCRIPTION/PREVALENCE

Depression is a serious health problem in older people, affecting approximately 19 million adults in the U.S. It is a medical disorder with genetic, biological, and psychological causes that is associated with pervasive low mood, loss of interest in usual activities, and diminished ability to experience pleasure. Identification and treatment can be more difficult in older people due to a variety of reasons: multiple chronic illnesses, medication side effects, impaired communication skills, numerous somatic complaints, and lack of time accorded to them in the clinical exam. Depression often remains unrecognized.

SYMPTOMS

Symptoms vary significantly: Some present with physical complaints or pain, while others may describe feeling sad, blue, unhappy, miserable, or down in the dumps. Early symptoms can include inability to sleep or sleeping too much, feelings of hopelessness, loss of appetite or eating too much, feeling easily angered or agitated and loss of interest in daily activities. These are usually present for two weeks or longer.

RISK FACTORS

The exact cause of depression is not known; many believe it is caused by chemical changes in the brain. Medical illnesses such as stroke, heart attack, cancer, Parkinson's disease, pain, and hormonal disorders can cause depressive illness. Alcohol or drug abuse can also precipitate depressive symptoms. Also, a serious loss, difficult relationship, social isolation, financial problems, or any stressful (unwelcome or even desired) change in life patterns can trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors are involved in the onset of a depressive disorder.

PREVENTION

Good preventive strategies include: Avoidance of illegal drugs or the inappropriate use of prescription drug (which can precipitate depressive symptoms), exercising, maintaining good sleep habits, volunteering or involvement in group activities that give pleasure, talking to a trusted friend or confidant, keeping in contact with positive, caring people. Recognizing and reporting early signs of depression to you doctor to start early intervention.

TREATMENT PLAN

Antidepressant medications and/or psychotherapy, especially in combination, can help. Cognitive-behavioral therapy with a professional has been found to be very effective in managing depressive symptoms or forms of talk therapy with trusted friend, clergy, or family member can improve mood.

CASE MANAGER FOCUS

- *Assess for depression and if depressed, assess for risk or warning signs of suicide*
- *Notify physician of any depression concerns*
- *Alert emergency support for suicidal threats with intent and plan*
- *Monitor and support adherence to treatment plan, especially following prescribed antidepressant regimen*
- *Facilitate physician follow up visit within 7 days of a behavioral health hospitalization*

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
All older people should be assessed for depression at least annually (or more often if indicated). • Administer PHQ-2 to all case management	1. Pre-Call Review to include: • Psychotropic medications and/or clinical diagnoses • Compliance with medication regimen • Prior behavioral health	• If the PHQ-2 is positive with a score greater than 3, or and/or member has a history of depression, or there is evidence of lack of adherence with medication/ treatment or other concern. a) Educate the member regarding benefits

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
participants • Administer the PHQ-9 if PHQ-2 is positive or there are concerns regarding depression, or suicidal thoughts or attempts (*See Attachment A*)	admission events 2. Administer PHQ-2 with member only.) 3. Ask: Do you have a history of depression?	b) Coach on the difference between "blues" (short term) versus depression (lasting longer than a few weeks), warning signs & symptoms and actions to take. c) Coach to Prevention activities (see Intro) d) Educate on the course of antidepressant treatment – Initiation of treatment—medicine may need to be titrated to therapeutic dose. Monitor for affect and side effects. – Response—may take up to 6 – 8 weeks. Dosage may be altered or new drug substituted if improvement not observed – Maintenance—continue medications to prevent relapse. – Discontinuation—is a decision member should make with their doctor based on history and risk for relapse. e) Send information from Healthwise® on depression, topics may include: – What is depression? – What causes it? – How is it treated?
	1. Administer PHQ-9 if PHQ-2 if greater than 3	Send PHQ-9 letter to physician if score >5, and advise member that information will be communicated. Call physician if there are any urgent or emergent concerns. • Educate as needed on: medications, treatments, importance of adherence, signs and symptoms, when to call physician and self-care preventive activities. • Send Healthwise® information on depression, if appropriate. Topics: – Medicines – Should I take an antidepressant? – Side effects of anti-depressants • Coach to schedule an appointment to physician to discuss the depressive symptoms and possible treatments. • Schedule follow-up call to member to check status. • Send Behavioral Health Consult Review, if additional information, resources or clarification, is needed.
Suicide Risk should be evaluated if suspected by positive depression screen; or statements made that cause concern. *(See Attachment B- Risk Factors for Suicide)*	1. Assess for suicide risk. If positive response to PHQ-9 Question #9—"Thoughts that you would be better off dead, or of hurting yourself in some way. " 2. Ask :	If positive findings and the member reports suicidal ideation, intent and/or plan or hopelessness about options, implement the following *Protocol for Handling Suicidal Member:* • Remain on the telephone with the member

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
(*See Attachment C - Warning Signs of Suicide in the Older Population)*	• Do you have the means? • Have you thought about a time and place? • Do you see no other options?	until help arrives at the member's home. • Enlist the aid of a peer case manager to make all the necessary telephone calls to 911 or PET team or the local police department, to request a safety check. • If member lives in a county with no PET team, the peer case manager should call either 911 or the telephone number for the local police or sheriff in the county in which the member lives. • The peer case manager provides the local police or sheriff with all needed demographic information regarding the suicidal member. • Remain on the telephone with the member until the first responders arrive at the residence. – Offer a warm, caring, non-judgmental response to anything the member may verbalize. – Be direct, talk openly and freely about the member's suicidal feelings – Offer hope that there are alternatives and options, without discounting the member by stating: "You have so much to live for" or "You don't really want to die" • When the police/PET Team or Sheriff arrives and the hand-off to the first-responders has been completed, the case manager may hang up the telephone and should document all findings and interventions in CCMS. • Communicate all significant findings and interventions in a follow-up telephone call and/or letter to PCP. • Follow-up with member upon discharge from ER or inpatient treatment to ensure aftercare appointments have been made or appointment(s) was kept.
RESOURCES *Healthwise® Resource:* http://intranet/HealthWise/HealthwiseDisclaimer.asp (CTRL + left click) OR (SCAN Intranet>>For Employees>>Useful Links>>HealthWise Knowledgebase>> • What is depression? • What causes it? • How is it treated? • Medicines • Should I take an antidepressant? • Side effects of anti-depressants • Suicide Thoughts or Threats		

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IMPACT-Evidence-based Depression Care, http://impact-uw.org/

Attachment A

PHQ-2:

1. Over the past two-weeks, how often have you had little interest or pleasure in doing things?
2. Over the last two-weeks, how often have you felt down, depressed or hopeless?

PHQ-9:
Over the last 2-weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things that you usually enjoy.
2. Feeling down, depressed or hopeless.
3. Trouble falling asleep/staying asleep or sleeping too much.
4. Feeling tired or having little energy.
5. Poor appetite or overeating.
6. Feeling badly about yourself or that you are a failure or have let yourself or your family down.
7. Trouble concentrating on things, such as reading the newspaper or watching the television
8. Moving or speaking so slowly that other people would have noticed, or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.
9. Thoughts that you would be better off dead, or of hurting yourself in some way.

Assess PHQ-9 Score:

- 5-9 indicates Mild Depression
- 10-14 indicates Moderate Depression
- 15-19 indicates Moderately Severe Depression
- >19 indicates Severe Depression

Note: The PHQ-9 score may not accurately reflect the severity of the depression or suicidal ideation, depending on the degree of member's understanding of the questions

Attachment B

Risk Factors for Suicide:

1. History of suicide in the family or prior attempt(s) by member.
2. Chronic medical illness, including pain and functional impairment.
3. Actively psychotic or severely depressed.
4. Alcohol or substance abuse.
5. Terminal illness.
6. Social isolation, recent death of spouse.
7. Financial difficulties.
8. Hopelessness
9. Non-Hispanic white males.
10. Age over 65.
11. Untreated & undiagnosed depression.

Attachment C

Warning Signs of Suicide in the Older Population:

1. Statements about death and dying.
2. Rush to complete a will.
3. Statements of hopelessness.
4. Reading material about death and dying.
5. Stockpiling medications.
6. Overt or covert suicidal statements or threats.
7. Sudden interest in firearms.

Case Management Guideline

Diabetes

Name

DESCRIPTION/PREVALENCE

Diabetes is a chronic illness that requires continuing medical care and ongoing self-management and monitoring to prevent acute complications and to reduce long term risks caused by elevated blood glucose (sugar) which can harm eyes, kidneys, nerves, skin, heart, and blood vessels. Diabetes is an important health condition for the aging population; at least 20% of patients over the age of 65 years have diabetes. The older adults with type 2 diabetes may have a wide range of clinical and functional differences in diabetes duration, complications, physical and cognitive capability, and life expectancy.

SYMPTOMS

Include increased urination and thirst, weight loss, excessive appetite (especially after eating), unexplained weight loss, blurred vision, headaches, extreme fatigue and irritability, frequent infections (recurring skin, gum, or bladder infections), cuts or bruises that are slow to heal, skin disorders , tingling/numbness in the hands/feet, and loss of consciousness (rare).

RISK FACTORS

Include having a first-degree relative with diabetes; adults who are overweight having a BMI ≥25 kg/m²); certain race/ethnic groups (e.g., African American, Latino, Native American, Asian American Pacific Islander); women who delivered a baby weighing >9lb or were diagnosed with gestational diabetes. Having a high BMI along with other risk factors further increases the risk of developing diabetes.

PREVENTION

Emphasis on life style changes that include, moderate weight loss (7% body weight) and regular physical activity with dietary strategies to reduce calorie intake and dietary fat and adding dietary fiber (14g fiber/1,000 kcal) and whole grains can reduce the risk for developing diabetes.

TREATMENT PLAN

Treatment plan should include a collaborative therapeutic alliance among the patient and family, the physician and other members of the health care team. Any plan should recognize self-monitoring of blood glucose, individualized meal plan and individualized medication therapy. Older adults who are functional, cognitively intact and have a significant life expectancy should receive diabetes care using the same goals developed for younger adults. If the older adult does not meet this criteria their glycemic goals may be relaxed. Also, the various screening activities may be relaxed for the older adult, but hyperglycemia leading to acute hyperglycemic complications should be avoided. The primary attention should be to avoid complications that would lead to functional impairment.

CASE MANAGER FOCUS

- *Assess level of knowledge and provide diabetes education and/or refer to program.*
- *Support self-management and adherence to treatment plan to avoid long term risks.*
- *Alert healthcare provider of possible deviations to the treatment plan.*
- *Educate on urgent vs. emergent signs and symptoms and actions to take.*

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
Adults over the age of 45 yrs with risk factors for diabetes or if BMI =>25 Kg/m2; should be screened annually for diabetes.	1. Are Blood glucose (BG) tested annually?	• Coach to discuss with PCP and screen for risk factors and complications of diabetes. • Educate on risks associated with poorly managed diabetes.
All people with diabetes should receive Diabetes Self-Management Education.	1. Assess member/ caregiver current level diabetes education. 2. Is there a basic level of understanding regarding	• Refer for diabetes education as appropriate. • Educate on diabetes monitoring and screening to prevent complications of diabetes. • Diabetics have a high risks of developing

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*

	diabetes self-management and routine screening?
	3. Does member/caregiver understand signs & symptoms of condition and actions to take?
		heart disease and should follow CAD guidelines that include smoking cessation, regular physical activity, a health diet, stress management *(See CAD/Angina Guideline for more information)*
		• Coach and support lifestyle changes and self-management. (*See Attachment A - Diabetes Guidelines For Self Management)*
		• Educate on sign & symptoms of hypoglycemia and actions to take:
		  • Signs & symptoms:
		  – rapid heart beat
		  – perspiration
		  – shakiness
		  – anxiety
		  – confusion
		  • Actions to take:
		  – Call 911—if unconscious or suddenly confused.
		  – Call Doctor—if BG >300 or higher if instructed by MD, sick and having trouble controlling BG, vomiting or diarrhea >6hrs. Problems with consistent high or low BG levels.(*See Attachment A-Diabetes Guideline for Self-Management--hypoglycemia)*

Self-monitoring of blood glucose for those using insulin (multiple dose/or pump) should be done at up to 3 to 4 times per day, or as ordered by their PCP.
 	
NOTE:
• Other people with diabetes on single-dose insulin, oral medications or diet-controlled; may find blood glucose monitoring helpful, self-monitoring may be ordered.
• All insulin-dependent people with diabetes should be knowledgeable on blood glucose self-monitoring and have monitor to assess for hypoglycemia as needed.
	1. Does member self-monitor blood glucose as directed?
	Recommendations for self-monitoring:
	Robust Adult:
	• On insulin (multiple injections)—3+ times/day
	• On oral hypoglycemics, single dose insulin or diet controlled— as ordered by PCP.
	Note: *Target BG-results should be >60 but<140.*
	Frail older Adult:
	• On insulin regimen, check 2 – 4 times/day or as ordered by MD
	Note: *Target BG- results >110 or <180.*
		• Educate on benefits of BG testing:
		  – Helps assess the effectiveness of the management plan
		  – Promotes self-awareness.
		  – Frequency and timing of BG testing should be dictated by the individual needs and goals of the member
		  – If frail older adult and not on insulin, may discuss necessity with PCP.
		  – Encourage patient to keep a log of BG results to take to the MD each visit
		• Coach to discuss BG monitoring with PCP and obtain recommendation.

Blood glucose control not achieved with weight loss, diet, and exercise may require medication therapy.	1. What are self-reported BG results? 2. Are they outside of normal range?	• Alert physician as needed for problems. • Educate on treatment modalities: lifestyle modification, oral medications (single or combo), and insulin.

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
	3. Does treatment plan include medications? Assess for problems with adherence or use of geriatric inappropriate meds. Note: *Diabinese (Chlorpropramide) should not be used with older adults.*	• Educate on medication compliance and the importance of taking meds as prescribed.
Diabetes requires continuing medical care and ongoing self-management and monitoring to prevent acute complications and to reduce long term risks caused by elevated blood glucose (sugar).	1. Does member have routine monitoring? • HgA1C • BP • Lipids • Retinal Eye Exam • Renal function	• Instruct on importance of regular lab test and monitoring to prevent complications of diabetes. • Focus on the following indicators:
Glycated hemoglobin (HgA1C)—check at least two times/year or more frequently if not achieving stable glycemic control. Control to reduce micro vascular complications Targets: HgA1C levels should be as close to 7% as possible Target • Robust Adult - <7% is good • Frail Older Adult - <8% or a more relaxed target, especially if history of severe hypoglycemia, or advanced disease.	1. What is HgA1C?	• Educate on importance of blood glucose control to prevent or delay diabetes-related complications. • Coach to discuss HgA1C with physician
Blood Pressure (BP)— Measure at each visit. Control to lower risk of stroke, heart disease, renal failure, and macro-vascular damage. Target BP for diabetics: • Robust Adult - <130/80	1. What is recent BP? 2. Does member monitor routinely?	• Coach on modifiable risk factors for hypertension; lifestyle therapies; diet, weight loss, moderate ETOH, increasing exercise, smoking cessation. *See HTN Guideline for more information* • Encourage to take the antihypertensive medications as prescribed • Should be on ACE or ARB if no history of renal disease/side effects • Might require multiple med treatment to control • Alert PCP for uncontrolled BP or barrier to adherence of current treatment plan.
Lipid Profile—annual, may be semi annual if stable. Control to lower risk of heart disease, stroke, macro vascular damage Targets: Robust Adult-- • Total Cholesterol <200	1. Are lipids monitored routinely?	• Educate the importance of lipids control. • Lifestyle modification w/ focus on diet low fat/low cholesterol and low CHO, and weight loss • Lipid management w/medication therapy • Registered Dietitian referral • Coach to discuss with physician

Guideline	*Clinical Task and/or Assessment Findings*	*Case Manager Actions*
• HDL >50 mg/dl • LDL <100 mg/dl • Triglycerides <150 mg/dl • Other values per discretion of PCP if co-morbid conditions. • Frail Older Adult—Total cholesterol <240		*(See CAD/Angina Guideline for more information)*
Retinal Eye Exam—annually. Control to prevent or slow retinopathy and blindness.	1. Dilated and comprehensive eye examination by an ophthalmologist or optometrist annually	• Refer to PCP for referral to specialist to assess for: – Severe Non-proliferative Diabetic Retinopathy (NPDR) – Proliferative Diabetic Retinopathy (PDR) – Macular edema.
Renal function should be monitored at least annually. Diabetic nephropathy occurs in 20-40% of people with diabetes and is the single leading cause of end-stage renal disease.	1. Annual test to assess urine spot microalbumin excretion with duration of 5 yrs with diabetes? 2. Annual serum creatinine level to assess	• Educate the importance of controlling BP and BG to prevent the progression of micro and macro albuminuria which leads to nephropathy. • Educate on the need to incorporate an ACE or ARB to delay the progression of CKD • Coach to discuss evidenced-based therapies with PCP as appropriate. *See CKD Guideline for more information*
RESOURCES: *Healthwise® Resource:* http://intranet/HealthWise/HealthwiseDisclaimer.asp (CTRL + left click) OR (SCAN Intranet>>For Employees>>Useful Links>>HealthWise Knowledgebase>>Diabetes • *Prediabetes* • *Type II Diabetes* • *Sick Day Guidelines for Diabetes* • *Taking Care of Your Feet* • *Travel Tips*		

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Healthwise ® Knowledgebase Diabetes

In the Clinic

Hip Fracture

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The content of **In the Clinic** is drawn from the clinical information and education resources of the **American College of Physicians** (ACP), including **PIER** (Physicians' Information and Education Resource) and **MKSAP** (Medical Knowledge and Self-Assessment Program). **Annals of Internal Medicine** editors develop **In the Clinic** from these primary sources in collaboration with the ACP's Medical Education and Publishing divisions and with the assistance of science writers and physician writers. Editorial consultants from **PIER** and **MKSAP** provide expert review of the content. Readers who are interested in these primary resources for more detail can consult http://pier.acponline.org, http://www.acponline.org/products_services/mksap/15/?pr31, and other resources referenced in each issue of **In the Clinic**.

CME Objective: To review current evidence for the prevention, diagnosis, and treatment of hip fracture.

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In the Clinic

Annals of Internal Medicine

Hip fracture is the most serious consequence of osteoporosis. About 1% of all falls in the elderly residing in the community result in hip fracture, often with life-changing consequences. Acute mortality from hip fracture is 3%–5%; the lifetime risk for death from hip fracture is similar to that from breast cancer. Far fewer than half of patients with hip fracture fully recover their ability to perform all of their basic activities of daily living. Outcomes are even more grim for those who have postoperative complications. Timely diagnosis and highly attentive perioperative care of the complex patient with a hip fracture aim to reduce the risk for such complications and to facilitate rapid transition to rehabilitation in the hopes of improving functional recovery.

Screening and Prevention

What medical comorbid conditions increase the risk for falls and hip fracture?

Comorbid conditions that increase the risk for falls include advanced age (older than 75 years), sensory impairments (such as hearing or vision loss), conditions that cause gait instability or abnormal proprioception, depression, muscular weakness, orthostatic hypotension, and impaired cognition. The use of ≥4 medications on a long-term basis, alcohol, and benzodiazepines can also increase the risk for falls (1, 2).

Osteoporosis increases the patient's risk for hip fracture when a fall occurs. Patients should be evaluated for risk for osteoporosis by eliciting historical risk factors for osteoporosis. Certain patients with risk factors should undergo bone densitometry. Risk factors include history of fracture, glucocorticoid use, family history of fracture, cigarette smoking, excessive alcohol consumption, and low bodyweight (3).

What are the mechanical risk factors for hip fracture?

Gait instability, foot deformities, and environmental hazards in the home all pose mechanical risks for fall. Patients with a history of or risk factors for falls should undergo interventions to reduce the risk for falls and fractures. Begin with an evaluation for risk factors, which should include a review of medications; review of home safety (such as ensuring highly trafficked pathways are well lit and clear of clutter); a detailed history of falls; and testing of muscle strength, balance and gait, and neurologic function (particularly cerebellar function, proprioception, vision, and hearing). Interventions should then be targeted at reducing or eliminating risk factors.

Patients with multiple risk factors are at highest risk and probably need a review of their calcium and vitamin D intake, medication adjustment (including pharmacotherapy for osteoporosis and reduction of polypharmacy), smoking cessation, balance training, environmental safety evaluation, and strengthening exercises to reduce their risk for fracture (1).

Refer to The American Geriatrics Society published clinical practice guidelines for the prevention of falls in the elderly (4). Interventions to eliminate risk factors (Table 1) (including medication adjustment, exercise, and behavioral modification) significantly reduced falls in a community of older people (5). This finding was also supported in a meta-analysis (6).

What is the role of bone densitometry in assessing risk for hip fracture?

Bone densitometry is a valid method to diagnose osteoporosis

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Table 1. Interventions to Eliminate Risk Factors for Hip Fracture

Risk Factor	*Intervention*
Age >75	
Sensory impairment	Vision correction, hearing aids
Gait instability	Physical therapy, assistive devices, strength and balance training
Foot deformities	Surgical correction, orthotic devices
Use of ≥4 chronic medications	Elimination of nonessential medications
Use of alcohol	Counseling to reduce or discontinue alcohol
Use of benzodiazepines	Reduction or discontinuation of benzodiazepines
Environmental hazards in the home	Ensure adequate lighting, install handrails in the bathroom and on the stairs, remove loose cords and rugs, store the most frequently used items in the kitchen within easy reach
Depression	Evaluation and treatment of depression
Muscular weakness	Physical therapy, exercise
Orthostatic hypotension	Behavioral modification (e.g., rising slowly from bed), reduction or elimination of medications that may worsen condition
Impaired cognition	Evaluation and treatment for dementia and for reversible causes of cognitive decline

FRAX: WHO Fracture Risk Assessment Tool

- Age
- Sex
- Weight
- Height
- History of previous fracture in adult life occurring spontaneously, or a fracture arising from trauma that, in a healthy individual, would not have resulted in a fracture.
- Parent fractured hip
- Current smoking
- Glucocorticoid use
- Rheumatoid arthritis
- Secondary osteoporosis—disorders strongly associated with osteoporosis, such as type 1 diabetes, osteogenesis imperfecta, untreated hyperthyroidism, hypogonadism, premature menopause, chronic malnutrition or malabsorption, and chronic liver disease.
- 3 or more units/day of alcohol
- BMD

Adapted from FRAX calculation tool Web site: www.sheffield.ac.uk/FRAX/tool.jsp.

and to predict the risk for fracture. The fracture-risk assessment tool (FRAX) (see the Box) integrates risk factors with bone densitometry measurement to predict 10-year risk for sustaining hip fracture. Factors that are most highly predictive of an osteoporotic fracture are a history of previous low-impact fracture and low bone mineral density (BMD) (7).

A meta-analysis showed that a 1-SD decrease in bone mineral density at the femoral neck was associated with a relative risk for hip fracture of 2.6 (8).

How often should bone densitometry be performed?

The U.S. Preventive Services Task Force has updated its screening recommendations for osteoporosis to women aged 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors. At this time, the U.S. Preventive Services Task Force does not make recommendations regarding screening intervals. Repeated screening has not been shown to be more predictive of subsequent fracture than the original screening measurement (9).

A prospective study of 4124 women aged 65 years or older found that neither repeated BMD measurement nor change in BMD after 8 years was more predictive of subsequent fracture risk than the original measurement. It may be useful, however, to rescreen patients if there is clinical suspicion for greater-than-average acceleration of BMD loss (10).

What pharmacologic interventions can prevent hip fracture?

Patients with known osteoporosis or risk factors for osteoporosis should be treated to prevent hip fracture. Effective therapies exist that have been shown to reduce fractures in both men and women with osteoporosis.

Antiresorptive agents: calcium and vitamin D

Inadequate intake of calcium and vitamin D leads to reduced calcium absorption, causing an increase in parathyroid hormone and subsequent increased bone loss. Vitamin D deficiency is also linked to reduced muscle function and higher risk for falling (3).

A meta-analysis of randomized, controlled trials (RCTs) showed that, compared with calcium or placebo, a vitamin D dose of 700–800 IU/d reduced the relative risk for hip fracture by 26% (11).

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A follow up meta-analysis looked at RCTs of oral vitamin D with or without calcium supplementation. Results suggested that oral vitamin D reduces risk for hip fracture only when supplemented with calcium (12).

The form and dose of vitamin D are a matter of debate. A meta-analysis of randomized trials suggested significant fracture reductions with higher doses of vitamin D administered and higher levels of serum 25-hydroxyvitamin D achieved in both community-dwelling and institutionalized older individuals (13).

However, very high doses of vitamin D have been shown to increase the risk for falls and fractures compared with placebo.

An RCT of 2256 community-dwelling women at high risk for fracture were assigned to receive 500 000 IU of cholecalciferol or placebo each autumn to winter for 3–5 years. Results showed that high-dose cholecalciferol resulted in an increased risk for falls and fractures compared with placebo (14).

Bisphosphonates: alendronate, risedronate, ibandronate, and zoledronic acid

Bisphosphonates inhibit osteoclastic bone resorption and have been shown to reduce the risk for hip fractures in women with osteoporosis.

Clinical trials of bisphosphonate therapy show reductions in risk for nonvertebral fracture, including hip fracture, of 20%–40% (3).

A recent study showed a significant dose-dependent loss of protection against hip fracture in patients receiving alendronate and a proton-pump inhibitor (15).

Hormone replacement therapy: estrogen

Estrogen has been shown to prevent a decrease in BMD. However, this therapy is associated with several health risks, such as breast cancer, coronary artery disease, stroke and thromboembolism. Therefore, it is not considered first-line therapy in management of postmenopausal osteoporosis (3, 16, 17).

Selective estrogen-receptor modulators: raloxifene and risedronate

Selective estrogen-receptor modulators have been studied in numerous trials and have been shown to have a beneficial effect on vertebral fractures but not nonvertebral fractures in patients with osteoporosis. However, these drugs do increase the risk for venous thromboembolism (3).

A large observational study evaluated women 65 years and older initiating either risedronate or raloxifene therapy. Women in the risedronate group had more risk factors for fracture at the time therapy was started. The study found that risedronate treatment in adherent patients rapidly decreased the risk for hip fractures, whereas raloxifene treatment did not (18).

Anabolic therapy: parathyroid hormone and strontium renelate

Parathyroid hormone stimulates bone formation and has been shown to decrease the risk for vertebral fractures. However, the evidence is less strong for its benefits in reducing hip fractures. Parathyroid hormone therapy is limited to 2 years because of concerns for long-term safety (19).

Strontium ranelate seems to simultaneously increase bone formation and decrease bone resorption, thus uncoupling the bone remodeling process. Data support the efficacy of strontium ranelate for the reduction of vertebral fractures (and to a lesser extent nonvertebral or hip fractures) in postmenopausal osteoporotic women over a 3-year period. Strontium ranelate increases the risk for diarrhea (20).

Calcitonin

Calcitonin decreases bone resorption and has been approved for treatment of osteoporosis. It is, however, less potent than other antiresorptive therapies and has not been shown to reduce hip fracture and therefore is not considered first-line therapy for treatment of osteoporosis (21).

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Monoclonal antibody: denosumab

Denosumab is a monoclonal antibody that inhibits development and activity of osteoclasts, decreasing bone resorption and increasing bone density. It has been approved by the U.S. Food and Drug Administration for treatment of osteoporosis in postmenopausal women at high risk for fracture. Although generally well-tolerated, diarrhea, nausea, and achiness have been noted in about 1 in 5 women receiving this therapy. Calcium and phosphate levels must also be monitored during therapy.

An RCT of 7868 women with a BMD T score less than –2.5 but not less than –4.0 at the lumbar spine or total hip were assigned either denosumab or placebo every 6 months for 36 months. Results showed that denosumab reduced the risk for hip fracture with a cumulative incidence of 0.7% in the denosumab group vs. 1.2% in the placebo group (hazard ratio, 0.60; 95% CI, 0.37–0.97; P = 0.04), indicating a relative decrease of 40% (22).

What is the role of exercise in preventing hip fracture?

Risk factors for falls and fractures include physical inactivity, inability to rise from a chair without using the arms, gait instability, and lower-extremity weakness. Exercise can reduce the risk for falls and fractures in appropriate patients.

The Study of Osteoporotic Fracture trial showed that exercise reduced the risk for hip fracture by 33% (23). Home-based exercise programs demonstrate a nonsignificant trend toward hip fracture reduction (24). A meta-analysis of the Frailty and Injuries: Cooperative Studies of Intervention Techniques study found that exercise, particularly with balance training or t'ai chi, reduces the risk for falls (25).

Can home safety evaluations prevent hip fracture?

The American Geriatrics Society has published clinical practice guidelines for the prevention of falls in the elderly. Their recommendations include a home environment assessment and intervention carried out by a health care professional for older people who have fallen or have risk factors for falls (4).

Hip fractures often occur after falls, but there has been controversy over the effectiveness of home safety evaluations. A meta-analysis of randomized trials found that home assessment interventions can reduce falls by 39% among populations at high risk for falls (26).

Can hip protectors prevent hip fracture?

The results of a recently updated Cochrane review suggest that the effectiveness of hip protectors in reducing hip-fracture risk in elderly people is still not clearly established. Hip protectors may reduce the risk for hip fracture in nursing home residents but not in community dwelling elderly people. Compliance is poor (27).

Screening and Prevention... Risk assessment tools, such as FRAX, which combine identification of risk factors for falls and bone densitometry, can predict the 10-year risk for sustaining hip fractures. Interventions aimed at eliminating risk factors, as well as pharmacologic therapies for osteoporosis (such as vitamin D and calcium supplementation, bisphosphonates, and monoclonal antibodies), have been shown to reduce the risk for hip fractures.

CLINICAL BOTTOM LINE

Diagnosis and Evaluation

What is the differential diagnosis of hip fracture?

A careful history and physical examination usually distinguishes a hip fracture from other disorders that present as pain in the hip area. Differential diagnosis includes referred pain from lumbar spine

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Differential Diagnosis for Hip Fractures

- Pathologic fracture
- Pelvic fracture
- Osteoarthritis
- Osteonecrosis
- Rheumatoid arthritis affecting the hip
- Septic hip joint
- Dislocation
- Soft tissue injury
- Trochanteric bursitis
- Meralgia paresthetica (lateral femoral cutaneous nerve entrapment)
- Pathology referred from the lumbar spine (e.g., spinal stenosis, arthritis, disk disease)
- Paget disease (osteitis deformans)

disease, various arthritides, periarticular disease, and certain neurologic disorders (see the Box). Radiographs can help distinguish hip fracture from other pathologic conditions.

What characteristics of a fall are most predictive of hip fracture?

Studies show that fall characteristics, such as fall direction and fall energy, are independent risk factors for fractures.

A study of fall severity as a risk factor for hip fracture in ambulatory elderly persons showed that a fall to the side and higher fall energy were at least as important as BMD in determining hip fracture risk (28).

A study of fall direction as a risk factor for hip fracture in frail elderly nursing home patients showed that a sideways fall was an independent risk factor for hip fracture (odds ratio for fall with hip fracture, 5.7 [CI, 1.7–18]; P 0.004 compared with patients who fell and did not sustain a fracture) (29).

What are the important elements of the history when hip fracture is suspected?

The patient should be asked about the location and characteristics of pain, which is usually felt in the groin or buttock but can be referred to the knee. The circumstances of the fall and any history of trauma or height loss should be elicited. A general medical history should also be obtained, focusing on premorbid conditions and function (Table 2).

Are physical examination findings of comorbid conditions (cardiac disease, cognitive impairment) predictive of hip fracture after a fall?

Examination findings that suggest rheumatoid arthritis, hypogonadism, chronic glucocorticoid use, or kyphosis may be associated with osteoporosis and increase the risk for hip fracture with a fall.

What physical examination signs are helpful to diagnose hip fracture and to distinguish it from other causes of hip pain?

Physical examination can confirm the diagnosis of hip fracture. The injured leg is often shortened, externally rotated, and abducted when the patient is in the supine position.

What are the different types of hip fracture?

Hip fractures are classified by the area of the upper femur affected and by whether displacement is present. The 3 types of hip fracture are intracapsular fractures at the level of the head and neck of the femur; intertrochanteric fractures between the neck of the femur and the lesser trochanter; and subtrochanteric fractures, which occur below the lesser trochanter (30).

What other injuries commonly occur with hip fracture?

In patients who present with a hip fracture after a fall, a search for other soft tissue injuries and other sites of fracture is warranted. Ask specifically whether concomitant head trauma occurred and examine the head for evidence of such. Some patients with hip fracture will have remained on the ground for a prolonged time, increasing their risk for deep venous thrombosis (DVT), skin ulceration, pneumonia, and rhabdomyolysis.

What radiographs and other imaging studies are used?

Radiographs are the cornerstone of diagnosis and are important in determining whether surgical repair is warranted. First, obtain plain anteroposterior pelvis and lateral radiographs.

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If clinical suspicion remains high and plain radiographs are negative, obtain magnetic resonance imaging (MRI) to evaluate for occult fracture. A bone scan may be useful to diagnose fracture in patients who cannot undergo MRI, but may take up to 72 hours to register as positive.

In studies of patients with suspicion of hip fracture but negative plain radiographs, MRI showed occult femoral fracture in 37% to 55% (31, 32).

Table 2. History and Physical Examination Elements for Hip Fracture

Category	*Element*	*Notes*
History	Trauma, particularly a fall from a standing position with impact directly on the hip	
	Hip pain (groin or buttock)	Rarely, pain may radiate or be referred to the knee or thigh
	Inability to bear weight or pain with weight-bearing	
	Circumstances surrounding fall	To identify unstable medical illness before surgery and to identify potential areas for secondary prevention
	Previous minimal trauma fracture or loss of height	
	Risk factors for osteoporosis and fracture (e.g., sedentary lifestyle; excessive alcohol or tobacco use; weight loss since age 25; maternal history of hip fracture; use of psychoactive medications; use of seizure medications; hyperthyroidism; low dietary intake of calcium or vitamin D; and comorbid conditions, such as dementia and sensory deficits)	
	Cardiovascular disease and other comorbid conditions	Preoperative evaluation to determine if further testing or treatment is necessary before surgical repair, only in some circumstances (see text)
	Premorbid function	Predicts morbidity and mortality after hip fracture
Physical examination	Observation of position and length of painful limb and gentle range-of-movement determination	Most patients do not tolerate anything more than a gentle attempt to roll the limb
	Musculoskeletal and neurologic survey	To evaluate for evidence of concomitant injury; particular consideration should be given to evaluation for head trauma
	Evaluation of distal motor, sensory, and vascular integrity of the affected limb	To evaluate for interruption of the neurovascular blood supply at the level of the injury
	Cardiac examination	To evaluate particularly for evidence of arrhythmia, congestive heart failure, valvular disease, or uncontrolled hypertension that may need to be managed before surgery
	General physical examination	To identify unstable comorbid illnesses that may need preoperative evaluation and treatment or that may predict complications in recovery after fracture
	Mental status testing	Delirium occurs in up to 60% of patients with acute hip fracture; the presence of cognitive impairment is a strong risk factor for development of delirium in the hospital and of worse recovery after hip fracture

31. Bogost GA, Lizerbram EK, Crues JV 3rd. MR imaging in evaluation of suspected hip fracture: frequency of unsuspected bone and soft-tissue injury. Radiology. 1995; 197:263-7. [PMID: 7568834]
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Diagnosis... History and physical examination distinguish hip fracture from other disorders that present as hip pain. Hip radiographs are important for diagnosis and for determining whether surgical repair is warranted.

CLINICAL BOTTOM LINE

Treatment and Management

When should conservative therapy for be considered?

Surgical repair is the cornerstone of therapy for hip fracture and has the best opportunity for functional recovery. Conservative therapy should be considered for patients who are too ill for surgery or anesthesia, patients who were bed- or wheelchair-bound before injury, or if modern surgical facilities are unavailable.

A Cochrane review of 5 randomized trials found no differences in medical complications, mortality, or long-term pain in conservative vs. surgical therapy for hip fracture. However, surgery was more likely to result in fracture healing without deformity and a shorter hospital stay (33).

Is there a role for traction in conservative management of patients with hip fracture?

No evidence indicates that skeletal or skin traction is beneficial for patients with hip fracture. In fact, traction may be associated with its own risks, such as increased patient discomfort, limited ability for bedpan transfer, increased immobility, and skin tears.

A review presented by the Cochrane Musculoskeletal Injuries Group did not show any significant benefit from use of preoperative traction in patients with hip fracture (34).

During what time frame should surgery be performed?

Hip fracture should be surgically repaired as soon as the patient is medically stable, although the precise timing of surgery remains controversial.

Retrospective cohort studies generally show that long-term mortality is reduced when surgery is performed within 24 to 48 hours; however, data on morbidity conflict, and many of the studies do not give a reason for surgical delay (e.g., medical instability) (35–38).

When should surgery be postponed?

Surgery should be postponed if the patient has one or more unstable medical conditions, such as active heart failure, ongoing angina, or a serious infection. Any medical condition that causes hemodynamic instability should be corrected before fracture repair.

How is the appropriate surgical approach determined?

First, identify the location of the fracture and the severity of displacement, if any. Femoral neck fractures are repaired by either internal fixation with screws (if nondisplaced or minimally displaced in younger patients) or with prosthetic replacement (if displaced or in patients with concomitant poor bone quality, joint disease, or an excessive propensity to fall). Intertrochanteric fractures are repaired with sliding screws or other similar devices, depending on the bone quality and the surgeon's preference. Subtrochanteric fractures can be treated with an intramedullary nail or a screw-plate fixation. The results of 1 randomized trial supported use of an intramedullary nail rather than screw-plate fixation; patients treated with the former method had shorter surgical times, fewer blood transfusions, shorter hospital stays, and fewer implant failures and/or nonunions than patients treated with a screw plate (39).

33. Handoll HH, Parker MJ. Conservative versus operative treatment for hip fractures in adults. Cochrane Database Syst Rev. 2008: CD000337. [PMID: 18646065]
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Note that displaced intracapsular hip fractures are very likely to disrupt the vascular supply to the femoral head, resulting in nonunion and osteonecrosis (up to 40%) if not treated with replacement arthroplasty (2, 40). Nondisplaced femoral neck and intertrochanteric fractures are less vulnerable to these complications and can often be treated adequately with internal fixation.

Should preoperative cardiac risk be assessed in all patients who will have surgery for hip fracture?

Orthopedic surgery is considered to have an "intermediate" cardiovascular risk; only patients with severe or unstable cardiac conditions are likely to benefit from revascularization before surgical hip repair. Thus, invasive and noninvasive cardiac testing are not indicated in hip fracture patients without comorbid cardiac conditions.

The American College of Cardiology/American Heart Association (ACC/AHA) Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery recommends perioperative testing and treatments only for the following specific cardiac conditions:

- Unstable coronary syndromes, such as unstable angina, acute myocardial ischemia or infarction, and recent myocardial infarction
- Decompensated heart failure
- Significant atrial arrhythmias, such as symptomatic bradycardia, high-grade atrioventricular block, supraventricular arrhythmias with rapid ventricular rate at rest, and atrial fibrillation with rapid ventricular rate at rest
- Ventricular arrhythmia
- Severe valvular disease.

Recommendations for perioperative medical therapies to reduce risk in patients with stable coronary artery disease have been updated in recent years. The ACC/AHA recommends continuation of β-blocker therapy in patients already receiving this therapy for angina, arrhythmia, and hypertension. They also recommend β-blockers to patients with identified coronary artery disease or high cardiac risk having intermediate-risk surgery (41, 42).

The ACC/AHA Guidelines for perioperative testing and therapy offer a complete set of recommendations. Consultation with a cardiologist may also benefit a certain subset of patients (41, 43).

What is the status of minimally invasive approaches for hip fracture repair?

Minimally invasive surgical approaches for repair of intertrochanteric hip fractures result in lower rates of blood transfusions but no difference in mortality (44).

What is the expected mortality of hip surgery?

Surgical-specific mortality after hip fracture repair is 2%–3% in most U.S. hospitals; however, hip fracture confers a 5-fold increase for women and an 8-fold increase for men in all-cause mortality compared with age- and sex-matched controls in the first 3 months after fracture (45).

What are the major postoperative complications of hip fracture?

Major postoperative complications of hip surgery include infection, dislocation and failure of the prosthesis, delirium, DVT, skin breakdown, and bladder problems. What should be evaluated to assess these risks and other appropriate follow-up measures are shown in Table 3.

Outpatient providers should be aware that late postoperative complications may occur months to years after repair and include osteonecrosis of the femoral head (after internal fixation), loosening of the prosthesis (after arthroplasty), and persistent pain (46, 47).

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When should rehabilitation begin following surgery for hip fracture?

Rehabilitation is a key component of treatment and should begin on the first postoperative day. Most patients should get out of bed on the first postoperative day, with progression to ambulation as soon as tolerated to prevent pressure ulcer formation, atelectasis, pneumonia, and muscle weakness.

More intense physical therapy within the first 3 days after surgery has been shown to be associated with improved ambulation 2 months after surgery; however, the improvement is attenuated by 6 months after surgery compared with less intense physical therapy in the first 3 days after surgery (48).

What are the goals of rehabilitation and how are they best accomplished?

The goals of rehabilitation are focused on regaining the previous level of ambulation and independence. The best strategies to improve mobility after hip fracture, however, have not been determined.

Most studies of rehabilitation strategies are small and methodologically limited (49).

What is the role of prophylactic antibiotics for patients who are having surgery for hip fracture?

Prophylactic antibiotics should be administered to all patients, including those having surgery for closed fracture fixation, as they decrease the rates of deep wounds, superficial wounds, and urinary tract infections (50)

The first dose of prophylactic antibiotics is given before surgery and continued for 24 hours after surgical repair. First- and second-generation cephalosporins have been used most often in trials.

Meta-analyses have shown a 44% lower risk for infectious complications with antibiotic use vs. placebo and a 40% reduction of infection with multiple vs. single doses (51).

What the major components of pain management for hip fracture?

Provide adequate analgesia to all patients with hip fracture, regardless of whether they have surgery. Analgesia increases patient comfort, facilitates rehabilitation, and decreases the risk for delirium.

A large prospective study found that patients with higher postoperative pain scores had longer hospital stays and worsened short- and long-term functional recovery (52).

Adequate doses of narcotics should be used to control pain, but meperidine should be avoided because it is strongly identified as a risk factor for delirium (53, 54).

How common is thromboembolism following a hip fracture, and should it be prevented and treated?

Rates of DVT up to 50% have been reported in patients with hip fracture not treated prophylactically. The rate of fatal pulmonary embolism was reported to be in the range of 1.4%–7.5% within 3 months after hip fracture surgery (55, 56).

Unless contraindicated, all patients should be treated with fondaparinux, low-dose unfractionated heparin, adjusted-dose vitamin K antagonist, or low-molecular-weight heparin to reduce the rate of thromboembolic complications.

A randomized trial sponsored by the makers of fondaparinux comparing that drug with enoxaparin showed lower rates of (largely asymptomatic) DVT with fondaparinux, without any difference in bleeding or death. Fondaparinux is more expensive than enoxaparin, heparin, or vitamin K antagonists (57).

Randomized trials that compared unfractionated or low-molecular-weight heparins with control showed a 59% reduction in DVT (51, 55, 58).

For patients undergoing hip fracture surgery, the American College of Chest Physicians (ACCP) recommends the routine use of fon-

Table 3. Elements of Postoperative Follow-up for Hip Fractures

Category	*Issue*	*How?*	*How Often?*	*Notes*
History	Pain control	Ask if pain is severe or if it is limiting therapy	At least daily while an inpatient, then periodically	Pain medications may need adjustment; new or increasing pain may warrant evaluation of stability of repair or for evidence of deep venous thrombosis or wound infection; evidence is insufficient to recommend one form of pain control over another (e.g., PCA pump vs. oral therapy), but most patients require narcotic therapy post-operatively, which can be tapered during recovery
	Bladder control	Ask how much the patient has voided and whether dysuria is present	At least daily during acute hospitalization	Postoperative urine retention and infection are common; the Foley catheter should be removed on postoperative day 1, then straight catheterization may be used if needed
Physical examination	Delirium	Monitor for confusion or altered level of consciousness	At least daily during acute hospitalization	A standardized screening tool, such as as the Confusion Assessment Method, may be useful for diagnosis; altered mentation should prompt a search for the underlying cause
	Pressure ulcer	Examine skin for evidence of breakdown		Daily during acute hospitalization, then periodically until full mobility is achieved
	Deep venous thrombosis	Check for unilateral edema, erythema, warmth, and palpable venous cord	Daily during acute hospitalization, then periodically until full mobility is achieved	Venous Doppler ultrasonography may be useful for evaluation if clinical suspicion warrants it
History and physical examination	Infectious complications	Observe vital signs; examine lungs and wound; ask about symptoms of fever, cough, leg pain, or dysuria		Daily during acute hospitalization, then during outpatient follow-up as symptoms warrant
	Cardiac complications	Ask about symptoms of chest pain, nausea, dyspnea, or diaphoresis; examine heart and lungs	Daily during acute hospitalization	Delirium may be the sole presentation for acute MI or CHF in the elderly; electrocardiography may be helpful
	Falls	Ask about recent falls and the circumstances surrounding them; perform neurologic an musculoskeletal examinations, focus particularly on gait and balance	Periodically at each outpatient visit	Assess efficacy and compliance with a falls-prevention program
Laboratory data	Postoperative complications	Check hematocrit and electrolyte levels	Daily during acute hospitalization until stable	
Nondrug therapy	Rehabilitation	Ask patient and therapist and observe functional abilities	Daily while an inpatient, then periodically	
History, physical examination, and laboratory data	Osteoporosis	Review medications, diet, alcohol and tobacco use, and exercise history; check serum TSH, 25-hydroxy vitamin D, calcium, phosphorus, and alkaline phosphate levels; consider checking serum and urine and protein electro-phoresis or DEXA; oral bisphosphonate therapy should be held off during hospitalization until the patient is able to take it with 8 oz of water and remain upright for 30 minutes before eating, drinking, taking other medications, or reclining	At the first outpatient follow-up appointment	Evaluate for diseases or conditions that cause or exacerbate osteoporosis, and treat those that are amenable to therapy; initiate specific osteoporosis treatment based on individual patient characteristics then monitor for side effects, compliance, and efficacy; DEXA may be useful for monitoring therapy to enhance compliance, but its cost-effectiveness is debated; because of ease of administration and reported ability to alleviate pain, calcitonin nasal spray may be initiated with calcium and vitamin D supplementation during hospitalization; evidence is insufficient that any osteoporosis therapies improve fracture healing rates

CHF = congestive heart failure; DEXA = dual-energy x-ray absorptiometry; MI = myocardial infarction; TSH = thyroid-stimulating hormone.

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daparinux, low-molecular-weight heparin, vitamin K antagonist (target international therapeutic range, 2.5; range, 2.0 to 3.0) or low-dose unfractionated heparin. They also recommend against the use of aspirin alone. Mechanical prophylaxis is recommended if anticoagulant prophylaxis is contraindicated because of a high risk for bleeding.

The duration of prophylaxis is controversial. Studies show that the risk for venous thromboembolism begins soon after fracture. Prophylaxis should, therefore, begin before surgery if the procedure is likely to be delayed and should be restarted once postoperative hemostasis has been demonstrated. The ACCP recommends that patients undergoing hip fracture surgery be given extended prophylaxis for up to 28–35 days after surgery (59).

What is the correct approach to secondary prevention in patients who have had a hip fracture?

Outpatient follow-up includes evaluation of return of function, monitoring for late postoperative complications, and institution of secondary prevention measures.

Analysis of data from the Framingham Heart Study showed that 2.5% of patients with hip fracture have a second hip fracture in the first year and 8.2% do so within 5 years of the first fracture (60).

Secondary prevention measures include treatment for osteoporosis and fall prevention.

A prospective, blinded, placebo RCT sponsored by industry showed that annual infusion of zoledronic acid started within 90 days after hip fracture and accompanied by daily calcium and vitamin D supplementation reduced both new fractures and mortality after hip fracture in the mean 1.9 years pf follow-up (61).

Treatment and Management... Surgical repair of hip fracture provides the best opportunity for functional recovery. Studies show that surgery performed within 24–48 hours reduces long-term mortality and should be done if the patient is medically stable. Perioperative cardiac testing and treatments are recommended only for specific cardiac conditions. Perioperative antibiotics reduce the risk for infectious complications. Postoperative anticoagulation is recommended to reduce the rates of DVT. Secondary prevention, including treatment for osteoporosis and efforts to reduce falls, is also indicated.

CLINICAL BOTTOM LINE

Patient Education

What should patients be told about primary prevention of hip fracture?

Patients should be educated about osteoporosis and its implications for risk for subsequent fractures if left untreated. They should also be educated about their future risk for falls and what they can do to prevent them. Poor vision, muscular weakness, certain medications, and many environmental factors are modifiable risk factors.

What should patients be told about immediate care after a fall and the detection of hip fracture?

Hip fracture and subsequent hospitalization are stressful to patients and their families. Knowing what to expect may alleviate some concern and guide modifications of the home

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or living arrangements to accommodate the increased needs of the patient. Approximately 50% of patients regain ambulatory status, and most gains in function are made in the first 6 months after fracture repair (2).

Patients and their caregivers should be told that, barring any unstable medical conditions requiring preoperative treatment, most patients have the fracture repaired in the first day or two of hospitalization. They should also be told that rehabilitation is likely to begin on the first day after surgery, a 2-week stay in a rehabilitation facility is required before they can return home safely, and they will require assistance at home and further therapy for several months.

What should patients with a hip fracture be told about the risk for recurrent fractures and how to prevent them?

Analysis of data from the Framingham Heart Study showed that 2.5% of patients with hip fracture have a second hip fracture within the first year and 8.2% do so within 5 years of the first fracture (60).

Commonly, patients with prior fractures are found to be receiving no specific therapy for osteoporosis at the time of their subsequent hip fracture, suggesting the opportunity to diagnose and treat osteoporosis before a hip fracture is missed. Therefore, it is important to educate patients about osteoporosis and its implications for risk for subsequent fractures if left untreated. Explain to the patient that he or she has "brittle bones" and requires therapy to reduce the chances of breaking other bones. Patient education can be instrumental in secondary prevention. Often, it is better if this information is delivered a few days after the fracture repair, when the patient is focusing on rehabilitation and recovery.

Patient Education... Patients and their families should be educated on treatment for hip fractures and postoperative physical rehabilitation. They should also be educated on how to prevent future hip fractures. Interventions should include assessment of risk factors for falls and therapy for osteoporosis.

CLINICAL BOTTOM LINE

Practice Improvement

What measures do U.S. stakeholders use to evaluate the quality of care for patients with hip fracture?

The Assessing Care of Vulnerable Elders, 3rd Set (ACOVE-3), quality indicators that are relevant to management of patients with hip fracture are those assessing perioperative care, falls, and osteoporosis management (62).

What do professional organizations recommend regarding the care of patients with hip fracture?

There are no guidelines from U.S. professional organizations; however, evidence-based guidelines for hip fracture management from Australia were published in 2008 and are consistent with the content of this manuscript (63).

60. Berry SD, Samelson EJ, Hannan MT, et al. Second hip fracture in older men and women: the Framingham Study. Arch Intern Med. 2007;167:1971-6. [PMID: 17923597]
61. Lyles KW, Colón-Emeric CS, Magaziner JS, et al; HORIZON Recurrent Fracture Trial. Zoledronic acid and clinical fractures and mortality after hip fracture. N Engl J Med. 2007;357:1799-809. [PMID: 17878149]
62. Wenger NS, Roth CP, Shekelle P; ACOVE Investigators. Introduction to the assessing care of vulnerable elders-3 quality indicator measurement set. J Am Geriatr Soc. 2007;55 Suppl 2:S247-52. [PMID: 17910544]
63. Mak JC, Cameron ID, March LM; National Health and Medical Research Council. Evidence-based guidelines for the management of hip fractures in older persons: an update. Med J Aust. 2010;192:37-41. [PMID: 20047547]

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In the Clinic
Tool Kit

Hip Fracture

PIER Module

http://pier.acponline.org/physicians/diseases/d165/d165.html

PIER module on hip fracture from the American College of Physicians (ACP). PIER modules provide evidence-based, updated information on current diagnosis and treatment in an electronic format designed for rapid access at the point of care.

Patient Information

www.annals.org/intheclinic/toolkit-hip-fracture.xhtml

Patient information that appears on the following page for duplication and distribution to patients.

www.nlm.nih.gov/medlineplus/hipinjuriesanddisorders.html

www.nlm.nih.gov/medlineplus/tutorials/hipreplacement/htm/index.htm

www.nlm.nih.gov/medlineplus/spanish/tutorials/hipreplacementspanish/htm/index.htm

Information on hip injuries and disorders from National Institutes of Health's MedlinePLUS, including an interactive tutorial on hip replacement in English and Spanish.

www.niams.nih.gov/Health_Info/Bone/Osteoporosis/Fracture/prevent_falls.asp

Information on preventing falls and related fractures from the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

www.cdc.gov/ncipc/factsheets/adulthipfx.htm

Information on hip fracture among older adults from the Centers for Disease Control and Prevention.

Clinical Guidelines

www.annals.org/content/149/6/404.full

Clinical practice guideline on the pharmacologic treatment of low bone density or osteoporosis to prevent fractures from the American College of Physicians.

www.nof.org/professionals/clinical-guidelines

Clinician's Guide to Prevention and Treatment of Osteoporosis, from the National Osteoporosis Foundation, released in 2008.

Diagnostic Tests and Criteria

www.uspreventiveservicestaskforce.org/uspstf10/osteoporosis/osteors.htm

Recommendations for screening for osteoporosis in postmenopausal women, from the U.S. Preventive Services Task Force, published in 2011.

http://pier.acponline.org/physicians/diseases/d165/tables/d165-t6.html

Garden classification of femoral neck fractures.

http://pier.acponline.org/physicians/diseases/d165/tables/d165-t7.html

Types of hip fracture repair.

Quality of Care Guidelines

www.qualitymeasures.ahrq.gov/

AHRQ quality indicator measure #19 for assessing the hip fracture mortality rate (the number of deaths per 100 discharges with principal diagnosis of hip fracture).

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THINGS YOU SHOULD KNOW ABOUT HIP FRACTURE

In the Clinic
Annals of Internal Medicine

What is hip fracture?

- A break near the top of the long bone running through the thigh (the femur), near the hip joint.
- Pain after hip fracture may be felt in the groin or buttock, and possibly the thigh or knee.
- Flexing or rotating the hip will cause discomfort.

What causes hip fracture?

- The fracture usually occurs after a fall or some other trauma.
- Most hip fractures occur in people older than 65 years, as aging bones become gradually weaker and more susceptible to breaks.
- Osteoporosis is the main risk factor.
- About 70% of hip fractures occur in women.

How is it treated?

- An x-ray or magnetic resonance imaging (MRI) is used to confirm diagnosis.
- Surgery is usually required for repair.
- The procedure is based on the location and extent of the fracture, patient age, and the surgeon's expertise.
- In rare cases, treatment is nonsurgical. Nonsurgical treatment is usually reserved for patients who are too sick to have surgery or those who were unable to walk before the injury.

What are common complications?

- It is important to start moving around soon after surgery to speed recovery and reduce complications.
- It is usually necessary to use a walker, cane, or crutches and to participate in physical therapy for several months after surgery.
- Muscle deterioration and weakness can lead to permanent loss of mobility.
- Patients on bed rest are at increased risk for infections, bed sores, pneumonia, blood clots, and nutritional wasting.

- People who have one hip fracture are significantly more likely to have another.

How can hip fracture be prevented?

- Keep bones strong by eating a nutritious diet with adequate amounts of calcium and vitamin D.
- Be physically active to help maintain bone strength.
- If you have osteoporosis, talk to your doctor about medicines that treat or prevent bone loss.
- Prevent falls by remedying household hazards like slippery floors, poor lighting, and cluttered walkways.
- Stairways should have handrails.
- Review your medicines with your doctor and take only as directed.
- Wear well-fitting, low-heeled shoes, and use walking aids correctly.

For More Information

http://orthoinfo.aaos.org/topic.cfm?topic=A00305
Information on preventing broken hips from the American Academy of Orthopedic Surgeons.

www.nlm.nih.gov/medlineplus/ency/article/007386.htm
www.nlm.nih.gov/medlineplus/ency/patientinstructions/000168.htm
Information on hip fracture surgeries and on postsurgical care from the National Institutes of Health's MedlinePLUS.

http://nihseniorhealth.gov/osteoporosis/toc.html
Patient information on osteoporosis from NIHSeniorHealt

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American College of Physicians
Internal Medicine | Doctors for Adults®

Patient Information

CME Questions

MKSAP
MEDICAL KNOWLEDGE Self-Assessment Program

1. An 87-year-old woman comes to the office for a routine evaluation. She reports that she has fallen once or twice a month for the past 4 months. The falls happen at various times of the day and occur immediately after standing up or after standing for some time. She does not experience dizziness, lightheadedness, vertigo, palpitations, chest pain or tightness, focal weakness, loss of consciousness, or injury at the time of the falls. The patient lives alone. Medical history includes hypertension and degenerative joint disease of both knees. Medications are acetaminophen and hydrochlorothiazide.

   On physical examination, temperature is normal, blood pressure is 135/85 mm Hg without postural change, pulse rate is 72/min, and respiration rate is 16/min. Visual acuity with glasses is 20/40 on the right and 20/60 on the left. Cardiopulmonary examination is normal. There is bony enlargement of both knees without warmth or effusion. On balance and gait screening with the "get-up-and-go" test, the patient must use her arms to rise from the chair. Neurologic examination, including cerebellar testing and a Romberg test, is normal. The patient's score on the Mini-Mental State Examination is 26/30 (normal ≥24/30).

   Results of a complete blood count and blood chemistry studies are normal.

   Which of the following should be included as part of her management at this time?

   A. Begin risedronate
   B. Measure serum 25-hydroxyvitamin D level
   C. Prescribe hip protectors
   D. Schedule 24-hour electrocardiographic monitoring

2. An 83-year-old woman who is recuperating from hip replacement surgery was evaluated on the orthopedic floor of a hospital when she became confused and was found on the floor of her room at about 3 am. Her assessment found no sign of injury, and vital signs were normal. The patient was released from the hospital without further incident 2 days later. The patient's medical history is significant for osteoporosis and hypothyroidism. A geriatric assessment within the past year revealed a Mini-Mental State Examination score of 29/30 (normal ≥24/30) and full activity of daily living capability. Current medications are hydrocodone, levothyroxine, diphenhydramine, aspirin, and fondaparinux.

   The patient's records show that meperidine was ordered on a routine schedule, and an additional order was to be given for breakthrough pain.

   Which of the following system-level interventions will be most helpful in preventing future falls in other patients in similar circumstances?

   A. Begin collecting adverse drug event prevalence data
   B. Implement a fall-risk prediction tool for newly admitted patients
   C. Reengineer the hospital room architecture to decrease fall risk
   D. Standardize protocols for management of opiate medications

3. An 85-year-old man presents with a left hip fracture. He has been very healthy and is able to walk 4 or more blocks. He has a 3-year history of occasional chest pain that occurs less than once each month and develops only after walking too quickly. There has been no change in the severity or frequency of the chest pain and no dyspnea. Medical history is significant for a myocardial infarction 4 years ago, type 2 diabetes mellitus, and hypertension. Current medications are metoprolol, fosinopril, atorvastatin, insulin glargine, metformin, and aspirin.

   Blood pressure is 140/80 mm Hg, pulse rate is 60/min. BMI is 30. There is no jugular venous distention. The lungs are clear. There are no murmurs or gallops. Serum creatinine is 1.5 mg/dL (132.6 µmol/L). An electrocardiogram shows normal sinus rhythm with Q waves in leads II, III, and aVF; nonspecific ST-T wave changes; and left ventricular hypertrophy. A chest radiograph is normal.

   Which of the following is the most appropriate preoperative cardiac testing?

   A. Coronary angiography
   B. Dobutamine stress echocardiography
   C. Exercise (treadmill) thallium imaging
   D. Resting two-dimensional echocardiography
   E. No additional testing is indicated

4. An 82-year-old woman is evaluated at the hospital after tripping and falling. She fractured her right hip and needs urgent hip replacement. She reports no angina, chest discomfort, syncope, or presyncope. She has had no signs or symptoms of heart failure. Before the fall, she was active and walked daily.

   On physical examination, temperature is normal, blood pressure is 164/82 mm Hg, and pulse is 96/min. BMI is 26. Point of maximal impulse is undisplaced. There is a normal S_1 and a single S_2. There is a grade 3/6 systolic ejection murmur on examination heard at the right upper sternal border that radiates to the left carotid artery. Carotid pulses are delayed.

   Transthoracic echocardiogram demonstrates severe aortic stenosis and normal left ventricular size and function. Pulmonary pressures are normal.

   Which of the following is the best perioperative management option?

   A. Aortic balloon valvuloplasty
   B. Aortic valve replacement
   C. Intra-aortic balloon placement
   D. Intravenous afterload reduction (nitroprusside)
   E. Proceed directly to hip replacement

Questions are largely from the ACP's Medical Knowledge Self-Assessment Program (MKSAP, accessed at http://www.acponline.org/products_services/mksap/15/?pr31). Go to www.annals.org/intheclinic/ to complete the quiz and earn up to 1.5 CME credits, or to purchase the complete MKSAP program.

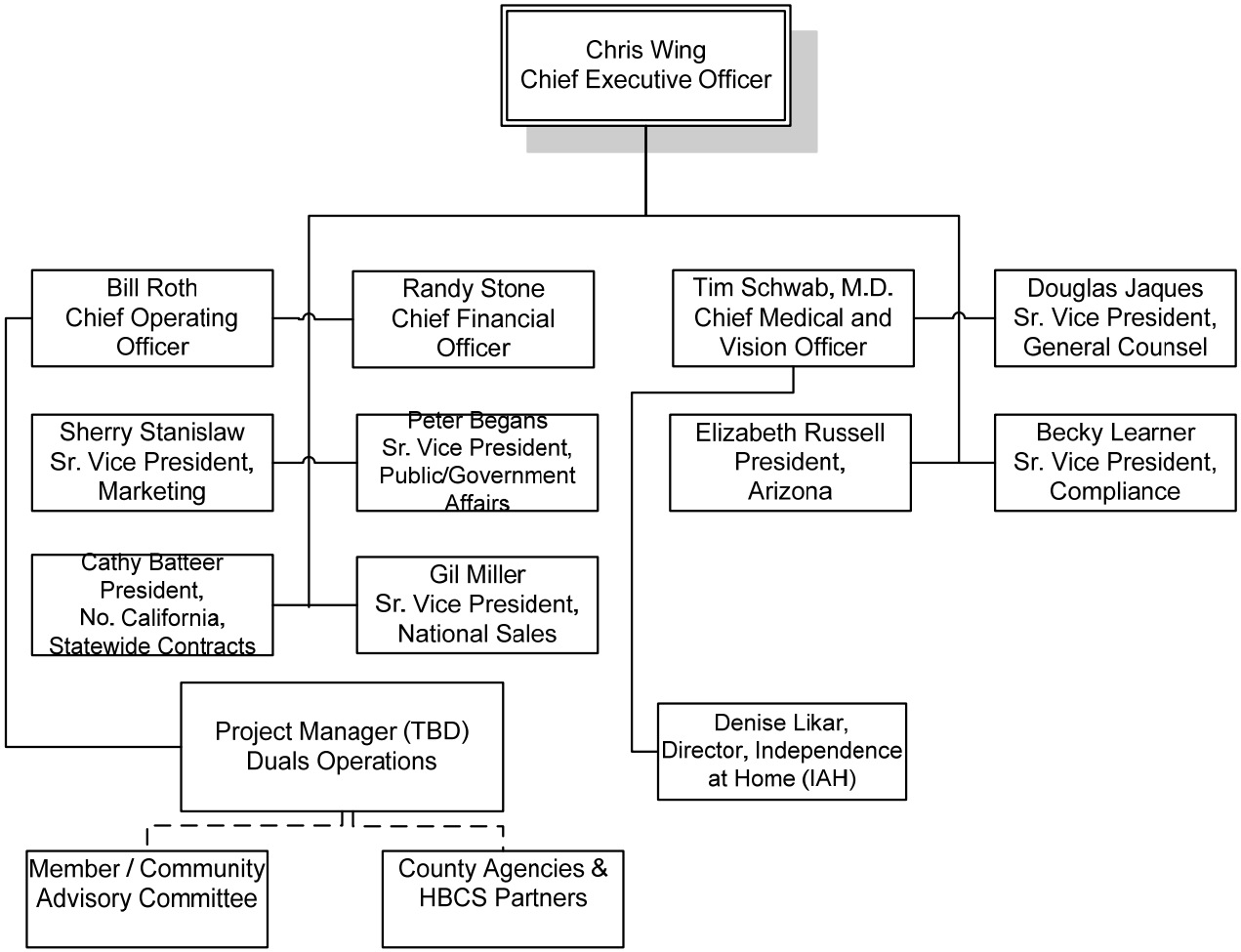
Appendix 12

SCAN HEALTH PLAN
Appeals and Grievances Process Currently In Force

ID	Title	Revision	In Force	Type	Last Revised
GA-0016	Web Site Grievance Submission	2	Y	PUBLISHED POLICY	09/10/2009
GA-0011	Expedited Grievance Process	3	Y	PUBLISHED POLICY	12/09/2009
GA-0018	Correspondence Processing	2	Y	PUBLISHED POLICY	02/05/2010
GA-0003	Grievance Resolution Policy	16	Y	PUBLISHED POLICY	02/12/2010
GA-0002	Expedited Appeals Process	16	Y	PUBLISHED POLICY	08/13/2010
GA-0020	Administrative Law Judge (ALJ) Hearing	3	Y	PUBLISHED POLICY	11/24/2010
GA-0024	Part D Expedited Grievance Process	2	Y	PUBLISHED POLICY	01/06/2012
GA-0019	California Department of Social Services Fair Hearings	2	Y	PUBLISHED POLICY	04/09/2010
GA-0001	Standard Appeals Process	17	Y	PUBLISHED POLICY	03/30/2010
GA-0030	Medi-Cal Grievance and Appeals Resolution Process	New	Y	PUBLISHED POLICY	04/09/2010
GA-0023	Part D Standard Grievance Resolution Process (pka: Part D Grievance Resolution Process)	2	Y	PUBLISHED POLICY	01/06/2012

Appendix 13

Duals Demonstration Program



Appendix 14

Proposed key staff members chart

Key Staff Members	Title	Relevant Skills and Leadership Ability
Tim Schwab, MD	Chief Medical Officer	Clinical and organizational leadership, knowledge of dual eligible public policies and regulations, quality assurance
Eve Gelb	VP Health Care Services Administration	Leadership, planning, case management expertise
Jodi Cohn	Research Director Geriatric Practice Innovation	Gerontological expertise and community relationships
Lisa Roth	Director of GHM, PALs and Independent Living Power	Project oversight, Case management and dual eligible expertise
Kimberley Johnson	Manager of PALs and Independent Living Power	Project management, Case management and dual eligible expertise
Moon Leung	VP Health Care Informatics	Research and evaluation skills, statistical skills
Roy Swackhamer	Chief Information Officer	Knowledge of IT hardware, software, leadership and planning skills
Karen Sugano	VP of Network Management	Knowledge of strategies for engaging contracted health care providers
Lena Perelman	Director of Community Outreach	Knowledge of and linkages with community based organizations
Denise Likar	Director of Independence and Home	Knowledge of and linkages with community based organizations
Nathan Norbryhn	Director of Health Care Services	Knowledge of strategies for engaging contracted health care providers
Ray Chan, MD	Medical Director	Knowledge of provider networks, established relationships with providers and knowledge of integrated care models

Appendix 15

CURRICULUM VITAE
Timothy Carl Schwab, M.D., F.A.C.P., M.H.A.

Chief Medical Officer – SCAN Health Plan

Professional Address: SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
Long Beach, CA 90801

Professional Telephone: (562) 989-8316

Email Address: tschwab@scanhealthplan.com

Education: B.S.- Colorado State University
Fort Collins, Colorado
1966-1970

M.D. - University of Colorado School of Medicine
Denver, Colorado
1970-1974

M.H.A. - University of LaVerne
LaVerne, California
1988-1991

Internship: St. Mary's Medical Center
Long Beach, California
1974-1975

Residency: Internal Medicine
St. Mary's Medical Center
Long Beach, California
1975-1977

Chief Resident Internal Medicine
St. Mary's Medical Center
Long Beach, California
1977-1978

Certification: American Board of Internal Medicine, 1977

Practice: Harriman Jones Medical Clinic
Long Beach, California
Em ployee 1978-1979
Partner 1979-1988
Chairm an of Board 1985-1987

Affiliation: 1978-1996
Assistan t Clinical Professor

CURRICULUM VITAE
Timothy Carl Schwab, M.D., F.A.C.P., M.H.A.

Departm ent of Medicine
School of Medicine, UCLA

Employment: June 1988 – February 1990
Medical Director
St. Mary's Medical Center
Physicians of Greater Long Beach, an IPA

February 1990-1992
Medical Director

January 1993-1998
Chi ef Medical Officer

1998-Present
Chief Medical/Informatics Officer
SCAN Health Plan
Long Beach, California

SCAN Health Plan Responsibilities:
Supervise Medical Director Department and all Quality oversight activities
Supervise Pharmacy Department
Supervise HealthCare Informatics Department (includes data warehouse, BI activities, HEDIS management, research and quality improvement activities (1999 – 2011)
Social HMO Site Director (1990-end of demo in 2007)
ESRD SNP demo site director (2005- end of demo in 2010)
Public and Government Affairs (1999- 2009)
CA relationship for duals contract

Memberships: American College of Physician Executives
American College of Physicians – American Society of Internal Medicine
Am erican Geriatric Society
Am erican Health Insurance Plans
Am erican Medical Association
Am erican Medical Directors Association
California Association of Health Plans – Medical Directors
California Medical Association
Gerontological Society of America
Long Beach Medical Association
Los Angeles County Medical Association
National Academies of Practice

Committees: ***American College of Physicians – American Society of Internal Medicine***
3rd Party Relations, Coding, and Payment Subcommittees (2001-2008)
Managed Care Subcommittee (1998-2000)

American Health Insurance Plans

Comm ittee on Quality Care

American Society of Aging
Leadership Council of the Managed Care and Aging Network (1997-1998)

American Society of Internal Medicine
Managed Care Committee (1996-1998)
Committee on Quality and Utilization (1994-1996)
Delegate 1988-1996 Conventions
Committee on Health Care Financing (1991-1993)

ARV Assisted Living
Medical Advisory Committee (1998-2000)

California Chapters ACP Services
Board of Directors (2005- present)

California Lutheran Homes
Board of Directors (1997-2000)
Com pensation Committee (1998)

California Society of Internal Medicine
Merger Committee ACP-CSIM (1998-1999)
President (1995-1996)
Secretary/T reasurer (1994)
Trustee (1988-1993)
Mem bership Committee (1987-1990)
Member Relations Committee (1987-1988)

Front Porch Corporation
Board of Directors (1999-2004, 2006-2011)
Business Development & Assessment Committee Chairman (2003-2004)
Finance Committee (1999-2003)
Audit Committee (2006-2011, chair 2008-2011)

Harriman Jones Medical Clinic
Director Executive Physical Program (1982-1988)
Medical Director Immediate Care Clinic (1982-1988)
Finance Committee (1981-1988)
Medical Records Committee (1985-1986)
Management Committee (1982-1986) (Chairman 1984-1986)
Chairman Department of Medicine (1982-1984)

Long Beach Society of Internal Medicine
President (1987-1988)

Prudential Plus of Orange County

Quality Assurance Committee (1988-1990)

St. Mary's Medical Center
Medicine Committee (1981-1984)
Geriatrics 1982-1984 (Chairman 1983)
Pharmacy & Therapeutics (1978-1982) (Chairman 1980-1982)
Utilization Review (1979-1982)

St. Mary's Medical Education Department
Clinical Competency Committee (1980-1991)
Intern-Resident Selection Committee (1980-1991)

Community Activities:

California Olmstead Committee (appointed by Secretary of HHS)
Member 2005 - present

California 1115 Waiver Committee (appointed by secretary of HHS)
Mem ber 2008 - present

California Long Term Care Integration Technical Advisory Committee
Member 2010 - present (support of CMMI dual integration grant)

California State University, Long Beach
Physical Therapy Advisory Committee (1994-2005)
Center for Health Care Innovation Advisory Committee (1998-2006)
Health Care Administration Dept Advisory Committee (2006 - present)

City Of Long Beach
Blue Ribbon Commission on Health in Long Beach (2001-2002)

Los Angeles County
Aging & Disabled Services Community Roundtable (2001-2002)

OnLok
PACE Regulatory Integration Project (2004-2005)

SCAN Health Plan
Developer and Facilitator, Geriatric Advisory Board (2005-present)

White House Conference on Aging
Appointed as Delegate (2005)

Appendix 16

SCAN Health Plan Operational Plan

Quarter	Timeline	Activity
Q1 2012	01/20/12 – 03/31/12	Outreach to key partners and stakeholders
	On 02/24/12	Submit Request for Solutions to DHCS
	On 03/01/12	Begin Network Analysis
	By 03/31/12	Conduct Business Impact Assessment
	By 03/31/12	Develop detailed operational work plans for all supporting functions and begin deployment of plans
	By 03/31/12	Explore initial facility/site expansion
	By 03/31/12	Conduct IT infrastructure review
Q2 2012	By 04/02/12	Submit NOIA to CMS
	04/01/12 – 04/30/12	Create separate Duals business unit and structure
	04/01/12 – 04/30/12	Recruit and hire Duals business unit leadership
	04/01/12 – 04/15/12	Finalize staffing plans for new CA Duals business unit and shared services departments within SCAN
	04/01/12 – 04/30/12	Confirm all workflow and IT business requirements
	04/01/12 – 05/15/12	Review business processes and protocols and update documentation as needed
	04/10/12 – 04/20/12	Develop staff recruitment strategy and staffing ramp-up plan
	By 04/15/12	Identify and hire external experts if needed
	By 04/16/12	Submit Part D Formulary for all SCAN product lines
	Start 05/01/12	Recruit staff and begin training
	05/01/12 – 05/31/12	Complete necessary facility build-out
	05/01/12 -05/31/12	Install or expand IT and/or telephonic systems
	05/01/12 – 12/31/12	Deploy provider contracting activities

Quarter	Timeline	Activity
	By 05/07/12	Submit MTMP to CMS
	By 05/15/12	Respond to DHCS via the Demonstration Proposal state comment period
	Start 06/01/12	Develop beneficiary outreach and educational materials and plan informing documents
	By 06/04/12	Complete CMS Bid/benefit design and submission
	By 06/08/12	Submit Supplemental Formulary Files, Free First Fill file, Partial Gap Coverage File to CMS
	On 07/30/12	Receive final CMS decision regarding state demonstration proposals
	08/01/12 – 09/20/12	Participate in Site Readiness Reviews with CMS and State of California
	08/01/12 – 09/30/12	Refine beneficiary on-boarding processes
	By 09/20/12	Execute contract with CMS and State of California
Q4 2012	10/01/12 – 12/31/12	Conduct support staff training
	Start 10/1/12	Begin distribution of plan materials
	Start 10/15/12	Start accepting enrollments for a 01/01/13 effective date
2013	Throughout 2013	Continue to execute staffing plan based on projected monthly enrollments
	Throughout 2013	Continue beneficiary on-boarding activities
	Start 01/01/13	Conduct health risk assessments
	Start 01/01/13	Assign case managers
	Start 01/01/13	Execute care plans
	Throughout 2013	Contracting continues and address any network gaps
	Throughout 2013	Develop and implement mechanisms to gather beneficiary and stakeholder input on year 1

Quarter	Timeline	Activity
		performance
	Throughout 2013	Develop and implement mechanisms to gather staff input on year 1 performance
	Throughout 2013	Conduct Stakeholder outreach
2014	Throughout 2014	Develop co-location arrangements for behavorial health and substance abuse treatments
	Throughout 2014	Continue with local stakeholder outreach activities
2015	Throughout 2015	Continue to develop co-location arrangements for behavorial health and substance abuse treatments
	Throughout 2015	Continue with local stakeholder outreach activities