701 GATEWAY BLVD., SUITE 400
SO. SAN FRANCISCO, CA 94080

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February 22, 2012

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

Re: Response to RFS, California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

Enclosed, please find one original proposal, six copies, and an accompanying CD as well as a large-print electronic version (section 508 compliant) in response to the RFS for California's Dual Eligibles Demonstration Project.

This proposal is submitted by the Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). HPSM has been serving vulnerable residents of San Mateo County since 1987, and currently provides services to nearly 100,000 members through multiple coverage programs including Medi-Cal, Healthy Families, Medicare Advantage and other local coverage initiatives. HPSM has participated in the Medicare Advantage Special Needs Plan (SNP) almost since its inception in January 2006. HPSM's SNP is only one of two Dual Eligible Special Needs Plans (D-SNPs) available in San Mateo County. Approximately 60%, or 8,400, of all duals in San Mateo County are currently enrolled in our D-SNP.

HPSM has worked in partnership with the San Mateo County Health System (SMCHS) for several years to develop a more integrated and locally-controlled health and social delivery system. The proposed Dual Eligibles Demonstration Project will build on the successes and strategies utilized in HPSM's SNP, as well as the work already underway with SMCHS's behavioral health program and long-term care supportive services to improve the delivery of services for dual eligibles, making a complex, often fragmented, system of care more responsive and effective for the people in our care.

Please feel free to contact me with any questions. I can be reached at maya.altman@hpsm.org or at (650) 616-2145.

Sincerely,

Maya Altman,
Chief Executive Officer

HPSM DUAL ELIGIBLES DEMONSTRATION PROJECT (DEDP)
TABLE OF CONTENTS

Section	Page Number
Cover Letter	-
Table of Contents	-
Project Narrative	1
Executive Summary	1
Section 1: Program Design	4
Section 2: Coordination and Integration of LTSS	31
Section 3: Coordination and Integration of Mental Health and Substance Use Services	52
Section 4: Care Coordination	66
Section 5: Consumer Protections	82
Section 6: Organizational Capacity	106
Section 7: Network Adequacy	119
Section 8: Monitoring and Evaluation	132
Section 9: Budget	136
Checklist/Attachments (with Documentation for Qualification Requirements)	138
RFS Proposal Checklist	140
Attachment 1. Knox-Keene License	144
Attachment 2. Financial Condition – DMHC letter	145

Attachment 3. Current Medicare Advantage D-SNP 147

- DMHC Order Approving Notice of Material Modification (SNP)
- D-SNP Contract Description Summary
- H55428 Benefit Attestation

Attachment 4. Current Medi-Cal Managed Care Plan 152

- Signature Page

Attachment 5. High Quality 154

- Three years of Quality Performance Indicators – HEDIS reports for DHCS
- Three years of Quality Performance Indicators – HEDIS reports for SNP
- SNP Quality Performance Measurements (Medicare Stars Report)

Attachment 6. Stakeholder Involvement 159

- Draft Operating Principles for the DEDP Advisory Committee
- Five (5) Letters of Support
- Stakeholder meeting list

Attachment 7. NCQA accreditation for D-SNP product 175

Attachment 8. Supplemental Benefits 181

Attachment 9. Letters of Agreement from County Officials 182

Attachment 10. Contract with the County Mental Health Agency 184

Attachment 11. HPSM Organizational Chart 236

Attachment 12. DEDP Project Manager Résumé 237

Attachment 13. DEDP Project Plan 239

Attachment 14. Diagram from Little Hoover Commission Report April 2011, *A Long Term Strategy for Long Term Care*. 244

Attachment 15. HPSM CareAdvantage Model of Care 2012 (modified per RFS Appendix C) 246

PROJECT NARRATIVE

Executive Summary

The applicant for this *Dual Eligibles Demonstration Project (DEDP),* the Health Plan of San Mateo (HPSM), is a County Organized Health System (COHS) which has served vulnerable residents of San Mateo County since 1987. HPSM currently provides services to nearly 100,000 members through multiple coverage programs including Medi-Cal, Healthy Families, a Medicare Special Needs Plan (SNP), and other local insurance and coverage initiatives. Nearly all San Mateo County residents covered by Medi-Cal are members of HPSM. Approximately 14,200 full-benefit duals receive their Medi-Cal benefit through HPSM, of whom 8,393 (59%) are enrolled in HPSM's SNP, called CareAdvantage, which has operated continuously since 2006.

HPSM, in partnership with the San Mateo County Health System (SMCHS), has long sought to adopt a more integrated system of care for duals, and comes to this RFS process after several years of intensive planning with the County around long-term care and behavioral health integration. These concepts came to fruition during the recent ADHC to CBAS transition, with an assessment and care planning team consisting of staff from HPSM and SMCHS (Aging and Adult Services, IHSS, MSSP and

Behavioral Health) working together in an integrated fashion. This history of integrated planning, along with the success of HPSM's SNP, provides a comprehensive foundation for the Dual Eligible Demonstration Project (DEDP) activities and innovations to be proposed.

Consistent with the goals of the California DHCS RFS, HPSM seeks to:

- Coordinate benefits and access to care, improving continuity of care and services.
- Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
- Increase availability and access to home- and community-based alternatives.
- Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.
- Improve health processes and satisfaction with care.
- Improve coordination of and timely access to care.
- Optimize the use of Medicare, Medi-Cal and other State/County resources.

HPSM will meet the goals of the DEDP through:

- Whole county coverage for all 14,200 full benefit dual eligibles;

- A consolidated, integrated assessment tool and care plan focused on each member’s medical, social and behavioral health needs;
- Establishment of person-centered, integrated interdisciplinary care teams (IDTs);
- Strategic partnerships and subcontracts with partners such as SMCHS, which includes Aging and Adult Services (in which the IHSS and MSSP programs are located), and Behavioral Health and Recovery Services (BHRS); Community-Based Adult Services (CBAS) Centers, other home and community based services (HCBS), and alternative housing providers; and
- A new, proprietary, integrated technology infrastructure (Data Mart) which has been developed to support coordination of data across partner agencies.

With years of planning and service integration strategies under its belt, HPSM and its partners are truly “ahead of the curve” in preparation for participation in this DEDP.

Section 1: Program Design

Section 1.1: Program Vision and Goals

The Health Plan of San Mateo (HPSM), a County Organized Health System (COHS) serving vulnerable residents of San Mateo County (SMC) since 1987, has long sought to adopt more integrated systems of care for its Medi-Cal only and dually eligible members. In addition, HPSM has participated in the Medicare Advantage Special Needs Plan (SNP) program almost since its inception in January 2006. The SNP, along with extensive cooperative planning with the San Mateo County Health System (SMCHS) around long-term care and behavioral health integration, provides a comprehensive foundation for the activities and innovations proposed for this Dual Eligibles Demonstration Project (DEDP).

HPSM is the entity providing care for nearly 60% of dual eligible individuals in SMC. With this background, HPSM has experienced firsthand the many systemic problems which encourage Medicare and Medi-Cal to shift costs to one another. Dually eligible beneficiaries are caught in the middle. They experience barriers to well-being such as:

- *Lack of or disjointed care coordination:* No single entity is responsible for ensuring dual eligibles receive necessary care and services – medical, behavioral and social – to remain in their homes and

communities for as long as possible. Segregation of medical, LTC, and HCBS funding streams create incentives for cost-shifting and inefficient care delivery rather than for high-quality care management in the most integrated and cost effective setting.

- *Needless complexity and fragmentation*: Consumers face a maze of programs as they try to navigate different systems to access the care and help they need. The best description of the system's overwhelming complexity is a diagram, as presented in the Little Hoover Commission's April 2011 report, *A Long Term Strategy for Long Term Care* (see Attachment 14). This complexity is especially problematic when a consumer must receive timely services in order to stay out of a nursing facility or prevent readmission to a hospital. Despite steps toward service integration and consolidation in SMC to date, mandated program requirements and separation of entities responsible for different levels of care have left existing services for the target population fragmented, posing a real challenge for consumers who are forced to navigate different eligibility criteria for different programs.
- *Lack of options:* Far too many people have no options other than institutional care, removing them from their homes and needlessly

increasing costs. A growing number of consumers have expressed desire to remain in their homes as long as possible. The Olmstead decision mandates such choices be available.

- *Cost inefficiencies that could be alleviated with better service integration:* The current duplication of services and systems results in administrative inefficiencies. Blended funds will reduce administrative complexities involved in operating programs under different oversight organizations, with better service integration resulting in significant savings.

With DHCS and CMS, HPSM seeks to build on its successful experience with its SNP as well as its existing strong partnerships with County and community services to pilot solutions *to provide seamless access to the full continuum of medical care, behavioral health and substance use services, along with the social supports and services dual eligibles need to maintain good health and a high quality of life in the setting of their choice*.

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

HPSM currently provides services to nearly 100,000 members through multiple coverage programs including Medi-Cal, Healthy Families, a

Medicare Special Needs Plan (SNP), and other local insurance and coverage initiatives. As a COHS, nearly all SMC residents covered by Medi-Cal, including dual eligibles, are members of HPSM.

Established in 2006, HPSM's Medicare Advantage SNP, called CareAdvantage, has been approved by the Centers for Medicare and Medicaid Services (CMS) for HPSM's most complex and vulnerable disabled and/or elderly adults. SMC has approximately 14,200 full benefit dual eligibles, of whom about 59% are enrolled in CareAdvantage. The remaining dual eligibles are in Fee for Service (FFS) Medicare, enrolled in the other SNP in the county (Kaiser Permanente), or enrolled in other Medicare Advantage plans.

Overall, HPSM also has the largest proportion of seniors and persons with disabilities (SPD) of any COHS Medi-Cal managed care plan in California (40%). Of the HPSM SNP members, 47% are age 75 or older. The majority of CareAdvantage beneficiaries have one or more chronic conditions, with the average risk score for the member population reaching 1.35 per year (or a 35% higher risk profile than the average Medicare beneficiary). In addition, CareAdvantage beneficiaries have the following important characteristics:

- 44% have a mental health diagnosis.

- 43% have been diagnosed with diabetes.
- 28% are disabled and under age 65.
- 7% have developmental disabilities.

HPSM performs an assessment of every member, develops a care plan, and ensures the care plan is implemented. HPSM also operates a Care Coordination Unit that focuses on those dual and Medi-Cal only members who are at highest risk for hospital admissions and ER utilization.

HPSM also works closely with county and community social service and mental health agencies and providers in providing care to vulnerable SPD populations, in ways that go beyond just service referrals, for example:

- HPSM works closely with SMCHS Aging and Adult Services (AAS), the agency which provides social support services to older adults and persons with disabilities, including IHSS, MSSP, Meals On Wheels, adult day care and Alzheimer's day services, information and referral, Adult Protective Services, and other Area Agency on Aging-funded services. This collaboration includes case conferences to resolve issues for HPSM members with complex needs.
- HPSM subcontracts with SMCHS Behavioral Health and Recovery Services (BHRS) to provide Medicare mental health services and seamlessly coordinate Medicare benefits and services with Medi-Cal

specialty mental health benefits and services. HPSM clinical staff collaborate closely with BHRS staff through regular meetings and ad hoc care conferences to provide appropriate and coordinated mental health and medical care for members with mental illness.

- Many HPSM dually eligible members are seen at the San Mateo Medical Center's (or SMMC, the county hospital) ambulatory care clinics in every region of the county, as well as the specialized Ron Robinson Senior Care Center, which provides a full range of interdisciplinary team care at two locations, one in the central SMC and one in northern SMC.
- HPSM works with community partners to tailor specialized services for people with developmental disabilities (DD). HPSM helped BHRS start the Puente Clinic, focused on developmentally delayed consumers with behavioral issues; nearly all HPSM CareAdvantage members. HPSM is also helping San Mateo Medical Center (SMMC) start a medical clinic focusing on developmentally delayed consumers. HPSM works closely with the Golden Gate Regional Center (GGRC) to ensure seamless care management for DD consumers, employs a nurse (previously employed by GGRC) to work with members and GGRC to ensure provision of social and

housing services, and contracts with a DD-experienced physician to provide primary care in group homes for DD members.

- HPSM and the SMCHS recently initiated a High Utilizers Group (HUG) pilot, funded by the Gordon and Betty Moore Foundation, to test an interdisciplinary team-based care management model for especially vulnerable and frail HPSM CareAdvantage dual members. HUG focuses on members who see private primary care physicians in the community, and also receive personal care services through IHSS. These members are at high risk for institutional care, and HUG IDTs have served as a “learning laboratory” for those proposed for DEDP.
- Because continuous benefit coverage is so critical for dual eligibles, HPSM devotes considerable resources to benefit and eligibility coordination and advocacy. Under CareAdvantage, HPSM coordinates benefits for members between Medicare and Medi-Cal in a way that is virtually transparent to members. Members use the same identification card to access services under either set of benefits. Benefits are described in a comprehensive, all-inclusive fashion in plan materials. HPSM is able to authorize and pay for services under Medi-Cal without having to wait for verification of

Medicare payment or denial, enabling members to access services as quickly as possible. Because HPSM tracks service utilization across both programs, staff ensures that members receive the most appropriate care without duplication of services. One of the greatest challenges is ensuring continuity of care for members who lose Medicare or Medicaid benefits temporarily, which threatens members' eligibility for CareAdvantage. HPSM has staff dedicated to tracking eligibility and proactively informing members of lapsed Medi-Cal eligibility.

In short, HPSM comes to this DEDP after several years of intensive planning, problem-solving, and program implementation around care integration and long-term care options. Thus, HPSM is truly "ahead of the curve" in preparation for participation in the DEDP.

Q 1.1.2 Why this program is a strategic match for HPSM's overall mission.

HPSM's mission is to *improve the health of our members through high quality and preventive care* – we seek to serve each member in the best, most coordinated manner possible.

The proposed DEDP will strategically support HPSM's mission and guiding principles by allowing care teams to develop consumer-centered treatment plans *based on the person and their individual needs*. It will

simplify the patient experience and reduce administrative barriers to care by eliminating administrative duplication and complexity. And it will encourage greater utilization of preventive services, resulting not only in improved health outcomes, but also in cost efficiencies and savings.

This aligns closely with many HPSM *Guiding Principles,* as follows*:*

- We advocate for the health care needs of our members and other underserved SMC residents.
- We address the local challenges faced by patients and providers in accessing and providing health care in SMC.
- We give individual and personal attention to our members and providers.
- We respond to the cultural and linguistic diversity of our members.
- We advocate for HPSM providers by ensuring they receive timely payment for their services and by reducing administrative obstacles.
- We support the effective and efficient use of health care services.

As a COHS, HPSM has assumed the risk for Medi-Cal services for dual eligible members for 25 years. While HPSM bears the entire clinical and financial responsibility for dual eligibles in its SNP, the Plan only covers Medi-Cal benefits for the 40% who are not in its SNP. Without access to Medicare-paid health information for these beneficiaries, there is little

opportunity for coordinated care. As a result, HPSM has long sought to integrate services and eliminate service carve-outs for duals and other populations so as to provide person-centered care as effectively as possible. Given this mission and philosophy, HPSM is uniquely positioned to address the challenges the State faces in managing care, health and costs for dual eligibles over the long-term.

Q 1.1.3 How the program meets the goals of the Duals Demonstration.

HPSM will work closely with DHCS, and its community partners – i.e., the San Mateo County Health System, which includes SMMC, Aging and Adult Services (AAS) and Behavioral Health and Recovery Services (BHRS), Community-Based Adult Services (CBAS) Centers, residential care facilities, and long-term care facilities – to implement solutions which meet the goals established for this DEDP:

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

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

Specific strategies to be implemented include:

- HPSM will enter into a three-way contract with the State of California and CMS to be the single accountable entity that will receive capitated funding to provide an integrated benefit package of high quality coordinated services.
- HPSM will subcontract with AAS, including the Public Authority, and CBAS Centers to arrange for and provide Home and Community Based Services (HCBS), including In-Home Supportive Services (IHSS) and the Multi-Purpose Senior Services Program (MSSP). As the local Area Agency on Aging, AAS will also coordinate all non-Medicaid funded home and community based services in conjunction with this DEDP.
- Under its subcontract with HPSM, AAS will manage the single point of entry (SPOE) for long term care integrated services, and will

ensure that consumers' health, functional status, and social service needs are assessed in a comprehensive, uniform manner.

- Program participants will be assessed using an integrated assessment tool to determine their medical, social and behavioral health needs.
- Building on current SNP care coordination models, the member will be at the center of an interdisciplinary care team (IDT), joined by HPSM and AAS staff, the Primary Care Provider (PCP), and – with member agreement – the in-home care worker(s). The ability to target those most in need of integrated services will be critical to program success. The initial goal is to identify those who are most at risk of being placed in an institution (hospitals or nursing facilities) and to target care management resources effectively. Risk stratification is not new to HPSM; it is currently done with SNP and Medi-Cal only members. A data-driven methodology allows care coordinators to identify members most in need of hands-on intensive case management. In the DEDP, IDTs will develop care plans for these members, coordinate their care and ensure they receive the assistance needed to maintain their health and remain in their homes and communities. Others, such as SMC Behavioral Health and

Recovery Services (BHRS) staff or HCBS providers, will also participate in the IDTs as appropriate. The care management services utilized in HPSM's HUG pilot (described earlier) has provided an initial testing ground for integrated care coordination as proposed in this DEDP.

- The SMCHS AAS Public Authority will continue to maintain responsibility for employing, training, and arranging for payment of IHSS caregivers through a contract with HPSM. With agreement from the client, qualified IHSS home care providers will be integrated into the primary care IDT to play a key role in monitoring and coaching their clients on their care plans. Functionally, all personal care services would continue to be consumer-directed.

These activities and innovations will help HPSM and its partners achieve DEDP goals outlined above.

Section 1.2: Comprehensive Program Description

Q 1.2.1 Overall design of proposed program, 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.

HPSM's DEDP will cover *all full benefit dual eligible members in SMC.* The approximate size of target enrollment is 14,200, all current full benefit dual eligibles who are SMC residents.

Of these, 8,393 are already members of HPSM's Special Needs Plan (SNP) for dual eligibles. This SNP – CareAdvantage – provides a comprehensive foundation for the DEDP activities and innovations proposed here. More than two-thirds of current SNP members are over the age of 65; the average age of SNP members is 70.

Remaining dual eligibles are in Fee for Service (FFS) Medicare, enrolled in the other SNP in the county, or in other Medicare Advantage plans. Any dually eligible member already enrolled in HPSM's California Children's Services (CCS) demonstration project will remain in the CCS pilot.

An integrated benefit package will include:

- All current Medi-Cal and Medicare benefits.
- All current HPSM SNP supplemental benefits, including coverage for dental, vision, transportation, and zero co-payments for generic drugs (further detail on supplemental benefits is provided in Attachment 7).
- A robust provider network, described in Section 7.
- Long-Term Services and Supports (LTSS), described in Section 2.1.
- In-Home Supportive Services (IHSS), as per Section 2.2.

- Person-centered care coordination through new IDT structures described in Section 4. As noted, HPSM will use data to stratify members according to risk, and target care coordination resources appropriately.
- Expert behavioral health integration under subcontract with BHRS, per Section 3.
- Home and Community Based Services such as Community-Based Adult Services (CBAS), Multipurpose Senior Service Program (MSSP), and others.
- Acute care.
- Institutional Long Term Care (LTC), including short term skilled care and custodial long term care. HPSM is already responsible for institutional long term care services (where almost all the beneficiaries are dual eligibles).
- Housing alternatives.

Furthermore, HPSM should have the flexibility, similar to PACE programs, to provide non-Medi-Cal funded services, or gap services, as needed – such as services provided in residential housing (e.g., assisted living or board and care), home modification services, or any other alternative service that can help prevent institutionalization

Key partners in the DEDP include San Mateo County Health System (SMCHS). HPSM has worked closely with SMCHS for many years to establish a more integrated and locally-controlled health and social service delivery system. In addition to the proposed DEDP, collaboration occurs in several other areas, including a DHCS-approved CCS integration pilot project.

AAS, a division of the SMCHS, serves as the Area Agency on Aging (AAA) for planning, coordination, funding, and advocacy for seniors and adults with disabilities in the County. AAS provides direct services, which include centralized intake and referral, assessment and consultation, protective and supportive services, and case management. These services are provided through: Information and Assistance (e.g., TIES) Line; Adult Protective Services; 24-Hour Response Team; In-Home Support Services (IHSS); MSSP; Public Guardian Program and the Representative Payee program. The SMC Public Authority is also housed within AAS, while in most California counties, these programs are dispersed throughout county government. This centralization has enabled AAS to develop expertise in case management and service coordination for HCBS. AAS responsibilities under the DEDP will include:

- Management of the single point-of-entry (SPOE) for members;

- Coordination of assessment using a new, consolidated assessment tool to be developed specifically for the DEDP;
- Coordination of IDT activities, together with HPSM;
- Utilization management functions for HCBS, with HPSM and BHRS;
- Medical management through participation in the IDT;
- Continued operation of the Public Authority, and provider contracting and payment for IHSS providers; and
- Stakeholder management and data reporting in collaboration with HPSM.

Per Section 3 of this proposal, HPSM will also work with SMCHS BHRS to ensure seamless mental health and substance abuse services for beneficiaries. BHRS already serves as HPSM's subcontractor for Medicare services provided for duals in the SNP.

A list of all partners, and their roles and responsibilities, is included in Section 6.1.

<u>Q 1.2.2 How HPSM will manage the program within an integrated financing model, (i.e. services are not treated as "Medicare" or "Medicaid" paid services.)</u>

As noted, as a COHS, HPSM has been assuming the risk for the dually eligible population for 25 years, albeit for a more limited array of services.

HPSM is already at risk for all Medicaid acute, primary and specialty care, allied health services, and long term care custodial services for duals population in SMC. With a few exceptions, all Medi-Cal beneficiaries in the county, including duals, are required to enroll in HPSM for their Medi-Cal services. Since 2006, HPSM has also held full financial risk for all Medicare covered services for the 8,393 enrolled in HPSM's SNP.

In the DEDP, HPSM will be the single entity accountable for financial, operational, and clinical outcomes. HPSM will develop contracts with all the organizations participating in the DEDP, and will enter into a three-way contract with the State of California and CMS to be the single accountable entity that will receive capitated funding to provide an integrated benefit package of high quality coordinated services.

This integrated approach will allow HPSM the flexibility to provide services based on individuals' needs, rather than on categorical program restrictions like those currently in place for Medi-Cal and Medicare. Integration of all financing, services, and covered benefits would provide appropriate financial incentives for helping people live in least restrictive environments, resulting in potential cost savings.

For instance, in the DEDP, HPSM will be able to identify DEDP participants who currently rely on institutional care, but may be able to live

in the community with appropriate HCBS. An integrated approach also would promote more use of HCBS for those at-risk for institutionalization in order to prevent or delay nursing home placement. HPSM would reinvest any institutional savings to fund and provide gap services that are medically necessary, but that current categorical programs do not cover or allow.

The following summarizes HPSM plans to manage the program within an integrated financing model:

- IDTs will be able to develop treatment plans based on the person and their individual needs.
- Blended funds will reduce the administrative complexities of operating two programs, under two different oversight organizations, serving the same individual. The new blended program will comply with the strictest consumer protections, whether under Medicare or Medi-Cal rules. However, the administrative burdens of complying with two sets of regulations do not benefit the consumer, but do add to the expense of programs for dual eligibles. Blended funding will ensure program alignment in the best interest of the beneficiary.
- Finally, blended funding will ensure that community and county-based social and behavioral health programs can bring their expertise and experience in service of dual eligibles in a coordinated way. These

programs are not designed to comply with the strict insurance-based standards of the SNP program, which is a subset of Medicare Advantage, making it very difficult operationally to subcontract with county or community based organizations under the SNP Program.

Again, these integrated financing strategies will simplify the patient experience, reduce administrative barriers to care by eliminating administrative duplication and complexity, *and* encourage greater utilization of preventive services.

Q 1.2.3 How the program is evidence-based.

HPSM is incorporating elements of several evidence-based practices into its DEDP model. These include:

- *Medical Homes:* The National Committee for Quality Assurance (NCQA), Physician Recognition Programs Patient Centered Medical Home (PPC-PCMH™) has set program requirements and standards for medical home settings. The NCQA-defined PCMH is a health care setting that facilitates partnerships between patients, and their personal physicians, and family. Care is facilitated by health information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically

appropriate manner. (*Note:* throughout this proposal we refer to medical homes by the SMC-preferred term, person-centered health care home.)

- *Evidence-based care coordination methodologies :* HPSM's care coordination methods are informed by the Care Transitions Program developed by Dr. Eric Coleman. Consistent with the goals of this DEDP, this practice aims to support patients and families; increase skills among healthcare providers; enhance the ability of health information technology to promote health information exchange across care settings; implement system level interventions to improve quality and safety; and develop performance measures and public reporting mechanisms.[1]
- *Validated assessment tool:* SMC AAS has developed a Uniform Assessment Tool (UAT) for assessment across a number of demographic, social, cognitive, behavioral, functional and clinical measures that reflect the various needs of the population served by AAS, including dual eligibles. This tool will serve as a basis for the integrated assessment tool to be developed for the DEDP. The AAS UAT and its implementation were evaluated by the Rand Corporation in 2009.[2]

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[1] http://www.caretransitions.org/

[2] Shugarman L, Mack K. *Evaluation of the Uniform Assessment Tool: Final Report,* Rand Corporation, May 2009.

- *Behavioral Health Care Integration:* In SMC, we have been designing an integrated model that builds on the National Council on Community Behavioral Health Care's Four Quadrant Model.[3] This model locates mental health and substance use services in primary care based person centered health care homes for most of the population. However it also provides for flexibility in tailoring health care homes for people with the most complex behavioral health problems. The health care home for the person with serious mental illness or addictions should tie directly to the specialty behavioral health services, which may be field based or located in a specialty setting. The Behavioral Health Integration Work Group recommendations for pilots under the 1115 Waiver and the California Mental Health Directors Association Recommendations for Pilots through the 1115 Waiver identify many of the key elements of this approach.
- *Overall care management approaches:* Little has been written about how various care management models affect the care that dual eligibles receive.[4] However, a recent study cited the following common features of care management practices across four successful integrated plans in

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[3] Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home, National Council for Community Behavioral Healthcare, 2009.
[4] For examples, see Edwards B, Tucker S, and Kluz B, Integrating Medicare and Medicaid: State Experience with Dual Eligible Medicare Advantage Special Needs Plans, AARP Public Policy Institute, September 2009.

Arizona and Massachusetts: a team approach to care management; an emphasis on person-centered approaches; regularly scheduled home visits to members by care managers; extensive use of advanced nurse practitioners and other strategies for extending and enhancing primary care; a focus on effective care transitions, particularly hospital discharges; heavy use of behavioral specialists; culturally sensitive approaches; flexible benefit packages, beyond contractually mandated Medicare and Medicaid services; frequent monitoring of members with chronic illnesses; emphasis on patient education and patient self-management programs; care management structures for dealing with particularly complex cases; and centralized information systems for sharing data across providers.[5] These lessons have informed the development of HPSM's care management programs for its SNP and for the planned DEDP.

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

HPSM's proposed DEDP applies to all dual eligibles in SMC, who are among the most vulnerable individuals in the county and who most need

[5] Burwell B, Saucier P, Walker L, *Care Management Practices in Integrated Care Models for Dual Eligibles,* AARP Public Policy Institute, October 2010.

care coordination. We strongly believe that carve outs of specific populations should be avoided as much as possible, especially since many beneficiaries do not fit neatly into certain categories and experience multiple conditions (e.g., behavioral health challenges, chronic conditions such as diabetes and hypertension, the presence of developmental disabilities, Alzheimer's or dementia).

An integrated approach would allow HPSM the flexibility to provide services based on individuals' needs, rather than on categorical program restrictions like those currently in place for many Medi-Cal and Medicare funded programs.

The approach to address health disparities, reduce the effect of multiple co-morbidities, and modify risk factors will include:

- Identification of highest risk DEDP participants, as described in Section 4, and Chapter 10 of the Model of Care (MOC) in Attachment 15 to this proposal;
- Integrated care coordination by IDTs, with the full involvement of the of PCP;
- Assistance with self-care management strategies, e.g., HPSM's Care Transitions Program which focuses on self management by providing coaching for individuals who are discharged from hospitals;

- Access to other HPSM programs for vulnerable members, such as the Long Term Care Clinical Management and Medication Therapy Management programs, described in Section 4.
- Integration with services from BHRS, as detailed in Section 3.

A key project partner, AAS, also serves as the Area Agency on Aging (AAA) for planning, coordination, funding, and advocacy for seniors and adults with disabilities in SMC, and contracts with community organizations for AAA-funded and other services, including: hospice; adult day care; Alzheimer's Day Care Resource Center services; transportation; Meals On Wheels, congregate nutrition, family caregiver support services, recreation, legal and ombudsman services, and other types of medical or non-medical care to help consumers maintain their health and well being. IDTs will ensure access to these services in the project's care coordination process. Per current SNP processes, IDTs will also collaborate closely with Golden Gate Regional Center (GGRC) staff to ensure appropriate supports for individuals with developmental disabilities.

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

HPSM's DEDP could include components that qualify under the Health Home Plans SPA. The following health home services are part of

this proposal and are required to be a health home provider: comprehensive care management; care coordination; health promotion; comprehensive transitional care; individual and family support; referral to community and support services; and use of HIT to link services. HPSM's DEDP could qualify in two ways – first, with the health plan serving as the health home and, in some instances (e.g., with the Ron Robinson Senior Care Center), contracting with a provider as a qualified health home. However, the challenge will be that health home services cannot be restricted just to dual eligibles DEDP participants. All categorically-eligible Medicaid beneficiaries receiving medical assistance must be eligible for health home services offered by HPSM or its contracted health homes. This will require substantial infrastructure development beyond that needed for the DEDP.

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

HPSM has identified several challenges to successful implementation of the Dual Eligibles:

- A clear understanding of risk-sharing arrangements among entities involved – CMS, state, and the contract entity.
- A transparent rate setting methodology.

- Appropriate risk adjustment so that plans can be assured that reimbursement will be at least as robust as under the Medicare Advantage program, reflecting the higher acuity needs of dual eligibles.
- Flexibility in use of DEDP funding for housing alternatives, since the lack of appropriate housing is a key factor in unnecessary institutionalization in SMC.
- Ability to use DEDP savings for reinvestment in long term HCBS development.
- Program start-up funding for historically under-funded and under-utilized services such as substance use prevention and treatment (since DEDP reimbursement will be calculated off of baseline funding).
- Differing categorical program rules and reporting requirements, especially for the range of HCBS programs, adding to administrative complexities and expense for operating these programs.
- Medi-Cal retention, which is a serious challenge for many in the duals population. Members who temporarily lose their Medi-Cal status risk losing all their duals-related benefits and are forced involuntarily back into FFS, often causing disruptions in care. We have found a surprisingly high amount of churning in the dual Seniors and Persons with Disabilities (SPD) population.

Some of these challenges and risks can be mitigated. For example, HPSM established an Eligibility Work Group as part of the DEDP planning process (see DEDP Project Plan in Attachment 13). As a result, as well as efforts of others within the county, the SMC Human Services Agency has agreed to create a special unit to focus on the needs of SPDs related to their Medi-Cal eligibility. Many of the other issues will need to be addressed in partnership with DHCS and CMS as plans for the DEDP proceed.

Section 2: Coordination and Integration of LTSS

Section 2.1: Long Term Support Services (LTSS) Capacity

Q 2.1.1 How HPSM proposes to provide seamless coordination between medical care and LTSS to keep people living in their homes and communities as long as possible.

Today, the segregation of medical, LTSS, and HCBS funding streams create incentives for cost-shifting and inefficient care delivery rather than for high-quality care management in the most integrated and cost effective setting.

HPSM's vision is of a system that:

- Integrates services so that HCBS are combined with acute and Long Term Care (LTC) into one system of care.

- Centralizes financial and administrative accountability for the entire range of acute, LTC, and HCBS.
- Builds on community partnerships among local healthcare programs and institutions to deliver high quality and cost effective care.

Since services are delivered piecemeal, each with its own eligibility standards and assessments, it is burdensome and frustrating for both consumers and providers. In response, HPSM will provide:

- A Single Point of Entry (SPOE) – A SPOE will provide information about all LTC and HCBS options and streamline access to services. It ensures the consumer is tracked through various systems and eliminates costly duplication of services and administrative functions.
- Uniform assessment – Consumers now must be assessed separately for each service, such as IHSS, MSSP, CBAS, and nursing facility services. Each assessment asks similar but not identical questions, and each was developed to determine eligibility for services that are specific to the program rather than to focus on the consumer's needs. Such duplicative assessment wastes consumers, family members, and agencies' staff time and resources.
- Care coordination across different systems of care – Coordinating medical care from various providers and institutions, such as primary

care, acute hospital, and nursing home services, has been shown to be critical in ensuring good outcomes for individuals. It is also critical to coordinate care across the array of long term care services and supports, including IHSS, CBAS, and HCBS. Quality coordination will ensure all services in these systems are working well together to meet the consumer's needs.

- Assurance of high quality throughout the continuum of services – Today, there is no single entity responsible for ensuring the quality of services.
- Care transitions between various settings (e.g., hospitals to homes and other settings) – In Medicare nationally, 20% of people discharged from a hospital return to the hospital within 30 days, largely because they need more support at home than is traditionally provided in our siloed systems. HPSM, working with the SMCHS and through its SNP, has already shown that with the right interventions, readmissions and admissions from nursing facilities can be reduced.

Seamless coordination of care will take place through DEDP person-centered *Interdisciplinary Care Teams (IDT).* Under the joint direction of HPSM and AAS, clinical, social services, and care management staff from HPSM, AAS, and Behavioral Health and Recovery Services (BHRS) will

join together with the members and their providers, to ensure that the members receive the assistance and care that they need. (The roles and responsibilities of IDTs are detailed in Section 4.)

While the IDT's focus will be on providing and brokering the services and supports to maintain members safely in their homes and communities, if a member's condition deteriorates and referral to long-term care is needed, the IDT will facilitate a smooth transition with representatives from the nursing facilities as described in Q 2.1.5.

Q 2.1.2 Potential contracting relationships with current LTSS providers and how HPSM would develop a reimbursement arrangement.

HPSM will offer Long Term Services and Supports (LTSS) through partnerships and subcontracts with SMCHS AAS (which also serves as the Area Agency on Aging), the SMC Public Authority, and CBAS Centers.

Many LTSS for seniors and adults with disabilities are currently centralized in AAS within SMCHS. This has enabled AAS to develop expertise in case management and service coordination. AAS provides direct services through programs such as IHSS, MSSP, Information and Assistance TIES Line, Adult Protective Services, 24-Hour Response Team, Linkages, the Public Guardian Program and the Representative Payee

Program. Two CBAS Centers operate in SMC and both have indicated interest in contracting with HPSM as part of the LTSS network.

HPSM will work in partnership with AAS to develop appropriate reimbursement arrangements for HCBS providers. AAS has many years of experience contracting with these providers in our community.

<u>Q 2.1.3 How HPSM would use Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.</u>

AAS, under contract with HPSM, will be responsible for managing the Single Point of Entry (SPOE) and intake for long term care integrated services, and will ensure that consumers are appropriately registered and that health, functional status, and social service needs are assessed in a comprehensive and uniform manner. This function will be integrated into the existing AAS phone line for information and assistance.

The goal is for HPSM, any hospital, home and community based organization, nursing facility, and other county divisions to serve as a “virtual” SPOE, meaning that every relevant organization in SMC through which a client may seek service (e.g., medical, social, emergency) will be trained to complete formal referral to the actual SPOE. This model will

ensure that there is “no wrong door” to access integrated long term care services.

Following referral to the SPOE, the TIES staff will conduct a screening process to ensure the appropriateness of inclusion in the DEDP. A uniform, consolidated assessment tool (to be developed especially for DEDP) will be utilized for assessment across a number of demographic, social, cognitive, behavioral, functional and medical/clinical domains that reflect the various needs of older adults and people with disabilities. This assessment tool will be the existing Health Risk Assessment modified to include the functional, social, and behavioral indicators that are currently gathered through separate tools. This tool will also build on the extensive work done by AAS to develop and implement a UAT for assessing clients across a range of measures that reflect the needs of dual eligibles and other populations served by AAS. To the extent permitted by state regulations, the goal is to have a single assessment tool in order to decrease unnecessary and burdensome duplicate efforts. In cases where such an integration may not be achievable in Year 1, e.g. CBAS and IHSS Assessments, the tools will be combined as regulatory changes allow.

This assessment will be used to help stratify participants by risk (e.g., risk of being placed in an institution, whether a hospital or a long-term care

facility) so as to target care management resources most effectively. The process for stratifying members by risk is detailed in Section 4.

Q2.1.4 HPSM experience working with the broad network of LTSS providers, ranging from home- and community-based service providers to institutional settings.

HPSM is currently responsible for long-term care services in institutional settings under both Medicare (via the SNP) and for Medi-Cal funded custodial care (since 2010). HPSM is committed to contracting with all necessary providers to ensure a sufficient service network is available to deliver timely, high quality care for all covered services. HPSM currently meets and exceeds network adequacy requirements in our existing Medi-Cal and SNP contracts. HPSM currently contracts with nearly all the long term care facilities in the county as well as with facilities throughout the region.

HPSM's subcontractor, AAS, brings to DEDP its extensive experience working with LTSS providers, both through the services offered directly by the agency and through contracts with community HCBS providers. In addition, we will include in the DEDP:

- Two CBAS Centers in SMC – Mills-Peninsula Senior Focus in Burlingame and Coastside Adult Day Health Center in Half Moon Bay – who will contract with HPSM as part of the LTSS network.
- Housing developers and operators, particularly those specializing in low income and senior housing, such as the Lesley Foundation, a non-profit operator of assisted living facilities for low-income consumers.
- Community residential care facilities that specialize in housing behavioral health and other dual beneficiaries.

As noted, AAS also serves as the AAA and contracts with community organizations for AAA funded and other funded services, including: hospice; adult day care; Alzheimer's Day Care Resource Center services; transportation; Meals On Wheels, congregate nutrition, family caregiver support services, recreation, legal and ombudsman services, and other types of medical or non-medical care to help consumers maintain their health and well being.

Question 2.1.5 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? Processes, assurances in place to ensure proper care?

HPSM's Current Programs: HPSM recently initiated a program through its SNP to provide more person-centered and comprehensive care for members living in institutional settings. To conduct this program, HPSM employs a part-time physician with expertise in gerontology, two nurse practitioners, and a nurse case manager. These staff have targeted those nursing facilities with high numbers of SNP members, largely in custodial long term care.

The program goals are to improve quality of care for HPSM's SNP members and reduce unnecessary hospitalizations and visits to the ED. In addition, HPSM clinical staff focuses on ensuring each member and their caregiver has had the opportunity to consider the end of life choices they prefer and specify them on a form such as that for California's Physician Orders for Life Sustaining Treatment (POLST). HPSM staff work closely with patients' primary care providers and facility medical directors to implement the program, conducting at least annual comprehensive assessments of HPSM SNP members, visiting targeted facilities on a regular basis to monitor patient status, and providing trainings for facility staff on areas such as geriatric syndromes and POLST. The goal is to intervene early to resolve medical issues before they escalate to a hospital admission or ED visit.

Planned Transition Programs: SMCHS and HPSM have begun planning strategies to transition residents from nursing facilities to community settings. They include:

1. Developing estimates of the number of people who might be able to live in alternatives settings (current estimates are that nearly 11% of California nursing facility residents have low care needs that could be met by services provided in their homes and communities).[6]
2. Developing a "placement unit," consisting of county and HPSM staff collaborating to find timely placements for nursing home residents or members being discharged from hospitals that may not be able to return home and need alternative placements.
3. Using the interdisciplinary care teams (IDTs) to conduct comprehensive assessments for nursing facility residents, beginning with the county operated facility.
4. Conducting comprehensive medical, social, and behavioral assessments, including determination of residents' wishes for alternative placements;

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[6] Reinhard S, Kassner E, House A, Mollica R. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. 2011; http://www.longtermscorecard.org/~/media/Microsite/Files/AARP_Reinhard_Realizing_Exp_LTSS_Scorecard_REPORT_WEB_v3.pdf.Accessed February 20, 2012.

5. Developing a detailed inventory of community placement alternatives and support services, such as assisted living facilities, residential care facilities, board and care homes, senior housing, and CBAS opportunities.
6. Estimating financial "patch" resources that will be needed to subsidize alternative community placements.
7. Exploring the feasibility of "transition allowances "for members transitioning home that may need funding for home modifications and household items.
8. Accessing funding from program savings to use for community transitions.

As members transition to other settings, it will be critical to continue monitoring care. The IDTs will be charged with continued case management to assure proper care in the member's new setting. In addition, the DEDP will develop contracting standards for the alternative housing and services providers (e.g., board and care homes, assisted living centers, RCFs, etc.) to ensure quality care provision. SMCHS has experience developing such standards and monitoring care in alternative settings through both its AAS and BHRS Divisions. Finally, we will explore

an ombudsperson role (similar to the current one in nursing facilities) for community placement and in-home care.

These plans are grounded in HPSM and SMCHS's recent experience with a major deinstitutionalization effort. In 2007 and 2008, we worked with the state and local agencies to transition 51 Developmentally Disabled (DD) clients from the Agnews Developmental center (many had lived there for decades) to group homes closer to their families. Many were dual eligibles who joined HPSM's SNP. HPSM and SMC developed a specialized and comprehensive care network for this group of members.

It is this history of innovation – and optimizing choices for each member – that HPSM can bring to the DEDP. However, HPSM's success with finding community alternatives will depend a great deal on the flexibility provided in the project. This includes the question of whether DHCS and CMS agree to include housing as an alternative service, and the extent to which the DEDP will allow the flexible and timely substitution of other alternative services to ensure members can stay in or transition back to the community.

Section 2.2: In-Home Support Services (IHSS)

Q 2.2.1 Certify intent to contract with County to administer IHSS services, through contracts with the Public Authority and County for IHSS administration in Year 1.

HPSM has already established an IHSS Work Group (see the DEDP Plan in Attachment 13). Discussions have begun with the SMC AAS Public Authority and the IHSS Program, both located in AAS, to administer IHSS services in Year 1 of DEDP. HPSM has also met several times with the Public Authority Advisory Committee, which includes both IHSS consumers and caregivers and which is very supportive of an integrated approach through a contract with HPSM A formal contract will be in place prior to the implementation, stipulating that:

- IHSS consumers retain their ability to select, hire, fire, schedule and supervise their IHSS 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 DEDP.
- 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 HPSM has determined additional hours will avoid unnecessary institutionalization.

HPSM certifies these conditions will be met in the Checklist in the Attachments.

Q 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, describe the interaction with the IHSS program through the evolution of the Demonstration in Years 2 and 3.

The fact that IHSS is not incorporated into a broader long-term care assessment and coordinated care approach is a significant problem for many consumers. There is no way to identify those who have the greatest

health needs and who are at most risk of entering a nursing home. There is no ability to tailor levels of care management and services to each consumer to support good health outcomes. This has become more of a problem as increasing numbers of elderly people and people with cognitive impairments join the program. The current IHSS assessment focuses on program eligibility and number of service hours needed per task rather than the comprehensive needs of the consumer (i.e., physical health, mental health, functioning, social resources, economic resources, and physical environment). Therefore, it is difficult to meet the needs of the whole person, whether social, medical, or psychological.

In Years 2 and 3, HPSM's DEDP will continue to maintain the following principles for ensuring participants in the DEDP:

- Be able to self-direct care and/or services and participate fully in the care team; for those consumers who are cognitively able to do so;
- Have the option of employing family members as personal care providers;
- Retain the right to hire, fire, and supervise personal care workers;
- Determine if the worker should be part of the care team;
- Participate in the process of determining eligibility and need for services;

- Be able to receive the highest quality care from providers and care workers;
- Have a voice in policy and program governance through participation in a formal and structured advisory process; and
- Be able to access services in ways that are tailored for consumers who are cognitively impaired, which may not fit the IHSS consumer directed care model.

The Public Authority will continue to arrange for payment of IHSS workers through a contract with HPSM and will be responsible for provider training. With agreement from the client, the IHSS home care providers will be integrated into the primary care IDT to play a key role in monitoring and coaching their clients on their care plans. Personal care services will continue to be consumer-directed.

For Years 2 and 3, HPSM will work with local stakeholders to integrate IHSS more fully with the DEDP. Plans are for IHSS integration to evolve in the following ways:

- *Identification of consumers who are at the greatest risk of entering a nursing home or hospitalizations.* During the initial phase of transition, focus will be on those HPSM members and IHSS recipients who have the greatest health care needs and are at most risk of entering a nursing

home or hospital. The Data Mart as described in Section 7.2 will be the tool to assist in properly identifying these individuals. The Data Mart will allow integration and analysis of information from the medical (diagnoses, hospitalizations, procedures), the social (IHSS functional scores and IHSS hours) and the behavioral health (level of care) perspectives to develop a composite of the individual's needs.

- *A proposed care management model integrated with IHSS, including the referral, assessment, and care coordination process.* The assessment process will integrate the IHSS assessment for determination of functional status into the uniform assessment described in Section 2.1.3 above for a fuller picture of the needs of the IHSS consumer. IHSS consumers will have access to a wide scope of medical and social services, including care coordination. These consumers will benefit from an interdisciplinary team based approach that reflects the diversity of individual needs and circumstances. Teams will include the consumer, their primary care providers, nurses, social workers, behavioral health specialists (if needed), and – if the consumer agrees – the IHSS provider.
- *Targeting of consumers who need and are willing to be engaged in integrated care management.* Most IHSS consumers can expect the

program to remain the same as it is today. Only the smaller number of IHSS participants with significant chronic health conditions, in a health care crises, or with cognitive issues that make consumer self-direction problematic will be targeted for integrated care management. The consumer or his or her representative will make the decision about whether to be engaged with HPSM and the IDTs for care coordination.

- *Training for the IHSS worker, incentivizing/coordinating training, including with regards to dementia and Alzheimer's disease.* Expanding IHSS tasks to include health issues will require training for the IHSS provider, including training in paramedical services and how to coach the consumer and monitor the consumer's health status. For the IHSS provider, participation means that he/she may be part of the IDT or care team (if the consumer agrees to the participation); the opportunity to learn new skills with additional training and an enhanced role in the consumer's care; and long term work force development for IHSS workers as they gain new skills and certifications. A training ladder for IHSS providers will be developed to assist them in building skills while serving as part of a broader health care team. HPSM would like to explore possibilities for higher "tiers" of IHSS provider payment to those able to take on more complex tasks and responsibilities.

- *A plan for coordinating emergency systems for personal attendant coverage*. HPSM will work closely with the AAS Public Authority to establish a cadre of IHSS workers who can be available on an urgent basis. These workers are critical to ensuring a seamless transition to home following a hospital discharge if there is insufficient time to engage a permanent caregiver. Having options for emergency coverage will also ensure continuity of care should a caregiver become ill and be unable to fulfill their caregiver duties.

Section 2.3: Social Support Coordination

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

HPSM certifies these conditions shall be met in the Checklist included in Attachment 1.

Q 2.3.2 How HPSM will assess and assist beneficiaries in connecting to community social programs that support living in the home and in the community.

HPSM will connect beneficiaries to community social programs through its relationship with AAS, which also operates as the local Area Agency on Aging. AAS contracts with community social programs like Alzheimer's Day Care Resource Center services; community-based independent living

centers; transportation; Meals On Wheels, congregate nutrition, family caregiver support services, recreation, legal and ombudsman services, and other types of medical or non-medical care to help consumers maintain their health and well being. These connections will occur through AAS participation in the IDT. In addition, HPSM will also coordinate with the SMC Human Services Agency which operates the county CalFresh program.

<u>Q 2.3.3 How HPSM would partner with the local Area Agency on Aging (AAA), Aging and Disability Resource Connection (ADRC), and/or Independent Living Center (ILC).</u>

HPSM will establish a subcontract arrangement with AAS, which functions in this county similarly to an ADRC. As noted, AAS is also the local AAA.

<u>Q 2.3.4 How HPSM 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.</u>

Understanding that DHCS intends to work with CMS and plans to explore housing as a supplemental benefit, HPSM plans to include housing developers and operators as important partners in the DEDP. In fact,

HPSM and SMC have already initiated planning with potential housing partners, as follows:

- Met with SMC Housing Department to identify potential senior housing development opportunities.
- Met with MidPeninsula Housing to discuss how to more effectively provide services for residents of this organization's housing projects.
- Held planning meetings with the Lesley Senior Communities, which together with Mercy Housing, has developed and operates a range of low-income subsidized housing programs for seniors in SMC. Lesley has recently opened a subsidized assisted living program to help its frailer residents "age in place," but is struggling from lack of funding to pay for supportive services. If the DEDP provides the appropriate flexibility, HPSM could pay for services at the assisted living program in lieu of paying for these residents to enter nursing facilities.
- Held meetings with the owners of a residential care facility who also operate a SNF to discuss the possibility of partnering with HPSM to offer care at the residential care facility in lieu of nursing facility care for lower costs.

HPSM has a track record of working with housing providers in innovative ways. For example, we worked with one residential care facility to broker

physician and pharmacy services delivered on site to residents, all of whom have joined HPSM's SNP. The physician came from SMMC's Senior Care Center, which offers in-home physician and nurse practitioner visits. In addition, we helped broker congregate IHSS services so that personal care services could be delivered in the most efficient way possible by a consistent set of IHSS caregivers. These services have helped prevent skilled nursing facility admissions among these residents, a key aim of the DEDP.

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

Q 3.1 How program 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 and for mental illness.

This proposed DEDP has the full support of Behavioral Health and Recovery Services (BHRS), a division of the SMC Health System (SMCHS). BHRS provides a continuum of services for children, youth, families, adults and older adults with Healthy Families, Healthy Kids, and Medi-Cal insurance. Services are provided for the prevention, early

intervention and treatment of complex, diagnosed mental illnesses and/or substance abuse conditions.

BHRS will be the DEDP partner primarily responsible for behavioral health supports. In fact, *BHRS already serves as HPSM's subcontractor for Medicare services provided to dual eligibles in the SNP*, including specialty mental health and substance use services for duals with complex issues. Since 2006, HPSM has delegated to BHRS the provision of mental health services for duals. In this way, the relationship between HPSM and BHRS already meets minimum expectations articulated in the DHCS RFS. BHRS also collaborates in the CCS integration pilot project and has worked closely with HPSM for many years to establish a more integrated and locally-controlled health and social service delivery system.

The innovations that BHRS plans to enhance in the DEDP include: 1) integration of the substance use benefit and subcontract to BHRS, and 2) establishing a more routine approach to stratifying HPSM members, and participating in targeted care management efforts to meet these needs. A more planned and targeted approach to care management can positively impact client utilization, cost, and outcomes.

HPSM will provide seamless and coordinated access to a full array of mental health and substance use benefits covered by Medicare and Medi-

Cal under contract with BHRS. In addition, HPSM currently administers the mental health pharmacy benefit for those who only have Medi-Cal; this experience will be easily transferable to the dual eligible population.

BHRS has also agreed to provide a robust set of mental health and substance use benefits in our Medicaid Coverage Expansion (MCE) offering under the 1115 waiver's Low Income Health Program as an important strategy to improve the "total health" of the low income populations served. This LIHP experience positions BHRS well to prepare for the delivery system coordination issues needed to best serve dual eligibles who face combinations of physical health, mental health and addiction challenges.

The current contract agreement (provided in Attachment 10) allows for BHRS to be reimbursed by HPSM for Medicare reimbursable mental health services, while BHRS claims through the State's Short Doyle Medi-Cal system for services reimbursable under the special mental health Medi-Cal program. The agreement also addresses a variety of compliance and coordination issues related to pharmacy benefits, processing of claims, grievances, credentialing, and the provider network. As a result of this agreement, dual beneficiaries currently enrolled in the CareAdvantage program already experience the close coordination required for the DEDP.

We envision expanding the agreement to include delegation of the provision of the Medicare substance use benefit to BHRS in Year 1, and establishing the same coordination of the Medicare and Medi-Cal components already in place for mental health services.

Seamless and coordinated access to a full array of behavioral health services will be supported through the participation of BHRS staff members on proposed person-centered interdisciplinary teams (IDTs). These care teams, discussed in Section 4, will build on the person-centered health care home framework to encourage all providers to work together to meet the full range of service needs of patients. This will include full access to the services available through the BHRS provider network, comprised of both directly operated and contracted mental health and substance use services that serve more than 19,000 clients a year (over 13,000 of these clients are adults, and 2,500 of these are dual eligible). Services operated or contracted by BHRS include:

- Five specialty mental health clinics operated by BHRS.
- An entry/call center operated by BHRS and staffed by licensed and unlicensed clinical social workers, substance use case managers, marriage family therapists, community mental health nurses, psychiatrists, community workers, and administrative staff.

- A mental health network is comprised of more than 120 private providers, 6 community non profit provider organizations and 3 hospitals. The network delivers the full range of screening/assessment, outpatient, case management, residential, inpatient and medication services currently reimbursable through Medicare and Medi-Cal. In addition, the most high risk/high utilizer seriously mentally ill clients are enrolled in community-based assertive community treatment teams, with 24 hour a day, 7 day a week in the field/home support.
- A substance use treatment system which includes 13 nonprofit provider organizations who deliver: screening/assessment, outpatient, case management, residential, non-medical detoxification, and medication assisted treatment.
- A pharmacy management system that coordinates with HPSM on issues related to psychiatric formulary, authorization procedures, and communications with prescribing psychiatrists, pharmacy, patient and family concerns.

The model would meet the needs of duals with serious mental illness and substance use problems by leveraging the capacity and continuum of rehabilitative services already provided through the BHRS system of care and providers. This system has the advantage of offering and linking

beneficiaries to other publicly available supports for people who qualify, such as housing. The providers in this system already collaborate with the providers of long term care and other older adult support services. (Mental health and substance abuse counseling services targeted at duals eligible with less serious and complex mental health and substance use problems will continue to be embedded in primary care settings.)

Enhancements to this existing system of care that would be possible through this integrated plan for dual eligibles include:

- Further integration of primary care, mental health, and substance use services to improve both health and behavioral health outcomes (Total Wellness) for people with serious mental health and substance use problems.
- Enhancing capacity to identify, assess, link, and treat substance use conditions in the target population.
- Integration of all types of treatment with the other supports that are provided through integration of long term care and other older adult home and community based support services.
- Integrated care management strategies for dual eligibles with the highest utilization patterns, poorest health outcomes, and highest costs across systems.

- Establishment of consistent warm hand-off, coordination, and follow-up. Warm hand-off refers to the process of guiding a referral by a provider or a member of that provider's team who personally knows the patient and will stay connected to the patient until the connection to the receiving provider is made. The warm hard-off guarantees that the connection is made and that the patient is not lost to follow-up or frustrated in making the next steps needed for care. Such coordination will soon be supported by the pilot of an integrated electronic view of behavioral health and medical electronic health records being developed by BHRS and SMMC in partnership with Apixio, a technology company, This integrated view will all providers to view key elements of the patient record.

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

The HPSM Medical Director and QA staff will continue to work with the BHRS Medical Director, Supervising Psychiatrist, and BHRS QI Manager to fulfill the responsibilities of the agreement. BHRS has geriatric psychiatry specialists assigned to its older adult service team. SMMC's Ron Robinson Senior Care Center has a gero-psychiatric specialist as well.

Q 3.3 How program supports co-location of services and/or multidisciplinary, team-based care coordination.

In SMC, we have been working towards an integrated model that builds on the National Council on Community Behavioral Health Care's 4 Quadrant Model, which is described in several papers on the DHCS website: *Behavioral Health and Primary Care and the Person Centered Health Care Home* and *Substance Use Disorders and the Person Centered Health Care Home.* This model locates mental health and substance use services in primary care-based person-centered health care homes for most of the population. However it also provides for flexibility in tailoring health care homes for people with the most complex behavioral health problems. The health care home for the person with serious mental illness or addictions should tie directly to the specialty behavioral services, which may be field based or located in a specialty setting.

More than 1,800 adult BHRS clients already receive their mental health services through providers co-located with primary care providers in each of the publicly operated SMMC primary care settings. SMMC has established a goal of implementing standard screening for mental health conditions as one of their multi-year performance goals under the 1115 Medi-Cal waiver. Last year, several specialty substance use providers

were also co-located with primary care providers, who have begun substance use screening using the SBIRT (Screening, Brief Intervention, Referral, Treatment) protocol. While SMMC and BRHS are revisiting SBIRT as the screening protocol, they will continue to expand substance use screening. For the past 18 months, BHRS has embedded a psychiatrist at substance use treatment programs. In addition, BHRS contracts with Ravenswood Family Health Center, a private non-profit federally qualified health center. to provide mental health services to their patients.

Conversely, there are nurse practitioners from SMMC primary care, nurse care managers, and peer wellness coordinators located in the BHRS specialty mental health clinics who provide primary care services to mental health clients who would not be successful accessing primary care clinics without this additional support. These clients who are at high risk for poor outcomes receive multidisciplinary team based care management. Clients with serious mental illness who are on anti-psychotic medications and face a range of physical challenges are targeted for enhanced support for their "Total Wellness." To date, 150 clients have received baseline screening for health indicators such as weight, blood pressure, and cholesterol; their mental health treatment plans now include a health goal. Clients have received individual nutritional consultation, learned about managing high

blood pressure, pre diabetes and weight. This initiative received substantial funding through the Mental Health Services Act as well as a SAMHSA grant. BHRS and SMMC have a goal to expand this model over time to improve access to primary care for clients who have addictions.

BHRS operates a team that works intensely on facilitating discharges from acute psychiatric care and manages longer term client residential placements including independent housing, residential care, skilled nursing care, and mental health rehabilitation centers for seriously mentally ill individuals, and those with co-occurring disorders. In that role, they also work closely with SMCHS staff to coordinate care. Recently a psychiatrist was added to the team to enhance their capacity to better serve individuals with complex needs.

As noted, coordination will soon be supported by the pilot of an integrated electronic view of behavioral health and medical electronic health records being developed by BHRS and SMMC. This pilot will help all providers view key elements of the patient's record.

Finally, Behavioral Health and Recovery Services embraces the principles of the Mental Health Services Act which emphasize consumer choice, and the potential of recovery for all individuals, including HPSM's dual eligible members.

Q 3.4 How program will include consumers and advocates on local advisory committees to oversee the care coordination partnership and progress toward integration.

HPSM includes consumers and advocates on advisory groups and will do so for this DEDP. In Section 6, HPSM discusses plans to form a dedicated DEDP Advisory Committee to ensure adequate consumer protections are in place during the transition to and implementation of the DEDP. In addition, by contracting with BHRS, the consumer, family member and advocate involvement in the BHRS Mental Health and Substance Abuse (MHSA) Commission and BHRS quality improvement and other activities will also be directed to this program. Currently there are 17 members of the BHRS MHSA Commission, and 10 are consumers or family members. BHRS also has an Office of Consumer and Family Affairs staffed by people with lived experience in the “system.” The office provides individual support for consumers and family members in navigating the system and offers opportunities for consumers and family members to become involved in BHRS system development activities.

Section 3.2: County Partnerships

Q 3.2.1 How model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders.

In Year 1, HPSM and BHRS are proposing to continue the coordination model already in place for mental health services and expand it to substance use treatment. This means expanding the contract between HPSM and BHRS for mental health services to include substance use treatment services and delegation of functions to BHRS for oversight of both mental health and substance use treatment. In addition, in Year 1, BHRS staff will become important participants in IDTs discussed in Section 2.1 for the subset of BHRS mental health and substance use clients who are dual eligibles and high utilizers of services, identified through data stratification. Discussions are currently being held on how to incentivize this program in Years 2 and 3 of the project.

Q 3.2.2 Evidence of existing local partnership for provision of mental health and substance use services that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.

As evidence of its well-developed behavioral heath partnerships, HPSM is including its contract with BHRS in Attachment 10.

We envision amending that agreement as needed as described above for Year 1. For Year 2, we are interested in exploring pursuing full integration of the substance use benefit for both Medicare and Medi-Cal in the HPSM capitation rate. For Year 3, we are interested in exploring full integration of the mental health benefit for both Medicare and Medi-Cal in the HPSM capitation rate. However, with unknown rates, we cannot to commit to this strategy at this time.

How HPSM will work with County partners to establish standardized criteria for targeting beneficiaries for care coordination: BHRS with assistance from HPSM has conducted an analysis using data from the HPSM and the SMMC to look at utilization and unmet need in patient populations served by BHRS, HPSM and SMMC. The analysis revealed that of 69,340 clients served by all three systems in FY 08-09, 6,742 (9.7%) received both medical and mental health services. Of the subset of 30,637 Medi-Cal clients, 8,144 (27%) had an identified behavioral health need, and 5,692 (70%) of these were already served by BHRS.

The analysis confirmed that there are opportunities to impact patient utilization, cost, and health outcomes through more routine review and identification of beneficiaries for targeted care coordination. HPSM is developing a new Data Mart to be able to perform this kind of analysis.

Among the factors to be considered for targeting care coordination will be the presence of mental health and/or substance use diagnosis as well as frequent utilization of emergency and acute care services of any sort; multiple medical and psychiatric diagnoses; enrollment in an assertive community treatment team; discharge from acute hospital or skilled nursing level of care; and/or medication regimen that includes antipsychotic medications. We anticipate that the person-centered health care home for these clients would likely be one of the primary care providers located in a specialty behavioral health setting or an assertive community treatment team.

How HPSM will overcome barriers to exchange information across systems for purposes of care coordination and monitoring: The current SMMC and BHRS pilot project described in Q 3.3 seeks to develop an integrated clinical view; this will be a substantial improvement for providers who currently have to coordinate data across two electronic health records. However even in the current system, primary care and mental health/substance use providers from BHRS or SMMC have access to both EHRs for clients they share, consistent with HIPAA and California privacy regulations. The new HPSM Data Mart will provide a system-wide overview

of client-level data to support monitoring and stratification of beneficiary data for quality and care coordination efforts.

Section 4: Care Coordination

Q 4.1 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.

Under the National Council of Quality Assurance (NCQA) standards, the Patient Centered Medical Home (or person-centered health care home) is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner. Patient-centered care is an integral part of the program, as is a health care home's ability to track care over time and across settings through this integrated approach.

This model, based on a comprehensive review of evidenced-based practice, strives for a stronger focus on integrating behavioral healthcare

and care management, robust patient centeredness and patient and family engagement in promoting and driving optimal care management.

HPSM expands upon this definition to include a health care home model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated, and person/family-centered manner.

Building on current SNP care coordination structures, the DEDP's proposed care coordination will occur through person-centered *interdisciplinary care teams (IDTs*) which build on the health care home framework, and encourage all providers to work together to meet the full range of service needs of patients across the continuum of care. The client will be at the center of an IDT, joined by staff members from HPSM, SMMC, AAS, BHRS and other agencies, as appropriate. The composition of an IDT will vary depending on the intensity and type of services that the member needs. The basic composition of the team will include:

- Member
- Member's caregivers including the IHSS Provider (if the member concurs)
- Physician or PCP

- HPSM Nurse Case Manager (from the health plan's Care Coordination unit)
- Medical Social Worker or Social Services representative (from AAS)
- Behavioral Health (BHRS) representative, as appropriate
- Other identified professional, as appropriate (e.g., HCBS providers, nutritionists, GGRC representatives, etc.)

These teams will develop care plans, coordinate care and ensure members receive the assistance they need to maintain their health and remain in their homes and communities. The Nurse Case Manager, in conjunction with the PCP, will serve as the team facilitator. Each participant will be assigned a key care coordinator/point of contact upon enrollment.

To maximize project resources, HPSM has a plan to target those most in need of care coordination services. Not everyone will require support from an IDT, and the initial goal is to identify those most at risk of hospitalization or being placed in a long-term care facility. This type of member stratification by risk is not new to HPSM; it is a key strategy used in the SNP. This data-driven methodology allows the Care Coordinators to identify members who are most in need of hands-on intensive case management. The process of the review, analysis, and stratification of health risk assessments is a two-step one that begins with data capture,

analysis, and stratification by HPSM’s survey vendor, and subsequent validation and action by HPSM Care Coordination staff. (Details on this process can be found in Element 7, Factor C of the Model of Care in Attachment 15).

For the DEDP, HPSM will build upon the stratification already completed based on medical needs, and add social and BHRS data elements from the Data Mart (described in Section 7.2) to identify additional members with pressing need for care coordination from an IDT.

IDTs will be responsible for identifying participants transitioning between levels of care and conducting necessary care coordination and follow up activities. HPSM’s Care Coordination team currently performs similar functions for our SNP members. Other responsibilities of the IDT include:

- Ensuring the DEDP participants are actively involved in defining their desired outcomes and their care management;
- Reviewing the health and social service needs of newly enrolled participants;
- Stratifying DEDP participants into risk categories for high-level management;
- Developing individualized health and social service care plans;

- Referring DEDP participants to social services, health or HCBS providers as needed;
- Monitoring care delivery across the continuum of services; and
- Regularly reassessing member needs as they move through their care plans.

Following referral to the SPOE as described in Section 2.1.3 above, a coordinated, integrated and shared assessment tool (to be developed as part of the DEDP) will be utilized; it will capture a number of demographic, social, cognitive, behavioral, functional and clinical domains that reflect the various needs of older adults and people with disabilities, and will be administered by the IDT upon enrollment.

Utilization of integrated, individualized and comprehensive assessments and care plans will form the basis for the care delivered and managed by the IDT. All dual members of the SNP already have detailed care plans, as required by CMS. As part of the DEDP, these members' plans will be reassessed and updated at least annually, or with any change in health status, with the assistance of the IDTs.

For DEDP participants not currently enrolled in HPSM's SNP, Care Coordinators will conduct a comprehensive assessment upon enrollment,

and develop an individualized care plan that addresses the full continuum of care – preventive, primary, acute, behavioral and long-term care.

Each care plan will also build on the individual's preferences, as well as their unique strengths and resources, e.g., the history of directing their own self care, and plan to provide them with the community supports (e.g., transportation, Meals on Wheels). Every care plan will be reviewed and updated as medically appropriate, including but not limited to a change in health status. Updates will be transmitted to the PCP and to the member and/or family, where appropriate. Each member of the IDT will be responsible for making notes on treatment (e.g., immunizations provided, prescriptions) and progress in his/her records, and in the centralized assessment and care planning case management tool.

The mechanism for sharing information and data among IDT members will be a new cutting-edge, proprietary Data Mart which integrates data from HPSM, AAS, and BHRS so that each IDT member can get a clear, coordinated picture of the medical, social, and behavioral health needs of a beneficiary. This Data Mart, described in detail in section 7.2, is a relatively easy and low-cost solution to the problem of having data stored in separate systems that are unable to talk to each other. It will provide a single source for HPSM staff, county behavioral health providers, and county HCBS staff

to view member data. When fully implemented, it will also support standardized reporting.

These processes can be adapted to meet the needs of individuals with a wide range of medical conditions, limitations and disabilities, and the team can follow the member across a variety of different community and living settings. For instance:

- HPSM already has substantial experience working with dual eligibles who have developmental disabilities (DD). HPSM was one of three managed care plans involved with the transition of former Agnews residents to homes in the community, and HPSM and SMCHS have developed two specialized clinics in recent years that provide tailored behavioral health and medical services to adult DD consumers. Because HPSM already enrolls more than 700 DD members in its SNP, it has tested specialized interventions for this population. Finally, HPSM works very closely with the Golden Gate Regional Center (GGRC), assigning a full-time nurse to ensure integration of medical services offered by HPSM with the social services delivered by GGRC.
- For dual eligibles with Alzheimer's and other dementia, the first task will be to ensure there is proper identification of these conditions,

which often go underreported. Inclusion of these identifications in the initial assessment will ensure a comprehensive planning approach that responds to these conditions. Having CBAS Centers as part of the directly contracted network will also help ensure appropriate services for these individuals and their families.

More than two-thirds of HPSM's current SNP members are over the age of 65, and the average age of membership is 70. Thus, HPSM's SNP has built several programs focusing on the needs of seniors who may need varying levels of care; we will apply the "lessons learned" from these experiences to the DEDP. These programs are:

1. *Complex Care Management/Care Coordination*: HPSM's Complex Care Management program uses proactive care management principles. High risk members are identified through a predictive model and health risk assessment screening tools, and services focus on providing well-coordinated community-based services, including limiting gaps in care between inpatient and outpatient and community-based services. Goals of our care management programs include: a) improving quality of care, b) improving member satisfaction and c) promoting the provision of medically appropriate care through a multidisciplinary, comprehensive approach in a cost effective manner.

HPSM also has a well-established care coordination model for the dually eligible population in our SNP. The integration of the comprehensive assessment with the health risk assessment (HRA) screening tool serves as a basis in development of individualized care plans. These plans are developed from the findings and analysis of the comprehensive HRAs, and focus on ensuring that members have access to the appropriate care and service within their health plan benefits, consistent with accepted standards of medical practice. Communication and coordination of care with the PCP is an integral component of the care management program. This model will be used as the base for the integrated assessment tool for the DEDP, as well as the IDTs.

2. *Care Transitions*: HPSM's Care Transitions Program focuses on self management by providing coaching for individuals who are discharged from acute care settings. Patients are empowered to manage their own care and given practical tools to do so. The intent of the care transition model is to improve health care outcomes and reduce re-hospitalization risk when members encounter a care transition from an acute care setting to home or to a skilled nursing facility.

HPSM has implemented Dr. Eric Coleman's evidence-based Care Transition Coaching model (as per Section 1) at the SMMC, selected as

the primary facility because some of the most vulnerable SNP patients are at this institution. Care Transitions is being evaluated under a grant from the Gordon and Betty Moore Foundation to help us determine how to better implement it. So far, we have increased the number of patients enrolled in this program by almost 300% over the past 4 months.

3. *In-Home Physician Program:* HPSM's In-Home Physician Program is a program for enhanced medical care and proactive cost management by treatment through a home delivery system, optimizing care in the home for HPSM's most medically vulnerable and complex members. The In-Home Physician Program provides: 24/7 patient access to a visiting physician; regularly scheduled in-home and facility visits, with additional visits as needed; coordinated care with primary care physicians, specialists, and HPSM's nurse Care Manager; clinical and pharmacy management; and patient education about their medical conditions and anticipated outcomes.

4. *Medication Therapy Management (MTM):* MTM encompasses the analytical, consultative, educational and monitoring services provided by pharmacists to CareAdvantage SNP members in order to facilitate the achievement of positive therapeutic and economic results from medication therapy. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve

medication compliance, address medication needs, and provide healthcare to plan members in a cost-effective manner. HPSM contracts with the vendor (Outcomes) to administer MTM services which include annual comprehensive medication review (CMR); prescriber consultations to assist physicians and other prescribers to coordinate care and resolve potential medication-related complications; and member compliance consultations, education and monitoring.

5. *Long-Term Care Clinical Management*: In 2010, HPSM instituted Long Term Care Clinical Management for SNP members residing in long term care facilities, based on the Evergreen model. This is a critical add-on service for some of our most vulnerable members. HPSM employs a part-time physician with expertise in gerontology, two nurse practitioners, and a nurse case manager to target those nursing facilities with high numbers of SNP members residing, largely in custodial care. The program goals are to improve quality of care for HPSM's SNP members and reduce unnecessary hospitalizations and visits to the ED. In addition, HPSM clinical staff focuses on ensuring each member and their caregiver has had the opportunity to consider and specify the end of life choices they prefer.

Finally, HPSM care management staff will continue to work with local hospital discharge staff to help dual eligible members transition to the most

appropriate settings, intervening early so that patients are not placed in long term care facilities when other options could be made available. HPSM, AAS, BHRS, and SMMC staff already work together closely in weekly meetings to help particularly vulnerable and difficult to place patients transition from SMMC to the most appropriate settings.

Q 4.2 The model of care coordination for dual eligibles as outlined in RFS Appendix C is included in Attachment 15 to this proposal, entitled *HPSM CareAdvantage, HMO SNP, Model of Care (MOC), 2012*.

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

Many dual eligibles currently enrolled in HPSM's SNP are assigned to the Ron Robinson Senior Care Center (RRSCC), a specialized outpatient clinic based within the county's public hospital and clinic system, as their health care home. RRSCC provides interdisciplinary care to older adults, including physical health, mental health, social services support, care management, and wellness education. Appointment times are as long as necessary and home visits are an option as well. RRSCC staff provide services to HPSM SNP members in congregate living situations as well.

With a central clinic and one satellite clinic, RRSCC will have capacity to expand as more dual eligibles are enrolled through the DEDP, and is an example of a health care home that provides its own care coordination services for HPSM members.

For most HPSM providers not working in interdisciplinary settings such as RRSCC, the proposed model offers IDT support to help ensure clients receive the services they need in a timely manner. PCPs are currently, and will continue to be, key members of the IDT, as follows:

- *Provider Support and Participation*: The PCP has the key role in HPSM's provider network to serve as primary gatekeeper and the coordinator of care, in collaboration with the HPSM, for his/her panel of dually eligible members. There are various avenues through which providers will be supported by the IDT and other providers to deliver specialized services. These include:
    - Sharing the identification of health care needs and risks through the annual assessment to identify the health care service needs of the member,
    - Sharing the member's individualized care plan that outlines the specific healthcare service needs with the member, PCP, and IDT,

- Providing the PCP and other member's of the IDT with a point of contact at the plan to coordinate care and ensure service delivery,
- Notifying the PCP of every care transition their assigned SNP members encounter to ensure smooth transition of care and follow-up to services,
- Providing the IDT with a Care Coordination Technician at HPSM who will work to schedule appointments and ensure follow-up,
- HPSM clinical representation and attendance at weekly IDT meetings at all major contracted hospitals and skilled nursing facilities to help facilitate, coordinate and authorize services as needed, and
- Sharing of utilization statistical reports at monthly meetings with the case management leadership of major contracted hospitals.

- *Provider Incentives:* HPSM is supportive of exploring incentives for physicians to participate in DEDP care coordination. Incentives are currently employed with physicians participating in the High Utilizers Group (HUG) project, which focuses on older dual eligibles with complex problems and at highest risk, who also receive IHSS services. HUG's goal is to bring interdisciplinary care coordination to members and their providers (generally private providers working in smaller practices) to ensure the best possible health outcomes. Incentives used for the initial

training (CME credit and monetary) and participation in the IDT (monetary) have been effective.

HPSM also has a history of using Pay For Performance incentives effectively with focus on specific quality measures.

- *Provider Training:* Contracted PCPs, specialists and relevant allied health providers will receive care management training on a regular and as needed basis. HPSM's strategic training goals are to increase understanding of the Model of Care (MOC), the provider's care management responsibilities, and care management support provided by HPSM's Care Management program; and to facilitate further participation and feedback on how the plan can continuously improve its Care Management/MOC training program, improving the successful function of IDT, and ultimately optimize health outcomes for members.

Provider network training is currently offered monthly at various sites, including hospital sites, large medical group offices, or at HPSM headquarters. To assure and document completion of training by contracted providers, a list of attendees is maintained for each physical training session. Web-based self-study incorporates computer training completion attestations. Providers who miss trainings receive direct face to

face follow-up communication by HPSM's Provider Services representatives.

In addition, Care Management training will be provided annually to all contracted physician providers in the HPSM provider network. Several MOC training methodologies will be employed, including: 1) direct face to face trainings utilizing a presentation style format with printed materials, 2) audio/video conferencing, and 3) interactive web based self study. Each training methodology incorporates direct participant feedback and evaluation for continuous quality improvement. Detailed training content can be found in the MOC in Attachment 15

In addition to the monthly trainings, HPSM's Provider Services and Quality Improvement departments distributes MOC materials to new contracted providers and vendors for review and input. All contracted HPSM providers receive an annual updated copy of MOC training materials in the annual Provider Manual update.

- *Training for IHSS workers to be part of the Care Coordination Teams:* As detailed in Q 2.2.2, one of the project goals will be to provide training for IHSS workers so that they can participate in the care teams with the member's permission. While these providers are not currently integrated in care teams and care coordination, their participation will be essential

for the success of the DEDP. IHSS workers are often family caregivers who live with the plan member and can be attuned to early warning signals of deteriorating health status if offered the right training. IHSS workers will be offered payment for training and participation in the care team to incentivize their involvement.

Section 5: Consumer Protections

Q 5.1: Certify that HPSM 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.

HPSM will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. All sites shall prove compliance during the Readiness Review. HPSM certifies these conditions shall be met in the Checklist included in Attachment 1.

5.1: Consumer Choice

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

Note: In recent communications with DHCS and CMS, it was stated that current SNP members would be automatically enrolled in DEDP without

having to go through an enrollment process. This section is written assuming this will be the case.

Choice is central to a person-centered service model, and the choice of a Primary Care Provider (PCP) in the person-centered health care home is particularly important to patient outcomes. As part of the proposed DEDP, health care homes/ PCPs will be established for each dual eligible upon enrollment.

In HPSM's current SNP, which will be used as the foundation for DEDP structures, new beneficiaries are given an opportunity to select a PCP at the time of enrollment. Beneficiaries receive an annual updated provider directory and can call the dedicated customer service staff if assistance is needed in finding a provider.

The beneficiary is assigned to that PCP during the enrollment processing. The PCP's name will appear on the beneficiary's program Identification (ID) card which is mailed to the beneficiary after the enrollment has been accepted by CMS.

CareAdvantage staff conducts new member welcome calls for all new enrollees within several days of enrollment. If the beneficiary has not selected a PCP by this time, CareAdvantage staff will review PCP options with the beneficiary, with the choice driven by medical needs/acuity, age,

cultural/linguistic, geographic and other member needs. The beneficiary can also change PCP by notifying the CareAdvantage Unit.

The beneficiary can be seen by specialists of their choice in and out of the CareAdvantage network; they can be seen by non-contract specialists and providers if they are willing to accept CareAdvantage and bill HPSM for services provided.

For new members enrolled in the DEDP, HPSM will have an open network for primary care providers for at least one year. HPSM maintained an open primary care provider network for the first several years of its SNP operation, in order to ensure continuity of care for all members enrolled in the SNP. The Plan's approach was to outreach to providers of current members to encourage them to contract with HPSM. This approach was very successful in growing the PCP contracted network, or at least ensuring that providers continued to see patients enrolled in the SNP even if they were unwilling to be assigned new members.

Also critical to a person-centered care model is the ability of the beneficiary to have others, particularly IHSS providers, participate in the care coordination process. While input from the IHSS provider can offer unique insights into the daily challenges and needs of the beneficiary, it

remains a core principle of this DEDP that the consumer has the right to determine whether or not the IHSS provider is part of the care team.

Q 5.1.2 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.

HPSM's SNP has a large network of providers in SMC and the bordering counties of San Francisco and Santa Clara; it is expected that this network will continue to be in place for the DEDP. Beneficiaries are able to self-direct care through a choice of providers in this network, as described immediately above.

Self-direction is also one of the most critical components of IHSS. Principles that must be part of any system are that consumers must:

- Be able to self-direct care and/or services and participate fully in the care team, for those consumers who are cognitively able to do so;
- Have the option of employing family members as personal care providers;
- Retain the right to hire, fire, and supervise personal care workers;
- Determine if the worker should be part of the care team;
- Participate in the process of determining eligibility and need for services;

- Be able to receive the highest quality care from providers, including the personal care worker;
- Have a voice in policy and program governance through participation in a formal and structured advisory process; and
- Be able to access services in ways that are tailored for consumers who are cognitively impaired, which may not fit the IHSS consumer directed care model.

Finally, these principles will be articulated in all DEDP IDT functions, including the choice whether to participate in IDTs. Members or their families will always have the option of participating in IDTs, or the option of refusing care coordination altogether.

5.2: Access

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

HPSM has a long history of adhering to DHCS standards, and has certified its further intent to comply with rigorous standards for accessibility established by DHCS in the Checklist included in the Attachments.

Q 5.2.2 How program will be accessible, while considering: physical, community, document/information, and doctor/provider accessibility.

HPSM is committed to program accessibility for its members, for example:

- All HPSM-contracted hospital-based primary care facilities must be physically accessible as required by federal and State laws, with accessible waiting rooms, hallways, examining rooms, rest rooms and examining tables.
- Any participants with specialized mobility needs will only be assigned to PCPs with mobility-accessible offices. In addition, HPSM can authorize medically necessary transportation services, such as a wheelchair or gurney van. SNP members receive transportation services as a supplemental Medicare benefit, which will be extended to all members enrolled in the DEDP.
- HPSM provides documents in alternative formats (as outlined in section 5.3), and can provide sign language interpreters.
- HPSM's Provider Directory provides detailed information on doctor/provider physical accessibility and language capabilities.
- A 24 hour Nurse Advice Line is available to members for clinical guidance.
- Physicians are rewarded for offering after hours clinical operations through HPSM's Pay for Performance program.

HPSM's Quality Improvement Program reviews data to identify any health disparities that could impact members with disabilities. For example, the department found a significant disparity in the mammogram rates for disabled members. This led to the development of a quality improvement project where mammography technologists were trained to provide mammograms to women with disabilities, and HPSM developed a brochure for disabled members outlining options for accessible mammography services.

HPSM's Quality Department also conducts annual "Secret Shopper" telephone surveys of providers to gauge actual primary care and specialty care access throughout HPSM's provider network. HPSM staff pose as members or primary care office staff to obtain appointments. Finally, HPSM conducts timely access surveys as required by the Department of Managed Health Care.

At all times, it is the role of the IDT to be an advocate for the member, and ensure that care is being provided appropriately and that a variety of community resource linkages are accessible to support needs.

Q 5.2.3 How HPSM communicates information about the accessibility levels of providers in your network to beneficiaries.

The HPSM Provider Directory, distributed to all HPSM members and available on the HPSM website (www.hpsm.org), contains several indicators of accessibility (e.g., if the provider has wheelchair access, days and hours of operation, languages that the provider and his/her staff speak). Members learn about providers who are accessible by locating the disabled symbol in the provider list; this indicates that the provider has accessible accommodations. HPSM also requires every physician in its provider network to demonstrate that they have a method to provide 24/7 access to care for patients, and this process must be communicated to each beneficiary.

5.3: Education and Outreach

Q 5.3.1 How HPSM will ensure effective communication in a range of formats.

The DEDP will utilize the wide variety of HPSM beneficiary communication formats (e.g., telephonically, electronically, in writing and in person) already in place. Communication options include:

- *A dedicated phone line:* HPSM offers a dedicated customer service toll-free phone line for SNP member inquiries related to benefits, PCP assignment, provider network, cost-sharing requirements, and eligibility. This phone line will continue for the DEDP, and staffing will

be increased as enrollment dictates. In 2011, the SNP Unit received 26,000 telephone calls; 98.1% of these calls were answered within 30 seconds. With 29% of the SNP membership Asian/Pacific Islander and 14% Hispanic, HPSM Member Services has CareAdvantage Navigators who speak Tagalog, Spanish, Russian, Cantonese and Mandarin. HPSM contracts with an interpretive call service for all other languages. HPSM also contracts with an after-hours call center to specifically respond to SNP beneficiary calls. Finally, 23% of all HPSM staff members are bi-lingual.

- *Nurse Advice Line:* HPSM offers a nurse advice line for basic clinical guidance about active health concerns; it operates 7 days a week, 24 hours a day. The service has bilingual capacity and access to the HPSM membership database.
- *Member newsletter and Health Education Materials:* HPSM publishes a quarterly member newsletter called *HealthMatters*. Written in both English and Spanish, it offers general information on plan benefits and health education topics that stress primary and secondary prevention topics. The newsletter also includes information on how to access HPSM services and personnel. A focused member newsletter is also available for patients living with diabetes. HPSM has a wealth

of health education materials available to members. Health education materials are written at a 6th grade level and made readily available to members in the county's threshold languages.

- *Beneficiary informing materials* (e.g., Provider Directory, Summary of Benefits, etc.) are provided to new beneficiaries at time of enrollment in CareAdvantage as part of the new member welcome packet. They are also provided annually to all CareAdvantage members, and are available in English, Spanish, Tagalog, Chinese Russian, large font formats, and Braille.
- *Website:* HPSM's major communication with the public is via its website, www.hpsm.org, which includes a wide variety of resources of health information, including health education, provider resources, health benefits, etc.
- *In person*: HPSM publishes office hours, and members are encouraged to visit to discuss specific issues. In addition, HPSM outreach staff conducts events in coordination with community partners throughout the county, in a variety of locations including senior congregate living centers and nursing facilities. Events have been conducted in English, Spanish, Tagalog, Russian, Cantonese, Mandarin, Tongan and Samoan. In addition, HPSM's Health

Educators provide comprehensive member health education, preventive health services, health promotion and patient education counseling, and monitors the effectiveness of health education services. Bilingual (English-Spanish) health education programs are provided in hospitals, clinics and community-based settings on topics such as asthma and diabetes management, nutrition, weight management, smoking cessation, and general health and wellness.

Q 5.3.2 How HPSM currently meets linguistic and cultural needs to communicate with beneficiaries in their own language, and any pending improvements in that capability.

HPSM already has extensive capacity to meet language needs and ensures access to interpreter services for all Limited English proficient (LEP) members to reduce language barriers to quality of care. HPSM provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact, including the IDTs for this DEDP. HPSM members can also utilize sign language interpreter services with advance notice. Further, HPSM can authorize face-to-face or on-site interpreters when medically necessary. All interpreter services are provided free of charge to members. HPSM informs members and providers regularly about the right to request interpreters in order to ensure that LEP members are

not subjected to unreasonable delays in receiving services. In addition, to the extent possible, members in the DEDP will be assigned care management staff who are fluent in their preferred language.

HPSM is committed to translating member materials in all Threshold Languages identified by DHCS for all Lines of Business (Spanish). For SNP members, materials are also translated into Tagalog, Russian and Chinese.

HPSM also maintains a culturally and linguistically diverse provider network and promotes language agreement between members and their primary care providers. HPSM conducts regular cultural competency trainings for employees and HPSM network providers to ensure that employees and providers are informed and aware of HPSM's policies and procedures regarding its cultural and linguistic services.

To ensure that HPSM providers adhere to cultural and linguistic policies, HPSM conducts regular monitoring activities including consumer satisfaction surveys, review of member grievances, annual provider language assessments, and provider site-reviews.

The DEDP will serve high rates of Asian/Pacific Islander and Hispanic members, as does HPSM's current SNP. HPSM's dedicated SNP customer service department will be expanded to accommodate newly enrolled

DEDP members. As noted, this staff speak the languages and often are from the ethnic groups highly represented in SMC's dual eligible population (i.e., Filipino, Chinese, Hispanic, and Russian).

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

Per the Checklist in the Attachments, HPSM will comply with DHCS requirements as follows:

- *A detailed operational plan for beneficiary outreach and communication***.** Based on a 2010 survey and HPSM member focus groups, designed to determine member preference for communications with HPSM, a plan has already been developed to conduct outreach and communications with members. It involves targeted use of mailings and a re-design of the HPSM website to enhance usability. HPSM can build on this communications plan during the DEDP period.
- *An explanation of the different modes of communication for beneficiaries' visual, audio and linguistic needs.* As indicated in Question 5.3.1, HPSM uses a variety of modes of communication to meet member needs. The overarching goal is to communicate with

beneficiaries in their preferred language (e.g., Spanish, Tagalog, Mandarin, Cantonese or Russian, and other languages available through a telephonic interpreter service). HPSM also prepares beneficiary materials in a variety of formats.

- *An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.* All member materials are written at the 6th grade level and are available in threshold languages. In addition, HPSM's Member Services Department is available to answer questions telephonically, or in person, to any member or provider. HPSM has already worked extensively with providers, community groups, and organizations such as the Health Insurance Counseling and Advocacy Program to help them explain HPSM's SNP benefits to eligible beneficiaries.

5.4: Stakeholder Input

Q 5.4.1 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.

HPSM has already built support from key providers and stakeholders through a series of in-person meetings to discuss interest in this

opportunity and program design ideas. Over a period of several years, we have discussed integrating long term supports with: hospitals in the community through the local Hospital Consortium; physicians through HPSM's physician advisory committees; nursing facilities; Adults Day Health Care centers (now CBAS); the IHSS/Public Authority Advisory Committee; Commission on Aging; Commission on Disabilities; Mental Health and Substance Abuse Recovery Commission; Health and Human Services Committee of the Board of Supervisors; SEIU, the union representing IHSS providers; community forums such as for the reauthorization of the Older Americans Act; the New Beginnings Coalition (a broad locally based coalition of community advocates); and non profit housing providers. Members and consumers have been involved in many of these meetings. Depending on the model designed to integrate behavioral health and substance use services, we will plan additional outreach activities with behavioral stakeholders in the community.

Meetings will continue to be held throughout 2012 to continue obtaining input as the program model develops and matures. In Attachment 6, HPSM includes a stakeholder meeting list, documenting the engagement efforts that have taken place since 2010.

Q 5.4.2 The stakeholder engagement plan throughout the three-year Demonstration.

HPSM will form a dedicated DEDP Advisory Committee that will ensure adequate consumer protections are in place during the transition to and implementation of the project. This advisory committee will be involved in the program design development process, and will meet on a regular basis to review potential implementation issues affecting DEDP participants and to make recommendations for consideration by the San Mateo Health Commission. We will actively seek representation from DEDP participants and providers throughout the continuum of care. Draft operating principles for DEDP Advisory Committee are included as Attachment 6 to this proposal.

Q 5.4.3 The method for meaningfully involving external stakeholders in the development and ongoing operations of the program.

In addition to collecting feedback through beneficiary and family member participation on the Advisory Committee, HPSM will regularly gather and incorporate feedback from DEDP enrollees through:

- Participation in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey done annually for SNP members.
- Annual timely access surveys of Medi-Cal members and providers.

- Annual member satisfaction surveys.
- Periodic focus groups of dual eligible members.

These vehicles enable HPSM to assess member opinions on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections – and to address any identified concerns through ongoing CQI processes.

5.5: Enrollment Process

Q 5.5.1 How HPSM envisions enrollment starting in 2013 and being phased in over the course of the year.

Note: It is assumed that HPSM's current SNP members will be able to automatically transition to the DEDP without going through the passive enrollment process. The following is based on this assumption.

In alignment with the DHCS RFS, HPSM believes that a passive enrollment process that allows beneficiaries to opt out is most likely to achieve the enrollment levels needed to make the new delivery system successful. In SMC, passive enrollment was successful during the launch of our SNP in 2005-2006. We experienced a low number of beneficiary complaints and a relatively low number of opt-outs (8.5% of the total passively enrolled population). Since there is already local support for, and experience using, this approach, HPSM supports using passive enrollment,

including strong consumer protections to protect the rights and choices of participants, and to ensure minimal disruption in care. HPSM's SNP continues to have a very low voluntary disenrollment rate (1.6% in 2010, one of the lowest disenrollment rates of all SNPs nationwide).

Given this experience, HPSM recommends the repeat of a one-time passive enrollment process. We do not advise any "phase-ins" of enrollment, which we strongly believe will lead to more beneficiary confusion than necessary. In 2006, nearly 10,000 beneficiaries were passively enrolled in HPSM without disruption. There are approximately 5,800 dual eligibles not currently enrolled in HPSM's SNP, 40% fewer beneficiaries passively enrolled in 2006. HPSM has demonstrated that a one time enrollment process can work in this community.

HPSM currently has a seamless conversion process for enrolling Medi-Cal members who turn age 65 and become dual eligible. The seamless conversion process begins 150 days prior to the beneficiary's 65th birthday month and provides informing materials and the opportunity to opt out of enrollment prior to the effective date.

HPSM will use a process similar to the current seamless conversion process and supplement it by holding informational sessions and other community outreach to these dual eligible beneficiaries. Dual eligible

beneficiaries will retain the opportunity to opt out of the program prior to the anticipated enrollment date.

HPSM is committed to working with DHCS, other health plans, stakeholders, beneficiaries, and the Federal government on the design of the enrollment process to make this as smooth as possible for beneficiaries.

Q 5.5.2 How HPSM will apply lessons learned from the enrollment of SPDs into Medi-Cal managed care.

As a COHS, HPSM has served SPDs since the Plan's inception in 1987. These include dual eligibles and beneficiaries in skilled nursing facilities. However, HPSM's SNP experience has highlighted the eligibility obstacles facing many dual eligible beneficiaries. HPSM is uniquely situated to view the beneficiary's access to health care holistically. It is at the Plan level that Medicare, Medi-Cal, Medicare Savings Programs, Extra Help (Low Income Subsidy), prescription drug benefits all come together to enable continuous access to health care. To do this effectively, HPSM must continuously monitor eligibility for the beneficiary through a variety of systems including SSA, CMS and Medi-Cal.

HPSM's SNP experience has shown that one of the biggest challenges is ensuring continuity of care for members who temporarily lose Medicare

or Medi-Cal eligibility. CMS requires that a beneficiary who does not meet SNP status (e.g., a dual eligible who loses Medi-Cal eligibility) for six months be involuntarily disenrolled from the SNP due to loss of special needs status. Such disruption can be especially harmful for those with chronic conditions requiring continuous care. An important function of HPSM's SNP, to be carried forward in the DEDP, is emphasis on retaining Medicare *and* Medi-Cal eligibility so that the dual eligible beneficiary can remain continuously enrolled in the D-SNP. HPSM utilizes the following strategies to address this problem:

- HPSM has staff dedicated to tracking eligibility and proactively informing members of lapsed Medi-Cal eligibility; in 2011, HPSM staff saved 1,022 at-risk members from involuntary disenrollment.
- HPSM staff works with SNP members and the County Human Services Agency (HSA), the local agency responsible for Medi-Cal eligibility, to facilitate timely renewal of Medi-Cal eligibility;
- Dedicated HPSM staff works with HSA to highlight cases that need immediate attention and to monitor that the cases are resolved in a timely manner;
- HPSM leadership meets on a regular basis with HSA leadership to recommend strategies for improving systemic Medi-Cal eligibility and

re-determination processes for D-SNP members. As a result of these meetings, HSA has agreed to create a special unit to focus on the specific needs of the SPDs related to their Medi-Cal eligibility. This will be vital to the success of the DEDP.

- HPSM contracts with the local Legal Aid Society of SMC to provide individualized attention and advocacy for SNP members with especially complex eligibility issues, such as Medi-Cal share of cost requirements and Medicare QMB issues.
- HPSM works with the local HICAP on Medicare-related issues, e.g., Medicare Savings Program eligibility, understanding prescription drug coverage, etc.

<u>Q 5.5.3 What HPSM needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot programs begin enrollment.</u>

HPSM has identified a number of issues to be addressed prior to the start of DEDP enrollment.

1. *Clarify status of current D-SNP contract number:* HPSM needs clarification on technical items such as the contract number to be assigned to the DEDP. Ideally, the D-SNP will be allowed to retain its current CMS

plan contract number, which is already used in a variety of materials, including beneficiary plan ID cards.

2*. Medi-Cal Eligibility:* As mentioned above, the administration of Medi-Cal eligibility can pose a significant obstacle to maintain continuity of care for dual eligibles. CMS allows a SNP up to six months of deemed continued eligibility if the beneficiary loses Medi-Cal eligibility. HPSM staff remains vigilant in monitoring changes to Medi-Cal eligibility so that dual eligible members do not incorrectly lose their eligibility, and thus, their special needs status and ability to remain enrolled in our D-SNP. It is recommended that DHCS and CMS allow DEDPs the flexibility to extend the deeming period beyond six months if it is shown that the beneficiary used due diligence to complete a timely Medi-Cal recertification but was delayed due to administrative processing or issues such as hospitalization.

3. Transition to Medicare Entitlement: HPSM is aware when a Medi-Cal-only member turns age 65 and qualifies for the Plan's D-SNP through the CMS-approved seamless conversion process. However, Medi-Cal plans do not know when Medi-Cal-only beneficiaries under the age of 65, receiving RSDI, and linked to Medicare due to disability have met their 24-month waiting period for Medicare. Therefore, HPSM cannot seamlessly enroll these beneficiaries into the D-SNP. Rigorous efforts by the State to

transition Medi-Cal-only beneficiaries who have met the 24 month waiting period to dual eligible status, and therefore eligible for the DEDP, is recommended.

In addition, there are members who receive Part B only benefits but do not qualify for free Medicare Part A. It is up to these members to apply for the Qualified Medicare Beneficiary (QMB) program to pay for Part A - a process is unduly complicated and is not automatic. It is recommended that DHCS consider buying Part A for all potential duals, transitioning financial responsibility from Medi-Cal to Medicare, and allowing participation in the DEDP.

5. Access to Up-to-Date Medi-Cal Eligibility Information and Medicare Status: Through the Medi-Cal Eligibility Data System (MEDS), HPSM has access to the most up-to-date and complete Medi-Cal eligibility information available including Medi-Cal termination and applications status, as well as Beneficiary Data Exchange information (BENDEX) between public assistance case files and Social Security records. However, in a letter dated 7/13/2011, the DHCS informed COHS Plans that MEDS access will be terminated in 9/2012.

Access to MEDS is critical to HPSM's daily operations including administering LTC benefits as well as the SNP, particularly given the

backlog at the county social services agency and the amount of information that is available only through MEDS. Community stakeholders and advocates have become increasingly reliant on HPSM staff to assist in resolving Medicare and Medi-Cal eligibility issues which impact their clients' continued accessed to health care as HPSM is seen as the single entity which can view the beneficiary holistically to assure access to quality care. Thus, continued Plan access to MEDS is critical to assuring that dual eligible beneficiaries remain continuously enrolled in the program without breaks due to loss of Medicare and/or Medi-Cal status.

5.6: Appeals and Grievances

Q 5.6.1 Certify that HPSM 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.

Per the certification in Checklist in Attachment 1, the complaint/grievance system for the DEDP will operate according to forthcoming processes to be outlined in the Demonstration Proposal and Federal-State MOU.

HPSM also has extensive existing policies to handle appeals and grievances, which have been developed in accordance with all applicable

federal and state statutory, regulatory, and contract requirements. These policies are available upon request.

Section 6: Organizational Capacity

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

As outlined in Section 1, the HPSM mission is to *improve the health of our members through high quality and preventive care.* Relevant guiding principles include*:* Advocating for the health care needs of our members and other underserved SMC residents; addressing local challenges faced by patients and providers in accessing and providing health care in SMC; providing individual and personal attention our members and providers; responding to the cultural and linguistic diversity of our members; advocating for HPSM providers by ensuring they receive timely payment for their services and by reducing administrative obstacles; and supporting the effective and efficient use of health care services.

HPSM operationalizes these principles in the array of programs it operates for populations with special needs and its ongoing quality improvement efforts:

- Care Advantage, with an enrollment of nearly 8,400 individuals. This SNP, which will provide the foundational structure for the DEDP, in 2011 earned 3.5 out of 5 stars for Medicare Part C and 4 out of 5 stars for Medicare Part D. HEDIS results, included in Attachment X, document ongoing improvement in SNP patient outcomes.
- A study of the impact of Care Coordination Services for high risk SNP members targeted for these services in 2008 looked at pre- and post-implementation of care coordination. Results revealed:
  - a 45% decrease in the percent who had at least one non-psychiatric hospitalization;
  - a 31% decrease in the percent who had at least 1 emergency room visit;
  - an 11% decrease in the average length of stay; and
  - a 42% decrease in the number of emergency room visits per member.
- Subsequent SNP care coordination evaluations have continued to confirm statistically significant reductions in hospital admissions and ER utilization.
- In 2010, the voluntary disenrollment rate for HPSM's SNP was 1.6%, the seventh lowest among SNP plans nationwide.

- HPSM's SNP Model of Care received a three year accreditation approval from NCQA and CMS in 2011.
- HPSM's Medi-Cal program has demonstrated marked approval in its HEDIS scores over the past several years, achieving high performance levels in seven measures and recording no minimum performance level scores in 2011. Many of the high performance level scores were in areas of particular importance to quality care for dual eligibles, such as diabetes screening and treatment.
- HPSM has already built several programs for its dual eligible SNP members, programs described elsewhere in this proposal. These include the Long Term Care Clinical Program for SNP members residing in nursing facilities, the High Utilizers Group (HUG) Project for older duals at highest risk who also receive IHSS services; a Care Transitions Program for members leaving the hospital for other settings; an in home physician visiting program; and medication therapy management,

HPSM's provider network includes the Ron Robinson Senior Care Center (RRSCC), which provides highly effective care coordination and interdisciplinary services for many of HPSM's SNP members. HPSM has also been involved with the SMCHS for many years in intensive planning

and problem-solving around care integration and long-term care options. This foundation puts the health plan well ahead of the curve in its understanding and preparation to implement an integrated demonstration project for dual eligibles.

Q 6.2 A current organizational chart (modified to highlight the key leaders for the DEDP from both HPSM and SMCHS) is included as Attachment 11.

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

Key staff members from HPSM are:

- Maya Altman, MPP– CEO: Ms. Altman has served as CEO of HPSM since 2005, and during her tenure, implemented CareAdvantage, HPSM's Medicare SNP, serving members eligible for both Medicare and Medi-Cal. She also led the establishment of the ACE TPA program serving nearly 15,000 participants; expanded HPSM's Healthy Families and HealthWorx programs; and negotiated with the State of California to assume responsibility for long term care skilled nursing services in San Mateo County. Ms. Altman came to HPSM after a decade of leadership positions in the SMC Health System, where she forged outstanding partnerships with key collaborating agencies such as AAS and BHRS.

- Ron Robinson - Director of Finance and Administration: Mr. Robinson has served as HPSM's CFO since 2005. He oversees Finance, Claims, Administration, and Sales/Marketing. Prior to joining HPSM, he held a number of leadership positions at the SMMC, including 5 years as Chief Operating Officer. He has also worked at the Braille Institute in Rancho Mirage, California as assistant regional director.
- Chris Baughman – Director of System Improvement /Project Manager for DEDP: Ms. Baughman functions as the HPSM Project Manager for the DEDP, and is also responsible for leading organizational improvement efforts through increased efficiency and effectiveness, decreased costs, and better quality. She has served as a CEO of non-profit community clinic, directed rehabilitation services for hospitals, and served as President of the San Mateo County Commission on Disabilities. Please see Attachment 12 for her detailed résumé.
- Fiona Donald, MD - Medical Director: Dr. Donald joined HPSM in 2006 as Associate Medical Director; she became Medical Director in 2012. She is responsible for all HPSM clinical oversight, including utilization management, clinical case management, quality initiatives, pay for performance, and clinical grievances. Prior to HPSM, Dr. Donald worked with Lumetra, California's Medicare Quality Improvement Organization

as Associate Medical Director. Dr. Donald received her MD from McGill University, completed a postdoctoral fellowship in Rheumatology, and is board-certified in Internal Medicine.

- Richard Moore, MD – Associate Medical Director: Dr. Moore became Associate Medical Director for Long-Term Care in 2009. He is responsible for overseeing the Long-Term Care Clinical Management Program described in Section 2.1.5 above. He also works closely with the HUG program, a special high intensity case management program for some of HPSM's most fragile SNP members. Dr. Moore received his MD form the University of Nevada School of Medicine, is board-certified in Internal Medicine and has extensive experience in gerontology.
- Mari Baca, RN, BS, MSN, PHN - HPSM Health and Provider Services Director: Ms. Baca has been Director of Health and Provider Services since May 2006, overseeing Pharmacy, Care Coordination, Health Services and Provider Services. She previously served in different clinical and managerial roles at HPSM: utilization management (UM) nurse, UM supervisor, and health services clinical manager. Prior to joining HPSM, she worked at Cigna Healthcare, HealthNet of California, Horizon Healthcare and SMC California Children's Services.

- Carolyn Thon – Director of Member Services: Ms.Thon has been the Member Services and Outreach Director since July 2005. She came to HPSM after 25 years of service in the County of San Mateo Human Resources and Health Departments. She worked in several financial and administrative capacities at the SMMC, including patient finance, case management, medical records, quality improvement and budget preparation for the outpatient clinics. She also served as the fiscal officer for the county's Mental Health Services Division.
- Ellen Dunn-Malhotra - Director of Compliance and Regulatory Affairs: Ms. Dunn-Malhotra has been with HPSM since 2001. She oversees operations for compliance, internal auditing, grievance and appeals, and provider disputes. She also serves as HPSM's Compliance / HIPAA Privacy Officer. Prior to joining HPSM, she worked in a variety of health care and policy settings.
- Eben Yong - Director of MIS: Mr. Yong joined HPSM since 1996 and has served as the Director of MIS since 1999. Prior to joining HPSM, he worked in provider services, member services and finance for a national health plan. He has more than 18 years of health care and health information technology expertise.

Key staff from San Mateo County Health Services (SMCHS) are:

- Louise Rogers - Deputy Chief: Ms Rogers has been with SMC since 2003. She is currently the Deputy Chief of the Health System where she oversees Family Health, Public Health, Emergency Medical Services, BHRS, and AAS. She was previously the Director of BHRS and was instrumental in developing agreements with HPSM for mental health services; prevention and early intervention and primary care integration activities; and the integration of the mental health and drug and alcohol systems. She is currently chair of the California Mental Health Director's Medi-Cal Policy 1115 Waiver Work Group. She has also held positions with San Francisco's Community Mental Health Services and the New York City Department of Juvenile Justice.

Aging and Adult Services (AAS):

- Lisa Mancini – Director: Ms. Mancini has served as Director of AAS since 2003 and has served in its leadership for over 25 years. Her background in county government includes oversight of grant funded projects for the most vulnerable frequent users of emergency medical services; providing executive level leadership to multidisciplinary meetings at the SMMC for patients who face extreme challenges because of social, medical, and financial instability; consulting on health

policy in collaboration with other SMCHS divisions and the community; providing strategic direction and oversight for agency budgeting, operations and programs; leading AAS to long-term integration older adults and people with disabilities. Ms. Mancini is also responsible for oversight of the Area Agency on Aging, the Commission on Aging, the Commission on Disabilities, and the In-Home Supportive Services Public Authority Advisory Committee.

- Chris Rodriguez - Health Services Manager: Mr. Rodriguez oversees and manages the supportive and protective care services operations, including adult protective services, representative payee, probate conservatorship investigation, MSSP and IHSS. In collaboration with the Health System and HPSM, Mr. Rodriguez has been a leader in the planning and development of: long-term care integration, pilot projects aimed at decreasing health disparities, and new solutions to improve patient transitions from acute medical, psychiatric and long-term care. Mr. Rodriguez has over 25 years of service for elderly and dependent adults in the Bay Area and San Mateo County.
- Joy Sarraga - IHSS Manager: Ms. Sarraga has 25 years experience with government and non-profit community based organizations in the Bay Area serving diverse communities and clients. She currently assumes a

lead role in the implementation of the quality assurance/improvement for the division and provides supervision of the case management supportive services; IHSS, MSSP and Linkages.

- Marsha Fong - Health Services Manager: Ms. Fong has worked for SMC for over 30 years. She currently oversees Community-Based Services which includes the Commission and Provider Services Unit (CPSU) and the Public Authority (PA) for IHSS. The CPSU provides administrative services for SMC's Area Agency on Aging and focuses on the provision of services to maintain the independence of seniors and people with disabilities in the community. The Unit also supports the Commission on Aging, the Commission on Disabilities and the New Beginning Coalition which oversees the development of the Area Plan for Older Adults and Adults with Disabilities.
- John Fong - MSSP Manager: Mr. Fong currently supervises a multi-program unit in AAS which includes the MSSP, Linkages and the HUG Project in coordination with HPSM. He has worked in the public sector since 2001, during which time he has held positions as Social Worker, Child Welfare Program Analyst, IT Reporting Analyst and Social Work Supervisor.

Behavioral Health and Recovery Services (BHRS):

- Stephen Kaplan, LCSW – Director: Mr. Kaplan has spent the better part of the last 20 years administering publicly funded substance abuse prevention and treatment, and mental health services in California. He is leading local efforts to transform the substance use treatment system in response to health care reform that includes the use of evidenced based practices and developing an integrated and comprehensive system of care for persons with co-occurring mental health and substance use disorders.
- Robert Cabaj, MD - Medical Director: Dr. Cabaj is a Board-certified psychiatrist and certified addiction medicine specialist who has served as the Medical Director for BHRS for several years. He has also been Director and Medical Director of San Francisco Community Behavioral Health Services for San Francisco Department of Public Health. He is an Associate Clinical Professor in Psychiatry at the University of California, San Francisco. He is the current Chairperson of the Council on Advocacy and Government Relations for the American Psychiatric Association, and Chair of the Greater Bay Area Mental Health Directors of the California Mental Health Directors Association.

Q 6.4 The résumé of the Demonstration Project Manager is included as Attachment 12.

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

HPSM is governed by the San Mateo Health Commission (SMHC), which includes two members of the County of San Mateo Board of Supervisors, the County Manager, community representatives, and provider representatives. It uses a structure of advisory boards and committees that participate in HPSM governance, including established consumer bodies such as a Consumer Advisory Committee (which meets quarterly). SMHC meetings are also open to all and include public comment opportunities.

For the proposed DEDP, HPSM will form a new, dedicated advisory committee of no more than 13 members, including three DEDP members (or their family members), and representatives from CBAS, IHSS, HCBS and LTC facilities. This committee will ensure adequate consumer protections are in place during the implementation of the DEDP. The committee will also be involved in program development, review potential implementation issues affecting participants, and make recommendations to the SMHC.

6.2: Operational Plan

Q 6.2.1 Preliminary operational plan/draft work plan showing planned implementation in 2013 and ramp up in the first year **AND** Q 6.2.3 Timeline of major milestones and dates for successfully executing the operational plan.

A detailed DEDP Project Plan has been developed and can be found in Attachment 13. This plan includes specific steps to be taken/milestones, persons responsible and proposed completion dates for executing the plan.

Q 6.2.2 Roles and responsibilities of key partners.

Key partners in the DEDP, along with their roles and responsibilities, are as follows:

Partner	**Roles and Responsibilities**
Health Plan of San Mateo (HPSM)	• Lead Agency - Provide Project Manager and lead care coordination staff • Convene IDTs • Provide Data Mart • Monitoring all fiscal integrations strategies and contracts • Participant enrollment • Provider and PCP training • Lead data collection and evaluation activities • Liaison with State DHCS
SMCHS – Aging and Adult Services (AAS)	• Participation in IDTs • Provide Single Point of Entry to DEDP • Contract with IHSS providers • Data submission to and shared participant monitoring through Data Mart

Partner	Roles and Responsibilities
SMCHS – Behavioral Health And Recovery Services (BHRS)	• Participation in IDTs • Integrated behavioral health funding strategies by 2015 • Data submission to and shared participant monitoring through Data Mart *A contract with BHRS is provided in Attachment 10.*
San Mateo County Public Authority	• Contract with SEIU, the union that represents 3,000+ Independent Providers and a contract personal care agency to provide personal care services for IHSS consumers.
San Mateo Medical Center (w/Ron Robinson Senior Care Center)	• Participation in IDTs • Specialty care for person with Developmental Disabilities

Q 6.2.4 HPSM will report monthly on the progress made toward implementation of the timeline. These reports will be posted publicly, per the certifications in the Checklist.

Section 7: Network Adequacy

Q 7.1 How HPSM will ensure that your provider network is adequate for enrollees.

HPSM operates a robust preventive, primary, acute, and long term care institutional provider network which includes:

- 850 primary care providers across the county
- 1,500 specialists, including oncology, neurology, orthopedics, etc.
- Hundreds of pharmacies

- 150 skilled and long term care nursing facilities
- Over two dozen contracted acute care facilities
- Tertiary care facilities
- A multitude of specialty allied health providers (home health agencies, outpatient rehabilitation facilities, multi-specialty clinics, radiology, surgery centers, audiology, medical transportation, hospice, durable medical equipment, orthotics and prosthetics providers)
- SMC safety net providers, including a public hospital (SMMC) and its 10 outpatient federally qualified health centers (FQHCs) and a non-profit FQHC (Ravenswood Family Health Center in East Palo Alto).
- A multi-disciplinary senior care center specializing in care for older dual eligibles
- A behavioral health and substance use network through subcontract with BHRS, as detailed in Section 3.

LTSS will be available through partnerships and subcontracts with AAS (which will in turn subcontract with HCBS), the SMC Public Authority, and certified Community-Based Adult Services (CBAS) Centers.

AAS provides direct services through programs such as: In-Home Supportive Services (IHSS); Multipurpose Senior Services Program

(MSSP); Information and Assistance TIES Line; Adult Protective Services; 24-Hour Response Team; Linkages; Public Guardian Program and the Representative Payee Program. The Public Authority currently contracts with SEIU, the union that represents more than 3,000 Independent Providers and a contract personal care agency to provide personal care services for IHSS consumers.

This network is successfully serving the needs of over 8,000 CareAdvantage members, and can be expanded, as necessary, to meet the needs of the 14,000+ enrollees in the DEDP.

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

Currently, HPSM's Medi-Cal primary care providers are capitated. Our Medicare providers are paid fee-for-service based on the Medicare physician fee schedule. HPSM also has a robust Pay for Performance program geared towards HEDIS quality measures. With a core group of interested providers, HPSM is exploring an expanded Medicare payment program for enhanced care coordination and quality indicators, which may be a capitation program or additional payments. The structure of this program has yet to be determined.

Q 7.3 How HPSM would encourage providers who currently do not accept Medi-Cal to participate in the Demonstration project.

HPSM has been successful in recruiting physicians to participate in our SNP even when they did not previously accept Medi-Cal members. We guarantee payment using the Medicare Physician Fee Schedule and an additional 10% for the crossover payment from Medi-Cal. Since HPSM handles the crossover, there are no additional billing requirements for the provider. In addition, HPSM's enhanced care coordination team and Long Term Care Clinical team provide extra value and support for the provider.

When starting up our SNP in 2006, HPSM worked intensively with providers to educate them about the SNP and its advantages for patients and providers. We continue to outreach to providers for dual eligibles who have not yet contracted with HPSM, and have succeeded in steadily growing our SNP provider network. These efforts will continue as part of the DEDP. Finally, as detailed in Section 4.3, HPSM will offer robust training and technical assistance to all providers participating in the DEDP.

Q 7.4 How HPSM will work with providers to ensure accessibility for beneficiaries with various disabilities.

HPSM has worked with providers to improve accessibility for beneficiaries with specific disabilities. As part of the Agnews

deinstitutionalization efforts, HPSM worked with primary care providers and specialists to offer training resources and incentives for improved care for developmentally disabled consumers. Working with SMCHS, the Plan helped start a specialized mental health clinic for DD consumers and is currently working with SMMC to establish a medical clinic focused on the special needs of DD patients. This past year, HPSM developed and implemented a training program for local mammography providers to improve their services and accessibility for persons with disabilities. We continue to develop innovative solutions to help providers improve their accessibility, whether through payment incentives or grant development efforts.

In 2012, HPSM will conduct a thorough assessment of provider accessibility in order to target those providers who may need to improve their level of accessibility. Appropriate incentives and assistance will be available to providers as needed.

<u>Q 7.5 Plan to engage with non-network providers and encourage them to join care network, to the extent those providers are working with the Demonstration.</u>

Please refer to Q 7.3 above.

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

The proposed DEDP-specific subcontract agreements are as follows:

Subcontractor	**Nature of Arrangement**
SMCHS – Aging and Adult Services (AAS)	• Contract for IHSS and MSSP social work services
SMCHS – Behavioral Health And Recovery Services (BHRS)	• Provision of behavioral health and substance use services to participants • Integrated behavioral health and substance use funding strategies by 2015 *A contract with BHRS is provided in Attachment 10.*
San Mateo County Public Authority	• Contract as the employer of record for IHSS caregivers (administration of IHSS payroll functions, registry functions, etc.)

HPSM will continue to contract with its current Pharmacy Benefit Manager, Argus, to provide Part D benefits. Argus has extensive experience with Medicare Part D.

Per the Checklist in Attachment 1, HPSM certifies that:

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

Q 7.8 HPSM 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. (Please note that HPSM already meets these requirements as a SNP.)

Q 7.9 HPSM will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data. (Please note that HPSM already meets these requirements as a SNP.)

HPSM has a decades-long history of subcontracting with county agencies and various members of the provider network to provided coordinated, integrated services to members while adhering to all regulatory standards and requirements.

7.2: Technology

Q 7.2.1 How HPSM 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.

HPSM has made significant strides in using technology to help provide better quality care and has plans to improve in the future. In 2011, HPSM undertook a major claims system conversion. Fine-tuning the new system

is a continuing process. Examples of HPSM technology used in support of quality care include:

- Electronic provision of case management lists to PCPs to help them target patients for preventive care;
- Current development of a provider portal that will eventually provide interactive features permitting individualized physician reporting on quality reports;
- Hospital ER collaboration project for transmission of near real-time ER data so that HPSM can immediately follow up with members and providers about inappropriate ER use;
- Pay-for-performance incentives for physicians using immunization registries; and
- Individualized physician pay-for-performance reports for physicians to report progress on organizational quality goals; these reports serve, in effect, as disease-specific registries for physicians to use in ensuring appropriate diabetes care and other preventative care interventions.

Many of HPSM's larger provider partners have already or are in the process of converting to Electronic Health Records (EHRs) and meeting federal meaningful use standards. These include SMMC, Ravenswood

Family Health Center (an FQHC), and physicians affiliated with Sutter's Palo Alto Medical Foundation (PAMF), Stanford Hospital and Clinics and Lucile Packard Children's Hospital. Together, these physician groups serve a major portion of HPSM members, including dual members.

HPSM is currently developing a new program to assist smaller provider offices to achieve "meaningful use" and receive the associated stimulus incentive funds. Through this program, HPSM will also assist physician offices in designing EHR templates to capture quality measures and appropriate risk adjustment data and help office staff with developing efficient workflows; and help reduce office administrative costs.

A unique HPSM offering specific to the DEDP is a proprietary Data Mart, developed for purposes of integrating the data elements from HPSM, the County AAS, and BHRS in order to capture a full picture of the medical, social, and behavioral health needs of each dual eligible beneficiary.

Intentionally designed as a Data Mart and not full interfaces of several complex systems, it provides a relatively easy and low cost solution to the problem of data kept in separate systems that are unable to "talk to each other." Now, data from each system are entered into the Data Mart via securely transmitted data extracts.

This is the first time that HPSM will have medical claims data crossed-matched with functional scores from IHSS, UAT values from MSSP, and LOCUS scores from BHRS. The result is a single data source for any IDT team member, from any partner agency. Each partner will continue to enter data into their respective systems, thereby avoiding extensive workflow re-engineering, staff training and system replication costs. When fully implemented in mid-2012, the Data Mart will allow for standardized as well as ad hoc reporting, in addition to the on-screen view.

Q 7.2.2 How HPSM intends to utilize care technology in the duals Demonstration for beneficiaries at very high-risk of nursing home admission.

In the first year of the DEDP, HPSM expects that its focus will be on developing and refining the project infrastructure for its model of care, such as staff structure and roles (incorporating both County and HPSM staff); structuring the IDTs and the provider network; training personnel and the provider network; conducting the uniform assessment; developing individualized care planning tools and the communication network; and targeting of the most vulnerable subpopulations.

In addition, we have already begun intensive data integration from AAS and BHRS, merging their data with HPSM's to develop a comprehensive

picture of members' medical, social, and behavioral health status. Analytical work remains to support this population management effort and ensure appropriate targeting of project resources to those members who could most benefit from project services.

In Year 2 of the DEDP, we anticipate a greater focus on potential technologies to support project goals. There are a number of emerging business and technology solutions that may be explored to manage care, improve access, and lower costs for dual eligibles, including:

- Medical adherence, managing patients with multiple medications;
- Tools to support population management and health care home efforts;
- Remote monitoring of patients (e.g., post-hospital discharge, seniors at home, home assessment/home monitoring reports; home-based support for health monitoring; observation of activity and environmental sensors);
- Asthma care and diabetic care – self-care and self-management monitoring and reminders, e.g., diabetes reminders for glucose testing, exercise programs, etc.;
- Telemedicine for behavioral health, dermatology, etc.;

- On-line patient appointments, appointment reminders, medications, etc.;
- Care coordination or care management system solutions;
- Caregiver support and training;
- Social connectivity through telephone and video connections; and
- Emergency room readmissions or inappropriate use; alternatives to ER use.

HPSM will conduct a careful analysis and select for implementation technology solutions that best support project goals. We will consider organizational capacity and provider interest, since many potential solutions require active provider participation.

HPSM and SMC have already explored some technology solutions, particularly for home monitoring, with the help of the California Health Care Foundation. We had demonstrations from several firms and considered a number of options, but decided to develop a better organizational infrastructure for service integration before proceeding.

That being said, SMC and HPSM have already initiated a number of technology projects related to the DEDP. SMMC, a major provider for HPSM and its dual members, has established a telemedicine program for hard-to-find specialties such as dermatology. HPSM has already developed

a sophisticated data analytics unit to support its SNP operations, quality efforts, HCC risk adjustment efforts, and program evaluation capabilities. That unit has also developed highly successful predictive modeling and member stratification tools that have helped HPSM target its care management resources effectively to reduce inpatient admissions and ER visits.

Finally, we are in the process of developing a Data Mart (see Q 7.2.1) to support population-based care management of Medi-Cal and dually eligible members. As described above, the Data Mart will help IDT members coordinate member needs.

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

N/A. HPSM is not currently using any remote monitoring or medication compliance devices, but as mentioned in Section 7.7.2 above will explore using them in the future. Utilization of technologies to meet information exchange and device protocol interoperability standards will be addressed at that time.

Section 8: Monitoring and Evaluation

Q 8.1 HPSM capacity for tracking and reporting:

HPSM has decades of experience tracking patient data and meeting DHCS reporting requirements and, with its partners, is fully ready to participate in the DEDP evaluation. HPSM is establishing a Program Evaluation Work Group (see the DEDP Project Plan in Attachment 13) to develop and oversee the evaluation process. Results of various evaluation activities will be reported to the DEDP Advisory Committee for ongoing assessment and review. Finally, HPSM has eight people dedicated to data reporting and analysis. HPSM has established an Informatics Center which co-locates these staff in one physical location, resulting in enhanced communication among staff members and underscoring HPSM's commitment to data and reporting.

HPSM capacity is further evidenced by the steps taken to ensure reporting in the three areas outlined in the RFS:

1. Enrollee satisfaction, self-reported health status, and access to care: HPSM participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey annually for SNP members and on a triennial basis for Medi-Cal members. In addition, HPSM conducts annual timely access surveys for Medi-Cal, as well as an annual member

satisfaction survey. Recently, HPSM has surveyed its SNP members for satisfaction with Care Coordination services. Finally, HPSM conducts annual secret shopper telephone surveys to assure access to care for HPSM members.

2. Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied): HPSM stores all utilization, encounter, and financial information that may be required for auditing purposes or calculations of capitation rates throughout its MIS (HEALTHsuite). All such data can be made available to DHCS to assist in tracking cost impacts on specific Medicare and Medicaid services. HPSM currently reports all Medi-Cal encounter data to DHCS monthly through the Long Paid Claims process.

The Data Mart, described in Section 7.2 will allow the analysis of encounter data across all covered services, including IHSS, MSSP, and BHRS.

Furthermore, HPSM's Utilization Management (UM) team monitors membership for under- and over-utilization of medical services by tracking and analyzing data from various sources (i.e., claims/payments, encounter data and medical records). Utilization data sets may include, but are not

limited to: acute bed days per thousand, admits per thousand, ER visits, average length of acute stay, behavioral health admits, readmission rate, and pharmaceutical utilization.

Utilization metrics are reviewed monthly by the HPSM Director of Health and Provider Services, Medical Director and/or the UM Workgroup to monitor appropriate utilization of care. A Medical Management Committee comprised of the CEO, CFO, Medical Director, Financial Analysis Staff and the Director of Health Services meets monthly to review medical trends and cost outliers.

Finally, HPSM will continue to adhere to Part D requirements for reporting PDE as it currently does for its SNP.

3. *Condition-specific quality measures:* HPSM participates in the annual HEDIS review, particularly for Medi-Cal and Medicare selected measures, where several condition-specific elements are measured. See Attachment 5 for results of the last three years.

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

In Section 8.1, above, HPSM outlined capacity to collect and store beneficiary data through use of its MIS, HEALTHsuite. The system stores

member demographics and eligibility information, in addition to full claims data. The Informatics Team has the ability to create ad hoc reports based on any existing data elements, if the information is not present in the hundreds of reports already developed.

A number of reports reviewing beneficiary outcomes by demographic characteristics are already developed and in use as part of HPSM's ongoing Quality Initiatives. These data are used to monitor for any health disparities, and develop programs to reduce any clinically significant outcome differences that are identified. This process would continue as part of the DEDP, in whatever method directed by DHCS.

The Data Mart can also be used to develop reports that will integrate information across the continuum of health, social and behavioral health services.

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

Per certifications in the Checklist in the Attachments, HPSM will fully participate in the demonstration project evaluation process organized by DHCS and CMS. It will participate in quality assurance and improvement initiatives, and meet integrated quality requirements, including a unified minimum core set of reporting measures, to evaluate quality improvement

during the DEDP period. HPSM will work with the external evaluator to measure quality and cost impacts to both Medicare and Medicaid. Detailed reporting on numerous process and outcome measures will be provided.

Section 9: Budget

Question 9.1 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).

HPSM has identified the following areas for possible infrastructure supports to further the goals of the DEDP:

- *IHSS Provider Training* - As discussed in Section 2.2.2 above, Years 2 and 3 in the evolution of IHSS should involve training for the IHSS caregiver, including training in paramedical services and how to monitor the consumer's health status. This is critical to fully addressing consumer health issues, in addition to the social and functional needs.
- *Substance Use Services* – Integration of substance use services are an important component of the DEDP. This is an area often not fully understood by members, or by the medical and social support community. Training targeted to primary care providers and their support staff, as well as IHSS workers and other care provides, could focus on

education about substance use, how to identify someone who may have a substance use issue, referral processes, how to access treatment, etc. Information on how to work effectively with members with these issues, e.g., training in Motivational Interviewing and Stages of Change, would also be valuable.

- *Information exchange and technology support for care management across settings* – while HPSM has made substantial strides in the development of a Data Mart to support service integration, further work is needed to facilitate real time data exchange among the members of the care teams. The DEDP project will need to invest in a care management system that can be used by HPSM staff as well as staff at other agencies to support care coordination efforts.

Checklist and Attachments
with Documentation for Qualification Requirements

RFS Proposal Checklist

Attachments which support applicable Qualification Requirements are as follows:

Attachment 1. Qualification and Checklist #1 - Knox-Keene License

Attachment 2. Qualification and Checklist # 2 - Financial Condition – DMHC letter

Attachment 3. Qualification 3, Checklist # 3a - Current Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

- DMHC Order Approving Notice of Material Modification (SNP)
- D-SNP Contract Description Summary
- H55428 Benefit Attestation

Note: *HPSM CareAdvantage, HMO SNP, Model of Care (MOC), 2012, modified to reflect the DEDP (per RFS Appendix C) appears at the end of the Attachments as #15.*

Attachment 4. Qualification and Checklist #4 - Current Medi-Cal Managed Care Plan – Signature Page

Attachment 5. Qualification 8, Checklist # 8a and b - High Quality

- Three years of Quality Performance Indicators – HEDIS reports for DHCS
- Three years of Quality Performance Indicators – HEDIS reports for SNP
- SNP Quality Performance Measurements (Medicare Stars Report)

Attachment 6. Qualification and Checklist # 12 - Stakeholder Involvement

- Draft Operating Principles for the Dual Eligibles Demonstration Project Advisory Council
- Letters of Support from: SMC Commission on Aging, Mills-Peninsula Senior Focus, Lesley Senior Communities, Carlmont Gardens Nursing Center and Legal Aid Society of San Mateo County
- Stakeholder meeting list

Attachments which support Criteria for Additional Consideration include:

Attachment 7. Criteria for Additional Consideration 5 - NCQA accreditation for D-SNP product

Attachment 8. Criteria for Additional Consideration 7 - Supplemental Benefits

Attachment 9. Criteria for Additional Consideration 8 - Letters of Agreement from County Officials (intent to work together in good faith)

- from SMCHS

Attachment 10. Criteria for Additional Consideration 10 - Contract with the County agency responsible for mental health (BHRS)

Other requested/supporting Attachments include:

Attachment 11. HPSM Organizational Chart

Attachment 12. DEDP Project Manager Résumé

Attachment 13. DEDP Project Plan

Attachment 14. Diagram from Little Hoover Commission's April 2011 report, *A Long Term Strategy for Long Term Care*.

Attachment 15. *HPSM CareAdvantage, HMO SNP, Model of Care (MOC), 2012,* modified to reflect the Dual Demonstration Application (per RFS Appendix C).

Applicant Name: HEALTH PLAN OF SAN MATEO Date: February 22, 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.	√	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	√	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	√	
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.	√	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	√	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	√	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.	√	None
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	√	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	√	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.	√	HEDIS
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	√	HEDIS Star Ratings
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	√	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	√	

Signature: [signature]

Applicant Name: HEALTH PLAN OF SAN MATEO Date: February 22, 2012

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

Signature: [signature]

Applicant Name: HEALTH PLAN OF SAN MATEO

Date: February 22, 2012

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	6 years	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	N/A	None
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	HPSM will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	For Model of Care
6	How long has the Plan had a Medi-Cal contract?	25 years	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	Dental, Vision, Transportation (Taxi rides), $0 copays for generic drugs
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 Mateo County Health System (IHSS, Public Authority, MSSP, BHRS)
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	While a contract is not yet is place, the letter of support from the San Mateo County Health System as well as our long-standing collaboration with Aging and Adult Services indicates that this will not be a barrier to the pilot implementation.
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes	
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligibles? Which groups?	Yes	Ron Robinson Senior Care Center Mills-Peninsula Senior Focus (CBAS) Coastside Adult Day Health Center (CBAS)

Signature:

Applicant Name: HEALTH PLAN OF SAN MATEO Date: February 22, 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.	√	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	√	
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.	√	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	√	
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.	√	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	√	
6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	√	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	√	
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.	√	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	√	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	√	

Signature: [signature]

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

933 0358
L 349 597 6274

San Mateo Health Commission
1500 Fashion Island Boulevard, Suite 300
San Mateo, CA 94404

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 TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES WITHIN THE STATE OF CALIFORNIA, CITY AND COUNTY OF SAN MATEO, 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.

Dated:
Los Angeles, California

JUL 3 1 1998

DALE E. BONNER
Commissioner of Corporations

By Barbara L. Braunstein
BARBARA L. BRAUNSTEIN
Senior Corporations Counsel

Attachment 2. Qualification 2 - Financial Condition

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

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

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Ellen Dunn-Malhotra
Director of Planning & Evaluation
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
So. San Francisco, CA 94080

Re: Letter of Standing – San Mateo Health Commission

Dear Ms. Dunn-Malhotra:

On February 8, 2012, you requested a letter regarding San Mateo Health Commission's ("SMHC") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] SMHC makes this request to satisfy requirements for a Request for Solutions ("RFS") issued by the California Department of Health Care Services, for the Dual Eligibles Demonstration Project.

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

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

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

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for SMHC was issued on January 28, 2008. There were no identified deficiencies from this Routine Medical Survey. The next Routine Medical Survey is scheduled to begin June 18, 2013.

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

Please contact me with any questions or concerns.

Sincerely,

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

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Christina Hooke, Division of Licensing
Dayana Joseph, Division of Financial Oversight

Attachment 3. Qualification 3 - Current Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

- DMHC Order Approving Notice of Material Modification (SNP)
- D-SNP Contract Description Summary
- H55428 Benefit Attestation

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF MANAGED HEALTH CARE

File No. 933-0358
Material Modification No. 20042231
Order No. L-05-1415

Licensee: San Mateo Health Commission dba Health Plan of San Mateo

ORDER APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed on December 20, 2004, requesting approval of Licensee's proposal to add a line of business to serve Special Needs Medicare Advantage enrollees in San Mateo County through a contract with the Centers for Medicare and Medicaid Services ("CMS"), are approved as of the date below.

This Order is issued subject to and conditioned upon the Licensee's full performance to the Department's satisfaction of the Undertakings attached hereto and incorporated herein by this reference.

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

Dated: February 11, 2005
Los Angeles, California

LUCINDA A. EHNES
Director
Department of Managed Health Care

By
JOHN M. PUENTE
Chief, Licensing Division

View Contract Materials

Contract Number: H5428
Organization Name: SAN MATEO HEALTH COMMISSION
Organization Type: Local CCP
Contract Plan Type: HMO/HMOPOS
Contract Type: Renewal
SAE Indicator: No
Contract Status: Active
Part D Offered: Yes
SNPs Offered: Yes
Type(s) of SNPs offered: Dual-Eligible
800-Series Only: No
Employer Plans Offered: No
2012 Contract Approval Date: 09/06/2011
Electronic Contracting Plan Sign-off Date: 8/29/2011 5:57:51 PM (RON ROBINSON)
Electronic Contracting CMS Part C Countersign Date: 9/16/2011 2:35:02 PM (DANIELLE MOON)
Electronic Contracting CMS Part D Countersign Date: 9/16/2011 9:41:27 AM (CYNTHIA TUDOR)

Select a document link to view/download the document.

Documents	Reviewed by the Plan
CCP Contract	8/29/2011 5:57:04 PM (RON ROBINSON)
CMS Mark License Agreement	8/29/2011 5:51:18 PM (RON ROBINSON)
MA-PD Addendum	8/29/2011 5:54:09 PM (RON ROBINSON)
Benefit Attestation	8/29/2011 5:54:33 PM (RON ROBINSON)
DUA Agreement	8/29/2011 5:55:13 PM (RON ROBINSON)
Signature Attestation	8/29/2011 5:57:51 PM (RON ROBINSON)

Back

Go To: Electronic Contracting 2012 Start Page

Medicare Advantage Attestation of Benefit Plan

SAN MATEO HEALTH COMMISSION

H5428

I attest that I have examined the Plan Benefit Packages (PBPs) identified below and that the benefits identified in the PBPs are those that the above-stated organization will make available to eligible beneficiaries in the approved service area during program year 2012. I further attest that we have reviewed the bid pricing tools (BPTs) with the certifying actuary and have determined them to be consistent with the PBPs being attested to here.

I further attest that these benefits will be offered in accordance with all applicable Medicare program authorizing statutes and regulations and program guidance that CMS has issued to date and will issue during the remainder of 2011 and 2012, including but not limited to, the 2012 Call Letter, the 2012 Solicitations for New Contract Applicants, the Medicare Prescription Drug Benefit Manual, the Medicare Managed Care Manual, and the CMS memoranda issued through the Health Plan Management System (HPMS).

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
001	0	6	HPSM CareAdvantage (HMO SNP)	HMO	Renewal	0.00	30.90	09/06/2011	01/01/2012

RON ROBINSON	8/29/2011 5:57:51 PM
Contracting Official Name	Date
SAN MATEO HEALTH COMMISSION	701 GATEWAY BLVD., SUITE 400 SOUTH SAN FRANCISCO, CA 94080
Organization	Address

Attachment 4. Qualification 4, Checklist #4 - Current Medi-Cal Managed Care Plan

On the following page, HPSM is including the signature page of its current contract with DHCS to operate a Medi-Cal Managed Care contract in San Mateo County. The full contract is available upon request.

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213_DHCS (1/08)

Attachment 4. Qualification and Checklist #4 - Current Medi-Cal Managed Care Plan Contract - Signature Page

08-85213

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

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)
San Mateo Health Commission dba: Health Plan of San Mateo

2. The term of this Agreement is: January 1, 2009 through December 31, 2013

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

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 pages
Exhibit A, Attachments 1 through 19 (See Provision 1 of Exhibit E for details)	Various pages
Exhibit B – Budget Detail and Payment Provisions	9 pages
Exhibit B – Attachment 1 – Former Agnews Developmental Center Member Payment Terms	3 pages
Exhibit C * – General Terms and Conditions	GTC 307
Exhibit D(F) – Special Terms and Conditions	12 pages
Exhibit D(F) – Attachment 1	1 page
Exhibit D(F) – Attachment 2	2 pages
Exhibit E – Additional Provisions	1 page
Exhibit E, Attachment 1 - Definitions	16 pages
Exhibit E, Attachment 2 – Program Terms and Conditions	26 pages
Exhibit E, Attachment 3 – Duties of the State	2 pages
Exhibit F – Contractor's Release	1 page
Exhibit G – Health Insurance Portability and Accountability Act (HIPAA)	11 pages

See Provision 1 of Exhibit E for additional incorporated exhibits.

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. *These documents can be viewed at http://www.ols.dgs.ca.gov/Standard+Language.*

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

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
San Mateo Health Commission dba: Health Plan of San Mateo

BY *(Authorized Signature)* [signature] DATE SIGNED *(Do not type)* 12/10/08

PRINTED NAME AND TITLE OF PERSON SIGNING
Maya Altman, Executive Director

ADDRESS
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

STATE OF CALIFORNIA

AGENCY NAME
Department of Health Care Services

BY *(Authorized Signature)* [signature] DATE SIGNED *(Do not type)* 12/18/08

PRINTED NAME AND TITLE OF PERSON SIGNING
Vanessa M. Baird, MPPA, Chief, Medi-Cal Managed Care Division

ADDRESS
1501 Capitol Avenue, Suite 71.4001, MS 4415, P.O. Box 997413,
Sacramento, CA 95899-7413

California Department of General Services Use Only

X Exempt per: W&I Code Section 14087.55(c)

Attachment 5. Qualification 8, Checklist # 8a and b - High Quality

- Three years of Quality Performance Indicators – HEDIS reports for DHCS
- Three years of Quality Performance Indicators – HEDIS reports for SNP
- SNP Quality Performance Measurements (Medicare Stars Report)

HEALTH PLAN OF SAN MATEO HEDIS RESULTS - MEDI-CAL

					HEDIS2011	
Measure	**Data Element**	**HEDIS2009**	**HEDIS2010**	**HEDIS2011**	**MPL**	**HPL**
CIS Childhood Imm Status	DtaP/DT Rate	86.49	92.21	89.29		
CIS Childhood Imm Status	IPV Rate	91.22	96.35	95.41		
CIS Childhood Imm Status	MMR Rate	95.95	98.30	95.41		
CIS Childhood Imm Status	HIB Rate	96.96	98.78	94.39		
CIS Childhood Imm Status	Hepatitis B Rate	90.88	94.40	94.39		
CIS Childhood Imm Status	VZV Rate	96.96	98.30	94.90		
CIS Childhood Imm Status	Pneumococcal Conjugate Rate	88.18	93.43	91.33		
CIS Childhood Imm Status	hepatitis A		54.01	46.43		
CIS Childhood Imm Status	rotavirus		70.07	83.67		
CIS Childhood Imm Status	influenza		80.29	77.04		
CIS Childhood Imm Status	Combo2 Rate	81.76	**88.56**	86.22		
CIS Childhood Imm Status	Combo3 Rate	79.05	**87.35**	**83.67**	63.5	82.0
URI Treat Child w/Upper Resp Inf	Rate	89.03	89.71	94.12	82.1	94.9
AAB Treat Adults w/Acute Bronchitis	Reported rate	26.41	**33.46**	26.49	19.7	35.9
BCS Breast Cancer Screening	Rate	55.92	57.01	60.98	46.2	63.8
CCS Cervical Cancer Screening	Rate	58.73	62.56	61.20	61.0	78.9
CDC Comprehensive Diabetes Care	Rate - HbA1c Testing	83.94	86.62	86.62	76.0	90.2
CDC Comprehensive Diabetes Care	Rate - Poor HbA1c Control	43.07	35.77	34.06	53.4	27.7
CDC Comprehensive Diabetes Care	Good HbA1c Control < 8.0	50.36	56.93	57.42	38.7	58.8
CDC Comprehensive Diabetes Care	Good HbA1c Control < 7.0	NA	NA	NA		
CDC Comprehensive Diabetes Care	Rate - Eye Exams	59.67	60.34	59.85	41.4	70.1
CDC Comprehensive Diabetes Care	Rate - LDL-C Screening	79.38	80.54	**84.18**	69.3	84.0
CDC Comprehensive Diabetes Care	Rate <100 LDL-C Level	42.70	**45.01**	**46.96**	27.2	45.5
CDC Comprehensive Diabetes Care	Rate - Mon Diabetic Neph.	85.22	**85.40**	**86.62**	72.5	86.2
CDC Comprehensive Diabetes Care	BP Control < 140/80	34.67	36.98	NR		
CDC Comprehensive Diabetes Care	BP Control < 140/90	58.58	62.29	63.26	53.5	73.4
ASM Medications Use for Asthma	Rate: age 5 to 9	92.31	discontinued	discontinued		
ASM Medications Use for Asthma	Rate: age 10 to 17	89.69	discontinued	discontinued		
ASM Medications Use for Asthma	Rate: age 18 to 56	89.20	discontinued	discontinued		
ASM Medications Use for Asthma	Rate - Total	90.09	discontinued	discontinued		
LBP Use of Imaging Studies low back pain	Rate		86.46	**84.62**	72.0	84.1
PPC Prenatal Postpartum Care	Rate - Timeliness of Prenatal Care	77.51	85.32	83.16	80.3	92.7
PPC Prenatal Postpartum Care	Rate - Postpartum Care	60.15	63.54	61.84	58.7	74.4
W15 Well Ch Vst 1st 15 Mon	zero visits Rate	2.00	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	one visit Rate	2.00	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	two visits Rate	4.24	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	three visits Rate	5.99	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	four visits Rate	9.48	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	five visits Rate	15.21	discontinued	discontinued		
W15 Well Ch Vst 1st 15 Mon	Six or More visits Rate	61.10	discontinued	discontinued		
W34 Well Ch Vst in 3456 Yrs	Rate	72.81	70.73	75.44	65.9	82.5
AWC Adol Well-Care	Rate	41.61	43.80	40.39	38.8	63.2
WCC Weight Assessment	BMI Percentile 3-11 years		60.50	48.87		
WCC Weight Assessment	BMI Percentile 12-17 years		56.52	44.68		
WCC Weight Assessment	BMI Percentile Total		59.61	47.89	13.0	63.0
WCC Weight Assessment	Counseling for Nutrition 3-11 years		70.85	77.99		
WCC Weight Assessment	Counseling for Nutrition 12-17 years		57.61	67.02		
WCC Weight Assessment	Counseling for Nutrition Total		67.88	**75.43**	34.3	67.9
WCC Weight Assessment	Counseling for physical 3-11 years		57.37	58.58		
WCC Weight Assessment	Counseling for Physical 12-17 years		54.35	60.64		
WCC Weight Assessment	Counseling for Physical Total		56.69	**59.06**	22.9	56.7

HEALTH PLAN OF SAN MATEO HEDIS RESULTS - CAREADVANTAGE (SNP)				
Measure	**Data Element**	**HEDIS2009**	**HEDIS2010**	**HEDIS2011**
ABA Adult BMI Assessment	Rate	NR	48.91	61.80
BCS Breast Cancer Screening	Rate	60.24	61.34	65.07
COL Colorectal Cancer Screening	Rate	47.20	52.55	56.10
GSO Glaucoma Screening in Older Adults	Rate	65.89	69.26	71.44
COA Care for Older Adults	Rate:Advance Care Planning	7.54	12.65	9.00
COA Care for Older Adults	Rate:Medication Review	59.85	63.75	49.88
COA Care for Older Adults	Rate:Functional Status Assessment	30.17	26.03	10.46
COA Care for Older Adults	Rate:Pain Screening	49.15	32.85	10.22
SPR Spirometry Test Assess & Diag COPD	Reported rate	22.32	21.65	26.64
PCE Pharmacotherapy Magt. COPD Exacerbation	Reported rate - systemic corticosteroid	53.33	51.85	59.26
PCE Pharmacotherapy Magt. COPD Exacerbation	Reported rate - bronchodilator	85.56	83.95	91.36
CMC Chol Mgt Patients w Cardio Cond	Rate - LDL-C Screening	87.07	86.27	88.66
CMC Chol Mgt Patients w Cardio Cond	Rate <100 LDL-C Level	53.99	55.36	57.09
CBP Controlling High Blood Pressure	Rate	56.69	63.03	63.80
PBH Persistence of Beta Blocker Treatment	Reported Rate	19/22	23/27	too small
CDC Comprehensive Diabetes Care	Rate - HbA1c Testing	87.83	89.54	89.05
CDC Comprehensive Diabetes Care	Rate - Poor HbA1c Control	37.71	31.87	25.79
CDC Comprehensive Diabetes Care	Good HbA1c Control < 8.0	56.20	60.83	68.13
CDC Comprehensive Diabetes Care	Rate - Eye Exams	66.67	70.07	70.32
CDC Comprehensive Diabetes Care	Rate - LDL-C Screening	86.13	84.67	87.10
CDC Comprehensive Diabetes Care	Rate <100 LDL-C Level	44.53	50.85	54.01
CDC Comprehensive Diabetes Care	Rate - Mon Diabetic Neph.	88.08	88.81	89.05
CDC Comprehensive Diabetes Care	BP Control < 130/80	34.79	37.96	48.91
CDC Comprehensive Diabetes Care	BP Control < 140/90	55.96	63.75	65.21
ART Disease Mod Drug Therapy in RA	Reported rate	36.25	37.86	57.14
OMW Osteoporosis Management in Women	Rate	13.64	20.93	21.88
AMM Antidepressant Medication Mngmt	Rate - Effect.Acute Phase Treatment	68.29	56.00	56.14
AMM Antidepressant Medication Mngmt	Rate - Effect.Continuation Phase Treat.	43.90	44.00	42.11
FUH Follow-up Hosp Men Illness	Rate - 7 Days	53.09	42.55	58.59
FUH Follow-up Hosp Men Illness	Rate - 30 Days	68.52	63.83	76.56
MPM Annual Mon on Persistent Meds	Reported rate - ACE inhibitors or ARBs	88.34	90.56	91.83
MPM Annual Mon on Persistent Meds	Reported rate - Digoxin	87.12	89.03	96.00
MPM Annual Mon on Persistent Meds	Reported rate - Diuretics	89.98	90.32	92.72
MPM Annual Mon on Persistent Meds	Reported rate - Anticonvulsants	70.00	71.19	76.79
MPM Annual Mon on Persistent Meds	Reported rate - Total	87.17	88.73	90.94
MRP Medication Reconciliation	Reported rate	38.44	39.66	16.55
DDE Potent Harmful Drug-Disease Interaction	Rate:Falls + antidepress or antipsych	17.49	25.60	27.69
DDE Potent Harmful Drug-Disease Interaction	Rate:dementia + antidepre or antipsy	37.08	38.93	40.28
DDE Potent Harmful Drug-Disease Interaction	Rate:CRF + Non Asp NSAID	16.07	13.21	14.00
DDE Potent Harmful Drug-Disease Interaction	Rate: Overall	30.85	33.48	34.92
DAE Drugs to be Avoided in the Elderly	Rate: 1+ prescriptions	33.73	33.82	33.02
DAE Drugs to be Avoided in the Elderly	Rate: 2+ prescriptions	9.29	9.36	9.00
AAP Adult Acc Prev/Amb Hlth Svcs	Rate 20-44	81.75	84.09	86.06
AAP Adult Acc Prev/Amb Hlth Svcs	Rate 45-64	90.59	91.00	92.98
AAP Adult Acc Prev/Amb Hlth Svcs	Rate 65+	93.54	94.81	95.62
AAP Adult Acc Prev/Amb Hlth Svcs	Rate - Total	91.99	93.23	94.34
IET Int Eng of Alcohol Drg Dep Treat	Rate - Initiation - Total	44.36	37.04	28.32
IET Int Eng of Alcohol Drg Dep Treat	Rate - Engagement - Total	7.52	5.56	4.34
CAT Call Answer Timeliness	Reported rate	82.43	74.40	96.12
CAB Call Abandonment	Reported rate	9.04	8.45	1.40
AMBa Ambulatory Care Tot	AMB Tot OP Tot Visit/1000	10486.98	11064.72	10118.08
AMBa Ambulatory Care Tot	AMB Tot ER Tot Visit/1000	705.25	763.63	568.11
AMBa Ambulatory Care Tot	AMB Tot Amb Tot Surg/Procs Procs/1000	495.47	508.82	discontinued
AMBa Ambulatory Care Tot	AMB Tot Observ Rm Tot Ds Stays/1000	29.06	21.12	discontinued
IPUa Inp Gen Hsp/Acute Tot	Tot IP Ds/1000 MM Tot	306.60	304.36	283.99
IPUa Inp Gen Hsp/Acute Tot	Medicine Tot Ds/1000	232.87	239.53	217.36
IPUa Inp Gen Hsp/Acute Tot	Surgery Tot Ds/1000	73.32	64.70	66.25
IPUa Inp Gen Hsp/Acute Tot	Maternity Tot Ds/1000	0.00	0.00	0.00
NONa Inp Nonacute Care Tot	Inpat Nonacute Tot Ds/1000	142.71	149.99	discontinued
IAD Identification of Alcohol & other	Any service % for male	3.65	4.71	8.13
IAD Identification of Alcohol & other	Any service % for female	1.82	2.07	3.84
IAD Identification of Alcohol & other	Any service % Total	2.51	3.07	5.46
IAD Identification of Alcohol & other	Inpatient service % for male	1.64	1.83	1.34
IAD Identification of Alcohol & other	Inpatient service % for female	0.85	0.98	0.94
IAD Identification of Alcohol & other	Inpatient service % Total	1.15	1.30	1.09
IAD Identification of Alcohol & other	outpatient service % for male	0.11	0.00	0.00
IAD Identification of Alcohol & other	Outpatient service % for female	0.02	0.00	0.00

HEALTH PLAN OF SAN MATEO HEDIS RESULTS - CAREADVANTAGE (SNP)				
Measure	**Data Element**	**HEDIS2009**	**HEDIS2010**	**HEDIS2011**
IAD Identification of Alcohol & other	Outpatient service % Total	0.05	0.00	0.00
IAD Identification of Alcohol & other	ED service % for male	2.43	3.76	7.69
IAD Identification of Alcohol & other	ED service % for female	1.29	1.54	3.48
IAD Identification of Alcohol & other	ED service % Total	1.72	2.38	5.07
MPT Mental Health Utilization	Any service % for male	21.63	23.02	23.11
MPT Mental Health Utilization	Any service % for female	15.96	17.09	16.59
MPT Mental Health Utilization	Any service % Total	18.11	19.33	19.05
MPT Mental Health Utilization	Inpatient service % for male	2.90	2.53	2.72
MPT Mental Health Utilization	Inpatient service % for female	1.93	1.50	1.69
MPT Mental Health Utilization	Inpatient service % Total	2.29	1.89	2.08
MPT Mental Health Utilization	outpatient service % for male	0.14	0.07	0.03
MPT Mental Health Utilization	Outpatient service % for female	0.13	0.15	0.08
MPT Mental Health Utilization	Outpatient service % Total	0.14	0.12	0.06
MPT Mental Health Utilization	ED service % for male	21.20	22.63	22.81
MPT Mental Health Utilization	ED service % for female	15.61	16.87	16.21
MPT Mental Health Utilization	ED service % Total	17.73	19.05	18.70
ORXa Outpatient Drug Tot	OP Rx Tot Avg Cst of Rx/Mem/Mnth	350.13	339.63	discontinued
ORXa Outpatient Drug Tot	OP Rx Tot Avg Num of Rx/	69.06	72.30	discontinued
PCR Plan All-Cause Readmission	Age: 18-44			23.56%
PCR Plan All-Cause Readmission	Age: 45-54			20.64%
PCR Plan All-Cause Readmission	Age: 55-64			17.42%
PCR Plan All-Cause Readmission	Age: 65-74			15.06%
PCR Plan All-Cause Readmission	Age: 75-84			16.25%
PCR Plan All-Cause Readmission	Age: 85+			16.17%
PCR Plan All-Cause Readmission	Total			16.90%

CY 2012 Part C Report Card Master Table

Medicare Part C Report Card Master Table																					
Contract Number	Organization Marketing Name	Contract Name	Contract Type	SNP Plans	Number Measures Required	Number Missing Measures	Number Rated Measures	Calculated Summary Mean	Calculated Variance	Variance Category	Integration Factor	Integration Summary	2012 Part C Summary Rating	2012 Part D Summary Rating	2012 Overall Rating	Low Performing Icon	High Performing Icon	Sanction Deduction	Calculated Score Percentile Rank	Variance Percentile Rank
H5428	Health Plan of San Mateo	SAN MATEO HEALTH COMMISSION	CCP	Yes	25 of 50	3	47	3.41333	1.28312	med	0	3.41	3.5	4	3.5 out of 5 stars	No	No	No	60	48

Attachment 6. Qualification and Checklist # 12 - Stakeholder Involvement

- Draft Operating Principles for the Dual Eligibles Demonstration Project Advisory Council
- Letters of Support from: SMCHS Commission on Aging, Mills Peninsula Senior Focus, Lesley Senior Communities, Carlmont Gardens, and Legal Aid Society of San Mateo County
- Stakeholder meeting list

Applicants must demonstrate a local stakeholder process that includes health plans,
providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the project.

> **Response:** HPSM has the full support of the San Mateo County Health System (SMCHS), including AAS and BHRS, who will be the primary providers of behavioral health and long term services and supports under the DEDP. HPSM has worked closely with SMCHS for many years to establish a more integrated and locally-controlled health and social service delivery system in San Mateo County. In addition to the DEDP, we also are collaborating in several areas, including a CCS integration pilot proposal. BHRS already serves as HPSM's subcontractor for Medicare services provided for duals in the SNP.

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

- The Applicant has at least one dual eligible individual on the board of directors of its parent entity or company.

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

> **Response:** HPSM will form a dedicated advisory committee that will ensure adequate consumer protections are in place during the transition to and implementation of the DEDP. This advisory committee will be involved in the program design development process, review potential implementation issues affecting participants, and make recommendations for consideration by HPSM's Commission. Representation from DEDP participants and providers throughout the continuum of care will be sought, as well as appropriate SMCHS staff. The advisory committee will report to the San Mateo Health Commission, HPSM's governing board. *Please see the Draft Operating Policies for the Advisory Board, attached following.*

- The Applicant has provided five letters of support from the community, with sources including individual dual eligible consumers, advocates for seniors and persons with disabilities, organizations representing LTSS, such as community-based organizations, and/or individual health care providers. **YES.** *Please see Letters of Support, attached following.*

- 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.

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

  Response: HPSM has already begun and will continue to build support from other key providers and stakeholders through a series of in-person meetings to discuss our interest in this opportunity and program design ideas. So far in this process, we have discussed integrating long term supports with: hospitals in the community through the local Hospital Consortium; physicians through HPSM's physician advisory committees; some nursing facilities through individual meetings; adults day health care centers; the IHSS Advisory Committee; Commission on Aging; Commission on Disabilities; SEIU, the union representing IHSS providers; community forums such as for the reauthorization of the Older Americans Act; the New Beginnings Coalition (a broad locally based coalition of community advocates); and non profit housing providers. *Please see the list of the various meetings and presentations held with stakeholders, attached following.*

DRAFT

HEALTH PLAN OF SAN MATEO
DUALS DEMONSTRATION PILOT ADVISORY COMMITTEE

The Duals Demonstration Pilot Advisory Committee is an advisory body to the San Mateo Health Commission ("Commission").

PURPOSE

The purpose of the Duals Demonstration Pilot Advisory Committee is to assist the Health Plan of San Mateo (HPSM) by:

1. Guiding the strategic vision of Duals Demonstration Pilot as it evolves;

2. Reviewing program policies and activities which impact and are of interest to eligible Duals Demonstration Pilot members;

3. Ensuring adequate consumer protections are in place during the transition to and implementation of the program; and

4. Making recommendations to HPSM's Commission on ways to improve the delivery of care and services to members during the ongoing operation of the Duals Demonstration Pilot.

MEMBERSHIP

HPSM will actively seek representation from consumers, providers, and other stakeholders throughout the continuum of care for membership on the Advisory Committee. Appropriate members of HPSM and San Mateo County (SMC) staff will participate as staff to the Advisory Committee.

<u>Committee Members</u>

The CareOptions Advisory Committee shall be comprised if no more than thirteen (13) members. The composition of the Committee shall be:

a) One (1) Commission members
b) Three (3) Duals Demonstration Pilot members or family members of Duals Demonstration Pilot members
c) One (1) representative from In-Home Supportive Services
d) One (1) representative from a Community-Based Adult Services Center
e) One (1) representative from a long-term care facility
f) One (1) representative from a Home and Community-Based Service provider other than mentioned above
g) One (1) representative from the Legal Aid Society of San Mateo County

h) Three (3) positions which may be at-large or may represent any of the categories above.

HPSM Staff

The Health Plan of San Mateo will provide staff support to this committee and as appropriate present reports on activities in their areas. The following staff and/or their designees will attend the meeting:

a) Executive Director
b) Medical Director
c) Director, System Improvement (Project Manager for Duals Demonstration Pilot)
d) Director, Member Services and Outreach
e) Director, Health and Provider Services
f) Grievance and Appeals Coordinator
g) Administrative Assistant shall provide staff support to the Committee

San Mateo County

The Health System of San Mateo County will provide staff support to this committee and as appropriate present reports on activities in their areas. The following staff and/or their designees will attend the meeting:

a) Director of Aging and Adult Services
b) Director of Behavioral Health Services
c) Health Services Manager
d) Management Analyst

Application Process

Individuals who are interested in participating will be required to complete an application for consideration. Following receipt of an application, prospective members will meet with selected staff and leadership of the Duals Demonstration Pilot Advisory Committee. Recommendations are then made to the Commission for appointment.

Appointment of Members

A roster of Duals Demonstration Pilot Advisory Committee members will be presented to the Commission annually. During the year, as the need arises, staff and committee members will fill vacancies to be ratified by the Commission.

Term of Membership

Appointment to the Duals Demonstration Pilot Advisory Committee shall be for a two-year term with the option of being re-appointed for a second consecutive two-year term (a total of 4 years). A member may be reappointed after being off the board for one two-year term.

Establishment of Rotating Terms

In order to prevent the terms of all members expiring at the same time, it is important to establish alternating term schedules schedules. Following the initial appointment of the Duals Demonstration Pilot Advisory Committee, all board members will randomly draw for one or two-year initial terms. Term expiration will follow the guidelines listed above under Term of Membership. Those who are initially appointed to a one-year term will be permitted to be reappointed to two consecutive two-year terms (a total of 5 years). Those who are initially appointed to a two-year term will be permitted to be reappointed to an additional two-year term (a total of 4 years).

MEETINGS

Meeting Schedule

The Duals Demonstration Pilot Advisory Committee meets on a bi-monthly basis. An annual meeting calendar will be distributed to committee members. Public notice of the date, time and location will be posted and published in accordance with the Brown Act.

Meeting Location

All meetings of the Duals Demonstration Pilot Advisory Committee will be held at the offices of the Health Plan of San Mateo.

Minutes and Meeting Notices

Each committee member and anyone making a special request will receive a meeting packet in advance of the next meeting. The packet will include an agenda and additional information when necessary.

February 13, 2012

Maya Altman, Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

We are writing to express our strong support for the Health Plan of San Mateo's (HPSM) application to implement a Duals Demonstration Project in San Mateo County through California's Dual Eligible Demonstration Request for Solutions.

The San Mateo County Commission on Aging (COA) functions as "The Principal Advocate for Older Adults" in our County. Our mission is to maintain, enhance, and improve the quality of life for seniors in San Mateo County through the promotion of independence and self-sufficiency, mental and physical health and social and community involvement. Our Commissioners are appointed by the County Board of Supervisors and are involved in a range of issues affecting older residents in our community, including housing and health.

We are very excited at the prospect of a Demonstration Project in San Mateo County, especially the opportunities associated with Long Term Care Integration (LTCI). The COA has worked with HPSM and the San Mateo County Health System for many years on this concept, and we are strong supporters of efforts to create alternatives to institutional care for people who prefer to live in their homes or in other community settings. This project promises a vastly improved long-term care system for many in our community.

As we understand it, among the goals of this Demonstration Project are to improve the health status and quality of life for vulnerable Dual Eligibles in San Mateo County and help people stay in their communities rather than enter nursing home facilities. The Commission's mission and the goals of this project are well aligned, and we look forward to contributing to this project's success.

We urge the favorable consideration of HPSM's application.

Sincerely,

Denis O'Sullivan, Chair

DO:e

Commission on Aging
225 37th Avenue • San Mateo, CA 94403
Phone (650) 573-2707 • **Fax** (650) 372-0729 • **CA Relay** 711 • **Website** www.smco-coa.org
24-hour line to report abuse (800) 675-TIES (8437)
Health System Chief • Jean S. Fraser

Mills-Peninsula
Senior Focus

1720 El Camino Real,
Suite 10
Burlingame, CA 94010
(650) 696 3660
(650) 696 3633 Fax

February 21, 2012

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

I am writing to express our strong support for the Health Plan of San Mateo's application to implement a Duals Demonstration Project in San Mateo County through California's Dual Eligible Demonstration Request for Solutions.

Mills-Peninsula Senior Focus is an Adult Day Health Care (soon to be CBAS) program founded in 1985 and serving the San Mateo County community. We also offer Adult Day Health and Alzheimer's Day Care Resource Center programs. Senior Focus currently serves more than 60 HPSM Medi-Cal and CareAdvantage members. We have worked with HPSM throughout the past year on the ADHC / CBAS transition and are well aware of HPSM's longstanding commitment to the development of an integrated long term care system. Such a system will incorporate home and community based services such as CBAS with the goal of helping people live as independently as possible.

The mission of Senior Focus is the prevention or delay of institutionalization through comprehensive and coordinated care provided through one organization. Therefore, we are excited at the prospect of a Demonstration Project in San Mateo County, especially the opportunities associated with long term care integration (LTCI). This project promises a vastly improved long term care system for many in our community.

As we understand it, among the goals of this Demonstration Project are to improve the health status and quality of life for vulnerable Dual Eligibles in San Mateo County and help people stay in their communities rather than enter nursing home facilities. Our organization's mission and the goals of this project are well aligned, and we look forward to contributing to this project's success.

We urge the favorable consideration of HPSM's application.

Sincerely,

Maureen Dunn, MSW
Director, Senior Focus

LESLEY SENIOR COMMUNITIES

A Non-profit California Corporation

P.O. Box 1839
San Mateo, CA 94401-0940

www.lesleyseniorcommunities.org
TEL: (650) 726-4888
FAX: (650) 726-5888

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Sarah Lambert
Executive Director

February 21, 2012

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

I am writing to express our strong support for the Health Plan of San Mateo's application to implement a Duals Demonstration Project in San Mateo County through California's Dual Eligible Demonstration Request for Solutions.

Lesley Senior Communities is a non-profit organization dedicated to providing housing and related services to low-income senior citizens in San Mateo County. Founded in 1944, we currently operate four senior communities in partnership with the U.S. Department of Housing and Urban Development (HUD). We were recently awarded the first Assisted Living Conversion Grant in the State of California by HUD, enabling Lesley Senior Communities to convert a number of independent living apartments to affordable assisted living units. This is an important option to help our residents requiring some assistance with their Activities of Daily Living to "age in place."

We are very excited at the prospect of a Demonstration Project in San Mateo County, especially the opportunities associated with long term care integration (LTCI). Lesley Senior Communities has worked with the Health Plan of San Mateo and the San Mateo County Health System for many years on this concept, and we are strong supporters of efforts to create alternatives to institutional care for people who prefer to live in their homes or in other community settings. This project promises a vastly improved long term care system for many of the people we serve.

As we understand it, among the goals of this Demonstration Project are to improve the health status and quality of life for vulnerable Dual Eligibles in San Mateo County and help people stay in their communities rather than enter nursing home facilities. Lesley's mission and the goals of this project are well aligned, and we look forward to contributing to this project's success.

We urge the favorable consideration of HPSM's application.

Sincerely,

Sarah Lambert
Executive Director

2140 Carlmont Drive, Belmont, California 94002
Tel: 650.591.9601 Fax: 650.591.2446

February 16, 2012

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

I am writing on behalf of Carlmont Gardens Nursing Center, a skilled nursing facility in San Mateo County. As you know, we currently contract with Health Plan of San Mateo (HPSM) to offer nursing facility services for its Medi-Cal and Medicare Special Needs Plan members.

We wish to express our strong support for HPSM's application to implement a Duals Demonstration Project in San Mateo County as part of California's Dual Eligible Demonstration Request for Solutions!

In addition to Carlmont Gardens Nursing Center (a 74-bed facility), we also own and operate a 38-bed residential care facility (RCFE) in Montara, CA. Our original business plan envisioned us having the ability to place our incoming residents or patients at whichever level best suited the individual. (We still do follow that practice whenever possible.) What we have found, however, is that there are many folks who (although better-suited for the RCFE) must be housed as long-term custodial residents at the skilled facility *solely* because their care is subsidized by Medi-Cal dollars.

With our unique insights into two different levels of care, it has become obvious that many folks who could really flourish at the less expensive RCFE level of care are actually being housed unnecessarily and unfortunately at the much costlier SNF level of care. This current reality is a shame for the affected residents and their families – and obviously causes a huge financial challenge within our State, which is constantly struggling to allocate and extend the dollars as judiciously as possible to meet the needs of its citizenry.

You are aware that we have worked with HPSM since 2006 when the Plan started its CareAdvantage Special Needs Plan for dual eligible beneficiaries in San Mateo County. We serve as one of HPSM's providers for Medicare funded skilled nursing services. In February 2010, when HPSM assumed responsibility for Medi-Cal

funded long term care, we also contracted with the Plan to offer custodial long-term care services. We have enjoyed our strong and successful partnership with HPSM.

Ms. Altman, please let me be as clear as possible. We are *extremely* excited at the prospect of a Demonstration Project in San Mateo County, especially the opportunities associated with long-term care integration (LTCI). We first learned of HPSM's plans for LTCI in early 2010 and have been strong supporters of this effort to create alternatives to institutional care for people who prefer to live in their homes or in other community settings. We know that this will be a vastly improved system for many of the people we serve. We can't WAIT to get started!

We are also eager to serve on HPSM's Demonstration Project advisory board and help guide this project to its full potential.

We strongly urge the favorable consideration of HPSM's application. If I can be of further assistance or clarify any of my observations above, please do not hesitate to contact me.

Sincerely,

SKriger

Sharolyn Kriger
Owner/Administrator
Carlmont Gardens Nursing Center

The Health Consumer Center of San Mateo County
www.healthconsumer.org

February 16, 2012

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

I am writing on behalf of the Legal Aid Society of San Mateo County. For the past three years we have contracted with the Health Plan of San Mateo (HPSM) to offer a member advocate program for HPSM's Medi-Cal and Medicare Special Needs Plan members. We have been impressed with HPSM's dedication to providing high quality, culturally sensitive services to its members. We wish to express our strong support for HPSM's application to implement a Duals Demonstration Project in San Mateo County as part of California's Dual Eligible Demonstration Request for Solutions.

The Legal Aid Society of San Mateo County was founded in 1959, with a mission of assisting the low-income members of our county to improve their lives through equal access to justice. Legal Aid not only provides individual representation, but is distinguished by its role as a "community voice" representing the low-income population of San Mateo County through systemic advocacy and public policy work at the state, county and local levels. Legal Aid has earned a reputation for successfully creating collaborative approaches to address the unique legal issues of the underserved and resolve problems in important areas of basic need. In particular, Legal Aid has developed a high level of expertise in the area of access to healthcare; our attorneys have worked effectively with state and local government agencies to reduce the legal barriers to healthcare and health coverage faced by the most vulnerable low-income San Mateo County residents, particularly seniors and the disabled. In this capacity, the Legal Aid Society has worked with HPSM since its founding in 1987. HPSM staff refers its members to the Legal Aid Society for assistance with Medi-Cal and Medicare eligibility-related issues which may negatively impact the members' continued access to quality health care. We have enjoyed a strong and successful partnership with HPSM.

We are extremely excited at the prospect of a Duals Demonstration Project in San Mateo County and are pleased that the focus will be on improved coordination of Medicare and Medi-Cal benefits and eligibility, including the opportunities associated with long term care integration (LTCI). We have been strong supporters of this effort to create alternatives to institutional care for people who prefer to live in their homes or in other community settings. We know that this will be a vastly improved system for many of the people we serve.

THE NATALIE LANAM JUSTICE CENTER
521 EAST 5TH AVENUE • SAN MATEO, CA 94402 • 650.558.0915 • FAX 650.558.0673 • TOLL-FREE 800.381.8898

Legal Aid currently participates in HPSM's Consumer Advisory Committee and also looks forward to serving on HPSM's Demonstration Project advisory board and helping to guide this project to its full potential.

We urge the favorable consideration of HPSM's application.

Sincerely,

M. Stacey Hawver
Executive Director

Health Plan of San Mateo
Stakeholder Engagement

Stakeholder/Meeting	Lead	Type	Date
Local Stakeholders			
Hospital Consortium	Maya	Presentation	9/7/2010
New Beginning Coalition	Lisa	Presentation	10/7/2010
IHSS/Public Authority Advisory Committee	Lisa	Presentation	11/11/2010
Peninsula Health Care District	Khoa	Presentation	12/9/2010
Commission on Aging	Lisa	Presentation	12/10/2010
SMC ADHC Meeting	Maya / Lisa / Khoa / Marsha	Planning Meeting	1/18/2011
Healthy Communities Collaborative	Lisa	Presentation	1/24/2011
Older Americans Act Reauthorization Forum	AAS	Participant	2/25/2011
Commission on Aging	Maya	Presentation	4/11/2011
Diane Kimarich, Addus	Maya	Planning Meeting	4/28/2011
Coastside ADHC visit	Maya/Lisa/Chris	Presentation	6/3/2011
Community-Based Continuum of Care Committee	Chris	Presentation	6/8/2011
ADHC visit - Senior Focus	Maya / Chris	Presentation	6/29/2011
Stakeholder meeting - Providers	Maya	Presentation	7/20/2011
IHSS/Public Authority Advisory Committee	Maya/ Chris	Presentation	8/3/2011
Meet w/Kevin Sharps, MidPen Housing	Maya / Lisa	Planning Meeting	8/4/2011
Ron Robinson Senior Center	Chris	Planning Meeting	8/31/2011
IHSS Advisory Committee	Maya	Presentation	9/7/2011
Senior Focus ADHC	Maya	Presentation	9/7/2011
Senior Focus ADHC	Maya	Presentation	10/26/2011
Stegner Registry	Chris	Planning Meeting	12/21/2011
ADHC / CBAS transitions meetings	HPSM/AAS	Planning Meeting	ongoing

Health Plan of San Mateo
Stakeholder Engagement

Stakeholder/Meeting	Lead	Type	Date
State / CMS / Policy			
State Technical Work Group	Maya	Presentation on LTCI with case studies	7/7/2010
Conference for Medicaid MCOs	Maya	Presentation	9/27/2010
C4A	Maya	Presentation	9/30/2010
Little Hoover Commission	Maya / Lisa	Presentation	11/10/2010
CMS (Melanie Bella)	Maya	Planning Meeting	12/9/2010
Scan Foundation	Maya	Presentation	1/25/2011
CMS (Melanie Bella, Barbara Edwards)	Maya	Planning Meeting	2/7/2011
Center for American Progress	Maya	Presentation	2/9/2011
CMS (Sharon Donovan	Maya	Planning Meeting	2/10/2011
Meeting with Paul Miller, DHCS	Maya	Planning Meeting	2/28/2011
Duals TAP	Maya	Participant	3/11/2011
ADHC Panel	Maya	Presentation	4/8/2011
DHCS/CalOptima/HPSM Integration Call	Maya	Planning Meeting	4/26/2011
Duals Meeting in Sacto, Aging and LTC Cmt Assembly	Maya	Presentation	5/17/2011
CMS Listening Session - Duals alignment	Maya	Presentation	6/20/2011
LTCI meeting in Sacto	Maya	Planning Meeting	7/28/2011
ADHC All Plan Call	Maya	Planning Meeting	8/8/2011
Meeting with Stuart Busby and Jane Ogle	Maya / Ron / Chris	Planning Meeting	8/8/2011
ADHC Budget Hearing	Maya	Presentation	8/16/2011
LTC Integration in Sacto with DHCS	Maya	Planning Meeting	8/17/2011
Olmstead Meeting	Maya	Presentation	8/18/2011
Data Analysis Needs for Duals	Maya / Chris / Khoa	Planning Meeting	8/24/2011
Duals RFI Conference, Sacto	Maya	Presentation	8/30/2011
Dual Eligible Senate Finance Comm Hearing	Maya	Presentation	9/21/2011
SCAN Summit on LTSS	Lisa / Chris / Joy	Participant	9/27/2011
BH Duals in Sacto	Maya	Participant	12/2/2011
Duals Consumer Protections, SF	Maya	Presentation	12/12/2011
LTSS Stakeholder Mtg - Duals (LA)	Maya	Presentation	12/15/2011

Health Plan of San Mateo
Stakeholder Engagement

Stakeholder/Meeting	Lead	Type	Date
Other			
Learning Session - AAS - LTCI	Maya / Lisa	Presentation	11/9/2010
All-Staff Meeting - AAS	Maya / Lisa	Presentation	1/25/2011
DHCS/CalOptima/HPSM Integration Call	Maya	Planning Meeting	3/7/2011
Long Term Care Coordinating Council	Maya	Presentation	3/10/2011
TAPCA Presentation	HPSM / AAS	Planning Meeting	3/14/2011
Learning Session - AAS - CareOptions	Chris	Presentation	5/18/2011
Learning Session - AAS - Person centered care	Marsha / Chris R / Joy	Presentation	6/22/2011
Duals Meeting	HPSM / BHRS	Planning Meeting	8/2/2011
Duals Meeting	HPSM / BHRS	Planning Meeting	10/14/2011
HPSM Commission	Maya	Presentation	Ongoing
LTCI Core Team Meetings	HPSM/AAS/BHRS	Planning Meeting	Ongoing

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: August 26, 2011

TO: All Medicare Advantage Organizations

FROM: Danielle Moon, J.D., M.P.A., Director

RE: Posting of NCQA SNP Approval Information and Guidance on Permitted Disclosure of this Information

The purpose of this memorandum is to: (1) announce the upcoming public posting of information about the National Committee for Quality Assurance's (NCQA) approval of Special Needs Plans (SNPs) for Contract Year (CY) 2012; and (2) provide Medicare Advantage organizations (MAOs) offering SNPs with guidance on the permitted disclosure of information regarding their NCQA SNP approval to current and prospective beneficiaries.

On April 5, 2011, we released a memorandum describing the criteria that NCQA would use to effectuate the Affordable Care Act (ACA) requirement that, starting in CY 2012, all SNPs be approved by the NCQA based on standards developed by the Secretary. NCQA completed its evaluation of SNP models of care (MOCs) in late May 2011. SNPs received either a one-, two-, or three-year approval depending on their MOC scores.

Public Reporting of CY 2012 NCQA SNP Approval Information

The CY 2012 NCQA SNP approval information will be available on our SNP webpage by mid-September 2011. For informational purposes, we will also post the *Special Needs Plan (SNP) Approval Process Scoring Criteria for Contract Year (CY) 2012* document we released with our April 5, 2011 HPMS memorandum. This document, which includes the elements and factors that comprise the MOC evaluation process, provided guidance to MA organizations regarding the specific criteria NCQA used during the SNP approval evaluation process for CY 2012. We will notify MAOs when the NCQA SNP approval information is posted, including the specific link for its location.

Marketing Guidance on Permitted Disclosures of Plan Information Regarding NCQA SNP Approvals

NCQA's approval of SNP MOCs is an important first step in ensuring that SNPs have in place a structure for care management processes and systems that will enable them to provide coordinated care for special needs individuals. We will be evaluating the implementation of MOCs separately and more rigorously beginning in 2012. We believe NCQA approval of SNP

MOCs is more an indicator of compliance with CMS requirements than an endorsement by CMS or NCQA of a plan or its quality of service, and want to ensure that beneficiaries understand this distinction.

Therefore, plan sponsors that choose to disclose NCQA approval information may disclose only the following information, verbatim, on any of their marketing materials, including their plan websites, and/or press releases:

> "[*Insert Plan Name]* has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until [*insert last contract year of NCQA approval]*. NCQA's approval is based on a review of [*insert Plan Name's]* Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of [*insert Plan Name]* or the quality of service provided by [*Insert Plan Name]*. [*Insert Plan Name]* will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at [*insert customer service number*]."

Plan sponsors may not disclose any information other that the language provided above, and under no circumstances may a plan sponsor discuss its numeric SNP approval score.

Alternatively, plan sponsors may choose not to disclose information about their NCQA SNP approval in any way in their marketing materials, including plan websites, or in press releases.

Please contact your Account Manager or Regional Office Marketing Reviewer if you have any questions.

Contract Year 2012 SNP Model of Care Approval Information

This file includes columns for each SNP with the following information – State, county, company name, plan name, plan and contract ID number, SNP type, SNP subtype, the length of time the approval has been granted for, and the approval start and end dates.

State	County	Organization Name	Contract ID	Plan ID	Parent Organization	SNP Type	SNP SubType	Approval Status	Approval Start Year	Approval End Year
CA	San Mateo	San Mateo Health Commission	H5428	001	Health Plan of San Mateo	D-SNP	Medicaid S	3 year	2012	2015

From:	HPMS Web [hpms@cms.hhs.gov]
Sent:	Friday, May 27, 2011 11:57 AM
To:	Maya Altman; Rosemary B. Stuessy
Cc:	SNP Applications; Ellen Dunn-Malhotra; HPMS Helpdesk
Subject:	H5428 - SNP Conditional Approval - Dual-Eligible - Medicaid Subset - $0 Cost Share

May 27, 2011

Maya Altman
Executive Director
SAN MATEO HEALTH COMMISSION
701 Gateway Blvd, Ste 400
South San Francisco, CA 94080

Re: Conditional Approval of SNP Application
H5428 - SAN MATEO HEALTH COMMISSION - Dual-Eligible - Medicaid Subset - $0 Cost Share

Dear Maya Altman:

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

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

Your Quality Improvement Program Plan passed.

Final Score

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

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

Element Summary	
Element 1	0
Element 2	0
Element 3	0
Element 4	0
Element 5	0
Element 6	0
Element 7	0
Element 8	0
Element 9	0
Element 10	0
Element 11	0
Total Points	0
Total Possible Points	160
Score 96.25%	

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

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

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

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

Sincerely,

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

HEALTH PLAN OF SAN MATEO

SUPPLEMENTAL BENEFITS

HPSM currently offers its SNP members the following supplemental benefits:

- Transportation (Taxi Rides)—HPSM's members are eligible for up to fifty (50) free one-way taxi rides (or 25 roundtrips) to medical, dental, or vision appointments per calendar year. This is a critical add on benefit for vulnerable SNP members who need regular and consistent care yet often have difficulty getting transportation to medical appointments.

- Dental Services—California's Medicaid program eliminated coverage for adult dental care in 2009. Therefore, HPSM's comprehensive dental coverage, including preventive and restorative dentistry, oral surgery, root canals, dentures, partials, crowns and bridges, is critical for the health of vulnerable SNP members.

- Vision Services—California has also eliminated coverage for many adult vision services under Medicaid. HPSM SNP members may receive an eye exam annually, glaucoma screening, and eye care services from an optometrist and ophthalmologist. Vision services include one free pair of eyeglasses with frames or contact lenses ($150 cap every year). This benefit is critical for prevention of falls and other trauma related to vision.

- Copayments—HPSM benefits include zero copayments for generic drugs up to the initial coverage limit. For the 2012 benefit year the initial coverage limit was $2,695. This is an important benefit for ensuring members are compliant with pharmacy regimens. We have found that copayment requirements, especially for mentally ill members or members in need of multiple prescriptions for their chronic conditions, can be a significant barrier to quality care outcomes. Many vulnerable members simply cannot afford multiple copayments, no matter how low. Once a member reaches the initial coverage limit, the standard low income subsidy copayments apply.

HPSM will continue to provide these benefits in the Dual Eligible Demonstration Pilot.

February 21, 2012

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Ms. Altman:

I am writing on behalf of the San Mateo County Health System (SMCHS) to express our strong support and eagerness to partner with the Health Plan of San Mateo (HPSM) in the proposed Dual Eligible Demonstration Project. HPSM, in collaboration with SMCHS, has long sought to develop a more integrated system of care for duals, and comes to this RFS process after several years of intensive planning with the County around long-term care and behavioral health integration.

SMCHS is uniquely positioned to participate in this important project, with the following areas organized under the Health System:

- *Aging and Adult Services (AAS)* - administers an entire range of long term supportive services, including In-Home Supportive Services and the Public Authority, the Multipurpose Senior Services Program, Meals On Wheels, adult day care services, information and referral, adult protective services, and other Area Agency on Aging-funded services. AAS serves as the Area Agency on Aging for San Mateo County.

- *Behavioral Health and Recovery Services (BHRS)* - provides services for the prevention, early intervention and treatment of complex, diagnosed mental illnesses and substance abuse conditions. BHRS already serves as a subcontractor for Medicare services provided to dual eligibles in HPSM's Special Needs Plan, including mental health services for duals with complex issues.

- *San Mateo Medical Center (SMMC)* - the County public hospital and clinic system, including a medical center, 10 outpatient federally qualified health centers (FQHC), and the *Ron Robinson Senior Care Center,* a multi-disciplinary senior care center specializing in care for older dual eligibles.

Health System Administration
225 37th Avenue, San Mateo, CA 94403
Phone (650) 573-2582 • **Fax** (650) 573-2116 • **CA Relay** 711 • **Website** www.smhealth.org
Health System Chief • Jean S. Fraser
Board of Supervisors • Dave Pine • Carole Groom • Don Horsley • Rose Jacobs Gibson • Adrienne Tissier

SMCHS will serve as a subcontractor for the Demonstration Project, primarily through AAS and BHRS. In addition to providing IHSS services and both behavioral health and substance use services, agency staff will be key members of the interdisciplinary care teams. AAS will also manage the project's single point of entry and oversee subcontracts with providers of home and community based services for long term care. BHRS will bring to the project its extensive network of mental health and substance use service providers, as well as its specialized care coordination expertise. SMMC will continue to offer inpatient and outpatient medical services to dual eligibles as an HPSM provider. Both SMMC and BHRS specialized interdisciplinary clinics will in many cases serve as health homes for members enrolled in the Project.

We have enjoyed a strong and successful partnership with HPSM, and look forward to combining the best of medical, social, and behavioral health support models to bring exceptional services to this county's dual eligible population.

We urge the favorable consideration of HPSM's application.

Sincerely,

Jean S. Fraser
Chief

Attachment 10. Criteria for Additional Consideration 10 - Contract with the County agency responsible for mental health (BHRS)

December 15, 2009

Maya Altman, Executive Director
Heath BHRS of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Dear Maya,

Enclosed is your approved copy of the Agreement between the Health Plan of San Mateo for Medicare CareAdvantage for the term January 1, 2009 through December 31, 2011 and San Mateo County Behavioral Health and Recovery Services. Through this Agreement the Health Plan of San Mateo shall reimburse Behavioral Health and Recovery Services for the provision of outpatient mental health services to residents with Medicare insurance as part of the Medicare Advantage Program.

Please feel free to call me if you have any questions or concerns regarding this Agreement. I can be reached at (650) 573-2537 or mvozikes@co.sanmateo.ca.us.

Sincerely,

Mary A. Vozikes
Contract Administration

Enclosure (1)

SERVICE AGREEMENT

THIS SERVICE AGREEMENT (hereinafter referred to as the "AGREEMENT") is entered into this 10' th day of November 2009, between the San Mateo Health Commission, hereinafter referred to as "HPSM", and the County of San Mateo Health System, Behavioral Health and Recovery Services, hereinafter referred to as "BHRS."

WHEREAS, HPSM has entered into and will maintain a contract with the Centers for Medicare and Medicaid Services (CMS), pursuant to which qualifying individuals who are dually eligible for Medicare and Medi-Cal and who have subscribed and enrolled under HPSM's CareAdvantage Program will receive, through HPSM, health services hereinafter defined as "Medicare Services".

WHEREAS, HPSM has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who subscribe and are enrolled under HPSM's CareAdvantage Program will receive, through HPSM, Medi-Cal services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Health Services".

WHEREAS, Medicare Services and Medi-Cal Wraparound Services together shall hereinafter be referred to as "Covered Services."

WHEREAS, BHRS has entered into and will maintain a contract with the California Department of Health Care Services (DHCS), pursuant to which individuals who are dually eligible for Medicare and Medi-Cal will receive, through BHRS, Medi-Cal-covered mental health and substance abuse recovery services provided as wraparound benefits to the Medicare Covered Services noted above, hereinafter defined as "Medi-Cal Wraparound Mental Health and Substance Abuse Recovery Services".

WHEREAS, BHRS has developed expertise in arranging for and managing delivery of mental health and substance abuse recovery services to Medi-Cal beneficiaries.

WHEREAS, HPSM seeks a delegated mental health and substance abuse recovery service benefit administrator to arrange for and manage the delivery of mental health and substance abuse recovery services to its CareAdvantage Program members.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, HPSM and BHRS hereby agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Benefit Plans. The term "Benefit Plan" shall mean the scope of benefits indicated in the CareAdvantage Evidence of Coverage (Attachment A) as it is updated on an annual basis and which includes Claims processing parameters and other information specifying healthcare coverage for CareAdvantage members, as those parameters currently exist or may be amended in the future. HPSM will provide BHRS with certain information relating to such Benefit Plan ("Benefit Plan Information") including, but not limited to the names of the CareAdvantage Members entitled to services and other parameters of the Benefit Plan as BHRS may reasonably request from time-to-time.

1.2 Case Management. The term "Case Management" shall mean the coordination and follow up by the Primary Care Physician of all services deemed necessary to provide the Member medically necessary and appropriate health care.

1.3 Commission. The term "Commission" shall mean the San Mateo Health Commission.

1.4 Contracted Hospital. The term "Contracted Hospital" shall mean a licensed hospital which has entered into an agreement with HPSM to provide Covered Services to Members.

1.5 Contracted Medical Group. The term "Contracted Medical Group" shall mean a medical group or independent practice association which has entered into an agreement with HPSM to provide Covered Services to Members.

1.6 Contracted Physician. The term "Contracted Physician" shall mean a physician who is duly licensed to practice medicine or osteopathy under California law and who has contracted with HPSM or is employed by or contracts with a Contracted Medical Group to provide Covered Services to Members.

1.7 Contracted Provider. The term "Contracted Provider" shall mean a Contracted Physician, Contracted Hospital, Contracted Medical Group or other licensed health facility or health professional which has entered into an agreement with HPSM to provide Covered Services to Members.

1.8 Copayment and Deductible. The term "Copayment and Deductible" shall mean cost sharing charges for Covered Services. CareAdvantage members shall not be subject to any Copayments or Deductibles for any services provided under the terms of this contract.

1.9 Covered Services. The term "Covered Services" shall mean those health care services, equipment and supplies, inclusive of Medicare Services and Medi-Cal Wraparound Services, which a Member is entitled to receive under the CareAdvantage program and which are set forth in the CareAdvantage Evidence of Coverage (Attachment A).

1.10 Delegated Entity. The term "Delegated Entity" shall mean a First Tier Entity with whom HPSM has contracted to perform specified delegated functions on HPSM's behalf in accordance with state, local, and federal laws, rules, and guidelines, as well as in accordance with HPSM policies and procedures.

1.11 Downstream Entity. The term "Downstream Entity" shall mean any party that enters into an acceptable written arrangement below the level of the arrangement between HPSM and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.12 Emergency. The term "Emergency" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her

unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

1.13 Evidence of Coverage. The term "Evidence of Coverage" shall mean the document issued by HPSM to a Member that sets forth the HPSM's Covered Services.

1.14 First Tier Entity. The term "First Tier Entity" shall mean any party that enters into a written arrangement with HPSM to provide administrative services or health care services for a Medicare eligible individual.

1.15 Formulary. The term "Formulary" shall mean the list of prescription drugs and medications that are recommended by HPSM for routine use and which will be dispensed through Contracted Pharmacies.

1.16 Identification Cards. The term "Identification Cards" ("ID Cards") shall mean printed identification cards containing information about the benefits to which the Members are entitled.

1.17 Medi-Cal Wraparound Services. "Medi-Cal Wraparound Services" shall mean those Medi-Cal services that HPSM provides to eligible Medi-Cal beneficiaries who are enrolled in HPSM under HPSM's Medi-Cal contract with the California Department of Health Care Services and that are provided secondary to services, including Medicare Services, covered by other payers or programs that have primary payment responsibility.

1.18 Medically Appropriate. The term "Medically Appropriate" means services and medical supplies which are required for prevention, diagnosis, or treatment of sickness or injury, and which are:

1.18.1 Consistent with the symptoms of a medical condition or treatment of a medical condition;
1.18.2 Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
1.18.3 Not solely for the convenience of the Member or provider of the service or medical supplies; and
1.18.4 The most cost effective of the alternative levels of service or medical supplies which can be safely provided to the Member in HPSM's judgment.

1.19 Medicare Services. The term "Medicare Services" means those health care services that are covered under the Original Medicare program in accordance with Medicare coverage guidelines and offered through HPSM CareAdvantage, as well as supplemental Medicare benefits offered through HSPM CareAdvantage in accordance with the Centers for Medicare and Medicaid Services approval of PLAN's annual Medicare Advantage-Prescription Drug Plan bid.

1.20 Members. The term "Members" shall mean those individuals who are enrolled in CareAdvantage who are entitled to receive Covered Services.

1.21 Non-Covered Services. The term "Non-Covered Services" means those services and supplies that HPSM is not required to provide to Members pursuant to the CareAdvantage Evidence of Coverage.

1.22 Non-Participating Provider. The term "Non-Participating Provider" means a provider of health care services or equipment that does not have a contract with HPSM to provide such services or equipment to Members.

1.23 Participating Providers. The term "Participating Providers" shall mean those individuals or organizations which contract directly with HPSM or BHRS to provide health care services or equipment for CareAdvantage Members.

1.24 Primary Care Provider (PCP). The term "Primary Care Provider" or "PCP" means a Participating Provider selected by a Member to render first contact medical care and certain Covered Services.

1.25 PCP Assignment. The term "PCP Assignment" refers to the process by which an Member is assigned by HPSM to a PCP for provision of certain Covered Services, or to the PCP assigned for a particular Member.

1.26 RBRVS. The term "RBRVS" (Resource-Based Relative Value Scale) means the current year's physician compensation schedules published by the United States Centers for Medicare and Medicaid Services ("CMS"), which are used by CMS to reimburse those physicians Contracted in the Federal Medicare Program ("Medicare").

1.27 Referral. The term "Referral" shall mean the process by which a Contracted Physician directs a Member to a Non-Contracted Provider.

1.28 Referral Provider. The term "Referral Provider" shall mean a Contracted Physician who is professionally qualified to practice his/her designated specialty and whose agreement with HPSM includes responsibility for providing Covered Services in his/her designated specialty.

ARTICLE 2
DUTIES TO BE PERFORMED BY HPSM

2.1 Member Eligibility. HPSM shall provide up-to-date information on the eligibility status of CareAdvantage members via its HPSM Web Claims system. Eligibility information provided shall be in accordance with HPSM's best available information. However, if retroactive changes are made to individual members' eligibility, final eligibility status information shall be honored by BHRS.

2.2 Benefit Plan Information. HPSM will deliver to BHRS detailed Benefit Plan Information. Such information shall contain all of the elements required by BHRS so that BHRS may verify, price, and pay the Claims submitted by Participating Providers, as well as prepare the various reports as described in Exhibit A. In addition, HPSM shall provide any Benefit Plan Information changes to BHRS within thirty (30) days of the date such changes shall become effective (the "change date").

2.3 Notification Requirements. HPSM will review all reports, statements, and invoices provided by BHRS and shall notify BHRS in writing of any errors or objections within ninety (90) days of receipt. Specifically, this shall also apply to all service requests,

benefit change requests, and any operation change requests. Until HPSM notifies BHRS in writing of any errors or objections, BHRS will be entitled to rely on the information contained in the reports, statements, and invoices. If HPSM does not notify BHRS in writing of any errors or objections within the ninety (90) day period, the information contained therein will be deemed accurate, complete, and acceptable to HPSM, and thereafter BHRS shall have no liability related thereto. This does not apply with respect to any undercharges or underpayments of HPSM. BHRS shall document and retain supporting documentation for audit purposes. If HPSM notifies BHRS within the ninety (90) day period of any errors or objections, BHRS shall compensate HPSM for any verifiable errors or objections. Nothing in this article will absolve BHRS of any liability of errors, discrepancies, objections, or omissions identified under Section 5.3 of this contract.

ARTICLE 3
DUTIES TO BE PERFORMED BY BHRS

3.1 Provision of Services to HPSM. BHRS shall provide to HPSM the services listed in Exhibit A, attached hereto and incorporated herein as referenced. These services shall be provided at the agreed upon rates listed in Exhibit B, attached hereto and incorporated herein as referenced.

3.2 Compliance with Laws and Regulations. BHRS shall comply with all applicable Federal laws, regulations, reporting requirements, and CMS instructions, and with HPSM's policies and procedures and contractual obligations with the California Department of Health Care Services, including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), HIPAA, and the HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. BHRS agrees to include the requirements of this section in its contracts with any Downstream Entity, and to require any Downstream Entity to comply accordingly.

3.3 Capacity to Contract. BHRS acknowledges that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with any entity that itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. BHRS warrants that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, Downstream Entity, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If BHRS finds any employee, manager, or Downstream Entity is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs.

ARTICLE 4
PAYMENT DUE BHRS AND TO HEALTH CARE PROVIDERS

4.1 Monthly Statement for Payment Administrative Services. As set forth in Exhibit B of this Agreement, HPSM shall remit payment to BHRS within thirty (30) calendar days of the close of each month payment of a monthly administration fee. HPSM will prepare a statement using current month's CareAdvantage member counts plus/minus adjustments for the previous month. If BHRS questions the amount of the monthly administrative services statement, BHRS shall notify HPSM of its questions regarding said amount. If HPSM receives such a notice, both BHRS and HPSM shall make a reasonable effort to resolve such questions within thirty (30) calendar days. Upon and in accordance with such resolution, HPSM will remit to BHRS any outstanding amount due, if applicable, to BHRS within thirty (30) calendar days of the resolution.

4.2 Payment to Health Care Providers. BHRS shall process and issue payments to health care providers based on approved claims for Covered Services provided to Members. As a delegated entity, BHRS shall follow all applicable CMS policies and guidelines regarding timely and appropriate processing of claims, member notification of claims denial, and appropriate payment levels to contracted and non-contracted providers.

4.3 Payment of Health Care Costs. BHRS shall electronically submit claims to HPSM for reimbursement of health care costs paid under this Agreement. HPSM shall issue payment according to Exhibit B for adjudicated claims to BHRS within thirty (30) calendar days from the date of submission.

4.4 No Member Liability. BHRS agrees that neither BHRS nor any of its Downstream Entities, in any circumstances, including, but not limited to nonpayment by HPSM shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any HPSM member for services performed under this Agreement. This provision shall survive the termination of this Agreement for any reason and shall be construed to be for the benefit of HPSM members.

ARTICLE 5
RECORDS

5.1 Maintenance of Records. BHRS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors, to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of ten (10) years. Such documentation, including books and records, shall be in a format and media deemed appropriate by BHRS and HPSM and sufficient to accommodate periodic auditing of the records to evaluate the quality, appropriateness and timeliness of services performed by BHRS under this Agreement. The records shall be accessible to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

5.2 Use of Information. BHRS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the

information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

5.3 Right to Audit Claims and Business Records. BHRS agrees to permit access to, inspection, and audit by HPSM, the California Department of Managed Health Care, the California Department of Health Services, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, and or their designees, at all reasonable times of all facilities, books, records and documents maintained or utilized by BHRS in the performance of this Agreement.

HPSM and representatives of a regulatory or accreditation agency may each inspect and audit, at least once annually, BHRS's business records that directly relate to billings made to HPSM for Claims. BHRS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and BHRS shall fully cooperate with and assist and provide information to representatives of each other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or BHRS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and BHRS will cooperate with the requirements of the auditing agency to the extent possible. An audit of BHRS's records may be conducted at BHRS's office where such records are located and shall be limited to transactions over the ten (10) year period preceding such audit unless the document retention period is extended according to applicable law. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

ARTICLE 6
INDEMNIFICATION

6.1 Mutual Indemnification. HPSM and BHRS shall indemnify and hold harmless each other from and against all third party claims, demands, losses, damages and reasonable expenses arising from or in connection with the performance of the terms of this Agreement, except to the extent that such claims, demands, losses, damages and expenses result from the negligence of the other.

6.2 Concurrent Negligence. In the event of concurrent negligence of HPSM, its officers and/or employees, and BHRS, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

ARTICLE 7
NON-DISCRIMINATION

7.1 Non-Discrimination.

7.1.1 BHRS shall comply with § 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

7.1.2 *General non-discrimination.* No person shall, on the grounds of race, color, ethnicity, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, claims experience, medical history, evidence of insurability, genetic information, source of payment, or political affiliation be denied any benefits or subject to discrimination under this Agreement. BHRS shall implement procedures to ensure that Members are not discriminated against in the delivery of health care services consistent with the benefits covered under CareAdvantage based on any of these factors.

7.1.3 *Equal employment opportunity.* BHRS shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. BHRS's equal employment policies shall be made available to HPSM upon request.

7.1.4 *Violation of Non-discrimination provisions.* Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject BHRS to penalties, to be determined by the HPSM Executive Director, including but not limited to:

7.1.4.1 termination of this Agreement;
7.1.4.2 disqualification of BHRS from bidding on or being awarded a contract with HPSM for a period of up to 3 years;
7.1.4.3 liquidated damages of $2,500 per violation;
7.1.4.4 imposition of other appropriate contractual and civil remedies and sanctions, as determined by the Executive Director.

To effectuate the provisions of this section, the Executive Director or his/her designee shall have the authority to examine BHRS's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to BHRS under the Service Agreement or any other Service Agreement between BHRS and HPSM.

BHRS shall report to HPSM the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified BHRS that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. BHRS shall provide HPSM with a copy of their response to the Complaint when filed.

7.1.5 *Compliance with Equal Benefits Ordinance.* With respect to the provision of employee benefits, BHRS shall comply with the San Mateo County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

7.1.6 Where applicable, BHRS shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

7.1.7 *Jury Service.* BHRS shall comply with the San Mateo County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from BHRS, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received for such jury service with BHRS or that BHRS deduct from the employees' regular pay the fees received for jury service.

ARTICLE 8
CONFIDENTIALITY

8.1 Confidential Information. The term "Confidential Information" means information of a confidential or proprietary nature relating to the subject matter described in this Agreement which is taken from or disclosed by one party (the "Disclosing Party") to the other (the "Receiving Party"). Confidential Information includes, but is not limited to, matters of a technical nature such as trade secrets, methods, compositions, data and know-how, designs, systems, processes, computer programs, files and documentation, similar items or research projects, and any information derived therefrom; matters of a business nature, such as the terms of this Agreement (including any pricing terms and contract terms which must be subject to a protective order), marketing, sales, strategies, proposals, and lists of actual or potential Members, Participating Providers as well as any other information that is designated by either party as confidential.

8.2 Treatment of Confidential Information. Subject to the California Public Records Act and related state and federal legislation, the Receiving party agrees: (i) to hold the Disclosing Party's Confidential Information in strict confidence and to take reasonable precautions to protect such Confidential Information (including, without limitation, all precautions Receiving Party employs with respect to its own confidential materials);

(ii) not to divulge any such Confidential Information or any information derived therefrom to any third party unless required in the performance of the Receiving Party's duties under this Agreement or pursuant to controlling law; (iii) not to make any use whatsoever at any time of such Confidential Information except for the purpose of this Agreement and will not use it for its own or any third party's benefit; and (iv) not to copy, analyze, transcribe, transmit, decompile, disassemble or reverse engineer any such Confidential Information, and not use such Confidential Information in any patent application. The confidentiality obligations of this Section 8.2 shall not apply to information which, as evidenced in writing:

8.2.1 is or becomes publicly known by Receiving Party through no breach of this Agreement;
8.2.2 is learned by the Receiving Party from a third party entitled to disclose it;
8.2.3 is rightfully obtained by the Receiving Party prior to this Agreement; or
8.2.4 is required by law to be disclosed.

The confidential obligations contained in the foregoing clauses (i), (ii), (iii) and (iv) shall be perpetual. Receiving Party may make disclosures required by law or court order provided Receiving Party uses diligent, reasonable efforts to afford the Disclosing Party the opportunity to limit disclosure and to obtain confidential treatment or a protective order.

8.3 No Transfer Or Right Or Title. Receiving Party acknowledges that it shall not acquire any rights or title to any Confidential Information merely by virtue of its use or access to such Confidential Information hereunder. Neither the execution of this Agreement nor the furnishing of any Confidential Information hereunder shall be construed as granting, either expressly or by implication, or otherwise, the Receiving Party any license under any invention or patent now or hereafter owned by or controlled by the Disclosing Party. Each party agrees that it may not be adequately compensated for damages arising from a breach or threatened breach of any of the covenants contained in this Article 8 by the other party, and each party shall be entitled to injunctive relief and specific performance in addition to all other remedies. None of the information that may be submitted or exchanged by the parties shall constitute any representation, warranty, assurance, guarantee, or inducement by a party to the other with respect to the infringement of patents, copyrights, trademarks, trade secrets, or any other rights of third persons.

ARTICLE 9
EXCLUSIVITY

9.1 Exclusivity. HPSM agrees that BHRS shall be the sole and exclusive agent providing administration services for behavioral health and recovery services provided to CareAdvantage members during the term of this Agreement.

ARTICLE 10
TERM AND TERMINATION

10.1 Term. This Agreement shall have an Effective Date of January 1, 2009 and shall be for a term of three (3) years, ending December 31, 2011. Termination shall have no effect

upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. This agreement supercedes the current agreement for these services.

10.2 Termination With Cause. This Agreement may be terminated at anytime by either party based on a material breach of any terms or conditions herein stated provided that thirty (30) days' advance written notice of such material breach shall be given to the other party and such party shall have the opportunity to cure such material breach during such thirty (30) day notice period.

10.3 Effect of Termination. If this Agreement is terminated pursuant to this Article 10: (i) all further obligations of the parties under this Agreement shall terminate (but not such party's obligation to make payments arising prior to the termination of this Agreement or any obligation surviving the termination hereof); (ii) all Confidential Information provided by either party shall, except for Confidential Information required by law to be retained by a party, be immediately returned by a Receiving Party (as defined in Section 8.1), or such Receiving Party shall certify to the Disclosing Party that such materials have been destroyed; (iii) neither party shall be relieved of any obligation or liability arising from any prior breach of such party or any provision of this Agreement; and (iv) the parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in Sections 5.1, 5.2, 5.3, 6.1, 6.2, 8.1, 8.2, 8.3, 11.1, 11.7, 11.9, 11.10, 11.12, 11.13, 11.17, 11.18, 11.19, 12.1, 12.2, and 12.4.

ARTICLE 11
GENERAL PROVISIONS

11.1 Use of BHRS Software. HPSM acknowledges that BHRS owns, or possesses license rights (including off-the-shelf vendor agreements) from certain third parties to the entire software system used by BHRS in processing Claims and preparing reports including computer programs, system and program documentation, and other documentation relating thereto (collectively, including certain license rights, the "BHRS Software System"), and that BHRS Software System is the exclusive and sole property of BHRS. HPSM disclaims any rights to BHRS Software System as described above (including access to any applicable source codes), any procedures or forms developed by BHRS, as well as development or modification of BHRS Software System as a result of any customization performed by any party.

11.2 Insurance. Each party shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which such party engages pursuant to this Agreement, professional liability (errors and omissions) insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party and comprehensive liability insurance. Upon request, either party shall promptly deliver to the other party evidence of such insurance. Each party agrees to notify the other party immediately upon such party's receipt of any notice canceling, suspending or reducing the coverage limits of its professional liability insurance or comprehensive liability insurance.

11.3 Successors and Assigns. Neither this Agreement nor any of the rights, interests or obligations hereunder shall be assigned by either party hereto (whether by operation of

law or otherwise) without the prior written consent of the other party hereto. Subject to the preceding sentence, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties and their respective successors and permitted assigns. Notwithstanding anything to the contrary contained in this Agreement (including this Section11.3), no consent shall be required and this Agreement will apply to, be binding in all respects upon, and inure to the benefit of any successors of HPSM to this Agreement resulting from a Change of Control. A "Change of Control" shall occur if as a result of one or a series of related transactions: (i) all or substantially all the assets of SMMC are disposed of to any entity not wholly owned and controlled by HPSM, outside the ordinary course of business; (ii) SMMC effects a merger with one or more other entities in which HPSM is not the surviving entity; or (iii) HPSM engages in a transaction that results in any entity holding securities possessing a majority of the voting power that does not hold such voting power as of the time of this Agreement. HPSM shall provide BHRS with thirty (30) days' advance written notice in the event of any transaction(s) resulting in a Change of Control, as well as an Officer's Certificate from the successor entity, agreeing to be bound by the terms and conditions of this Agreement.

11.4 Waiver. Any term or condition of this Agreement may be waived at any time by the party that is entitled to the benefit thereof, but no such waiver shall be effective unless set forth in a written instrument duly executed by or on behalf of the party waiving such term or condition. No waiver by any party of any term or condition of this Agreement, in any one or more instances, shall be deemed to be or construed as a waiver of the same or other term or condition of this Agreement on any future occasion.

11.5 Severability. In the event that any provision of this Agreement shall be determined to be invalid, unlawful, void or unenforceable to any extent, the remainder of this Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

11.6 Further Assurances. Each party hereto shall execute and cause to be delivered to each other party hereto such instruments and other documents, and shall take such other actions, as such other party may reasonably request (at or after the date hereof) for the purpose of carrying out or evidencing any of the transactions contemplated by this Agreement.

11.7 Choice of Law. This Agreement shall be construed, interpreted, and governed according to the laws of the State of California without regard to its conflict of laws and rules.

11.8 Force Majeure. The performance obligations of BHRS and/or HPSM respectively hereunder shall be suspended to the extent that all or part of this Agreement cannot be performed due to causes which are outside the control of BHRS and/or HPSM, and could not be avoided by the exercise of due care, including but not limited to acts of God, acts of a public enemy, acts of a sovereign nation or any state or political subdivision or any department or regulatory agency thereof or entity created thereby, acts of any person engaged in a subversive or terrorist activity or sabotage, fires, floods, earthquakes, explosions, strikes, slow-downs, lockouts or labor stoppage, freight embargoes, or by any enforceable law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as

soon as conditions cease, the party affected thereby shall fulfill its obligations as set forth under this Agreement. In order to benefit from the provisions of this Section 11.8, the party claiming force majeure must notify the other reasonably promptly in writing of the force majeure condition. If any event of force majeure, in the reasonable judgment of the parties, is of a severity or duration such that it materially reduces the value of this Agreement, then this Agreement may be terminated without liability or further obligation of either party (except for any obligation expressly intended to survive the termination of this Agreement and except for all amounts that have become or will become due and payable hereunder).

11.9 Entire Agreement; No Third Party Beneficiaries. This Agreement, including the Exhibits: (i) constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings, both written and oral, among the parties with respect to the subject matter hereof; and (ii) is intended solely for the benefit of each party hereto and their respective successors or permitted assigns, and it is not the intention of the parties to confer third party beneficiary rights, and this Agreement does not confer any such rights, upon any other third party.

11.10 Use of Name. Neither party shall use the other party's name, trade or service mark, logo, or the name of any affiliated company in any advertising or promotional material, presently existing or hereafter established, except in the manner and to the extent permitted by prior written consent of the other party.

11.11 Notice. Any notice required or permitted by this Agreement, unless otherwise specifically provided for in this Agreement, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight courier; (ii) one (1) day following receipt by facsimile during the receiving party's business hours with written confirmation thereof; or (iii) three (3) days after the date it is deposited in the United States mail, postage prepaid, registered or certified mail, or hand delivered addressed as follows:

To: Health System — Jean Fraser, Chief
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

To: BHRS — Louise Rogers, Director
Behavioral Health and Recovery Services
225 West 37th Ave
San Mateo, CA 94403

To: HPSM — Maya Altman, Executive Director
Health BHRS of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Any party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

11.12 Counterparts; Facsimile. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other parties, it being understood that all parties need not sign the same counterpart. This Agreement may be executed and delivered by facsimile and upon such delivery the facsimile signature will be deemed to have the same effect as if the original signature had been delivered to the other party. The original signature copy shall be delivered to the other party by express overnight delivery. The failure to deliver the original signature copy and/or the nonreceipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

11.13 Independent Contractors. HPSM and BHRS are independent entities and nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent or franchiser and franchisee or any relationship, fiduciary or otherwise, other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Nothing in this Agreement is intended to be construed, or be deemed to create, any rights or remedies in any third party, including but not limited to a Member. Nothing in this Agreement shall be construed or deemed to confer upon BHRS any responsibility for or control over the terms or validity of the Covered Services. BHRS shall have no final discretionary authority over or responsibility for HPSM's administration. Further, because BHRS is not an insurer or HPSM sponsor, BHRS shall have no responsibility for: (i) any funding of HPSM or CareAdvantage benefits; or (ii) any insurance coverage relating to HPSM or any BHRS contract of HPSM or Members, except as described in Exhibit A.

11.14 Consent to Amend. This Agreement or any part or section of it may be amended at any time during the term of this Agreement only by mutual written consent of duly authorized representatives of BHRS and HPSM.

11.15 Headings. The headings of Articles, Sections and Exhibits contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

11.16 Compliance with Laws and Regulations. This Agreement will be in compliance with all pertinent federal and state statutes and regulations. If this Agreement, or any part hereof, is found not to be in compliance with any pertinent federal or state statute or regulation, then the parties shall renegotiate the Agreement for the sole purpose of correcting the non-compliance.

11.17 Construction.

11.17.1 For purposes of this Agreement, whenever the context requires: the singular number shall include the plural, and vice versa; the masculine gender shall include the feminine and neuter genders; the feminine gender shall include the masculine and neuter genders; and the neuter gender shall include the masculine and feminine genders.

11.17.2 The parties hereto agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be applied in the construction or interpretation of this Agreement.

11.17.3 As used in this Agreement, the words "include" and "including," and variations thereof, shall not be deemed to be terms of limitation, but rather shall be deemed to be followed by the words "without limitation."

11.17.4 Except as otherwise indicated, all references in this Agreement to "Articles," "Sections" and "Exhibits" are intended to refer to Articles of this Agreement, Sections of this Agreement and Exhibits to this Agreement.

11.18 Remedies Cumulative; Specific Performance. The rights and remedies of the parties hereto shall be cumulative (and not alternative). The parties to this Agreement agree that to the extent permitted by applicable law, in the event of any breach or threatened breach by any party to this Agreement of any covenant, obligation or other provision set forth in this Agreement for the benefit of any other party to this Agreement, such other party shall be entitled (in addition to any other remedy that may be available to it) to: (i) a decree or order of specific performance to enforce the observance and performance of such covenant, obligation or other provision; and (ii) an injunction restraining such breach or threatened breach. Neither party shall be required to provide any bond or other security in connection with any such decree, order or injunction or in connection with any related action or legal proceeding.

11.19 HIPAA Compliance. For the purposes of this Agreement, BHRS is deemed to be a "Business Associate" of HPSM as such term is defined in the Privacy Standard of the Federal Register, published on December 28, 2000 (Business Associate Requirements, Exhibit C, attached hereto and incorporated herein as referenced). The parties will endeavor to comply with all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

11.19.1 all services provided by BHRS under this Agreement will be provided in such a manner as to enable HPSM to remain at all times in compliance with all HIPAA regulations applicable to HPSM, to the extent that HPSM's compliance depends upon the manner in which such services are performed by BHRS;

11.19.2 all software, application programs and other products licensed or supplied by BHRS under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that HPSM's use of such software, application programs and other products and associate documentation from BHRS, when utilized by HPSM in the manner as directed by BHRS, will fully comply with the HIPAA regulations applicable to HPSM. In the event any amendment to this Agreement is necessary for HPSM to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, HPSM and BHRS will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations; and

11.19.3 all software, application programs, eligibility lists or other member-specific information and other products licensed or supplied by HPSM under this Agreement will contain such characteristics and functionality (including as

applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that BHRS's use of such software, application programs and other products and associate documentation from HPSM, when utilized by BHRS in the manner as directed by HPSM, will fully comply with the HIPAA regulations applicable to BHRS. In the event any amendment to this Agreement is necessary for BHRS to comply with the HIPAA regulations as they relate to this Agreement or its subject matter, including, but not limited to, requirements pertaining to Business Associate agreements, BHRS and HPSM will negotiate in good faith and amend this Agreement accordingly, with such amendment to be effective prior to the date compliance is required under each standard of the HIPAA regulations.

11.20 Cultural Competence. BHRS shall ensure that all services, both clinical and non-clinical, are accessible to all CareAdvantage members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds.

ARTICLE 12
COMPLIANCE WITH CAREADVANTAGE LAWS AND REGULATIONS

12.1 BHRS understands that HPSM oversees and is accountable to the Centers for Medicare and Medicaid Services (CMS) for any functions or responsibilities that are described in the laws or regulations applicable to Medicare Plans, and that HPSM may be held accountable by CMS if BHRS and/or its Downstream Entity violates the provisions of such law or regulations or HPSM's policies in the performance of this Agreement. In furtherance of the foregoing, BHRS shall comply with and ensure any of its Downstream Entities or related entities providing services under this Agreement also comply with applicable Medicare laws, regulations, reporting requirements, and CMS instructions, and will cooperate, assist, and provide information, as requested.

12.2 BHRS shall comply with the reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.310 for submitting data to CMS for the purposes of reporting costs, utilization, quality, enrollee health status, and fiscal soundness to CMS, as well as of enabling CMS to characterize the context and purpose of each item and service provided to a Medicare enrollee for accurate application of CMS's risk adjustment payment model. BHRS also agrees to furnish medical records and/or ensure that Participating Providers furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

12.3 BHRS understands and agrees that HPSM is responsible for the monitoring and oversight of all duties of BHRS under this Agreement, and that HPSM has the authority and responsibility to: (i) implement, maintain and enforce HPSM's policies governing BHRS's duties under this Agreement; (ii) conduct audits, inspections and/or investigations in order to oversee BHRS's performance of duties described in this Agreement; (iii) require BHRS to take corrective action if HPSM or an applicable federal or state regulator determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty, if BHRS fails to meet HPSM standards in the performance of that duty. BHRS shall cooperate with

HPSM in its oversight efforts and shall take corrective action as HPSM determines necessary to comply with the laws, accreditation agency standards, HPSM policies governing the duties of BHRS or the oversight of those duties.

12.4 If BHRS gives Confidential Information including Protected Health Information, as defined in 45 CFR §164.501, received from HPSM, or created or received by BHRS on behalf of HPSM, to any of its Downstream Entities, including agents or subcontractors, BHRS shall require the Downstream Entity to agree to the same restrictions and conditions that apply to BHRS under this Agreement. BHRS shall be fully liable to HPSM for any acts, failures or omissions of the Downstream Entity in providing the services as if they were BHRS's own acts, failures or omissions, to the extent permitted by law. BHRS further expressly warrants that its agents will be specifically advised of, and will comply in all respects with the terms of this Agreement.

12.5 BHRS shall comply with CMS instructions regarding responsibilities of delegated entities as outlined in Attachment B.

The provisions of this Agreement shall bind and inure to the benefit of the parties hereto and their heirs, legal representatives, successors and assignees. This Agreement constitutes the entire understanding between the parties hereto.

SAN MATEO HEALTH COMMISSION d.b.a. HEALTH PLAN OF SAN MATEO	COUNTY OF SAN MATEO
BY **MAYA ALTMAN** **EXECUTIVE DIRECTOR**	BY **MARK CHURCH** **PRESIDENT, BOARD OF SUPERVISORS**
10/14/09 DATE	11/10/09 DATE

Certificate of Delivery
(Government Code Section 25103)
I certify that a copy of the original document filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.
Marie L. Peterson
Deputy Clerk of the Board of Supervisors

EXHIBIT "A"
SCOPE OF SERVICES

In consideration of the payments set forth in Exhibit "B", BHRS shall provide the services as set forth in the corresponding Appendix referenced below. Services shall be provided in accordance with Medicare guidelines, as detailed in Attachment B as relevant.

Appendix 1-A: Claims Processing and Data Management
Appendix 1-B: Outpatient Behavioral Health and Recovery Services Benefit
Appendix 1-C: Provider Relations
Appendix 1-D: Utilization and Medical Management
Appendix 1-E: Customer Service
Appendix 1-F: Grievances and Appeals
Appendix 1-G: Quality Assessment and Improvement
Appendix 1-H: Reporting

APPENDIX 1-A
CLAIMS PROCESSING AND DATA MANAGEMENT

1. Claims Processing. BHRS shall process claims for payment from Participating Providers, and Non-Participating Providers as needed, for authorized Covered Behavioral Health and Recovery Services on behalf of HPSM. Claims shall be processed at least twice per month.

2. Payment to Participating Providers. BHRS shall make payments to Participating Providers, and Non-Participating Providers as needed, for Covered Services to Members. BHRS shall not be obligated to pay Participating Providers (i) for services that are not Covered Services; or (ii) if Participating Providers fail to verify an individual's eligibility for Covered Services.

3. Encounter Data. BHRS shall submit encounter data in the form of claims to HPSM in electronic form. BHRS shall supply encounter data at least monthly, by the 10th of the month following the month of claim processing. BHRS will employ appropriate data security procedures to ensure rapid recovery and transmittal of all encounter data.

4. Certification of Data. BHRS agrees that by submitting any data to HPSM BHRS is certifying that the information is based on its best knowledge, information and belief available, and such information is accurate, complete and truthful.

APPENDIX 1-B
OUTPATIENT BEHAVIORAL HEALTH AND RECOVERY SERVICES BENEFIT

BHRS shall provide Medicare-covered outpatient behavioral health and recovery services benefit to Members under this contract, as well as Marriage and Family Therapy (MFT) services for each calendar year that the MFT benefit is available to CareAdvantage members as a Medicare supplemental benefit. The outpatient behavioral health and recovery services benefit shall be provided in accordance with Medicare rules and guidelines and HPSM policies and procedures.

In providing such services, BHRS shall ensure that CareAdvantage members are held harmless for payment of fees that are the legal obligation of HPSM or BHRS.

APPENDIX 1-C
PROVIDER SERVICES

BHRS shall be responsible for maintaining and monitoring a network of behavioral health and recovery services providers that is sufficient to provide adequate access to and availability of covered behavioral health and recovery services. BHRS shall be responsible for credentialing and executing contracts with Participating Providers, as designated by HPSM, to provide behavioral health and recovery services to Members under the CareAdvantage Program. Credentialing requirements will be waived if BHRS already has on file an up-to-date credentialing record. However, BHRS will re-credential the provider in accordance with the Participating Provider's existing credentialing schedule. BHRS's credentialing and re-credentialing process shall adhere to federal laws, rules, and guidelines under the Medicare program. HPSM shall at all times monitor the performance of BHRS and the network of behavioral health and recovery services providers and retains the right to approve, suspend, or terminate any arrangement set up by BHRS that in the opinion of HPSM does not contribute to the provision of good quality care to Members.

In contracting with Providers, BHRS shall ensure that each provider contract contain the following provisions.

- Provider shall agree to safeguard Member privacy and confidentiality, consistent with all federal and state laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records.
- Provider shall look only to BHRS for payment of Covered Services and shall at no time seek compensation from Members for Covered Services. Such payment by BHRS shall be considered payment in full. Provider shall not hold Members responsible for any Medicare or Medi-Cal cost sharing in accordance with the agreement that payment from PLAN for Covered Services shall be considered payment in full. In addition, the Provider shall not invoice or balance bill a Member for the difference between the provider's billed charges and the reimbursement paid by BHRS for Covered Services.
- Provider shall agree that neither the Provider or any of its Downstream Entities in any circumstances, including, but not limited to nonpayment by BHRS, insolvency of BHRS, or breach of this Agreement, shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than BHRS for services provided pursuant to this Agreement. At no time will Provider or any party with a claim against Provider for Covered Services provided to Members bill or otherwise seek compensation from Members for Covered Services except in the case when a third party payer is primarily responsible and has paid Member for a Covered Service.
- Provider shall agree that CareAdvantage Members' health services are being paid for, in whole or in part, with federal funds and, therefore, payments for such services are subject to laws applicable to individuals or entities receiving federal funds. Provider shall at all times during the term of this Agreement comply with, and require any of its Downstream Entities comply with, all applicable federal, state and municipal laws, regulations, reporting requirements, and CMS instructions (including applicable Medicare laws, regulations, and instructions), HPSM's contractual obligations to CMS, all HPSM policies and procedures related to health service delivery, and all applicable rules and regulations of the their applicable licensing

bodies. This includes compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), and HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. Provider shall also agree to audits and inspections by CMS and/or its designees and cooperate, assist, and provide information as requested. If at any time during the term of this Agreement, Provider shall have Provider's license to practice in the State of California suspended, conditioned or revoked, Provider's agreement with BHRS shall terminate immediately and become null and void without regard to whether or not such suspension, condition or revocation has been finally adjudicated. Provider agrees to include the requirements of this section in its contracts with any Downstream Entity.

- Provider shall agree: (1) not to differentiate or discriminate in his/her provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, health status, marital status, sexual orientation, age, or other protected classes according to federal and state law; and (2) to render Covered Services to Members in the same manner, in accordance with the same standards and within the same time availability as offered to non-Members consistent with existing medical/ethical/legal requirements for providing continuity of care to any patient.
- Provider shall agree that Provider understands that BHRS has certain obligations including the credentialing of Provider, and that BHRS and HPSM will have the right to oversee and review the quality of care and services provided to Members by Provider. Provider shall agree to be accountable to cooperate and comply with BHRS and HPSM whenever BHRS, HPSM, and/or their Medical Directors impose such obligations on Provider. Obligations may include, but may not be limited to: on-site review, member transfer from or to referring facilities, cooperation with Healthcare Effectiveness Data Information Sets ("HEDIS") measurements and other internal and external quality review and improvement programs, and risk adjustment programs.
- Provider shall acknowledge that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with a provider who itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. Provider shall warrant that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If Provider, any employee, manager, or Downstream Entity is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs. Provider further understands that BHRS and HPSM are prohibited by CMS from including as a Contracted Provider, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. In such an event, BHRS reserves the right to terminate the Agreement with Provider immediately and require Provider to reimburse BHRS immediately for any direct or indirect payments to Provider and the amount of any sanctions imposed on BHRS or HPSM by CMS or Medi-Cal for violation of this prohibition.
- BHRS shall agree to promptly pay Provider for all clean claims within sixty (60) calendar days.

- Provider shall ensure that all services, both clinical and non-clinical, are accessible to all CareAdvantage members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds.
- Provider shall maintain records related to any services provided to CareAdvantage members for a minimum of ten (10) years.

BHRS will also engage in standard provider services activities with Participating Providers, including maintaining a Claims department responsible for responding to inquiries related to claims processing, claims submission, and claims payment and maintaining a Utilization Review department responsible for responding to inquiries related to prior authorization for Covered Services. Departments will be available to respond to provider inquiries during regular business hours, from 8:00 a.m. to 5:00 p.m. Monday through Friday.

APPENDIX 1-D
UTILIZATION AND MEDICAL MANAGEMENT

1. Prior Authorization Review. BHRS shall perform initial review of prior authorization requests for Covered Services as determined by the Benefit Plan. BHRS agrees that in performance of prior authorization requests, BHRS shall comply with the prior authorization policies and procedures, and guidelines used and approved by HPSM, including policies and procedures and guidelines required under federal laws, rules, and guidance for the Medicare program. BHRS shall make authorization decisions based on relevant documentation received.

2. Timeframes. BHRS shall make authorization decisions on all emergent and urgent authorizations within 72 hours of receipt of the information reasonably necessary to make a decision. BHRS shall make authorization decisions on all non-urgent authorizations within fourteen (14) business days of receipt of the information reasonably necessary to make a decision.

3. Retroactive Authorizations. BHRS shall have a written process for reviewing retroactive authorizations for Covered Services and take action on all retroactive authorizations within thirty (30) calendar days of receipt of the information reasonably necessary to make a decision.

4. Notification of Decision. BHRS agrees that it shall notify the Member, Participating Provider, and/or Referring Provider of the specific benefits that were denied, modified, or deferred, in writing, by mail. BHRS agrees that such notification to Members shall be in English and Spanish and shall be provided within the same timeframes as those required for making the authorization decisions.

5. Utilization Management and Quality Review Programs. BHRS shall cooperate with, participate in, and comply with HPSM's Utilization Management and Quality Review Programs, including any revisions and updates that may occur upon review.

APPENDIX 1-E
GRIEVANCES AND APPEALS

BHRS shall process Member complaints if a Member or applicant is dissatisfied with his/her experience accessing or utilizing behavioral health and/or recovery services under the CareAdvantage Program. BHRS will accept complaints in writing, by phone, or through BHRS's website.

Complaints include both appeals and grievances, as follows:

- Appeals. Appeals are complaints related to BHRS or HPSM's decision to deny a benefit to the member to which he/she believes he/she is entitled. Appeals are generated in response to a denied request for authorization. BHRS differentiates between standard Appeals and expedited Appeals. BHRS processes an Appeal on an expedited basis when the standard timeframe for processing an appeal could seriously jeopardize the participant's life, health, or ability to regain maximum function.

- Grievances. Grievances are complaints related to any other aspect of HSPM or BHRS operations, excluding Appeals. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.

BHRS acknowledges receipt of all Appeals or Grievances within 5 business days. Standard Appeals and Grievances shall be resolved within 30 calendar days from the date of receipt. Expedited Appeals shall be resolved within 72 hours from the time of receipt.

APPENDIX 1-F
QUALITY ASSESSMENT AND IMPROVEMENT

BHRS shall provide the following quality assessment and improvement services:

- BHRS shall regularly monitor HPSM Members' access to care, including wait times for appointments and office wait times. Target timeframes for new patients for routine appointments for longstanding problems is 30 days; for urgent appointments for stable conditions is 72 hours; for urgent appointments for less stable issues is same day/next day (depending on clinician triage), and immediately for emergency situations.
- BHRS shall regularly review grievances and appeals to address any quality of care concerns that arise. A clinical staff member needs to review any issues involving clinical quality of care; a physician needs to review any issues involving medication management.
- BHRS shall regularly monitor utilization to protect against overutilization and underutilization of behavioral health and recovery services. Quarterly reports shall be made available to HPSM for review.
- BHRS shall develop at least one clinical and one non-clinical quality improvement project annually that demonstrate its commitment to QAI services. Over time, these should represent the different age ranges, if they are not applicable at one time to all age ranges. Periodic monitoring to demonstrate maintenance of improvement should occur, even after the projects have been closed. Quality reports shall be submitted to HPSM at least annually describing the plans, their methodology, their implementation and their outcomes, in a Plan/Do/Study/Act format, or comparable, to demonstrate improvements achieved over the year(s).

HPSM acknowledges and agrees that it is the ultimate decision maker on quality assurance programs and that it agrees to the quality assurance services set forth herein.

APPENDIX 1-G
REPORTING

BHRS shall supply such encounter, quality and cost data as HPSM may require to perform its disclosure, reporting, administrative, supervisory, and other functions required under HPSM's contract with the Centers for Medicare and Medicaid Services and under applicable State and Federal laws and regulations or as requested. Standardized reports include the following (contingent upon services to be performed by BHRS under this Addendum).

Quarterly Reports:

- Prior Authorization. BHRS will report annually information about the use of the prior authorization tool, including but not limited to: (i) the number of requests denied due to the need for prior authorization; (ii) the number of prior authorizations requested; (iii) the number of prior authorizations approved.

- Grievances and Appeals. BHRS will report annuallly information about the receipt and processing of grievances and appeals, including detailed information on each case, including but not limited to the identify of the member, the member's complaint, the resolution, receipt and resolution dates, as well as summary data including but not limited to:

  - The number of grievances received;
  - The number of grievances resolved beyond 30 days;
  - The number of appeals received;
  - The number of appeals upheld;
  - The number of appeals overturned;
  - The number of appeals resolved beyond 30 days; and
  - Any quality of care concerns identified through grievances and appeals.

Annual Reports:

BHRS shall provide other ad hoc reports as required by HPSM to conduct cost and quality analyses.

EXHIBIT "B"
PAYMENT

For the Administrative services provided pursuant to the Agreement, HPSM shall pay BHRS a mutually agreed upon rate per participant per month. Participation shall be determined by the Member count determined each month by HPSM. HPSM Finance will prepare the invoice and payment by the 15th of the following month.

HPSM is fully responsible for the health care costs incurred under Agreement in so far as they are properly adjudicated and paid by BHRS in accordance with the Benefit Plan for services provided to Members. BHRS shall pay providers, and HPSM shall reimburse BHRS, in accordance with the following rate table. Payment for these health care costs shall vary by contract year.

Year	Payment provided as part of Medicare Services	Payment provided under Medicare Supplemental Services	Total Payment Rate
2009	80% of Medicare incurred expenses, which is equal to 50% of the Medicare Fee Schedule	45% of the Medicare Fee Schedule	95% of the Medicare Fee Schedule
2010	80% of Medicare incurred expenses, which is equal to 54.8% of the Medicare Fee Schedule	25.2% of the Medicare Fee Schedule	80% of the Medicare Fee Schedule
2011	80% of Medicare incurred expenses, which is equal to 54.8% of the Medicare Fee Schedule	TBD	TBD

Total payment shall reflect 100 percent of the Medicare Fee Schedule adjudicated for benefits based on the Medicare Fee Schedule effective on the date of service. Benefits reflect coverage under the standard Medicare benefit package, as well as coverage of additional supplemental benefits (i.e. reductions in cost-sharing) incorporated into HPSM's annual bid. HPSM shall issue reimbursement only for those Covered Services provided to Eligible Members.

HPSM shall issue reimbursement to BHRS in response to clean claims submitted by BHRS to HPSM within sixty (60) days of receipt of the clean claim.

EXHIBIT "C"
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
BUSINESS ASSOCIATE REQUIREMENTS

Definitions

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations section 160.103 164.304 and 164.501. (All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.)

a. *Designated Record Set.* "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
b. *Electronic Protected Health Information.* "Electronic Protected Health Information" ("EPHI") means individually identifiable health information that is transmitted or maintained in electronic media, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.
c. *Individual.* "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
d. *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
e. *Protected Health Information.* "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by BHRS from or on behalf of HPSM.
f. *Required By Law.* "Required by law" shall have the same meaning as the term "required by law" in Section 164.501.
g. *Secretary.* "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.
h. *Security Incident.* "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, but does not include minor incidents that occur on a daily basis, such as scans, "pings", or unsuccessful random attempts to penetrate computer networks or servers maintained by Business Associate
i. *Security Rule.* "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

Obligations and Activities of BHRS

a. BHRS agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
b. BHRS agrees to use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. BHRS agrees to mitigate, to the extent practicable, any harmful effect that is known to BHRS of a use or disclosure of Protected Health Information by BHRS in violation of the requirements of this Agreement.
d. BHRS agrees to report to HPSM any use or disclosure of the Protected Health Information not provided for by this Agreement.
e. BHRS agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by BHRS on behalf of HPSM, agrees to the same restrictions and conditions that apply through this Agreement to BHRS with respect to such information.
f. If BHRS has protected health information in a designated record set, BHRS agrees to provide access, at the request of HPSM, and in the time and manner designated by HPSM, to Protected Health Information in a Designated Record Set, to HPSM or, as directed by HPSM, to an Individual in order to meet the requirements under Section 164.524.
g. If BHRS has protected health information in a designated record set, BHRS agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that HPSM directs or agrees to make pursuant to Section 164.526 at the request of HPSM or an Individual, and in the time and manner designed by HPSM.
h. BHRS agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by BHRS on behalf of, HPSM available to HPSM, or at the request of HPSM to the Secretary, in a time and manner designated by HPSM or the Secretary, for purposes of the Secretary determining HPSM's compliance with the Privacy Rule.
i. BHRS agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for HPSM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
j. BHRS agrees to provide to HPSM or an Individual in the time and manner designated by HPSM, information collected in accordance with Section (i) of this Schedule, to permit HPSM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
k. BHRS shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that BHRS creates, receives, maintains, or transmits on behalf of HPSM.
l. BHRS shall conform to generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.
m. BHRS shall ensure that any agent to whom it provides EPHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such EPHI.
n. BHRS shall report to HPSM any Security Incident within 5 business days of becoming aware of such incident.
o. BHRS shall makes its policies, procedures, and documentation relating to the security and privacy of protected health information, including EPHI, available to the Secretary of the U.S. Department of Health and Human Services and, at HPSM's request, to HPSM for purposes of the Secretary determining HPSM's compliance with the HIPAA privacy and security regulations.

Permitted Uses and Disclosures by BHRS

Except as otherwise limited in this Schedule, BHRS may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, HPSM as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by HPSM.

Obligations of HPSM

a. HPSM shall provide BHRS with the notice of privacy practices that HPSM produces in accordance with Section 164.520, as well as any changes to such notice.
b. HPSM shall provide BHRS with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect BHRS's permitted or required uses and disclosures.
c. HPSM shall notify BHRS of any restriction to the use or disclosure of Protected Health Information that HPSM has agreed to in accordance with Section 164.522.

Permissible Requests by HPSM

HPSM shall not request BHRS to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by HPSM, unless BHRS will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of BHRS.

Duties Upon Termination of Agreement

Upon termination of the Agreement, for any reason, BHRS shall return or destroy all Protected Health Information received from HPSM, or created or received by BHRS on behalf of HPSM. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of BHRS. BHRS shall retain no copies of the Protected Health Information.

In the event that BHRS determines that returning or destroying Protected Health Information is infeasible, BHRS shall provide to HPSM notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, BHRS shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as BHRS maintains such Protection Health Information.

Miscellaneous

a. *Regulatory References.* A reference in this Schedule to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
b. *Amendment.* The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for HPSM to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

c. *Survival.* The respective rights and obligations of BHRS under this Schedule shall survive the termination of the Agreement.
d. *Interpretation.* Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits HPSM to comply with the Privacy Rule.
e. *Reservation of Right to Monitor Activities.* HPSM reserves the right to monitor the security policies and procedures of BHRS

[signature]	6/20/09	Louise F. Rogers
BHRS's Signature	Date	BHRS's Name (Please Print)

REQUIREMENTS FOR DELEGATED ENTITIES
BHRS

Note: All references to the Medicare Advantage Organization (MAO) apply to the delegated entities with whom HPSM has contracted for services

MARKETING/MEMBER MATERIALS	Applicable to Contract?	Notes
Appropriate Submission and Distribution of Marketing Materials The MAO follows the requirements contained in the regulations and Medicare Marketing Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials. 42 C.F.R. § 422.80(a), (c), and (e)(1)(v); Section 613 of BIPA; Manual Ch. 3 – Section 20; Chapter 9 of the Medicare Marketing Guidelines	X	Such requirements would apply to materials such member letters, notices of denial of authorization, notices of denial of claims payment, and other materials providing benefit information to CareAdvantage members.
Materials Provided for Significant Non-English Speaking Population For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals. 42 C.F.R. § 422.80(c)(5); Manual Ch. 3 – Section 60.4	X	HPSM currently provides information to members in English, Spanish, Chinese, Tagalog, and Russian. HPSM may assist in obtaining translations of documents as needed.

ARRANGEMENT OF SERVICES	Applicable to Contract?	Notes
Services Provided with Cultural Competence The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. 42 C.F.R. § 422.112(a)(8); Manual Ch. 4 – Section 120.2	X	
Confidentiality of Member Information The MAO implements procedures to ensure the confidentiality of member medical records and other member information. 42 C.F.R. § 422.118; Manual Ch. 4 – Section 140.1	X	
No Member Discrimination in Delivery of Health Care The MAO implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. 42 C.F.R. § 422.110; Manual Ch. 4 – Section 100.1 and 100.3	X	
Call Center Performance Standards The MAO's call center meets the following call center performance standards: - 80 percent of incoming calls must be answered within 30 seconds. - Abandonment rate of incoming calls must not exceed 5 percent. CMS Medicare Marketing Guidelines for MA, MA-PDs, PDPs, and 1876 Cost Plans, July 2006, Addendum	X	

PROVIDER NETWORK AND CONTRACTING	Applicable to Contract?	Notes
Adequate and Appropriate Provider Network The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services. 42 C.F.R. § 422.112(a)(1); Manual Ch. 4 – Section 120.2	X	
Required Contract Provisions: Privacy and Confidentiality The MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records. 42 C.F.R. § 422.118; Manual Ch. 11 – Section 100.4	X	It should be noted that BHRS is considered a first tier entity, and that the contracted providers are considered downstream entities. The BHRS's contracts with providers must include the provisions indicated in this section on Provider Network and Contracting.
Required Contract Provision: Prompt Payment The MAO's written contracts with first tier and downstream entities must contain a prompt payment provision. 42 C.F.R. § 422.520(b); Manual Ch. 11 – Section 100.4	X	
Required Contract Provision: Hold Harmless The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO. 42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i); Manual Ch. 11 – Section 100.4	X	

PROVIDER NETWORK AND CONTRACTING	Applicable to Contract?	Notes
Required Contract Provisions: Abide by Federal Requirements The MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information, as requested; and maintain records a minimum of 10 years. 42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v); Manual Ch. 11 – Section 100.4	X	
Required Contract Provisions: Compliance with MAO's Policies and Procedures The MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures. 42 C.F.R. § 422.504(i)(4)(v); Manual Ch. 11 – Section 100.4	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
<u>Correct Claim Determinations</u> The MAO must make correct claim determinations, which include developing the claim for additional information, when necessary, for: • Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO; • Ambulance services dispatched through 911; • Emergency services; • Urgently needed services; • Post-stabilization care services; and • Renal dialysis services that Medicare members obtain while temporarily out of the service area. 42 C.F.R. § 422.100(a) and (b)(1); § 422.132; § 422.504(g)(1); Manual Ch. 4 – Section 10.2	X	
<u>Reasonable Reimbursement for Covered Services</u> The MAO must provide reasonable reimbursement for: • Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO; • Ambulance services dispatched through 911; • Emergency services; • Urgently needed services; • Post-stabilization care services; • Renal dialysis services that Medicare members obtain while temporarily out of the service area; and • Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal. 42 C.F.R. § 422.100(a) and (b)(1)-(2); Manual Ch. 4 – Section 10.2	X	
<u>Timely Payment of Non-Contracting Provider Clean Claims</u> The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
42 C.F.R. § 422.500; § 422.520(a)(1); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1		
Interest on Clean Claims Paid Late If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842(c)(2)(B). 42 C.F.R. § 422.520(a)(2); Manual Ch. 11 – Section 100.2	X	
Timely Adjudication of Non-Clean Claims The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt. 42 C.F.R. § 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1	X	
Claim Denials (Notice Content) If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason. 42 C.F.R. § 422.568(d) and (e); Manual Ch. 13 – Section 40.2.2	X	BHRS must use the template for claims denials that CMS has approved for HPSM.
Medicare Secondary Payer (Claims) The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. 42 C.F.R. § 422.108; Manual Ch. 4 – Section 80.2	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
Adverse Standard Pre-Service Organization Determinations (Timeliness) If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified). 42 C.F.R. § 422.568(a)	X	This is a request for prior authorization. BHRS must use the template for claims denials that CMS has approved for HPSM.
Adverse Standard Pre-Service Organization Determinations (Notice Content) If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. 42 C.F.R. § 422.568(d) and (e)	X	BHRS must use the template for authorization denials that CMS has approved for HPSM.
Receipt and Documentation of Expedited Organization Determination Requests The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file. 42 C.F.R. § 422.570(c)(1)	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
Requests for Expedited Organization Determinations (Timeliness) The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification. 42 C.F.R. § 422.570(c)(2) and (d); § 422.572(a)-(c)	X	
Adverse Expedited Organization Determinations (Notice Content) If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. 42 C.F.R. § 422.572(e)	X	BHRS must use the template for authorization denials that CMS has approved for HPSM.
Organization Determination Extensions (Notice Content) If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension. 42 C.F.R. § 422.568(a); § 422.572(b)	X	BHRS must use the template for extension of authorization timelines that CMS has approved for HPSM.
Decision Not to Expedite an Organization Determination (Notice Content) If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an	X	BHRS must use the template for denials of decisions to expedite authorizations that CMS has approved for HPSM.

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes. 42 C.F.R. § 422.570(d)(2)		
Correctly Distinguishes Between Organization Determinations and Reconsiderations The MAO must correctly distinguish between organization determinations and reconsiderations. 42 C.F.R. § 422.564(b); § 422.566(b); § 422.580	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
<u>Acceptance of Standard Reconsideration Requests</u> The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days). 42 C.F.R. § 422.582(a)-(c)	X	
<u>Appropriate Person(s) Conduct the Reconsideration</u> A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not be, in all cases, of the same specialty or subspecialty as the treating physician. 42 C.F.R. § 422.590(g)(1)-(2)	X	
<u>Favorable Claims Reconsiderations (Timeliness)</u> If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request. 42 C.F.R. § 422.590(b)(1); Manual Ch. 13 – Section 140.1.3	X	
<u>Adverse Claims Reconsiderations (Timeliness)</u> If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity. 42 C.F.R. § 422.590(b)(2), (c), and (e)	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
Effectuation of Third-Party Claims Reconsideration Reversals If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. 42 C.F.R. § 422.618(b)(2) and (c)	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
Favorable Standard Pre-Service Reconsiderations (Timeliness) If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). 42 C.F.R. § 422.590(a)(1)	X	
Adverse Standard Pre-Service Reconsiderations (Timeliness) If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action. 42 C.F.R. § 422.590(a)(2) and (e)	X	
Effectuation of Third-Party Standard Pre-Service Reconsideration Reversals If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. 42 C.F.R. § 422.618(b)(1) and (c)	X	
Receipt and Documentation of Expedited Reconsideration Requests The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
42 C.F.R. § 422.584(c)(1)		

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
<u>Requests for Expedited Reconsiderations (Timeliness)</u> The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination, and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
42 C.F.R. § 422.584(c)(2) and (d); § 422.590(d)(1)-(3) and (5), (e), and (f)		
Decisions Not to Expedite a Reconsideration (Notice Content) If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes. 42 C.F.R. § 422.584(d)(2)	X	
Effectuation of Third-Party Expedited Reconsideration Reversals If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision. 42 C.F.R. § 422.619(b) and (c)	X	
Reconsideration Extensions (Notice Content) If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension. 42 C.F.R. § 422.590(a)(1); 42 C.F.R. § 422.590(d)(2)	X	

CHAPTER 13 ORGANIZATION DETERMINATIONS, GRIEVANCES, AND APPEALS	Applicable to Contract?	Notes
Organization Determinations and Reconsiderations Not Categorized as Grievances The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms. 42 C.F.R. § 422.564(b); § 422.566(b); § 422.580; Manual Ch. 13 – Sections 10.1 & 20.2	X	
Grievance Decision Notification (Timeliness) The MAO must notify the member of its decision as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the complaint involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies a need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay. 42 C.F.R. § 422.564(e)(1)-(2) and(f)	X	
Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written complaint with the QIO. 42 C.F.R. § 422.564(e)(3)	X	
Method of Grievance Decision Notification The MAO must respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted. 42 C.F.R. § 422.564(e)(3)	X	

CONTRACT INSURANCE APPROVAL

DATE: October 14, 2009

TO: Faiza Steele FAX: 363-4864 PONY: HRD 163

FROM: John Klyver

PHONE: 573-2641 FAX: 573-2841 PONY: MLH 322

The following is to be completed by the department before submission to Risk Management:

CONTRACTOR NAME: Health Plan of San Mateo – Medicare Advantage

DOES THE CONTRACTOR TRAVEL AS A PART OF THE CONTRACT SERVICES?

NUMBER OF EMPLOYEES WORKING FOR CONTRACTOR: +15

DUTIES TO BE PERFORMED BY CONTRACTOR FOR COUNTY: We are the service provider through this agreement. Please see attached.

The following will be completed by Risk Management:

INSURANCE COVERAGE:	Amount	Approve	Waive	Modify
Comprehensive General Liability	$1,000,000	☐	☑	☐
Motor Vehicle Liability	$1,000,000	☐	☑	☐
Professional Liability	$1,000,000	☐	☑	☐
Workers' Compensation	Statutory	☐	☑	☐

REMARKS/COMMENTS:

Faiza Steele (signature) 10/15/09

Faiza Steele
Risk Management Analyst

Date

RESOLUTION NO. 070510

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * * *

RESOLUTION: 1) AUTHORIZING THE PRESIDENT OF THE BOARD TO EXECUTE A REVENUE AGREEMENT WITH THE HEALTH PLAN OF SAN MATEO FOR MEDICARE CAREADVANTAGE SERVICES FOR THE TERM JANUARY 1, 2009 THROUGH DECEMBER 31, 2011; AND 2) AUTHORIZING THE CHIEF OF THE HEALTH SYSTEM OR DESIGNEE TO EXECUTE CONTRACT AMENDMENTS WHICH MODIFY THE COUNTY'S MAXIMUM FISCAL OBLIGATION BY NO MORE THAN $25,000 (IN AGGREGATE), AND/OR MODIFY THE CONTRACT TERM AND/OR SERVICES SO LONG AS THE MODIFIED TERM OR SERVICES IS/ARE WITHIN THE CURRENT OR REVISED FISCAL PROVISIONS

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, there has been presented to this Board of Supervisors for its consideration and acceptance an Agreement, reference to which is hereby made for further particulars, whereby the Health Plan of San Mateo shall reimburse Behavioral Health and Recovery Services for the provision of outpatient mental health services to residents with Medicare insurance as part of the Medicare Advantage Program, for the term January 1, 2009, through December 31, 2011 ; and

WHEREAS, this Board has been presented with the Agreement and has examined and approved it as to both form and content and desires to enter into the Agreement.

NOW, THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the President of this Board of Supervisors is authorized to execute said Agreement for and

Regularly passed and adopted this 10th day of November, 2009.

AYES and in favor of said resolution:

Supervisors:	*MARK CHURCH*
	CAROLE GROOM
	RICHARD S. GORDON
	ROSE JACOBS GIBSON
	ADRIENNE J. TISSIER

NOES and against said resolution:

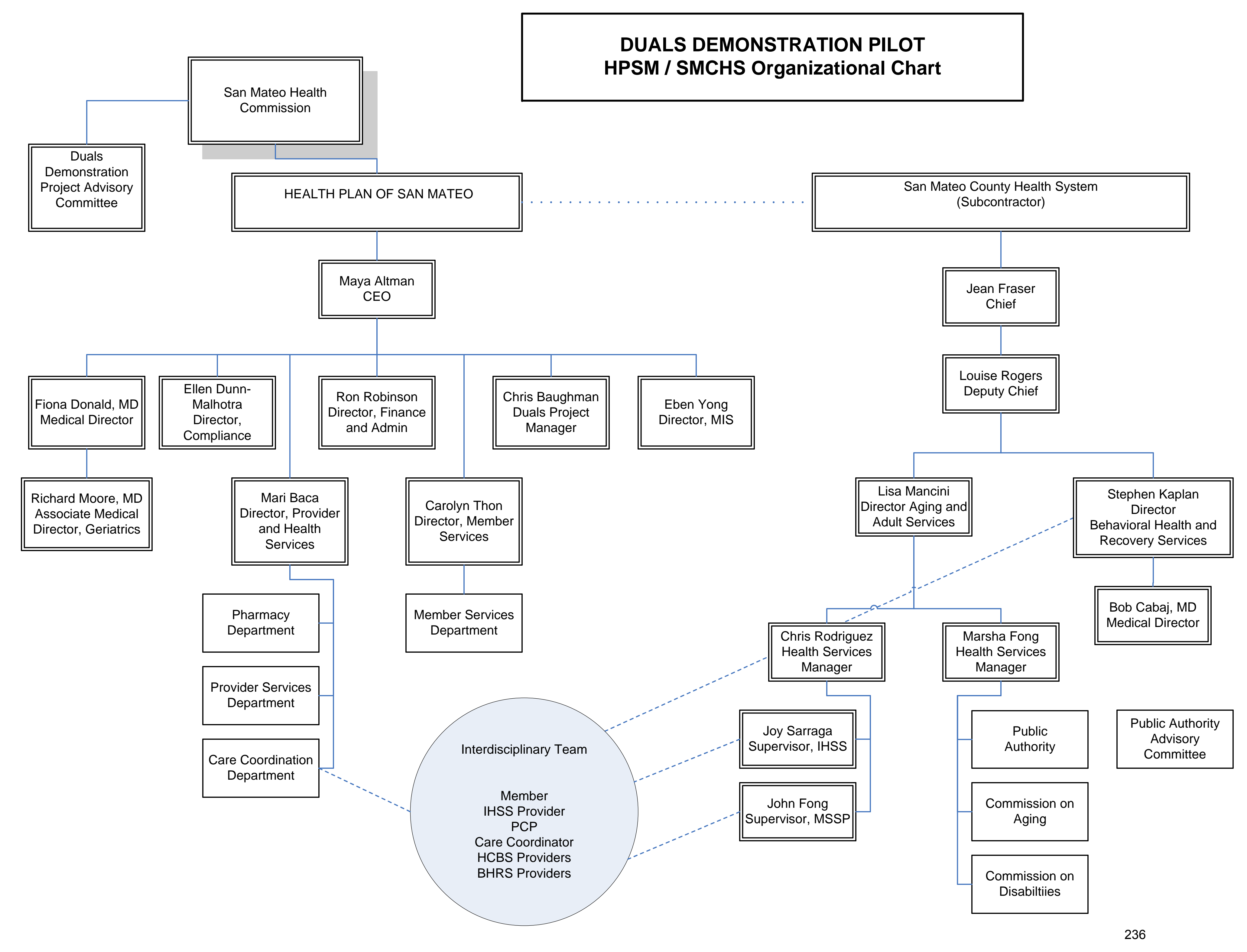
Supervisors:	*NONE*
Absent Supervisors:	*NONE*

Mark Church
President, Board of Supervisors
County of San Mateo
State of California

Certificate of Delivery

I certify that a copy of the original resolution filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.

Marie L. Peterson, Deputy
Clerk of the Board of Supervisors



DUALS DEMONSTRATION PILOT
HPSM / SMCHS Organizational Chart
San Mateo Health Commission
Duals Demonstration Project Advisory Committee
HEALTH PLAN OF SAN MATEO
San Mateo County Health System (Subcontractor)
Maya Altman CEO
Jean Fraser Chief
Louise Rogers Deputy Chief
Fiona Donald, MD Medical Director
Ellen Dunn-Malhotra Director, Compliance
Ron Robinson Director, Finance and Admin
Chris Baughman Duals Project Manager
Eben Yong Director, MIS
Richard Moore, MD Associate Medical Director, Geriatrics
Mari Baca Director, Provider and Health Services
Carolyn Thon Director, Member Services
Lisa Mancini Director Aging and Adult Services
Stephen Kaplan Director Behavioral Health and Recovery Services
Pharmacy Department
Provider Services Department
Care Coordination Department
Member Services Department
Bob Cabaj, MD Medical Director
Chris Rodriguez Health Services Manager
Marsha Fong Health Services Manager
Joy Sarraga Supervisor, IHSS
John Fong Supervisor, MSSP
Public Authority
Public Authority Advisory Committee
Commission on Aging
Commission on Disabiltiies
Interdisciplinary Team
Member
IHSS Provider
PCP
Care Coordinator
HCBS Providers
BHRS Providers

CHRISTINE J. BAUGHMAN

PROFESSIONAL EXPERIENCE

2008 – Present **Director of System Improvement, Health Plan of San Mateo**
South San Francisco, California

Responsible for increasing the health of the HPSM through increased efficiency, increased effectiveness, decreased costs, and improved organizational quality. Work closely with HPSM leadership to ensure the efficiency and effectiveness of systems solutions deployed in support of business goals and objectives. Function as ***Project Manager for Duals Demonstration Project*** and Long-Term Care Integration. Lead interagency and multidisciplinary project team, coordinating HSPM staff along with those from the County of San Mateo's Aging and Adult Services and Behavioral Health and Recovery Services. Developed Data Mart concept to integrate data from above entities. Lead HPSM's efforts in ADHC transition to CBAS. Also functioned as ***Business Project Manager***, overseeing the organizational business units during implementation for conversion to a new Managed Care Information System. Worked closely with MIS project manager during planning, design, configuration, testing and process re-design activities. Coordinated the functional teams to ensure the efficiency and effectiveness of systems solutions deployed in support of business goals and objectives.

2005 – 2008 **Chief Operating Officer, Endoscopy Management Services Organization**
Los Altos, California

Responsible for all management operations of physician-owned development and management company which provided turn-key services to physicians wanting to establish their own ambulatory surgery centers. Responsible for patient care services, patient billing, payor contracting, physician credentialing, quality assurance, purchasing, IT and finance. As COO, responsible for ensuring smooth operations at both the corporate office as well as at each of the 16 ASCs operated. Functioned as project lead when opening new centers, ensuring all deadlines and goals are met. Lead de-briefing and "lessons learned" activities following implementation. Continuous attention was paid to improving operational efficiencies, patient and physician satisfaction and effective resource allocation. Participated in strategic planning, governing board meetings, and physician partnership meetings.

2002 – 2005 **President/CEO, Coastside Family Medical Center**
Half Moon Bay, California

Responsible for all operations of non-profit community clinic providing family practice and pediatric care to rural health community. Work closely with 7-member medical staff as well as 13-member Board of Directors. Responsible for daily operations, strategic planning, financial management (including account management, financial reporting and analysis, and budget development and implementation), on-site personnel functions, and fund-raising. Continuous emphasis on cost-containment and revenue enhancement to ensure long-term viability of the clinic. Brought billing services in-house resulting in a 50% decrease in AR days. Decreased staff turn-over through fair and respectful leadership.

2000 – 2002 **Director, Outpatient Services, Madonna Rehabilitation Hospital**
Lincoln, Nebraska

Responsible for development and implementation of all outpatient programs, including four sites as well as outreach programs. Developed capital and operational budgets, identified opportunities for

efficiencies, implemented new programs, and performed personnel functions for areas of responsibility, including Physical, Occupational, Aquatic, and Speech Therapies, and Neuropsychology, including the Pediatric Program, Mild Traumatic Brain Injury Clinic, Spasticity Clinic, Geriatric Functional Assessment Clinic, Adaptive Sports Program, and Gait and Motion Analysis Lab. Member of Senior Management Team as well as several organizational committees, including Strategic Planning, Corporate Compliance, Telehealth, and Outcomes and Informatics. Operational lead for implementation of computerized clinical documentation system.

1991 – 2000 **Administrative Director, Mills-Peninsula Health Services**
San Mateo, California

Operationally responsible for Rehabilitation Nursing, Physical Therapy, Occupational Therapy, Speech and Audiology, Neuropsychology, Social Work, Pediatric Rehabilitation, Arthritis Center, Cardiac Rehabilitation, Aquatics, Recovery Care Inn (short-stay post-surgery) and Occupational and Employee Health Services. Responsible for four acute and outpatient sites. Worked closely with rehabilitation physicians to ensure provision of high quality integrated rehabilitation services. Monitored division quality assurance activities to ensure the delivery of quality patient care in an efficient and effective manner.

As JCAHO Coordinator for the organization, responsible for developing and implementing plan to ensure full preparedness for accreditation survey, including preparing staff, managers, senior management, and 13 sites for JCAHO and DHS survey. Served as internal consultant to department managers on improving operations in order to meet accreditation standards. Organization received highest score it had ever achieved.

1981 – 1991 **Evangelical Health Systems (now Advocate)**
Christ Hospital and Medical Center
Oak Lawn, Illinois
1987 – 1991 Director of Rehabilitation Services
1985 – 1987 Supervisor, Vocational Services
1981 – 1985 Staff Positions, Vocational Services

EDUCATION

J. L. Kellogg Graduate School of Management, Northwestern University, Chicago, Illinois, 1987
Master of Management (Majors: Hospital and Health Services, Managerial Economics, Management Policy)

Bowling Green State University, Bowling Green, Ohio, 1980, Master of Rehabilitation Counseling

Ohio Northern University, Ada, Ohio, 1979, Bachelor of Arts in Psychology

PROFESSIONAL AFFILIATIONS

1992 – 1997 San Mateo County Commission on Disabilities
1994 – 1996 President 1992 – 1994 Vice-President
The Commission is a 21-member advisory board appointed by the San Mateo County Board of Supervisors to advise on issues related to persons with disabilities.

Duals Demonstration Pilot
Implementation Plan

1		**Long-term Care Integration Program Design**	**4/19/2011**			**Maya Altman,Lisa Mancini**
2		Develop initial proposal and submit to State	8/12/2009	Yes		Maya Altman,Lisa Mancini
3		Develop initial proposal and submit to CMS	4/19/2011	Yes		Maya Altman,Lisa Mancini
4		**Duals Demonstration Project**	**7/31/2012**			
5		Comment on site selection criteria	1/9/2012	Yes		Khoa Nguyen
6		Final selection criteria released	2/10/2012	Yes		DHCS
7		Application Due	2/24/2012			HPSM
8		Sites Selected	3/31/2012			DHCS
9		Comments on Demonstration Proposal	3/31/2012			HPSM
10		Complete NOIA to CMS	3/31/2012			Rosemary Stuessy
11		Demonstration Proposal to CMS	4/30/2012			DHCS
12		Demonstration plan selection	7/31/2012			CMS
13		**Model of Care**	**1/1/2013**			
14		**SPOE / Assessment**	**11/30/2012**			**Chris Rodriguez**
15		Initiate Work Group	7/27/2011	Yes		Chris Rodriguez
16		Develop SPOE/Assessment workflow	2/29/2012	Yes		Work Group
17		Develop Assessment Tool(s)	4/30/2012			Work Group
18		Define resource needs - Plan A (no add'l resources)	3/31/2012			Work Group
19		Define resource needs - Plan B (optimal plan)	3/31/2012			Work Group
20		Develop new policies and procedures as needed	9/30/2012			Work Group
21		Train SPOE staff on Duals Pilot procedures	11/30/2012			Chris Rodriguez
22		**Care Coordination**	**11/30/2012**			**Mari Baca,Chris Rodriguez**
23		Initiate Work Group	2/29/2012	Yes		Mari Baca,Chris Rodriguez
24		Develop Care Coordination workflow	2/29/2012			Mari Baca,Chris Rodriguez
25		Identify Care Plan tool needed	3/31/2012			Work Group
26		Develop Care Plan tool	4/30/2012			Work Group
27		Define resource needs - Plan A (no add'l resources)	4/30/2012			Work Group
28		Define resource needs - Plan B (optimal plan)	4/30/2012			Work Group
29		Develop new Care Coordination policies and procedures as needed	9/30/2012			Work Group
30		Train Care Coordination staff on Duals Pilot procedures	11/30/2012			Mari Baca,Chris Rodriguez
31		**Eligibility**	**12/31/2012**			**Carolyn Thon,Srija Srinivasan**
32		Initiate Work Group	9/1/2011	Yes		Carolyn Thon,Srija Srinivasan
33		Define process, including potential barriers	9/1/2011	Yes		Work Group
34		Address barriers as needed	10/31/2011	Yes		Work Group
35		Define strategies for next steps	12/31/2011	Yes		Work Group
36		Establish SPD Unit for Human Services	5/1/2012			County HSA
37		Monitor progress of SPD Unit	12/31/2012		Ongoing	
38		**Interdisciplinary Team**	**11/30/2012**			
39		**Provider/Resource Network**	**11/30/2012**			**Scott Slayton,Marsha Fong**

Duals Demonstration Pilot
Implementation Plan

ID	Indicators	Task Name	Target Date	Completed	Notes	Lead
40		Identify potential providers/resources including SMMC, HBCS, BHRS, etc.	4/30/2012			Work Group
41		Identify capacity in the community	5/31/2012			Work Group
42		Educate providers on pilot purpose / SPOE / etc.	11/30/2012			Scott Slayton
43		Update provider contract as needed	11/30/2012			Scott Slayton
44		Contract with new providers/resources, e.g. HCBS	11/30/2012			Scott Slayton
45		Update Provider Directory	4/19/2011			Scott Slayton
46		**Data submission**	**11/30/2012**			
47		Identify providers who will need to submit claims/encounters	9/30/2012			MIS
48		Train providers on submission	11/30/2012			Scott Slayton S
49		HEALTHsuite modifications identified	9/30/2012			MIS
50		HEALTHsuite modifications made	10/31/2012			MIS
51		HEALTHsuite modification tested	11/30/2012			MIS
52		**IHSS**	**8/1/2012**			**Lisa Mancini**
53		Initiate Work Group	3/23/2011	Yes		Chris Baughman
54		Develop workflows for current program	4/19/2011	Yes		Chris Baughman
55		Identify possible program changes	11/15/2011	Yes		Work Group
56		Expand Provider Registry as needed	6/30/2012			Marsha Fong
57		**Work Force Training**	**8/1/2012**			**Marsha Fong**
58		Identify training needs	1/1/2012			Marsha Fong
59		Identify resource for providing training	3/31/2012			Marsha Fong
60		Obtain support for training from SEIU	4/30/2012			Marsha Fong
61		Begin training	8/1/2012			Marsha Fong
62		Define resources needs	4/30/2012			Marsha Fong
63		Develop new policies and procedures as needed	6/30/2012			Marsha Fong
64		**MSSP**	**5/31/2012**			**Chris Rodriguez**
65		Develop workflow	2/29/2012			
66		Define resource needs - Plan A (no add'l resources)	4/30/2012			
67		Define resource needs - Plan B (optimal plan)	4/30/2012			
68		Develop new policies and procedures as needed	5/31/2012			
69		**CBAS**	**7/1/2012**			**Maya Altman,Lisa Mancini**
70		Complete list of Categorically Eligible and Presumptively Eligible members	12/21/2011	Yes		DHCS
71		Complete face-to-face assessments	2/29/2012			DHCS Nurses
72		Applications for CBAS are due	1/27/2012	Yes		ADHC Centers
73		Publish CBAS-certified list	2/15/2012			DHCS
74		Final list of CBAS eligible	2/15/2012			DHCS
75		Determine referral process to CBAS centers	3/1/2012			Mari Baca
76		Initiate Enhanced Case Management services	3/1/2012			Mari Baca
77		HPSM staff to receive training in CBAS Assessment	6/30/2012			Mari Baca

Duals Demonstration Pilot
Implementation Plan

ID		Task Name	Target Date	Completed	Notes	Lead
78		HPMS to begin conducting CBAS Assessments	7/1/2012			Mari Baca
79		**Housing**	**8/31/2012**			**Maya Altman**
80		**Define current needs and resources**	**8/31/2012**			**Ed Ortiz**
81		**Meet with potential housing partners**	**8/31/2012**			**Ed Ortiz**
82		SMC Housing Department	8/31/2012			Ed Ortiz
83		**Non-profit housing developers and operators**	**8/31/2012**			**Ed Ortiz**
84		Lesley Senior Communities Assisted Living	8/31/2012			Ed Ortiz
85		MidPen Senior Housing	8/31/2012			Ed Ortiz
86		Three Bells RCFE	8/31/2012			Ed Ortiz
87		Jewish Home of San Francisco	8/31/2012			Ed Ortiz
88		Mercy Housing	8/31/2012			Ed Ortiz
89		Research demographic projections to identify extent of unmet needs	8/31/2012			Ed Ortiz
90		Develop housing strategic plan	11/30/2012			Ed Ortiz
91		Develop Joint Placement Fund in partnership with SMCHS	1/1/2013			Ed Ortiz/SMCHS
92		Develop partnerships with housing developers and operators for short and longer term solutions	12/31/2012		Ongoing	Ed Ortiz
93		**Rate Determination**	**11/30/2012**			**Ron Robinson**
94		Engage Actuary	2/21/2011	Yes		Ron Robinson
95		HPSM data submitted	3/31/2011	Yes		Ron Robinson
96		County data submitted	9/30/2011	Yes		Ron Robinson
97		State data submitted	10/31/2011	Yes		Ron Robinson
98		Obtain rate analysis from actuary	2/29/2012			Optumas
99		Rates finalized	9/20/2012			CMS,DHCS,HPSM
100		HEALTHsuite modifications identified	9/30/2012			MIS
101		HEALTHsuite modifications made	10/31/2012			MIS
102		HEALTHsuite testing complete	11/30/2012			MIS
103		Inventory existing claim mechanisms	3/31/2012			
104		**Contracting**	**5/1/2012**			**Ron Robinson**
105		Revise contract (3-way with HPSM, State and CMS)	3/31/2012			
106		Develop contracts/MOUs with Public Authority	5/1/2012			
107		Develop contracts/MOUs with County of San Mateo	5/1/2012			
108		**Program Evaluation**	**6/30/2012**			**Maya Altman,Lisa Mancini**
109		Initiate Work Group	3/31/2012			Chris Baughman
110		Identify program measurements	4/30/2012			Work Group
111		Identify baselines as appropriate	4/30/2012			Work Group
112		Identify data sources for program measurements	4/30/2012			Work Group
113		Develop tracking process for measures	6/30/2012			Chris Baughman
114		Develop reporting format	6/30/2012			Chris Baughman
115		Develop policy and procedure for Program Evaluation	6/30/2012			Chris Baughman
116		Incorporate DHCS/CMS required reporting elements as needed	6/30/2012			Chris Baughman

Duals Demonstration Pilot
Implementation Plan

ID	Indicators	Task Name	Target Date	Completed	Notes	Lead
117		**Data / IT**	**11/30/2012**			**Chris Baughman**
118		**Data Sharing**	**11/30/2012**			
119		Initiate Work Group	10/3/2011	Yes		Chris Baughman
120		Identify data needs	10/31/2011	Yes		Chris Baughman
121		Identify data sources	10/31/2011	Yes		Chris Baughman
122		Identify Data elements	11/30/2011	Yes		Chris Baughman
123		Develop data mart	4/30/2012		In process	Michael Lussier
124		Demonstrate data mart	1/15/2012	Yes		Chris Baughman
125		Refine data elements as needed	2/29/2012		Iterative process	
126		**Develop file transfer process**	**3/31/2012**			**Chris Baughman**
127		**Q System**	**3/31/2012**			**Will Whitlock**
128		Program Dates	3/31/2012			
129		Caps and Scales	3/31/2012			
130		CMIPS	3/31/2012			
131		**BHRS**	**3/31/2012**			**Pat Miles**
132		LOCUS	3/31/2012			
133		Avatar	3/31/2012			
134		Test data mart	5/31/2012			Chris Baughman
135		Finalize Data Use Agreement	3/31/2012			Chris Baughman
136		Identify standard reports needed	4/30/2012			Data Team
137		Develop reports	7/31/2012			Vicky Shih,Michael Lussier
138		Run test reports	8/31/2012			Chris Baughman
139		Develop Training Manual for using Data Mart	7/31/2012			Chris Baughman
140		Train staff on Data Mart	11/30/2012			Chris Baughman
141		**Program Marketing**	**10/1/2012**			**Russ Hoyle**
142		Identify collaterals needed	7/1/2012			Russ Hoyle
143		Develop collaterals	9/1/2012			Russ Hoyle
144		Develop marketing program	9/1/2012			Russ Hoyle
145		Implement marketing activities	10/1/2012			Russ Hoyle
146		Update Website	10/1/2012			Russ Hoyle
147		**Advisory Committee**	**5/31/2012**			**Maya Altman,Lisa Mancini**
148		Define group purpose / frequency of meetings / etc.	10/31/2011			Chris Baughman
149		Identify potential Advisory Committee members	2/29/2012			Maya Altman,Lisa Mancini
150		Invite members to join Advisory Committee	3/31/2012			Maya Altman
151		Hold first Advisory Committee meeting	5/31/2012			Maya Altman
152		**Implement Duals Demonstration Pilot**	**7/1/2013**			
153		Identify number of members targeted for Phase 1	1/31/2012			Chris Baughman
154		DHCS/CMS begins Readiness Audit	7/20/2012			DHCS,CMS
155		DHCS/CMS completes Readiness Audit	9/30/2012			DHCS,CMS
156		Prepare Member Materials	10/1/2012			Russ Hoyle,Carolyn Thon,Ellen

Duals Demonstration Pilot
Implementation Plan

ID		Task Name	Target Date	Completed	Notes	Lead
157		Send out Passive Enrollment letters	10/1/2012			Carolyn Thon
158		Prepare DEDP ID cards	12/15/2012			Fred Elsner
159		Notify CMS of enrollees	12/31/2012			MIS file
160		Identify members for Phase 1	12/31/2012			
161		Dual Demonstration Pilot begins - Phase 1	1/1/2013			
162		Assess ability to increase target group beyond Phase 1	7/1/2013			DEDP Team

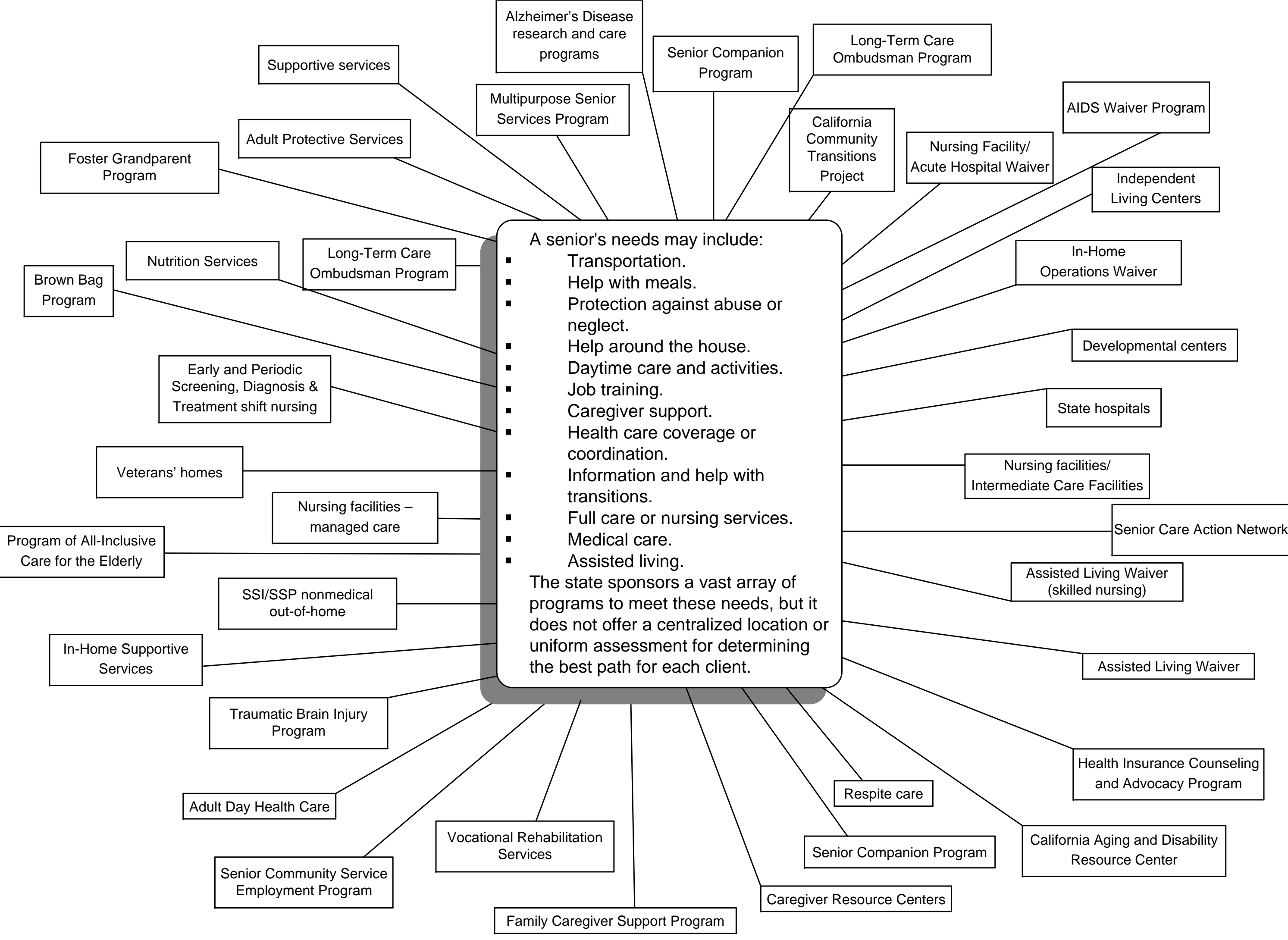
Attachment 14. Diagram from Little Hoover Commission's April 2011 report, *A Long Term Strategy for Long Term Care*.

A Long-Term Strategy for Long-Term Care

Little Hoover Commission

April 2011

A Consumer's View of Long-Term Care Services



The structure of California's long-term care system is inconsistent in how it links people with programs. Because of the fragmented structure, someone may enter the system through a county office, a services hotline, a doctor, a senior center or a variety of other points. As the services provided by these organizations vary, so do the assessment processes they offer for connecting people with programs. Government offices and other organizations offer a wide array of services, but people often must take several steps to identify their needs and locate the most approriate programs.

Source: Legislative Analyst's Office. February 2006. Analysis of the 2006-07 Budget Bill. Improving Long-Term Care." also, SCAN Foundation. May 25, 2010. Program Compendium. Written testimony to the Commission.

Health Plan of San Mateo (H5428)

HPSM CareAdvantage (HMO SNP)

Model of Care 2012

May 9, 2011
Modified: February 2012

H5428-001: San Mateo Health Commission
dba Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
650-616-0050
www.hpsm.org

Table of Contents

Acronyms 1
Introduction 2
1. Description of the SNP-specific Target Population 3
2. Measurable Goals 6
  a. Describe the specific goals 6
  b. Describe the goals as measurable outcomes 15
  c. Discuss actions MAO will take if goals are not met 24
3. Staff Structure and Care Management Roles 32
  a. Identify the specific employed or contracted staff to perform administrative functions. 32
  b. Identify the specific employed or contracted staff to perform clinical functions 39
  c. Identify the specific employed or contracted staff to perform oversight functions 44
4. Interdisciplinary Care Team (ICT) 59
  a. Describe the composition of the ICT 59
  b. Describe how the MAO will facilitate the participation of the beneficiary 63
  c. Describe how the ICT will operate and communicate 65
5. Provider Network–Specialized Expertise/Use of Clinical Practice Guidelines and Protocols . 71
  a. Describe the specialized expertise in the MAO's provider network 71
  b. Describe how it is determined that providers are actively licensed and competent 77
  c. Describe who determines which services beneficiaries will receive 90
  d. Describe how the provider network coordinates with the ICT and the beneficiary 93
  e. Describe how the MAO assures that providers use evidence-based CPGs 108
6. Model of Care Training for Personnel and Provider Network 112
  a. Describe how the MAO conducted initial and annual model of care training 112
  b. Describe how the MAO assures and documents completion of training 116
  c. Describe the personnel responsible for oversight of the model of care training 120
  d. Describe actions taken when the required training has not been completed 123
7. Health Risk Assessment 125
  a. Describe the health risk assessment tool 128
  b. Describe when and how the initial/annual health risk assessments are conducted 132
  c. Describe the personnel who review, analyze, and stratify health care needs 133
  d. Describe the communication mechanism the MAO institutes to notify the ICT 135
8. Individualized Care Planning 140

a. Describe which personnel develops the individualized plan of care 140
b. Describe the essential elements incorporated in the plan of care 145
c. Describe the personnel who review the care plan and review frequency 152
d. Describe how the plan of care is documented 160
e. Describe how the plan of care and any care plan revisions are communicated 169
9. Communication Network 175
a. Describe the MAO's structure for a communication network 175
b. Describe how the communication network connects stakeholders 178
c. Describe how the MAO preserves aspects of communication as evidence of care 187
d. Describe personnel having oversight responsibility for communication effectiveness 191
10. Care Management for the Most Vulnerable Subpopulations 197
a. Describe how the MAO identifies its most vulnerable beneficiaries...........................197
b. Describe the add-on services and benefits for most vulnerable beneficiaries 202
11. Performance and Health Outcome Measurement 216
a. Describe how the MAO will to evaluate the model of care 216
b. Describe who will evaluate the model of care 227
c. Describe how evaluation will be used to improve the model of care 231
d. Describe how the evaluation of the model of care will be documented 234
e. Describe personnel having oversight responsibility for model of care effectivenes.....236
f. Describe how the MAO will communicate improvements in the model of care 241
Appendices
A. Predictive Modeling Overview *(applicable to Element 10, Factor A)*
B. P&P UM-20: Case Identification of High Risk Members for Case Management *(applicable to Element 10, Factor A)*
C. High Utilizers Group (HUG) Work Plan *(applicable to Element 4, Factor A)*
D. HPSM Communications Survey 2010 *(applicable to Element 9, Factor D)*
E. HPSM Website Usability Study *(applicable to Element 9, Factor D)*
F. Health Risk Assessment Tool *(applicable to Element 7, Factor A)*
G. CR-02 Recredentialing of Physicians, Non-Physician Medical Practitioners, Mid-Level Clinicians, and HIV/AIDS Specialists *(applicable to Element 5, Factor B)*
H. CR-07 Denial, Reduction, Suspension, or Termination of Practitioner Status *(applicable to Element 5, Factor B)*

Acronyms

AAS	Aging and Adult Services (San Mateo County)
BHRS	Behavioral Health and Recovery Services (San Mateo County)
CAC	Consumer Advisory Group
CAHPS	Consumer Assessment of Health Plans and Systems
CCT	Care Coordination Technician
CPOP	Clinical Pharmacy Outreach Program
GGRC	Golden Gate Regional Center
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HOS	Health Outcomes Survey
HPSM	Health Plan of San Mateo
ICT	Interdisciplinary Care Team
LEP	Limited English Proficiency
LTC	Long Term Care
MOC	Model of Care
MTM	Medication Therapy Management
NCM	Nurse Case Manager
PAG	Physician Advisory Group
PRG	Peer Review Committee
QAIC	Quality Assessment and Improvement Committee
QAIP	Quality Assessment and Improvement Program
QIP	Quality Improvement Project
QIPI	Quality Improvement Projects and Initiatives
QMOC	Quality Management Oversight Committee
RRSCC	Ron Robinson Senior Care Center (at San Mateo Medical Center)
SMHC	San Mateo Health Commission
SMMC	San Mateo Medical Center
SNF	Skilled Nursing Facility
SNP	Special Needs Plan

Introduction

The Health Plan of San Mateo's (HPSM) Special Needs Plan (SNP) Model of Care (MOC) has been designed to ensure that all dual eligible members of the Dual Eligible Demonstration Project receive the specialized health and care management services needed to meet their health care needs. Please note: The original HPSM SNP MOC has been modified to reflect additional items for the Duals Demonstration. All references to CareAdvantage (current SNP) are considered to be applicable to the Dual Eligible Demonstration Project as well.

The MOC is designed to promote the provision of medically appropriate care; to monitor, evaluate, and manage resource allocation; and to monitor cost-effectiveness and quality of the healthcare delivered to dual-eligible members through a multidisciplinary, comprehensive approach.

The elements of our MOC include the following:

1. Defined target population
2. Measureable goals
3. Customized program and staff structure and care management roles
4. Interdisciplinary Care Teams
5. Provider network depth, quality, and oversight
6. Staff and provider training
7. Health risk assessment
8. Individualized care planning
9. Communication network
10. Care management
11. Performance and health outcomes measurement

1. Description of the SNP-specific Target Population

CareAdvantage is a Medicare Advantage Dual Eligible Special Needs Plan (Medicaid subset D-SNP) administered by the Health Plan of San Mateo (HPSM). The target population for enrollment in CareAdvantage is dual eligible beneficiaries who reside in San Mateo County, who have their Medi-Cal benefits administered through the Health Plan of San Mateo. To be eligible to enroll in CareAdvantage a beneficiary must have:

- Medicare Part A and Part B.
- Full-scope Medi-Cal (the Medicaid program in California) through the Health Plan of San Mateo (HPSM).
- Reside in San Mateo County.

The Health Plan of San Mateo (HPSM) is a health care plan that has been serving San Mateo County residents since December 1987. It was originally created as a County Organized Health System (COHS) Plan to serve all Medi-Cal beneficiaries in San Mateo County through a contract with the State of California Department of Health Care Services. HPSM was created in response to local health care providers' dissatisfaction with the State-administered Medi-Cal program.

HPSM is an independent public agency created by federal waiver, state law and a San Mateo County ordinance to provide access to health care for Medi-Cal eligible beneficiaries and other at risk residents of the county. It is governed by the San Mateo Health Commission, a nine-member body composed of representatives from the community, physicians, a pharmacist, members of the San Mateo County Board of Supervisors and the San Mateo County Manager.

The organizational vision of HPSM is that "healthy is for everyone." Since 1987, HPSM has continuously explored new program opportunities and worked with local, state, and federal partners to realize this vision, which has resulted in adding five other product lines to the original Medi-Cal managed care product. Its current membership across all programs is approximately 100,000.

Most Medi-Cal beneficiaries who live in San Mateo County are automatically enrolled in HPSM when they are determined Medi-Cal eligible. In addition to families receiving Temporary Aid to Needy Families (TANF) funds, this includes dual-eligible Medicare-Medi-Cal, seniors and persons with disabilities and beneficiaries in skilled nursing facilities. This makes HPSM uniquely qualified to offer a Dual Eligible Special Needs Plan (D-SNP) to dual eligible beneficiaries who are San Mateo County residents because these beneficiaries are already HPSM members through their Medi-Cal linkage.

HPSM created CareAdvantage as a dual eligible Special Needs Plan in January 2006. Prior to 2006, dual eligible beneficiaries who lived in San Mateo County received Medicare benefits

through either Original (Fee-for-Service) Medicare or another Medicare Advantage Plan; HPSM covered their Medi-Cal benefits.

Now, dual eligible beneficiaries who live in San Mateo County have the option to enroll in CareAdvantage. CareAdvantage manages Medicare Parts A and B and Medicare Part D prescription drug benefits under the Health Plan of San Mateo's contract with the Centers for Medicare and Medicaid Services (CMS). At the same time, HPSM also coordinates, manages, and offers Medi-Cal wraparound benefits under its Medi-Cal contract with the California Department of Health Care Services. This coordination of Medicare and Medi-Cal benefits enables HPSM to provide a comprehensive set of inpatient, outpatient, and prescription drug benefits that reduces beneficiary confusion and administrative burden while focusing on improvements in quality of care.

The following are examples of the coordination of Medicare and Medi-Cal benefits that HPSM is able to process seamlessly for the benefit of its SNP beneficiaries:

- Skilled nursing facility (SNF)/long term care (LTC) benefit. While skilled nursing facility (SNF) days are covered through Medicare, long term care custodial days are not. However, through CareAdvantage, once a beneficiary exhausts his/her Medicare-covered SNF days, he/she is converted to the Medi-Cal long term care benefit.
- Medications not covered by Medicare Part D can be processed through the Medi-Cal formulary. DESI (Drug Efficacy Study Implementation) drugs such as Epifoam are not covered by Medicare Part D. However, the drug could possibly be covered under the Medi-Cal wraparound benefit if the physician submits a formulary exception request.
- Providers also benefit because CareAdvantage eliminates the need to submit a claim to Medicare and, once Medicare pays, to submit a crossover claim to Medi-Cal for the coinsurance. HPSM is able to automatically process the Medicare and coinsurance claim and reimburse the provider appropriately.

HPSM has approximately 8,400 dual eligible beneficiaries enrolled in CareAdvantage out of approximately 14,200 dual eligibles in San Mateo County. CareAdvantage beneficiaries are culturally and ethnically diverse as reflected in the following language breakdown:

Language	%
English	63%
Spanish	14%
Mandarin/Cantonese	9%
Tagalog	9%
Russian	2%
Other	3%

This language diversity means that already complex Medicare and Medi-Cal eligibility requirements must be explained to this population in a variety of languages. HPSM's customer

service staff speaks Spanish, Mandarin, Cantonese, Tagalog and Russian and utilizes telephonic interpreters for other languages.

CareAdvantage beneficiaries also have specialized health care needs. These members often have complex health and social service needs that demand care management interventions above and beyond the scope of services traditionally provided by Original Medicare or a non-SNP Medicare Advantage plan.

The majority of CareAdvantage beneficiaries have one or more chronic conditions, with the average HCC risk score for the member population reaching 1.35 per year. The following are some important characteristics of the CareAdvantage beneficiaries:

Characteristic	%
Beneficiaries with Mental Health diagnosis	44%
Beneficiaries with Diabetes	43%
Disabled under age 65	28%
Beneficiaries with developmental disabilities	7%

Moreover, 47% of CareAdvantage beneficiaries are 75 years old or older, reflecting a population that is or will soon be frail and facing end-of-life considerations.

This Model of Care will demonstrate that as the administrator of both Medicare and Medi-Cal benefits, HPSM is able to provide CareAdvantage beneficiaries with a seamless system of care coordination and benefit administration for both their Medicare and Medi-Cal coverage.

2. Measurable Goals

a. Describe the specific goals including:

1. Improving access to essential services such as medical, mental health, substance use, LTSS and social services
2. Improving access to affordable care
3. Improving coordination of care through an identified point of contact (e.g., gatekeeper)
4. Improving seamless transitions of care across healthcare settings, providers, and home and community-based services
5. Improving access to preventive health services
6. Improving access to Home and Community-Based Services
7. Assuring appropriate utilization of services
8. Improving beneficiary health outcomes (specify MAO selected health outcome measures)

The following describes the goals of HPSM's Model of Care for the 2012 calendar year (please refer to Factor B for the measurable component):

1. Improving access to essential services such as medical, mental health, substance use, LTSS and social services

HPSM uses licensed staff, including nurses and social workers to serve as care coordinators for our CareAdvantage members. These care coordinators use information from tools such as (1) our high risk assessment--HRA (mailed to every CareAdvantage member upon enrollment and then annually), (2) a comprehensive assessment (completed by phone with each CareAdvantage member identified as highest risk by the HRA, predictive modeling, physician referral, etc) or (3) through specific known linkages such as Behavioral Health and Recovery Services (BHRS—mental health unit) or Golden Gate Regional Center (GGRC—follows developmentally disabled people in our county). In this way, the care coordinators identify CareAdvantage members who are most in need of hands-on intensive case management. For 2012, our care coordinators will improve identification and outreach to these highest need members so that they can assure these members have increased access to essential services including a primary care physician, any specialty medical care they need, access to mental health and substance use services through BHRS, access to long-term services and supports (LTSS) and access to social services. Access to LTSS and social services is provided through ongoing linkages and coordination with San Mateo County's Aging and Adult Services (AAS). HPSM care coordinators work closely with this county department, which is responsible for Adult Protective Services, the Public Guardian, In-Home Supportive Services (IHSS), and Multipurpose Senior Services Program (MSSP). AAS staff representatives are regular team members on numerous Interdisciplinary Teams

(ICTs—see below) that support CareAdvantage patients and their physicians. They also are keenly aware of all county resources related to food, housing, in-home support, etc, that our members could need in the way of social services.

Example: Ms. Arlene Jason is a 49 year old CareAdvantage member with schizophrenia. Because of her illness, she often forgets to pick up her SSI check, pay her rent, and winds up homeless. She forgets her medications, becomes belligerent and paranoid, and then bounces between hospitalization and jail. (This occurred when she was on original Medicare.) During a previous hospitalization, the discharge planner suggested she sign up for CareAdvantage because she might get better care. She said if someone could help her stay on track, she'd do "almost anything." Her initial CareAdvantage comprehensive assessment identified her basic issues, and also her mental health counselor (MHC), who had kept with her for the past 8 years. Ms. Jason was identified as high risk, needing care coordination, and assigned a nurse case manager (NCM). The NCM connected with the MHC, who had the trust of Ms. Jason, and together they identified some important steps to help the member. These included getting a conservator for the member, who would be responsible for paying her bills; looking for a board and care residence for her, since she didn't seem safe living alone; finding a primary care physician, to ensure she had her regular medical needs cared for, since the MCH commented that it seemed like Ms. Jason had flares in her schizophrenia when she had an illness like an untreated urinary tract infection. Together, in discussion with Ms. Jason, these arrangements were made, she regained some structure in her life, which helped her stay on track with her medicines, and she has been stable in her community setting for the past 8 months.

2. Improving access to affordable care

HPSM is able to ensure that our CareAdvantage members have access to affordable care at all times because we are a dual eligible SNP. Thus, these patients do not need to worry that they will not be able to afford a co-pay or a large deductible in order to see a physician. That is covered by their Medicaid (Medi-Cal in California) "wrap-around" benefit.

Sometimes financing is not the barrier, however; access is. That is why HPSM has a robust Provider Services unit that works diligently to attract physicians of all specialties ranging from primary care to neurosurgery to become part of our CareAdvantage and Medi-Cal physician networks. As a dedicated non-profit organization, where the member is our first priority, HPSM also works to ensure that any Medicare Advantage rebate dollars we have are returned back to services for our members. Thus, when California's Medi-Cal program cut the optional vision and dental benefits for adult beneficiaries, those became our highest priority to provide for our CareAdvantage members as supplemental benefits. We recognized, and identified from surveys of our CareAdvantage members, that vision and dental services were two of the most highly desired benefits for members. Therefore, we provided these services at a reasonable cost so that our CareAdvantage members would have access to these key additional services, thus increasing their access to affordable dental and vision care. We also recognized that access includes being able to get to where

your care is located. Many of our older adult patients do not drive, and the public transportation system in San Mateo County is not as user friendly as it is in other more urban areas. Therefore, the other supplemental benefit HSPM sponsors is a taxicab transportation benefit, which is one of the most used benefits of our CareAdvantage population. We provide 50 one-way taxi rides per member per benefit year to use for any health-related transportation need. That is another way HPSM ensures access to affordable care.

Example: Mr. Jose Vasquez is a 70 year old CareAdvantage member with multiple medical problems. He has a number of specialty providers, for his heart, lungs and kidneys, whom he sees at Stanford, HPSM's tertiary care provider. Stanford is located in the northern part of Santa Clara County, but Mr. Vasquez lives in Daly City, which is in the northern part of San Mateo County, a distance of over 30 miles. Mr. Vasquez doesn't drive, and has no relatives to help him get to his appointments. He often missed appointments because he had to take buses and the connecting buses either were late, or canceled. He is weak, but because he doesn't use a wheelchair and has a bus stop right near his apartment building, he didn't qualify for Redi-Wheels. He was delighted when CareAdvantage added the transportation benefit—it was exactly what he needed. The taxi picks him up in his apartment driveway and drops him off right in front of the door to the office building where his doctor's appointment is. Then, it picks him back up there, and takes him home. He could never have afforded the taxi rides himself, but with the HPSM benefit, he is no longer worried about missing appointments.

3. Improving coordination of care through an identified point of contact (e.g., gatekeeper)

HPSM uses licensed personnel, including nurses and social workers, to serve as care coordinators for our highest risk CareAdvantage members. However, every CareAdvantage patient starts with a care coordinator who serves as the gatekeeper for their care. That person is their primary care physician (PCP). This is expected as part of the PCP's contract with HPSM, and as part of their training. As a dual eligible Special Needs Plan, CareAdvantage encourages every patient to choose a PCP. We have an excellent range of PCPs to choose from, many who are bilingual/bicultural, which aligns with the bilingual/bicultural heritage of our members. For example, in the North County area of our county, a majority of the CareAdvantage members residing there are Tagalog or Chinese speakers. Fortunately, almost every CareAdvantage PCP who practices in that area also speaks one or the other of these languages. In addition, they have staff who speak the other languages our members in that region speak (Russian and Spanish, as well as English). The PCP manages the patient's overall care, decides which specialist they need, and who to send them to, provides follow-up, and also generally determines when the patient might need hospitalization. For the local hospitals that have developed hospitalist programs, HPSM works with the PCPs to alert them when their patient has been hospitalized so that they aware when they need to follow-up, in case the hospital discharge summary does not get to them in a timely manner. However, for CareAdvantage members who need more than the PCP coordination, HPSM's care coordination unit is available. Our

care coordinators provide the intensive level of services, including regular contact with the member that is needed when the case management provided by the PCP is not sufficient to meet the needs of a complex, highest risk patient. For the latter patients, a specific care coordinator is assigned to them. This care coordinator assists them in such tasks as arranging multiple medical, behavioral health, and other appointments, particularly specialty care, ensuring that the information from each visit is made available to the PCP, assistance with home care needs, including equipment, home health, etc, medication management, referral to home and community based services, and other concerns that may arise in meeting the special clinical and psychosocial needs of the member.

Example: Ms. Henrietta Jacque is an 87 year old CareAdvantage member with diabetes, congestive heart failure and COPD, among other conditions. Her PCP, Dr. PC, has diligently tried to manage her care in the home, without much success, because of her frailty and clinical instability. He has been her identified point of contact for her for years, and has authorized clinical services, durable medical equipment, medication, etc that she has needed. Unfortunately, due to her instability, he needed help. For this reason, Ms. Jacque was referred to a special HPSM care management program called HUG (high utilizers group). As part of this program, she has an HPSM HUG nurse practitioner case manager, who is her point of contact for Ms. Jacque, Dr. PC, and other members of her interdisciplinary care team, to coordinate the care services she needs, be the person that any of the above will contact if a specific service need or question arises, and serve as the "go to" person for ensuring that Ms. Jacque can get the information, equipment and other services she needs to remain safely in her home.

4. Improving seamless transitions of care across healthcare settings, providers, and home and community based services

For the HPSM CareAdvantage program, we use two specific approaches to following members through care transition. One is applied more generally to patients at any hospital where nurse case managers perform on-site hospital stay reviews. This occurs at every hospital in San Mateo County where CareAdvantage members might be hospitalized. The other is focused at the safety net county hospital, San Mateo Medical Center (SMMC), as part of a pilot program which is now being studied with additional grant funding from the Gordon and Betty Moore Foundation (GBMF). The general care transitions program involves the on-site nurse case manager (NCM) connecting with the hospital discharge planner (DCP) for every CareAdvantage member as soon as they are noted to be hospitalized. The HPSM NCM works with the DCP to ensure that the patient is followed during the hospital stay, and that the patient's needs will be met once he/she is home after discharge. Any home health needs, durable medical equipment, change in medications, and so forth, are reviewed with the DCP and, where possible, with the patient/caregiver, prior to discharge. After discharge, the NCM calls the patient/caregiver to ensure everything was received appropriately, and things are in place to assist the patient as needed to recuperate post hospitalization, including a follow-up appointment with the PCP

or specialist as applicable. If the patient has not been discharged to home, but has gone to a long term care setting, the NCM notifies another HPSM program for follow-up. This is the Long Term Care Clinical Management Program (LTC-CMP). This program, which includes a geriatrician, two nurse practitioners and support staff, follows CareAdvantage patients in LTC with the aim of helping them return home, or, if the LTC is their home setting, keeping them stable clinically to help avoid return emergency department (ED) or hospital admissions. The LTC-CMP team works in concert with the patient's PCP so that any care plan changes are made in concert with the agreement of the PCP. The other Care Transitions program in place at HPSM, and which includes CareAdvantage members, is structured in the manner of Dr. Eric Coleman's model. HPSM has one nurse case manager serving as the coach, and any patients selected for participation at the pilot hospital of SMMC are recruited, introduced to the four pillars of the Coleman model, receive the intervention of the home visit and follow-up phone calls, and are thus empowered to take charge of their self care and health care management. As noted earlier, HPSM recently received a generous grant from GBMF to help us determine how to better implement this program successfully. As a result, we have increased the number of patients enrolled in this program by almost 300% over the past 4 months.

Example: Mr. William Bretan is a 56 year old CareAdvantage member with multiple sclerosis who is ready to be discharged from San Mateo Medical Center. He has been hospitalized for 3 days, due to weakness and possible systemic infection. HPSM's Care Transitions (CT) Nurse/Coach, Karen, has identified him as a suitable candidate for HPSM's CT program, developed with the guidance, and in the manner of Dr. Eric Coleman's model. Karen introduces herself to Mr. Bretan, explains what the program is, its purpose, what it involves, that it is a free benefit to CareAdvantage members, and that she thinks it would be a great, beneficial service to Mr. Bretan, so she hopes he is interested in participating. She shows him the attractive Personal Health Record (PHR) he receives as a member of the program. He readily agrees, and she signs him up, makes an appointment for the home visit they will have, gives him her card, and plans to see him in a few days. Karen calls Mr. Bretan to confirm the appointment and check in with him about how he is doing. She then goes out on the planned day for the appointment, reviews the four pillars of the CT model, checks with Mr. Bretan to see that her coaching is successful, encourages him to make a phone call to his PCP if he hasn't yet got one made, has him complete the relevant sections of the PHR, and so forth. She then plans her follow-up phone call. At the appropriate time, the f/up phone call is completed. If Mr. Bretan hasn't completed the satisfaction survey, he is reminded that it is important for HPSM to know how well we are doing, so please complete it. Any questions are answered. Then, the intervention is finished.

5. Improving access to preventive health services

By increasing access to affordable care, including to essential medical, vision and dental services, HPSM's CareAdvantage program is ensuring that our members are obtaining increased access to preventive services as well. In addition, we are emphasizing the

importance of these services to both providers and members in our outreach and educational materials so that members become more aware of the importance of these services and ask for them when they go to their doctor visits. HPSM believes in the public health model of prevention. We agree with the United States Surgeon General, Dr. Regina Benjamin, that our first emphasis should always be on primary prevention, keeping members healthy before a disease develops. For this reason, our member communications, such as our member newsletter, focus on ways members can stay healthy by being active, eating healthy foods, stopping smoking and so forth. In addition, we urge our CareAdvantage members to get their annual flu shot, get a pneumonia shot if they haven't had one, get a mammogram, etc.

We use birthday card reminders, posters, brochures and the like to get these messages across in as many different ways as possible. We include these same messages in our provider communications, such as newsletters, mailings, toolkits, etc, so that the providers and the plan can work as partners to improve our members' health status. We know, however, that the majority of our CareAdvantage members already have existing diseases, and the average member has four co-morbidities. So for that reason we move to secondary prevention, trying to control the existing disease so that it doesn't progress further. We again use outreach and include incentives to both providers and members to do so, in our aim to improve member health status. An example of this is our diabetes program. This is a key area since over 43% of our CareAdvantage patients have diabetes. For members, we produce a newsletter just on diabetes (called "Diabetes Matters") every 6 months, which is mailed to any member identified by claims data as having received a diagnosis of diabetes. This newsletter, written at an appropriate literacy level, educates members on the basics of diabetes, and includes tips for members on how to live and be healthy with this disease. In addition, our Pay for Performance (P4P) program for PCPs has a major focus on diabetes. This includes extra reimbursement for testing of hemoglobin A1c (HbA1c), low density lipoprotein-C (LDL-C), retinopathy screening, nephropathy screening, as well as for HbA1c results under 8% and LDL-C values under 100. We also reimburse for diabetes education classes at our local hospitals so that members can attend, as well as other related health classes (on nutrition, etc) as needed. For 2012, we plan to increase the level of information we return to our PCPs on diabetes so they can see where they rank in comparison to their peers in their specialty and at their hospital. We also intend to add a member incentive for participating in a diabetes education program. The last level of prevention is tertiary prevention. This is when complications of a disease have already occurred, so the purpose is to now try to minimize further complications. Using the diabetes example, this would be someone who is already manifesting kidney complications, but does not yet have end stage renal disease from their diabetes. In this case, we would want to be sure the patient gets any necessary education and support so that they know the special diet they need to protect the kidney function they have left. We would work with the PCP to ensure the patient received nephrology consultation as needed, and adequate medications for diabetes to assist with compliance. If this patient kept going in and out of the hospital, we would identify them as highest risk, and they would be assigned a care coordinator. We would also do this if the PCP requested

assistance in ensuring the patient attended appointments, took his/her medications, etc. Thus, at what ever level of preventive services a patient might find him/herself in need, HPSM's CareAdvantage program is prepared to assist in increasing access to these services.

Example: Ms. Rosario Mendoza is a 68 year old CareAdvantage member with diabetes. She has had a hysterectomy. As part of her annual contacts from HPSM, she gets a lovely-designed birthday card reminder encouraging her to get her annual mammogram. If she does so, and sends proof of this signed by her PCP, she will get a $15 gift card. She also gets the bi-annual "Diabetes Matters" newsletter, with articles and tips about lively a healthy lifestyle with diabetes, created just for HPSM's members with diabetes. This includes the list of any free classes about diabetes available to HPSM members. In 2012 we anticipate each member will also be getting a birthday card reminder (tied in with others they already get, where applicable) telling them what their current HbA1c and LDL-C are, and reminding them that these, along with eye, kidney and foot exams, need to be checked yearly.

In addition, Ms. Mendoza's PCP, Dr. LC, receives quarterly lists of all his HPSM members who have not had their yearly diabetes tests as yet, or for those who have, lists of those not yet meeting targets. This serves as Dr. LC's diabetes registry, so she can recall any patient who has not been seen, or who needs to be retested, in order to get their diabetes under control, and also earn HPSM's Pay for Performance (P4P) incentive for each of these goals.

6. Improving access to Home and Community-Based Services

   A critical component in reducing institutionalizations (whether in hospitals or long term care facilities) is the ability to obtain necessary supportive services in the community. HPSM ensures that the member will have improved access to Home and Community-Based Services by continuing to strengthen its long-standing collaboration with San Mateo County's Aging and Adult Services (AAS). AAS serves as the local Area Agency on Aging (AAA) and is also responsible for providing In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Meals on Wheels, congregate nutrition, transportation, and other Area Agency on Aging funded services.

   Community-Based Adult Services (CBAS) Centers also play an important role in assuring that those who are most vulnerable and at risk of being placed in a long-term care facility can remain in their community. HPSM led the local effort during the state-mandated transition from adult day health care (ADHC) centers to the CBAS program. This required close cooperation with the staff of the ADHCs as well as AAS. As both financial and eligibility responsibility shifts to the managed care plans in July 2012, HPSM will continue to work closely with the CBAS centers and AAS to assure ongoing access to these services.

7. Assuring appropriate utilization of services so as to assure cost-effective service delivery

A key component of any care management program is providing the right service at the right time to the right patient at the right level of care. The latter aspect determines that utilization must be appropriate. When working with tax dollars, the services rendered need to be scrutinized so that what is approved and paid for is what is medically appropriate, leaving remaining dollars for other members and their needed services. HPSM does this as part of its CareAdvantage program in multiple ways. First, there is a set of services that needs to be prior authorized. This includes any hospital stay with the exception of emergency hospitalizations; these are reviewed for authorization after the medically exigent issues are taken care of. Hospital stays are usually the single most costly item in a plan's budget. HPSM manages to cost efficiency by ensuring that there is exceptional utilization review so that only medically necessary acute inpatient hospitals stays are authorized.

Any questionable stays are reviewed by the Medical Director or Associate Medical Director for Health Services and Quality; both of these physicians were medical directors at a CMS-contracted Quality Improvement Organization (QIO) prior to joining HPSM. Thus, they are well-versed in the Medicare rules of observation, level of care determinations and appropriate utilization under Medicare. Other Part C services requiring prior authorization include surgical services of high cost/high variability including major organ transplants, bariatric surgery and genetic testing. HPSM of course follows all National Coverage Determinations or Local Coverage Determinations, as applicable. For areas that may have less precise directives, our medical directors confer with our local Medicare Contractor's Medical Director, other SNP medical directors, California's QIO, and so forth. Further, HPSM has numerous initiatives to reduce admissions or readmissions, such as our quality efforts in primary prevention, our Care Transitions coaching using the Coleman model, our LTC-CMP (all noted above), etc. Another significant component of utilization review is pharmacy, since ongoing cost increases impact Part D expenses. HPSM's CareAdvantage program has experienced pharmacists who, working with our Pharmacy and Therapeutics committee, have established guidelines for approval of medications that are step-therapy or otherwise go beyond basic formulary guidelines. In addition, for non-formulary medications, clinical pharmacists, both at HPSM (for medical) and at BHRS (the mental health unit—for psychiatric medications) review all requests for medical necessity to determine if the requests substantiate the need to use a drug that is not on our formulary list.

Questionable issues are discussed with the medical directors prior to a final determination. In this way, HPSM has multiple levels of review prior to finalizing the utilization review. And, to ensure the beneficiary's rights, every denial can be appealed according to CMS guidelines.

Example: HPSM's on-site nurse, Sue, brings a chart in from Seton Hospital for review with HPSM's Associate Medical Director (AMD). The case involves an 80 year old CareAdvantage patient who presented to the emergency room with a severe headache. When two boluses

of IV pain medicine didn't help, the attending physician decided to admit the patient, with the diagnosis of rule out stroke. After two hours of IV fluids, the patient suddenly felt better, sat up and said he was ready to go home. His neurologic exam was completely normal at that time, his electrolytes were within normal limits, and further probing revealed that he had been fasting for a religious reason, which he had forgotten to mention because his head hurt so badly. He was discharged the same day as he was admitted, less than 24 hours after admission, but the hospital still asked for an acute inpatient admission. The AMD concurred with the on-site nurse that acute inpatient hospitalization was not medically justified and outpatient services only could be approved.

8. Improving beneficiary health outcomes (specify MAO selected health outcome measures) through reduced hospitalizations; reduced ED visits; improved self-management; improved mobility and functional status; improved quality of life

The overall result expected of the efforts that HPSM has invested into our CareAdvantage program is: improved health outcomes and health status for our CareAdvantage members. There are numerous ways to demonstrate these outcomes, but some of the key ways we want to see better outcomes manifested include: reduced hospitalizations for our CareAdvantage members who have been case managed by our care coordinators; reduced ED visits for the same group; improved HEDIS diabetes measurements for all of our CareAdvantage members as reported to NCQA for HEDIS 2012; and improved quality of life as reported on an assessment tools for our high risk members. The tools and data sets we will use to documents these improvements, and the specific measureable improvements expected, are outlined in detail in Factor B, below.

Example: The story of Ms. Donna Sanchez exemplifies all of the items identified in factor 7. Donna Sanchez is a 56 year old woman weighing more than 500 pounds, with complex medical conditions including heart failure, respiratory failure and recurrent skin ulcers. She was homebound due to her weight. Nursing facilities refused to accept her due to her weight. She could not care for herself and had no family support. She had many (more than 20) hospitalizations and visits to the Stanford emergency room over a six month period. She was extremely high risk because of her respiratory status in particular. She would get anxious, then short of breath, call 911, end up in the ER, and ultimately intubated and on a ventilator due to her rapid downward spiral as soon as her respiratory symptoms began. She had a primary care physician whose office was a few blocks away from Ms. Sanchez' home, so he would stop by to or from his office and make a home visit. However, this rapidly became untenable because Ms. Sanchez was quite needy, and his practice was quite busy.

HPSM assigned a nurse case manager (NCM) to Ms. Sanchez' case, and had multiple interdisciplinary team meetings about her situation. In brief, numerous services were put in place for the member, to help her health condition, social situation and quality of life improve; these then led to decreases in hospitalizations and ED visits, and a stabilization of her circumstances in her home, which further empowered the member to improve her self-

care and continued health improvement. These services included arranging for meals on wheels (with a weight reducing diet); home health services; and enrolling the member in HPSM's in-home visiting physician program. The NCM also helped the patient obtain in-home mental health counseling; worked with a local community church for volunteers to provide home visits for socialization and check-ins; and obtained medical equipment for in home use, including a bariatric bed, scooter, and lift chair.

These measures led to an increase in Ms. Sanchez' physical mobility and weight loss, which enabled her to be able to take Redi-Wheels to attend community activities and keep her appointments with specialist physicians. Hospitalizations and visits to the ER have been dramatically reduced, and Ms. Sanchez' self-confidence, self-worth and sense of empowerment over her health have improved immeasurably.

b. Describe the goals as measurable outcomes and indicate how MAO will know when goals are met

In choosing our measurable outcomes, HPSM studied our CareAdvantage population, and considered where we should choose goals that would have an important impact and that would also be realistic to meet over the next 6 and 12 month period. Further, we wanted to focus on where consistent data could be pulled, so that comparable information could be collected over the time periods to be reviewed. The following data measures were identified. Each measure is described below, including how we will know when the measure has been met:

1. By June 30, 2012, hospitalizations for our CareAdvantage members who have been case managed by our care coordinators will be reduced by 15%; and by December 31, 2012, hospitalizations for this group will have been reduced over the year by 30%. Reduction (from 2011) will be compared to the entire CareAdvantage patient population.

    i) HPSM will know that these results have been achieved by taking the list of all members case managed by care coordinators for the first 6 months of the year, and looking at the whole list by the end of the year. For each analysis, claims data will be matched by ID number for these patients, to look for any acute inpatient hospital stays during each of the time periods in question. The reduction in hospital stays for both time periods in 2012 will be compared to the number of hospital stays each patient had in comparable time periods in 2012, (prior to being case managed by HPSM's care coordinators). These results will be compared to a similar analysis for the entire CareAdvantage patient population (to control for regression to the mean).
    ii) HPSM has two data points for analysis because if we are not near the midpoint goal by June, some root cause analysis can be started, so that we don't end up surprised in December that we are way off the mark.

How this goal relates to the 8 bullet points in Factor A:

(a) Access to essential services—Although not explicit, this goal is intimately tied with access to essential care as follows: for patients such as our CareAdvantage members, with ongoing medical, mental health and social service needs that have to be controlled in order to prevent hospital stays, any reduction in preventable hospitalizations will only be able to occur if our members have ready access to these essential sources of care. For example, if a patient develops worsening symptoms of congestive heart failure, and cannot get access into his primary care provider's office for a follow-up visit, his condition will only worsen until the only care suitable to control his symptoms will be at the acute level of care in a hospital setting. Conversely, if, using our care coordinators, we are able to demonstrate a reduction in hospitalizations over 6 and 12 month periods, this indicates that outpatient care services have been adequately accessible, leading to prevention of avoidable hospital stays.

(b) Access to affordable care—this is another implicit component of our goal. If outpatient services, or means to access outpatient services is not affordable, this system will fall apart, leading to higher level of care services as the ones that end up being used. However, if we are able to reduce hospitalizations, then this supports that we are providing affordable care that patients can access and utilize. For example, if a mental health patient stops taking her psychotropic medication (e.g., Zyprexa) because they can't afford it/the co-pay, etc, then the next thing one can expect is worsening psychiatric symptoms until the patient ends up either hospitalized or in jail. In contrast, by ensuring patients are categorized correctly, they are classified to get their LICS (low income subsidy) for Part D accurately, etc, this will ensure a better health outcome, and in turn prevention of avoidable hospital stays.

(c) Coordination of Care—our goal of reducing hospital stays is specifically tied to the member having a nurse case manager (NCM). This is because we hypothesize, and numerous publications in the medical literature support, that providing personalized case management for a patient, to address their medical, mental health, and social service needs, is critical to prevent avoidable hospital stays and keep them stable in their homes in the community. Each case managed patient during 2012 is one who will become part of our "case" group in which we expect to see a decrease in avoidable hospital stays.

(d) Seamless transitions of care—we have seen that numerous hospitalizations among our CareAdvantage population occur as re-hospitalizations. That is why we have implemented a Care Transitions program. In addition, our NCMs are targeting their hospitalized patients in particular for extra support to help prevent re-hospitalizations, by ensuring that anything that might be necessary to stabilize the patient in their home is available upon patient discharge from the hospital. Thus, we are tying seamless transitions of care

with care coordination, and when both of these function well together, our goal of reduced hospitalizations should be achieved.

(e) Access to preventive services—one of the main tasks of our NCMs is to reconnect their case managed members to their PCPs. This ties back to "a' above, also, since access to acute and follow-up care is a requisite for reducing hospitalizations. Further, access to a PCP who will follow a patient for preventive services is key to reducing hospitalizations and thus is implicit in this goal, as well. This is because for members like ours, where 43% have diabetes, managing a patient's diabetes with regular testing, follow-up of medications, and so forth, are important steps to prevent hospitalization due to the complications of diabetes. In addition, pneumonia is a common reason for hospitalization among our members. Thus, annual flu shots, and ensuring that all members get a pneumococcal immunization, are also significant preventive efforts to reduce avoidable hospitalizations.

(f) Access to Home and Community-Based Services— increased access to HCBS can have a positive effect on decreasing hospital admissions. Monitoring of chronic conditions through an IHSS provider or a CBAS center can allow for early identification (and therefore early intervention) of a potential problem which, left untreated, would result in the need for hospitalization.

(g) Appropriate utilization—this goal is intrinsically a utilization measure; reducing avoidable hospitalizations is inextricably linked to ensuring any authorized hospitalization is a medically necessary one.

(h) Improving beneficiary health outcomes—if our goal of reducing hospitalizations is achieved, and patients can be maintained safely and more healthily in the community, rather than becoming so ill they need to be hospitalized in the acute care setting, we will have achieved a major triumph in improved health outcomes for our CareAdvantage members.

2. By June 30, 2012, ED visits for our CareAdvantage members who have been case managed by our care coordinators will be reduced by 10%; and by December 31, 2012, ED visits for this group will have been reduced over the year by 20%. Reduction (from 2011) will be compared to the entire CareAdvantage patient population.

   i) HPSM will know that these results have been achieved by taking the list of all members case managed by care coordinators for the first 6 months of the year, and looking at the whole list by the end of the year. For each analysis, claims data will be matched by ID number for these patients, to look for any ED visits during each of the time periods in question. The reduction in ED visits for both time periods in 2012 will be compared to the number of ED visits each patient had in comparable time periods in 2012, (prior to being case managed by HPSM's care coordinators). These results will be compared to a similar analysis for the entire CareAdvantage patient population (to control for regression to the mean).

ii) HPSM has two data points for analysis because if we are not near the midpoint goal by June, some root cause analysis can be started, so that we don't end up surprised in December that we are way off the mark.

How this goal relates to the 8 bullet points in Factor A:

(a) Access to essential services—Although not explicit, this goal is intimately tied with access to essential care as follows: for patients such as our CareAdvantage members, with ongoing medical, mental health and social service needs that have to be controlled in order to ED visits, any reduction in preventable ED visits will only be able to occur if our members have ready access to these essential sources of care. For example, if a patient develops worsening symptoms of COPD, and cannot get access into her primary care provider's office for a follow-up visit, her condition will only worsen until the only care suitable to control her symptoms will be initiated in the ER. Conversely, if, using our care coordinators, we are able to demonstrate a reduction in ED visits over 6 and 12 month periods, this indicates that outpatient care services have been adequately accessible, leading to prevention of avoidable ED visits.

(b) Access to affordable care—this is another implicit component of our goal. If outpatient services, or means to access outpatient services is not affordable, this system will fall apart, leading to higher level of care services as the ones that end up being used. However, if we are able to reduce ED visits, then this supports that we are providing affordable care that patients can access and utilize. For example, if a mental health patient stops taking his psychotropic medication (e.g., Abilify) because they can't afford it/the co-pay, etc, then the next thing one can expect is worsening psychiatric symptoms until the patient ends up either hospitalized or in jail. In contrast, by ensuring patients are categorized correctly, they are classified to get their LICS (low income subsidy) for Part D accurately, etc, this will ensure a better health outcome, and in turn prevention of avoidable ED visits.

(c) Coordination of Care—our goal of reducing ED visits is specifically tied to the member having a nurse case manager (NCM). This is because we hypothesize, and numerous publications in the medical literature support, that providing personalized case management for a patient, to address their medical, mental health, and social service needs, is critical to prevent avoidable ED visits and keep them stable in their homes in the community. Each case managed patient during 2012 is one who will become part of our "case" group in which we expect to see a decrease in avoidable ED visits.

(d) Seamless transitions of care—often, ED visits among our CareAdvantage population occur after a patient has just been discharged from the hospital. That is why we have implemented a Care Transitions program. In addition, our NCMs are targeting their recently-hospitalized patients in particular for extra support to help prevent rapidly recurring ED visits, by ensuring that

anything that might be necessary to stabilize the patient in their home is available upon patient discharge from the hospital. Thus, we are tying seamless transitions of care with care coordination, and when both of these function well together, our goal of reduced ED visits should be achieved.

(e) Access to preventive services—one of the main tasks of our NCMs is to reconnect their case managed members to their PCPs. This ties back to "a' above, also, since access to acute and follow-up care is a requisite for reducing ED visits. Further, access to a PCP who will follow a patient for preventive services is key to reducing ED visits and thus is implicit in this goal, as well. This is because for members like ours, where 43% have diabetes, managing a patient's diabetes with regular testing, follow-up of medications, and so forth, are important steps to prevent ED visits due to the complications of diabetes. In addition, pneumonia is a common reason for ED visits among our members. Thus, annual flu shots, and ensuring that all members get a pneumococcal immunization, are also significant preventive efforts to reduce avoidable ED visits.

(f) Access to Home and Community-Based Services — increased access to HCBS can have a positive effect on decreasing ED visits. Monitoring of chronic conditions through an IHSS provider or a CBAS center can allow for early identification (and therefore early intervention) of a potential problem which, untreated would result in the need for ED visit.

(g) Appropriate utilization—this goal is intrinsically a utilization measure; reducing avoidable ED visits is directly linked to ensuring any authorized ED visit is a medically necessary one at the appropriate billing level.

(h) Improving beneficiary health outcomes—if our goal of reducing ED visits is achieved, and patients can be maintained safely and more healthily in the community, rather than becoming ill enough that they need to go to the ED, we will have achieved a notable triumph in improved health outcomes for our CareAdvantage members.

3. In 2013, the CareAdvantage HEDIS scores for the diabetes measures that are part of the HPSM Pay for Performance program (HbA1c testing, HbA1c <8%, LDL-C testing, LDL-C < 100, Retinal eye exam, Attn for nephropathy) will each increase by 2%.

   i) Since HEDIS results measure the previous year, the 2012 year looks at 2011 data; thus, the 2013 year will look at 2012, where our current and planned interventions will take place, and will reflect the impact of 2012 programs.

   ii) HPSM will participate, as is required of a Medicare Advantage plan and a SNP, in the annual NCQA HEDIS data collection process in winter and spring 2012.

   We will collect all the designated measures as noted above, using the hybrid technique, since none of these measures is an administrative-only measure. We will submit our data to our certified auditor via the approved IDSS system, as is the

usual requirement, in a timely fashion. Our auditor will finalize the submission to NCQA, as is the normal procedure.

iii) NCQA will release our audited results in late summer, and we will determine our results.

iv) HPSM will know that the goals are met when we analyze our HEDIS results from NCQA. We will compare our 2013 results for these six diabetes measures to our 2012 results, and determine if each measure increased by 2%.

How this goal relates to the 8 bullet points in Factor A:

(a) Access to essential services—as in earlier goals, the link here is implicit; however, in order to achieve the HEDIS diabetes measures improvements that we have targeted, it is crucial that our CareAdvantage members have access to the essential services of medical, mental health and social services. Without a primary care provider (PCP) managing their care, ordering their diabetes testing, prescribing medications as necessary, guiding them on a healthy diet and exercise program, etc, there is no possibility that our members' HEDIS scores will reach high performance target levels. Further, numerous studies in the medical literature have documented that a patient's mental health greatly affects their physical well-being; thus, for our members with depression, no matter how well a physician is recommending care, their adherence to a treatment regimen will be below expectations unless the depression is treated. In addition, without social service support as needed to assist with the home environment where possible, food stamps, in home support, etc, our members will not be able to self-manage their diabetes adequately, either. Thus, all these aspects directly impact our HEDIS results, and need to be provided so that we can address these outcomes.

(b) Access to affordable care—.Similar to essential services, care needs to be affordable too. As outlined in 2a, transportation services, assistance as needed with medications, etc, are key here so that a member can get the ongoing continuity of care needed, including to see specialists the PCP might refer to. This can become a key piece of achieving proper control of the patient's diabetes.

(c) Coordination of Care—Many of our members with diabetes will receive case management services from our Care Coordination unit; as described above, these will be important services to link the patient with their PCP, ensure they know which lab to use for testing, are aware of where nearby diabetes classes are, get the equipment (including glucometers) they need to self-manage their condition, etc. However, others will not need NCM; for those, the PCP will be the key care coordinator, along with HPSM health educators, who will provide useful educational resources, in the appropriate language

and at an appropriate literacy level, for members looking for ways to live healthy with diabetes.

(d) Seamless transitions of care—a number of our Care Transitions members are patients with diabetes; these patients are often at a good point re: willingness to participate and be open about the Coleman model/four pillars and self-empowerment after a hospitalization. Our CT coach works successfully with these patients in particular, since there are many concrete issues that can be reviewed re: self-management.

(e) Access to preventive services—this goal is tied closely to preventive services since a number of the HEDIS measures are preventive care-related. Ongoing outreach with both the PCP and the member are included in the steps we plan to increase our HEDIS diabetes measures outcomes; some are primary prevention—related to care all CareAdvantage members need, such as annual flu shots, but many others are secondary prevention, including checking eyes and kidneys, along with the diabetes lab testing of HbA1c and LDL-C, since all of these tests aim to keep complications for diabetes from developing.

(f) Access to Home and Community-Based Services — Monitoring of chronic conditions such as diabetes through an IHSS provider or a CBAS center can have positive results. Without utilizing social service supports as needed to assist with the home environment where possible, food stamps, in home support, etc, our members will not be able to self-manage their diabetes adequately.

(g) Appropriate utilization—for this goal, a lot of the utilization focus is to avoid underutilization. We will be encouraging members and PCPs to get evidence-based-guideline-recommended testing done at least annually. However, if there are indications of some providers over-utilizing resources, or utilizing brand name medications when generics will do (we see this often after a drug rep has made the rounds of our providers), then we will focus closely on that form of overutilization.

(h) Improving beneficiary health outcomes—since diabetes is so common among our members, and we see so much morbidity and mortality as a result, our focus is on HEDIS measures that are associated with improved health and function. We also target early intervention (primary and secondary prevention) so that the end result is firstly, improved beneficiary health outcomes, which then will lead to increased HEDIS measures.

4. Our fourth measurable goal for our model of care is that CareAdvantage members who receive HPSM care coordination services will demonstrate that for at least 25% of members, quality of life will be the same or better, as documented on one of the assessment tools they respond to over the course of the subsequent year (e.g. if the intervention starts on January 1, 2012, the improvement will be documented by December31, 2012).

i) HPSM does comprehensive assessments and high risk assessments (HRAs) of potentially highest risk members, and those who are determined to be in greatest need because they are indeed highest risk, become case managed and are assigned to a care coordinator for intensive services. For those who receive such services, it is expected that this will help stabilize their quality of life because unmet needs will now be met, frustration with the complex medical care system will be eased due to the assistance of the care coordinator, etc. However, it is understood that, at the same time, the aging process, combined with the multiple co-morbidities of these highest risk members who receive care coordination, will work at detracting the quality of life of the member. Their diseases may progress, particularly if at an end stage, new complications may arise, etc. Therefore, we expect that, at least for 25% of these highest risk members, given all the above, quality of life will be maintained or improved, over the year following the start of the care coordination intervention.

ii) We expect that these results will occur as compared to the same time period (e.g. one year) prior to their service intervention. These results will be compared to a similar analysis for a stratified sample of other CareAdvantage patients with comparable clinical findings if possible, since we are looking at the highest risk members; for information about the way the entire CareAdvantage population is changing in this aspect, a general analysis may be done as well.

iii) We will know that we have achieved these results because we will look for the annual HRA results of any case managed member (reported to us by our vendor), to use as a comparison for pre-post services analysis. If the baseline results are a comprehensive assessment, we will repeat that tool via phone call to the member (by a neutral party) 12 months after the start of their case management services. If information from CMS' Health Outcomes Survey is available for a specific member, that will be utilized. If, by chance, a selected patient has more than one assessment tool completed over the time period in question, a composite score will be calculated and used for the comparison.

iv) The results of the pre-post assessment tools will be entered into an appropriate database and used by our informatics team to compare results to see if our goal was achieved.

v) Because we anticipate that sense of quality of life, as a subjective emotional perception, is likely to change more slowly than something objective such as hospitalizations or ED visits, we are only planning to measure this goal after the one year mark, to start.

How this goal relates to the 8 bullet points in Factor A:

(a) Access to essential services—we believe that having access to essential services is necessary for improved quality of life. A member who is struggling to find a PCP who will care for him/her, be there when he/she is sick, be someone he/she can develop a long-term relationship with is not someone who will consider his/her health a positive or high quality part of his/her life. The same goes for someone suffering from mental illness, or living with developmental disabilities and unable to get the care they need/deserve. Similarly, if a member is in dire poverty, and cannot access the basic necessities of life, with no place to turn, life is of poor quality as well. Thus, in order for this goal to be met, there must be adequate to good access to essential services.

(b) Access to affordable care—as noted above, one's quality of life will not be good if one cannot get the care they need. Thus, providing services as described in 2a, including taxi rides, social service supports, linkages that assist in making care affordable, and reaching out to members ahead of time, or as soon as we identify that they are in need of help, are key to achieving our goal of improved quality of life.

(c) Coordination of Care—as in the earlier-mentioned goals, this goal is also intrinsically wrapped up with care coordination activities—the intervention of a nurse case manager (NCM) in providing care coordination for a member, to help ensure access, for example, is a key way a member will realize an increase in his/her quality of life.

(d) Seamless transitions of care—as part of care coordination activities, the NCM will work to help ensure a smooth transition from a hospital stay to back home, and that the member is regularly reconnected with his/her PCP. Sometimes the only entity that knows about member transitions is the plan, since the PCP does not follow the patient in the hospital (due to hospitalists), and often the PCP is not even contacted about the patient's hospital stay until the patient makes a follow-up appointment. However, the NCM is a key to alerting the PCP about these transitions so that medication reconciliation can take place, prompt follow-up appointments can be made, and so forth. These activities all contribute to improved quality of care, and quality of life for the member.

(e) Access to preventive services—this is also implicit in a quality of life goal. If a disease that can sicken you, and perhaps kill you, is prevented by a shot, or lab tests, medication and follow-up, that is a much easier trajectory than having to fight the actual disease. One of the NCM's roles is to follow-up on preventive services, working in concert with HPSM's health educators, on projects that are the focus of quality initiatives. The NCM can also request additional health education information for a specific member about a particular condition. By ensuring preventive services are offered and encouraged, and that the member can avail him/herself of them, the NCM is a critical piece in the work of meeting this goal of improved quality of life.

(f) Access to Home and Community-Based Services—For many, a major component impacting their quality of life is being able to stay in their home and community for as long as possible as they age or have a disabling condition. HCBS from in-home supportive services and meals on wheels to CBAS centers are vital to making this possible.

(g) Appropriate utilization—keeping someone in the hospital when they don't need to be there, or sending them to the ED when it's not necessary do not contribute to improved quality of life. Equally, not having outpatient services or necessary preventive care available, or not diagnosing depression appropriately do not lead to better quality of life either. Thus, appropriate utilization is a key factor leading to increase in quality of life, which is our goal.

(h) Improving beneficiary health outcomes—if we can achieve an improvement in our beneficiaries' perspective and perception in their quality of life, as we hope to do, this will undoubtedly be due to improving their health outcomes. Preventing avoidable hospitalizations or ED visits, improving their health status for chronic diseases, ensuring their ongoing access to a PCP, all of these efforts ultimately will lead to improved health outcomes. This is our overall goal, and what we expect to achieve by providing case management services to our CareAdvantage members.

c. Discuss actions MAO will take if goals are not met in the expected time frame

For each of the four measurable goals listed above, HPSM will review and do a root cause analysis if the expected results are not achieved in the timeframe outlined. HPSM follows the Deming model for improvement, promulgated by the Institute for Healthcare Improvement. This model encourages one to (1) identify the barriers that impeded the ability to meet the objective, (2) determine strategies for overcoming the barriers; (3) establish a work plan for implementing the strategies, including specific action items and timelines and (4) implement the work plan. The following provides some examples of actions that we will take, in concurrence with this model, if each goal is not met in the timeframes outlined above:

1. What if hospitalizations are not reduced by 15% by June 30, 2012, or 30% by December 31, 2012?

   i) The first step HPSM will take in the root cause analysis (RCA) is to see if there has been some problem with data collection. Did we get all the members? All the hospitals? Were the numbers unexpectedly small or large? Did something skew the data unexpectedly (like another H1N1 epidemic)? Did one or two members impact the data adversely? If so, what happens if we remove just those few members? These are the kinds of analysis we will do to see if the data is the issue.

   ii) Next, was there an issue with the intervention? Was there a staffing issue during the large part of the intervention period? Loss of staff? New or less trained staff?

And so on. Were there problems with the intensity of intervention vs. intensity of need? Were the frailest members needing services, and even though services of high quality were rendered, was there nothing that could be done to prevent many of the hospitalizations? This piece would be done with medical director input, sampling of chart reviews, staff interviews, etc., particularly with the on-site staff.

iii) Was there some improvement, but only in a certain group of patients? Were patients of a certain PCP, or at a certain hospital, or from LTC, etc, the outlier in hospitalization? These subsets would be looked for as part of the analysis. Then, perhaps a separate intervention might need to be developed to target a specific group beyond the general group initially identified.

iv) Was the initial goal realistic? Were we too ambitious with our highest risk members, in thinking they could be stabilized as outpatients considering their co-morbidities, or did we miss something that needed to have an intervention first, etc?

v) These would be the type of steps we would take as a team in performing a RCA of the problem if the goal to reduce hospitalizations is not met in the expected time frame.

Example: Our Senior Health Statistician reports to us on July 31, 2012, that she has collected and analyzed all the data for the first 6 months of our case management program, and compared the 400 members who were in the program, with the 8000 members not case managed. Unfortunately, hospital stays were only reduced by 10% so far, not 15% vs. the entire CareAdvantage group.

The Medical Management team would gather together to analyze the data, looking at both the individual patient data, and the collective data. In our root cause analysis (RCA) effort, we note that the rate of admission of the case managed members is not as different as we would hope vs. the entire group. Looking at the individual data, we noticed a number of points:

- Four of the case managed patients had more than 3 hospital stays in the six months under review; one had five hospital stays.
  - We noticed that this latter patient was being case managed by one of the best, most experienced NCMs. This seemed very curious. The Director of Health and Provider Services said she would find out more details about the case.
  - One of the four patients had a hospital stay that appeared to involve two readmissions in a short period of time. The Medical Director said she would follow up on that case.
  - The other two cases were managed by one case manager. The Director of Health and Provider Services groaned when she saw that NCM's initials. She was a new hire who had been assigned those two members as her only two "high risk" patients. This NCM had come with good references, but immediately had flaked out—taking days off without calling in, then having a flimsy excuse. But because the director had one NCM off on disability and another on maternity leave, she felt

she was stuck until that NCM had finally just not shown up for three days. At that point, she was terminated (this had been just last week). These two high risk patients were now being case managed by a more veteran NCM, so hopefully things would be in control and their needs would be better met.

- There didn't seem to be any other pattern or abnormality in the rest of the data.
- The group agreed to meet after the other two cases were examined.

At the next Medical Management meeting, both the Director of Health and Provider Services had interesting information to report:

- Regarding the case of the patient hospitalized five times, the director had found out the following:
    - o This patient was 79 years old, had severe advanced liver disease and accumulation of abdominal fluid. The problem was, when the fluid was tapped, she was awake and alert, conversed normally, and was of completely sound mind. She knew the president, the date, could even tell you what her husband had had for breakfast. However, when the fluid re-accumulated, she became somnolent, short of breath, had a rapid heart rate and was at risk for cardiac and pulmonary failure. Her family just didn't know what to do. They couldn't agree to hospice because they couldn't believe she was ready to die when she was so alert on many days. Due to the rapidity of her decline with the fluid accumulation, no skilled nursing facility would take her because they would immediately send her back to the hospital as soon as her symptoms developed. So the family took her home, kept her until her fluid reappeared, and then brought her back to the hospital where she would get tapped, given fresh frozen plasma to stabilize her, and wake up again. Sadly, the last episode also led to spontaneous bacterial peritonitis, which spread systemically. When it seemed likely that she would have to be intubated, her family all said she had told them repeatedly, she never wanted that, so she expired in the hospital during the fifth admission. According to the NCM, although end of life and POLST information had been offered, the family didn't want to address any of that until the final deterioration. The patient just deferred to her family. The PCP and the liver specialist had tried multiple medications without success, and the surgeon had declined any drainage tube placement due to the risk of infection. The group agreed that there didn't seem to have been anything else the NCM could have done.
- The Medical Director's case, involving what appeared to be multiple readmissions was found to include the following:
    - o The patient was a 45 year old patient with Down Syndrome who lived in a intermediate care facility for the developmentally disabled (DD). He was in relatively good health, except for his DD and occasional seizures, until the initial admission, when he started coughing, choking and turning blue. 911 was called, and someone in the home started suctioning him a little till the ambulance arrived. Once brought to the ER, he was intubated because he couldn't maintain his oxygen saturation. He was given IV antibiotics, IV fluids, and finally improved. On the day he was ready to go home, he was given some food, noticed to choke a bit,

but nothing was made of it, until he got home, and after only 2 hours, started to have the same type of episode. So again, 911 was called, he was back in the ER, and again needed to be intubated. Apparently no one had charted the choking episode after eating, so only reflux was considered, and he was started on medication, but no one did a swallowing check, etc. When he was again ready to go home, and had already been discharged, he was waiting with a nursing student, and someone brought his lunch tray. That's when she (the student) noticed him choking after eating, but this time, his episode occurred outside while waiting for the van to pick him up and take him home. He was brought back into the ER, given oxygen immediately, and readmitted for further work-up of aspiration pneumonia. Luckily the last episode didn't lead to intubation. But this series of admissions clearly involved a problem in quality of care; it was agreed this would be brought to the attention of the hospital. In addition, it didn't appear appropriate to have all these hospitalizations be billed as individual DRGs, so that would also be addressed with the hospital (which would change the data somewhat).

- After this change, the numbers would be re-run. It was also decided that instead of waiting till December for the next analysis, we would ask our Senior Health Statistician to run the numbers in September as well, to see if we were making any headway.

2. What if ED visits are not reduced by 10% by June 30, 2012, or 20% by December31, 2012?

   i) The first step HPSM will take in the root cause analysis (RCA) is to see if there has been some problem with data collection. Did we get all the members? All the EDs? Were the numbers unexpectedly small or large? Did something skew the data unexpectedly (like another flu epidemic)? Did one or two members impact the data adversely by having a large number of ED visits? If so, what happens if we remove just those few members? These are the kinds of analysis we will do to see if the data is the issue.

   ii) Next, was there an issue with the intervention? Was there a staffing issue during the major part of the intervention period? Loss of staff? New or less trained staff? And so on. Were there problems with the intensity of intervention vs. intensity of need? Were the frailest members needing services, and even though services of high quality were rendered, was there nothing that could be done to prevent many of the ED visits? Were the symptoms the patients developed of such severity that they would be sent to the ED by any reasonable clinician or lay person? This piece of analysis would be done with medical director input, sampling of chart reviews, staff interviews, etc., particularly with the on-site NCM staff.

   iii) Was there some improvement, but only in a certain group of patients? Were patients of a certain PCP, or from LTC, etc, the outlier here? E.g. were patients of one PCP always being sent to the ED vs. seen in the office? These subsets would be

looked for as part of the analysis. Then, perhaps a separate intervention might need to be developed to target a specific group beyond the general group initially identified.

iv) Was the initial goal realistic? Were we too ambitious with our highest risk members, in thinking they could be stabilized as outpatients considering their co-morbidities, or did we miss something that needed to have an intervention first, etc?

v) These would be the type of steps we would take as a team in performing a RCA of the problem if the goal to reduce ED visits is not met in the expected time frame

Example: the ED visit issue is similar in format to the hospitalization issue discussed in the example of Goal 1. This would also be handled by having the Senior Health Biostatistician bring the results of her claims analysis to the Medical Management meeting. If she found that ED visits were only reduced by 15%, rather than 20%, by June 30, 2012, then we would pursue the root cause analysis in a similar fashion to what was done in the example in Goal 1. Then, ED visits are 5 levels; they can divide into two different questions—was the ED visit an emergency (with many experts considering ED visit levels 1 to 4 as outpatient clinic levels and only level 5, or even only those ED visits leading to an admission as true emergencies) or not as well as was the ED visit preventable. Further, while hospital stays are numerous, ED visits are much higher in number, so analysis of individual data is more of a challenge. Nevertheless, our Medical Management team would look at patterns, seeing if any individual case managed members had multiple ED visits, their diagnoses, etc; we would check to see who the NCM was for any specific outlier cases; see if there was an access issue for particular PCPs, and so forth. In addition, we would plan to check our data more frequently (e.g. quarterly) if we did not meet our initial target goals.

3. What if our 2013 HEDIS scores for the six diabetes measures reflected in our P4P program do not improve by 2% as expected?

   i) If our 2013 HEDIS scores do not improve as expected, each one will be examined to see which did not meet the 2% improvement mark. A root cause analysis will be done for each one, but this is not quite as helpful as in other goals, since each is a hybrid measure, and contains only 411 members per item. Some will overlap with the same members; some will not.

   ii) Because of the small number of members in each hybrid measure, it is difficult to make a case for each PCP re: how well he or she did on a particular HEDIS measure, especially if he/she is in a smaller practice, since having 2 or 3 members chosen doesn't make much of a pattern necessarily. Therefore, although we can prepare provider HEDIS report cards with the HEDIS data, with the assistance of our HEDIS vendor, this may not be as helpful to the provider as we would like.

iii) For this reason, we are developing, and plan to roll out soon (when the vendor is ready), comparison reports for our P4P providers on all of these diabetes measures, comparing the provider's results for all of his/her HPSM patients on all six measures to colleagues in their specialty, and the hospital at which they attend. For our CareAdvantage HEDIS measure goal's analysis and follow-up, we will pull out just their Medicare members, and see how they did. This can provide the PCP with a more realistic picture of how many of their CareAdvantage members are getting their annual recommended tests, and even more importantly, how many are meeting goals for HbA1c and LDL-C.

iv) For PCPs who are not performing well, we will focus our outreach to assist them in recalling their members to, at a minimum, get their annual tests. We will also intensify member outreach so that members who may be less compliant with PCP recommendations for testing and medication or diet will be encouraged with reminders and incentives to attend classes, get their lab work, pick up their medications and so forth.

v) By following the lab results that we have access to, we can monitor our success monthly. This may not be exactly equivalent to HEDIS, as it is not a random sample, but it will give us a picture of how the plan is doing overall with our CareAdvantage members and their diabetes testing parameters. Then we can continue to intervene in specific areas if we repeatedly find we are not improving as we expect.

4. What if our follow-up assessments show that our members' quality of life is not improved by 25% one year after the intervention?

Example: We follow our HEDIS measures carefully, and intend to increase by 2% for each of our measures. Here is an example of what we will do if we don't increase 2% for the HbA1c screening for our CareAdvantage members.

- We will get this result as soon as we turn in our final numbers from our vendor. It will then be validated by our auditor and submitted to NCQA. We will know then if we have increased by 2% from our previous year.
- If we have not, we will begin our root cause analysis. First of all, how well did our administrative data provide results for this measure? Where were we weak? We are now getting lab data from almost all of our hospital-based labs. But there are a couple that still not on board. There area (e.g. South County for one of the key labs) would have needed to be covered by a hybrid sample. Did we have a lot of charts where the results were not found in that area? Was that because the charts could not be found, or the patient was never tested? Are there particular doctors or clinics that stand out? In the South County, we have a three safety-net clinics as our key providers. Did they lag on getting their patients in for testing? If that was the case, do we need to outreach further with our Pay for Performance diabetes program to

them? Do we need to outreach with our private lab partner, that has lab sites very near their clinics? What about our private providers? Same story?

- Were there certain groups of members who consistently were missing their HbA1c testing? For example, did our South County Hispanic members have a low testing rate? If so, then we will need to emphasize outreach to them as part of our diabetes quality project. We have our "Diabetes Matters" newsletter translated into Spanish, but are they getting it or is there a problem with outdated addresses?
- These are examples of the specific steps we will take to diagnose the problem, and identify possible solutions, if a HEDIS measure result does not meet our target.

i) Of all of the goals we are measuring for our Model of Care, this one is perhaps the most tenuous, since it is the most subjective. However, because our model of care is for our patients, and its heart is to serve the patients, improvement of patient quality of life is a significant concern that we want to demonstrate.

ii) Throughout our interaction with patients and their caregivers, we expect our care coordinators to check in with members, to ensure the members' needs are being met, that all questions are being answered, and that the services the care coordinators are providing are being rendered in a culturally and linguistically sensitive way. Nevertheless, as noted above, we recognize that while these services may be of help, many other factors contribute to a patient's sense of quality of life. A RCA of this measure, if results demonstrate that quality of life is not maintained or improving for at least 25% of the intervened group, as expected, would need to look at an array of the above factors.

iii) A key factor in the analysis of this measure, if it does not reach the expected goal, will be to see if there are subgroups that meet what we expected. Does the outcome change by diagnosis? By hospitalization or other service usage? By PCP? And so forth.

iv) In addition, while overall quality of life may not be maintained or improved, we might also find that certain aspects of quality of life were met, and for which the intervention was directly responsible. These could be aspects such as reduction in stress about their diagnosis, or more peace about end of life issues, for example. Any of these findings would be informative and important to help tailor the intervention further.

Example: We realize that this goal is the most qualitative of the four we have chosen. Yet, it is very important to us because we want to know that, to our members, when they are getting our care coordination services, we are making their lives better. However, if after one year, we are not demonstrating a 25% improvement in their quality of life from baseline, we basically want to know why. The tools we use have subsets of questions, and we will look to the analysis of those to see if there are some things in our program that are helping, or working, and others that may not be.

Perhaps our members are happier about their functional status, but not overall. That, in itself, is something noteworthy, just not where we want to go all the way. It would, however, provide us with a start in the direction of improvement, and then might give us ideas about where else we can improve.

We would want to look at the individual data in this measure, to see who is seeing an improved quality of life (QOL), and who isn't, first of all. For example, are there one or two NCMs who are very successful, and others who are not? What are the best practices that are helping the NCMs with members with good QOL scores succeed? Or, conversely, what are the NCMs with members with poor scores doing/not doing? Are there certain ethnic groups overrepresented? For example, multiple reports have noted that Chinese members are more stringent in expectations than other groups might be for surveys such as CAHPS. Perhaps that might apply here as well. Are members with specific types of diagnoses more likely to report higher QOL scores than others—e.g. are those with a mental illness such as depression likely to have lower scores than others without such a diagnosis? We would analyze any such items that we can identify, such as these. We might also find that we are not getting full answers from all our members. That might indicate we need to be better at getting responses from members so we have more accurate data to analyze.

If we see that our data is coming in regularly, then it may be useful to start examining this data more frequently than annually—we may want a running total, e.g. quarterly, at least of how the data is being returned. In that way, we at least know how we need to target getting more complete data collected, etc. Additionally, if we find that nothing in our analysis really points to why we are not making the headway we want, our next step is likely to be patient focus groups. We have held them to address other issues, and have found them exceedingly helpful. For issues that are more subjective such as quality of life, the focus group approach lends itself quite well to allowing representative members to voice opinions, perspectives and ideas about how a program such as our care coordination program could, from the member's viewpoint, provide services in a way that would improve their QOL.

These would be steps we would take to understand why this goal is not being met, if it is not at target by our first year of measurement.

3. Staff Structure and Care Management Roles

a. Identify the specific employed or contracted staff to perform administrative functions (e.g., process enrollments, verify eligibility, process claims, etc).

The following describes the specific employed or contracted staff that performs administrative functions for the SNP program, by functional area. Each HPSM Department has a Director responsible for oversight of activities pertinent to their specialty area. More information about the staff that provides oversight for these areas is included with factor c under this element. An organizational chart can also be found under factor c of this element.

Member Services Overview

The customer service functions at HPSM are under the direct supervision and guidance of the Director of Member Services and Outreach. The department with 34 staff is organized into two major sections. Member Services provides customer service to members in five of the six HPSM lines of business. The CareAdvantage Unit focuses on customer service for HPSM's dual eligible members enrolled in HPSM's SNP. This unit includes the enrollment and disenrollment functions; the customer call center; eligibility verification; and member outreach activities. The description focuses on the SNP functions within the department.

Enrollment/Disenrollment and Eligibility Verification

HPSM's Enrollment and Disenrollment Team consists of one Supervisor and three Enrollment/Disenrollment Specialists. The team is responsible for verifying Medi-Cal (Medicaid) and Medicare eligibility; and processing enrollment and voluntary and involuntary disenrollments according to CMS guidelines and within CMS required timeframes. The team verifies information on enrollment forms submitted by HPSM sales staff or directly by members. If any discrepancies are identified (which may include an incorrect date of birth or address), the eligibility staff follows up with the member and corrections are made to the application. The team maintains an internal member database. Medi-Cal eligibility and share of cost are documented, as well as enrollment and disenrollment information.

The team also works to ensure that eligibility data is maintained correctly. The team processes the CMS transaction reply report (TRR) that provides information on member status. This includes factors that impact a member's eligibility such as changes in low income subsidy status and residency so staff is aware whether a member has moved out of HPSM's service area. The team also receives a monthly eligibility report from HPSM's MIS Department. This report is reconciled with CMS eligibility records to ensure the accuracy of HPSM's records.

Call Center

HPSM's CareAdvantage call center provides dedicated customer service to CareAdvantage members. The call center is staffed by seven "Navigators" and a supervisor. All are bilingual (four in Spanish, two in Chinese (Cantonese/Mandarin) and one each in Russian and Tagalog). Staff calls potential members prior to enrollment (following an approved CMS Outbound Enrollment Verification (OEV) script) to verify that members enrolling in CareAdvantage understand their enrollment decision. Following enrollment, staff calls all new members to welcome the member to the Plan and provide additional information about HPSM and CareAdvantage and to answer any questions the members might have. On an on-going basis, Navigators assist members both on the phone and face-to-face in understanding their benefits; how to access care, change primary care providers, resolve billing issues; retain Medi-Cal eligibility; or to address complaints.

An after hours call center is available for CareAdvantage members. Daily reports of the previous day's calls are provided HPSM staff and are reviewed every morning. Follow up calls are made to members to assure that the member's questions were answered fully.

Outreach Staff and Eligibility Retention

Two outreach staff, including a Community Liaison, meet with potential members at sales events and with continuing members in the community and at senior centers to educate them about HPSM and their CareAdvantage benefits. Outreach staff also serve as liaisons with community advocates and other government agencies (e.g., Social Security Administration, San Mateo County Human Services Agency which determines Medi-Cal eligibility, etc.) to provide information about HPSM and assist in coordinating services to HPSM members.

An important function of the member services staff is the emphasis on retention of Medicare **and** Medicaid eligibility. Because of HPSM's State Medicaid contract, HPSM receives Medicaid eligibility files several times per week. These files are reviewed for changes in Medicaid status which would impact a member's continued eligibility for special need status. Member services staff contacts members and works with the San Mateo County Human Services Agency, which is responsible for determining Medicaid eligibility, to assure that members are reinstated onto Medicaid during their period of deemed SNP eligibility.

Finance and Administrative Services - Overview

The Director of Finance and Administrative Services oversees claims processing for HPSM. Finance is also responsible for financial budgeting, planning and analysis including actuarial projections. With eleven staff, the department prepares and presents financial statements and reports for internal management, the San Mateo Health Commission, the governing body of HPSM, local providers, as well as for state and federal entities. Staff manages cash flow, invests surplus funds and protects corporate liability and exposure to risk through a comprehensive risk management program.

The Director of Finance and Administrative Services also oversees HPSM administrative services; marketing efforts for the SNP; a project specialist who coordinates SNP related activities; a contract specialist who is responsible for negotiating and executing contracts for the SNP, and a Medicare Risk Adjustment Specialist.

Claims

HPSM operates a claims department with 32 staff members divided into three units under the direction of the Director of Finance and Administrative Services and two supervisors. One unit adjudicates claims and staffing includes three Development Specialists. These staff members focus on non-contracted providers whose CareAdvantage (SNP Medicare) claims are "unclean" and cannot be paid. Letters are generated to inform the non-contracted providers of the reasons their claim(s) are pended and staff works with providers to resolve issues. If the problems cannot be resolved within CMS timeframes, the claims are denied and claims denial letters sent to members. All letters are reviewed for accuracy prior to being mailed.

A second unit within the Claims Department is primarily staffed by five Claims Provider Services Representatives who staff a call center for providers. These employees primarily assist providers inquiring about the status of their claims or questions about denials that have been processed. The third unit within the Department focuses on recoveries of overpayments.

In addition to staff, an HPSM contractor has developed, and continues to refine, a claims database that is used to run queries and reports used primarily by Claims Department staff as well as those processing provider claims appeals.

Marketing

HPSM's Marketing Director leads HPSM's marketing team in developing, executing, and measuring strategic plans to market HPSM and its programs in the community; creating and producing member and provider materials; and performing sales functions. The department is staffed by seven employees. Two sales staff exclusively performs sales and marketing tasks to increase dual eligibles' enrollment in CareAdvantage. The other staff focus on the design, layout, and creation of marketing materials; the writing, revision and updating of documents including manuals, directories, brochures, flyers, and other documents for members and providers in accordance with regulatory guidelines; and the tracking, on a daily basis, the status of all marketing jobs. HPSM contracts with a vendor to translate documents into four languages (Spanish, Russian, Tagalog, and Chinese) for CareAdvantage members and into Spanish for members in HPSM's other lines of business. The Communications Specialist in Marketing also prepares fact sheets and other materials about the SNP for the public. The Senior Graphic and Web Designer is responsible for maintaining and updating HPSM's web site, and ensuring it is in compliance with CMS standards and requirements.

Administration Services

Under the leadership of the Director of Finance and Administrative Services and the Administrative Services Manager, the Administrative Services Department, with a staff of thirteen, provides internal administrative and operational support for the entire organization. The department areas include facilities management, coordinating with leasing and building management, health and safety, disaster planning, equipment and supplies procurement, printing and copying, reception and telephone services, and mail processing services. The Administrative Services Manager provides overall leadership and management of all aspects of the operation providing administrative support to HPSM staff.

Project Management, Contracting, and Medicare Risk Adjustment

Under the direction of the Director of Finance and Administrative Services, project management staff plan, develop, and implement special projects for HPSM for all lines of business. This includes conducting research and analysis to support decision-making and planning; setting and meeting goals and objectives; coordinating individual, departmental, and/or cross-departmental activities to accomplish project goals; and reporting on findings and outcomes. The Project Specialist prepares an annual report on SNP operations, staffs monthly meetings focused on SNP operations and policies with all of HPSM's Senior Managers; monitors all CMS communications related to the SNP and distributes them throughout the organization; and helps prepare and upload all required reports and documents to CMS.

The Contract Specialist oversees the contracting process for HSPM, including contractors who perform SNP functions. While contract substance is developed in the department with subject expertise, the Contract Specialist develops Requests for Proposals and assures that contracts are comprehensive and meet HPSM and CMS standards and requirements. Contracts related to the SNP line of business include: the Pharmacy Benefit Manager, Informed Rx, contracted to administer the Part D pharmacy benefit, including network development and contracting, claims payment, and certain administrative services related to submission of PDE encounter data; Delta Dental, contracted to administer the SNP dental benefit, including network development and contracting and claims payment; and American Logistics Company, contracted to provide the transportation benefit, including contracting with and assuring the quality of drivers and vehicles, and operating a call center. Contract monitoring occurs through specific department staff and through the compliance function of the organization.

The Risk Adjustment Specialist is responsible for all risk adjustment activities, including quality control to assure risk adjustment submissions are accurate and meet CMS standards and requirements. He performs provider education and works closely with staff in other departments to assure risk adjustment activities are well integrated into the overall function of the SNP. He oversees a contract with PopHealthMan, a firm that assists with risk adjustment retrospective review in provider offices and analysis of risk adjustment activities.

Provider Services

Provider Services is part of the Health and Provider Services Department (health services clinical functions are described in factor b under this element). The Provider Services Team consists of three Representatives and a Credentialing Specialist under the direction of the Director of Health and Provider Services and the Provider Services Manager. The Provider Services team is responsible for recruiting new providers as well as educating and supporting current providers. Staff develops and maintains strong relationships with current and new providers to assist in resolving problems. Staff conducts initial and ongoing training and education of providers and their office staff. In addition the staff assists non-contracted providers who have provided services to HPSM members. These providers often have questions regarding member benefits and claims payment. The Credentialing Specialist in the Department is responsible for serving as the focal point for HPSM's credentialing process, distributing and receiving applications, analyzing applications and performing primary source verification, preparing files for review, and monitoring and documenting credentialing efforts.

The Provider Services Manager not only supervises staff but is responsible for provider network development, contracting, and provider relations management for contracted and non-contracted providers. The Director of Health and Provider Services oversees the Provider Services area, and serves on the Credentialing Committee, which reviews credentialing applications after all information has been submitted by a provider for review.

Member and Provider Grievances and Appeals

The member and provider grievances and appeals functions are overseen by the Director of Compliance and Regulatory Affairs. Two Grievance and Appeals Coordinators focus on member complaints that include customer service complaints, quality of care issues, and reconsiderations regarding denials for requested services or medications. The Grievance and Appeals Coordinators contact the members and or/providers, are responsible for keeping electronic data files for each case, and work closely with the Medical Directors and clinical and pharmacy staff regarding any denials for services or medications. HPSM's Staff Grievance and Appeals Committee, chaired by the Grievance and Appeals Coordinators, meets biweekly to review all open and recently closed cases to get input from staff that includes the Medical Directors, Providers Services Manager, Director of Member Services and Outreach, Member Services Manager, a claims auditor, and the Director of Compliance and Regulatory Affairs.

HPSM also has a Provider Dispute Resolution Team, consisting of two Specialists and one Assistant, who are responsible for processing, resolving and responding to provider disputes from contracted and non-contracted providers. These disputes concern denied claims, requests for reimbursement of overpayments, or appeals of a medical necessity/utilization management decision (that has been paid). All provider disputes are entered and maintained in an electronic database. Staff works with the Medical Directors and other clinical staff on all UM disputes. This unit also reports to the Director of Compliance and Regulatory Affairs.

Management Information Systems (MIS)

The MIS Department with a staff of 16 under the Director of MIS is responsible for directing and distributing computer resources to the operating departments of HPSM. Priority is given to maintaining the productivity of claims processing, payment to providers, and the development of business solutions. The Department consists of three units. The Configuration Unit supports the Claims Department by configuring the claims system for pricing and benefits and Provider Services in the configuration of key provider information to ensure appropriate payments to providers. The Programming Unit supports HPSM's current software and writes new applications to approved specifications. The Computer Operations Unit controls the hardware environment, produces and distributes reports, purchases and stocks supplies, installs PC based software, and maintains linkages with external providers for on-line data exchange.

Informatics and Data Analysis

Under the direction of the Director of Compliance and Regulatory Affairs and in collaboration with the MIS Director, the Senior Health Statistician and four analysts perform the more highly complex professional and technical work involved in the gathering, analyzing, and reporting of statistical data.
The Senior Health Statistician and her staff develop statistical tools and perform the analysis and interpretation of data to evaluate the effectiveness of HPSM quality studies and programs, and produce necessary reports. In addition, as the lead of the Informatics Unit at HPSM, the Senior Health Statistician directs the assignment of tasks for data analysis projects requested by HPSM departments. Further, she provides expertise and guidance to management based on the analytical studies. The Informatics Unit includes contracted and employed analytic staff from other departments: a data analyst who reports to the Health and Provider Director and a database contractor who reports to the Director of Member Services and out. The Informatics Unit staff sit and work together as a team to ensure all data analytic needs of the organization are met.

Examples of Specific Administrative Functions

Following are specific examples and a case study of activities undertaken by HPSM administrative staff for members of CareAdvantage, HPSM's Special Needs Plan:

1. Among HPSM SNP members are a group of about 40 nuns who live at Oakwood, a retirement community for the Religious Society of the Sacred Heart in San Mateo County.

   The **HPSM Community Liaison** has worked closely with the Oakwood facility administrator to make sure that the health care and eligibility needs of the community are met. Many of the nuns are elderly and had difficulty going to outside medical providers. The nuns also prefer to be seen by female providers. The Community Liaison

arranged services from the local county hospital-based Federally Qualified Health Center (FQHC), which operates a senior care center that provides geriatric primary care. The physician and nurse practitioner at the senior care center are both female and gerontologists. These providers accepted the 40 nuns into their practice and also make visits to the center to see patients as necessary. The Community Liaison also arranged with a local pharmacy provider to make regularly scheduled prescription deliveries to Oakwood which has made it easier for members living at the facility to access the large number of prescriptions needed to maintain their health.

2. **CareAdvantage Navigators** make monthly new member welcome calls to all new CareAdvantage members. The CareAdvantage Navigators are bilingual/bicultural in one of the following languages: Spanish, Tagalog, Mandarin, Cantonese and Russian. New members indicate their language preference on the CareAdvantage enrollment form so a Navigator who speaks that language can call the member and explain program benefits in the member's preferred language. CareAdvantage staff accesses telephonic interpreters for all other languages.

3. Each **CareAdvantage customer service and enrollment/disenrollment staff member** has access to the State of California Medicaid eligibility system. The staff continuously monitors the Medi-Cal system for changes in members' Medicaid eligibility status that would adversely impact the members' dual eligible SNP status. The staff sends letters and calls members to assist them with retention and reinstatement of Medicaid eligibility. This includes making three-way calls with the County Social Services Agency, the agency that processes Medicaid eligibility determinations in San Mateo County, to determine what information the member needs to provide in order to retain his/her Medicaid eligibility. HPSM has an agreement with the Legal Aid Society of San Mateo County and more difficult eligibility cases are referred to Legal Aid for attorney assistance. In 2010, these HPSM staff and Legal Aid assisted 843 SNP members and saved them from involuntary disenrollment due to loss of DE SNP eligibility status. In 2011 year to date, 244 SNP members have been assisted and saved from disenrollment.

Case Study: Medicaid Eligibility Retention Work by HPSM Enrollment/Disenrollment Staff

Mr. G is 36 years old and disabled. His father is his authorized representative. In order to be eligible for CareAdvantage, a beneficiary must have both Medicare Parts A and B and Medi-Cal through HPSM. Mr. G has been enrolled in CareAdvantage since January 2006. At the time of his enrollment, it was confirmed that Mr. G had both Medicare Parts A and B and Medicaid through HPSM. However, in April 2009, HPSM received a Transaction Reply Report (TRR) notification from CMS indicating that Mr. G did not start receiving Medicare Part B coverage until 3/1/2009. CMS retroactively disenrolled Mr. G from CareAdvantage effective 1/1/2006 and automatically assigned him to another Medicare Prescription Drug Plan (PDP).

Mr. G's authorized representative did not want his son to be disenrolled form CareAdvantage and had documentation that Mr. G was covered through both Parts A and B under a different Medicare Health Insurance Claim Number (HICN); his Part A coverage began in September 2000 and his Part B coverage began in January 2002. HPSM referred the authorized representative to Legal Aid for assistance. The Legal Aid attorney attempted to resolve the case through the Social Security Administration (SSA), but in spite of the documentation, was unsuccessful in getting the Part B coverage reinstated on appeal.

HPSM **enrollment/disenrollment staff** found documentation in the state Medicaid eligibility system proving that Mr. G had uninterrupted Part B coverage as of January 1, 2002 and that he was also covered by the Qualified Medicare Beneficiary program through which Medicaid paid Mr. G's premiums. HPSM staff submitted this documentation to the District Manager of the local SSA office. The District Manager reinstated the Part B coverage. The CMS system now shows that Mr. G has uninterrupted Part B coverage retroactive to January 2002. Without these extra efforts on the part of HPSM administrative staff, this disabled member would have been inappropriately disenrolled from the SNP program and had his coverage and health care disrupted.

b. Identify the specific employed or contracted staff to perform clinical functions (e.g., coordinate care management, provide clinical care, educate beneficiaries on self-management techniques, consult on pharmacy issues, counsel on drug dependence rehab strategies, etc.)

The following describes the specific employed or contracted staff that performs clinical functions for the SNP program, by functional area. Each HPSM Department has a Director responsible for oversight of activities pertinent to their specialty area. More information about the staff that provides oversight for these areas is included with factor c under this element. An organizational chart can also be found under factor c of this element.

As the principal director in charge of medical services, the Medical Director is responsible for the appropriateness and quality of medical care delivered to members throughout HPSM's provider network and for the cost-effectiveness of the utilization of services. She also oversees the work of the Quality Department and health education. The Director of Health and Provider services is responsible for the management of the Health Services, Care Coordination, Provider Services, and Pharmacy Departments. More information about these staff is included under factor 3 of this element. This section focuses on other staff performing clinical functions.

Associate Medical Director—Health Services and Quality

The Associate Medical Director—Health Services and Quality assists the Medical Director in overseeing the appropriateness and quality of medical care delivered to members through the HPSM provider network and for the cost-effectiveness of the utilization of services. This

position reports directly to the Medical Director. This Associate Medical Director has no direct reports, but works directly day-to-day on member and provider issues that arise, in conjunction with the Medical Director, the Health Services staff and all parts of the organization to ensure a medical program of the highest quality.

Associate Medical Director—Long Term Care

The Associate Medical Director for Long Term Care reports to the Medical Director and, with the guidance of the Medical Director, is responsible for coordinating the appropriateness and quality of medical care delivered to HPSM members receiving long term care services of any type through or outside of the HPSM provider network, as well as assuring the cost-effective utilization of these services. The Associate Medical Director also clinically supervises HPSM nurse practitioners and is the clinical consultant for the HPSM licensed clinical and Care Coordination staff working in LTC settings to provide Medicare risk assessments and ongoing medical care management for selected patients to manage length of stay and prevent recurrent hospital readmissions and ED visits where possible and appropriate.

Other Health Services Department includes the following other staff that performs clinical functions related to the SNP program:

Care Coordination Manager

The Care Coordination Manager is accountable to plan, organize, develop and manage the care coordination system in Health Services for the SNP Program. The Care Coordination Manger's primary focus is on high risk members as identified through emergency and inpatient recidivism and also those members requiring complex medical care coordination. The Care Coordination Manager interacts regularly with the provider community and outside agencies including but not limited to the Regional Centers (who provide services to people with developmental disabilities), Behavioral Health and Recovery Services, the County public hospital (San Mateo Medical Center) and Aging and Adult Services (the County agency responsible for social services for older residents and people with disabilities). The Care Coordination Managers supervises eight Care Coordination Nurse Case Managers, two Care Coordination Technicians, a Social Worker Case Manager, a Care Transitions Coach, and an Authorization Assistant.

Care Coordination Nurse Case Managers

The Care Coordination Nurse Case Managers are accountable to carry out intensive case management, comprehensive assessments and individualized care planning for HPSM's SNP members in order to facilitate and promote quality, cost effective outcomes and minimize fragmentation of health care delivery. The Case Manager also interacts with the member's family, providers, and other administrative personnel to assist members in linkage to healthcare, home and community-based services and other necessary services.

Social Worker Case Manager

The Social Worker Case Manager is responsible for complex case management activities as part of interdisciplinary team with the Nurse Case Managers and other clinical staff at HPSM. This Case Manager initiates and coordinates case conferences regarding the care of SNP members, makes determinations regarding appropriateness of social services, home and community-based services, and liaisons with County Behavioral Health and Recovery Services and Aging and Adult Services regarding crisis situations and placement issues.

Care Transition Coach

The Care Transition Coach interacts with members in the hospital setting and home setting to ensure a smooth transition to home after hospital discharge. The primary objective of this role is to support the patient in identifying concerns and/or problems and building of relationships with his or her practitioner. In this role as a patient educator-advocate, and patient empowerment facilitator, the Care Transition coach provides information and guidance to the patient/caregiver for effective care transitions, improves self management skills and enhanced patient- practitioner communication.

Nurse Practitioner (NP) – Long Term Care

HPSM's two Nurse Practitioners report clinically to the Medical Director and administratively to the Director of Health and Provider Services. Under the general supervision of the Associate Medical Director--Long Term Care (LTC), the NPs provides annual comprehensive risk assessments to designated HPSM members in the CareAdvantage SNP program, primarily in the LTC setting. The NPs are also responsible for ongoing medical care management for selected HPSM LTC patients to manage length of stay and prevent recurrent hospital readmissions and ED visits where possible and appropriate.

Long Term Care Nurse Case Manager

The LTC RN Case Manager functions as a facilitator and coordinator of member care and services; and is the liaison between the plan, skilled nursing facilities (SNFs) and the LTC Associate Medical Director and LTC Nurse Practitioner. She is a liaison to members who are discharged from acute to a lower level of care or vice versa and assists with discharges and monitors and tracks bed day holds; and helps with the discharge planning process and coordination between acute and LTC facilities to ensure a smooth transition throughout the continuum of care. She also does individualized care planning in order to facilitate and promote quality, cost effective outcomes and minimize fragmentation of health care delivery. She interacts with member's family, providers, provider office staff and other administrative personnel to assist member in linkage to healthcare and specialty services.

Care Coordination Technician (CCT)

The Care Coordination Technicians are non licensed staff that serve as member liaison and clinical guides, providing assistance with care management for the identified high risk CareAdvantage SNP members. This position functions as the member's liaison, ensuring that adequate communication occurs between medical professionals and the member. The CCT assist members in their understanding of their medical conditions and how to adhere to medical treatments. Coordinating clinical care across the different disciplines and settings, contacting members after hospitalizations and emergency room visits to ensure that appropriate follow-up has been arranged and making sure the member and his/her care givers understand the follow-up plan of care. The CCT contacts and establishes links with physicians and other providers including community partners. CCTs also identify members who may be candidates for plan add-on services such as the home visiting physician program.

Authorization Specialist

The Authorization Specialist processes Treatment Authorization Requests (TARs) in order to facilitate reimbursement to HPSM providers. The Authorization Specialist assists the Provider Services, Member Services, and Claims staff to expedite resolution of reimbursement issues. As a member of the support services staff in the Health and Provider Services Division, this position is also accountable to communicate information regarding TAR and rate adjustment factor (RAF) processing to providers.

Pharmacy Manager and Clinical Pharmacists

Under the direction of the Health and Provider Services Director, the Pharmacy Services Manager has management responsibility for overseeing pharmacy benefits operations activities for all HPSM lines of business, including the Medicare Pharmacy Part D program. More information about the Pharmacy Manager's oversight functions is included under factor c of this element.

The two Clinical Pharmacists who report to the Pharmacy Manager provide pharmacotherapy expertise for the pharmacy program, providing support for the development and maintenance of internal Health Plan Drug Formulary for all product lines, providing pharmacist support for the drug prior authorization program and reviewing drug treatment authorizations, serving as a resource HPSM team members regarding the clinical use of drugs, reviewing utilization, auditing pharmacies, helping with claims adjudication problems, handling the provider education program and academic detailing, and oversight of pharmacy interns.

Quality and Health Education

The Medical Director is responsible for the Quality Assessment and Improvement Program and directly supervises the Quality Department. The specific staff in this department include four Health Educators who conduct specific quality projects improvement projects; two RN Nurses who conduct provider site reviews for credentialing and re-credentialing of providers and work

with a certified vendor to carry out chart audits for the collection of HEDIS data; and administrative staff.

The Health Education Team is responsible for developing, recommending, and implementing health education programs to improve the health of HPSM members. Team members also lead quality improvement projects improvement projects which are aimed at improving the health outcomes of HPSM members. They also develop training and materials for staff and providers to address the cultural, disabilities and linguistic needs of HSPM members. Finally, health educators work with staff in the Marketing Department to develop culturally and linguistically appropriate member materials, as well as materials appropriate for our members with disabilities.

Examples of Specific Clinical Staff Activities

Following are examples of functions and activities undertaken by clinical staff for the SNP program.

1. The **Care Transitions Coach** is stationed at the county hospital, where a significant proportion of HPSM SNP members are hospitalized. These tend to be younger disabled members, often with serious behavioral issues. Therefore, they have particular problems with transitions from the hospital to community or nursing facility settings. This Coach is a Nurse RN who has received specialized training under the Eric Coleman model for care transitions. The Coach works with the hospital clinical staff to select candidates for this intervention. She provides home visits and follow-up phone calls, and educates members in self-care and health care management. She helps each member develop a health record binder to organize their interactions with health care professionals. As part of an evaluation of the Care Transition interventions funded by the Gordon and Betty Moore Foundation, HPSM contracted for focus groups conducted by an independent facilitator. These focus groups included HPSM and county hospital staff involved in care transitions, as well as separate focus groups with HPSM SNP members who had participated in the Care Transitions coaching program. The findings from these focus groups informed program improvements and changes in the Care Transitions Coach approaches. As a result, the number of patients successfully enrolled in this program has increased by nearly 300% over a period of four months. Direct feedback from one participant is included in the case study below.

2. The **Long Term Care Case Manager** plays a key role in assuring the appropriate coordination of Medicaid and SNP Medicare long term care benefits. HPSM is also responsible for the Medicaid long term care institutional benefit; therefore, the Care Manager ensures that the transition from the Medicare-covered Skilled Nursing Facility benefit to the Medicaid covered custodial benefit works smoothly for the SNP member. She does this by staying in close touch with network nursing facilities and the SNP members residing in those facilities. The Long Term Care

Case Manager also is an active participant in interdisciplinary weekly meetings at the county hospital, where staff from several county agencies (Behavioral Health, the County hospital, and Aging and Adult Services) and HPSM collaborate to develop creative placement options for the most difficult to place county hospital patients, including HPSM SNP members, who are ready to leave the facility. It is often extremely difficult to find appropriate community or nursing facility placements for these members, who may have severe behavioral and/or substance abuse issues.

3. HPSM **Clinical Pharmacists** conduct "academic detailing," to promote the use of evidence-based medications by network physicians who serve HPSM SNP members. The pharmacists evaluate cost and utilization data to identify the top prescribing physicians, analyze the data associated with specific physicians to determine if evidence-based practices are in use, and prepare educational packets tailored to the physician practices. The pharmacists then visit those physician offices to provide educational sessions about evidence-based prescribing, HPSM's formulary, and clinical data about their patients. An evaluation has shown that this program has been effective in changing physician prescribing practices, not only increasing the use of evidence-based medication, but also decreasing medication costs substantially as well.

Case Study: Experience of a Care Transitions Coaching Participant

The following voice mail message was recently recorded by Ray T., a Care Transitions coaching participant:

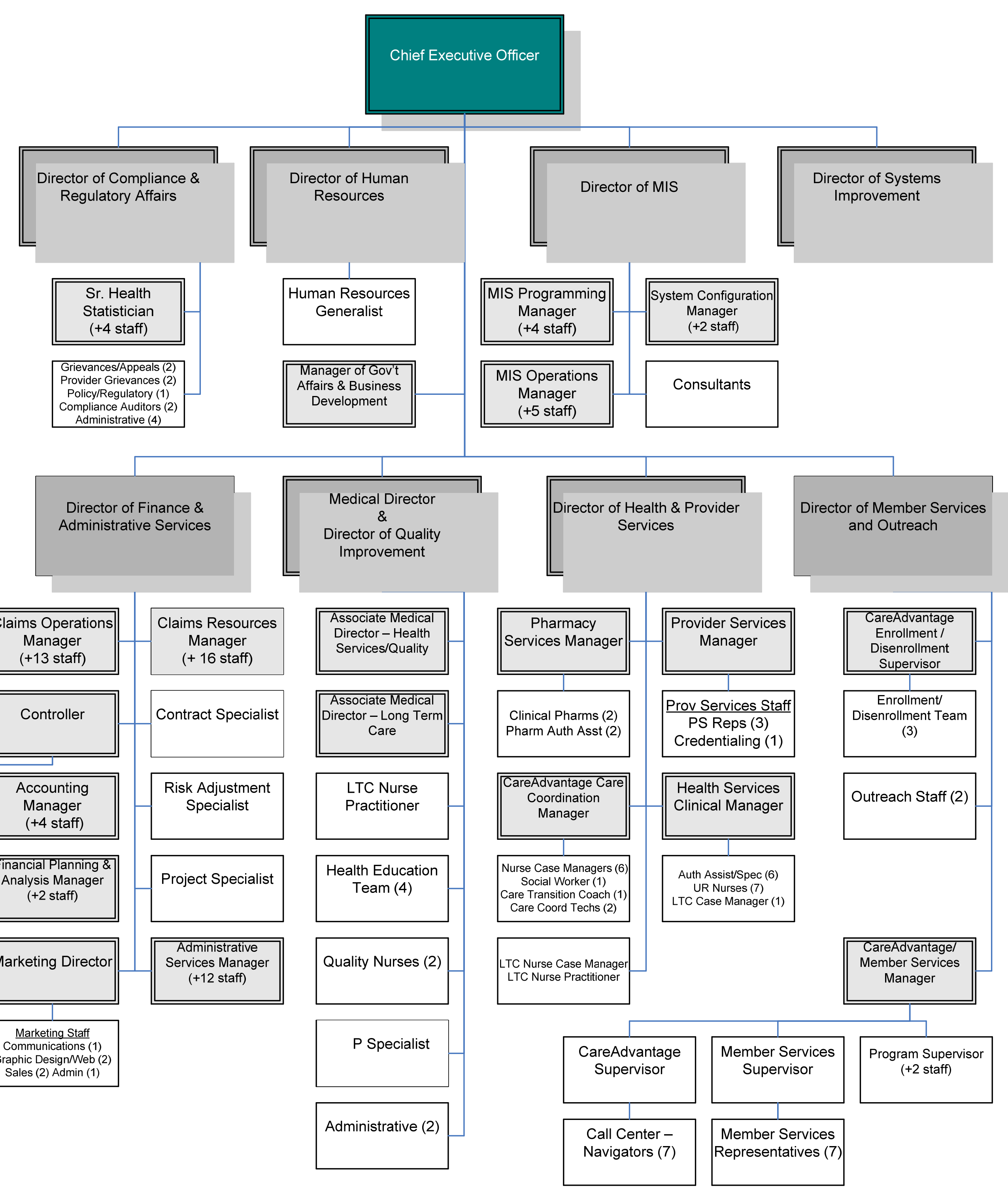
"Karen M. (HPSM Care Transitions Coach) was over at my house last week and I just wanted to say that she was wonderful; she really helped me out and was very nice. I just filled out the evaluation from to mail but I just wanted to give a call and again say how helpful Karen was. In fact, I just went to the doctor on the 18th, following her visit, and he was very impressed with my health record binder. I am pretty good with details but this even tops what I do. It is very good. Thank you again."

c. Identify the specific employed or contracted staff to perform administrative and clinical oversight functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.)

The following chart provides an overview of administrative and clinical functions and staff responsible for oversight.

Health Plan of San Mateo

4/8/2011



All HPSM Senior Managers are responsible for assuring compliance and service quality in their areas. The Director of Finance and Administrative Services is responsible for proper and timely payment of claims; appropriate and accurate financial monitoring and reporting; risk adjustment activities, contracting; marketing and sales; project management; and administrative functions. The Medical Director is responsible for overall clinical oversight, quality improvement efforts for member health; and health education and preventive services.

The Director of Health and Provider Services is responsible for the Care Coordination Unit, Provider Services, Pharmacy, and other health service functions. The Director of Member Services and Outreach oversees enrollment/disenrollment, the customer call center, and community and member outreach activities. The Director of Management Information Services (MIS) is responsible for HPSM's data systems and the quality and integrity of the organization's data. The Director of Human Resources is responsible for organizational hiring and personnel functions. The Director of Compliance and Regulatory Affairs oversees all compliance activities, appropriate implementation of regulations, grievances and appeals, and internal audit functions. The Director of System Improvement is responsible for continuous quality improvement efforts throughout the organization. HPSM has an informatics unit. That staff sit and work together as a team, with individuals reporting to various Directors depending on their area of expertise.

Finally, the CEO is responsible for the overall functioning and quality of the organization and SNP operations, with all the Senior Mangers described above reporting to her. The CEO reports to the Health Commission, HPSM's Board of Directors. The San Mateo Health Commission (SMHC) has ultimate accountability and responsibility for the quality of care and services provided to HPSM members. The Commission has eleven members appointed by the San Mateo County Board of Supervisors, including community representatives, provider representatives (hospital, physician, and pharmacy), beneficiary representatives, members of the Board of Supervisors, and the County Manager.

The following is a more detailed description of clinical and administrative oversight staff and the specific areas they oversee.

Medical Director

Under the general direction of the CEO, the Medical Director provides leadership for delivery of health care to HPSM members; she serves in a liaison capacity between HPSM and the provider community and network, and makes final medical decisions on behalf of HPSM. The Medical Director provides clinical oversight and guidance to HPSM's utilization review, care coordination, and quality assessment and improvement staff. As the manager of the Quality Department, the Medical Director leads special projects to improve the quality and effectiveness of medical care provided to HPSM members and is actively involved in the development of all plans and policies related to health promotion and HPSM's quality studies.

The Medical Director chairs or is the lead HPSM support for the following committees that oversee clinical functions and quality:

- Quality Management Oversight Committee (QMOC) which includes the CEO, Director of Finance and Administrative Services, Director of Health and Provider Services, Director of Human Resources, MIS Director, Director of Member Services and Outreach, Director of Compliance and Regulatory Affairs, Site Review Nurses, QAI Health Educators, Senior Health Statistician, and the Associate Medical Director—Health Services and Quality. QMOC reviews and provides input on quality initiatives and reviews utilization management, provider access, and member and provider grievances and appeals reports.
- Physician Advisory Group/Peer Review Committee, which is made up of community physicians that reflect HPSM's provider network. The Committee evaluates quality efforts, advises HPSM clinical staff on practice guidelines, and reviews credentialing activities and quality of care issues. Because of its membership, it serves as a "focus group" of the physician network for HPSM (chaired by a member of the Commission). This Committee advises the Health Commission in the clinical area.
- Quality Assessment and Improvement Committee, which also serves in an advisory capacity to the San Mateo Commission quality assessment and improvement program. Committee membership includes: Public/Consumer member of the Commission, a Physician member of the Commission, a Pharmacist member of the Commission, a physician provider of the San Mateo Medical Center, a physician member of the San Mateo County Health Department, the Director of Quality at Kaiser Permanente (who is also a geriatrician), the chair of the Department of Family Practice at Stanford Medical School and three additional primary care and specialty physicians. Because of the expertise of its membership, this committee provides evaluation and analytic input regarding quality projects, strategies, guidelines, and so forth for HPSM's quality program and initiatives (chaired by a member of the Commission).
- The Medical Management Review Committee comprised of the CEO, Director of Finance and Administrative Services, the Director of Health and Provider Services, controller, and lead finance analysts. The committee meets monthly to discuss issues of potential under or overutilization across the company's lines of business, as well as strategies to address any areas of concerns.
- Quality Projects and Initiatives Committee, which serves as the primary group to review in detail the work of the Quality Department, examining each quality project, how it is progressing, any barriers, root cause analysis, additional activities necessary to address them, and so forth so that measureable goals can be met. It is this committee where Deming's model of improvement is implemented in a step-wise manner for each quality project as they come under review.

Director of Health and Provider Services

The Director of Health and Provider Services is responsible for management of the Health Services, Care Coordination, Provider Services, and Pharmacy Departments. In collaboration with the Medical Director, the Director of Health and Provider Services reports on Health

Services activities to the Senior Management team at monthly medical management review meetings and is responsible for ensuring that the program is properly developed, implemented and coordinated. The Medical Director and the Director of Health and Provider Services are the Chief Executive Officer's designees for oversight of the day-to-day implementation of the Model of Care and are responsible for ensuring that the program is properly developed, implemented and coordinated.

This Director has management oversight of most clinical areas, including care management and coordination of care; interdisciplinary care teams; care transitions; health risk assessment process; care plan development; coordination of benefits; administration of the Part D benefit; provider credentialing; network development; and provider services and education.

Pharmacy Services Manager

The Pharmacy Services Manager oversees pharmacy benefit operations for the Medicare Part D program, including:

- Managing the administration of pharmacy services provided by HPSM; acts as PBM and specialty pharmacy and medical therapy management liaison; manages the prior authorization process.
- Ensuring implementation and maintenance of HPSM formulary.
- Identification and development of prior authorization clinical guidelines.
- Performing pharmacy utilization review and developing cost effective pharmacy measures.
- Providing supervision, training to HPSM Pharmacists.
- Developing program goals, objectives, policies and procedures to meet current and projected program delivery needs.
- Identifying operational and program delivery problems; develops, recommends, implements and evaluates solutions that comply with all applicable regulations.
- Performs ongoing integration of Pharmacy processes with medical management UM program.

Staff responsible for oversight of administrative functions include the following:

<u>Director Member Services and Outreach</u> - The customer service functions at HPSM are under the direct supervision and guidance of the Director of Member Services and Outreach. This position is responsible for SNP customer service, enrollment and disenrollment, eligibility verification, member outreach, and member retention.

<u>Director of Finance and Administration</u> - The Director of Finance and Administrative Services oversees claims processing for HPSM. This position also oversees financial budgeting, planning and analysis including actuarial projections. In addition, this Director oversees HPSM administrative services; marketing efforts for the SNP; a project specialist who coordinates

SNP related activities; a contract specialist who is responsible for negotiating and executing contracts for the SNP, and a Medicare Risk Adjustment Specialist.

Director of Compliance and Regulatory Affairs - This position oversees compliance activities related to the SNP, grievances and appeals functions, provider dispute resolution, and data analysis. This Director also oversees internal audit functions and is responsible for coordinating the organizational response for audits by third parties. Finally, the position oversees audits of delegated entities and contractors, such as the PBM, the SNP dental provider, and Behavioral Health and Recovery Services (subcontractor under HPSM's SNP).

Director of MIS - The Director of MIS is responsible for directing and distributing computer resources to the operating departments of HPSM. Priority is given to maintaining the productivity of claims processing, payment to providers, and the development of business solutions. He oversees the Configuration Unit which supports the Claims Department by configuring the claims system for pricing and benefits and Provider Services in the configuration of key provider information to ensure appropriate payments to providers. He also oversees the Programming Unit which supports HPSM's current software and writes new applications to approved specifications. Finally, this position directs the Computer Operations Unit which controls the hardware environment, produces and distributes reports, purchases and stocks supplies, installs PC based software, and maintains linkages with external providers for on-line data exchange.

The information below provides more details and examples of oversight by HPSM in specific functional areas.

Verifying Licensing and Competency

The Human Resources Director oversees verification of licenses and other competency requirements (e.g., board certification, educational degrees, etc.) of clinical staff prior to hire. The competency of clinical staff is assessed on an ongoing basis through annual evaluations and ongoing oversight by the Medical Director, the Associate Medical Directors, the Director of Health and Provider Services, and the Pharmacy Services Manager.

The Provider Services Manager, under the direction of the Director of Health and Provider Services, oversees the credentialing function, carried out by a Credentialing Specialist. Policies and procedures are in place to ensure active licensure and competency. Associate Medical Directors review all credentialing and re credentialing applications, as do the Director of Health and Provider Services and the CEO. All credentialing activity is reviewed by an oversight body, the Peer Review Committee. This committee is appointed by the governing body of HPSM, the Health Commission. Its membership includes ten physicians who are also HPSM network providers. More information on the credentialing process can be found under Element 5b, which describes provider network licensing and competency procedures in detail.

Reviewing Encounter and other Data for Appropriateness and Timeliness of Services

The staff responsible for reviewing encounter data include the Medical Director, Associate Medical Directors, the Director of Health and Provider Services, and the Pharmacy Manager. Also involved are analytical staff from the Informatics Unit to ensure that all encounter data are complete and accurate. On a monthly basis, the Medical Director chairs a Medical Management meeting attended by the CEO, the Director of Finance, the Director of Health and Provider Services, the Manager of Financial Planning and Analysis, and, as necessary, the Senior Health Statistician, the Associate Medical Directors, and the Pharmacy Manager, to review areas where under or overutilization of services may be occurring. The topics discussed at recent meetings include: rates of avoidable hospital admissions for members residing in various network nursing facilities; increases in cataract surgeries and differentials in costs between hospital and outpatient settings; ER differentials in billing levels; and areas of increase and decrease in 2010 pharmacy utilization.

The timeliness and appropriateness of services provided HPSM members is assessed in a number of ways. The Director of Compliance and Regulatory Affairs oversees compliance auditors who assess HPSM's processing of authorizations for medical, DME, and prescriptions. Audits are done quarterly and reports are presented to the Compliance Committee whose membership includes the Medical Director and Director of Health and Provider Services. Grievances and appeals are reviewed bi-weekly at the Staff Grievance and Appeals Committee and discussed with the Medical Director and Associate Medical Directors. Any clinical issues, particularly related to quality of care or timeliness of care, are investigated by the Medical Directors or Associate Medical Directors or, in the case of dental services, by the appropriate delegated entity.

Issues of concern regarding specific providers are brought to the attention of the Peer Review Committee/Physician Advisory Group (PRC/PAG) which provides guidance and peer input into corrective actions as necessary to ensure that all practitioners and providers who serve HPSM members meet generally accepted standards for their profession or industry. Grievance and Appeals Coordinators provide quarterly reports to the Quality Management Oversight Committee. The report includes data on the number of treatment authorization requests received in the quarter and the number of appeals that are filed with HPSM. Trends are also analyzed through an assessment of the type of complaints received during the quarter and for the year.

Monitoring Access to Services

The Director of Member Services and Outreach, the Health and Provider Services Director, the Medical Director, and the Provider Service Manager are all responsible for monitoring access to services.

HPSM surveys providers to measure access timeliness under the direction of the Provider Services Manager. Throughout the year, Provider Services Representatives are completing a survey with provider office staff on site visits to gather information regarding triage services.

Standards require that HPSM members be able to speak with clinical staff within 30 minutes. A second provider survey, also under the direction of the Provider Services Manager, will be sent to providers to assess their experience in receiving authorizations for services from HPSM and their patients' access to specialty services. HPSM will also survey members on their experience receiving access to services. A contractor will conduct the survey and report findings to HPSM. HPSM staff prepare member newsletter articles and information in member handbooks to provide members updates on access standards. In addition, Quality Department staff under the direction of the Medical Director continue to conduct secret shopper surveys to gather information on the availability of appointments at both primary care offices as well as at various specialists' offices in HPSM's network. Finally, the Director of Member Services and Outreach collects information from Navigators in the customer service call center who hear about access problems from members. Information is compiled and trends analyzed to pinpoint and address specific access to care issues.

HPSM staff also receives information on access to services regularly from consumers and consumer advocates who serve on HPSM's Consumer Advisory Committee (CAC). The Director of Member Services and Outreach provides staff support for this committee. CAC members advise HPSM staff and the San Mateo Health Commission on HPSM's performance from the consumer's perspective. The CAC meets quarterly and provides enrollees and their advocates with a forum for comment and input on HPSM's performance. The CAC also reviews the Plan's operational reports including Grievance and Appeals statistics, provider capacity, and other issues impacting members.

Reviewing Pharmacy Claims, Utilization, and Services

The Pharmacy Manager has primary responsibility for reviewing pharmacy claims and utilization data. The Medical Director and Director of Health and Provider Services also participate in reviews. As described above this information is reviewed on a regular basis at the regular Medical Management meeting. In addition, the Pharmacy Manager reviews data and the SNP formulary on a bimonthly basis with the Pharmacy and Therapeutics (P&T) Committee. Appointed by the Health Commission, HPSM's governing body, the P&T Committee members include community pharmacists and pharmacists employed by some of HPSM's major network providers and subcontractors, such as the county hospital and County Behavioral Health.

This Committee advises HPSM on pharmacy polices, formulary decisions, and appropriate actions for responding to under and overutilization of pharmacy services.

The Pharmacy Manager and the Director of Health and Providers Services are also responsible for clinical and administrative oversight of HPSM's Pharmacy Benefit Manager, Informed Rx. They hold weekly calls with the PBM staff and also engage a pharmacy consultant who helps HPSM staff monitor PBM performance. The Director of Compliance and Regulatory Affairs oversees annual audits of PBM compliance with CMS standards and conducts site visits at the PBM together with the Pharmacy Manager and the Director of Health and Providers Services.

Assuring Provider Use of Clinical Practice Guidelines

The Medical Director is key to assuring the use of evidence-based guidelines by HPSM's network providers. Working with the members of HPSM's Physician Advisory Group, the most likely guidelines needed in their daily practice are identified and are placed on HPSM's Provider Resources page of our website. The expectation that evidence-based clinical guidelines are used in daily practice is also part of a CareAdvantage physician's contract with HPSM. Further, we include articles in our provider newsletter about the importance of clinical guidelines. In these, we point our providers to our website, as an accessible place to find these most-commonly-needed guidelines. Every provider office receives our newsletter regularly, so we hope this outreach helps them when they look for updates on how to treat their patients. Finally, HPSM receives frequent notifications about free webinars or continuing education trainings put on by our partners in San Mateo County, including the tertiary medical care facilities that serve our members. When this occurs, we e-mail blast and fax-blast these notices to the pertinent groups (e.g. PCPs, or selected specialty types, depending on the focus of the training) so that they are aware of these helpful ways to update their knowledge about important clinical areas.

Other monitoring of network providers' clinical practice occurs through cases brought via member grievances, cases raised through pharmacy claims review, findings from chart review by on-site nurse case managers or prior authorization review nurses and provider concerns re: the practice of another physician in the network. Any issue raised in these ways is reviewed by a medical director to determine if a clinical quality of care concern exists, particularly one related to the lack of adherence to evidence-based guidelines. These cases are pursued and quality improvement plans are requested where applicable.

Additionally, when HPSM site review nurses, under the direction of the Medical Director, review office medical records as part of triennial physician recredentialing, they look to see if treatment documented is consistent with standard of care and evidence-based guidelines.

When any questionable cases are identified, these are brought back to HPSM's medical directors for further review and action as necessary.

Other examples of clinical and quality oversight include the following:

Clinical Oversight - Pay for Performance:

Since January 2008, HPSM has had a Pay for Performance (P4P) program to incentivize primary care physicians' involvement in quality of care activities. Dev eloped by the Medical Director, in collaboration with the CEO and Director of Finance and Administrative Services, the program is available to all contracted primary care providers (PCPs) and obstetricians (OBs) who serve Medi-Cal members (which includes all of the dual eligibles in our SNP).

An example of HPSM's P4P that coincides with goal 3 of performance measures of our Model of Care include:

- Hemoglobin A1c (HbA1c) Screening and Test Results
- Low Density Lipoprotein Cholesterol (LDL-C) Screening and Test Results
- Retinopathy Screening
- Nephropathy Screening

Over the past two years, HPSM's P4P program has contributed to significant improvements in the clinical care of our diabetic members. This has occurred because a key tool the P4P program offers to provider is that it serves as a registry for our practitioners. While any of our providers, when given the name of a specific "regular" on their patient panel, could tell us if he/she were a diabetic, they would be challenged to name a complete list of all their HPSM CareAdvantage members who are diabetics without help. Especially for our solo practitioners who have not yet been able to move to an electronic health record format, the P4P feature that provides them with a list quarterly of all their patients with diabetes, whether or not they have had a claim submitted in the current year for a HbA1c, for example, and whether the result was at goal (<8%) or not, makes the difference in quality of care management or hit and miss care. This feature of the program, along with the financial alignment of a P4P incentive for the physicians, has led to notable improvements across most of the HEDIS diabetes care measures in 2009, representing better quality of care for our members. The most significant improvement was the number of diabetics with good LDL-C control. HPSM also achieved a high performance level for the LDL-C <100 measure, meaning we ranked above the 90th percentile among all participating health plans for that measure.

Clinical Oversight – Quality Improvement Studies:

Another area of oversight of clinical practices is through HPSM's Quality Improvement Projects and Initiatives (QIPIs) which have been developed under the guidance of HPSM's Medical Director and implemented by HPSM's Health Educators and Health Promotion Specialist. Analysis is provided through the work of the analytic team under the direction of the Senior Health Statistician. The projects have been developed to encourage specific health care practices, measured by HEDIS or guided by HPSM's contracts.

For example, current projects include:

- Diabetes Management -focused on our CareAdvantage population in particular, since 43% of CareAdvantage members have a diagnosis of diabetes
- Decreasing Avoidable ER Visits
- Timeliness of Prenatal Care
- Child and Adolescent Health Visits
- Postpartum Care
- Immunization Registry Program
- Asthma Improvement Project

- Fluoride Varnish Initiative

The Diabetes Management QIP, for example, provides a number of components common to most of the QIPs. This includes member education (promoting individual counseling and group diabetes self-management classes offered at no cost to HPSM members through our community partners) and provider education (providing up-to-date clinical guidelines on diabetes management on the HPSM provider website, and opportunities for provider discussion on diabetes care at meetings of our physician advisory and quality advisory groups). Health Educators, Medical Directors, as well as Provider Services staff works in concert to implement QIPs. In the case of diabetes, there is a pay-for-performance component for six key HEDIS-based diabetes care measures, as described above.

In 2011 HPSM plans to launch a set of diabetes comparison reports for PCPs. These reports will show the clinical outcomes of each provider's diabetic patients in relation to those of other HPSM providers. The hope is that by showing where PCPs stand among their peers, as well as highlighting their diabetic members most in need of care, our PCPs will focus their efforts even more on improving the clinical outcomes of their diabetic patients overall. HPSM staff is also developing a new provider toolkit including materials for medical office staff and members, such as a diabetes management checklist in a "prescription pad" style for distribution to patients.

Quality Oversight--Member Focus Groups:

In 2010, the Director of Member Services and Outreach oversaw a contract with a consultant to hold member focus groups. The purpose of the focus groups was to assess, in part, members' level of satisfaction with medical providers and medical services, understanding of their benefits, and satisfaction with HPSM member services. Seventeen focus groups were conducted with 128 HPSM members and their representatives and included (though weren't limited to) aged and special needs members. The focus groups were conducted in five languages (English, Spanish, Tagalog, Mandarin, and Russian), to ensure that members of key demographic groups in San Mateo County were adequately represented. Results, which were overwhelmingly positive about CareAdvantage services, physicians and plan staff, were reported to the Health Commission and Consumer Advisory Committee as well as senior staff.

Additional Examples of Clinical and Administrative Oversight and Case Study

Following are additional specific examples of staff involved in clinical and administrative oversight:

1. The **Associate Medical Director** oversees HPSM's Long Term Care Clinical Program, which focuses on improving quality of care for SNP members residing in nursing homes and reducing unnecessary hospital admissions and ED visits. This individual is a geriatrician with many years of experience, including a clinical practice with older adults and service as a medical director for nursing facilities and for other health plans. With a

team of two Nurse Practitioners, he has targeted 10 nursing facilities that together have 80% of the HPSM SNP members residing in nursing homes. Working with HPSM's Senior Biostatistician, they have established a data baseline as well as a control group for these nursing facilities and members, including hospital admission rates, readmission rates, avoidable hospital admission rates, ED rates and avoidable ED rates. These data will form the basis for an evaluation of the program's effectiveness. This physician and the NPs are working closely with the medical directors and staff at the nursing homes to support appropriate medical interventions. They have also conducted trainings with facility staff on best practices and are working to improve POLST (Physician Orders for Life-Sustaining Treatment) compliance and training.

2. The **Director of Member Services and Outreach** provides oversight to ensure a high quality SNP member experience. In 2010, she oversaw a contract with a consultant to hold member focus groups. The purpose of the focus groups was to assess members' level of satisfaction with medical providers and medical services, understanding of their benefits, and satisfaction with HPSM member services. Seventeen focus groups were conducted with 128 HPSM members and their representatives and included SNP members. The focus groups were conducted in five languages (English, Spanish, Tagalog, Mandarin, and Russian), to ensure that members of key demographic groups in San Mateo County were adequately represented. Findings from the focus groups included the following, which are being addressed in a work plan developed by the Director of Member Services and Outreach:

    - The majority of CareAdvantage (CA) respondents view membership in HPSM very positively. Several respondents described the sense that they "have it better" than beneficiaries in other counties.
    - Most CareAdvantage participants believe that there are enough PCPs and specialists in their geographic region who accept CA. The exception was within the Russian-speaking and Chinese-speaking focus groups, and to a lesser degree in the Spanish-speaking groups. Members of these three groups reported that there are an insufficient number of PCPs, specialists and/or dentists in their area.
    - The majority of CA members who reported contacting HPSM for help with their dental benefits reported a successful resolution of their issue.
    - Approximately half of CA members reported using the transportation benefit. A majority reported high levels of satisfaction. A small percentage reported not having used the benefit because they were unaware of it.
    - Several participants recommended HPSM create visual aids to clarify roles and relationships between CA, Medicaid, HPSM, and local medical providers. Participants believed that such aids would help teach members how they can best advocate for themselves in the local health care system.

3. The **Director of Compliance and Regulatory Affairs** conducts annual audits of HPSM's delegated entities to assure compliance with CMS requirements. As an example, she conducts annual on-site audits of HPSM's Pharmacy Benefit Manager (PBM) to ensure

compliance with Medicare Part D requirements, reviewing the PBM's records and interviewing PBM staff. She has issued a Corrective Action Plan (CAP) when problems have not been resolved.

The CAP includes detailed HPSM analyses of each issue and outlines the required steps for PBM follow up, steps which are being closely monitored by the Director of Compliance. Excerpts from the CAP are presented below as an example.

<table>
<tr><th colspan="3">EXAMPLE—Corrective Action Plan
From 2010Annual Audit
Items were identified and relayed to PBM's Director of Quality Accreditation and Client Review</th></tr>
<tr><th>Problem</th><th>HPSM Analysis</th><th>PBM Follow-Up</th></tr>
<tr><td>Pharmacy Audits</td><td>There has been significant enhancement of PBM's policies and procedures regarding the conduct of both desk and field audits of network pharmacies. Nonetheless, HPSM has not received a written summary report of audits conducted in 2009 and 2010 (though an oral report was provided at the time of the audit). PBM staff indicated that beginning in 2011, HPSM should expect a monthly check regarding recoveries (with one month delay). According to HPSM staff, the last audit recovery checks were received by HPSM on December 17, 2010 for the third quarter of 2009.</td><td>The following steps must be taken immediately.
PBM must:
1. Send HPSM a summary report regarding all desk and field audits from 2009 and 2010 and field audits completed or scheduled for 2011. The report must include at a minimum:
a. Name of pharmacy.
b. Type of audit.
c. Amount of recoveries.
d. List of problems identified to validate the reason for the recoveries.
2. Send a report that outlines anticipated timeframes and amounts of payments for audits completed in 2009 and 2010 audits.
3. Explain why HPSM has not received a report and check for recoveries for the fourth quarter of 2009 and all subsequent quarters. Provide anticipated dates for reports and checks for 2011.
4. Provide a summary report that describes the edits in place to identify possible fraud related to narcotic drugs.</td></tr>
</table>

EXAMPLE—Corrective Action Plan From 2010Annual Audit Items were identified and relayed to PBM's Director of Quality Accreditation and Client Review		
Problem	**HPSM Analysis**	**PBM Follow-Up**
Contractual Issues	HPSM staff identified a problem with two infusion agencies in the Bay Area. These two agencies informed HPSM staff that they are not in HPSM's network. This resulted in delay and service and consequently higher payments to these agencies through HPSM. HPSM could not get definitive contracting status of these two agencies through PBM. HPSM requested written confirmation from PBM regarding these two agencies.	Beginning March 2011, PBM must provide HPSM network status updates. PBM must also provide a report that PBM staff has also reached out to Crescent Healthcare and Coram to educate their staff on how to properly bill pharmacy claims online to PBM and how to seek assistance from the PBM Help Desk for general billing issues.

Lack of Follow-Up Regarding HPSM Memos	Throughout the year, CMS informs Plans of implementation issues through HPMS memos. Health Plan of San Mateo staff cannot verify when or if PBM has implemented the necessary changes outlined in the memos.	Health Plan staff will provide PBM a list of open HPSM memos. During the weekly meetings, PBM staff will report on the progress of all open items on the HPMS memos. An email message confirming completion of specific memo items must be sent to Barrie Cheung to document completion of tasks.
Lack of follow-up on cases where sales tax was paid on Part D drugs in Louisiana	A CMS memo dated 12/21/2010 indicated that some Louisiana pharmacies had erroneously applied sales tax to part D claims. The memo instructed Part D plans to immediately move forward with recouping any sales tax paid on 2010 Part D prescriptions in Louisiana and resubmitting corrected PDEs for these transactions. HPSM staff has requested updates on the progress of this during weekly conference calls and PBM has not presented a plan for identifying any transactions, recouping sales tax, and resubmitting corrected PDEs.	PBM must **immediately**: 1. Develop and present a plan for addressing the requirements in the referenced CMS memo. 2. Identify any HPSM member prescriptions filled in Louisiana that included sales tax. 3. Begin the process of recouping the applied sales tax. 4. Once identification and recoupment is complete, PBM must resubmit corrected PDEs.

4. Interdisciplinary Care Team (ICT)

a. Describe the composition of the ICT and how the MAO determined the membership

For HPSM's CareAdvantage members, the composition of an Interdisciplinary Care Team (ICT) for a member varies, and the source of the team's members also varies, depending on the intensity of services that the member needs. The basic composition of the team includes:

- Patient and Caregiver (if patient concurs)
- Physician
- Nurse Case Manager
- Medical Social Worker or Social Services Representative
- Behavioral Health Representative
- Other identified professional, as appropriate

This composition of the ICT is determined by looking at the overall services a member generally needs, beyond just clinical services, and finding a suitable representative for the team whose activities address that need. This membership can vary from an ICT that includes primarily internal HPSM team members, primarily external contracted team members, or a mix of both. Additionally, some members of the ICT are determined by the type of ICT held, e.g. if the member is a part of the HUG program (see description in factor c below), that program's professional participants will collaborate as part of the ICT, including the member's PCP. Another example is the visiting physician program (again see below)—CareAdvantage patients in that program have their ICT membership selected based on the team professionals already serving them in that program The following describes further how a more specific ICT membership is determined for an individual member.

The patient is, of course, the member in need of case management services, and the one whose case is being discussed during the ICT meeting. This doesn't vary, regardless of whether the ICT is primarily made up of internal or external members.

The caregiver, who is included upon the agreement of the patient, where applicable, is often a family member, but may also be an in-home support services provider who helps take care of the patient on a regular, even daily basis. In California, these personal care providers are called In Home Supportive Services (IHSS) Workers. Many of our CareAdvantage members, who otherwise live alone, have this support in the home, and the observations of the IHSS worker are often critical in understanding the multiple needs of our CareAdvantage members. IHSS is a program run out of the county Aging and Adult Services (AAS) program, with which HPSM's CareAdvantage staff work closely. We welcome both a family caregiver, if involved with the patient, and their IHSS worker, if also a regular part of the patient's care, to participate as part of the ICT because of the valuable insights into the patient's needs that they often can provide as long as the patient agrees to their participation.

A physician is another important member of the ICT for many reasons. Who this physician might be can vary for our CareAdvantage members. For our highest risk CareAdvantage members, they might be eligible for a special grant-funded pilot we are working on called High Utilizers Group (HUG), very generously funded by the Gordon and Betty Moore Foundation (GBMF). (The HUG work plan is included as Appendix C.) Members are identified for this program by testing HPSM's predictive modeling algorithm for highest risk, which incorporates such parameters as: frequency of hospitalizations over the past nine months; frequency of emergency department visits over the past nine months; presence of case management sensitive diseases such as congestive heart failure, diabetes or chronic obstructive pulmonary disease; presence of a behavioral health diagnosis; presence of end stage renal disease; HCC of 5 or more. This three year grant also aims to include a CareAdvantage member's private provider primary care physician (PCP) as part of their ICT. With the flexibility of the grant, we can move the weekly ICT to a participant's private provider's office, or even the member's home, if so desired by the patient, to ensure ease of participation. The purpose of involving the PCP is to learn from them the direction the treatment of the patient's medical needs is going, while at the same time share the psychosocial issues and discuss workable solutions. Using the trusted physician-patient relationship, we hope to improve the likelihood of success of whatever treatment plan is to be effected, getting the physician and patient/caregiver concurrence at the ICT whenever possible, since having everyone present at one time will hopefully ensure any hesitations or questions are addressed together. We have another program besides HUG that serves patients who are homebound and can no longer visit their PCPs in their offices. While we do have some physicians who make home visits out of their offices, this is only for elective appointments. However, for our high risk homebound patients, we have a visiting physician program with a physician who is on call for them and will respond at any time including nights and weekends. This doctor, who works in conjunction with the patient's PCP, is also available to participate in an ICT. Generally, the patients who he follows are also in need of other disciplines' support, and the benefits of an ICT to problem solve these multiple needs are very evident. These meetings, held as needed, based on the circumstances of this program's changing case load, can be held using technology to assist with everyone's participation (e.g. the patient can participate by phone, as can the visiting doctor) so that the member's needs can be met.

For patients who are less high risk than HUG program or visiting physician members, internal ICT meetings, held bi-weekly at a minimum, occur to discuss members with interval acute problematic circumstances. The physician in these cases is generally one of HPSM's medical directors, who has been informed about the case as the patient has been cared for in an acute hospital or long term care (LTC) facility, or has had a challenge or need arise. This internal physician's clinical expertise is utilized to help plan for next steps in the continuum of care for the member.

A Nurse Case Manager is included as a team member whether the team is an external or internal ICT. For HUG, the nurse is the clinical lead coordinator for the project, following highest risk patients assigned to her because their primary needs are mostly complex medical

co-morbidities. The lead case managers call their patients every week, checking to see if anything is happening that might be a clue that the patient's condition is worsening and needs intervention. Due to the high medical fragility of some of the HUG patients, a nurse case manager is an instrumental position in the program and on the team. The same holds true for the ICT serving the visiting physician's patients. All of his caseload members are patients with multiple complex medical conditions that make his patients homebound. A case coordinator with clinical skills and experience is a necessity for this position. This is generally one of HPSM's nurse care coordinators.

For the internal ICT, the Nurse Case Manager is one of HPSM's nurse care coordinators. The representative on the internal team is whichever care coordinator is following the patient in one of these ways: (1) as the member's care coordinator because of the patient's high risk status as determined by analysis of the results of each member's initial and/or annual health risk assessment or comprehensive assessment; (2) as the NCM for the acute care or LTC episode of care. During the ICT, this NCM raises any issues of concern that have made the case one in need of ICT analysis and discussion, so that potential approaches to resolution can be brought forth.

The Social Services Representative staffing again depends on the level of intensity of services the member needs. For HPSM's CareAdvantage members at highest risk, and part of HUG, this person is an Aging and Adult Services (AAS) staff. AAS is the county agency that is responsible for programs such as Adult Protective Services, Public Guardianship , IHSS, and MSSP. The AAS staff participates in all HUG ICTs to provide advice, information on available social service programs and resources and so forth. Moreover, for those HUG participants whose primary complicating feature of their medical condition is a social service need (e.g. homeless or unstable housing, caregiver needs), the social services representative is their lead case manager. For the ICTs called to address concerns involving one of the visiting physician's patients, the social services representative could be an AAS staff who knows the patient because of services rendered through one of the AAS programs or could be HPSM's medical social worker (see below) who has been working to provide assistance to the patient.

For the internal ICT, the social services representative is HPSM's medical social worker who is part of the CareAdvantage care coordination team. This team member, who is familiar with local County and regional social service resources, helps specifically with internal member cases where issues such as transportation, housing, lack of food, inability to care for self, etc., are identified as barriers to the member's ongoing positive health status and quality of life. She works closely with her AAS colleagues, but knows HPSM resources as well, so provides a unique view for members of how their health plan benefits can work with external social service resources.

The Behavioral Health Representative for our highest risk members who are part of HUG is a Behavioral Health and Recovery Services (BHRS) staff. This department is the county agency responsible for all Medi-Cal mental health services in San Mateo County, which are carved out of our Medi-Cal managed care contract. HPSM has a long history of working closely with

BHRS. As a Medi-Cal managed care plan that has always had seniors and persons with disabilities as our members, the seriously mentally ill (SMI) have long been a notable component of our Medi-Cal patient population. Because of this, HPSM chose BHRS to be the entity to manage the mental health services of our CareAdvantage members when we started our SNP. BHRS knows our SMI patients under Medi-Cal and continues this relationship when they become CareAdvantage members as well. This helps tremendously in developing the trust that is so critical in helping patients with behavioral health conditions work with and respond to support offered from a care manager. That is why, for HUG members who have a behavioral health condition as their primary factor for high risk, the BHRS staff is their lead case manager for the ICT.

For the visiting physician program, patients he follows who have a behavioral health issue have almost universally had a BHRS staff involved in their care. In such cases, that person is the behavioral health representative on the ICT brought together for the patient.

For the internal HPSM ICT, there is not a behavioral health specialist on staff, as there is a social worker. However, due to our longstanding close working relationship with BHRS, the Medical Directors work personally with the BHRS Medical Director. Thus, for any patient needing BHRS input on their case due to having a behavioral health concern, it can be arranged that either the BHRS Medical Director, or if applicable, the BHRS therapist involved in the patient's care can be part of a specific ICT.

Other identified professionals, as appropriate, can also be included in specific ICTs. For HUG, or the visiting physician program, this might be a physician specialist from one of our tertiary care facilities, a social worker or medical director from the Regional Center that works with our developmentally disabled adults (an important segment of our CareAdvantage members, including some of our highest risk ones), a pain clinic specialist from our local program or one of HPSM's clinical pharmacists (see below), for example. It also could be someone the patient or caregiver would like to invite who can provide additional insight on the needs of the patient—a home health nurse or physical therapist, as examples. The ICT model is open and flexible in this regard, to ensure that the clinical information necessary to communicate fully about the patient's condition, and also that can provide insight to help create a care plan for the patient that is appropriate to meet the patient's current needs is available.

For the internal ICT, additional professionals available include: (1) Director of Health and Provider Services—this Master's prepared nurse is the director of the care coordination unit, and has many years of experience in case management, patient assessment and ICT coordination. Therefore, her facilitation of the biweekly ICTs as necessary helps ensure that the key issues necessary for reviewing patient needs and improving health status are addressed. (2)Pharmacy Manager or other Clinical Pharmacist—HPSM's pharmacy unit adjoins the care coordination unit, and its trained, licensed clinical pharmacy staff, all Pharm.Ds with many years of experience, are readily available to provide insight into a patient's medication regimen, possible side effects or drug interactions, assist with enrollment in the Medical Therapy Management (MTM) program, and so forth. (3)Health Educators—HPSM's health

education unit is also near the care coordination unit, where its Master's prepared health educators are available with information and materials to provide CareAdvantage members on preventive services at all levels, including healthy aging, activity, eating, stop smoking, along with living with diabetes or arthritis, as well as dealing with complications, cancer, and other conditions facing many of our CareAdvantage members. The ICT team would decide when these other professionals would be asked to attend.

One other type of ICT that might occur on an ad-hoc basis is one set up by an acute care hospital as staff readies to discharge an HPSM CareAdvantage member. While this would not be an ICT for which HPSM would be in charge or responsible for, our on-site nurse case manager would certainly participate as part of facilitating an appropriate member discharge, and work with the patient, his/her PCP and the acute care staff to arrive at the best care management strategy for addressing the acute issues at hand.

b. Describe how the MAO will facilitate the participation of the beneficiary whenever feasible

Participation of the beneficiary in ICTs: At all levels of ICT, the patient is welcome to attend. Below is a description of ways that have been successful, and ways we plan to employ further in 2012 that we hope will bring us even more success in including the patient in our ICTs.

Patient participation begins with the completion of the HRA, and the comprehensive assessment by phone. The member's perspective, perception and needs are gathered, and become the center of any care plan that is created. At HPSM, this perspective is always included in any ICT held internally. Moreover, for patients with issues brought to the ICT by their nurse case managers, the care coordinator has usually recently spoken to the member, gotten their perspectives and concerns and is bringing their issues forward for advice and approaches for solutions to the ICT. Similarly, the NCMs presenting on-site cases at the internal ICT are expressing the issues voiced by their patients in acute hospitals or LTC whom they have recently seen, and performed chart reviews. Thus, outreach and communication by phone or in person, depending on the patient's circumstance, is an ongoing process to facilitate patient participation and input in their ICT. Although not "real-time," the beneficiary participates in these team meetings as represented by his/her care coordinator, and is promptly informed of the results after the meeting.

In the visiting physician program, ICTs can occur with real time patient participation if the patient agrees, because the ICT can be held in the patient's home. This is possible when a concern involves next steps in the visiting physician's treatment program, the PCP does not disagree with the treatment program, other members of the ICT can travel to the patient's home or participate by phone, and because the visiting physician's program is based on the physician traveling to the patient's home. Outreach and communication here occurs directly face-to-face or via phone with the patient, in the usual course of the visiting physician's work with the patient. Sometimes the patient's home can be a barrier, due to space, or patient ability to participate due to his/her condition. In these cases, the ICT is held at a clinical space, and the patient is informed of the results immediately afterwards.

Some of the barriers in each of these settings to patient participation include logistics e.g. can the patient get to the site of the ICT? If the patient's home is the site, is that acceptable to the patient? Is the home a realistic site for the ICT? Additionally there are clinical barriers for the patient as well—the ICT can be long and detailed—can the patient tolerate sitting through it? Is the patient capable of understanding it? Who should determine what is best?

While many different clinicians might have as many different answers to the above questions, HPSM has decided to take a straightforward approach to this issue as part of the HUG grant (see description above). This is where we hope to set an example for clinicians of various disciplines as well as set a welcoming and facilitative standard for patients regarding their participation in ICTs. As part of HUG, it is the basic tenet that patients are to participate in every ICT that involves them. If our focus is patient-centered care, then the patient needs to be at the center. If the patient isn't physically or mentally able to do so, then a caregiver can represent them. That is our norm, and setting that standard, we hope will develop a new culture of patient participation, rather than have the exception be that a really insistent patient is the only one in attendance at the ICT.

Since the patient's and caregiver's perception often has to change as well as the clinicians' for this to occur, we plan to do the following outreach and communication steps to educate our patients, and thus facilitate their inclusion in ICTs:

- Each time a new patient is introduced to the HUG program, participation in the ICT will be highlighted. We will be framing the ICT as a major aspect of the HUG intervention benefit, along with its other components such as ongoing support of the private PCP, weekly calls with the patient's lead care coordinator, and active attention to the needs of the patient/caregiver.
- Our focus in highlighting the patient's ICT participation will be on how important the information the patient/caregiver has to share will be to the success of the ICT—how what they need and what is going on with them is critical to what we discuss and what approaches we develop as part of the individual care plan.
    - We hope that this emphasis will resonate with the patients, many of whom are used to doing what the physician says. So we hope that if we say this is really needed by the physician and the rest of the team, that will align with their desire to contribute and also will help them realize that at last someone finally is interested in hearing what they have to say.
- We will also schedule the ICT as much as possible in a way that is convenient to the patient. CareAdvantage members have 50 one way taxi rides for health-related needs, so transportation shouldn't be a problem. Caregiver support should not be an issue, as AAS will assist with that. We have face-to-face interpreters available if we need language services. Thus, we will work to make the ICT as member-friendly as possible. We hope that by focusing on the member in these specific ways, the likelihood of their participation in person will be increased.

- For those members who still will find it difficult to sit in a face-to-face meeting, we will offer phone conferencing. We will work to accommodate them as necessary so they can participate in real time with the ICT.
- The HUG project manager will follow up after each ICT to see how the member perceived the interaction, in order to find out ways we can improve our outreach, communication and meeting process, and thus make things even more acceptable to future HUG patients.

c. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.)

The following describes how the ICTs at various levels operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.)

High Utilizers Group (HUG) ICT

As patient participants enroll in HUG, they are assigned a lead care coordinator, based on a determination by the care coordinator group of the patient's primary reason for being highest risk (e.g. clinical, behavioral health or social services). The HUG Project Manager (PM) is informed of the decision, and he notifies the patient's PCP as well as the rest of the HUG ICT team. The assigned lead care coordinator calls the patient to introduce herself and explain the program further. The PM handles the ICT calendar, and schedules the participant case discussions after ensuring both the PCP and patient/caregiver are available. The ICT meets weekly, so new participant discussions are scheduled based on need, team availability, patient/PCP convenience, etc. Meanwhile, the lead care coordinator of each patient calls the patient weekly to check in, before and after the ICT, follows up with the PCP and other physicians as necessary, works with the patient on self-empowerment re: his/her medical conditions, and so forth.

Notification of meetings is by e-mail, or for PCPs and patients, if necessary by phone or fax. The PCP is the case presenter at his/her patients' ICTs. The lead care coordinator is the record keeper of her cases. All three agencies that are part of the program (HPSM, AAS and BHRS), share a HIPAA compliant HIS system where the data from the uniform assessment tool to be used as part of the program's initial patient assessment is kept; thus all program staff can access any data from it. In addition, all professionals who are part of the ICT, including the PCPs, have access to a web-based HIPAA compliant case management program that is where key team clinical updates are documented/shared, e.g. results of phone calls between the participant and lead care coordinator; or the PCP and the lead care coordinator, etc. If any documents need to be added to the overall case management file, they are scanned as a pdf into this case management program. Any progress notes from the PCP medical records, any notes from other providers, and any documents the patient feels he/she wants in the record can be uploaded into the case management file readily. Thus, any of the team members can

update or check on the status of the member. In this way, all stakeholders who are part of the team can have ICT reports at their fingertips. In addition, if these ICT reports need to be disseminated to other stakeholders confidentially (e.g. another physician specialist, a Regional Center medical director), they can be printed or saved and forwarded in a HIPAA secure fashion.
Records for the program are kept for ten years, according to CMS requirements.

A case example illustrating the success of HPSM's High Utilizers Group ICT is included below:

High Utilizers Group Case Study: HUG Case-Managed Participant Henrietta Jacque (not the patient's real name)

Ms. Henrietta Jacque is an 87 year old CareAdvantage member who is one of HPSM's highest risk members. She has diabetes, CHF, COPD, peripheral vascular disease, and coronary artery disease. She has been hospitalized 5 times in the past 8 months, and been to the emergency room 6 times in the past 3 months. Her CMS RAPS score is > 5. When her primary care provider (PCP), Dr. PC, was asked about having her join HUG, he almost shouted for joy, because he stated he was feeling, "like I've been drowning," trying to manage her and keep her at home, which is what her large family insisted was where she would stay until she died.

Her Case Manager, Anya, contacted Ms. Jacque, and her daughter, Pearl, who is her primary caregiver and IHSS worker. She informed them about the HUG program, and that Dr. C had recommended the program for her. Anya outlined the services available, including the ICT, and that she would be contacting Ms. Jacque weekly to see how things were going. She would also be focusing on providing anything in the home that Ms. Jacque might need to help keep her out of the hospital and comfortable at home. Since Anya is a nurse practitioner, she would be able to see Ms. Jacque in the home, and review her medicines, working closely with Dr. C, to see if anything would need to be adjusted to them so that an ED visit could be avoided. Both Ms. Jacque and Pearl readily accepted the HUG program, and made an appointment with Anya to go over the enrollment paperwork, completion of the Uniform Assessment Tool (UAT), etc.

After the initial visit, Anya came back with information to an internal core team meeting, where Ms. Jacque's case was reviewed prior to the ICT case conference that would be scheduled for the patient, Pearl and Dr. C to attend, along with the full array of consultants. Anya reported to her supervising physician and the internal core team social worker (the other HUG care coordinator) that Ms. Jacque's home was an older style and had stairs between almost every room. Ms. Jacque just couldn't manage them with her walker anymore. She had a manual wheelchair, but she couldn't propel it herself, so she dragged herself from room to room, hanging onto walls, and had frequent falls, some which led to ED visits. She also noted that Ms. Jacque's grandkids were leaving potato chips everywhere,. Ms. Jacque freely admitted that if they were around, she ate them, and if they were not, she was okay. Both Pearl and Ms. Jacque acknowledged that most of the hospital stays and ED visits were associated with increased salt intake. It seemed like the hospital stays and ED visits were connected to her diagnosis of CHF .

The other conditions weren't too bad; though the COPD was also exacerbated by all the stairs. The team developed some possible interventions including a power wheelchair, a no-potato-chip rule for the grandkids and a scale for checking Ms. Jacque's weight daily.

The HUG Project Specialist, Preston, helped make arrangements for the ICT case conference. Dr. C could make time during his lunch hour to attend. He had a conference room in his office building that he could reserve. The Jacques lived near Dr. C's office, and were comfortable going to that familiar place, so they agreed that it was a fine place to meet. The ICT professional team members arranged to meet in person there as well. When the case conference time arrived, a light, healthy lunch was provided (chicken wraps plus a salad, and water), and everyone arrived. After everyone introduced themselves, Anya gave a brief summary of why they were there, and what the goals were. Then, Dr. C was asked to talk about his perspective and thoughts about Ms. Jacque's condition. Ms. Jacque and her daughter were then asked to express their thoughts. Dr. C basically summarized her diagnoses, and that he was concerned that she was going in and out of the hospital because she was getting too ill to stay at home. Ms. Jacque, expressed that she had known Dr. C for years, and he had always taken good care of her, and she knew he meant well, but she wasn't going to any home but her own. At that point, Anya stepped in and talked about how, when she went to visit and examine Ms. Jacque at home, there were things that were there that looked like they could be changed to help make the home healthier for Ms. Jacque. She then brought up the issues of the stairs and the potato chips. Dr. C said he hadn't been aware of the stairs or the chips, that could explain a lot. The daughter said she didn't think her mother would use a chair, but Ms. Jacque said yes she would, she was tired and didn't want to sit in a living room chair all day, she would be ready to use a power chair. Dr. C agreed immediately to order it, and Anya (who works for HPSM) stated she could approve it. There would need to be ramps built across each of the stairs, though—Pearl said her husband and sons could easily take care of that.

Then, the issue of the potato chips came up. Pearl acknowledged it was her boys with the problem. She decided that she would start buying individual bags of chips rather than bulk ones—that way there wouldn't be any leftovers for Ms. Jaque. Ms. Jacque was asked about weighing herself daily. Pearl said that she could help Ms. Jacque do it, and write it down—they both needed to watch their weights and could do it together. Ms. Jacque agreed.

The ICT also reviewed Ms. Jacque's remaining medical conditions, her current medications, and Dr. C made sure the doses were correct. Pearl had a question about Ms. Jacque's Medicare renewal, and the social worker was able to clear it up immediately. Dr. C said he would like to keep in touch with Anya, and then Ms. Jacque might not need appointments so frequently—he would go to once a month for now, and then reduce these if all was going well—he stated he now was feeling more optimistic for the first time in a long time about Ms. Jacque's condition. The ICT wrapped up, and Anya stated she would arrange for the power wheelchair company to come and measure Ms. Jacque for the chair, do all the ordering, and get that authorized as soon as possible. Ms. Jacque said she had been a bit nervous initially, but that this was a great meeting, and she looked forward to the next one.

Anya summarized the meeting in the internal case management tool, and excerpted key points into the web-based case management tool, for all the internal and external parties

to have a record of it. Dr. C added a note to the web-based tool, stating that as a result of the meeting, Ms. Jacque might actually be able to remain safely at home for a while longer.

Visiting Physician ICT

Because any ICTs planned/carried out for patients followed by the visiting physician will be held as needed, there isn't a regular schedule of such meetings. However the following is what occurs when it is decided that such an ICT is necessary:

- The visiting physician program's nurse care coordinator is notified that a patient concern needs an ICT. This includes an explanation of the issue of concern.
- The ICT staff members serving the patient are identified, including designating who needs to be the lead if the issue is not a medical (i.e. HPSM care coordinator or physician) one.
- The HPSM care coordinator contacts the patient to see if he/she can be part of the meeting, and if so, does he/she want the meeting at their home. If yes, the scheduling proceeds with that in mind; if not, another site is planned, or a teleconference is planned.
- The staff representatives, and any pertinent HPSM other professionals (e.g. pharmacist if a medication issue such as pain medication usage is identified) are notified via e-mail or phone; the PCP is updated; the date is set and the ICT is held, preferably with the patient in attendance in person or by phone.
- The lead care coordinator is responsible for ICT notes; the visiting physician also takes notes that are kept on a web-based HIPAA compliant server, accessible to the PCP.
- Records for the program are kept for ten years, according to CMS requirements.

A case example illustrating the success of HPSM's ICT working in conjunction with the visiting physician is included below.

Interdisciplinary Care Team and Visiting Physician Case Example: Donna Sanchez (not the patient's real name)

Donna Sanchez is a 56-year-old woman weighing more than 500 pounds, with complex medical needs including heart failure, respiratory failure and recurrent skin ulcers. Nursing facilities refused to accept her due to her weight. She could not care for herself and had no family support. She had more than 20 hospitalizations and visits to the Stanford ED over a six month period. She was extremely high risk because of her respiratory status in particular. She would get anxious, then short of breath, call 911, end up in the ER, and ultimately intubated and on a ventilator due to her rapid downward spiral as soon as her respiratory symptoms began. Her most recent hospitalization at Stanford lasted 3 months due to difficulty in weaning her off the ventilator.

Multiple internal HPSM Staff ICT meetings were held, since the patient could not go to a nursing facility and insisted on returning home. One nurse case manager was assigned to Ms.

Sanchez, and she led each internal ICT, where every aspect of Ms. Sanchez' case was reviewed. Equipment was a key component —since Ms. Sanchez spent most of her days in bed, pressure-reducing surfaces were necessary. In order to try and get her to sit up, a bariatric bed that would allow her to shift into some type of mobility device was also needed. Social services were also critical, as well as mental health, since the team identified that isolation and depression were main factors for Ms. Sanchez' anxiety, which most often triggered her episodes of respiratory distress.

The ICT identified solutions such as working with county departments to maximize services, including more IHSS and meals on wheels (with a weight-reducing diet). The team also agreed that more home health services could help support Ms. Sanchez in the home and help avoid medical destabilization. Ms. Sanchez was unable to leave her home to visit her PCP. Fortunately, his office was a few blocks away from her home, so he agreed to make home visits. However, this became untenable for him, due to his workload. Therefore, the ICT recommended that Ms. Sanchez be referred to HPSM's in-home visiting physician program. The PCP was eager to have her enter the program, but she wanted her PCP to continue making the home visits. However, when he explained he would continue to direct her care in consultation with the new physician, she agreed.

The visiting physician gave lots of information to the ICT, which included many of the same staff as the internal HPSM ICT, but which also included an external mental health (MH) counselor who had been arranged for Ms. Sanchez. The nurse case manager led the discussion, identifying areas where Ms. Sanchez still needed additional support. Per the visiting MD's report, after seeing Ms. Sanchez in the home, she needed a lift chair to help her get up. Then she could walk around slowly. For more mobility, she needed a bariatric scooter, since a wheelchair would be too difficult for her to get in and out of. In addition, the MH counselor recommended that Ms. Sanchez needed visitors. The team identified a local church that Ms. Sanchez had mentioned once as having "friendly people." The MH counselor agreed to work with Ms. Sanchez to contact the church and see if they could set up a regular visiting schedule. The nurse case manager reported that already, since Ms. Sanchez could call the visiting physician or the MH counselor when she felt anxious, instead of 911, the ambulance trips, ED visits and hospital stays had dropped dramatically. Every time the nurse case manager checked in with Ms. Sanchez, she seemed more upbeat, and had specific issues to address (e.g., my medications are low—what pharmacy should I call, vs. I feel miserable, I don't know what to do, that's why I eat). The nurse case manager agreed she would continue to follow up with the visiting physician and Ms. Sanchez on a regular basis.

The nurse case manager entered the notes of the meeting into the internal database, and also summarized the meeting into the web-based HIPAA compliant database used by the visiting physician so he would have a record of the ICT. She forwarded a copy of the notes (encrypted securely) to the MH counselor. She called Ms. Sanchez to let her know that the MH counselor would be working with her to arrange for folks to come visit her, and that she (the NCM) would be contacting her on a regular basis, just as they had been doing, to keep in touch and address any problems or issue that came up, so that she wouldn't have to worry about anything she needed for her health.

Internal HPSM Staff ICT

HPSM's internal ICT meets no less than biweekly, and meets more often if needed. The plan's Care Coordination ICT focus is to improve the quality of care delivered to members via a collaborative process through assessment, planning, facilitation, and advocacy for options and services to meet the individual's health needs through communication and available resources to promote quality cost-effective outcomes.

HPSM's ICT is held on a specific day and time every other week, and is on all the care coordination units' calendars, so no additional notice is necessary, unless a special meeting is being held. An agenda is distributed for every meeting. Minutes are taken by the department's administrative assistant. All members of the plan's internal ICT receive copies of minutes prior to the subsequent meeting.

d. Describe how the activities of the ICT will be documented and maintained.

Individual member case summaries and interventions discussed at the ICT are documented in the plan's electronic Care Coordination database. Member-specific case summaries and interventions are communicated to the PCP and/or other parties, and copies of the minutes are sent securely to other stakeholders (e.g. BHRS or AAS representatives who have attended), as appropriate, to effectively carry out required care management interventions that improve the patient's health care outcomes.

Records for the program are kept for ten years, according to CMS requirements.

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols

a. Describe the specialized expertise in the MAO's provider network that corresponds to the target population including facilities and providers (e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.)

HPSM contracts with an extensive network of health care providers with specialized expertise to meet the healthcare needs of the CareAdvantage population. This network includes hospitals and other health care facilities, medical specialists, behavioral and substance use specialists, nursing professionals, allied health professionals, pharmacies, home and community-based services, and long-term care facilities. In addition, members of this network range from physicians managing solo practices to large multi-specialty physician groups and hospital and medical systems. HPSM's provider network also includes a wide range of safety net providers, including the San Mateo County public hospital and clinic system. HPSM requires physicians to be board-certified or board-eligible for contracting purposes.

HPSM has over 1,500 specialists in its network. This includes, but is not limited to, specialists in radiology, ophthalmology, cardiology, geriatrics, oncology, pulmonology, nephrology, infectious disease, hematology, cardiothoracic surgery, dermatology, pathology, urology, orthopedics, rheumatology, vascular surgery, neurosurgery, and endocrinology. Additionally, CareAdvantage members have access to a primary care network with nearly 850 primary care physicians, hundreds of pharmacies, 150 skilled and long term care nursing facilities, over two dozen contracted acute care facilities and a tertiary care acute care facility within the San Francisco greater Bay Area ensuring access to and continuity of care. CareAdvantage members also have access to a multitude of specialty allied health providers to meet the health care needs of the CareAdvantage population which include home health agencies, outpatient rehabilitation facilities, chiropractic, multi-specialty clinics, radiology, surgery centers, audiology, medical transportation, hospice, durable medical equipment and orthotics and prosthetics providers to name a few. Specialty, primary care and allied health provider representation is described in greater detail in the following paragraphs. We include specific examples of the unique and specialized services of our network tertiary hospital- Stanford Hospital, senior care center- Ron Robinson Senior Care Center, and our mental health provider services through Behavioral Health and Recovery Services that provide complex and specialty health care services that meet the needs of our CareAdvantage population.

CareAdvantage members reside in San Mateo County which extends north to the San Francisco County border and south to the Santa Clara County border. The primary care network almost all practices within San Mateo County. However, due to the practice patterns of the specialty network, and thus to meet the needs of our CareAdvantage population, the HPSM specialty network service area covers the greater San Mateo county area extending

north to San Francisco and south to Santa Clara County. The HPSM CareAdvantage network includes, but is not limited to:

- Over 60 individual practice physician specialty types including but not limited to :
  - 235 Radiologists
  - 126 Opthalmologists
  - 83 Cardiologists
  - 80 Orthopedic surgeons
  - 68 Dermatologists
  - 58 Otolaryngologists
  - 76 Neurologists
  - 40 Urologists
  - 32 Gastroenterologists
  - 30Neurological surgeons
  - 29 Physical Medicine and Rehabilitation Specialists
  - 26 Thoracic Surgeons
  - 25 Pulmonologists
  - 25 Radiation Oncologists
  - 20 Rheumatologists
  - 20 Endocrinologists
- 26 acute care hospitals
- Numerous National Dialysis Centers (Da Vita), San Mateo Dialysis Center
- 150 skilled nursing/long term care facilities
- 234 local and national pharmacies
- 70 durable medical equipment providers
- 52 podiatrists
- 26 acute care hospitals
- 50 optometrists/opticians
- 20 home health agencies
- 16 outpatient physical rehabilitation specialists
- 11 chiropractic specialists
- Over 100 multi-service specialty clinics extending within and outside of our contracted tertiary care center
- 7 home infusion providers
- More than 2 dozen laboratory/pathology sites
- 13 audiologists/hearing aid specialists
- 4 hospice providers
- 5 medical transport providers
- 18 Alcohol and Drug specialty agencies
- 7 inpatient mental health facilities
- Over 100 mental health providers
- Several Community-Based Adult Services (CBAS) Centers both in-county and out-of-county

- Over a dozen county community social service agencies including but not limited to Aging and Adult Services (with In-Home Support Services, Multipurpose Senior Services Program (MSSP), Meal on Wheels, congregate nutrition and other Older Americans Act funded services), Family Health Services/ Public Health Nursing, Golden Gate Regional Center.

The current specialty physician to patient ratio for the CareAdvantage population is 1:5. The primary care physician to patient ratio for the CareAdvantage population is 1:10.

Network Expertise Example 1: Behavioral Health and Recovery Services

Approximately 44% of the plan's CareAdvantage population is dually diagnosed with a mental illness. HPSM contracts with the county mental health provider, Behavioral Health and Recovery Services (BHRS), to provide access to and specialty expertise in mental health and alcohol and other drug rehabilitation services for the CareAdvantage population.

BHRS is responsible for providing needed mental health services to all plan CareAdvantage members. All services are aimed at helping individuals with mental illness improve their quality of life and health status, and maintain their independence. BHRS serves clients through outpatient service centers in San Mateo County, in the cities of Daly City, San Mateo, Half Moon Bay, Redwood City, and East Palo Alto and through a network of community agencies and independent providers. These county and community resources provide outpatient services, residential treatment, rehabilitation and other services for CareAdvantage members. BHRS also operates the Cordilleras Mental Health Center, a 120 bed skilled nursing facility in Redwood City providing short and long term care for CareAdvantage members with mental health care needs requiring skilled nursing inpatient services.   Through BHRS, HPSM's CareAdvantage members have access to several community health agencies including:

- Caminar- Programs and services that emphasize client choice, interdependence, community support and rehabilitation services that enhance each client's potential.
- Cordilleras Mental Health Center- A 24 hour in patient mixed use facility with 68 beds within the locked mental health rehabilitation center and 49 residential beds. The center also operates three licensed Adult Residential Facilities.
- Depression and Bipolar Support Alliance of San Mateo County- A support group for persons with Depression or Bipolar illness.
- Garfield Mental Health Center- A resource for persons who are non-ambulatory or fragile elders, and who require a high level of supervision and therapy for neurological or mental illness.
- Gladman Hospital- A Mental health Rehabilitation Center providing high level care for persons with serious symptoms and behavioral problems caused by mental illness.
- Puente Clinic- A specialty clinic offering mental health services for individuals with developmental disabilities, bridging resources between San Mateo County's BHRS, Golden Gate Regional Center and Health Plan of San Mateo. This unique clinic

provides comprehensive mental health treatment including medication management for members with intellectual/cognitive disabilities and behavioral/mental health challenges.

- Women's Recovery Association- Provides gender specific treatment for women and their families with the goal of helping them resume productive, meaningful lives in the community free from the effects of alcohol and drugs.
- Asian American Recovery Services- community based partnership implementing strategies to prevent and reduce alcohol and drug abuse in North San Mateo County.
- Catholic Charities- offers day recovery services for adults, relapse prevention support and individual counseling sessions.
- Horizon Services- provides outpatient substance abuse treatment and recovery services.

BHRS's core service mandate, as the San Mateo County's public Mental Health Plan, is to assure access to necessary services to adults and older adults with serious mental illness/psychiatric disabilities with specific focus on the Medi-Cal and dual –eligible CareAdvantage population. BHRS also partners with other County and community agencies to provide crisis intervention and a mental health response to critical community incidents and disasters.

BHRS's mission is to build opportunities for people with or at risk of alcohol and other drug abuse and or mental illness challenges achieve wellness and or recovery through patient centered care. Strategic initiatives include:

- Promotion of Diversity and Equity: Elimination of health inequities, promoting cultural competence as a strategy to improve access and services to under/underserved and inappropriately served communities.
- Advance Prevention and Early Intervention: Preventing mental illness, substance abuse, and co-occurring disorders and promoting positive well-being for all people in the community.
- Welcome and Engagement: Develop a culturally competent and client sensitive entry system that connects clients and family members to appropriate services and supports at the right level and at the right time.
- Empowering Clients and Families: Provide opportunities for consumers and their family members to voice their opinions and thoughts to influence the delivery of services and the development of policies.
- Foster Total Wellness: Reduce Health Disparities for BHRS clients by increasing access to prevention, disease management and health care services. Develop creative client driven wellness and disease prevention/management programs. This emphasis on preventive services at all levels is especially important for our CareAdvantage members, who also have multiple co-morbidities besides SMI.

- System of Care Enhancements and Supports toward Wellness and Recovery: Enhancements to service capacity, structure, policy, and procedure to support organizational values and desired client outcomes.
- Cultivate Continuous Learning and Improvement: Incorporate best clinical, administrative and policy practices into developing customized training and education. Support the development of core competencies necessary to promote wellness/recovery and fully integrated treatment within BHRS and contract agencies.
- Anticipate and Prepare for Disasters: Provide information, procedures and training to prepare for emergencies and disasters.
- Build Organizational Capacity and Support Transformation: Implement electronic innovations and administrative best practices to increase efficiency, quality, and effectiveness of service delivery, program planning and accountability of BHRS.

Network Expertise Example 2: Stanford Hospital

HPSM contracts with Stanford Hospital and Clinics to provide tertiary care and complex medical management for the plan's CareAdvantage population. Greater than 60% of our CareAdvantage population has 4 or more chronic illnesses, many with complicated conditions such as cardiovascular disease, cancer, and complex endocrine and pulmonary diseases. Stanford Hospital and Clinics is a leader in the advanced treatment of complex disorders in areas such as cardiovascular care, cancer treatment, neurosciences and surgery and organ transplants. Stanford Hospital has 613 acute care beds and is a level 1 trauma center.

Stanford Hospital provides both general acute care services and tertiary medical care for the plan's CareAdvantage population. Stanford's Specialty Clinics offer more than 100 specialty and subspecialty service areas. The Clinics employ more than 493 full time physicians with areas of expertise ranging from primary care to advanced medical and surgical specialties. Stanford's Specialty Clinics include:

- Anticoagulation
- Bariatric Surgery for Morbid Obesity
- Breast and Breast Cancer Surgery
- Cardiology and Cardiovascular Surgery
- Heart Failure and Cardiomyopathy
- Colon and Rectal Surgery
- Adult Congenital Cardiology
- Dermatology
- Ear, Nose, Throat
- Endocrine and Metabolism
- Facial Nerve
- Gastroenterology
- Hand and Upper Limb Surgery
- Heart and Lung Transplant

- Hematology
- Hepatology
- Immunology
- Infectious Disease
- Interventional Neuroradiology
- Kidney and Pancreas Transplants
- Liver Transplants
- Heart/Lung Transplants
- Nephrology
- Neurology/Neurosurgery
- Oncology
- Oral maxillofacial Surgery
- Otolaryngology
- Pain management
- Pituitary Center
- Pulmonary medicine
- Rheumatology
- Spine clinics
- Primary care
- Thoracic Surgery
- Urology
- Vascular Surgery
- Women's Health

In addition, Stanford has 6 Centers of Excellence that include: the Cancer Center, Heart Center, Neuroscience, Orthopedic Surgery, Surgical Services (vascular and reconstructive) and Transplantation.

Network Expertise Example 3: Ron Robinson Senior Care Center

The plan's CareAdvantage population is medically complex, requiring a multitude of medical and psycho-social services which often puts them at risk for fragmentation of care and unnecessary avoidable hospital admissions.

The Ron Robinson Senior Care Center (RRSCC) is located adjacent to our community safety net hospital. The RRSCC is an integrated health care delivery clinic that focuses on the health and well-being, including physical, mental, social and lifestyle health, of seniors 60 years of age and older.

The integrated model of care utilizes an interdisciplinary team approach. Physicians and nurse practitioners provide primary care with an integrated multidisciplinary team, which includes nurses, a psychiatrist, psychologist, licensed clinical social workers, nutritionists and rehabilitation therapists.

The RRSCC incorporates a Geriatric Assessment Program. This program is a consultative service provided by their team of healthcare professionals. Patients are evaluated for physical health, mental health, social needs, and functional status. CareAdvantage members experiencing memory loss, confusion, recent falls, and frequent hospitalizations benefit from the Geriatric Assessment program services at the RRSCC. The center's multidisciplinary team provides coordination of services with community resources such as Aging and Adult Services (IHSS and MSSP) and other community based services.

To ensure that our network facilities and providers are actively licensed and competent, all providers must undergo HPSM's credentialing procedures that include passing the HPSM's site review and medical record review standards, and receive approval by the San Mateo Health Commission in order to become a contracted network provider with HPSM. In addition, all providers must be re-credentialed every three years, and they must agree in their contracts to provide services in accordance with nationally-recognized clinical guidelines to ensure high quality of care.

b. Describe how the MAO determined that its network facilities and providers were actively licensed and competent

HPSM provider contracts specify that providers must be in good standing in terms of all applicable legal, professional and regulatory standards as a participating CareAdvantage provider. Physicians, network facilities, and ancillary providers who are excluded from participation in the Medi-Cal or Medicare programs may not provide services under the CareAdvantage program. CareAdvantage providers must further agree to any providers working for them are and will continue to be properly licensed by the State of California and the U.S. Department of Health and Human Services.

To ensure providers have active certification and in good standing to provide services under the Federal Medicare program, all CareAdvantage primary care provider, specialist, facility and allied health provider contracts mandate participation requirements within Health Plan of San Mateo. These participation requirements are outlined in the primary care provider, specialist, facility and allied health provider contracts (section 6.20-Participation Requirements and the provider manual section 8- Provider Services). Examples of relevant sections of the provider contract and the Provider Manual are included below. The Provider Manual is an additive document to the contract between Health Plan of San Mateo and the provider that further outlines the policy and procedures of HPSM and provider participation in the plan. This is outlined in section 13.1- Provider Manual of the CareAdvantage PCP agreement: "…PCP agrees to comply and will have any Downstream entity agree to comply with Plan standards and policies outlined in the Provider Manual."

Continuous monitoring of provider compliance with these standards is the responsibility of the Credentialing Specialist. Specific monitoring criteria and the plan's Policy and Procedure for monitoring these standards is outlined below. Examples of the plan's CareAdvantage contract

and Provider manual sections that mandate HPSM's network facilities and providers are actively licensed and competent follow with verbatim verbiage.

Example 1: Section 6.20 of the primary care provider, specialist, facility and allied health provider contracts states:

> "Participation Requirements: PCP (Specialist/hospital/allied Health provider) understands that PLAN is prohibited by CMS and the California Department of Health Care Services from contracting with a provider who itself, its employees, managers, or Downstream Entities are excluded from participating in the Medicare or Medi-Cal programs. PCP warrants that it shall review the Office of the Inspector General, General Services Administration and the Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, or subcontractor responsible for administering or delivering benefits under any federal or state health care programs is excluded. PCP further understands that PLAN is prohibited by CMS from including as a Contracted Provider, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. In such an event, Plan reserves the right to terminate this Agreement immediately and require PCP to reimburse Plan immediately for any direct or indirect payments to PCP and the amount of any sanctions imposed on Plan by CMS or Medi-Cal for violation of this prohibition."

Example 2: Section 6.9 (Compliance with Law and Ethical Standards) of the HPSM CareAdvantage Provider agreements state:

> "PCP (facility/Specialist/Allied health Provider) shall at all time during the term of this Agreement comply with and have any of its Downstream Entities comply with all applicable federal, state and municipal laws (including applicable Medicare laws and regulations), all applicable rules and regulations of the Medical Board of California or the California Board of Osteopathic Examiners and the ethical standards of the American and California Medical Associations. If at any time during the term of this Agreement, PCP shall have PCP's license to practice medicine in the State of California suspended, conditioned or revoked, this Agreement shall terminate immediately and become null and void without regard to whether or not such suspension, condition or revocation has been finally adjudicated. "

Example 3: Section 8 page 3 of the Provider Manual – Contractual Requirements for Credentialing and Regulatory Compliance states:

> "In your contract you agreed that you and any providers working for you are and will continue to be properly licensed by the State of California. Additionally, you represented that you are qualified and in good standing in terms of all applicable

legal, professional and regulatory standards as a participating Medi-Cal provider. Physicians who are excluded from participation in Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not provide services under the Medi-Cal, Healthy Families, Healthy Kids and HealthWorx programs.

As a contracted CareAdvantage provider, you agreed that you and any providers working for you are and will continue to be properly licensed by the State of California. Additionally, you represented that you are qualified and in good standing in terms of all applicable legal, professional and regulatory standards as a participating Medicare provider. Physicians who are excluded from participating Medicare programs by the U.S. Department of Health and Human Services may not provide services to HPSM CareAdvantage members.

You are required to notify us within fourteen (14) calendar days in writing if the following actions are taken against you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification or clinical privileges.
- A peer review action, inquiry or formal corrective action proceeding, or investigation.
- A malpractice action or governmental action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National practitioner Data Bank of adverse credentialing or peer review action.
- Any material change in the credentialing information.
- Sanctions under the Medicare or Medi-Cal programs.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

If you fail to meet the credentialing standards or, if your license, certification or privileges are revoked, suspended, expired or not renewed HPSM must ensure that you do not provide any services to our members. Any conduct that could adversely affect the health or welfare of a member will result in written notification that you are not to provide services to our members until the matter is resolved to our satisfaction."

Example 4: Page 4 of Section 8 of the Provider Manual- Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion states:

"Your contract references this certification in Section 2 of the Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx Agreements, and in Section 6 of the CareAdvantage Agreement. HPSM qualifies as a contractor receiving funding from the Federal Government. Any such contractor is required to represent to the

government that they and their subcontractor have not been debarred, suspended, or made ineligible. By completing and signing Section XVI (Attestation Questionnaire) and the Release of Information/Acknowledgements Form of the California Participating Physician Application, you certify that you are eligible to participate in our program and receive funds provided by the government. This form must be signed and returned with your agreement. Pursuant to this certification and your agreement with HPSM should you or any provider with whom you hold a sub contract become suspended or ineligible you shall notify HPSM immediately. "

To ensure continued compliance that network facilities and providers are in good standing, actively licensed and competent to participate in HPSM's program, by the standards outlined above, the Health Plan of San Mateo's Providers Services department conducts ongoing monitoring of the network on a monthly basis to ensure our network providers have no l imitations or sanctions reported by the noted Regulatory agencies.

This is outlined in the HPSM's Provider Services policies and procedure CR-01 Credentialing, CR-02 Recredentialing and the Credentialing Specialist's job description. The Provider Services policies and procedures CR-01, CR-02 and CR-07 are included as an appendix to this Model of Care document. The Credentialing Specialist's job description is also defined and outlined in Section 3–Staff Structure/Care Management Roles of this Model of Care document. The Credentialing Specialist holds responsibility for the monthly monitoring of the network to ensure our providers have no limitations or sanctions reported by regulatory agencies. This standard is outlined in the HPSM Provider Service Policy and Procedures CR-02, CR-07, and the Credentialing Specialists job description. The following criteria are monitored monthly for continued participation in HPSM's provider network:

- A physician never had his/her license to practice revoked or suspended by any state licensing board nor had been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of his or her profession, or other health care related matters including but not limited to fraud, third-party reimbursement, controlled substance violations, child/adult abuse charges, or any other matter that in the opinion of HPSM would adversely affect the ability of the practitioner to participate with HPSM.
- Additionally, in compliance with CMS regulations, the physician or medical group must never been excluded or precluded from participation in the Medicare or Medicaid programs and never been convicted of Medicare, Medicaid or other governmental or private third party pay or fraud or program abuse or has been required to pay civil penalties for the same.
- CareAdvantage physician may not "opt out" status for Medicare.
- Has never had his/her medical staff appointment or clinical privileges denied, revoked or terminated by any health care facility or other health plan.

The Provider Services policy and procedure CR-07 – Reduction, Suspension, and Termination outlines the Health Plan of San Mateo's process for Care Advantage providers who fail to meet the standards outlined above. CR-07- Reduction, Suspension, and Termination states:

> "A provider's status may be reduced, suspended or terminated for any lawful reason, including but not limited to a lapse in basic qualifications such as licensure, insurance, board certification or required medical staff membership or privileges at a specified hospital/healthcare facility; a determination that the provider cannot be relied upon to deliver the quality or efficiency of patient care desired by the Health Plan of San Mateo (HPSM); a determination that the provider cannot be relied upon to follow HPSM's clinical or business guidelines or directives; a determination that the provider is not complying with the terms of the Medical Services Agreement; or a change in business needs. HPSM will not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. No practitioner shall be denied an agreement with HPSM, have any sanctions imposed, or have their agreement terminated on the basis of sex, race, creed, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition, age, marital status, sexual orientation, or other protected classes according to State or Federal law. "

A copy of CR-07 is included as an appendix to this document.
Credentialing

To ensure providers initiating participation in the Plan's CareAdvantage program are in good standing, actively licensed and competent to provide services to CareAdvantage members under their scope of license, all providers must meet the plan's credentialing standards through a formal credentialing review before consideration of participation in the plan's network. Credentialing of HPSM's provider network includes, but is not limited to, verification of the following:

- Work history (continuous five years) or curriculum vitae
- Physical and mental health status
- History of impairment due to chemical dependency/substance abuse
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Name of primary admitting facility (if applicable)
- Signed attestation by the applicant to the correctness and completeness of the application
- Verifiable form of license identification

- Copy of DEA, CDS, CHDP, CLIA, CCS and CPSP Certificates, (as applicable/necessary)
- Documentation of initial California State Medi-Cal Program certification process or active certification and in good standing to provide service under the California State Medi-Cal Program
- Active certification and in good standing to provide service under the Federal Medicare Program (if applicable)

The ensure all necessary documentation is obtain to determine that HPSM's network facilities and provider are actively licensed and competent, the Credentialing Specialist utilizes a documentation checklist in completing the packet for the credentialing committee as outlined in CR-01 and CR-02. An example of this checklist is shown below:

HPSM Provider File Audit Checklist

Provider Name: ______________________

Application: ______________

Provider Number: ______________________

180 Days: ______________

Provider Representative: ______________________

Credentialing Specialist: ______________________

Participating Provider	

New Provider	

Board Status:	
Certified	
Eligible	

Contract Type:	
PCP	
Referral	
Other	

Medical Specialty:

Medi-Cal		Hlthy Fam		Hlthy Kids		Hlth Worx		Care Adv

Application:	**Obtained**	**Missing**	**MGR**	**Expires**
Contract Signature Page(s)				
Medical Group Addendum (if applicable)				
Attachment E (if applicable)				
Attachment F (if applicable)				
W9 Tax Form				
Attestation Signature Page				
Information Release Signature Page				
Addendum Application Signature Page				
Addendum B Signature Page				
Disclosure Response: legal/board documents (7 yrs.)				

Credentials:				
Curriculum Vitae				
Continuous Employment (5 years)				
Professional Liability Cover Sheet				
Premises Liability Cover Sheet				
Professional License				
DEA (or CDS) License				
CHDP Certificate (if applicable)				
CLIA Certificate (if applicable)				
CPSP Certificate (if applicable)				
ECFMG Certificate (if applicable)				
State Ankle Certificate (Podiatrists only)				

Primary Source Verifications:	**Date Req.**	**Date Rec.**		
Medical School Verification / ECFMG Verification				
Residency Verification				
Medi-Cal License Status				
Medicare Participation				
Hospital Privileges — Location(s)				
Board Certification				
NPDB Query				
Medical License				
Medicare Opt Out				
OIG/LEIE				

Site Visit Evaluation:

Pass		Fail	

Requested on:	**Performed on:**

Signature/Date (Credentialing Specialist): ______________________

In addition to the above noted verification, all HPSM contracted physicians must be board certified and achieve a passing score on the Medical Record and Facility Site Review conducted by the Quality Program Department. The physician/physician office must maintain a medical practice or service within San Mateo County with a minimum of 40 practice hours per week; or provide regular consistent service to HPSM members located in out-of-county placements; or provide a service not currently available within San Mateo County. The Physician must be on staff at one or more of the hospitals within the county that contracts with HPSM, with clinical privileges commensurate with the services to be performed as a participating practitioner.

Primary Source Verification for Credentialing

The Provider Services Department obtains and reviews information on the application and verifies such information from the following primary sources:

Item	Source of Primary Verification
California Physician/Practitioner License- MD, DO, DD, DPM, DC*	Query Medical Board of California or appropriate licensing board. Verify License is current and valid. Verify existence of any accusations or 805 reports.
DEA/CDS	Copy of certificate.
Board Certification or Candidacy* (if applicable)	Review the American Board of Medical Specialties (ABMS) Compendium or query the AMA Physician Master Profile.
Medical School Training and Residency Completion*	Query, via letter, applicable Medical School, and Teaching Hospital where Residency was completed.
Professional Liability Insurance	Copy of the current coverage that shows dates, including expiration date and amounts of coverage (minimum $1 million/$ 3 million).
Professional Liability Claims History*	Query the National Practitioner Data Bank (NPDB) via Internet.
Hospital Clinical Privileges** At HPSM Contracted Primary Admitting Facility	Oral or written confirmation from facility of clinical privileges in good standing ;includes date of appointment, restrictions, and recommendations/actions.
Adverse Actions Against License*	Query NPDB
State/Federal Sanction Activity*	Query Office of the Inspector General/List of Excluded Individuals and Entities (OIG/LEIE)
Medicare/Medicaid Sanction*	Query Office of the Inspector General/List of Excluded Individuals and Entities (OIE/LEIE)
Medicare Status (if applicable)*	Query CMS Medicare website for participation in Medicare, and query Palmetto/current MAC website to confirm absence or Opt Out status

Work History or CV	Five (5) years post-residency clinical work history, with dates. A review of any work history gap time period of six months or more must be reviewed and should be clarified in writing. Verification from primary sources is not required, except if questions arise.
California State Medi-Cal Certificate*	Query California Department of Health Services through HPSM's computer system.
Full Scope Site and Medical Record Review	Full Scope Site and Medical Record Review as described in HPSM's QAI-02 within the last 36 months of the Peer Review Committee review. Audits are conducted on all Medi-Cal PCPs, and others as resources permit.
* Must be primary source verified. ** Oral verification requires a dated, signed note in the practitioner's credentialing file stating who verified the applicant's status and how it was verified. Non-privileged practitioners must admit members through an HPSM practitioner while awaiting staff admission to a specific facility where they do not have privileges. Letter of agreement if not admitting hospital patients directly required.	

A sample query of the National Practitioner Data Bank (NPDB) of a provider in good standing is shown below:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832
DCN:
Page: 1
For authorized use by:
Process Date:
5500000068168467
05/04/2011
HEALTH PLAN OF SAN MATEO
of 1
Dr. Sample

A. SEARCH RESULT

Medical Malpractice Payment Report(s): No Reports Professional Society Action(s): No Reports
State Licensure Action(s): No Reports DEA/Federal Licensure Action(s): No Reports
Exclusion or Debarment Action(s): No Reports Peer Review Organization Action(s): No Reports
Clinical Privileges Action(s): No Reports
(Based on the subject identification information provided, the reports found are listed below.)

B. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Subject Name: Sample, Doctor
Gender: MALE
Date of Birth: 09/25/1950
Organization Name: San Mateo UROLOGY CENTER, INC.
Other Name(s) Used:
Organization Type: MEDICAL GROUP/PRACTICE (365)
00000 EL CAMINO REAL
STE. 101
Sample, CA 94027
Work Address:
City, State, ZIP:
9993 Sample LANE
REDWOOD CITY, CA 94061
Home Address:
City, State, ZIP:
Social Security Numbers (SSN): ***-**-0000
Individual Taxpayer Identification Numbers (ITIN):
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: A00000, CA
Specialty: UROLOGICAL SURGERY (86)
Drug Enforcement Administration (DEA) Numbers: BB999999999
Federal Employer Identification Numbers (FEIN): 999999999
Unique Physician Identification Numbers (UPIN): H99999
Professional School(s) & Year of Graduation: DUKE UNIVERSITY SCHOOL OF MEDICINE (1995)
National Provider Identifiers (NPI): 9999999999

C. ENTITY INFORMATION

Entity Name: HEALTH PLAN OF SAN MATEO (DBID ending in ...30)
Authorized Agent:
Authorized Submitter's Name:
Authorized Submitter's Title:
Authorized Submitter's Telephone:
PAUL DELA CRUZ
CREDENTIALING SPECIALIST
(650) 616-2107

QUERY RESPONSE

This query was processed under the provisions of:
X Title IV (NPDB) X Section 1921 (NPDB) Section 1128E (HIPDB)
CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

An example of a provider query for Medicare participation is shown below:

Physician Compare

Additional Information

Education

Graduated: 1995
School: DUKE UNIVERSITY SCHOOL OF MEDICINE

Physician Quality Reporting System

This professional chose to take part in Medicare's Physician Quality Reporting System and reported quality measure information satisfactorily for the year 2009.

What is the Physician Quality Reporting System?

First Name/Last Name Add To My Favorites

Urology

Accepts the Medicare-approved amount as payment in full

Office Locations Group Practice Locations

Call a group practice location for office location details.

Peninsula Urology Center Inc **View map of area locations »**

3031 Main Street STE 101 ATHERTON, CA 94027 **Map & Directions** (650) 555-5555

No locations for this organization were found outside of your search criteria.

Education and Training Standards

Physicians must possess verification of graduation from a Medical School accredited by the Association of American Medical Colleges (AAMC) or the equivalent thereof and verification of completion from an internship and training program affiliated with the AAMC.

All physicians applying to contract with HPSM after October 1, 1997 are expected to be or to become board certified or re-certified in the specialty and/or subspecialty in which the physician wishes to be credentialed. For board certification, the physician must be listed in the ABMS Compendium or accrediting body in his/her current physician specialty acceptable to HPSM or considered qualified to take the specialty board exam.

Physicians who request to be listed as a sub-specialist only and who are not board certified in their sub-specialty will be reviewed on a case-by-case basis. Those in this category who are not certified in their primary specialty (e.g. Internal Medicine) may not be listed solely as a sub-specialist (e.g. Cardiology).

Provider Oversight

In addition to the oversight of the provider network through the plan's Provider Services department HPSM conducts provider oversight through several additional mechanisms, including through:

- Site review and medical record review to ensure that safety, licensing, and documentation standards are met
- Claims analysis, including outlier analysis, to ensure that practice and billing patterns are within the community norms
- Review of provider-based HEDIS performance in order to determine whether or not providers are following clinical guidelines in the practice of medicine
- Secret-shopper surveys of provider offices to ensure that access and availability standards are met
- Site reviews, claims analysis, and analysis of member complaints to ensure that providers use evidence-based clinical practice guidelines and nationally recognized protocols

Providers are also prohibited from collecting any cost-sharing amounts from CareAdvantage members in their contracts since all members are dually eligible for both Medi-Cal and Medicare.

These activities help ensure that our providers provide a high level of service to our members that is clinically sound, cost-effective, and affordable for members.

To facilitate members' access to appropriate services, HPSM assigns members to primary care providers (PCPs) who are responsible for overseeing the full spectrum of members' health care

in accordance with professional standards of care. PCPs manage all preventive, diagnostic, and treatment services that the members receive, including through referral to specialty and ancillary providers. In addition, PCPs take a primary role in overseeing the services provided by the interdisciplinary care teams, which are discussed in more detail in the previous section.

Summary: HPSM's Credentialing Process and Review to Determine Active Licensing and Competency

A primary care doctor contacts HPSM's Provider Services department to find out how to contract with HPSM and the participation requirements of becoming part of the HPSM Care Advantage network. The provider services representative explains that HPSM has specific participation requirements, including that the provider or its employees, managers or any other downstream entities must not be excluded from participating in the Medicare or Medi-Cal programs. A review of the Office of the Inspector General, General Services Administration and the Medi-Cal exclusions, debarment, licensure or sanction lists at the time of contracting and annually thereafter to ensure that neither itself, nor any employee, manage, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is excluded. Physicians and other health care services providers who are excluded from participation in the Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not participate as a Care Advantage provider.

The HPSM provider services representative also outlines that participation requirements include that the PCP, at all times during the term of the agreement, shall comply with and have any of its downstream entities comply with all applicable federal, state and municipal laws (including applicable Medicare laws and regulations) all applicable rules and regulations of the Medical Board of California and the ethical standards of the American and California Medical Associations. The physician is also notified that HPSM monitors monthly for continued participation in HPSM's provider network.

The HPSM provider services representative explains that as part of the credentialing process, HPSM must verify components of the application process. This includes, but is not limited to, his/her work history, history of impairment due to chemical dependency/substance abuse, history of loss of license and/or felony convictions, admitting privileges, license identification, and documentation of good standing under the California State Medi-Cal and Federal Medicare program. The physician must also have admitting privileges at one of HPSM's contracted hospitals, maintain a practice with a minimum of 40 practice hours per week and be board certified.

The physician asks the HPSM provider services representative how the plan verifies components of the application. The HSPM representative explains that the plan utilizes various data sources that include a query of the Medical Board of California, verification of existence of any 805 reports, copy of their DEA/CDS certificate, American Board of Medical Specialties (ABMS) compendium, query or letter of medical school/residency training, query of the Office of Inspector General/List of excluded individuals and entities and query of CMS Medicare website for participation in Medicare and a query of Palmetto/ current MAC website to confirm absence or Opt out status.

After explaining HPSM's network participation and credentialing requirements, the HPSM representative may send the requesting provider an application to start the process.

c. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.)

Ultimate responsibility for determination of which health care services Care Advantage members receive are with the member's primary care physician (PCP). However, through the initial health assessment, the HPSM's ICT (as describe previously - i.e., RN Case Managers, Medical Directors, Pharmacist, Medical Social Workers, Behavioral Health Specialists, etc.) works in collaboration with the PCP to identify the health care service needs of every Care Advantage member across the continuum of care. The PCP and HPSM's ICT work collaboratively as the Care Advantage member's point of contact for coordination of care. Together, the PCP's and HPSM's collaboration of care for the Care Advantage member help to ensure improved coordination of care, improved access to medical, preventive care, mental health and substance use services, home and community-based services and other social services, and smooth transitions of care across healthcare settings and providers. This collaboration of care maximizes opportunity to improve beneficiary health outcomes including:

- Reduction in unnecessary hospitalizations and skilled nursing facility (SNF) placement,
- Improved patient self management and independence,
- Improved mobility and functional status
- Improved pain management
- Improved quality of life as self-reported by the patient
- Improved satisfaction with health status and health services.

To facilitate identification and coordination of member needs, HPSM mails a copy of every initial health assessment and analysis summary, as outline in section 7, to the Care Advantages member's PCP. A copy of the assessment summary is shown below.

701 GATEWAY BLVD., SUITE 400
SO. SAN FRANCISCO, CA 94080

healthy is for everyone

www.hpsm.org

Date

MD's name
Address
Address

Re: <Member Name and ID>

Dear <Dr's Name>:

This letter is to notify you that your patient, named above, has completed the Health Risk Assessment Survey (HRAS) developed by Health Plan of San Mateo (HPSM). This survey is a self-assessment of his/her medical and functional needs and current abilities. His/her responses have helped us determine the most clinically appropriate health care services that we are able provide him/her. Enclosed is a copy of the HRAS, as well as the individualized care plan based on his/her responses from the HRAS. The care plan includes HPSM's recommendation that he/she make an appointment to see you for ongoing medical care and services.

Your patient was also advised that a Care Coordination Nurse Case Manager at HPSM can help him/her with questions about their CareAdvantage benefits and/or about their medical treatment, such as:

- Coordination of referrals
- Receiving recommended services within the plan's benefit structure
- Using appropriate community resources

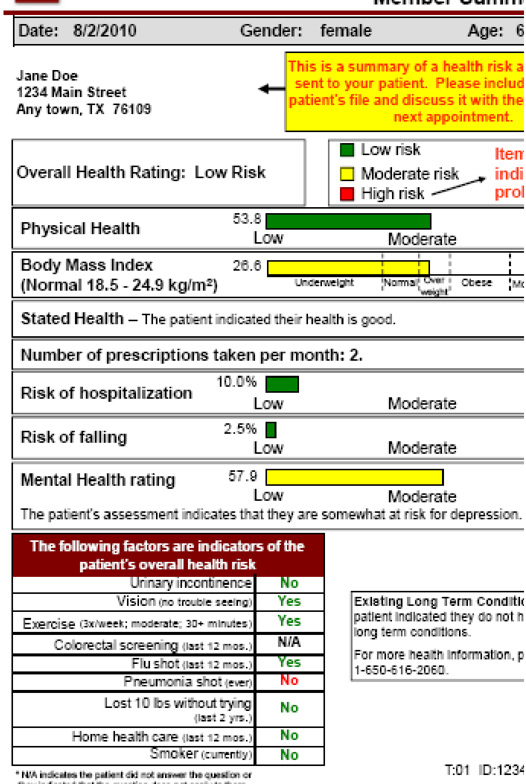
We are telling you all this to assist you in continuing to provide high quality care for your patient/our member. Please include the copies of the HRAS and care plan in your office chart of this member. We hope that you find this additional information about the member to be useful.

If you have any questions about this letter, please do not hesitate to call the Care Coordination Department at 650-616-2060. Our office hours are Monday through Friday 8 a.m. to 5 p.m.

We look forward assisting you and your patient through CareAdvantage.

Sincerely,

Mary D. Giammona, M.D., M.P.H.
Medical Director


DSS RESEARCH *Looking Beyond the Expected*

Member Summ

Date: 8/2/2010 Gender: female Age: 6

Jane Doe
1234 Main Street
Any town, TX 76109

This is a summary of a health risk a
sent to your patient. Please includ
patient's file and discuss it with the
next appointment.

Overall Health Rating: Low Risk

Low risk
Moderate risk
High risk

Item
indi
prol

Physical Health	53.8	Low	Moderate
Body Mass Index (Normal 18.5 - 24.9 kg/m²)	26.6	Underweight, Normal, Over weight, Obese, Mo	
Stated Health – The patient indicated their health is good.			
Number of prescriptions taken per month: 2.			
Risk of hospitalization	10.0%	Low	Moderate
Risk of falling	2.5%	Low	Moderate
Mental Health rating	57.9	Low	Moderate

The patient's assessment indicates that they are somewhat at risk for depression.

The following factors are indicators of the patient's overall health risk	
Urinary incontinence	No
Vision (no trouble seeing)	Yes
Exercise (3x/week; moderate; 30+ minutes)	Yes
Colorectal screening (last 12 mos.)	N/A
Flu shot (last 12 mos.)	Yes
Pneumonia shot (ever)	No
Lost 10 lbs without trying (last 2 yrs.)	No
Home health care (last 12 mos.)	No
Smoker (currently)	No

* N/A indicates the patient did not answer the question or they indicated that the question does not apply to them.

Existing Long Term Conditio
patient indicated they do not h
long term conditions.

For more health information, p
1-650-616-2060.

T:01 ID:1234

To ensure each Care Advantage member is connected to the appropriate service provider, HPSM mandates case management responsibilities in the PCP contract. Every contracted Care Advantage provider is made aware of and accountable to the case management responsibilities and expectations of Care Advantage members through the contract with HPSM. These responsibilities are outlined in the Case management protocol and primary care contract as outlined below. Section 6.1-6.2 of the contract and the contract's case management protocol outline the CareAdvantage provider's obligations as a PCP. Examples from the CareAdvantage contract and case management protocol follow.

To ensure members have timely access to medical care and preventive health services, the CareAdvantage Primary Care contract Section 6.2- Obligations of PCP states:

> " Timely access to care pursuant to department of health care regulation (title 28, section 130.67.2.2) the plan is obligated to ensure PCP shall provide covered health care services in a timely manner appropriate for the nature of a member's condition consistent with good professional practice and offer members appointments that meet the following timeframes:

- urgent care within 48 hours of the request (section 6.2 (a))
- Non-urgent appointments for primary care within 10 business days of the request (section 6.2 (b))
- … Preventive care services, and periodic follow up care, including but not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the PCP acting within the scope of his or her practice…"

The PCP has 24 hours per day, 7 days per week triage responsibility in coordination and determination of services for the member. Section 6.2.1 of the CareAdvantage contract outlines this responsibility of the PCP.

- 6.2.1: "PCP shall provide or arrange for the provision, 24 hours per day, 7 days per week of Triage or screening services."
- 6.2.2: "PCP shall ensure that telephone triage or screening services are provided in a timely manner … and that the triage wait time does not exceed 30 minutes."

The PCP's role extends beyond improving timely access to care for the member. The PCP must also develop individualized care plans that include identification of services, referral and coordination of care of services and benefits that the member needs as part of the health care plan. Referral and coordination may be to the identified care coordinator supporting the member, physician specialists, community agencies, allied health providers, and other health members that are identified as members of the interdisciplinary team. The Health Plan of San Mateo's PCP case management protocol outlines these responsibilities in section 1.6 – Primary Care Physician responsibilities.

PCP Case Management Protocol

Section 1.6.1 of the PCP Case Management protocol outlines the PCP's care coordination and case management responsibilities as follows:

- 1.6.1 B- To make all medically necessary referrals to physician specialists for each case managed member on the PCP's assigned list.
- 1.6.1 C- To arrange for those services to be delivered by hospitals and physician specialists who contract with the Health Plan of San Mateo and arrange for services with specialists outside of the Plan's network when necessary.
- 1.6.1 D- To provide medically appropriate preventive health services to each Case Managed member on their assigned list, including a comprehensive history and physical examination annually, and with development of an individualized plan of care that includes identification of health care service needs and coordination and referral of health care services.
- 1.6.1 E – To coordinate and direct appropriate care for members by means of diagnosis and treatment, obtaining second opinions as necessary, Consultation with contracting physician specialists, and working with applicable county services such as Golden Gate Regional Center and other similar agencies.
- 1.6.1 F- To follow-up consulting referral services to assess the results of the care, medication regimen and special treatment within the framework of integrated, continuous care.
- 1.6.1 M- To coordinate member discharge planning and referral to long term care, home health services and other needed post-discharge care with the hospital and HPSM staff.
- 1.6.1 N- To refer members identified as requiring mental health services to the county mental health agency, Behavioral Health and Recovery Services, for treatment or other program as applicable.

d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.)

The PCP has the key role in HPSM's provider network, as outlined above, to serve as primary gatekeeper and the coordinator of care, in collaboration with the HPSM, for his/her panel of CareAdvantage patients. There are various avenues through which our provider network works with the ICT and other providers to deliver specialized services. This includes 1) Sharing the identification of health care needs and risks through the annual assessment to identify the health care service needs of the member , 2) sharing the member's individualized care plan with the member, PCP, and external ICT that outlines the specific healthcare service needs, 3)

providing the PCP and other member's of the ICT with a point of contact at the plan to coordinate care and ensure service delivery, 4) notifying the PCP of every care transition that their assigned Care Advantage member may encounter through the care transition process (outlined in section 8) to ensure smooth transition of care and follow-up to services, 5) Providing the ICT with a coordinator (Care Coordination Technician) at the HPSM who will work with the , PCP staff and ICT to schedule appointments and ensure follow-up, 6) HPSM also has clinical representation and attendance at weekly ICT meetings at all major contracted hospitals and skilled nursing facilities to help facility, coordinate and authorize services as needed and 7) sharing of utilization statistical reports at monthly meetings with the Case management leadership of major contracted hospitals. These components are described in detail below and are followed by a case study at the end of this section.

Sharing the identification of health care needs and risks through the annual assessment—HPSM sends the PCP a copy of the member's annual initial health assessment and assessment analysis. The annual assessment and analysis is accompanied with an explanatory letter identifying the healthcare service needs and concerns of the Care Advantage member. Samples of the components of the physician packet are included below.

Sample cover letter included with the physician packet

HealthPlan OF SAN MATEO
701 GATEWAY BLVD., SUITE 400
SO. SAN FRANCISCO, CA 94080

healthy is for everyone
www.hpsm.org

Date

MD's name
Address
Address

Re: <Member Name and ID>

Dear <Dr's Name>:

This letter is to notify you that your patient, named above, has completed the Health Risk Assessment Survey (HRAS) developed by Health Plan of San Mateo (HPSM). This survey is a self-assessment of his/her medical and functional needs and current abilities. His/her responses have helped us determine the most clinically appropriate health care services that we are able provide him/her. Enclosed is a copy of the HRAS, as well as the individualized care plan based on his/her responses from the HRAS. The care plan includes HPSM's recommendation that he/she make an appointment to see you for ongoing medical care and services.

Your patient was also advised that a Care Coordination Nurse Case Manager at HPSM can help him/her with questions about their CareAdvantage benefits and/or about their medical treatment, such as:

- Coordination of referrals
- Receiving recommended services within the plan's benefit structure
- Using appropriate community resources

We are telling you all this to assist you in continuing to provide high quality care for your patient/our member. Please include the copies of the HRAS and care plan in your office chart of this member. We hope that you find this additional information about the member to be useful.

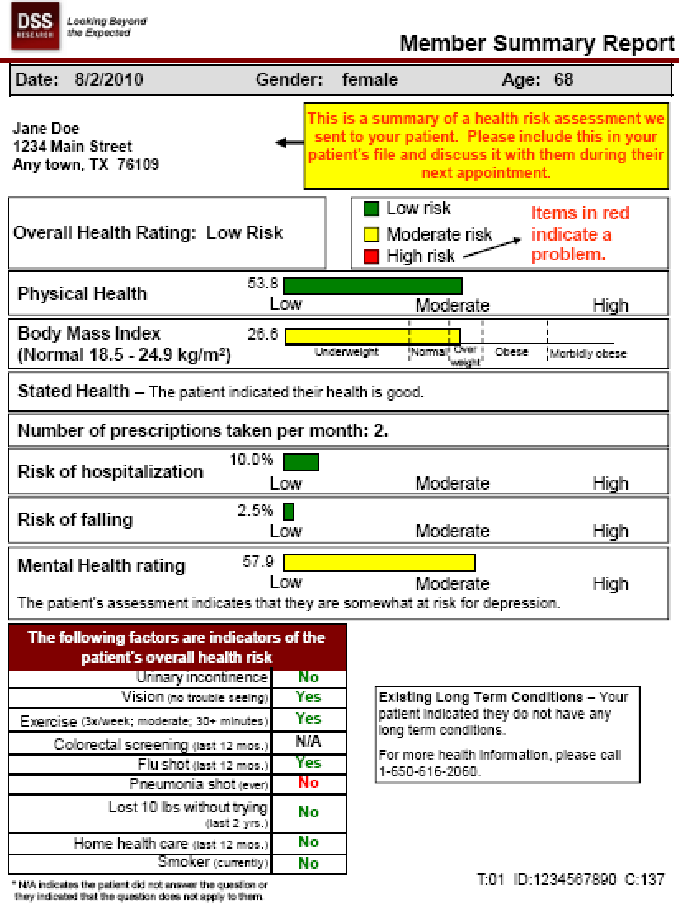
If you have any questions about this letter, please do not hesitate to call the Care Coordination Department at 650-616-2060. Our office hours are Monday through Friday 8 a.m. to 5 p.m.

We look forward assisting you and your patient through CareAdvantage.

Sincerely,

Mary D. Giammona, M.D., M.P.H.
Medical Director

Sample member summary report included with physician packet



DSS RESEARCH Looking Beyond the Expected

Member Summary Report

Date: 8/2/2010 Gender: female Age: 68

Jane Doe
1234 Main Street
Any town, TX 76109

This is a summary of a health risk assessment we sent to your patient. Please include this in your patient's file and discuss it with them during their next appointment.

Overall Health Rating: Low Risk

Low risk / Moderate risk / High risk — Items in red indicate a problem.

Measure	Score	Scale
Physical Health	53.8	Low / Moderate / High
Body Mass Index (Normal 18.5 - 24.9 kg/m²)	26.6	Underweight / Normal / Over weight / Obese / Morbidly obese
Stated Health – The patient indicated their health is good.		
Number of prescriptions taken per month: 2.		
Risk of hospitalization	10.0%	Low / Moderate / High
Risk of falling	2.5%	Low / Moderate / High
Mental Health rating	57.9	Low / Moderate / High

The patient's assessment indicates that they are somewhat at risk for depression.

The following factors are indicators of the patient's overall health risk	
Urinary incontinence	No
Vision (no trouble seeing)	Yes
Exercise (3x/week; moderate; 30+ minutes)	Yes
Colorectal screening (last 12 mos.)	N/A
Flu shot (last 12 mos.)	Yes
Pneumonia shot (ever)	No
Lost 10 lbs without trying (last 2 yrs.)	No
Home health care (last 12 mos.)	No
Smoker (currently)	No

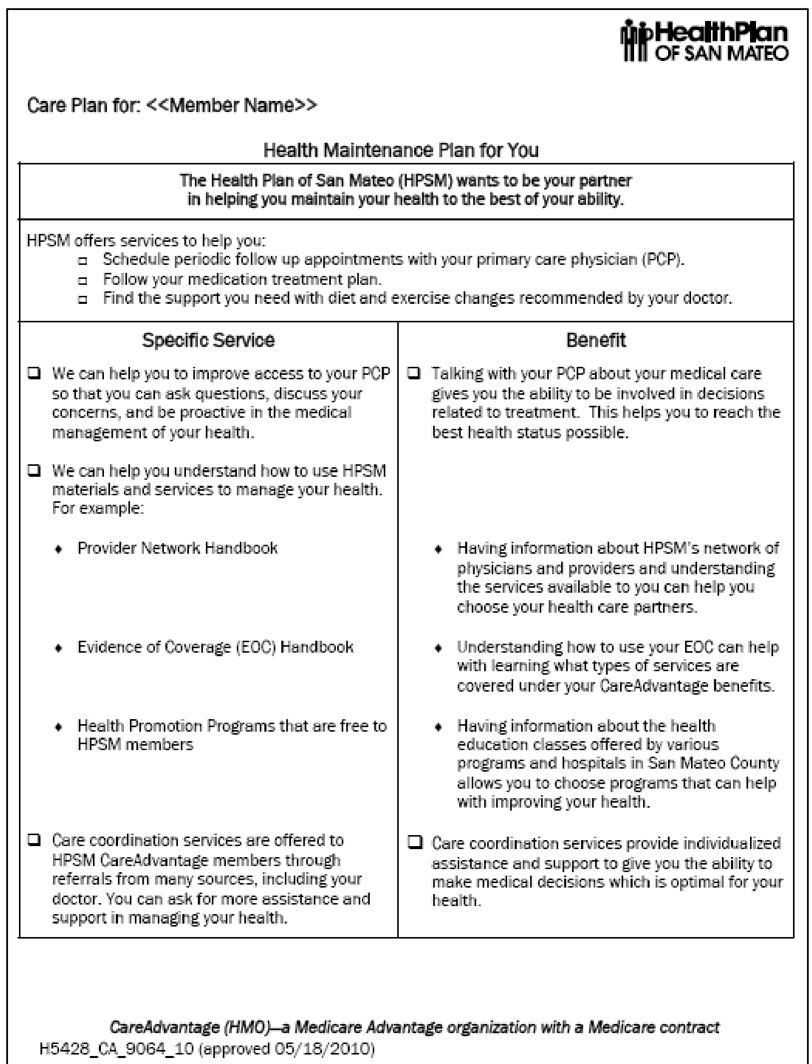
* N/A indicates the patient did not answer the question or they indicated that the question does not apply to them.

Existing Long Term Conditions – Your patient indicated they do not have any long term conditions.

For more health information, please call 1-650-616-2060.

T:01 ID:1234567890 C:137

Sharing the member's individualized care plan with the member, PCP and external ICT—The Health Plan of San Mateo develops individualized care plans for each Care Advantage member. This care plan is developed in conjunction with the PCP and shared with the member, PCP and other relevant stakeholders of the member's ICT. The member and PCP receive a copy of the care plan for every Care Advantage member on his/her panel. An example of this care plan is shown below.



HealthPlan OF SAN MATEO

Care Plan for: <<Member Name>>

Health Maintenance Plan for You

The Health Plan of San Mateo (HPSM) wants to be your partner in helping you maintain your health to the best of your ability.

HPSM offers services to help you:

- Schedule periodic follow up appointments with your primary care physician (PCP).
- Follow your medication treatment plan.
- Find the support you need with diet and exercise changes recommended by your doctor.

Specific Service	Benefit
❑ We can help you to improve access to your PCP so that you can ask questions, discuss your concerns, and be proactive in the medical management of your health.	❑ Talking with your PCP about your medical care gives you the ability to be involved in decisions related to treatment. This helps you to reach the best health status possible.
❑ We can help you understand how to use HPSM materials and services to manage your health. For example:	
♦ Provider Network Handbook	♦ Having information about HPSM's network of physicians and providers and understanding the services available to you can help you choose your health care partners.
♦ Evidence of Coverage (EOC) Handbook	♦ Understanding how to use your EOC can help with learning what types of services are covered under your CareAdvantage benefits.
♦ Health Promotion Programs that are free to HPSM members	♦ Having information about the health education classes offered by various programs and hospitals in San Mateo County allows you to choose programs that can help with improving your health.
❑ Care coordination services are offered to HPSM CareAdvantage members through referrals from many sources, including your doctor. You can ask for more assistance and support in managing your health.	❑ Care coordination services provide individualized assistance and support to give you the ability to make medical decisions which is optimal for your health.

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract

H5428_CA_9064_10 (approved 05/18/2010)

Providing the PCP and other members of the ICT with a point of contact at the plan to coordinate care—The Primary Care Physician, member and appropriate members of the ICT are given a Nurse Case Manager as point of contact within the Care Coordination department at HPSM to help educate the provider network and ICT on services and benefits available to the Care Advantage member.

The HPSM Nurse Case Manage also serves as a point of contact to the provider network and ICT to facilitate and authorize all needed Care Advantage and Medi-Cal services. An example of this communication of the member point of contact letter is shown below.

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

JANUARY 05, 2011

Re: **Nurse Case Manager for Transition of Care**

Dear CareAdvantage Member:

This is to inform you of services provided through our Care Transition Management program that will help you with your transition to a new setting. These services are covered by CareAdvantage to support continuity of care when you are transferred from one facility to another (for example, from a hospital to your home, or to a nursing home).

You are being assigned to **Celeste Medios,** a Nurse Case Manager from the Care Coordination department at Health Plan of San Mateo (HPSM). She will make sure your care is coordinated during your transfer and will be available to respond to your questions and help with information you might need when you are transferred. You can call **Celeste Medios** at phone Number (650) 616-2060, Monday through Friday, 8 a.m. to 5 p.m.

Your nurse case manager will:

- Support coordination of care by responding to questions from you, your family and/or caregivers.
- Help you understand what brought you to the hospital, and help you develop a practical care plan that will work in the future.

HPSM's Care Transition Management program **does not provide direct skilled nursing services.** If you are being transferred to a nursing home, hospital, or your home, you may receive services from a home health nurse, physical therapist or licensed social worker that are arranged outside of the Care Transition Management program.

If you are not satisfied with the services you receive through the Care Transition Management program, please call Mari Baca, Health and Provider Services Director at (650) 616-2083.

Thank you.
Care Coordination

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
CareAdvantage Unit **1-866-880-0606** (toll-free) or **(650) 616-2174** | Fax: **(650) 616-2190**
Hearing Impaired: TTY **1-800-735-2929** (California Relay Service) or Dial **711**
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.
H5428_CA_9065_10 (approved 05/27/2010)

The PCP, in coordination with the HPSM, ensures the delivery of specialized services that our Care Advantage patients may need. The PCP assesses the clinical or home condition of the patient to determine the specialty physician services, allied health or support services (durable medical equipment, home health services, meals on wheels and other home and community-based services), needs of the CareAdvantage patient. The PCP discusses these with the

patient/caregiver either during an office visit, while the patient is in the hospital or over the phone.

The PCP follows up with the specialist or other service provider and the patient to ensure the services were rendered, to see if they benefited the patient, and to determine next steps.

However, HPSM recognizes that, due to the complexity of our CareAdvantage members' conditions, the number of patients that PCPs follow, and the demand on most PCPs nowadays, that physicians need a team to help them provide the best care for our members. That is why we provide many levels of support for our PCPs, with the intensity based on the degree of risk the member has for adverse health outcome (e.g. hospitalization, ED visits). This risk is determined by HPSM's application of our predictive modeling algorithm for likelihood of hospitalization in the next nine months, and patients' responses to our High Risk Assessment tool (administered to every CareAdvantage member annually) and comprehensive assessment tool, administered by phone to members as they come into contact with our care coordination unit. Any members who are identified as highest risk on these tools are entered into our Care Coordination database, and become members assigned to an Interdisciplinary Care Team (ICT—see element 4 for more details). Once this assignment is made, the PCP and the ICT lead coordinator for a patient keep in contact via phone or e-mail, with documented updates available to all ICT team members via a HIPAA compliant web based case management tool. Then, in between the times around patient visits to the physician office, the ICT lead coordinator communicates regularly (depending on the patient, from weekly to monthly) via a method of patient preference, often phone, to check in with the patient about ongoing care, including specialized care delivery, to ensure that the patient knows what care is planned, is in agreement with this care, and that the care is delivered as scheduled.

At the ICT weekly or bi-weekly meetings, when a specific patient's issues are under discussion, preferably with the patient or caregiver, and the PCP, in attendance (please see element 4 for more details about how this is to take place), the planned specialized services and their outcome will be discussed. Multiple aspects of the care will be reviewed, to determine whether or not the care has been rendered in a timely fashion, and if these services meet the level of quality expected. An example would be if a specialty consultation appointment at the contracted tertiary care center has been arranged successfully in the time frame anticipated. At the ICT meeting, the patient's lead care coordinator and the patient could report whether or not the appointment has been set up, or if there has been some barrier to doing so. If the latter, other members of the ICT could help problem solve and see if another team member (e.g. the PCP, a medical director) could assist in expediting the appointment. If, in continuing this example, the appointment had occurred, the team could discuss whether or not the consult report adequately answered the questions in the consult referral. This discussion would help assess the quality of the service. As noted in the descriptions in element 4, the lead coordinator for a patient is responsible for note taking for each of the cases presented during the ICT team meetings. Team members from different sites, such as Aging and Adult Services (social services representative), Behavioral Health and Recovery Services (mental health representative) or the PCP, as well as the HPSM nurse care coordinator, all have access to a

web based HIPAA compliant case management tool where case notes, care plans and updates can be posted to ensure continuity of communication among all team members. To ensure patients have their own copies of care plans, these are mailed to them regularly when updated, with a full copy also sent to the patient's PCP. Each care plan includes what is expected re: care to be delivered from providers across the HPSM network in various settings.

For example, if a patient with COPD, CHF, diabetes, and severe osteoarthritis was going to need a total hip replacement, and after much planning with the PCP, orthopedist, caregiver and ICT, was cleared for surgery, the care plan could include what needed to be done before hospitalization, during the hospital stay, during the LTC rehabilitation stay, and what supports would be in the home to continue the rehabilitation process. A complete, updated copy of each care plan is also kept in the HPSM Care Coordination database.

Additional supports for the PCP and ICT that exist at HPSM include:

- HPSM's Care Coordination Unit, as described below:

  - For individuals who meet criteria for participation in HPSM's Care Coordination Program, HPSM conducts comprehensive care coordination activities. These activities include:
    - Prospective, concurrent, and retrospective review of each case, based on medical condition, diagnosis, and age, to identify eligibility for the special needs programs like behavioral health, GGRC, or Aging and Adult Services described below.
    - Coordination of individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services, and preventive services on a case-by-case basis to facilitate the achievement of realistic treatment goals.
    - Completion of a comprehensive assessment to achieve a baseline understanding of the members' health status upon enrollment in the Care Coordination program.
    - Assessment of the appropriateness of the individualized care plan in light of any changes in the members' health status since the most recent care plan was developed, and coordination with the patient's ICT to update the plan as needed.
    - Development of specific timelines to monitor, evaluate, and reassess the members' health status and the appropriateness of the individualized care plan in order to make changes to the plan.

  - Both the Director of Health and Provider Services and the Medical Director conduct oversight of the Care Coordination functions, including through direct case review when required, and through review of care coordination reports on a quarterly basis to determine referral patterns and utilization of appropriate community resources and specialty programs.

- The staff of the Care Coordination Unit includes a Unit Manager, 8 Nurse Case Managers, a Medical Social Worker and 2 Care Coordination Technicians.

- HPSM's electronic database system- HEALTHsuite. The plan utilizes an electronic data system to capture all services authorized and delivered under the plan. The plan's HEALTHsuite system records all claim, authorization, pharmacy, and care management activities for the plan's CareAdvantage members. HEALTHsuite serves as the centralized database repository of services for each CareAdvantage member.
- As noted above, HPSM also utilizes a care coordination database system to store, document, and update the CareAdvantage member's individualized assessment and interdisciplinary care plan. This care coordination database is known as CCDB.
- HPSM communicates individual components of specialized services to stakeholders, e.g. members and requesting physicians, via the prior authorization process:
  - HPSM requires prior authorization of several services and benefits under CareAdvantage, including but not limited to:

    - All inpatient admissions
    - Skilled nursing facility admissions
    - Durable medical equipment
    - Home health visits
    - Non-emergency medical ambulance transport

  - HPSM's Care Coordination department reviews prior authorization requests for specialized services from the provider network to ensure that services requested are appropriate and medically necessary, and to identify members who may require more intensive care management in coordination with the member's PCP. All specialized services requiring prior authorization are recorded in the plan's electronic data system- HEALTHsuite. CareAdvantage members identified as high risk and in need of intensive case management also have their care plan and service request updated and documented in the plan's care coordination database system known as CCDB. Each specialized care request is reviewed for medical appropriateness and benefit inclusions under CMS standards. Final authorization determinations are shared with the primary care physician, member, requesting provider and other stakeholders of the ICT as determined appropriate by the plan's clinical Care Coordination team and the member's PCP. This communication is performed through written correspondence within 24 hours of the authorization request decision.

    Should the plan's clinical reviewer question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on national review criteria and guidelines, the HPSM Medical Director will be consulted for case review. The HPSM Medical Director or designee will contact the PCP of requesting provider to discuss the case, if necessary.

Should the HPSM Medical Director or designee determine that the proposed services are not medically necessary or indicated, a denial determination might be made by the HPSM Medical Director. Denial notification and communication will be made in accordance with all Medicare Advantage timeliness standards and denial notification requirements which include communication to the PCP, the member, requesting provider and other stakeholders as required.

Specialized service request determinations that are approved for high risk case managed CareAdvantage members require coordination and follow-up to ensure service delivery. The plan's Care Coordination department, in conjunction with the primary care provider, holds responsibility to ensure the specialized service is delivered timely. Scheduling of the specialized service delivery is often coordinated through the authorization process at the plan level.

For example, inpatient service requests are tracked and followed by the plan's nurse case managers, through the discharge care transitions process outlined below, to ensure members receive timely and appropriate care. DME, home health services, and non-emergency transport service are tracked and followed by the plan's nurse case managers to ensure the member receives timely and high quality services.

- HPSM also uses a process of concurrent/continued stay review of inpatient admissions (acute, rehabilitation) and communication of care needs service determinations to support CareAdvantage members in need of specialized services from the provider network as follows:

    - Concurrent/Continued Stay Review is a process coordinated by a Care Coordination Nurse Case Manager during a member's inpatient stay, which may include an acute hospital, acute rehabilitation, or skilled nursing inpatient stay, to assess the medical necessity and appropriateness of the requested level of care. Concurrent/Continued Stay review may also involve the telephonic or on-site medical record review that occurs after admission.

      Additional objectives of continued stay review are:

        - To ensure that services are provided in a timely and efficient manner.
        - To ensure that established standards of quality care are met.
        - To implement timely and coordinated care transitions and care transition communication when clinically indicated and appropriate.
        - To implement effective discharge planning.
        - To identify cases appropriate for referral to Care Coordination because the patient is at high risk for adverse health outcome, and could thus benefit from intensive case management services.

The Concurrent Review Procedure is followed throughout the member's acute hospitalization and continuum of care. Communication of changes in the member's health care status, resulting in a transition of care, to stakeholders, e.g. the PCP, any specialty physicians involved in the patient's care, allied health providers, etc, is performed through the plan's Care Transition process.

- HPSM uses its Care Transition process as another means to coordinate the delivery of specialized services to CareAdvantage members

  - To ensure a smooth transition from one care setting to the next, and to minimize risks to patient safety and improve quality of care, HPSM makes a special effort to coordinate care when members move from one setting to another, also known as a Care Transition. This is accomplished through our Care Transition process. The Care Transition process incorporates communication and coordination of care across all care settings and providers. The plan's Nurse Case Managers serve as a facilitator of care, in collaboration with the PCP, in ensuring care delivery and thus improve quality of care through coordination and communication. The Care Transition process is outlined in the plan's policy and procedure UM -13: Care Transitions. Specific examples of the care transition process are detailed below.

  - For both planned and unplanned transitions, the plan's Nurse Case Managers facilitate safe transitions through communication with the member and the ICT/PCP within 1 day of the CareAdvantage member's care transition. This includes changes in the member's health status requiring modifications and updates to the member's individualized care plan. Each care transition a CareAdvantage member may experience, (e.g. home to hospital, hospital to a skilled nursing facility/long term care or home) is monitored by the plan's Nurse Case Manager. The plan's Nurse Case Manager (NCM) has responsibility to ensure communication of the member's change in health status to the PCP/ICT, the need for modification to the member's care plan, and to serve as a point of contact and liaison to the member, ICT, and PCP to facilitate and coordinate services and communication. Since all member transfers to and from a facility are monitored by an HPSM Nurse Case Manager, s/he can notify the relevant stakeholders via phone, e-mail or fax immediately upon identifying the transition. Thus, a member who has previously been identified as high risk, and has an ICT, is readily identifiable in the CCDB. This database is searched with the Care Transition list, and if any members who have a care coordinator (and thus an ICT) are identified, the NCM e-mails that nurse (or outside staff as applicable, if in HUG—see element 4 for more details) as well as the patient's PCP about the transition. If this patient has not been part of the Care Coordination Unit before, the member's PCP is notified about the Care Transition. Either way, the patient's individualized care plan is updated.

    The plan's Nurse Case Manager is also responsible for assisting with the communication and sharing of pertinent clinical information from the setting

sending the member to the receiving setting so that transfer data is complete. This is critical, since medical studies have demonstrated that innumerable medical errors occur in these types of transitions. The NCM helps by ensuring the discharge instructions, discharge summary, and /or transfer summary are received by the receiving facility. The plan's nurse case manager is responsible for ensuring that communication has taken place between the sending and receiving facility within 1 business day of the transition. Any gap in communication between the sending facility and receiving facility is minimized because the plan's Nurse Case Manager is a point of contact for both the member, PCP/ICT and the facility. Members receive written notification of their Nurse Case Manager the contact information as the direct point of contact during the care transition within 1 business day of the care transition.

For every member care transition, the plan holds responsibility to send written notification to the PCP and ICT of the care transition. The plan's Care Coordination department clinical staff sends written documentation of the member's care transition by sending the "HPSM Provider Notice of Admission" letter to the PCP/ICT within one day of the admission. Every care transition discharge is also communicated to the PCP /ICT by the plan through the "HPSM Provider Notification of Discharge" within 1 day of discharge. The plan's Nurse Case managers collaborate with the member's ICT in identification of post acute discharge needs and communicates these needs by having our Care Coordination Technicians also call directly for follow-up with the member to ensure scheduling and delivery of post acute care services. See below for a sample physician notification of discharge.

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

HPSM Provider Notice

Date:

To: [Insert PCP Name]

Subject: Discharge Notification

Member Name:
Member ID:

Dear [Insert PCP Name],

Health Plan of San Mateo (HPSM) CareAdvantage member, [insert member name], was admitted to [insert facility name], on [date of admission].

As part of our Care Transitions Management program, you are receiving this notification because you are identified as this member's primary care physician. HPSM's Care Transition management program is making a special effort to improve the continuity of care as our members' transition from one setting to the next. Your patient will be assigned a plan case manager to help support care coordination efforts. The case manager for your patient is [insert Case Manager name].

If you have any questions about this notice or our Care Transition management program, please contact our CareAdvantage Care Coordination Unit at (650) 616-2060.

- HPSM plans enhancements to the data management system, HEALTHsuite, in 2012 to further improve further our abilities to ensure delivery of specialized services to CareAdvantage members. The enhancement would include reporting capability of confirmed service delivery. We anticipate that this would allow network providers to have the ability to update each service request within their domain to allow confirmation of service reporting to the plan. The system would query providers on service delivery status based on the appropriate time line established by the PCP and the plan. Generation of daily reports would include identification of any outstanding services awaiting confirmed delivery. Distribution of this report will include the PCP and the member's primary Nurse Case manager at HPSM to facilitate implementation of follow-up, scheduling, care plan updates and communication to the ICT.
- Another example of how HPSM communicates information about specialized services to stakeholders is via its coordination of case management services with community agency/network partners, many of which are representatives on an individual patient's ICT, as applicable. This is described further as follows:
    - The plan's community network partners include physician specialists, primary care doctors, allied health providers and county based social and mental health

service providers such the plan's mental health provider, Behavioral Health and Recovery Services and Golden Gate Regional Center. Golden Gate Regional Center provides comprehensive case management services for adults with developmental disabilities.

In addition to the case management responsibilities of the PCP for coordination of care of specialized services previously outlined in the PCP Case Management Protocol as summarized above, the PCP, in coordination with HPSM's nurse case managers, work collaboratively to communicate and coordinate specialized care across the continuum to all stakeholders, including the interdisciplinary care team.

For individuals with specialized needs, including individuals with developmental disabilities, individuals at risk of institutionalization, or individuals with behavioral health or substance abuse problems, HPSM ensures linkages to the appropriate health and social service providers, including Golden Gate Regional Center, Aging and Adult Services (with In-Home Support Services, Multipurpose Senior Services Program (MSSP), Meal on Wheels, congregate nutrition and other Older Americans Act funded services), , and Behavioral Health and Recovery Services in collaboration with the PCP.

HPSM staff participates in standing meetings with each of these agencies in order to ensure that high-level policy, programmatic, and operational considerations are addressed to best meet the clinical and social service needs of affected members in communication with the PCP. In addition, as needed, when a member with unique needs has an ICT involving these agencies, HPSM will often ask the applicable representative of these agencies, representing or working with the member, to attend the ICT so that the specialized perspective of that agency can be brought into the discussion and incorporated into the care plan of the patient.

Case Example: HPSM Coordinates with the ICT to Deliver Specialized Services

Mr. Jones is a 74-year-old male with COPD, CHF, diabetes, severe osteoarthritis, a mental health history, and limited social supports. Mr. Jones has been complaining of severe right hip pain and has demonstrated decreased mobility function for the past 9 months. Mr. Jones now cannot perform his activities of daily living- shopping, bathing, cleaning, dressing, without severe pain and shortness of breath. Due to his pain and recent health status decline, Mr. Jones has been non-compliant with his medications due to not being able to obtain medication refills secondary to his limited mobility and function. As a result of not obtaining his medications, Mr. Jones had an emergency admission to the hospital for CHF and hyperglycemia. Mr. Jones was also evaluated by orthopedics for his hip pain during his acute admission and subsequently required hip replacement surgery. HPSM was notified of Mr. Jones' admission as part of the HPSM's

Care Transition process and daily hospital census review and daily tracking of hospital admissions by the HPSM's Care Coordination department. HPSM's Care Coordination team notified Mr. Jones' primary care physician of the admission through the PCP notification of hospital admission letter (see an example below) providing the PCP with a direct

Nurse Case Manager (NCM) contact at HPSM to assist with care coordination needs of Mr. Jones during the hospitalization and post hospital d/c. During hospitalization Mr Jones's diabetes and CHF was stabilized and he received clearance for hip replacement surgery with a non-eventful hospital course.

During hospitalization an IDT meeting was established that included behavioral health for his mental health issues that may affect compliance issues and post acute care, the HPSM NCM for coordination and authorization of benefit service needs within the plan's provider network, the hospital NCM for assistance of post acute needs, and the hospitalist. The goal of the IDT team was to ensure the best possible health outcome for Mr. Jones during and post hospitalization and development of an individualized care plan that includes input from each team member, including Mr. Jones.

As part of the IDT assessment process, it was identified that Mr. Jones post d/c needs require home health skilled nursing follow-up, short term rehab, DME, hip replacement education , and medication delivery assistance, specialty care follow-up and transportation assistance. During the ICT, Mr. Jones expressed concern of not returning to his prior level of mobility and function of living independently and ambulating without assistive devices.

The care plan required that Mr. Jones' concerns be addressed including expectations of the hospital course and post d/c needs. A care plan was given to Mr. Jones outlining the critical pathway expectations including rehab goals, medication regimen, and post rehab services for his input and questions. The care plan also identified that hip replacement rehab required arrangement and authorization. The hospital NCM collaborated with the hospitalist, orthopedic team, and HPSM NCM to identify a SNF that Mr. Jones would transfer to post acute care. The HPSM NCM provided authorization to the rehab facility and transportation agency for Mr. Jones' transfer post acute hospitalization and ensured that appropriate communication between the discharging hospital, transportation agency and rehab facility occurred during the Care Transition process. Mr. Jones' specialists also required that he be seen by them within 1 week of d/c from rehab. Documentation of specialist care is also included on the care plan for coordination of care and follow-up by the HPSM NCM. The PCP was notified of Mr. Jones's d/c via the PCP hospital d/c notification letter (shown above) and a copy of the member's care plan is also sent to the PCP.

The HPSM NCM follows Mr. Jones through the continuum of care and updates the care plan and the PCP at each juncture of Mr. Jones' Care Transition process (with a

provider notification of hospital admission letter shown below). During the post acute rehab, the HPSM NCM attends IDT meetings at the rehab facility and monitors Mr. Jones' progress and needs during the rehab phase of care, updating the care plan appropriately. During the rehab phase, the care plan identifies that Mr. Jones will need home health, DME, medications, and specialty care follow-up with his orthopedic physician, PCP and behavioral health specialist. The HPSM NCM also makes a referral to BHRS, and the HPSM Care Transition Nurse to provide follow up in the home. This includes empowering the patient on medication management, education on signs of symptoms to watch out for and how to work with his physician and a personal health record to track appointments, medications and questions (as describe in section 8. of this MOC document) The HPSM NCM works with the Rehab/SNF case manager to identify and coordinate home health and DME service providers from which Mr. Jones will obtain his services. Services are authorized by the HPSM NCM. Documentation of all post-acute care needs are done on the Care Transition form (shown and describe in section 8 of this MOC document). The Care Transition Form is then given to the HPSM Care Coordination Technicians for follow-up with Mr. Jones to ensure that Home Health and DME services were obtained and that he is seen by his physician specialists and primary care doctor. Barriers to obtaining post d/c services get immediate intervention by the HPSM Care Coordination team to work with our community providers in getting the services Mr. Jones needs. Mr. Jones is also given a NCM point of contact at HPSM for questions and assistance with any healthcare service needs and provider access problems (see example below).

Sample of hospital admission notification to PCP

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

HPSM Provider Notice

Date:

To:

Subject: Admission Notification

Member Name:
Member ID:

Dear ,

Health Plan of San Mateo (HPSM) CareAdvantage member, , was admitted to , on .

As part of our Care Transitions Management program, you are receiving this notification because you are identified as this member's primary care physician. HPSM's Care Transition management program is making a special effort to improve the continuity of care as our members' transition from one setting to the next. Your patient will be assigned a plan case manager to help support care coordination efforts. The case manager for your patient is .

If you have any questions about this notice or our Care Transition management program, please contact our CareAdvantage Care Coordination Unit at (650) 616-2060.

Sample of point-of-contact letter to patient

701 Gateway Blvd., Suite 4
South San Francisco, CA 94
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

JANUARY 05, 2011

Re: **Nurse Case Manager for Transition of Care**

Dear CareAdvantage Member:

This is to inform you of services provided through our Care Transition Management progra that will help you with your transition to a new setting. These services are covered by CareAdvantage to support continuity of care when you are transferred from one facility to another (for example, from a hospital to your home, or to a nursing home).

You are being assigned to **Celeste Medios,** a Nurse Case Manager from the Care Coordination department at Health Plan of San Mateo (HPSM). She will make sure your ca is coordinated during your transfer and will be available to respond to your questions and help with information you might need when you are transferred. You can call **Celeste Medi** at phone Number (650) 616-2060, Monday through Friday, 8 a.m. to 5 p.m.

Your nurse case manager will:

- Support coordination of care by responding to questions from you, your family and/ caregivers.
- Help you understand what brought you to the hospital, and help you develop a practical care plan that will work in the future.

HPSM's Care Transition Management program **does not provide direct skilled nursing services.** If you are being transferred to a nursing home, hospital, or your home, you may receive services from a home health nurse, physical therapist or licensed social worker tha are arranged outside of the Care Transition Management program.

If you are not satisfied with the services you receive through the Care Transition Management program, please call Mari Baca, Health and Provider Services Director at (650) 616-2083.

Thank you.
Care Coordination

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contrac
CareAdvantage Unit **1-866-880-0606** (toll-free) or **(650) 616-2174** | Fax: **(650) 616-219**
Hearing Impaired: TTY **1-800-735-2929** (California Relay Service) or Dial **711**
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.
H5428_CA_9065_10 (approved 05/27/2010)

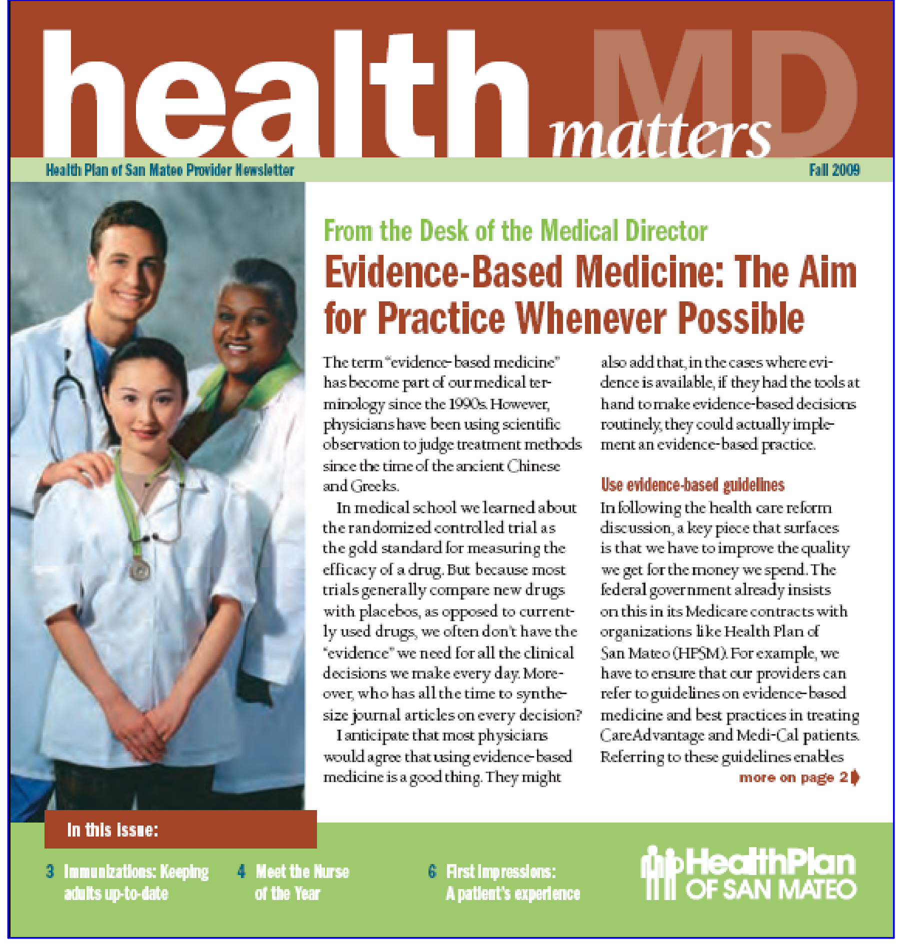
e. Describe how the MAO assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to MAO Medical Director for review, etc.)

HPSM assures that our providers use evidence-based guidelines in a variety of ways. First and foremost, we have established the use of such guidelines as an expectation for our primary care physicians and our specialists by placing such usage as part of our contracts with these physicians. Knowing that their contract contains such a provision is the underpinning for their keeping this expectation in mind, and also gives HPSM the authority to challenge care that does not meet this expectation, where that may be clinically appropriate.

Next, HPSM highlights specific evidence-based clinical guidelines on our Provider Resources page of our website (http://www.hpsm.org/providers/provider-resources/clinical-guidelines.aspx). These guidelines are ones that our Physician Advisory Group (PAG), which consists primarily of practicing PCPs and some general specialists, has helped us determine are the most likely ones that our provider network need in their daily practice. They address the illnesses most common to our member population, such as diabetes, hypertension, chronic obstructive pulmonary disease, and so forth. In addition, the links of the guidelines go to the National Guidelines Clearinghouse or the Centers for Disease Control, or other national sites as recommended by the Agency for Healthcare Quality and Research (AHRQ). While we know that some other health plans recommend clinical guidelines that they have internally developed and update, HPSM believes that a key factor in evidence-base is consistency; thus, by using the national guidelines as they are promulgated, our providers are most likely to follow them in a way that will lead to the greatest consistency and highest quality of care for our members.

Recognizing that our website information is not useful remains unseen, we also have articles in our provider newsletter about the importance of clinical guidelines. In these, we point our providers to our website, as an accessible place to find these most-commonly-needed guidelines. Every provider office receives our newsletter regularly, so we hope this outreach helps them when they look for updates on how to treat their patients. The image below illustrates one method of communication from HPSM to providers about the importance of using evidence-based clinical guidelines.

Image of the Fall 2009 issue of HealthMatters, HPSM's provider newsletter



health matters MD

Health Plan of San Mateo Provider Newsletter

Fall 2009

From the Desk of the Medical Director

Evidence-Based Medicine: The Aim for Practice Whenever Possible

The term "evidence-based medicine" has become part of our medical terminology since the 1990s. However, physicians have been using scientific observation to judge treatment methods since the time of the ancient Chinese and Greeks.

In medical school we learned about the randomized controlled trial as the gold standard for measuring the efficacy of a drug. But because most trials generally compare new drugs with placebos, as opposed to currently used drugs, we often don't have the "evidence" we need for all the clinical decisions we make every day. Moreover, who has all the time to synthesize journal articles on every decision?

I anticipate that most physicians would agree that using evidence-based medicine is a good thing. They might also add that, in the cases where evidence is available, if they had the tools at hand to make evidence-based decisions routinely, they could actually implement an evidence-based practice.

Use evidence-based guidelines

In following the health care reform discussion, a key piece that surfaces is that we have to improve the quality we get for the money we spend. The federal government already insists on this in its Medicare contracts with organizations like Health Plan of San Mateo (HPSM). For example, we have to ensure that our providers can refer to guidelines on evidence-based medicine and best practices in treating CareAdvantage and Medi-Cal patients. Referring to these guidelines enables

more on page 2

In this issue:

3 Immunizations: Keeping adults up-to-date

4 Meet the Nurse of the Year

6 First Impressions: A patient's experience

HealthPlan OF SAN MATEO

Further, HPSM receives frequent notifications about free webinars or continuing education trainings put on by our partners in San Mateo County, including the tertiary medical care facilities that serve our members. When this occurs, we e-mail blast and fax-blast these notices to the pertinent groups (e.g. PCPs, or selected specialty types, depending on the focus of the training) so that they are aware of these helpful ways to update their knowledge about important clinical areas.

In addition, our providers all must be recredentialed every three years. This involves a number of steps that help us monitor whether or not our providers are rendering care that is evidence-based as appropriate. We ensure that each provider has maintained their physician license as current; California requires a minimum number of continuing education credits for re-licensure, so that helps us know that the physician has taken some updated courses. Next each provider must maintain their board certification. While some of our providers are "grandfathered" in for board certification, this helps ensure that a large number are keeping up with the latest evidence-based changes in their field.

HPSM also monitors the care our providers render to CareAdvantage members, via site review chart surveys. As part of recredentialing, each PCP in particular must undergo a quality site review, to meet specified state standards. This includes chart review by a quality nurse specialist of a sample of medical records. As part of the review, these nurses check to see if the care they see being provided as documented in the charts meets appropriate standards of care, and is consistent with clinical guidelines, or whether it is outside what would be expected if following evidence-based guidelines. If the latter, the chart is brought to the attention of one of HPSM's medical directors, a sampling of charts of patients with those same diagnoses cared for by that provider can be selected, and further review is done to assure appropriate quality of care is being rendered to HPSM patients. The case example below demonstrates HPSM's provider monitoring through chart reviews to ensure use of evidence-based clinical practice guidelines.

Case Example: HPSM Chart Reviews Ensure Evidence-Based Clinical Practice Guidelines are Followed

> When a chart comes in for any type of review (e.g. for an appeal, level of care review, etc), it is also reviewed for application of evidence-based guidelines. For example, Mrs. C complains that her physician did not address her concern that her diabetes medicine, metformin, was causing diarrhea. She states that she went to two different appointments with the doctor, telling him that she didn't like the side effects of the medicine, and he didn't do anything, just said that sometimes happens. She states in her grievance call to HPSM that her doctor should do something more than that—at least give her something for the diarrhea, and she isn't satisfied with his care.
>
> As part of our standard procedure, prior to MD review of a potential quality of care grievance, we request the office notes surrounding the issue, as well as any pertinent other documents. When the records come in, and are brought to the medical director, we notice a number of things: 1) the physician documented that the patient reported she is taking an over the counter (OTC) stool softener a while ago—it appears she still may be taking that, and it could be exacerbating the diarrhea; 2) unrelated to the metformin, but certainly important to the diabetes, the patient's blood pressure is noted to be elevated (160/90 or more) at three visits in a row—yet no mention of it is made in the notes—this is not best practice, and needs to be addressed. Thus, in our letter to the physician, we will question both issues, the continued use of the OTC stool softener, as well as any other dietary intake that could be making the patient's diarrhea problematic, and the apparently overlooked elevated blood pressure, with a reference to the national guidelines re: blood pressure treatment recommendations.
>
> We use any opportunities such as this to ensure evidence-based guidelines are followed to optimize the care of our members.

Examples of other ways care is monitored to assure evidence-based care is being provided include:

- Follow-up of patient grievances—if a member complains about the care received from a CareAdvantage physician, the case is reviewed. If a clinical quality of care issue is identified, a medical director reviews the chart. Care that does not meet clinical quality of care standards, including following of current evidence-based guidelines, can lead to further review and a quality improvement plan for the physician.
- Quality call-outs of pharmacy claims—HPSM works with a pharmacy consultant to review medication claims where care does not seem to meet expected quality standards, following evidence-based guidelines. This may be due to drug-drug interactions, prescribing much higher doses of a drug than is recommended, not using appropriate step therapy (e.g. going to drugs with greater side effects before trying less toxic drugs for a patient condition) etc. HPSM's pharmacy manager and medical directors meet monthly with the consultant to review the highlighted case claims, and use the medical claims, case records, etc., to see if other extenuating medical conditions might explain the reasons for the pharmacy claim findings. If not, contact with the physician prescriber is initiated to get further information, which can lead to a quality improvement plan if indicated.
- Findings of on-site review nurses or prior authorization nurses—if a nurse case manager reviewing a case on site or for prior authorization services identifies a concern in how care is being rendered, s/he brings that chart to the attention of the medical directors for review. This can involve care that does not follow recommended evidence-based guidelines, such as an orthopedic procedure not medically appropriate for a patient's clinical condition, or medications causing side effects that are not being addressed, and so forth. When this occurs, the medical directors contact the attending physicians to get further information to understand the proposed treatment plan, raise the necessary clinical questions, and proceed appropriately from there.
- Referrals from other physicians in the provider network—on occasion, a patient who has been cared for by one HPSM physician leaves his/her care and goes to another physician, who becomes concerned about the quality of care rendered by the first physician. Often this concern is shared with one of the HPSM medical directors as a quality grievance. In these instances, the specific case records from physician one are requested, the case is reviewed (confidentially for all involved), and appropriate action is taken based on the findings.

In these ways, HPSM works to assure that its providers use evidence-based clinical practice guidelines and nationally recognized protocols in their care and treatment of HPSM's members.

6. Model of Care Training for Personnel and Provider Network

a. Describe how the MAO conducted initial and annual model of care training including training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.)

HPSM undertakes several approaches to ensure appropriate training and communication among staff, providers, the interdisciplinary care team, and beneficiaries.

Model of Care Training

HPSM ensures that all employed and contracted personnel receive Model of Care (MOC) Training on a regular and as needed basis. Employed staff includes licensed clinicians and support staff, as well as all staff responsible for implementation of any aspect of the MOC within each Health Plan of San Mateo department including Health Services, Care Coordination, Provider Services, Pharmacy, Quality, Member Services, Marketing, Finance, Claims, Administration, Project Management, Regulatory and Compliance, and Management Information Technology departments. Whether full-time, part-time, permanent, or temporary – all employees of the plan (approximately 200 at this time) receive initial and annual training on the plan's CareAdvantage MOC. Training is also provided to the Health Plan of San Mateo's governing board, the San Mateo Health Commission.

Training is performed annually, usually within the first quarter of each calendar year. Training for internal staff is provided by HPSM's Medical Director and the Director of Health and Provider Services or delegated staff.

Model of Care Training is also provided annually to all contracted providers within the plan's provider network. Provider network training is offered monthly at various sites within San Mateo County, including major contracted hospital sites, large medical group office sites, or at the Health Plan of San Mateo's headquarters. The provider community training is conducted by the plan's Provider Services staff and Health and Provider Services Director. Usual attendance at these trainings is 20-30 provider offices/hospital representatives, etc., per training.

The Health Plan of San Mateo's strategic goal for our Model of Care training is to increase understanding of the MOC, facilitate further participation and thus motivate all participants to share and express ideas to allow the plan to continuously improve our Model of Care. This occurs via integration of plan staff and network partners' ideas and experience, which helps improve the successful function of interdisciplinary care team, and ultimately optimal health outcomes for our CareAdvantage members. To implement this goal the plan employs several MOC of care training methodologies. These include 1) direct face to face trainings utilizing a presentation style format with printed materials, 2) audio/video conferencing, and 3)

interactive web based self study. Each training methodology incorporates direct participant feedback and evaluation for continuous quality improvement.

Training content includes:

- Course Overview
- Learning Objectives
- Introduction to Special Needs Plans
  - Types of SNP
  - Health Plan of San Mateo's SNP
  - Criteria for eligibility in Health Plan of San Mateo's SNP
- Health Plan of San Mateo's SNP Model of Care
  - Defining factors
  - Benefits to members of HPSM's Special Needs Plan
  - Goal of HPSM's MOC
    - Improve access to medical, mental health, and social services
    - Improve access to affordable care
    - Improve Coordination of Care through a point of contact
    - Improve Transitions of Care across healthcare settings and providers
    - Improve access to preventive health services
    - Assure Appropriate Utilization of services
    - Assure Cost Effective Service Delivery
    - Improve Beneficiary Health Outcomes
      - Reduce hospitalizations and SNF placements
      - Improve self-management and independence
      - Improve mobility and functional status
      - Improve pain management
      - Improve quality of life as self-reported
      - Improve satisfaction with health status and health services
    - How Health Plan of San Mateo's SNP Model of Care operates
      - Programs within HPSM's SNP
        - Care Management
        - Care Transitions
        - Medication Therapy Management
        - Add-on benefits
          - Transportation
          - Dental
          - Vision
        - Seamless coordination of Medicare/Medi-Cal benefits
      - Roles of key staff personnel
        - Medical Management
        - Care management
        - Pharmacy

        - Health Service
        - Member Services
        - Provider Services
        - Health Promotion
    - Health Risk Assessment Survey
        - What it looks like
        - How it is use
        - Health Risk Assessment Survey contents
            - Functional
            - Activities of Daily Living
            - Past medical history
            - Medications
            - Psycho –social needs
                - Care giver support
                - Types of Living status- Board and Care, Assistive living, independent
            - Community Resource utilization
            - Care giver support
        - Process for administering HRA survey
            - Contracted vendor –DSS
            - Tracking of completed surveys
                - Outreach to members when survey not returned
            - Risk stratification based on survey
        - Next steps after completion of survey and stratification
            - Referral to HPSM's Care Coordination program
            - Additional outreach, validation of survey results and individualized care planning
        - How we communicate with the SNP team
            - Care Coordination meetings
            - ICT meetings
        - Evaluation of Program Goals
            - Annual program evaluation
            - Past program results
    - Contact information to staff department leads
        - Executive
        - Member Services
        - Health Services
        - Quality Department
        - Provider Services
- Q and A
- Participant feedback and evaluation
- MOC Areas of Improvement participation follow-up

- Obtainment of contact information
- Scheduling of focus groups

Following are examples of the MOC training presentation.

For 2012, the model of care self study materials for new staff will be provided in the new hire orientation packet. To help meet the continuous quality of care training goal of improving the plan's Model of Care, all employees will be required to do a Model of Care evaluation with suggestions for improving the model of care based on one's direct knowledge and experience of individual components of the MOC. An evaluation of the training itself will also be required of all staff members.

b. Describe how the MAO assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.)

In addition, to the monthly Model of Care trainings for the provider network (see a above), HPSM's Provider Services and Quality Improvement departments distributes MOC materials to new contracted providers and relevant vendors (e.g. for disease management, home visits, etc).for review and input. In addition to the monthly on-site provider training sessions all contracted HPSM providers receive an annual updated copy of the Model of Care training materials in the annual Provider Manual update. HPSM currently includes verbiage in all provider contracts that address provider process and procedure responsibilities, including model of care training references in the Provider Manual. Thus, the providers understand that understanding of HPSM's MOC is a key part of their role as a HPSM contracted provider.

To assure and document completion of training by contracted providers for each training session, a list of providers who attended each training is maintained. For 2012 the Provider Services Manager will hold responsibility for maintaining this list and tracking of contracted providers who have not received the annual training.

Several attendance and training attestation methods occur based on the methodology of the training. For monthly provider trainings, an attendance sheet is maintained, as noted above. Web based self-study incorporates computer training completion attestations. Health Plan of San Mateo's Provider Services Manager also maintains a list of providers who attend training sessions by audio/video conferencing.

For 2012, automated report generation of providers missing the training is planned for implementation. A sample report is shown below.

Sample report of **providers** whose MOC training is past due

Model of Care training Past Due Providers									
Newly Added?	Provider #	NPI #	Specialty	Last Name	First name	Past due y/n	last Training date	Rep's name	Training method
	5474160001	1114077328	Durable Medical Equipment	A & T Medical Supply					
	00G296010	1912903329	Ophthalmology	Abrams	James				
	DME03092F	1144299157	Durable Med Equip	Admiral Medical Supp.					
	00C354780	1255332334	Ophthalmology	Allen	Arthur				
	00A692760	1487685368	Nephrology	Alvarez	Luis				
	HA0021450	1316024995	Hearing Aids	American Hearing Aid Center					
	00A432030	1912904806	Thoracic Surgery	Anastassiou	Peter				
	00C324810	1487646188	Ophthalmology	Atkins	Roger				
	00G296120	1487742425	General Surgery	Bailey	Susan				
	DC0190300	1487728242	Chiropractic	Balbon	Brian				
	00G842181	1558323360	Ophthalmology	Banez	Mary Ann				
	XB0016280	1669490777	Prosthetic and Orthotic Appliances	Berke	Gary				

Physician providers and all other provider types based locally in the San Mateo County area who miss trainings will receive direct face to face follow-up communication by the plan's Provider Services representatives.

To ensure all plan employees receive initial and annual Model of Care training, HPSM will incorporate this training in the human resources policies and procedures. Planned for 2012, the plan's Human Resources department will incorporate the Model of Care training into all new employee orientations and establish a web based employee training module with a web based attendance tracking mechanism to ensure every employee receives this training annually. Coordination of annual face to face employee MOC training with web-based training will be ensured and tracked by the Human Resources department. Tracking of employee training will be maintained in the Human Resource department utilizing an Excel Spreadsheet. A sample template of this spreadsheet is shown below:

Sample report of **employees** whose MOC training is past due

Model of Care training HPSM employees									
New Hire date	Employee #	Department	Last Name	First name	Past due y/n	last Training date	Training method	Attestation on file
		Executive						
		Health Services						
		Member Services						
		Member Services						
		Member Services						
		Health Services						
		Claims						
		Claims						
		Executive						

The plan currently includes verbiage in all provider contracts that address provider process and procedure responsibilities, including model of care training references in the Provider Manual.

The scenario below describes how HPSM ensures and documents completion of MOC training by employed and contracted personnel.

Scenario: Model of Care Training Management

HPSM added three 3 new providers to its network and two 2 new employees to staff January 3, 2012. Model of Care (MOC) training is held the second 2nd week of every month. Each new provider and each new employee will require model of careMOC training. For both the new providers and new employees, documentation of MOC training is required within 30 days of joining the plan. Responsibility for implementing, tracking and documenting Provider MOC training is held by the HPSM Provider Services Manager. Responsibility for implementing, tracking and documenting new HPSM staff MOC training in 2012 is held by the HPSM Human Resource Director as a component of new employee orientation. Of note, one new provider, DME vendor A, already completed MOC training via the web-based training tool

Providers and employees are given two 2 separate options for MOC training. This includes web based and face-to-face presentation style trainings. Since the new providers and new employees joined HPSM on January 3 and the MOC monthly training has not occurred, both the new employees and new providers may receive the face-to-face training together at the regularly scheduled January 2012 meeting presentation. The second option for the new employees and new providers is to opt for web-based training.

Regardless of MOC training methodology, the HPSM Provider Services Manager shall add the 3 new providers to the MOC tracking list (shown in sample report of providers due for MOC training above) at the time of confirmed completed credentialed status, completing all variables of the list (i.e., newly added, provider number, specialty, name, etc.) leaving the last training date and training method and name open. Immediately upon provider completion of

the MOC training, HPSM Provider Services Manager updates the MOC training tracking list (shown above) based on the monthly face-to-face and or audio/video conferencing presentation attendance sheets and the web-based computer attestations of completion.

For the new provider that already completed the MOC training via the web, this provider may still attend the face-to-face MOC training session. However, the HPSM Provider Services Manager should update the MOC training tracking form identifying that provider DME vendor A completed MOC training via the web on Jan 4, 2012 and the attestation is on file and in the provider's record. The HPSM Provider Services Manager will also query the MOC training tracking list (shown above) bi-weekly to identify providers missing the training or who are due for annual re-training. The HPSM Provider Services Manager notifies the HPSM Provider Services representative of specific providers who missed the MOC training within 30 days of their confirmed contracting status. The Provider Services representatives re-educates the provider of their contract responsibilities in the MOC training completion as outlined in section 3.2, 13.1 and 3.3.1 of the Provider CareAdvantage contracts. Providers continually refused to become compliant with MOC training completion are at risk for disciplinary action and brought to the Physician Review Committee for review and recommendations for a corrective action plan, including contract termination as describe in Element 6, Factor D.

The HPSM provider service representative, representing the new provider's region, shall put together the new provider packet as outlined in Policy and Procedure PS-01-03-Provider Training procedure (example referenced in Element 6, Factor C) which includes the MOC PowerPoint presentation shown in element 6, Factor A and the HPSM Provider Manual.

For the two new employees, the Human Resources Director will incorporate the MOC PowerPoint presentation in every new employee orientation as outlined in HR- 01 and give the option of the employee to receive the training via web or at the monthly face-to-face with the Provider community. The HR Director updates the MOC training tracking list for employees (shown in sample report above of employees due for MOC training) immediately upon employee completion of the training and will maintain attestation sheets from the employee attesting that MOC training was completed in the employee record. The HR Director queries the MOC training tacking list monthly to identify employees missing the MOC training completion or who are due for annual re-training of the MOC. Employees identified as not completing the MOC training are brought to the immediate attention of their respective department supervisors for staff development on MOC training. Employees not compliant with completion of MOC training are reminded of their responsibility under the plan's HR policies outlined in their employee handbook section 700 page 33. Employees who continually fail to adhere to MOC training completion are subject to disciplinary action, including termination of employment from the plan (as describe in Element 6, Factor D).

c. Describe who the MAO identified as personnel responsible for oversight of the model of care training

Oversight of HPSM Model of Care (MOC) training is the responsibility of both the plan's Medical Director- Mary Giammona, MD, MPH, and the Health and Provider Services Director- Mari Baca, RN, MSN, BS, PHN. Both share responsibility for ensuring the MOC goals are consistent with HPSM mission, values, and principles. They also have responsibility to ensure the MOC meets CMS expectations and requirements. Both the Medical Director and Health and Provider Services Director are accountable for the Model of Care training's continuous quality improvement efforts.

Annual Model of Care training for internal staff is ensured by the Human Resources Department. Content is the responsibility of the Medical Director and Health and Provider Services Director. Trainings are conducted face-to-face or via web training, by these two directors or their designees.

The Medical Director is also the Director of the Quality Department, and the Health and Provider Services Director leads the Care Coordination Unit. Both have had instrumental roles in creating and implementing the MOC. They are also key members of Interdisciplinary Care Team planning, performance measurement and MOC goal development and monitoring, and so forth.

These individuals were identified for this responsibility because of their clinical leadership role at HPSM in the CareAdvantage program, their expertise in quality improvement, their intimate knowledge of HPSM's SNP Model of Care, and their responsibility overall for care coordination activities. Thus, both of these directors have the knowledge, training and experience to impart the essence of and inspire the HPSM staff about the MOC.

New employee training on the MOC is to be incorporated into all new employee orientation packets, under the responsibility of HPSM's Human Resources department. This training is to be modeled after the annual training, but tailored in a way to also provide background needed for a new employee to understand the context of the MOC. Again, the Medical Director and Director of Health and Provider Services are responsible for the content of this training.

Employees are required to attend the face-to-face training; any employees who cannot attend a face-to-face training due to scheduling conflicts are required to undergo the training as a self study training module.

Initial and annual Model of Care Training is also provided to all contracted providers within the plan's provider network. Provider network training is offered monthly at various sites within San Mateo County, including major contracted hospital sites, large medical group office sites, or at the Health Plan of San Mateo's headquarters. The provider community training is conducted by the plan's Provider Services staff and Health and Provider Services Director or

delegated staff under the Health and Provider Services Director. Content is the responsibility of the Medical Director and Health and Provider Services Director, as described above.

Policy and Procedure PS.01.03- Provider Training procedure outlines the Provider Training procedure responsibility and authority with the Medical Director, Health and Provider Services Director, and Provider Services Manager as responsible for provider training. A policy and procedure is being added to include Model of Care training for all employees under the responsibility of the Human Resources Director in collaboration with the plan's Medical Director and Health and Provider Services Director for 2012. An example of the policy and procedure PS 01.03 is shown below, on which the additional policy and procedure is to be patterned:

Health Plan of San Mateo
Procedure Manual

Procedure: PS-01-03	Provider Training Procedure	Original Date: 04/95 Effective Date: 07/2010
Revision: 3	Dept: Provider Services	Page 122 of 3
Approval By:		Date:
Provider Services Manager		July 2010
Health and Provider Services Director		July 2010
Medical Director		July 2010
Annual Review Date:		July 2011

Purpose and Scope:

To ensure that all contracted Health Plan of San Mateo providers receive information/education and training related to HPSM's lines of business, operations guidelines and other related information.

Responsibility and Authority:

The Provider Services Manager, Health and Provider Services Director, and Medical Director are responsible for oversight and ensuring that practitioners accepted into Health Plan of San Mateo's (HPSM's) contracted network receive appropriate and on-going training.

Definitions:

Providers are defined as a person, group or company that signs a contractual agreement with HPSM under one or more of the company product lines. .

Policy:

HPSM is responsible for the quality of care and satisfaction of its members as well as the satisfaction of its network of contracted providers. HPSM's staff of Provider Services Representatives will assume responsibility of delivering all necessary topic of information t the provider community within 10 calendar days after a provider has been accepted as an HPSM participating provider. In addition, Provider Services staff will deliver all subsequent education items to the provider on an on-going basis.

Procedure
1.0 Initial Provider Education

Upon notification of a provider's acceptance in HPSM's provider network, the Provider Services representative will contact the office to schedule an orientation meeting with the provider. At this meeting, the following items will be delivered and discussed:

a. Provider Manual
b. Model of Care training presentation
c. Current Provider Directories
d. Provider Quick Reference Guide

The scenario below describes how HPSM ensures and documents completion of MOC training by employed and contracted personnel.

Scenario: HPSM-identified personnel responsible for oversight of the model of care training

The plan identifies new trends, community practice standards and changes in CMS expectation requirements in the MOC as a result of an increase in beneficiary population size and demographics. The current model of care has not been updated for 11 months.

The HPSM Medical Director and Director of Health and Provider Services review the MOC at minimum on an annual basis. The Medical Director and Director of Health and Provider Services review member demographic trends and population statistics on a monthly basis. Additionally, both the Medical Director and Director of Health and Provider Services keep abreast of CMS expectations and requirements requiring updates to the MOC. Updates to the MOC training materials are performed by the Medical Director and Director of Health and Provider Services.

The MOC updates are distributed to key personnel at the plan by the Medical Director and Director of Health and Provider Services, including those responsible for MOC training, within 14 days of the update. Key personnel in MOC training include the HR Director, Web portal IT designer and Provider Services Manager for appropriate distribution and re-training. For 2012, web-based MOC updates notification will be posted through email alerts with notification to allow providers to attend monthly face-to-face MOC trainings. Hard copy updates will be sent to providers in their annual Provider Manual update deliverables. Monthly face-to-face MOC training meetings will have the updated MOC materials at the next face-to-face training session.

Employees receive updates to the MOC through the plan's HR division via email alerts requesting web-based re-training.

d. Describe what actions the MAO will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.)

Several actions may be taken when employees or contracted providers do not complete the Model of Care training. This includes disciplinary action for plan employees and possibly contract termination for contracted providers.

Plan employees who fail to complete the Model of Care (MOC) training as outlined in the new employee orientation or in organizational policy and procedure will have the reason reviewed. Since scheduling problems for the face-to-face session can be overcome by completing the

self-study version, the staff will be reminded of this option. Failure to comply after this reminder will be brought to the attention of the employee's supervisor. If completion still does not occur, at this point the lack of cooperation may be considered for disciplinary action based on failure to comply with the policies and procedures of the plan. HPSM's Human Resource manual section 700 outlines conduct and continuity standards of all employees. Employees who still fail to complete the Model of Care training may be considered insubordinate and considered for disciplinary action. Following is an excerpt from HPSM's Human Resources manual section 700, pg 33:

> "**Insubordination**
> Insubordination, refusing to follow a manager's/supervisor's directions, or other disrespectful conduct to a manager/supervisor or other employees."

Providers who fail to complete the MOC training will receive follow-up by the plan's Provider Services department to identify barriers to training completion. The plan's Provider Services representatives will work with the provider to overcome the provider's barriers to training and develop a plan that will facilitate the provider's completion of the Model of Care training. Addition actions the plan may take in improving MOC training completion include:

- Identification of trends of non compliance around MOC training
- Development of individualized corrective action plans that improve compliance , including re-enforcing benefits of the plan's Model of Care and collaborative care
- Consideration of provider incentives
- Re-education of providers on the requirements under their contract with HPSM, including sections 3.3, 3.3.2, and section 13, which emphasize their responsibilities in this area.

Providers who still fail to complete the MOC training may be in violation of their HPSM contract agreement. The plan's CareAdvantage provider contracts section 3.3 and 3.3.2 mandate provider compliance with plan's policies. Section 3.3 of the CareAdvantage contract states:

> "3.3 Compliance with CareAdvantage Laws and Regulation and plan policies. <PCP/Specialist/Allied Health provider/hospital> understands that Plan oversees and is accountable to CMS for any functions or responsibilities that are described in the laws or regulations applicable to Medicare plans, and that plan may be held accountable by
> CMS if <PCP/Specialist/Allied Health provider/hospital> and or its downstream entity violates the provisions of such law or regulations or plan's policies in the performance of this agreement. ...."

Section 3.3.2 of the provider CareAdvantage contract agreement states as follows:

"<PCP/Specialist/Allied Health provider/hospital> understands and agrees that the plan is responsible for the monitoring and oversight of all duties of <PCP/Specialist/Allied
Health provider/hospital> under this agreement and the plan has the authority and responsibility to: (i) implement, maintain and enforce Plan's policies governing <
PCP/Specialist/Allied Health provider/hospital> under this agreement…and/or revoke the delegation of duty if the PCP fails to meet plan standards in the performance of that duty. "

Section 13.1 of the CareAdvantage provider contract agreements state:

"13.1 Policies and Procedures. Plan offers the PCP/Specialist/Allied Health Provider/Hospital> with a Provider Manual that contains those Plan policies and procedures necessary for the proper operation of the <PCP Specialist/Allied Health provider/hospital> argeement….PCP/Specialist/Allied Health provider/hospital> agrees to comply and will have any downstream entity agree to comply with plan standards and policies outlined in the provider manual. "

Generally, when a provider is reminded of these requirements in their contract, they step up and comply with whatever task is asked of them. Those that still resist are brought to HPSM's Physician Review Committee for review. A corrective action plan is developed, and the provider is notified of the plan, including consequences up to contract termination if there is continued non-compliance. After this level of notification, it is anticipated that documentation of training completion will be relatively straightforward, as it has been for other requirements that have needed to be brought to this level (e.g. cooperation with facility site review, compliance with other contracting requirements, etc).

A Health Plan of San Mateo policy and procedure on the plan's actions for Model of Care training completion compliance is under review and will be in effect in 2012. The example below illustrates the steps HPSM will take when the required MOC training has not been completed.

Scenario: HPSM actions to ensure MOC training completion

HPSM added three new providers to its network and two new employees to staff on January 3, 2012. MOC training is held the second week of every month. Each new provider and each new employee will require model of care training. For both the new providers and new employees, documentation of MOC training is required within 30 days of joining the plan. A new HPSM employee, Mary K, and two new providers, Donald's Prosthetics and Dr. Mary Forgetful, fail to complete the MOC training. The employee, Mary K, is 45 days past due on MOC training and one of HPSM's providers, Dr. Mary Forgetful, is 8 months past due. Donald's Prosthetics is 90 days past due on MOC training. Dr. Mary Forgetful has had several outreach

attempts by the plan's Provider Services representative reminding her of her contract obligations around MOC training.

For any provider who fails to complete MOC training, the HPSM Provider Services Manager (PSM) notifies the HPSM Provider Services representative of specific providers who missed the MOC training within 30 days of their confirmed contracting status. The Provider Services representatives re-educates the provider of their contract responsibilities in the MOC training completion as outlined in section 3.2, 13.1 and 3.3.1 of the Provider CareAdvantage contracts. Providers continually refusing to become compliant with MOC training completion are at risk for disciplinary action and brought to the Physician Review Committee for review and recommendations for a corrective action plan, including contract termination, as described in Element 6, Factor D.

Dr. Mary Forgetful received 8 monthly outreach calls from her HPSM Provider Services representative and 2 calls from the plan's Medical Director and Director of Health and Provider Services regarding her obligations on MOC training. Dr. Forgetful was also offered direct 1:1 training by her PS representative without success. Dr. Forgetful's case was brought forth to the plan's physician review committee (PRC). The committee was presented with the communication log and outreach attempts to Dr. Forgetful, the contract obligations outlined in her PCP CareAdvantage contract and the training options available to Dr. Forgetful. The PRC consensus was that Dr. Forgetful was a non-compliant provider who failed to adhere to her contract obligations under the plan in serving the best interest of the plan's beneficiaries. A corrective action plan letter was sent to Dr. Forgetful offering one last opportunity to correct her MOC training deficiency within 30 days of receipt of the corrective action plan before a notice of intent to terminate her Care Advantage contract. Dr. Forgetful completed MOC training at the next face-to-face training session and has successfully maintained her contract with HPSM for the current calendar year. Dr. Forgetful was reminded at the face-to-face meeting that MOC training is required every calendar year.

Donald's Prosthetics received 3 outreach attempts by his HPSM Provider Services representative. The plan's PSM and Director of Health and Provider Services made a face-to-face visit with Mr. Donald at his prosthetic shop to discuss the importance of MOC training and ramifications of failing to adhere to the MOC contract obligations (outlined above). Mr. Donald opted for web-based training and completed his MOC training within 3 days of the face-to-face visit.

Employee MOC training is monitored by the HPSM Human Resources (HR) Director. The HR Director will incorporate the MOC PowerPoint presentation in every new employee orientation as outlined in HR- 01 and give the option of the employee to receive the training via web or at the monthly face-to-face with the Provider community. The HR Director updates the MOC training tracking list for employees (shown above) immediately upon employee completion of the training and will maintain attestation sheets from the employee attesting that MOC training was completed in the employee record. The HR Director queries the MOC training tacking list monthly to identify employees missing the MOC training completion or who are due for annual re-training of the MOC. Employees identified as not completing the MOC training are brought to the immediate attention of their respective department supervisors for staff development on MOC training. Employees not compliant with completion of MOC training are reminded of their responsibility under the plan's HR policies outlined in

their employee handbook section 700, page 33. Employees who continually fail to adhere to MOC training completion are subject to disciplinary action, including termination of employment from the plan (as described in Element 6, Factor D)

Mary K, HPSM's newest employee, was found to be 45 days delinquent on MOC training completion through the plan's HR monitoring of the MOC training tracking database for employees (outlined in Factor A, Element 6 above). The HR Director did not receive a web-based completion attestation or employee attestation of MOC training through the monthly face-to-face training meetings. The HR director notified Mary K's department supervisor. Mary K's supervisor reminded Mary that failure to complete the MOC training may be considered insubordination, as outlined in the employee handbook under employee responsibilities. Mary's supervisor also helped Mary prioritize her work load and gave Mary dedicated time to complete web-based MOC training. Mary's supervisor also explained to Mary the importance of the HPSM MOC and the foundation it provides to better serve our members. Mary K completed her MOC training and has a successful career at HPSM.

7. Health Risk Assessment

a. Describe the health risk assessment tool the MAO uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial, functional, and cognitive needs, medical and mental health history, etc.)

HPSM has a variety of health risk assessment tools that it uses for determining the level of severity of a CareAdvantage member's risk for an adverse health outcome, in particular for hospitalization or emergency room visit, in the upcoming nine months. While a number of the assessments (comprehensive assessment tool—used by the care coordination team after someone is determined to be high risk; universal assessment tool, used after someone is determined to be eligible for the High Utilizers Group—HUG,), uses a comprehensive health risk assessment tool to identify the medical, psychosocial, functional, and cognitive needs of beneficiaries, in addition to capturing medical and mental health histories. The 38-question instrument uses a number of validated question sets and individual response items that include the following measures:

- Brody Frailty Index – uses four questions to reliably predict the level of frailty in senior populations.
    - We have chosen this index because it has been validated, and, with a few short questions, can help us identify which of our older adults in CareAdvantage are frailest. This descriptor is considered a key component of risk for factors (e.g. falls, pneumonia, etc) that increase the likelihood of an upcoming adverse health outcome.
- CMS Frailty Scale – uses an index of activities of daily living to show high correlation with Medicare claims linked to HCC.
    - As part of alignment with tools from CMS guidance, HPSM's HRA uses the CMS frailty score. Having assessment questions from two frailty scores assists us in strengthening the likelihood that the great majority of our frail members will be identified.
- Pra Tool – most common measure for calculating probability for repeated hospital admissions.
    - We are using the eight questions on this elder health assessment survey tool, developed based on questions asked after extensive study by the National Center for Health Statistics and the National Institutes of Health. After a study by the Robert Wood Johnson foundation supported that this tools was integral to any assessment done by a Medicare Advantage plan, because of its success in predicting likelihood of the patient's readmission within the next four years or sooner, we added these questions to our HRA tool.
- SF-12 – proven instrument for assessing mental and physical health of all populations.

- This tool has questions that ask the patient about their perception of their mental and physical health, which relates as feedback on their quality of life. Thus, questions from this tool are ones that we will use to determine whether or not our MOC performance measure goal 4 (please see Element 2, above) is met successfully or not.
-
- BMI – standard calculation of body mass index and reference to latest clinical guidelines.
  - Using a member's calculated BMI (by having them provide their height and weight) allows us to have a relatively consistent trend about our members' weights over time, which can be used to determine presence of an ongoing serious illness generally. Whether severely overweight or underweight, or demonstrating a notable change in weight over time, the BMI is a way we can track and trend physical changes in our patients via a survey tool.
- 5-item depression screener – most common depression screening items (multiple sources).
  - Numerous medical studies have shown that a high proportion of patients with chronic illness have coinciding, undiagnosed depression, which, if treated, greatly improves the outcome of the medical condition (e.g. better compliance, improved adherence to an exercise regimen and healthy diet and so forth). For this reason, we have placed extra attention on identifying depression in our CareAdvantage patient population which has so many comorbidities.
- 17 chronic conditions – items with highest prevalence and greatest relationship to future claims.
  - Here we ask specifically about specific conditions that have been shown to exist with increased prevalence in our patient population.
- Demographics – age, gender, ethnicity, educational level, type of residence and current living arrangement selected for their descriptive and predictive characteristics.
  - This information is extremely helpful as nowhere else do we have the data in one place, available to HPSM for analysis and matching with the other data pieces collected in the HRA.
- Health service usage – physicians, outpatient, ER, inpatient and prescription usage is measured for overall understanding of health status and utilization history
  - Although HPSM collects this information via claims data, we have found that we have gaps in our data information due to members who go out of network and/or pay themselves for these services, or get these services from providers who decide not to bill HPSM (either because HPSM is the secondary payer, or the provider doesn't bother to bill). Thus, getting this information directly from the member is an important way to get a more complete history of our members' utilization patterns.
- Preventive care – adherence to best practices for preventive care (e.g. pap smears, mammograms, flu shots, etc. at recommended intervals).

- Although HPSM collects this information via claims data, we have found that we have gaps in our data information due to members who go out of network and/or pay themselves for these services, or get these services from providers who decide not to bill HPSM (either because HPSM is the secondary payer, or the provider doesn't bother to bill). Thus, getting this information directly from the member is an important way to get a more complete history of our members' utilization patterns.

HPSM reviews the assessment form on an annual basis to ensure that it remains effective in identifying CareAdvantage beneficiary needs. HPSM has created this HRA with our vendor, DSS, a company with years of experience in many types of surveys including the CAPHS survey, and with working with the Medicare population. DSS in turn is responsible for the administration of the survey.

Below is an image of HPSM's health risk assessment tool. The complete health risk assessment tool is included with this submission as Appendix F.

Member Health Survey for Health Plan of San Mateo Members

Name: ______________________ Date of Birth: ______________

CareAdvantage ID: ______________________ ☐ Male ☐ Female

Address: ______________________ City: ______________ Zip: ______________

Phone: ______________________

This survey is about your health. It is important that you complete the survey. Your health care benefits will not be affected in any way by your responses. A family member or caregiver can complete the survey for you if you are unable.

1. In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago
- ☐ Somewhat better now than one year ago
- ☐ About the same as one year ago
- ☐ Somewhat worse now than one year ago
- ☐ Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes limited a lot	**Yes limited a little**	**No, not limited at all**
Moderate activities, such as moving a table, pushing a vacuum cleaner, or bowling	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	**No**
Accomplished less than you would like	☐	☐
Were limited in the kind of work or other activities	☐	☐

b. Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary (e.g., initial assessment within 90 days of enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary, etc.)

HPSM conducts an initial health risk assessment of each beneficiary upon enrollment and an annual reassessment of every beneficiary who joins our CareAdvantage plan. The following survey methodology is used for both the initial assessment and annual reassessment:

- The health risk assessment tool described above is mailed by our vendor, DSS, to new beneficiaries within 30 days of their enrollment effective date.
  - The HRA tool is written with questions that are literacy adjusted for our dual eligible members
  - It is translated from English into all the CareAdvantage languages considered threshold languages for our members: Spanish, Tagalog, Russian and Chinese
  - HPSM sends name/address/telephone number files securely to our vendor, sorted by language and DSS mails out the HRA tool so that each new member receives the HRA well within 90 days of their enrollment in CareAdvantage
- For beneficiaries not responding to the first questionnaire within three weeks, a second assessment form is mailed by DSS.
  - DSS has a tracking system that it uses to note which members respond to the survey within the time period in question. This is done in an automated fashion, so that if the first HRA is not returned within the three week time, the second HRA is sent out directly. As this happens member by member, having it automated makes this process time and cost efficient.
- For beneficiaries not responding to the second assessment request within two weeks, at least ten follow-up telephone calls are made by DSS staff over a three-week period to complete the assessment telephonically in order to obtain as high a response rate as possible.
  - Once the member does not respond in writing, an intensive telephone follow up effort is made by DSS to contact the member. The initial phoning is done at a wide variety of times during the day and evening, respecting the member's condition, so early morning and late evening calls are not done. The initial call is done in an automated manner, and if the call is connected successfully, it is transferred to a live person to complete the HRA with the member. The DSS staff are carefully trained to work with older adults and the disabled, so they are sensitive about the needs of our member population while at the same time persuasive regarding the importance of getting the HRA completed.
  - They go over the HRA with the member question by question, completing it in the member's preferred language. A DSS staff member who speaks the beneficiary's language is used where possible; a phone interpreter is used where necessary.

Reassessment forms are mailed out to beneficiaries on an annual basis during the month of their initial effective enrollment date. The annual reassessment survey process follows the same methodology described above.

- The surveys are mailed out by our vendor DSS, as outlined above.
- Two mailings are sent, and if the HRA is not received back after the five week (total) period, the ten follow-up calls are made as outlined above.
  - We recognize that members receiving annual versions of the survey may be a bit more resistant to completing it again, for it may seem "just like yesterday" that they
    answered the same questions. Thus, some may be less likely to mail the survey back. For this reason, we anticipate and our vendor, DSS, is prepared that the annual surveys initially may need more intensive phone follow-up in the first few years, until our members realize that the survey is part of an annual effort by HPSM to help keep them as healthy as possible.

c. Describe the personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.)

The process of the review, analysis, and stratification of health risk assessments is a two-step one that begins with data capture, analysis, and stratification by HPSM's survey vendor, DSS, and subsequent validation and action by HPSM Care Coordination staff. This process and the staff involved are described in the paragraphs below.

HPSM works with DSS Research to conduct initial health risk assessments and annual reassessments. DSS Research is a nationally known, respected research firm and is one of a small number of companies certified to conduct both the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

DSS follows the survey methodology described in section b above, compiles and analyzes beneficiary response data, and sends beneficiary reports and raw data to HPSM for validation. The initial beneficiary risk stratification is performed by DSS using the stratification algorithm defined by HPSM and DSS, and derived from beneficiaries' individual survey responses. This is done by DSS's Analytical Services Team, which specializes in providing clients with insightful, actionable research, and includes the following staff:

- Published Ph.D. survey expert who is the scientific lead on the project
- Senior Statisticians, with Master's and Doctorate degrees in statistical analysis
- Data Analysts with many years of experience in analyzing survey data
- Operations Technicians with training and experience in taking survey data and turning it into a format readily able to be analyzed by the scientific staff
- Technical Writers to assist in preparing the final reports presented to HPSM

Using their scientific staff, DSS stratifies the HRA results into high, medium and low risk groups. Once DSS submits the reports that summarize the analysis of beneficiary risk to HPSM, these beneficiary-specific summary reports and actual survey responses are reviewed in oversight by the Care Coordination Team (RNs and the Health and Provider Services Director, Master's prepared nurse—MSN, BSN). Any questionable cases are brought to the Medical Director (MD, MPH) or Associate Medical Director—Health Services and Quality (MD) for review. Reports of these HRAs are sent to both the member and the member's PCP (MD)—please see factor d (below) for further details.

- For any beneficiary determined by DSS stratification to be high risk, the results are also forwarded to the member's interdisciplinary care team (ICT), which is coordinated by HPSM's Nurse Case Managers (RNs, BSNs). These ICTs analyze the results of each beneficiary's initial or annual health risk assessment and incorporates them into a care plan that is appropriate for each beneficiary. Thus, the individualized care plans are updated, and this information is stored in the Care Coordination database, as well as updated securely in the applicable web based care management tools, depending on the specialized programs/services the member may be a participant of (please see Element 4 for a more detailed explanation).

  HPSM's internal ICT meets no less than biweekly, and meets more often if needed. The plan's Care Coordination ICT focus is to improve the quality of care delivered to members via a collaborative process through assessment, planning, facilitation, and advocacy for options and services to meet the individual's health needs through communication and available resources to promote quality cost-effective outcomes.

  HPSM's ICT is held on a specific day and time every other week, and is on all the care coordination units' calendars, so no additional notice is necessary, unless a special meeting is being held. An agenda is distributed for every meeting. Minutes are taken by the department's administrative assistant. All members of the plan's internal ICT receive copies of minutes prior to the subsequent meeting.

  Individual member case summaries and interventions discussed at the ICT are documented in the plan's electronic Care Coordination database. Member-specific case summaries and interventions are communicated to the PCP and/or other parties, and copies of the minutes are sent securely to other stakeholders (e.g. BHRS or AAS representatives who have attended), as appropriate, to effectively carry out required care management interventions that improve the patient's health care outcomes.

As additionally outlined in Element 4, a patient's ICT consists of HPSM staff and contracted providers involved in beneficiary care and include the following professionally knowledgeable individuals, as well as the patient:

- Patient and Caregiver (if patient concurs)
- Physician (MD)
- Nurse Case Manager (RN)
- Medical Social Worker (MSW) or Social Services Representative (LCSW)
- Behavioral Health Representative (Psy. D or Ph.D)
- Other identified professionals, as appropriate, such as Pharm. D, MPH Health Educators, Master's prepared nurses, and so forth)

These professionals further analyze the results of the HRA, and apply the results to the member's clinical and psychosocial condition, updating and clarifying issues with the member (if he/she is in attendance) during ICT meetings, as well as on follow-up phone calls. This information is also used, as noted above, during the MOC evaluation, as part of the HPSM leadership team's assessing progress toward MOC goals.

d. Describe the communication mechanism the MAO institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification, secure electronic record, etc.)

DSS Research, HPSM's health risk assessment survey vendor, provides comprehensive reporting related to assessments to HPSM, beneficiaries, and providers. At the completion of each survey cycle, DSS mails a packet to each beneficiary and each beneficiary's primary care physician that consists of an explanatory cover letter, the beneficiary's summary health risk report, and the beneficiary's care plan. Examples of all of these materials are included with the relevant descriptions below. Here is more detail about the steps we take:

- HPSM determined that every beneficiary should have a copy of his/her recommended individualized care plan (ICP), as required by CMS for SNPs, that would be based on the findings of his/her HRA.
    - For members who are at low or medium risk, this HRA-based ICP generally suffices as their stand-alone care plan unless a notable change in their condition occurs.
    - However, for members at high risk, this HRA-based ICP is just the base-line for their more expansive ICP that is developed further after a member's ICT is held.
- In working with DSS so that the development and mailing process could be as efficient and timely as possible, specific care plan structures were developed that would result from certain findings on the HRA. Thus, just as stratification occurs based on specific HRA results, groupings of these results lead to specific care plan findings as well. This allows for an automated generation of care plan findings for all levels of risk stratification.

    - An example of this would be if on multiple parts of the HRA, a member indicates that they are depressed. This would trigger the finding from the HRA that the member has a mental health need. If also coupled with results of multiple co-morbidities, that member would stratify as a high risk patient. Thus, the responses to these certain types of questions, yielding a particular grouping of answers, would trigger a specific stratification, and also a specific type of care plan (e.g. indicating a high risk need, for mental health intervention).
- Consequently, when a member's HRA is received, it is processed through the DSS algorithm and stratification analysis. It comes out with a ranking as high, medium or low, based on its results. Also, based on its results, a member-specific care plan is produced. (See previous example).
-
- Once these findings are ready after analysis, an information packet is prepared and sent to the following places:
    - A patient information packet is sent to the member; it includes a cover letter signed by the HPSM Medical Director explaining the packet, a copy of the HRA summary and a copy of the member's individualized care plan. Samples of the components of the member packet are included below.

Sample cover letter included in the member packet

HealthPlan OF SAN MATEO
701 GATEWAY BLVD., SUITE 400
SO. SAN FRANCISCO, CA 94080

healthy is for everyone
www.hpsm.org

Date

Member Name
Address
Address

Dear <member name>:

Thank you for completing the Health Risk Assessment Survey (HRAS). Your responses help us determine the best possible health care and services that we can provide for you. We have developed the enclosed individualized care plan based on your responses from the HRAS. Your care plan includes our recommendation that you see your primary care physician for ongoing medical care and services.

A Care Coordination Nurse Case Manager at HPSM can help you with questions about services covered by your CareAdvantage benefits and/or about your medical treatment such as:

- Coordination of medical referral
- Receiving recommended services within the benefit structure
- Using appropriate community resources
- The treatment plan developed by your doctor for your medical condition

If you have questions about this letter, please call our Care Coordination Unit at 650-616-2060. TTY users can use the California Relay Service (CRS) at 1-800-735-2929 or dial 711 to speak with an operator. Our office hours are Monday through Friday 8 a.m. to 5 p.m.

We look forward to helping you get the health care services you need through CareAdvantage.

Sincerely,

Medical Director

H5428_CA_9064_10 (approved 05/18/2010)

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
CareAdvantage Unit 1-866-880-0606 (toll-free) or 650-616-2174 I Fax: 650-616-2190
Hearing Impaired: TTY 1-800-735-2929 (California Relay Service) or Dial 7-1-1
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.

Sample care plan included in the member packet

Care Plan for: <<Member Name>>

Health Maintenance Plan for You

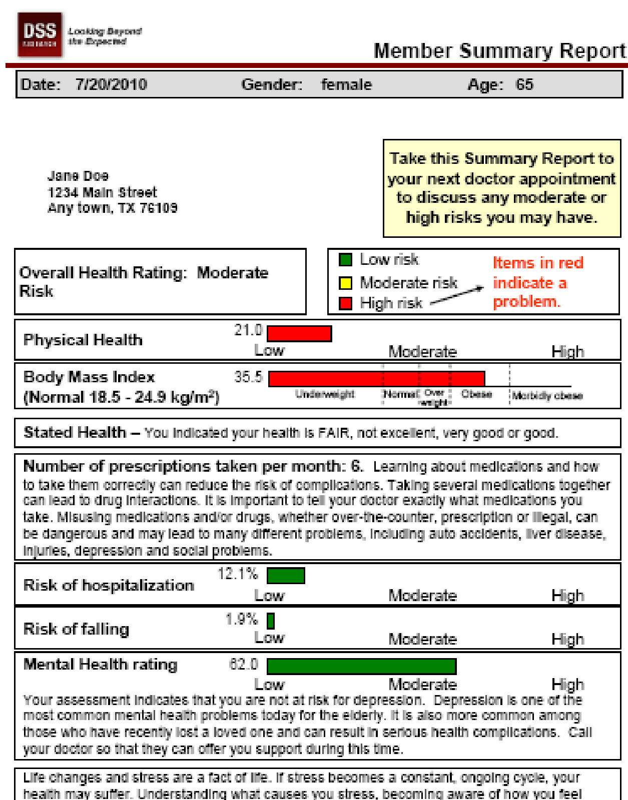
The Health Plan of San Mateo (HPSM) wants to be your partner in helping you maintain your health to the best of your ability.

HPSM offers services to help you:
- Schedule periodic follow up appointments with your primary care physician (PCP).
- Follow your medication treatment plan.
- Find the support you need with diet and exercise changes recommended by your doctor.

Specific Service	Benefit
❑ We can help you to improve access to your PCP so that you can ask questions, discuss your concerns, and be proactive in the medical management of your health.	❑ Talking with your PCP about your medical care gives you the ability to be involved in decisions related to treatment. This helps you to reach the best health status possible.
❑ We can help you understand how to use HPSM materials and services to manage your health. For example:	
♦ Provider Network Handbook	♦ Having information about HPSM's network of physicians and providers and understanding the services available to you can help you choose your health care partners.
♦ Evidence of Coverage (EOC) Handbook	♦ Understanding how to use your EOC can help with learning what types of services are covered under your CareAdvantage benefits.
♦ Health Promotion Programs that are free to HPSM members	♦ Having information about the health education classes offered by various programs and hospitals in San Mateo County allows you to choose programs that can help with improving your health.
❑ Care coordination services are offered to HPSM CareAdvantage members through referrals from many sources, including your doctor. You can ask for more assistance and support in managing your health.	❑ Care coordination services provide individualized assistance and support to give you the ability to make medical decisions which is optimal for your health.

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
H5428_CA_9064_10 (approved 05/18/2010)

Sample member summary report included in the member packet



DSS Research — Looking Beyond the Expected

Member Summary Report

Date: 7/20/2010	Gender: female	Age: 65

Jane Doe
1234 Main Street
Any town, TX 76109

Take this Summary Report to your next doctor appointment to discuss any moderate or high risks you may have.

Overall Health Rating: Moderate Risk

Low risk / Moderate risk / High risk — Items in red indicate a problem.

Measure	Value	Scale
Physical Health	21.0	Low / Moderate / High
Body Mass Index (Normal 18.5 - 24.9 kg/m²)	35.5	Underweight / Normal / Over weight / Obese / Morbidly obese

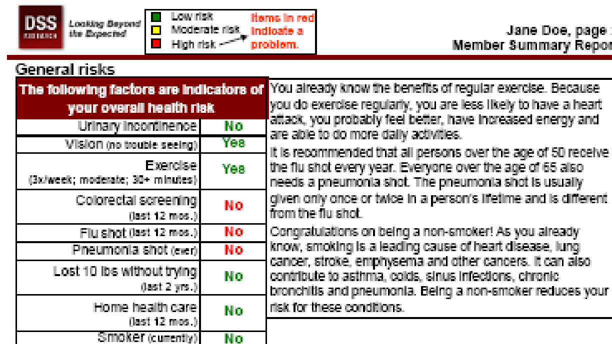
Stated Health – You indicated your health is FAIR, not excellent, very good or good.

Number of prescriptions taken per month: 6. Learning about medications and how to take them correctly can reduce the risk of complications. Taking several medications together can lead to drug interactions. It is important to tell your doctor exactly what medications you take. Misusing medications and/or drugs, whether over-the-counter, prescription or illegal, can be dangerous and may lead to many different problems, including auto accidents, liver disease, injuries, depression and social problems.

Measure	Value	Scale
Risk of hospitalization	12.1%	Low / Moderate / High
Risk of falling	1.9%	Low / Moderate / High
Mental Health rating	62.0	Low / Moderate / High

Your assessment indicates that you are not at risk for depression. Depression is one of the most common mental health problems today for the elderly. It is also more common among those who have recently lost a loved one and can result in serious health complications. Call your doctor so that they can offer you support during this time.

Life changes and stress are a fact of life. If stress becomes a constant, ongoing cycle, your health may suffer. Understanding what causes you stress, becoming aware of how you feel under stress and finding solutions and/or coping strategies can help you manage the stress in your life.



DSS Research — Looking Beyond the Expected

Low risk / Moderate risk / High risk — Items in red indicate a problem.

Jane Doe, page 2
Member Summary Report

General risks

The following factors are indicators of your overall health risk	
Urinary incontinence	No
Vision (no trouble seeing)	Yes
Exercise (3x/week; moderate; 30+ minutes)	Yes
Colorectal screening (last 12 mos.)	No
Flu shot (last 12 mos.)	No
Pneumonia shot (ever)	No
Lost 10 lbs without trying (last 2 yrs.)	No
Home health care (last 12 mos.)	No
Smoker (currently)	No

You already know the benefits of regular exercise. Because you do exercise regularly, you are less likely to have a heart attack, you probably feel better, have increased energy and are able to do more daily activities.

It is recommended that all persons over the age of 50 receive the flu shot every year. Everyone over the age of 65 also needs a pneumonia shot. The pneumonia shot is usually given only once or twice in a person's lifetime and is different from the flu shot.

Congratulations on being a non-smoker! As you already know, smoking is a leading cause of heart disease, lung cancer, stroke, emphysema and other cancers. It can also contribute to asthma, colds, sinus infections, chronic bronchitis and pneumonia. Being a non-smoker reduces your risk for these conditions.

* N/A indicates you did not answer the question or you indicated that the question does not apply to you.

Existing Long Term Conditions - Conditions identified by responses to the survey are high cholesterol, hypertension and COPD.

Heart disease is a serious condition, but there are many things that you can do to reduce your chances of having a heart attack. These include: not smoking, eating a diet low in fat, controlling your blood pressure, getting regular exercise, maintaining a good body weight and reducing cholesterol levels.

Blood Pressure is the force of your blood pushing against the walls of your blood vessels. When blood pressure is high, it often damages your arteries and places you at risk for many medical problems, including heart attack, stroke and kidney problems. You can help control high blood pressure by not smoking, eating a low-fat diet and exercising regularly. There are also medications that can help in controlling high blood pressure. You should have your blood pressure checked regularly.

Good nutrition is important for healthy living. It can lower your risk of heart disease, stroke, cancer, obesity, high blood pressure, elevated blood cholesterol levels, diabetes and tooth decay. You should eat a diet that is low in fat and high in fiber. Include choices from fruit, vegetable, bread and cereal and pasta groups. You should avoid greasy fried foods, red meat (try to reduce your weekly servings) and whole milk (drink low fat instead).

For more senior health information, please call 1-800-XXX-XXXX.

- Another information packet is sent to the patient's PCP; it includes a cover letter signed by the HPSM Medical Director explaining what's contained in the provider packet, and that includes a copy of the member's HRA summary and the individualized care plan to be sent to the member's PCP. Samples of the components of the physician packet are included below.

Sample cover letter included with the physician packet

HealthPlan OF SAN MATEO
701 GATEWAY BLVD., SUITE 400
SO. SAN FRANCISCO, CA 94080

healthy is for everyone
www.hpsm.org

Date

MD's name
Address
Address

Re: <Member Name and ID>

Dear <Dr's Name>:

This letter is to notify you that your patient, named above, has completed the Health Risk Assessment Survey (HRAS) developed by Health Plan of San Mateo (HPSM). This survey is a self-assessment of his/her medical and functional needs and current abilities. His/her responses have helped us determine the most clinically appropriate health care services that we are able provide him/her. Enclosed is a copy of the HRAS, as well as the individualized care plan based on his/her responses from the HRAS. The care plan includes HPSM's recommendation that he/she make an appointment to see you for ongoing medical care and services.

Your patient was also advised that a Care Coordination Nurse Case Manager at HPSM can help him/her with questions about their CareAdvantage benefits and/or about their medical treatment, such as:

- Coordination of referrals
- Receiving recommended services within the plan's benefit structure
- Using appropriate community resources

We are telling you all this to assist you in continuing to provide high quality care for your patient/our member. Please include the copies of the HRAS and care plan in your office chart of this member. We hope that you find this additional information about the member to be useful.

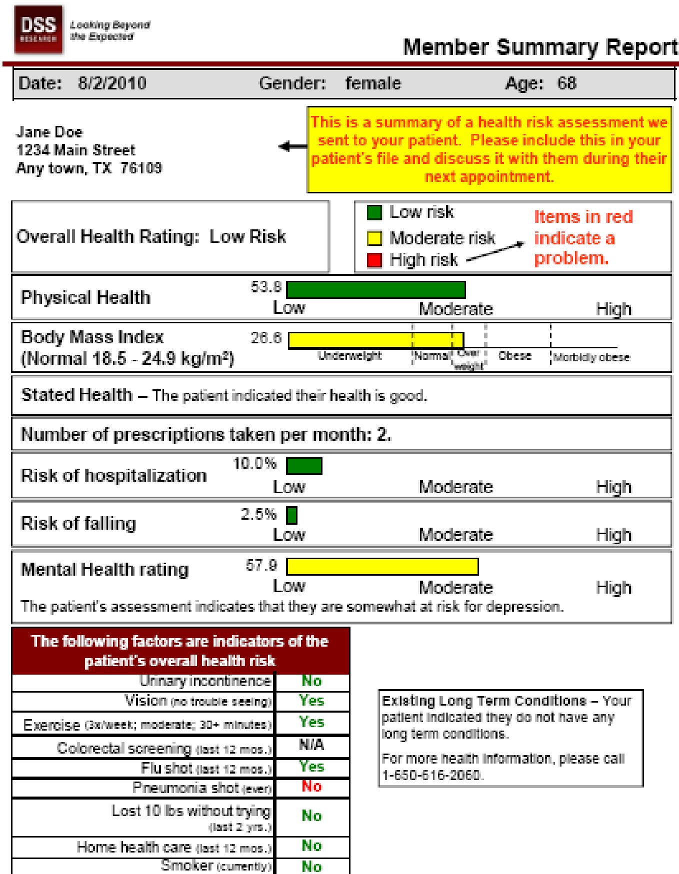
If you have any questions about this letter, please do not hesitate to call the Care Coordination Department at 650-616-2060. Our office hours are Monday through Friday 8 a.m. to 5 p.m.

We look forward assisting you and your patient through CareAdvantage.

Sincerely,

Mary D. Giammona, M.D., M.P.H.
Medical Director

Sample member summary report included with physician packet



DSS RESEARCH Looking Beyond the Expected

Member Summary Report

Date: 8/2/2010 Gender: female Age: 68

Jane Doe
1234 Main Street
Any town, TX 76109

This is a summary of a health risk assessment we sent to your patient. Please include this in your patient's file and discuss it with them during their next appointment.

Overall Health Rating: Low Risk

Low risk / Moderate risk / High risk — Items in red indicate a problem.

Measure	Value	Scale
Physical Health	53.8	Low / Moderate / High
Body Mass Index (Normal 18.5 - 24.9 kg/m²)	26.6	Underweight / Normal / Over weight / Obese / Morbidly obese
Risk of hospitalization	10.0%	Low / Moderate / High
Risk of falling	2.5%	Low / Moderate / High
Mental Health rating	57.9	Low / Moderate / High

Stated Health – The patient indicated their health is good.

Number of prescriptions taken per month: 2.

Mental Health rating: The patient's assessment indicates that they are somewhat at risk for depression.

The following factors are indicators of the patient's overall health risk	
Urinary incontinence	No
Vision (no trouble seeing)	Yes
Exercise (3x/week; moderate; 30+ minutes)	Yes
Colorectal screening (last 12 mos.)	N/A
Flu shot (last 12 mos.)	Yes
Pneumonia shot (ever)	No
Lost 10 lbs without trying (last 2 yrs.)	No
Home health care (last 12 mos.)	No
Smoker (currently)	No

* N/A indicates the patient did not answer the question or they indicated that the question does not apply to them.

Existing Long Term Conditions – Your patient indicated they do not have any long term conditions.

For more health information, please call 1-650-616-2060.

T:01 ID:1234567890 C:137

Physicians also receive a copy of the care plan sent to the member, example below

Care Plan for: <<Member Name>>

Health Maintenance Plan for You

The Health Plan of San Mateo (HPSM) wants to be your partner in helping you maintain your health to the best of your ability.

HPSM offers services to help you:
- Schedule periodic follow up appointments with your primary care physician (PCP).
- Follow your medication treatment plan.
- Find the support you need with diet and exercise changes recommended by your doctor.

Specific Service	Benefit
❑ We can help you to improve access to your PCP so that you can ask questions, discuss your concerns, and be proactive in the medical management of your health.	❑ Talking with your PCP about your medical care gives you the ability to be involved in decisions related to treatment. This helps you to reach the best health status possible.
❑ We can help you understand how to use HPSM materials and services to manage your health. For example:	
• Provider Network Handbook	• Having information about HPSM's network of physicians and providers and understanding the services available to you can help you choose your health care partners.
• Evidence of Coverage (EOC) Handbook	• Understanding how to use your EOC can help with learning what types of services are covered under your CareAdvantage benefits.
• Health Promotion Programs that are free to HPSM members	• Having information about the health education classes offered by various programs and hospitals in San Mateo County allows you to choose programs that can help with improving your health.
❑ Care coordination services are offered to HPSM CareAdvantage members through referrals from many sources, including your doctor. You can ask for more assistance and support in managing your health.	❑ Care coordination services provide individualized assistance and support to give you the ability to make medical decisions which is optimal for your health.

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A copy of both packets is sent to HPSM's care coordination unit so staff know what to expect if either the provider or the member calls with a question about the packet they received.

- In addition, HPSM included an article about this process in the provider newsletter to alert our providers about this new process and its value and importance in improving the health care status of our CareAdvantage members.

8. Individualized Care Planning

Results from the assessments described in Element 7 and predictive modeling analysis are used to develop individualized care plans for each member on an annual basis, or when the members' health status changes. Assessments are analyzed in order to stratify members as high, medium, or low risk, as well as identify the most vulnerable beneficiaries including frail or disabled individuals, individuals with end-stage renal disease, beneficiaries near the end-of-life, and beneficiaries with multiple or complex chronic conditions.

a. Describe which personnel develops the individualized plan of care and how the beneficiary is involved in its development as feasible

Individual care plans are developed by the member's interdisciplinary care team (ICT), with primary responsibility by the HPSM Nurse Case Manager for coordinating the efforts of the ICT and developing the individual care plan. The HPSM Nurse Case Manager includes the CareAdvantage member in the care planning process whenever feasible.

HPSM recognizes that the development of an individualized plan of care for each CareAdvantage member is at the heart of the services we offer to our SNP members. For this reason, we have made the Health Risk Assessment (HRA) the fundamental source of these individualized care plans (ICPS). As described in detail in Element 7, the HRA is derived completely from information provided by the beneficiary. Although it is not the only information used to create a high risk patient's ICP, it is where all ICPs at HPSM start, because in our CareAdvantage SNP, everything starts with our members, who are the reason we created a SNP in the first place.

The interdisciplinary care team includes both the clinical team at Health Plan of San Mateo and direct care external health care providers. The Health Plan of San Mateo ICT includes the HPSM Nurse Case Manager Medical Social Worker, Pharmacist, Medical Director, a Health Educator and a Behavioral Health Specialist. The external ICT clinical team includes the member's PCP and other clinicians directly involved in the care of the member. This may include, but is not limited to, rehabilitation specialists (Physical Therapist, Occupational Therapist, and Speech Language Pathologists) , Physician Specialists (i.e., Cardiologist, Psychiatrist or Pulmonologist), Nutrition Services, Licensed Clinical Social Workers or Medical Social Workers from community agencies (Regional Centers, Mental Health, etc) as appropriate . Determinates of ICT participation is identified through the individualized care planning process.

The ICPs of low and medium risk CareAdvantage members are developed based on the algorithm using the HRA analysis that has been agreed upon by the scientific experts of our vendor, DSS, and the clinical leadership of HPSM (Medical Director—MD, MPH; Director of Health and Provider Services—MSN, BSN; please refer to Element 7 for more details). As

explained in Element 7, and above briefly, since this algorithm is completely based on data supplied only by the member, each member is involved wholly in the ICP development. He/she is also made aware and in charge of the plan as well; this occurs when the HRA explanation and the ICP packet is mailed to the member after the HRA analysis is complete.

As long as the beneficiary's condition remains low or medium risk, the ICP continues annually in this status, with the member's HRA responses the data sources of the ICP each year.

Individuals identified as high risk receive additional outreach and assessment from the Nurse Case Manager. Individualized care plans for these members are developed by the member's interdisciplinary care team (ICT). Depending on the program, the lead care coordinator for the member has the primary responsibility for coordinating the efforts of the ICT in the development of the individualized care plan. As explained in detail in Element 4, for the High Utilizers Group (HUG) program, the lead care coordinator is the staff for the area where the patient's primary high risk is (e.g. medical, behavioral health, social services). For the visiting physician program, the lead care coordinator is usually the HPSM Nurse Case Manager working with the patient in that program. For internal ICT, the HPSM Nurse Case Manager following the member is the lead care coordinator.

Development of the individualized care plan is patient/member centric. HPSM's care management philosophy and policy is to engage the patient, whenever feasible, in care planning efforts. Evaluating member social needs and personal preferences can drive activities, supports and case management services. Assessment and understanding of the member's social needs and preferences are the foundation of individualized and person centered care plans. Social and practical needs can include transportation, shelter and food. Personal preference can include values and areas of interest such as religious affiliations. Understanding the member's social needs and preferences help to develop care plans that address the member's issues and barriers to participating in their care.

Each program's interdisciplinary care team (ICT) includes contracted providers and internal HPSM staff. The ICT functioning of the three programs above is described in detail in Element 4. As an example here, the functioning of the internal ICT regarding further work with an ICP, how a beneficiary is included where feasible, and so forth will be used. (The other two programs are further described in great detail in Element 4.)

The HPSM internal ICT consists of the patient where feasible, the clinical staff at Health Plan of San Mateo and direct care external health care providers. As in any HPSM ICT, usual members are:

- Patient and Caregiver, including IHSS provider (if patient concurs)
- Physician
- Nurse Case Manager
- Medical Social Worker or Social Services Representative
- Behavioral Health Representative

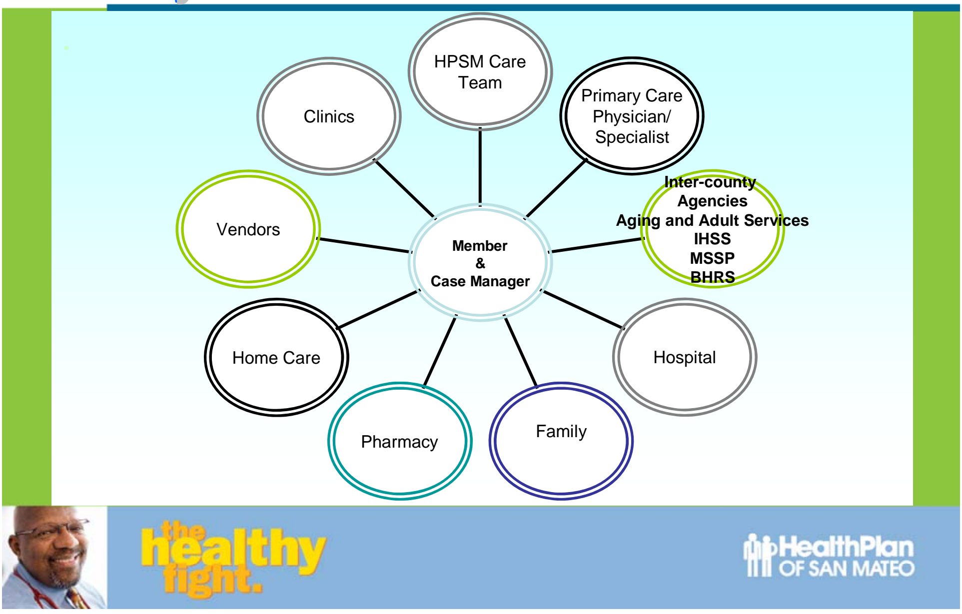
- Other Health Professional, as applicable

The physician is the medical director; the Nurse Case Manager is the nurse care coordinator working with the patient, the Medical Social Worker is HPSM's internal staff social worker, and other professionals would include an internal clinical pharmacist and health educator, as appropriate. The external ICT clinical team includes the member's PCP and other clinicians directly involved in the care of the member. This may include, but is not limited to, rehabilitation specialists (Physical Therapist, Occupational Therapist, and Speech Language Pathologists) , Physician Specialists (i.e., Cardiologist, Psychiatrist or Pulmonologist), Nutrition Services, Licensed Clinical Social Workers or Medical Social Workers from community agencies (Regional Centers, Mental Health, etc) as appropriate . Determinates of ICT participation are identified through the individualized care planning process.

For internal ICTs, the patient's participation may not be "real time," e.g. actually with the patient present in person or by phone during the ICT. However, a myriad of efforts take place, beyond the starting of the care plan with the patient's own thoughts/perspectives via the HRA, to ensure that the patient's input into the ICP is at the heart of care plan development, and that the patient has ongoing access to the ICT members and ICT activities and results, as described below.

The HPSM care management team utilizes several mechanisms to promote member centric care/member input in the care planning process. These mechanisms include 1) annual and new hire training of the care management staff in member centric/member outreach and input in the care planning process, 2) documentation validation in the HPSM care coordination database system from the care plan developer (nurse/clinician) that member input was obtained in the care plan process, and 3) written communication to the member requesting input and participation in the care planning process.

Clinical staff training on the care management process and patient centric care planning is performed annually by the Health and Provider Services Director and also within 2 weeks of a new clinical hires within the plan's Health Service division. An example of the training presentation that emphasizes patient/member centric care is shown below.



Initial care planning from the CareAdvantage member's subjective initial health risk assessment/comprehensive assessment starts with outreach to the CareAdvantage member by the plan's Nurse Case Manager or physician to validate assessment findings, conclusions and areas of health care needs with the member. This outreach process with the member engages the CareAdvantage member in the care planning process and identifies member specific concerns and perspectives that help drive the care planning process.

This outreach process occurs via telephone. Every CareAdvantage member identified at high risk via the HRA, by referral to the Care Coordination Unit, by the predictive modeling algorithm developed by HPSM's senior health statistician, or other means, is contacted by a Nurse Case Manager and is administered HPSM's internal comprehensive assessment that complements the HRA with questions about functional status, physical and mental health, psychosocial needs, etc. The information collected is also used as part of ICP development, and is included in the information shared in the ICT. The processes of ICT, ICP and so forth are discussed and explained to the member during this phone call, and subsequent follow-up one. The Nurse Case Manager communicates how she will be the member's single point of contact regarding any concerns about the member's health, the ICT, any resources, services, etc. In this way, the communication process for the member is clarified and the member is made aware that he/she is the center of the ICP and purpose of having an ICT. The Nurse Case Manager is the member's ready access to the ICT, and any questions about activities, needs, changes can be explained through her.

To further engage the CareAdvantage member in the care planning process the HPSM Nurse Case Manager sends our CareAdvantage members follow-up letters to the initial care planning

outreach efforts to encouraging the member to have ongoing participation in their health care planning needs. This letter provides the Nurse Case Manager's name in writing for the member, and serves as a reference for the subsequent phone calls the two share as they develop an ongoing relationship to help continue to support the member and address the member's needs and move toward the ultimate goal of improved health outcomes. A sample of this letter is below.

healthy is for everyone

www.hpsm.org

<Date>

<Member Name>
<Address>
<Address>

Dear <member name>:

Thank you for partnering with us on your care management needs. You are eligible for care management services based on <multiple chronic conditions / multiple medications / repeated hospitalizations / multiple ED visits / referral from your primary care doctor / [other, explain]>. Your input and participation is important in determining the best possible health care and services that we can provide for you. I've enclosed your care plan based on your input. Your care plan includes our recommendation that you see your primary care physician for ongoing medical care and services.

Care coordination services provide individualized assistance and support to give you the ability to make medical decisions that are optimal for your health. You may contact me directly at the Care Coordination department Monday through Friday 8:00 a.m. to 5:00 p.m.

I can help you with questions about services covered by your CareAdvantage benefits and/or about your medical treatment such as:

- Coordination of medical referral
- Receiving recommended services within the benefit structure
- Using appropriate community resources
- The treatment plan developed by your doctor for your medical condition

You may opt out of the Plan's care management services at any time.

If you have questions about this letter, please call our Care Coordination Unit at 650-616-2060. TTY users can use the California Relay Service (CRS) at 1-800-735-2929 or dial 7-1-1 to speak with an operator. Our office hours are Monday through Friday 8:00 a.m. to 5:00 p.m.

We look forward to helping you get the health care services you need through CareAdvantage.

Sincerely,

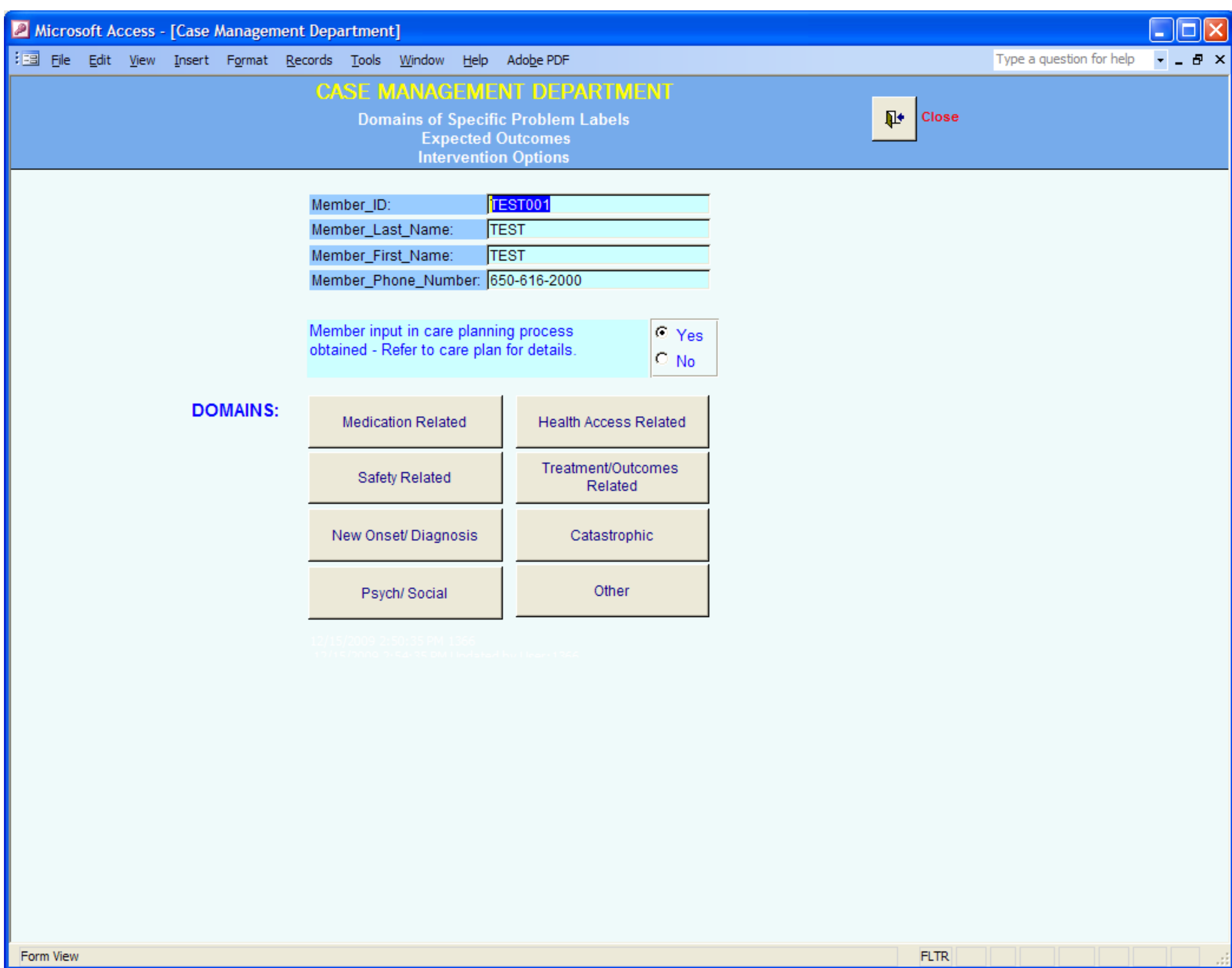
<Manager Name>
Care Coordination Nurse Case Manager

Enclosure: Care Plan

H5428_CA_9067_11_EN CMS Approved 02232011

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
CareAdvantage Unit 1-866-880-0606 (toll-free) or 650-616-2174 | Fax: 650-616-2190
Hearing Impaired: TTY 1-800-735-2929 (California Relay Service) or Dial 7-1-1
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.

The plan also requires originators of the care plan to document outreach and member input in the care planning process in the plan care coordination database (CCDB). Following is a screenshot of the CCDB data collection of member input in the care planning query.



b. Describe the essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc)

The CareAdvantage individualized care plan (ICP) degree of complexity varies depending on whether or not it is for low, medium or high risk members. As described in element 7, those for the low or medium risk members is based completely on the findings of these members' High Risk Assessments (HRA), and has goals/objectives, specific services, etc., as directed by the HRA.

The ICP for high risk members is the most detailed that HSPM prepares, as is to be expected, since this level of ICP is to address the complex needs of these most fragile patients. The ICP for high risk members has several essential elements: 1)Goals, both short term and long term goals, including time frames for re-evaluation 2)objectives, 3)specific services and benefits to be provided and 3) measurable outcomes. Additionally, the care plan addresses specific services and benefit needs as identified from the comprehensive assessment, which is the internal assessment carried out by phone a Nurse Case Manager with each CareAdvantage member once he/she is determined to be high risk. The comprehensive assessment includes questions regarding the member's preferences for care and allows for incorporation of plan-sponsored add-on benefits or wrap around Medi-Cal benefits that are not specifically part of the CareAdvantage program. These benefits may include services that address the specific service needs for vulnerable CareAdvantage members such as our physically, mentally or developmentally disabled or those near the end of life. The care plan also addresses planning for continuity of care, including transition of care and transfers. Lastly the care plan incorporates a collaborative approach including member and family participation, integrating social and personal preferences.

Evaluating member social service needs and personal preferences can drive activities, supports and case management services. Assessment and understanding of the member's social service needs and preferences are the foundation of individualized and person centered care plans. Social service and practical needs can include transportation, shelter and food. Personal preference can include values and areas of interest such as religious affiliations. Understanding the member's social service needs and preferences may help to develop care plans that address the member's issues and barriers to participating fully in their health care.

Along with the Health Risk Assessment (HRA), the HPSM comprehensive risk assessment is the next building block of the individualized care plan for our high risk members. The comprehensive assessment serves as a tool to gather a holistic picture of the member. Components of the HPSM assessment tool include:

- Demographics
  - Aid code
  - Gender
  - Address
  - Other health insurance
  - Primary care physician
  - Primary contact/caregiver
- Social data
  - Occupations
  - Living status
  - Language of preference
  - Cultural beliefs, practices, food preferences
- Past Medical history
  - Hospitalizations

    - ED history
    - Patient's statement of present complaints or problems
    - Primary Care /Specialty Care history
- Review of Systems
    - History of chronic disease, major illnesses
    - History of falls
    - Cardio-vascular/ pulmonary/neuro etc
    - Communication
    - Sensory/perceptual, vision, hearing
- Medication history
    - Use/frequency
    - Prescriber,
    - Pharmacy
    - O_2
    - MTM eligibility
    - Subjective RX history
    - OTC and herbal usage
- Social and Emotional status
    - Isolation
    - Loss in past year
    - Socialization
- Cognitive assessment
    - Receptive and expressive communication
- Disability assessment
- Exercise
- Fall Risk assessment
- Community Resource utilization
- Primary Care Giver status
- Legal contact
    - Life planning
    - Durable power of attorney
    - POLST
- DME/Medical supplies/benefit assessment

Along with the information from the member's self-completed HRA, the HPSM Nurse Case Manager utilizes data from the CareAdvantage member's additional responses to the comprehensive risk assessment, outlined above, to gather a holistic picture of the member and to identify areas of need from which to develop a care plan that is unique and individualized to the member. For example, the HPSM Nurse Case Manager may identify through the comprehensive assessment that a member is home bound, cannot state who the primary care physician is, has a high fall risk score, has a history of a fall with no DME utilization, no caregiver support, multiple chronic illnesses and is on multiple medications without understanding of the medication regimen. Perhaps some or even none of this was identified from the HRA because the questions were asked in a different way, or things have changed in

the patient's circumstances between when the HRA was completed and the comprehensive assessment is being completed. Using this example, the HPSM Nurse Case Manager is able to identify many areas of need from the assessment. Development of a care plan with objectives and interventions that address the identified problem areas will follow directly from the answers received from the member. The HPSM Nurse Case manager will establish specific short term and long term goals with a specific timeframe for obtainment. The objective and goals must be realistic and measurable.

Care management and care coordination interventions are developed and initiated to meet the goals and objectives outlined within the specified timeframe. These interventions may include, but are not limited to, identification of and linkage to a primary care physician.

The care plan interventions may also establish a home health order for an evaluation by both nursing and physical and occupational therapy, provide linkages to a MTM pharmacist, referral to a community social agency such as Aging and Adult services for a social service support and evaluation. The HPSM Nurse Case manager may also utilize Milliman Chronic Care guidelines to assess chronic disease management for referral and coordination of care with a primary care physician. Before each of the goals is developed and finalized, the Nurse Case Manager asks the member what his/her goal is for each identified concern. Sometimes the member may have a solution planned and just needs some help to put it into place e.g. "if I could get a ride to the pharmacy every month, I would not run out of my medicines." This is where the Nurse Case Manager's knowledge of CareAdvantage's benefits is crucial—e.g. for the example above, the member may not be aware that HPSM offers 50 one way taxi rides a year for health-related visits. The member could be informed about how to use this benefit. However, if the member is truly home bound, even having such a benefit might not be sufficient to ease a burden for her. Then, the Nurse Case Manager could inform the member that we have some pharmacies that can deliver medicines for home bound CareAdvantage members. This could be a solution that truly meets her needs. In this way, each of the goals developed as part of the ICP will be discussed with the member prior to being finalized so that the member's input is taken into account as part of the focus of member-centric planning with the ICP and ICT.

As the coordinator and facilitator of care, the HPSM Nurse Case manager evaluates attainment of the goals and objectives in the care plan within the specified timeframe and adjusts the care plan as needed in collaboration with the patient and other appropriate members of the ICT. Outcome measures are also reviewed, as determined in the ICP for each member. For example, if a member's specified outcome is to be able to remain safely in the home with additional in home supportive services (IHSS) and appropriate durable medical equipment (DME) with a timeframe of 3 months, the Nurse Case Manager would work with the patient, the Aging and Adult Services social services representative (agency in charge of IHSS hours), the PCP (who can order the DME) and the DME provider to ensure these goals are on track. Then, within three months, if the patient's condition has remained stable, and the equipment and support hours have been arranged, with the Nurse Case Manager facilitating authorization of the equipment, and ensuring with the PCP and HPSM's Medical Director that the appropriate equipment has been provided, the patient can report whether or not the goal has

been achieved. If it has, all team members can be glad that this improved health outcome has been achieved by the patient; and if not, the ICT can discuss where barriers are, so that the team can continue to pursue this goal with the patient.

Care management plan interventions often include specific services and benefits to meet the individualized care plan goals, which may include HPSM-sponsored add on benefits under the CareAdvantage program such as taxi services, as described in the earlier example above, dental care and vision services. Additionally, the HPSM Nurse Case Manager reviews benefit utilization to incorporate coordination of Medi-Cal wrap-around benefits available under the CareAdvantage member's Medi-Cal benefit that are not available under the CareAdvantage program. This ensures seamless coordination of benefits for the member.

ICP services/benefits particularly for our most vulnerable beneficiaries may include a combination of community/Medi-Cal and CareAdvantage-covered services for disabled members, such as in the example just above. They may involve supports for members in various levels of care, such as in the long term care setting (LTC). Often our members in LTCs are the frailest of our CareAdvantage population. Many are our most elderly (age 85 or older). They frequently go back and forth to the emergency department or for recurrent acute hospitalizations.

While they are CareAdvantage members, they are at the custodial level of care in the nursing home setting, residing there under their Medi-Cal benefit. When we have studied many of these patients, we have identified that they are among the group frequently described in national scientific studies as those patients getting a high intensity of care services during the last six months of their lives. A large proportion has dementia, and we have found that end of life choices have not been fully discussed with their families. For this group of CareAdvantage members who are usually represented at their ICTs by a caregiver, we are working with their PCPs to more fully discuss end of life decision-making. We want to be sure that all CareAdvantage and Medi-Cal benefits including hospice are available to the patient and family if they choose that approach in these final months of their lives. In California, the Physician Order for Life Sustaining Treatment (POLST) form is now a legal document that is recognized at any level of care, including LTC. We are working with the local medical society, hospital consortium, nursing homes, churches, etc, to increase knowledge about patient end of life choices so that all of our members know about their available benefits and can freely choose what is right for them/their family member at this time of their lives. This is another example of the way that HPSM supports our CareAdvantage members using the ICP and the ICT.

Care Coordination Care Plan Sample

PSYCH/ SOCIAL

PROBLEM LABEL	EXPECTED PATIENT OUTCOMES	INTERVENTION OPTIONS	DATE RESOLVED
☐ Failure to apply for assistance	☐ Patient applies for assistance and understands for remaining eligible	☐ Assessment/chart review	Date:
☐ Failure to qualify for assistance	☐ Patient obtains alternate community resources to maintain life and understand eligibility	☐ Consult MD	Date:
☐ Financial Abuse	☐ Appropriate legal referral completed	☐ Referral to Dept. of Public services or social security	Date:
☐ Inability to obtain adequate resources	☐ Financial issues identified and addressed	☐ Patient/ Family education	Date:
☐ Inability to manage adequate	☐ Patient obtains adequate resources	☐ Referral to ROP	Date:
☐ Failure to obtain mental health	☐ Patient access appropriate Mental Health Services	☐ Referral to Public Guardian	Date:
☐ Failure to complete Advance directives	☐ Patient will make an informed choice regarding completion of an advanced directive	☐ Referral to Adult Protective Services	Date:
☐ Inadequate coping skills	☐ Patient demonstrates increased coping skills	☐ Referral Victim Witness	Date:
☐ Suspected Elder/Child Abuse/ Domestic Violence	☐ Elder/Child Abuse Domestic Violence issues identified and addressed	☐ Police Report	Date:
☐ Other (Please Describe)	Short-term goals:	☐ Supportive Counseling	Date:
	Long-term goals:	☐ Referral to community resourc	Date:
	Other:	☐ Referral to vocational rehabilitation	Date:
		Other:	Date:

Member ID	.
Member Name	Test, Test
Date Opened	
Case Manager	

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HPSM is currently developing an RFP for additional software support in the care planning process that will have multi-interface functionality with HPSM's new IT system, HEALTHsuite. Care Coordination database and Milliman Chronic Care Guidelines/Standards of Care. Ideal components of this software should include integration of the annual health risk assessment, comprehensive assessment (an additional objective assessment tool performed for high risk CareAdvantage members) and additional assessment findings from the ICT in the development of individualized care plans. We anticipate finalizing the RFP by Q4 of 2011.

Case Study—Ms. Jin Dow

HPSM's nurse case manager (NCM), identified the following from the completion of the **Care Coordination Comprehensive Assessment**: Ms. Jin Dow is a 92 year old Mandarin-speaking Chinese woman, with chronic renal failure, CHF, coronary artery disease, peripheral vascular disease, status post stroke, and dementia. She gets recurrent decubitus ulcers Her family consists of her daughter, son-in-law and 3grown grandchildren, all involved in her care. One of her granddaughters is a nurse. Ms. Dow weighs 92 pounds, is essentially bed bound, though her family gets her up into a wheelchair to go to church, go to the doctor and to go see other extended family on occasion. (Only one of the grandsons can push the wheelchair because it is an old manual one they used for their grandfather before he died.)

The family will never consent for Ms. Dow to go to a nursing home ("over our dead bodies," said the granddaughter). She is incontinent of bowel and bladder. Her creatinine is elevated, but not yet in the range where she needs dialysis. The family sees she is slowly declining. She is still full code, but they are open to talking about palliative care—the nurse granddaughter recently attended a course about it, and her hospital is starting a palliative care team, working on the POLST, so she has been talking to the family about comfort care for her beloved grandmother when the time comes. Ms. Dow is on oral medications for all her conditions. Her PCP is an internist and cardiologist, Dr. TB. The family is wondering if all the medications are still necessary. They mentioned in the comprehensive assessment that they could use some home health services because the nurse granddaughter has recently changed to working the day shift, so she can help at night, and the family at home (Ms. Dow's daughter) has bad arthritis, so is not able to do the wound care as well as is needed. Maybe some additional equipment to help reduce the pressure would assist also. The family had nothing else to add on the health risk assessment—Ms. Dow's daughter sent it back blank to the NCM, saying—"You already got all this information when you called us and completed your first assessment. I know you are a bright girl. I don't need to tell you this all again."

Based on the information obtained, the **goals/objectives** are: 1) Ms. Dow is to remain comfortably at home for as long as possible; 2) Try to minimize decubitus ulcer formation; 3) Provide medical equipment and supplies to assist with mobility, decrease pressure, help address incontinence; 4) Authorize home health evaluation, including hospice/palliative care, to include wound care, and social services support; 5) Discuss spiritual support as part of end of life care, to see if this would help comfort/sustain family.

Specific services/benefits: 1) Lightweight manual wheelchair, with positioning cushions to decrease pressure when sitting; 2) Appropriate incontinence supplies as needed to reduce skin breakdown (HPSM Medi-Cal wraparound benefit); 3) Pressure reducing surface for Ms. Dow's bed; 4) Home health evaluation, with SNV/wound care, MSW and hospice/palliative care evaluations; 5) Ask family if they would like a church or hospital chaplain to visit; if so, arrange that.

Outcome Measures: 1) Ms. Dow will remain at home, without the need for ED or hospital admissions for the next 3 months. 2) Ms. Dow's family will feel informed about the services Ms. Dow receives from HPSM, know who her HPSM NCM is and feel comfortable contacting the NCM if something is needed for Ms. Dow. 3) All the HPSM authorized services will be in place and serving Ms. Dow's needs within 3 days of authorization. 4) Ms. Dow and her

family will receive adequate information and support regarding end of life care from the authorized HHA services, and from the chaplain, if they so agree. If additional support is requested, e.g. from the PCP, HPSM staff can also be utilized

Preferences for Care: 1) Ms. Dow will remain at home, with her family members as her primary sources of care. 2)Ms. Dow and her family will receive adequate information about end of life and palliative care options through the authorized HHA services, and chaplain, if they so agree. If additional support is requested, e.g. from the PCP, HPSM staff can also be utilized.

Add-on Benefits: 1) Incontinence Supplies and related (HPSM Medi-Cal benefit—no longer covered by state Medi-Cal). 2) Assistance with palliative care via HPSM Nurse Practitioners, if the PCP so desires.

c. Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the interdisciplinary care team (ICT), beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified, etc.)

As noted above, individualized care plans for HPSM's high risk members are developed by the member's interdisciplinary care team (ICT). Depending on the program, the lead care coordinator for the member has the primary responsibility for coordinating the efforts of the ICT in the development of the individualized care plan. As explained in detail in Element 4, for the High Utilizers Group (HUG) program, the lead care coordinator is the staff for the area where the patient's primary high risk is (e.g. medical, behavioral health, social services). For the visiting physician program, the lead care coordinator is usually the HPSM Nurse Case Manager working with the patient in that program. For internal ICT, the HPSM Nurse Case Manager following the member is the lead care coordinator.

Each program's interdisciplinary care team (ICT) includes contracted providers and internal HPSM staff. The ICT functioning of the three programs above is described in detail in Element 4. As an example here, the functioning of the internal ICT regarding further work with an ICP, who reviews and revises the care plan, and how frequently, how the beneficiary is included, and so forth, will be used. (The other two programs are further described in great detail in Element 4.)

The HPSM internal ICT consists of the patient where feasible, the clinical staff at Health Plan of San Mateo and direct care external health care providers. As in any HPSM ICT, usual members are:

- Patient and Caregiver, including the IHSS provider (if patient concurs)
- Physician
- Nurse Case Manager
- Medical Social Worker or Social Services Representative

- Behavioral Health Representative
- Other Health Professional, as applicable

The physician is the medical director; the Nurse Case Manager is the nurse care coordinator working with the patient, the Medical Social Worker is HPSM's internal staff social worker, and other professionals would include an internal clinical pharmacist and health educator, as appropriate. The external ICT clinical team includes the member's PCP and other clinicians directly involved in the care of the member.

The CareAdvantage member's care plan is reviewed and updated by the HPSM's interdisciplinary care team, in conjunction with the primary care physician, no less than annually or as a change in health status is identified. HPSM's interdisciplinary care team holds weekly case conferences no less than bi-weekly on active cases that require an immediate interdisciplinary care team approach to the member's care plan revisions. Active cases are defined as those cases where a change in health status is identified through hospitalization or other catastrophic event.

As noted above, the HPSM ICT is comprised of the member, the member's primary care physician, and clinicians from multiple specialties and licensures. On staff within our Health Services and Care Coordination departments are 3 Medical Directors (2 full time and 1 half time physician), 12 full time Registered Nurses/Case Managers, 2 full time Registered Nurse Clinical Managers, 1 full time Registered Nurse Division Director, 1 full-time Medical Social Worker, 3 full time pharmacists, 2 certified pharmacy technicians, and 2 bilingual Care Coordination technicians with medical assistant or health education training and experience. Additionally, the plan contracts with the county mental health provider, Behavioral Health and Recovery Services (BHRS). Representatives from BHRS attend HPSM ICT meetings as needed. The primary care physician is an integral member of the ICT. All care plans are shared with the CareAdvantage member's PCP for input and revisions. The plan's Nurse Case Manager holds responsibility for information gathering, initiating and coordinating care with the member and both the external and internal plan interdisciplinary care team of members with any active cases assigned to that particular plan Nurse Case Manager. The plan's Nurse Case Manager also holds responsibility for communication of care plans updates and revisions to all stakeholders of the member's care, including the member.

Our Medical Director and Associate Medical Directors are board certified physicians. Our Medical Director has over twenty years of Public Health, Medi-Cal and Medicare training and experience. Our Associate Medical Directors have extensive training and experience in Rheumatology and /or Geriatrics. Our Nurse Clinical Manager and Nurse Division Director both have extensive geriatric training and experience. Staff structure and role descriptions are outlined in Element 3 above. The plan also contracts with San Mateo County's mental health service agency, Behavioral Health and Recovery Services, for specialty behavioral health and drug and alcohol recovery services for the plan's CareAdvantage population. The plan also enlists and engages ICT expertise from among its provider network of over 1100 physician

specialists, as needed, to meet the unique health care planning needs of our CareAdvantage population.

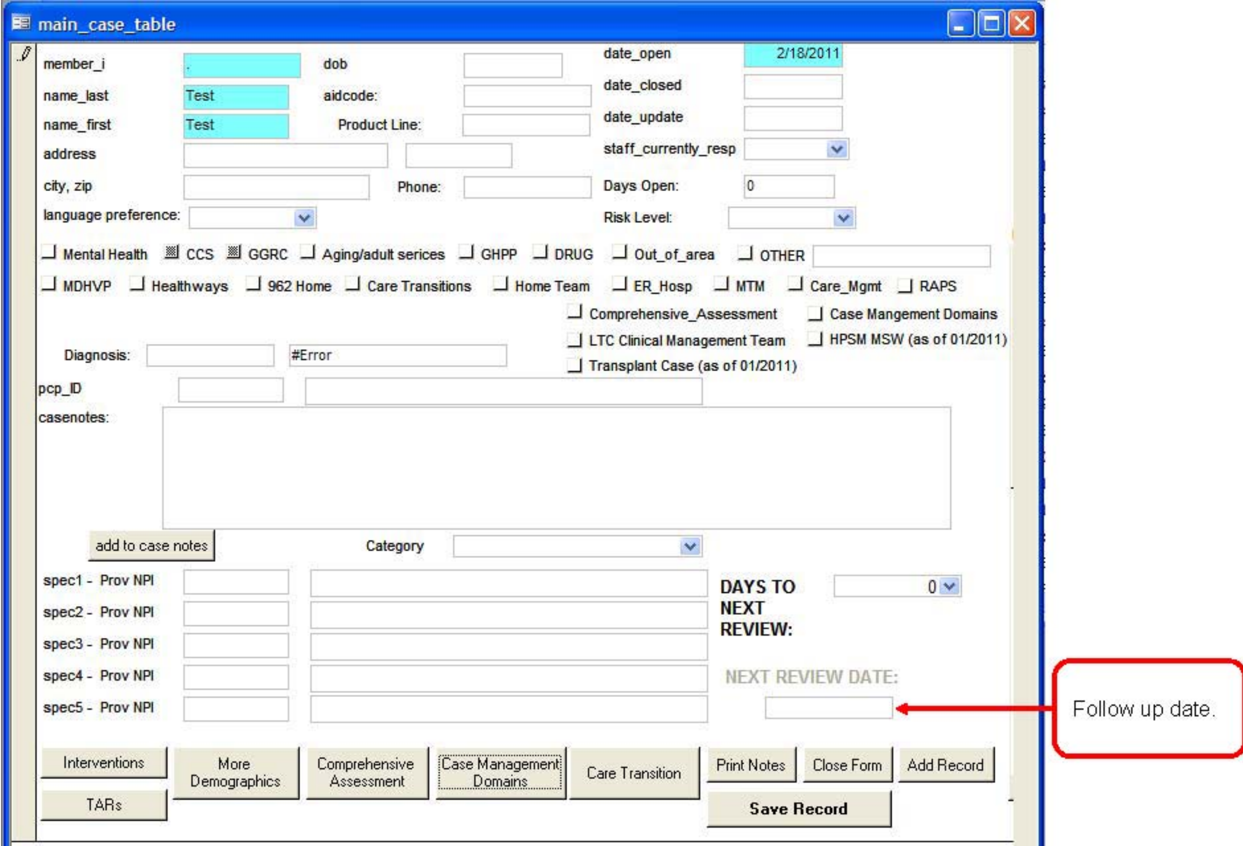
Care plans are reviewed and revised no less than annually or when the health status of the CareAdvantage member changes necessitating a care plan revision as previously noted. Care plan updates are also based on obtainment of the member's progress toward care plan goals and objectives. Health Plan of San Mateo's Care Coordination policy UM 03.03 – Care Management section 7.0 outlines the standards of the care plan including the frequency of care plan review and revision, and inclusion of the member whenever feasible. This policy and procedure states that each care plan shall:

- Be developed for each CareAdvantage member by the respective ICT
- Involve CareAdvantage members and/or caregiver whenever feasible
- Be reviewed and revised annually or when the member's health status changes (e.g., hospitalization or other catastrophic event)
- Include both short term and long term goals and objectives
- Include timeframes for re-evaluation
- Include specific services and benefits to be provided
- Have measurable outcomes
- Be communicated to beneficiary, caregiver, and providers
- Maintain care plan records to assure access by all stakeholders
- Maintain records per HIPAA and professional standards

Health Plan of San Mateo has several mechanism to assure that all CareAdvantage members have their care plan reviewed annually or when the members' health status changes.

These include but are not limited to 1) functionality in the Care Coordination database to establish a tickler file of when a member's care plan is due for annual review and revision, 2) Coordination with the plan's vendor, DSS Research, of all annual re-assessments and 3) the plan's Care Transition process that identifies changes in health status and inpatient admissions of the CareAdvantage member. Additionally, HPSM has several mechanisms for referrals to the plan's Care Coordination department for members experiencing a change in health status.

The HPSM Care Coordination database (CCDB) which holds CareAdvantage member's assessments and care plans has functionality to establish a next review date. This functionality serves as a tickler file reminder and work flow queue update to have the HPSM Nurse Case Manager review the care plan. A screenshot of this functionality is shown below.



HPSM contracts with DSS Research for the mailing, tracking and analysis of the initial and annual health risk assessments (HRAs) for every CareAdvantage member. DSS research sends the HPSM initial and annual assessments and assessment summaries monthly to HPSM. These assessments are delegated to the HPSM Nurse Case Managers for review and creation/update of the care plan as appropriate. The CareAdvantage member monthly response rates to the DSS Research annual assessment mailing varies between 48% and 100%. Those CareAdvantage members who do not complete an assessment receive up to ten follow-up calls by DSS Research to verify the CareAdvantage members' preference for participation in the care management program.

Additional follow-up is performed by the HPSM Nurse Case manager for members who do not complete the DSS Research assessment and are identified on the HPSM high risk case management list describe in previous sections of this MOU.

An additional mechanism for identifying members needing revisions to the care plan because of a change in their health status is through the care transition process. The care transition process identifies every CareAdvantage hospital admission and skilled nursing facility admission. HPSM requires authorization and review of every acute hospital admission and skilled nursing facility (SNF) admission. This ensures that HPSM is notified of every CareAdvantage admission. We require that acute care hospitals and SNFs notify HPSM within

one day of admission. This allows the HPSM Nurse Case Manager opportunity to begin care management coordination and care planning early during the health change/care transition process. The HPSM has 2 on-site Nurse Case Managers and 2 Care Coordination Support Technicians to follow and manage CareAdvantage members through the continuum o f care, modifying and updating the member's individual care plan through the care transition/health care status change. As the CareAdvantage member moves through the continuum of care-home to hospital or SNF, SNF to home or rehabilitation facility, changes to the care plan are implemented as part of providing ICT support. The HPSM on-site Nurse Case manager holds responsibility for updating the member's care plan during the care transition process and notifying the ICT, including the PCP and member, of the member's care transition and change in health care needs. Communication of care plan service needs, identified by the member's acute care clinical team, is recorded on the Care Transition form by the HPSM Nurse Case Manager, updated in the member's care plan, and presented to the HPSM ICT at regular case conferences.

Post acute and post SNF care follow-up is performed by the HPSM Care Coordination Technicians and includes a follow-up phone call to the member to verify how the member is doing after the transition. Topics discussed include, but are not limited to, follow-up physician access, home health follow-up, medication access, DME /medical supply delivery, and social service support. A snapshot of the Care Transition form used in care planning is shown below.

DISCHARGE FOLLOW-UP CHECKLIST / CARE TRANSITION FORM
CASE MANAGER

Today's Date: ___________________ **Case Manager:** ____

Member's Name: _______________________________ **Member's ID#:**__________________________________ **Responsible Party (to help make complex medical decisions):**_________________________________ **Relationship to member:**________________

Admitting ☐ **Hospital** ☐**SNF Name:** ____

☐ **Elective Admission** ☐ **Emergency Admission**

Date of Admission: ____________________________________ **Date of Discharge (D/C):**____________________

Discharged to: ☐ **Home** ☐ **B&C** ☐ **Family Member's Home** ☐ **ICF** ☐ **Other:**___________________
☐ **SNF** ☐ **LTC** ☐ **Short Term Stay in SNF**
Name of SNF:____

D/C Plan after Short Term Stay in SNF:____

Confirmed Communication between sending and receiving facility: ☐ **YES** ☐ **NO** (A-2)
Confirm with ☐ **member** ☐ **receiving facility:** **Date Received:** _________________
☐**discharge instructions** ☐ **discharge orders** ☐ **transfer summary** **Should be one business day from Discharge Date*

Admitting / Discharge Diagnosis:____

Other Relevant Diagnosis:____

CARE TRANSITION

1) Was HPSM Case Manager notified of change in care plan as a result of care transition? ☐ **YES** ☐ **NO**

HPSM Case Manager: ____**DATE:**___________________(B-2)

2) Communication with member or Responsible Party (R.P.) of Care Transition Process/Point of Contact to support member during care transition: ☐ **YES** ☐ **NO**

Date Notified to member/R.P.:________________(B-1, B-3)

Interventions done by Case Manger:

☐ **HPSM Case Manager information given to member/Responsible Party**

☐ **Other:** ____

DME / SUPPLIES *(currently)*:____

PROVIDER NAME:____________________________________ **Phone #**________________________________
Equipment/Supplies Ordered: ☐ **FWW** ☐ **Commode** ☐ **Wheelchair** ☐ **Hospital Bed** ☐ **Dressings**
☐ **Other:** _______________________________

HOME HEALTH AGENCY: ☐ **YES** ☐ **NO**

Name:___________________________________**Address:**____

Phone #:___________________**Frequency:** _______**/hours per day** _______**/days per week X** ________ **weeks**

FOLLOW-UP APPOINTMENTS
PCP Name & Address:_______________________________________ **Date and Time:** ________________________

SPECIALIST Name & Address:________________________________ **Date and Time:** ________________________

FOLLOW UP LAB TESTS: ☐ **YES** ☐ **NO Date and Time:**____

IN-HOME SUPPORT SERVICES (IHSS): ☐ **YES** ☐ **NO**

Name of Caregiver:____ **Relationship:** __________________________

Frequency: _____**/hours per day** _______**/days per week X** ________ **weeks**

COMMENTS:____
____

CARE COORDINATION TECHNICIAN
To be performed within 7-10 days after discharge

Where is member staying at this time?
☐ **Home/Primary Residence** ☐ **with Family Member** ☐ **SNF** ☐ **B&C** ☐ **ICF** ☐ **Other:**_______________

Medications confirmed in PBM System: ☐ **YES** ☐ **NO**
Any difficulty obtaining medications? ☐ **YES** ☐ **NO**

Pharmacy Name: ____ **Phone #** ___________________________

Pharmacy Address: ____

CARE TRANSITION (A-3)
Notified PCP of Care Transition (Name of MD): ____

Phone #: ____________________________________ **Fax #:**__________________________________

☐ **Admission to:** ☐ **Hospital** ☐**SNF** **DATE:** _____________________
(date of notification that was sent to MD)

Name of Facility:_________________________________ **Should be 1-2 days from Admission Date*

☐ **Discharge from:** ☐ **Hospital** ☐**SNF** **DATE:** ______________________
(date of notification that was sent to MD)

Name of Facility:__________________________________ **Should be 1-2 days from Discharge Date*

Was member able to obtain follow-up MD appt? ☐ **YES** ☐ **NO**
Any difficulty obtaining appointments? ☐ **YES** ☐ **NO** **Date Confirmed:** ____________

PCP: _________________________________**Date/Time:**____

Address:______________________________________ **Phone #:** __________________________________

Specialist:_____________________________ **Date/Time:**____

Address:______________________________________ **Phone #:** __________________________________

HOME HEALTH AGENCY (HHA): ☐ **YES** ☐ **NO** **Date Confirmed:** ____________

Name: ____ **Phone #**___________________

Nurse/Therapist name(s): _____________________________**Date(s) HHA came to visit:** __________________
☐ **RN** ☐ **PT** ☐ **OT** ☐ **ST** ☐ **MSW** ☐ **Home Health Aid** ☐ **Other:**_______________________

Frequency: _________ **hours per day/** _______**x week**

OUTPATIENT THERAPY: ☐ **YES** ☐ **NO** **Date Confirmed:** ____________

Name: ____ **Address:**__________________________________

Phone # ________________ **Frequency:** _______**/hours per day** _______**/days per week X** ________ **weeks**

DME/SUPPLIES: ☐ **YES** ☐ **NO** **Date of equipment/supplies delivery:**______________

Provider:____ **Phone #**__________________________________
☐ **FWW** ☐ **Commode** ☐ **Wheelchair** ☐ **Hospital Bed** ☐ **Dressings**

☐ **Other** ____ **Date Confirmed:** ____________

SOCIAL SERVICES
Who helps you at home (cooking, cleaning, laundry, grooming, bathing)? ________________________
How do you get around the community (transportation)? (Dr. appointments, shopping, church, etc.):
____

Do you have IHHS? ☐ **YES** ☐ **NO** **If yes:** ____ **hours per day X** _____ **days a week**

Does member have any questions on health care needs?: ☐ **YES** ☐ **NO**
If so, what questions? ____

REFERRED TO CM FOR ADDITIONAL FOLLOW UP: ☐ **YES** ☐ **NO**

Case Manager:_______________________________________ **Date Referred:**__________________________

Reasons:____

Every CareAdvantage member experiencing a care transition is given a direct point of contact during the health status change/ care transition process to facilitate member engagement and

participation in the care planning process. Below is a copy of the CareAdvantage member point of contact letter.

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

JANUARY 05, 2011

Re: **Nurse Case Manager for Transition of Care**

Dear CareAdvantage Member:

This is to inform you of services provided through our Care Transition Management program that will help you with your transition to a new setting. These services are covered by CareAdvantage to support continuity of care when you are transferred from one facility to another (for example, from a hospital to your home, or to a nursing home).

You are being assigned to **Celeste Medios,** a Nurse Case Manager from the Care Coordination department at Health Plan of San Mateo (HPSM). She will make sure your care is coordinated during your transfer and will be available to respond to your questions and help with information you might need when you are transferred. You can call **Celeste Medios** at phone Number (650) 616-2060, Monday through Friday, 8 a.m. to 5 p.m.

Your nurse case manager will:

- Support coordination of care by responding to questions from you, your family and/or caregivers.
- Help you understand what brought you to the hospital, and help you develop a practical care plan that will work in the future.

HPSM's Care Transition Management program **does not provide direct skilled nursing services.** If you are being transferred to a nursing home, hospital, or your home, you may receive services from a home health nurse, physical therapist or licensed social worker that are arranged outside of the Care Transition Management program.

If you are not satisfied with the services you receive through the Care Transition Management program, please call Mari Baca, Health and Provider Services Director at (650) 616-2083.

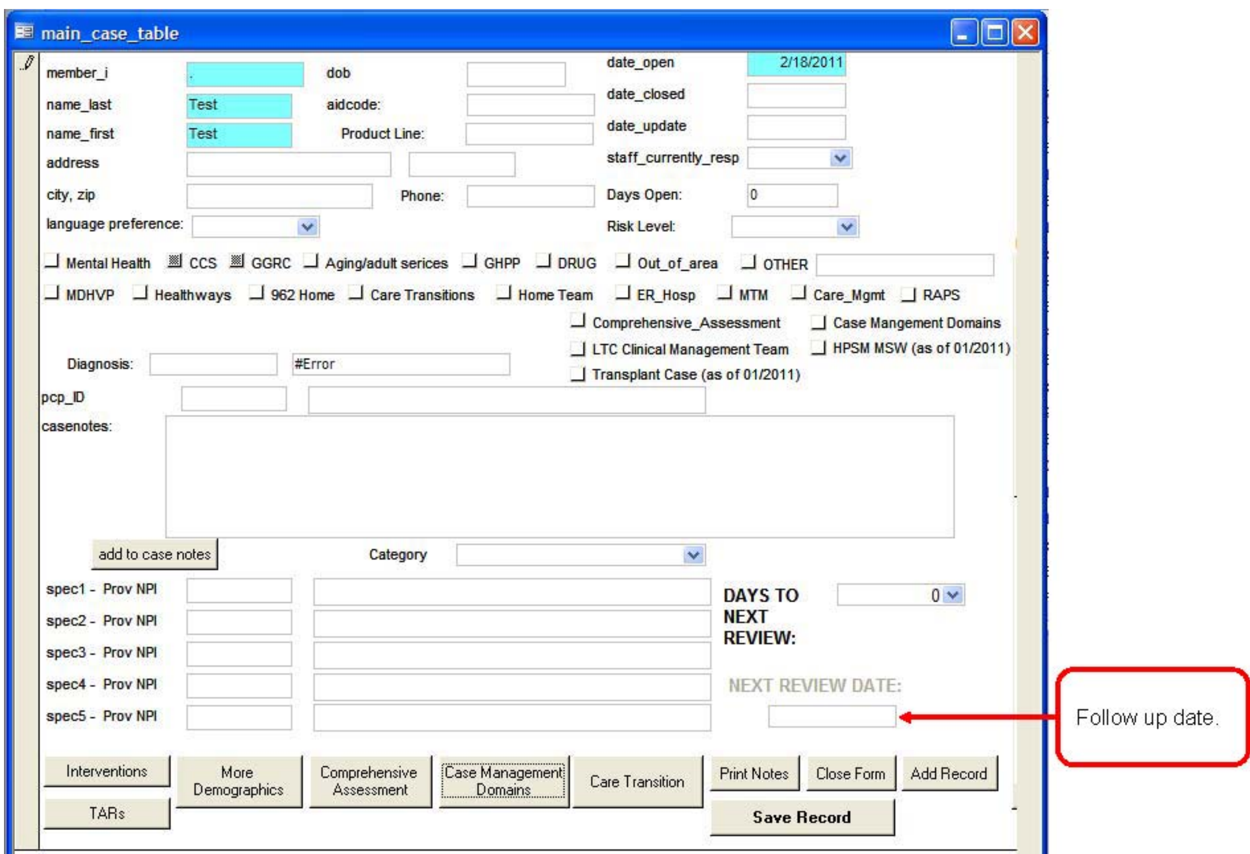
Thank you.
Care Coordination

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
CareAdvantage Unit **1-866-880-0606** (toll-free) or **(650) 616-2174** | Fax: **(650) 616-2190**
Hearing Impaired: TTY **1-800-735-2929** (California Relay Service) or Dial **711**
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.
H5428_CA_9065_10 (approved 05/27/2010)

Lastly, HPSM has several mechanisms for referrals to the plan's Care Coordination department for care plan coordination and assistance. The Plan's Care Coordination department accepts referrals from any source.

CareAdvantage members may self refer and seek assistance in coordination of care, healthcare access, benefit access, health promotion, or community resources referrals to name a few. Every CareAdvantage member participating in the plan's care coordination program will undergo a comprehensive assessment review to establish an individualized plan of care. This is because any member who accesses the Care Coordination Unit for services is considered high risk until shown to be otherwise.

Referrals for the plan's care coordination department may also be made by any person in the community. Care coordination referral forms are available on the plan's website and may be faxed directly to HPSM's Care Coordination department for review and acceptance into the program. All referrals accepted into the program will undergo a comprehensive assessment review and individualized care plan.



The example below illustrates how care plans are reviewed and revised, including the personnel involved in review.

Example: Care Plan Review and Revision

Mr. Jones is a 74-year-old male with COPD, CHF, diabetes, severe osteoarthritis, a mental health history and limited social supports. Mr. Sample has been complaining of severe right hip pain and has demonstrated decreased mobility function. Mr. Jones encountered a fall and was emergently admitted to All Saints Hospital with a fractured hip. Mr. Jones was also evaluated by orthopedics and subsequently required hip replacement surgery. Mr. Jones had already been open to HPSM's Care Management program prior to this hospital admission due to his complex medical status and multiple co-morbidities. Mr. Jones ' HPSM Nurse Case Manager is Joan. Because Mr. Jones had a change in health status, he has new health care and care coordination needs and requires a care plan revision.

The Health Plan of San Mateo (HPSM) was notified of Mr. Jones ' admission as part of HPSM's Care Transition process (outlined above) that includes daily hospital census review and daily tracking of hospital admissions by HPSM's Care Coordination department. The Health Plan of San Mateo's Care Coordination technicians (CCTs) are the first to receive the daily hospital census notifications. The CCTs are the clinical supports to the nursing case management team at HPSM. CCTs have a strong foundation in medical office support that includes licensure as a medical or dental assistant, health information technology, or community health. As first line gatekeepers, CCTs alert the HPSM Nurse Case Managers of every hospital admission on a daily basis.

The CCT identified that Mr. Jones was already open to HPSM's Care Management program and had an HPSM Nurse Case Manager Joan assign as Mr. Jones ' Nurse Case Manager. The CCT notified Joan of Mr. Jones' admission. The CCT also notified Mr. Jones ' PCP and immediately sent Mr. Jones 's PCP a written notice of admission (sample shown below).

HPSM Nurse Case Manager, Joan, performs daily review of admissions at All Saints Hospital. Joan immediately contacted All Saints Hospital care management department to inform Mr. Jones ' hospital nurse case manager that Joan is the point of contact at HPSM for Mr. Jones 's care. Joan also contacted Mr. Jones' PCP to let him know that we sent him notification that Mr. Jones was admitted to All Saints Hospital and that she will follow Mr. Jones through the continuum of care. Joan also informed Mr. Jones' primary care contact that she will serve as Mr. Jones' point of contact throughout this care transition/ hospitalization and post discharge. Joan also informed Mr. Jones ' primary contact and PCP that she would update Mr. Jones 's care plan in conjunction with the PCP and the ICT at HPSM and All Saint's Hospital ICT.

Mr. Jones underwent hip replacement surgery on his second day of hospitalization with a non-eventful hospital course.

During hospitalization an ICT meeting was established that included behavioral health for his mental health issues that may affect compliance issues and post acute care, the HPSM Nurse Case Manager, Joan, for coordination and authorization of benefit service needs within the plan's provider network , the hospital Nurse Case Manager for assistance of post acute needs, the PCP, the hospitalist serving as the point of contact for Mr. Jones 's All Saints

Hospital physician specialist care , and Mr. Jones and by request of Mr. Jones , his primary contact. The goal of the ICT was to ensure the best possible health outcome for Mr. Jones during and post hospitalization and development of an individualized care plan that includes the expertise and responsibilities from each team member, including Mr. Jones.

As part of the ICT assessment process, it was identified that Mr. Jones 's post discharge needs require home health skilled nursing follow-up, short-term rehab, DME, hip replacement education support and reinforcement, and medication delivery assistance, specialty care follow-up and transportation assistance. During the ICT, Mr. Jones expressed concern of not returning to his prior level of mobility and function of living independently and ambulating without assistive devices.

The care plan required that Mr. Jones' concerns be addressed including expectations of the hospital course and post discharge needs. A care plan was given to Mr. Jones by the hospital Nurse Case Manager outlining the critical pathway expectations including rehab goals, medication regimen, and post rehab services that include home health agency follow up for his input and questions. The ICT and care plan also identified that immediate short term hip replacement rehabilitation required arrangement and authorization to ensure Mr. Jones encounter a smooth transition from All Saint's hospital acute care to skilled nursing facility (SNF) rehabilitation.

The hospital nurse case manager collaborated with the hospitalist, orthopedic team, and HPSM nurse Case Manager to identify a skilled nursing facility that Mr. Jones would transfer to post acute care. The HPSM Nurse Case Manager provided authorization to the rehabilitation facility and transportation agency for Mr. Jones' transfer post acute hospitalization and ensured that appropriate communication between the discharging hospital, transportation agency and rehabilitation facility occurred during the Care Transition process. This communication is documented on the Discharge follow-up checklist / Care Transition form as well to ensure that communication barriers during care transitions are minimized and included in the care planning process. Mr. Jones' specialists also required that he be seen by them within one week of discharge from rehab. Documentation of post physician specialist care is also included on the care plan for coordination of care and follow-up by the HPSM CCT. The PCP was notified of Mr. Jones' discharge via the PCP hospital discharge notification letter (shown below) and a copy of the member's care plan is also sent to the PCP. The HPSM Nurse Case Manager, Joan, completed the discharge follow-up checklist/Care Transition form throughout Mr. Jones ' hospitalization as a communication to the HPSM CCT for follow-up and inclusion in the care plan by Joan.

The HPSM Nurse Case Manager followed Mr. Jones through the continuum of care and updated the care plan and the PCP at each juncture of Mr. Jones' Care Transition process so that the PCP may follow Mr. Jones in the Rehabilitation facility/SNF. The PCP was also notified in writing of Mr. Jones' discharge from All Saints to SNF Rehabilitation. Joan communicated Mr. Jones' All Saints Hospital acute care discharge and SNF admission information to the HPSM CCT so that the CCT may send written notification of both the discharge and admission to the PCP (sample copies of these letters are shown below).

During the post acute rehabilitation, the HPSM Nurse Case Manager, Joan, attended ICT meetings at the Rehabilitation facility to assess Mr. Jones' progress and needs during the rehab phase of care with updates to the care plan as appropriate. The SNF/Rehab ICT

including the SNF Physical Therapist, Occupational Therapist, Social Worker and Case Manager. During the rehab phase, the care plan identified that Mr. Jones' post SNF rehab needs included home health, DME, medications, and specialty care follow-up with his orthopedic physician, PCP and behavioral health specialist at HPSM contract mental provider, San Mateo County Behavioral Health and Recovery Services. Joan worked with the Rehabilitation/SNF case manager to identify and coordinate home health and DME service providers from which Mr. Jones will obtain his services. Joan provided authorization of the home health services and DME services Mr. Jones' care plan is updated by Joan and distributed to Mr. Jones and the SNF Rehabilitation team. Joan also completes an additional Discharger follow-up Checklist/Care Transition form for Mr. Jones' SNF rehabilitation phase of care. Mr. Jones' SNF Rehabilitation course was uneventful and he met his rehab goals. Mr. Jones discharged home after 10 days of SNF rehabilitation.

Post Mr. Jones' SNF Rehab discharge, Joan, made a referral to the County behavioral health team, Behavioral Health and Recovery Services (BHRS) to ensure that the BHRS team is aware of Mr. Jones' behavioral health status is stable. Joan also made a referral to the HPSM Care Transition Nurse. The HPSM Care Transition Nurse provides follow up services in the home within 3 days of discharge. This includes empowering Mr. Jones on medication management, education on signs of symptoms to be alert to, how to work with his physician and a personal health record to track appointments, medications and questions (as describe in section 8 of this MOC document). Joan also updates the care coordination database noting a next follow-up date within 3 days of anticipated discharge from the SNF/rehab facility.

All benefit service needs of Mr. Jones are authorized by the HPSM Nurse Case Manager. Documentation of all post-acute care needs are done on the care plan and the Care Transition form (shown above and describe in section 8 of this MOC document). The Care Transition Form is then given to the HPSM Care Coordination Technicians for follow-up with Mr. Jones to ensure that Home Health and DME services were obtained and that he is seen by his physician specialists and primary care doctor. Any barriers to obtaining post discharge services get immediate intervention by the HPSM CCT and Nurse Case Manager to work with our community providers in getting the services Mr. Jones needs.

Within 3 days of Mr. Jones' post discharge from the SNF rehabilitation facility , Joan checks in with Mr. Jones, Mr. Jones' PCP, the HPSM Care Transition Nurse, and HPSM's CCT to assess if additional care needs are identified requiring her interventions and updates to Mr. Jones' care plan. Joan reminds Mr. Jones that he may call her directly for any changes in his health status or care coordination needs and that her name and phone contact information was mailed to him. (Care Transition letter shown above).

Mr. Jones is doing well, ambulating with a cane and no additional issues identified. Mr. Jones' final assessment and attainment of goals are noted in the care plan by Joan. Joan closes Mr. Jones' current care plan noting a new annual follow-up date. Joan will re-open Mr. Jones' case at any point prior to the annual follow-up anniversary, should Mr. Jones experience a change in health status.

Sample of hospital admission notification to PCP

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

HPSM Provider Notice

Date:

To:

Subject: Admission Notification

Member Name:
Member ID:

Dear ,

Health Plan of San Mateo (HPSM) CareAdvantage member, , was admitted to , on .

As part of our Care Transitions Management program, you are receiving this notification because you are identified as this member's primary care physician. HPSM's Care Transition management program is making a special effort to improve the continuity of care as our members' transition from one setting to the next. Your patient will be assigned a plan case manager to help support care coordination efforts. The case manager for your patient is .

If you have any questions about this notice or our Care Transition management program, please contact our CareAdvantage Care Coordination Unit at (650) 616-2060.

Sample of hospital admission notification to PCP

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
TEL (650) 616-0050
FAX (650) 616-0060
www.hpsm.org

HPSM Provider Notice

Date:

To: [Insert PCP Name]

Subject: Discharge Notification

Member Name:
Member ID:

Dear [Insert PCP Name],

Health Plan of San Mateo (HPSM) CareAdvantage member, [insert member name], was admitted to [insert facility name], on [date of admission].

As part of our Care Transitions Management program, you are receiving this notification because you are identified as this member's primary care physician. HPSM's Care Transition management program is making a special effort to improve the continuity of care as our members' transition from one setting to the next. Your patient will be assigned a plan case manager to help support care coordination efforts. The case manager for your patient is [insert Case Manager name].

If you have any questions about this notice or our Care Transition management program, please contact our CareAdvantage Care Coordination Unit at (650) 616-2060.

Describe how the plan of care is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.)

The plan utilizes a Care Coordination database to serve as a centralized repository for documentation of the comprehensive assessment, care plan, case notes and a follow-up timeframe tickler file. A snap shot of the database is shown below. The database is HIPAA compliant, password protected and accessible only by security level access. Only interdisciplinary care team staff members employed at HPSM with appropriate level security may access this database through a password protected account.

The Care Coordination database was created to match the components of the comprehensive assessment. It was modified so that any changes in the assessment could be included, and also so that the tool became dynamic, having a tickler system to allow for reminders for updating of the individualized care plan (ICP) component. It has a reporting capacity so various aspects of members' files can be sorted and run, when only pieces of ICPs are needed. It also is formatted so that readable copies of the ICP can be printed and forwarded securely to external ICT members, such as the patient/caregiver, the ICP and other external team members.

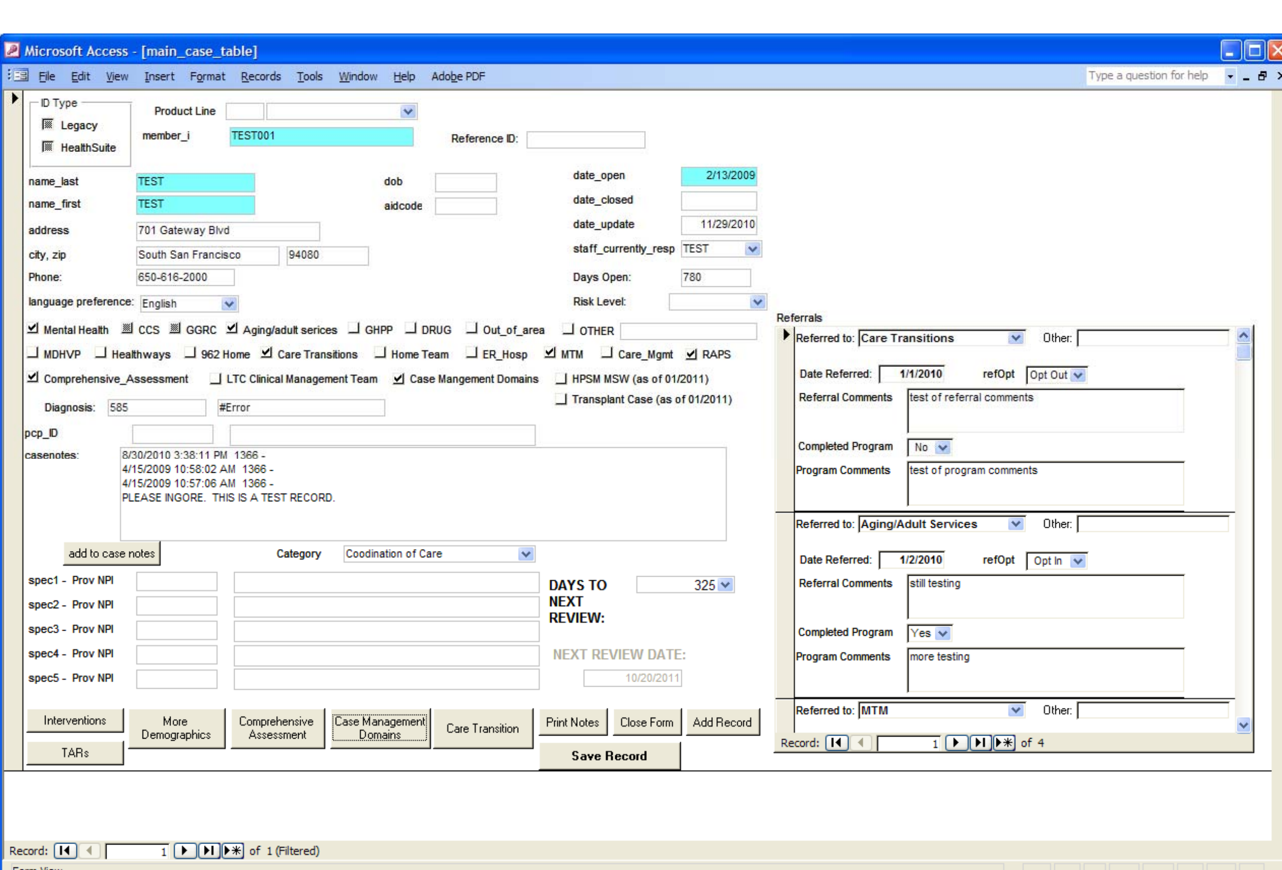
Planned for 2012 is to establish this database as a HIPAA compliant web-based database to allow accessibility by external ICT members. In the interim, the HPSM Nurse Case Manager serves as the primary contact and facilitator for updating the care plan in the care coordination database and distribution of a HIPAA compliant copy of the care plans to external ICT members including the primary care physician and the member. Members receive a copy of the care plan with an explanatory letter noted as described in Element 7, Factor d.

Data in the database is preserved according to industry practices. CareAdvantage medical record retention is maintained in this database for 10 years per 42, CFR 422.504.

The database utilizes multiple tabs at the bottom of the screen to access the member's comprehensive assessment, care plans, interventions, service authorization requests (TARs), transition summaries and documentation and additional member demographics. A sample screenshot of the database care plan domain is shown below. The data base also has multiple report capability that includes tracking of referrals to the plan's LTC Clinical management team, HPSM's Medical Social Worker, and community agencies such as Mental Health, Aging and Adult Services and the Regional Center. A sample screenshot of the referral note functionality, assessment and care plan in the CCDB is shown below. From these screen shots, one can see the great level of detail available in this database, because of the amount of detail entered regarding the patient. This starts with the comprehensive assessment, and proceeds with every other contact with the member, updates from the PCP, and so forth. HPSM has built in this level of detail because we believe that the more complete picture of the member's goals, services and needs, the better ICP can be developed, and the more likely that successful tracking and meeting of goals can be accomplished.

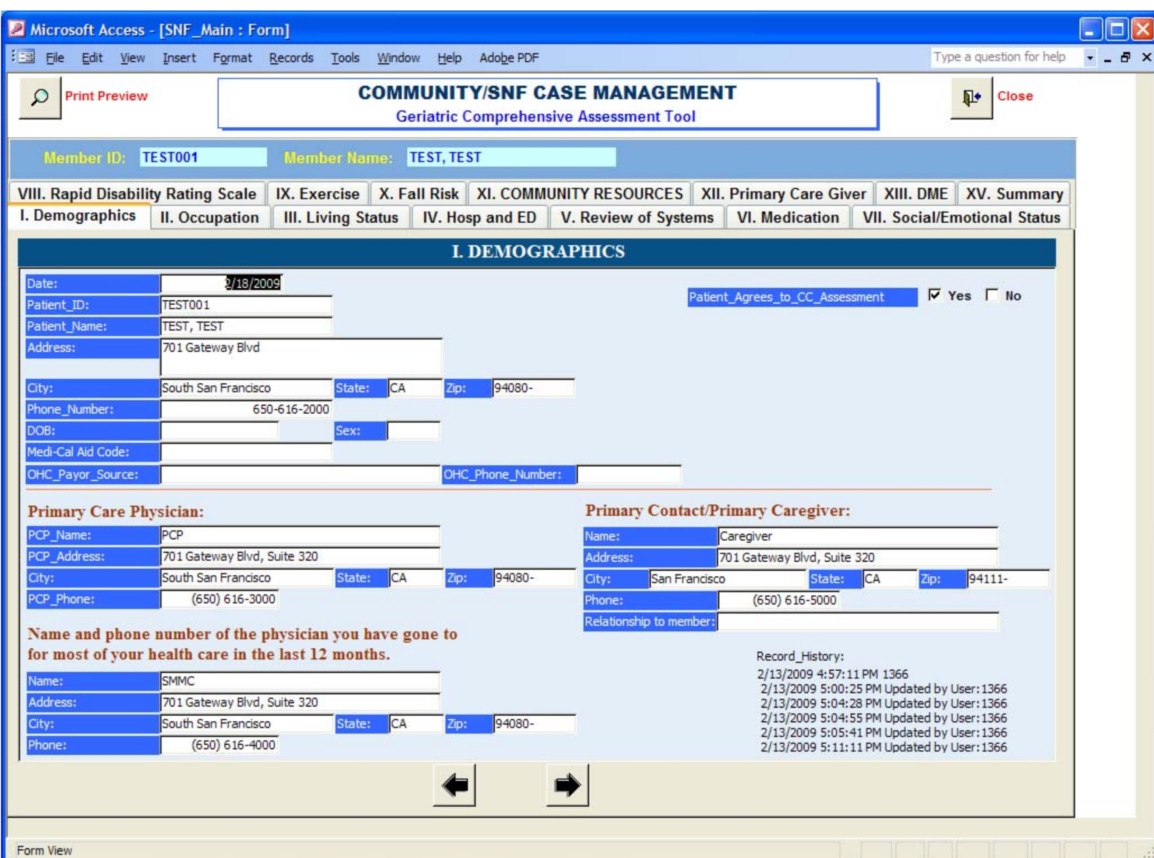
The example below from the Care Coordination Database (CCDB) shows the opening screen of a care management case. All cases start with the initial documentation identifying the member demographics, diagnosis, referrals , linkages to community resources such as the Regional Center, California Children's Services, the Long Term Care Clinical Management team, and Aging and Adult Services to name a few. Identification of the member's primary care physician and physician specialists is also noted on the case's opening screen in the Care Coordination Database. Case notes may also be viewed from the opening screen. From the CCDB initial case screen the nurse case manager can also access the member's comprehensive assessment, add a care plan and add additional case notes from the tabs at the bottom of the screen.

Figure 1 Referral case notes



The CCDB screenshot in Figure 2 shows the demographic section of the comprehensive assessment. The comprehensive assessment (describe in Element 8, Factor A) has 13 components. The comprehensive assessment is the foundation of care management intervention care planning. The HPSM Nurse Case Manager can update any component of the comprehensive as the member's case status changes. A change/update record history is recorded automatically and displayed in the lower right corner.

Figure 2 Comprehensive Assessment components



The screenshot of the CCDB in Figure 3 below shows the care plan problem domains. The care plan problem domains initiate the care plan portal of the CCDB. The care plan problem domains are accessed after the comprehensive assessment is performed identifying the areas of health care needs requiring care management care planning intervention by the ICT.

There are 8 care plan problem domains. The first seven domains (medication related, safety, access, psycho-social, new diagnosis, treatment/outcome related problems, and catastrophic cases such as brain/spinal cord injury and transplants) are the most common. The last problem domain "other" is reserved for all other unique needs and problems that are assessed as part of a member's comprehensive assessment. Here is where the nurse may enter a specific and unique care plan that best meets the member's care management needs. The member may have multiple problem domains within his/her care plan. Each domain requires the Nurse Case Manager to include both short and long term goals in the care plan. Updates to the care plan may be made by any member of HPSM's internal ICT. The CCDB automatically records date, time, and user of the care plan update.

Figure 3 Care plan domains

Microsoft Access - [Case Management Department]
File Edit View Insert Format Records Tools Window Help Adobe PDF
Type a question for help

CASE MANAGEMENT DEPARTMENT
Domains of Specific Problem Labels
Expected Outcomes
Intervention Options
Close

Member_ID: TEST001
Member_Last_Name: TEST
Member_First_Name: TEST
Member_Phone_Number: 650-616-2000

Member input in care planning process obtained - Refer to care plan for details.
Yes
No

DOMAINS:
Medication Related
Health Access Related
Safety Related
Treatment/Outcomes Related
New Onset/ Diagnosis
Catastrophic
Psych/ Social
Other

Form View
FLTR

e. Describe how the plan of care and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers

Every CareAdvantage member receives their personalized plan of care. HPSM utilizes several avenues for communication of the member's care plan to the member him/herself, interdisciplinary care team and other pertinent stakeholders in the member's care. To address each CareAdvantage member's unique needs and to preserve the individuality of the health care planning process, the avenue of communication of the care plan is dependent on the member's risk stratification status and identified health service needs by the plan.

CareAdvantage members are assigned a risk stratification score of low, moderate or high risk. This stratification methodology is derived from multiple sources including the member's hospitalization history, admission into a nursing facility, emergency room utilization, medication utilization, aid code status, disability status, HCC score, chronic illness index, and the plan's predictive model. It is also based on the algorithm agreed upon by DSS and HPSM clinical leaders using the results of HRA findings. The risk is risk for an adverse health outcome e.g. hospitalization or ED visits in the upcoming 9 months.

Risk classification of Low and Moderate risk

Members who are identified as low and moderate risk for adverse health outcome (e.g. hospitalization as outlined above) receive their initial and annual care plan through the plan's contracted assessment and care plan vendor DSS Research. DSS Research provides outreach to each CareAdvantage member to obtain a completed comprehensive assessment as described in detail in Element 7. DSS analyzes each assessment and develops a unique plan of care based on the analysis of the member's self reported assessment. DSS a ensures that the member and the member's PCP and the care coordination program at HPSM receive a copy of this assessment and care plan within 14 days of completion of the assessment. Members are given a direct number to the Plan's Care Coordination department for assistance with their care plan. Below is a sample DSS care plan.

Care Plan for: <<Member Name>>

Health Maintenance Plan for You

The Health Plan of San Mateo (HPSM) wants to be your partner in helping you maintain your health to the best of your ability.

HPSM offers services to help you:

- Schedule periodic follow up appointments with your primary care physician (PCP).
- Follow your medication treatment plan.
- Find the support you need with diet and exercise changes recommended by your doctor.

Specific Service	Benefit
❑ We can help you to improve access to your PCP so that you can ask questions, discuss your concerns, and be proactive in the medical management of your health.	❑ Talking with your PCP about your medical care gives you the ability to be involved in decisions related to treatment. This helps you to reach the best health status possible.
❑ We can help you understand how to use HPSM materials and services to manage your health. For example:	
♦ Provider Network Handbook	♦ Having information about HPSM's network of physicians and providers and understanding the services available to you can help you choose your health care partners.
♦ Evidence of Coverage (EOC) Handbook	♦ Understanding how to use your EOC can help with learning what types of services are covered under your CareAdvantage benefits.
♦ Health Promotion Programs that are free to HPSM members	♦ Having information about the health education classes offered by various programs and hospitals in San Mateo County allows you to choose programs that can help with improving your health.
❑ Care coordination services are offered to HPSM CareAdvantage members through referrals from many sources, including your doctor. You can ask for more assistance and support in managing your health.	❑ Care coordination services provide individualized assistance and support to give you the ability to make medical decisions which is optimal for your health.

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract

H5428_CA_9064_10 (approved 05/18/2010)

High Risk Classification

Members identified as having a high risk classification receive direct 1:1 outreach from a HPSM Nurse Case Manager. The plan's Nurse Case Manager performs and reviews the member's comprehensive assessment for validation of information in the high risk assessment and performs additional assessment processes. From this assessment, additional individualized plan of care elements are developed in conjunction with the member. This care plan is review with the member and sent to the member or caregiver, as appropriate, by mail. A copy of this care plan is shared with and accessible to the plan's ICT via the Care Coordination Database. The plan's Nurse Case Manager also discusses the care plan with the member's PCP and sends a copy of the care plan to the PCP for inclusion in the member's primary care medical record in the PCP's office. High risk members are case managed by the plan's Nurse Case Manager for the duration of their high risk status. The Nurse Case Manager maintains a care plan review schedule with the member and ICT in the Care Coordination database. The Nurse Case Manager will update the plan of care should there be any changes in the member's health status necessitating a care plan revision and update. The Nurse Case Manager will be notified of any change in health care status through the Care Transitions process, weekly plan ICT meetings and/or the PCP.

Change in Health Status

Any CareAdvantage member, regardless of risk stratification, experiencing a change in health care status or a care transition requires a review and revision of the care plan. The plan's Nurse Case Manager assesses the change in health status and may initiate an ICT case conference at the plan's weekly ICT meeting. Care plan revisions and updates are performed in conjunction with the member, when feasible, and the PCP. The care plan is updated in the CCDB case notes and care plan domains and is accessible to the plan's ICT. The Nurse Case Manager will mail a copy of the care plan to the member or responsible party and the PCP for inclusion into the member's medical record in the PCP's office. Below is a sample screenshot of the introductory letter sent to the CareAdvantage member with their care plan.

Following are some examples of the documentation used regarding care plans. Below is a sample screenshot of the introductory letter sent to the CareAdvantage member identified as high risk with their care plan, based on the completion of the HRA:

healthy is for everyone
www.hpsm.org

Date

Member Name
Address
Address

Dear <member name>:

Thank you for completing the Health Risk Assessment Survey (HRAS). Your responses help us determine the best possible health care and services that we can provide for you. We have developed the enclosed individualized care plan based on your responses from the HRAS. Your care plan includes our recommendation that you see your primary care physician for ongoing medical care and services.

A Care Coordination Nurse Case Manager at HPSM can help you with questions about services covered by your CareAdvantage benefits and/or about your medical treatment such as:

- Coordination of medical referral
- Receiving recommended services within the benefit structure
- Using appropriate community resources
- The treatment plan developed by your doctor for your medical condition

If you have questions about this letter, please call our Care Coordination Unit at 650-616-2060. TTY users can use the California Relay Service (CRS) at 1-800-735-2929 or dial 711 to speak with an operator. Our office hours are Monday through Friday 8 a.m. to 5 p.m.

We look forward to helping you get the health care services you need through CareAdvantage.

Sincerely,

Medical Director

H5428_CA_9064_10 (approved 05/18/2010)

CareAdvantage (HMO)—a Medicare Advantage organization with a Medicare contract
CareAdvantage Unit 1-866-880-0606 (toll-free) or 650-616-2174 | Fax: 650-616-2190
Hearing Impaired: TTY 1-800-735-2929 (California Relay Service) or Dial 7-1-1
Call Center Hours: Monday through Sunday 8 a.m. to 8 p.m.

The recommended care plan is shared with the ICT, including the PCP and the member and/or the member's caregiver(s), for additional input – including consideration of beneficiary preferences – and final approval. The Nurse Case Manager works to support the PCP in his/her responsibility for maintaining and updating the individual care plan in the member's medical record, monitoring the member's adherence to the care plan, and making the care plan available to other members of the ICT as needed and upon request. High risk members enrolled in HPSM's Care Management program have care plans updated as needed but no less than annually. The plan's clinical team has responsibility to determine appropriate timeframes for re-review and care plan revisions. Revisions and care plan updates are based on obtainment of the member's progress toward care plan goals and objectives.

Documentation of the plan's care management activities, including the comprehensive assessment and care plans are maintained in the Care Coordination Database. Care plan goals are communicated to the member and PCP.

Determination of benefit services may be performed through the individualized care plan. Ultimate responsibility for determination of services is with the member's primary care physician. The primary care physician or usual care practitioner works with the plan's health services and care coordination departments in coordinating authorization and delivery of services. The plan notifies members of all service authorizations requests. These requests are documented in HPSM's electronic database, HEALTHsuite.

At every level, from member to PCP to Nurse Case Manager to ICT, requests through authorizations, all items are documented in secure, HIPAA compliant systems. Key team members, in particular the patient and the PCP, are included in decision-making as much as possible, and kept apprised of all tasks in ICP creation and ICT activities. They are sent copies of the individualized care plan, and updates are forwarded annually or whenever the patient's health status changes.

Example: Updated Care Plan is Communicated by Plan Case Managers to Beneficiary, ICT, and Pertinent Network Providers

To demonstrate how an updated care plan is communicated by the Plan nurse case managers (NCMs) to the other pertinent participants, we will return to the case of Ms. Jin Dow, as described in the example associated with factor 8b. After the care plan was developed, it was presented to the ICT when it met. The care plan is accepted, and it was discussed by phone in detail with the family representative, the nurse granddaughter, who had been chosen to represent Ms. Dow by the family (since Ms. Dow has dementia), to ensure it was acceptable to her. Ms. Dow' PCP, Dr. TB, also gets a copy, sent by mail or fax (at his preference). Then, the care plan is implemented. The patient's new equipment is delivered. Her medications are adjusted so only the meds absolutely necessary for her health and comfort are continued. Her wound care is being handled with home health visits three times a week. The family has listened to the HHA staff's description of palliative care. However, she seems to be doing better, so they decide to just keep things as they are for now, and see how things go. Then, in spite of the excellent care in place, the HHA staff calls Dr. TB to inform him that a new wound has developed. Dr. TB asks for the NCM's help with the POLST, since the family hadn't really moved ahead much. Thus, one of HPSM's nurse practitioners who makes home visits arranges to the family home with a face-to-face Chinese-speaking interpreter (since Ms. Dow's daughter prefers Mandarin, though the nurse granddaughter is fluent in English) to discuss the POLST, end of life options, comfort care, etc. After a thoughtful, open discussion, the family decides to choose that Ms. Dow not be resuscitated nor even go to the hospital unless it is critical for her comfort. They contact Dr. TB by phone while the NP is still in their home, and he agrees that this is a good choice, so the nurse granddaughter brings the POLST form in to his office the

next day and they both sign it. Ms. Dow continues to be comfortable in her home, and her condition is being managed at home. The family had not been interested in having a chaplain come to their home previously. At this juncture, they decide that having one come would be helpful. Ms. Dow's ICP is updated, based on the new changes.

The main areas of the ICP that are updated are, for **goals/objectives**, that Ms. Dow will remain comfortably at home for the rest of her life; that any further services to be authorized will be focused on comfort care for Ms. Dow; **specific services/benefits—**anything related to hospice/palliative care, such as comfort medications; if the family decides to sign up officially for hospice, then the hospice benefit will move into place (the other portions remain as is, except that wound care is geared for comfort only); **outcome measures—**the main update is that Ms. Dow will remain at home unless something occurs (like a fall an hip fracture) that cannot be controlled at home; otherwise there will be no more ED visits or hospital stays; she will remain at home as in the goals above; the ongoing support/information will come from HHA or the chaplain, as needed; no other changes in the final two areas.

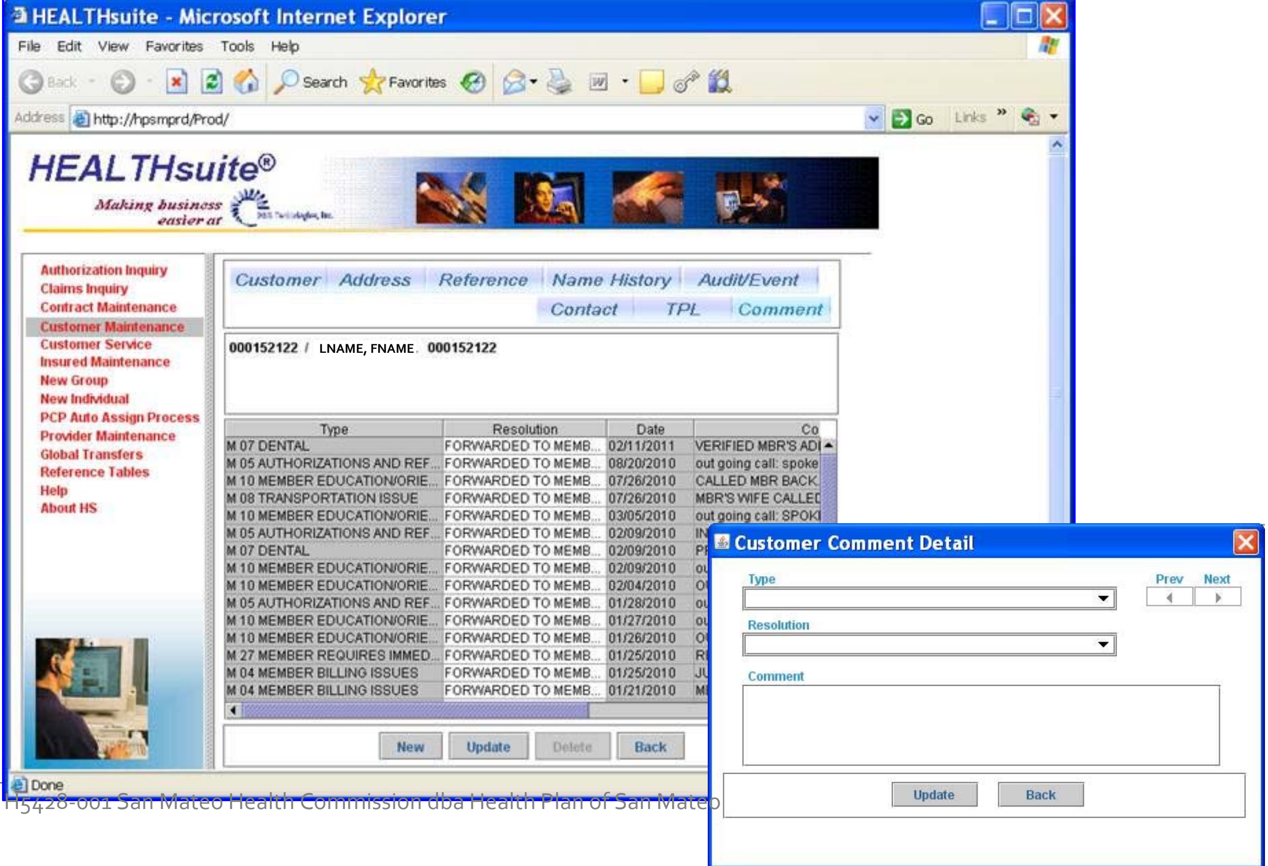
The ICT, PCP and her family are sent new copies of the ICP confidentially via mail or e-mail or fax, depending on their preference. The NCM also updates the Care Coordination Database to ensure all the changes are documented internally at HPSM as well.

9. Communication Network

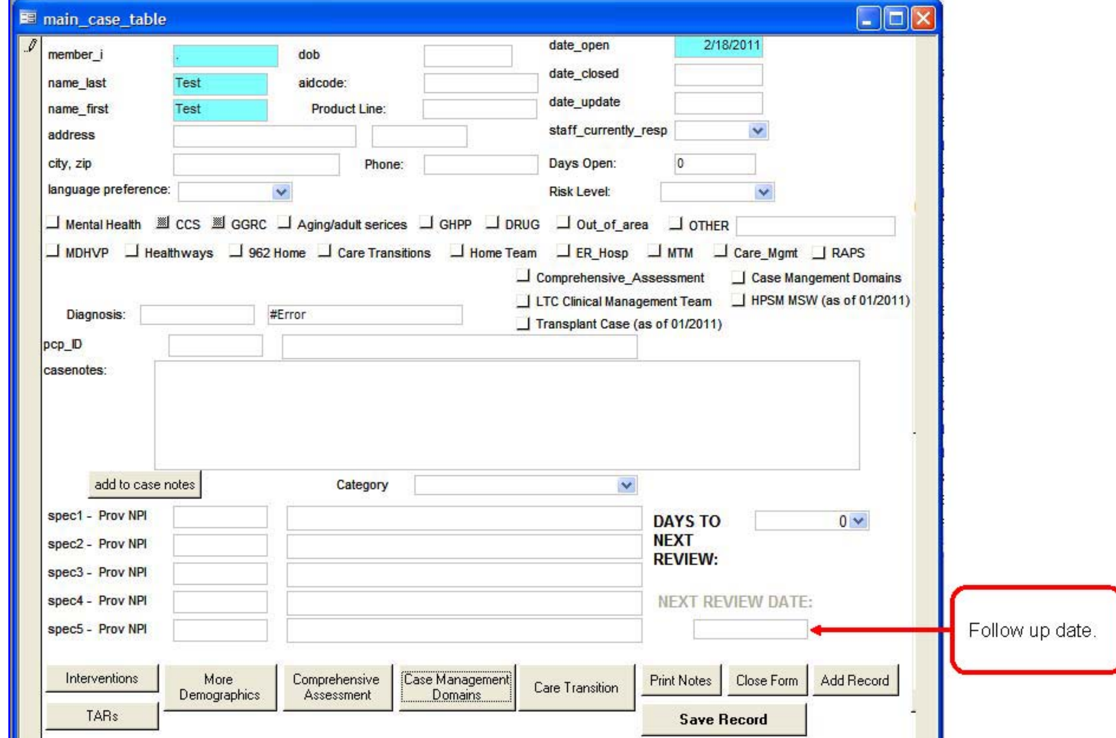
a. Describe the MAO's structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.)

Internally, HPSM's structure for communication is facilitated through a combination of electronic communication using two main databases, HEALTHsuite Membership database and the Care Coordination database, and personal interaction (face to face meetings, printed communication). In 2011, HPSM went live with a new information management system. This new system (HEALTHsuite) allows internal staff to document member interactions through the use of the membership database. An image of the functionality used to document member interactions follows. In addition, HPSM maintains a Care Coordination Database where the Health Risk Assessments (HRA), comprehensive assessment, individualized care plans (ICPs) and the documentation of the Interdisciplinary Care Team live. An image of the Care Coordination database follows. Weekly meetings of the Medical Management Team, standard organizational committee meetings and ad hoc meetings round out the communication structure for internal staff. To the extent possible and if germane, PCPs and clinical personnel from outside agencies are included in these meetings. (Please see the detailed descriptions in Elements 3, 4, 5, 7 and 8 for the specifics of how communication in these meetings is handled.)

Below is an image from HPSM's HEALTHsuite member database, where interactions with members are maintained.



The image below illustrates the main page of HPSM's Care Coordination database.



For 2012, external communications between HPSM, members and providers will continue to rely heavily on face to face, telephonic interaction and print media (member and provider newsletters) as we slowly transition our members and providers to electronic and web based communication.

An HPSM Communications Survey was conducted in 2010 to determine the level of online activity by members; level of acceptance of online/text communications; and the quality of materials sent by HPSM for readability/content. Sixty six percent (66%) of the respondents had no email access and eighty eight percent (88%) preferred to receive information through the mail. In addition, 17 focus groups were conducted in late 2010 with 128 HPSM members that included asking what are consumers' preferred methods of communication with HPSM. Again, the majority of participants reported a preference for receiving information by mail. These surveys influenced our planning for 2011 and 2012. Also in 2010, HPSM contracted with a vendor to conduct a heuristic evaluation of HPSM's website to assess its usability for members, providers and internal staff. As a result of those findings, HPSM has completely redesigned its corporate website to enhance usability for our members and providers. A screenshot of HPSM's redesigned website follows this paragraph. Further, the information tool that HEALTHsuite provides for internal staff is the only one being rolled out initially, this robust

new system also includes a web portal for providers (eHEALTHsuite) with numerous interactive communication features. HPSM intends to roll out this facet of HEALTHsuite to providers over the next year. Currently, providers will use the portal for eligibility, verification of claim and authorization status and claims submittal. We look forward to opening up the additional features of interactive communication for providers in 2012.

The following image illustrates HPSM's corporate website, recently redesigned to enhance usability for our members and providers.

Also planned for 2012, HPSM is currently working with a vendor to conduct an enterprise wide member communications audit. The audit will explore member touch points across all modalities, analyze performance, consider cost and define opportunities for HPSM to streamline efforts, improve impact and deliver efficiencies in process and cost. This effort will be included in the 2012 Marketing Plan.

While multiple internal surveys, including those noted above, have demonstrated that many of our members, including our CareAdvantage SNP members, still rely on more traditional communication methods, we also know that anecdotally, our physicians are reporting at meetings such as the Physician Advisory Group (PAG) or the Quality Assessment and Improvement Committee (QAIC) that more of their patients, including their CareAdvantage patients, are coming in with smart phones or computer printouts asking about their health conditions, publicized treatments, and so on. Therefore, HPSM intends to work in 2012 and ahead on strategies that involve social media (twitter, Facebook, etc), that might resonate with a growing proportion of our members, so that we include any avenue to reach members on preventive health education, HPSM CareAdvantage benefits, and so forth with our goal to improve member health outcomes.

b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies

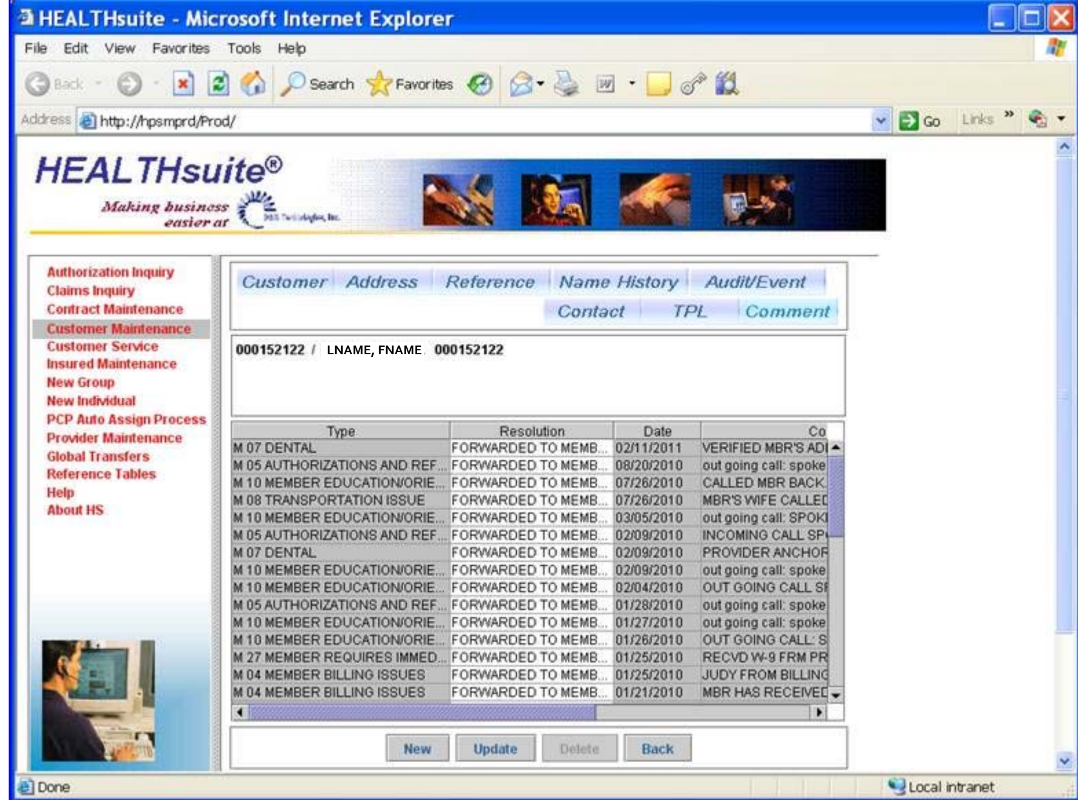
HPSM connects with members, providers, the community, and State and Federal agencies using various communication methods. HPSM maintains a website and produces newsletters to provide information to our members, providers and the general community. HPSM has an active Marketing Department that includes a Communication Specialist to coordinate newsletter mailings, approve content, and oversee the distribution of required member materials. HPSM's Compliance and Regulatory Affairs Department maintains a close liaison relationship with the State Department of Health Care Services and the CMS Regional Office.

As described below, HPSM maintains both general and targeted communications systems to address member and provider concerns related to members' care management. Detailed examples are included where appropriate.

- A general customer service line for member inquiries related to benefits, PCP assignment, provider network, cost-sharing requirements, and eligibility. With 29% of the CareAdvantage membership Asian/Pacific Islander and 14% Hispanic, HPSM Member Services has a talented bilingual and bicultural staff providing quality and personal service. The CareAdvantage Navigators include Tagalog, Spanish, Russian, Cantonese and Mandarin speakers and HPSM contracts with an interpretive call service for all other languages. All communications with members are documented in the comments function of the membership database. The organization staff, including care management personnel, have access to this function. The Navigators are trained to alert medical management personnel via

email or if more urgent with a phone call when identifying member medical management issues.

Below is an image from the member database, where interactions with members are maintained.



- A Nurse Advice Line for basic clinical guidance related to active health concerns. HPSM contracts with a Nurse Advice line which is available to members 7 days a week, 24 hours a day. The service has bilingual capacity and has access to our membership database. The Nurses document conversations and outcome of the call. Daily, the Nurse Advice Line sends HPSM the call log report which is made available to care management personnel, and is reviewed regularly by senior clinical staff for oversight to ensure appropriate quality of care as well as to assist with cases for providers where members may have had problems with regular access to care.

Below is a sample triage disposition summary report from Nurse Response, HPSM's 24-hour Nurse Advice Line.

Nurse Response
Quality Nurse Telehealth Services

Health Plan San Mateo
Triage Disposition Summary
January-2011

Count of Disposition Description		
NetworkName	Disposition Description	Total
HPSM - Coastside Clinic	Provide Home/Self Care	2
	Provide Information or Advice Only	1
	See Provider within 24 hours	1
HPSM - Coastside Clinic Total		4
HPSM - Daly City Clinic	Activate EMS 911	4
	Call Provider Immediately	2
	Call Provider within 24 Hours	1
	Provide Home/Self Care	14
	Provide Information or Advice Only	5
	See ED Immediately	20
	See Provider within 24 hours	23
	See Provider within 4 hours	4
	See Provider within 72 Hours	3
HPSM - Daly City Clinic Total		76
HPSM - Daly City Youth Health Center	See Provider within 24 hours	1
	See Provider within 72 Hours	1
HPSM - Daly City Youth Health Center Total		2
HPSM - Fair Oaks Clinic	Activate EMS 911	4
	Call Provider When Office is Open	1
	Call Provider within 24 Hours	4
	Provide Home/Self Care	1
	Provide Information or Advice Only	2
	See ED Immediately	10
	See Provider within 2 Weeks	1
	See Provider within 24 hours	8
	See Provider within 4 hours	4
HPSM - Fair Oaks Clinic Total		35
HPSM - Fair Okas Children's Clinic	Activate EMS 911	2
	Call Provider Immediately	1
	Call Provider within 24 Hours	1
	Provide Home/Self Care	26
	Provide Information or Advice Only	2
	See ED Immediately	21
	See Provider within 2 Weeks	1
	See Provider within 24 hours	16
	See Provider within 4 hours	7
	See Provider within 72 Hours	5
HPSM - Fair Okas Children's Clinic Total		82
HPSM - OB-GYN Clinic Main Campus	Activate EMS 911	2
	Provide Home/Self Care	1
	Provide Information or Advice Only	1
	OB Triage Immediately	1

- A member newsletter offering general information on plan benefits and health education topics. HPSM prints and mails to all members a quarterly newsletter called HealthMatters. The newsletter contains general health related articles that stress primary and secondary prevention topics. The newsletter also includes information on how to access HPSM services and personnel.

The images below provide examples of our Spring 2011 member newsletter, HealthMatters, in both English and Spanish.

health matters

HealthPlan OF SAN MATEO

Health Plan of San Mateo Member Newsletter—Contains Health or Wellness or Prevention Information

Spring 2011

Shake the Salt Habit

A dash of salt can help make food taste good. But too much can ruin a meal.

Salt contains sodium. Too much can make you sick. The more sodium you eat, the higher your blood pressure goes. High blood pressure is linked to heart disease and stroke.

So how much is too much? Everyone should limit sodium intake to less than 1,500 milligrams a day. That is a little more than half a teaspoon of salt.

There are many ways to cut back. One easy way to start? Take the saltshaker off the table.

That will help, but most of the sodium we eat is not added at meals. It is hidden in the processed foods we eat.

Foods that can be high in sodium include:

- Soups
- Sauces
- Condiments, such as ketchup and salad dressing
- Canned foods

more on page 4

Immunizations

New Requirements for Grades 7 to 12

This coming school year (2011–2012) which begins in September, all students in grades 7 through 12 are required to get a whooping cough shot, called Tdap. Preteens and teens entering any of these grade levels must have proof of receiving this shot before the school year begins. Students who do not have proof of the Tdap vaccination will not be allowed to start school.

What is ... Tdap is ... first rec... It safely ... disease... whoop... Whoop... that ca... deadly...

In this issue:

2 Dr. G: How to help a loved one with depression

3 Dining out? Try these tips to eat well

4 Stay healthy with www.hpsm.org

la salud importa

HealthPlan OF SAN MATEO

Boletín Para Miembros del Health Plan of San Mateo—Contiene Información de Salud, Bienestar o Prevención

Primavera 2011

Olvídese de la Sal

Una pizca de sal puede dar más sabor a la comida. Pero demasiada sal puede arruinarla.

La sal contiene sodio. Demasiada sal puede enfermarlo. Mientras más sodio consuma, más alta será su presión arterial. La presión alta está ligada a la enfermedad cardiaca y embolio.

Entonces, ¿cuánto es demasiado? Todos deben limitar la cantidad de sal a menos de 1,500 miligramos por día. Eso es un poquito más de media cucharadita de sal.

Hay muchas formas de reducir su uso. ¿Una forma fácil de empezar? Quite el salero de la mesa.

Eso ayudará, pero la mayoría de la sal que ingerimos no se añade al comer. Está escondida en los alimentos procesados que comemos.

Entre los alimentos con alto nivel de sodio están:

- Las sopas.
- Las salsas.
- Los condimentos como catsup y aderezos de ensalada.

más en la página 4

Inmunización

Nuevos Requisitos para los Grados 7 a 12

El próximo año escolar (2011–2012) empieza en septiembre y todo estudiante de 7° a 12° grado debe recibir la vacuna de tos ferina, llamada Tdap. Todos los jovenes que entren a cualquiera de estos grados deben tener prueba de haber sido vacunados antes de empezar el año escolar. Los que no tengan dicha prueba no podrán empezar la escuela.

¿Qué es la vacuna Tdap?

Tdap es un refuerzo de una vacuna que los niños reciben antes de comenzar la escuela (kindergarten). Da protección segura contra tres enfermedades peligrosas: el tétanos, la difteria y la tos ferina (también llamada pertussis). La

más en la página 6

En esta edición:

2 Dra. G: Cómo ayudar a un ser querido con depresión

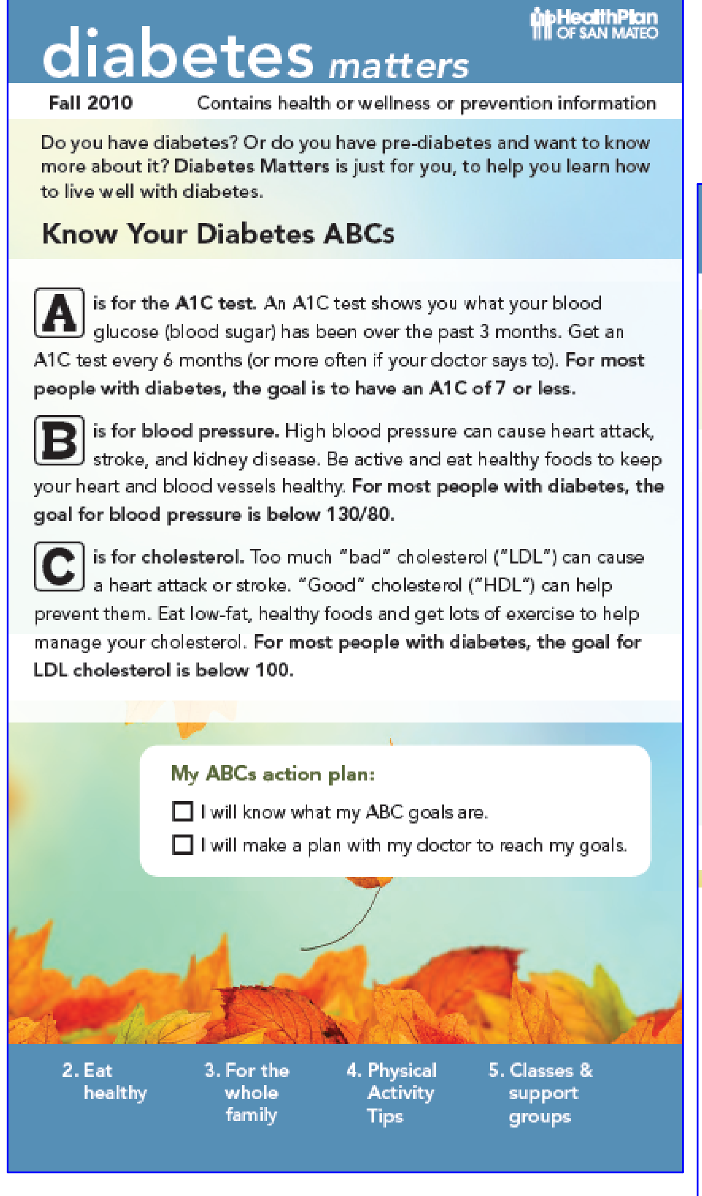
3 Consejos para que coma sano cuando salga a comer

4 Conserve su salud con www.hpsm.org

6 Tome estos pasos para evitar las caídas

- A focused member newsletter for patients with diabetes containing specific information and tips for members living with diabetes. This newsletter, called Diabetes Matters, is mailed twice a year to all members diagnosed with diabetes.

  The images below provide examples of our Fall 2010 newsletter for members with diabetes, Diabetes Matters, in both English and Spanish.



HealthPlan OF SAN MATEO

diabetes *matters*

Fall 2010 Contains health or wellness or prevention information

Do you have diabetes? Or do you have pre-diabetes and want to know more about it? **Diabetes Matters** is just for you, to help you learn how to live well with diabetes.

Know Your Diabetes ABCs

A is for the **A1C test.** An A1C test shows you what your blood glucose (blood sugar) has been over the past 3 months. Get an A1C test every 6 months (or more often if your doctor says to). **For most people with diabetes, the goal is to have an A1C of 7 or less.**

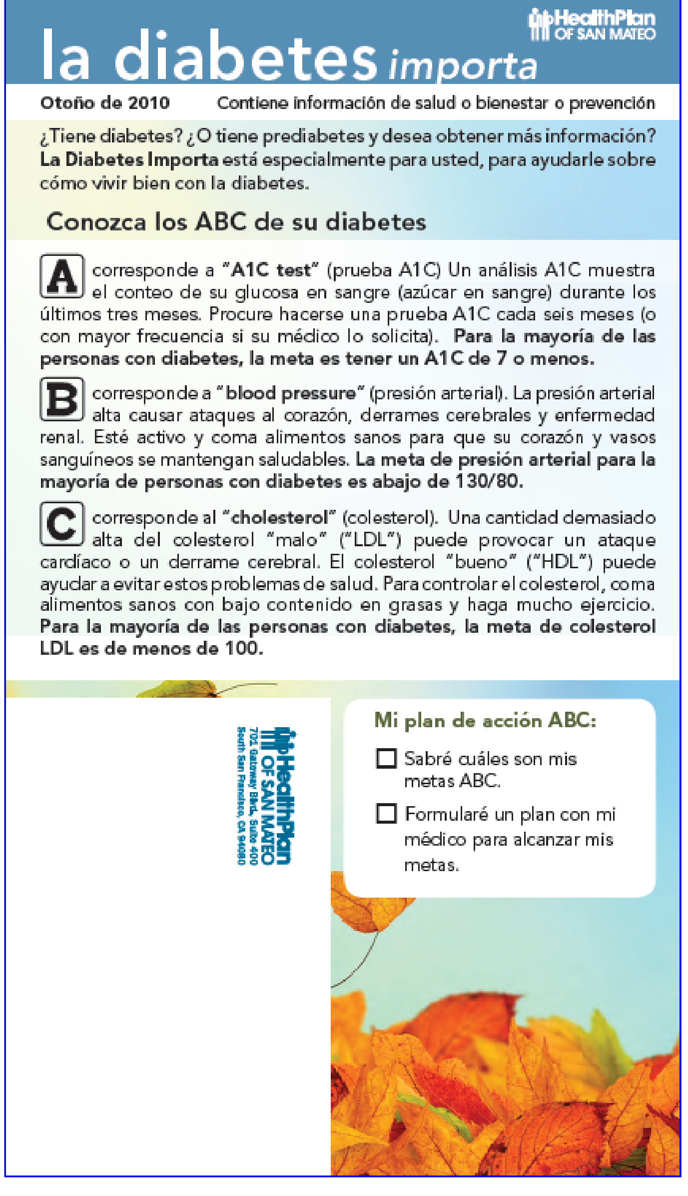
B is for **blood pressure.** High blood pressure can cause heart attack, stroke, and kidney disease. Be active and eat healthy foods to keep your heart and blood vessels healthy. **For most people with diabetes, the goal for blood pressure is below 130/80.**

C is for **cholesterol.** Too much "bad" cholesterol ("LDL") can cause a heart attack or stroke. "Good" cholesterol ("HDL") can help prevent them. Eat low-fat, healthy foods and get lots of exercise to help manage your cholesterol. **For most people with diabetes, the goal for LDL cholesterol is below 100.**

My ABCs action plan:

- ☐ I will know what my ABC goals are.
- ☐ I will make a plan with my doctor to reach my goals.

2. Eat healthy
3. For the whole family
4. Physical Activity Tips
5. Classes & support groups



HealthPlan OF SAN MATEO

la diabetes *importa*

Otoño de 2010 Contiene información de salud o bienestar o prevención

¿Tiene diabetes? ¿O tiene prediabetes y desea obtener más información? **La Diabetes Importa** está especialmente para usted, para ayudarle sobre cómo vivir bien con la diabetes.

Conozca los ABC de su diabetes

A corresponde a **"A1C test"** (prueba A1C) Un análisis A1C muestra el conteo de su glucosa en sangre (azúcar en sangre) durante los últimos tres meses. Procure hacerse una prueba A1C cada seis meses (o con mayor frecuencia si su médico lo solicita). **Para la mayoría de las personas con diabetes, la meta es tener un A1C de 7 o menos.**

B corresponde a **"blood pressure"** (presión arterial). La presión arterial alta causar ataques al corazón, derrames cerebrales y enfermedad renal. Esté activo y coma alimentos sanos para que su corazón y vasos sanguíneos se mantengan saludables. **La meta de presión arterial para la mayoría de personas con diabetes es abajo de 130/80.**

C corresponde al **"cholesterol"** (colesterol). Una cantidad demasiado alta del colesterol "malo" ("LDL") puede provocar un ataque cardíaco o un derrame cerebral. El colesterol "bueno" ("HDL") puede ayudar a evitar estos problemas de salud. Para controlar el colesterol, coma alimentos sanos con bajo contenido en grasas y haga mucho ejercicio. **Para la mayoría de las personas con diabetes, la meta de colesterol LDL es de menos de 100.**

HealthPlan OF SAN MATEO
701 Gateway Blvd, Suite 400
South San Francisco, CA 94080

Mi plan de acción ABC:

- ☐ Sabré cuáles son mis metas ABC.
- ☐ Formularé un plan con mi médico para alcanzar mis metas.

- A general Provider Services line for provider inquiries. HPSM maintains a Provider Services Department. There is not only a direct line for provider questions, but the Department also assigns Provider Services Representatives for each hospital and physician. These representatives visit provider offices frequently to offer assistance and provide guidance.
- A provider newsletter offering general information on provider-centered plan initiatives and updates. This newsletter, called HealthMattersMD is published twice a year and sent to the entire provider network.

The image below provides an example of HPSM's Winter 2010 provider newsletter, HealthMattersMD.

health matters MD

Health Plan of San Mateo Provider Newsletter

Winter 2010

From the Desk of the Medical Director

HPSM and You—How Providers Can Become More Involved With Our Work

Whenever anyone asks me who I work for at Health Plan of San Mateo, there's a short answer and a more detailed answer. While the latter involves our contracts with the state and federal governments, the short answer is clear—our patients/members. If they continue with "Well, how do you do that?" the only answer is, "Through you, our physicians and providers."

HPSM could not care for our members, and meet their needs, without the primary care and specialty physicians and their office staffs who deliver health care to our members. Along with all our other providers—hospitals, nursing homes,

more on page 2

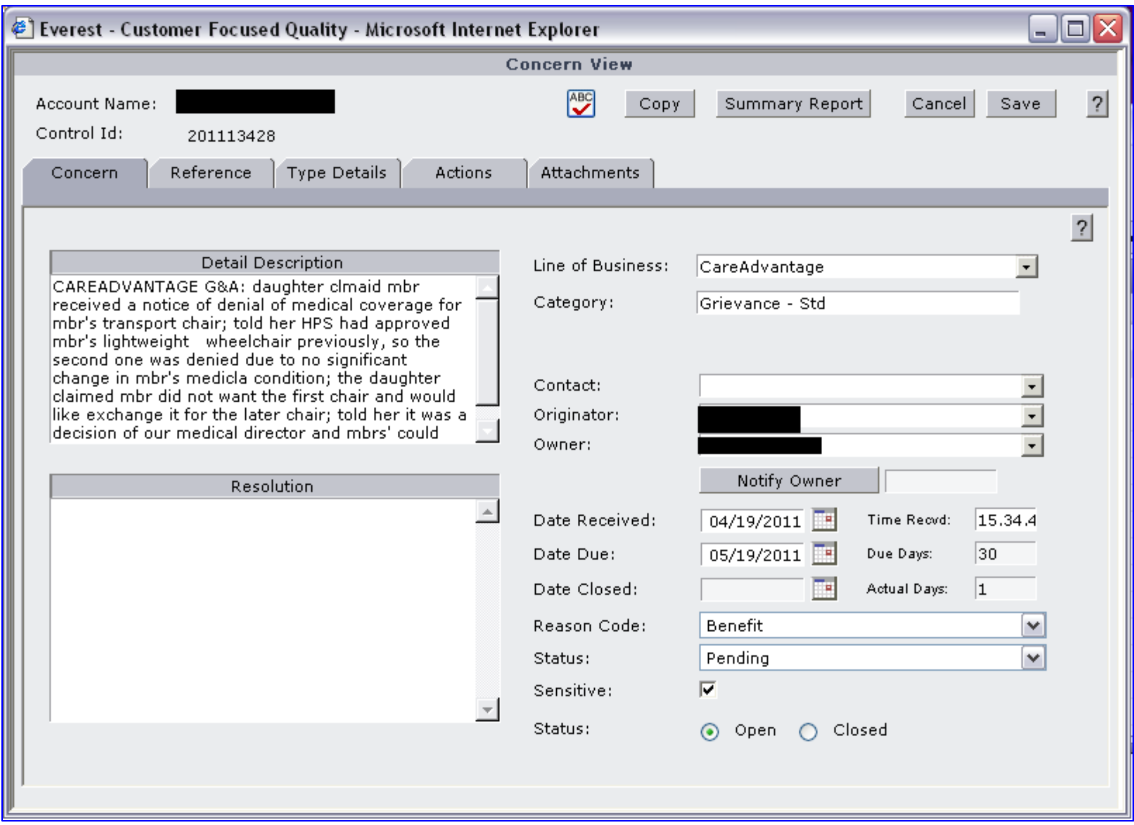
In this Issue:

3 New Spanish Shapedown program successful
4 Nurse advice line provides 24-hour support
6 Incentive for annual well visits: children and teens

HealthPlan OF SAN MATEO

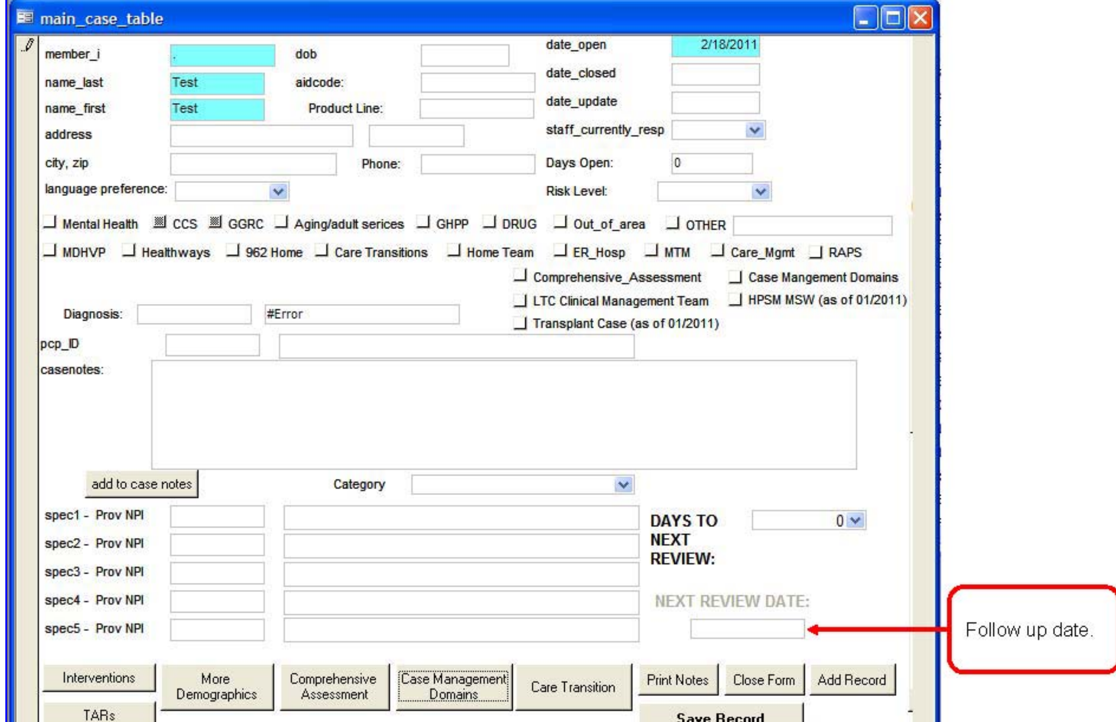
- HPSM operates a grievance and appeals system that is available to take, investigate, and resolve member and provider complaints. Grievance and Appeals (G & A) Specialists use a data system (Everest) to document member grievances and appeals and all subsequent actions pertaining to the member. Everest is a complaint management, customer service, and corrective action software by Lynk Software, Inc. The call center team through the membership database is able to identify a caller's issue as a possible grievance and the caller's information is uploaded automatically into Everest for intervention by the G & A Specialists.

  The image below illustrates HPSM's grievance management system.



- Care Coordination Database. – This database is the central repository of the care management activities of HPSM. Health Risk Assessments, individualized care plans (ICPs) and the documentation of the Interdisciplinary Care Team live in this database. Interactions with the PCP are recorded and maintained here. Interactions with the member are documented and maintained here. All medical management staff has access to the database allowing informed interactions to take place between the members of the internal ICT. This database is also available to the visiting physician through a HIPAA compliant web based server.

An image of the main page of the Care Coordination database follows.

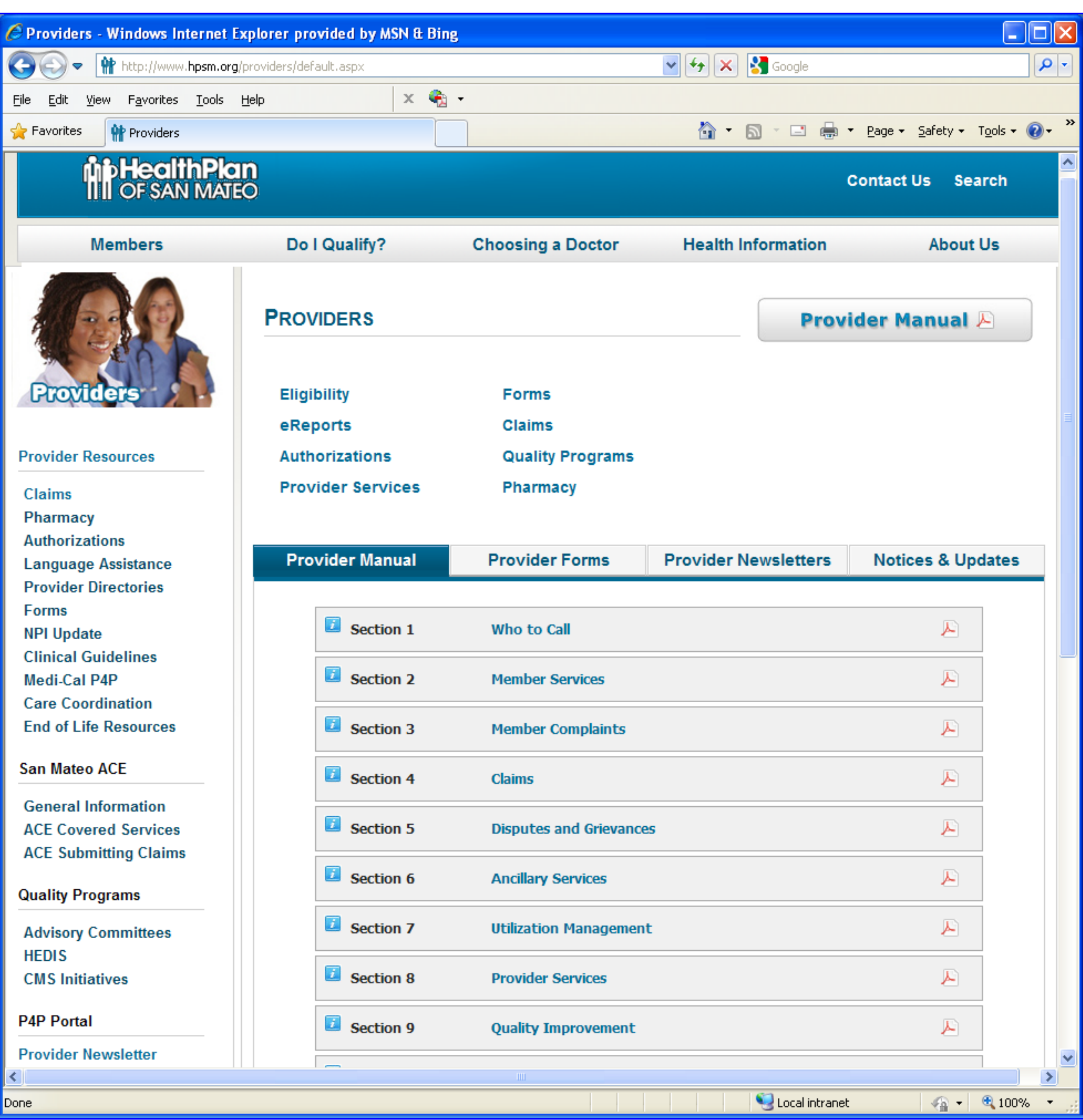


For managing individual members' health and social service needs, HPSM also facilitates communication among the ICT, plan providers, and members and/or their family and caregivers, HPSM also engages in the following activities:

- For all CareAdvantage members who are hospitalized or residing in a skilled nursing facility, HPSM case managers conduct on-sight review of members, including through review of patient medical records, to track members' status and determine appropriate levels of care.
- HPSM conducts no less than bi-weekly care coordination meetings where the members of the ICT on HPSM staff review high-risk cases and discuss appropriate steps for the Care Coordination staff to undertake.
- As appropriate to ensure that relevant stakeholders have all necessary information, HPSM staff will engage in direct communication with stakeholders via conference calls, email, fax, and other written correspondence.
- ICT members establish a schedule for conducting conference calls or in-person meetings to review active cases, as necessary. In addition, the ICTs may conduct ad hoc conference calls or meetings in urgent or unusual cases. (For more detail on ICTs for the various programs at HPSM, please see element 4.)

HPSM's major communication with the public is via its website, www.hpsm.org, which includes a wide variety of resources of health information, including health education, provider resources, health benefits etc., as well as information about who HPSM, our governing body, leadership staff, and so forth. Moreover, HPSM has numerous links to other health agencies, clinical guidelines, etc, that the public can find useful if searching for validated health information. In addition, HPSM regularly creates press releases about notable results or incidents occurring at HPSM. These are sent to major news sites as well as to our providers via e-mail, fax blast, and so forth.

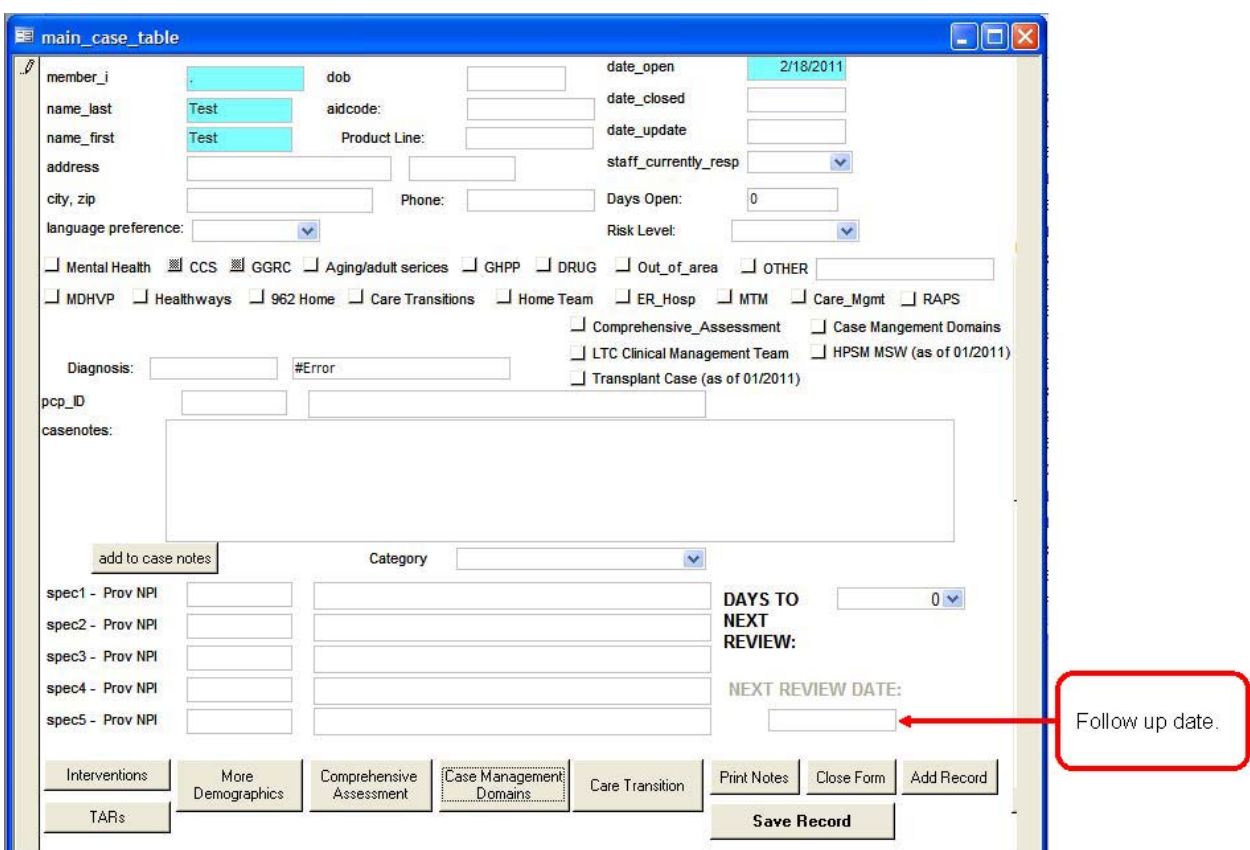
The following is an image of the provider page on HPSM's website, www.hpsm.org.



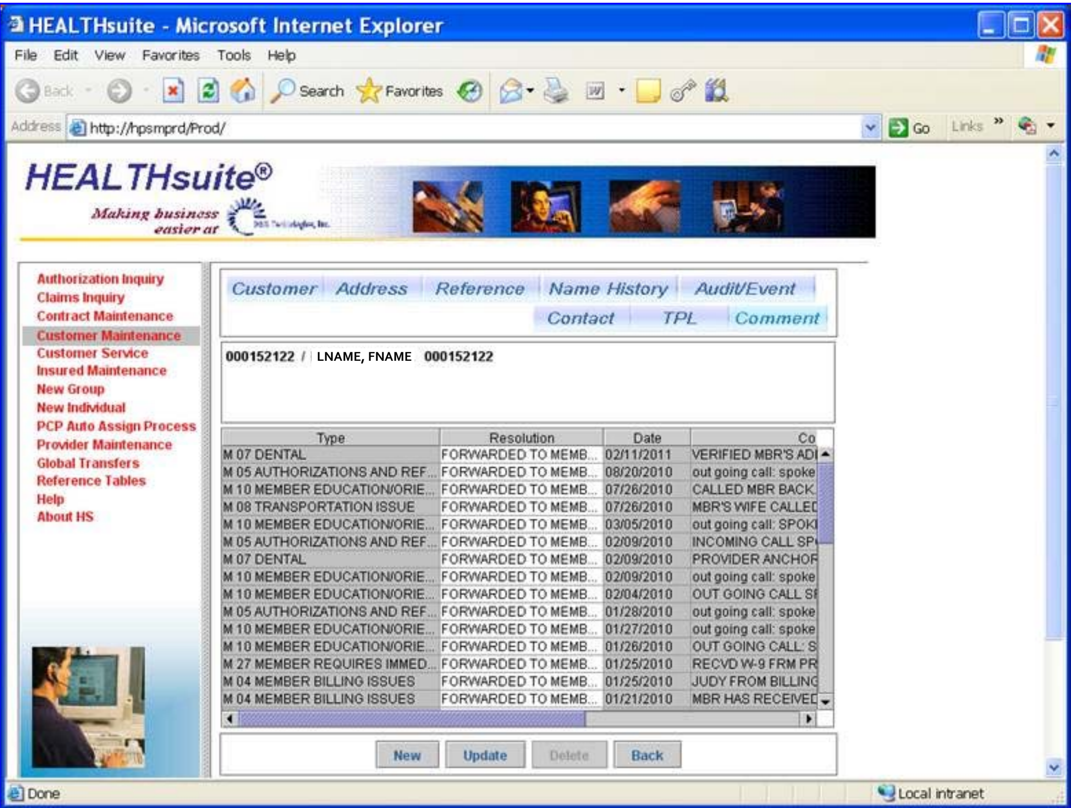
c. Describe how the MAO preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.)

HPSM recognizes the importance of preserving all information related to the interactions of staff, members and providers influencing the management of care for our members. Staff is able to see all information about a member and their care through the two main databases where these interactions are regularly documented, the Membership and the Care Coordination Databases (screenshots below). Every interaction, whether it is with a member, the PCP, other providers or with internal staff is recorded in one or the other of these two databases. Most staff interactions at HPSM with members or providers are via the telephone. Each of these interactions are summarized and logged either during or immediately after the interaction so that the goal of documentation of 100% of interactions is achieved. As stated above, these two repositories maintain all communications and care management activities. The entire system is backed up daily and archived.

The following is an image of the main page of the Care Coordination database.



Below is an image from the member database, where interactions with members are maintained.

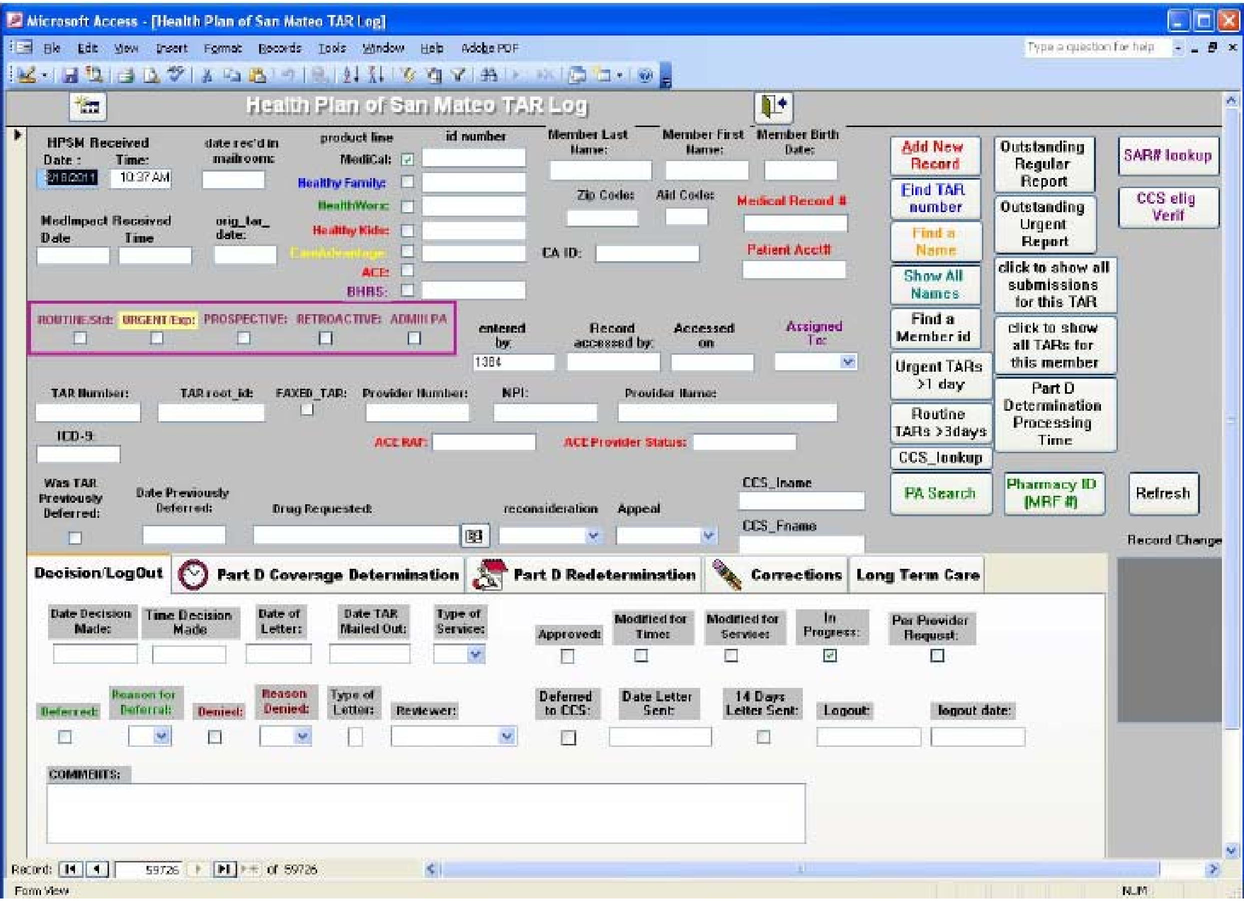


In addition there are several other methods of handling and storing of member activity as described below.

- All calls to the call center are recorded via Avaya, HPSM's automated call distribution (ACD) software. Thus, when a member calls, they are informed that the call may be recorded for training and quality purposes, and each call is recorded. If there is any question about the call, the supervisor, manager or director can listed to it and assess the issues. Moreover, if, for some reason there was a failure in documentation, the call remains available to be able to document.

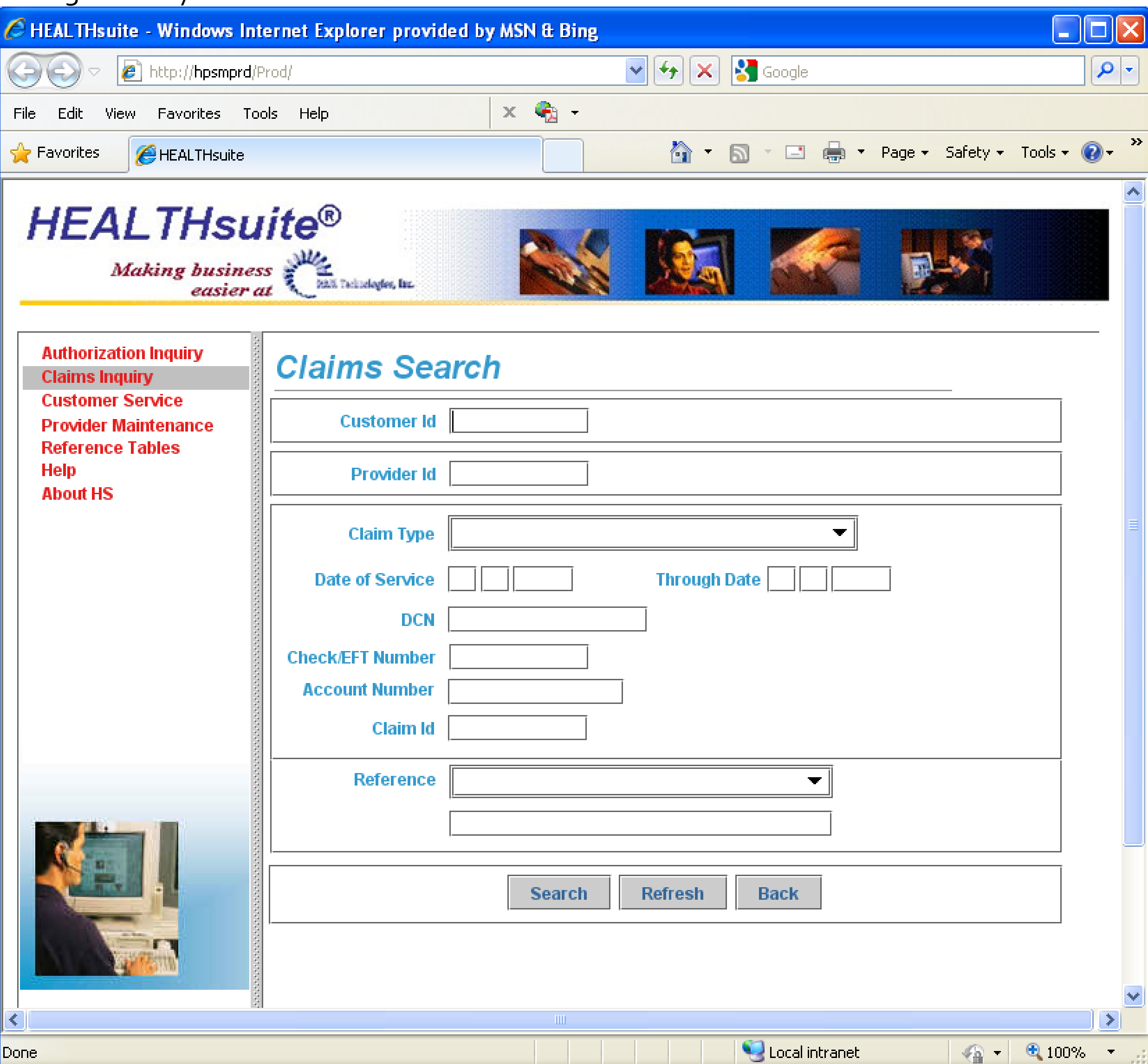
- Any requests for prior authorization of medical services are handled via electronic document requests, called treatment authorization requests, or TARs. These TARs are not only kept in a TAR database (screenshot below), but also scanned into HPSM's document imaging database, DOCSTAR. This allows for their backup and also for their retrieval as an image, not just as a data set.

The following image represents HPSM's TAR Log.

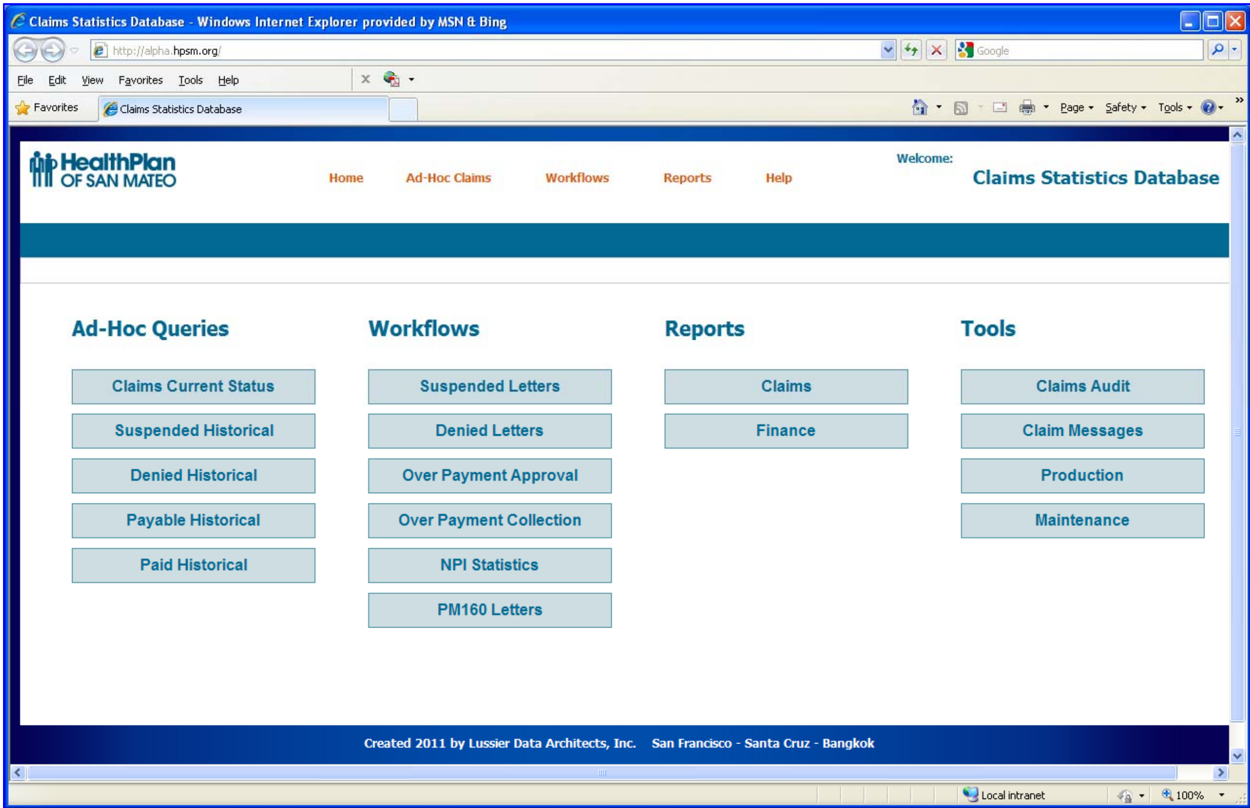


- Claims and related information is available as well, in multiple systems. These include the HEALTHsuite Claims management system and a separate Claims Statistics Database (ClaimStat). Screenshots of both are included below. Further, if the claims are submitted as paper claims, they and their written supporting documentation are scanned in DOCSTAR.

The image below illustrates the initial Claims Inquiry screen of HPSM's HEALTHsuite claims management system.



The image below represents the main page of HPSM's Claims Statistics database (ClaimStat).



- The bi-weekly Care Coordination meetings and all organizational committee meetings such as the Physician Advisory Committee, Quality Assessment and Improvement Committee, any Interdisciplinary Committee meetings, and so forth all have recorders who take written minutes, which are subsequently made available as appropriate for each meeting.

- HPSM offers numerous trainings, for members, providers, outside agencies and internal staff. All such trainings require a written sign in sheet for attendees, or an attestation, depending on the topic, that the signee has attended/completed the training.

d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness

The Director of Marketing and the Communication's Specialist have oversight responsibility for monitoring and evaluating communication effectiveness. The current Director of Marketing has over 10 years of communications experience. With a Bachelor's Degree in Communications, a Master's Degree in Public Administration and work experience as an Editor, Communications Officer, Communications Manager and an Internal Communications

Manager, he has worked for private and public entities. He has extensive communications management experience in writing, editing, public relations, media relations, internal communications, printing and web design.

The Communications Specialist has over 15 years in health related communication experience and has a Bachelor's Degree in Social Welfare and a Master's Degree in Public Health. Her experience ranges from project management of health communications, healthcare quality improvement and assisting in collaborative efforts between health plans, medical groups and clinic participation in disease management and patient education initiatives.

In collaboration with senior management, the Marketing Department monitors and evaluates communication effectiveness by conducting communication audits as exampled in factor a. above and included as Appendix D: HPSM Communications Survey 2010, member and provider satisfaction surveys, commissioning usability testing of our website (included as Appendix E) and focus groups. The Marketing Department develops an annual marketing plan which includes strategies to enhance communication effectiveness.

Several standing committees review and discuss HPSM performance, and also provide a formal, documented forum for provider, member, or general public input, including:

- The San Mateo Health Commission
- The Peer Review Committee/ Physician Advisory Group
- The Quality Assessment and Improvement Committee
- The Consumer Advisory Committee

Examples are provided below with the first page of recent minutes for each committee.

April 13, 2011 minutes of the San Mateo Health Commission

DRAFT

SAN MATEO HEALTH COMMISSION and
SAN MATEO COMMUNITY HEALTH AUTHORITY
Meeting Minutes
April 13, 2011 – 12:30 p.m.
Health Plan of San Mateo - Boardroom
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

AGENDA ITEM: 4.5
DATE: April 13, 2011

Commissioners Present: Lorraine Auerbach, Jeanette Aviles, M.D., David Boesch, Barbara Erbacher, Teresa Guingona Ferrer, Don Horsley, Raymond Jajeh, Pharm.D., Katy Rhoades, Stephen Scheifele, M.D., Adrienne Tissier, Chair

Commissioners Absent: David Amann

Counsel: David Levy

Staff Present: Maya Altman, Charlene Barairo, Chris Baughman, Jeff Buck, Corinne Burgess-Greenaway, Melissa Casey, Jean Dail, Ellen Dunn-Malhotra, Anita Harris, Russell Hoyle, Cindy Lem, Francine Lester, Khoa Nguyen, Ron Robinson, Scott Slayton, Jose Santiago, Carolyn Thon, Lia Vedovini, and Eben Yong.

1. **Call to order/roll call**
   The meeting was called to order at 12:35 p.m. by Commission Chair Adrienne Tissier. A quorum of the Commission was present.

2. **Public Comment**
   There were no public comments.

3. **Approval of Agenda**
   The agenda was approved as presented. **M/S/P.**

4. **Consent Agenda**
   The consent agenda was approved as presented. **M/S/P.**

5. **Specific Discussion/Action Items**

   5.1 **Discussion/Action on Audited Financial Statements for the Twelve-Month Period Ending December 31, 2010 by Moss Adams.**

Ms. Altman introduced Chris Pritchard and Rianne Suico from Moss Adams who presented the 2010 financial audit. A copy of the presentation handout is attached as part of this record.

Mr. Pritchard noted that Moss Adams is issuing an unqualified audit opinion for HPSM's financial statements, which is the best opinion that can be provided. He reported a fully adjusted set of financial statements was received from management. Based on audit procedures, the auditor's opinion is those financial statements are reasonably stated. Mr. Pritchard verbally reviewed the financial statements and noted some of the audit procedures performed.

Ms. Suico reviewed the presentation, noting the report shows the comparison from 2009 to 2010. She reviewed asset composition noting that the gain between the two years was due to increases in capitation rates from the State and the addition of Long Term Care (LTC) benefits

1 of 6 April 13, 2011 Commission Meeting Minutes

December 1, 2010 minutes of the Peer Review Committee/Physician Advisory Group

AGENDA ITEM: 4.5

DATE: April 13, 2011

PEER REVIEW COMMITTEE
PHYSICIAN ADVISORY GROUP
Wednesday, December 1, 2010 7:30 a.m.
San Mateo Medical Center
222 West 39th Avenue
San Mateo, CA

Members Present: Drs. Manuel Luna, Tali Bashour, Vincent Mason, Janet Chaikind, James Hutchinson, Philip Eastman, and Randolph Wong, Tom Stodgel, and Roberto Diaz

Members Excused: Kamal Shamash

HPSM Members Present; Mary Giammona, M.D., Fiona Donald, M.D., Richard Moore, M.D., Evelyn Charriez, Paul Dela Cruz, Denise Gurgens, Scott Slayton

1. Call to Order by Mary Giammona, M.D
2. Approval of October 6, 2010 Minutes by All Members
3. Agenda Approved by All Members
4. PRC Closed Session - Called to Order
   4.1. Credentialing Update
   4.2. Review of Pending Providers
   4.3. Dr. Carcamo Update
5. Discontinue Closed PRC Session – Open PAG Session
6. PAG – Old Business – None
7. New Business
   7.1. CMS Star System - Dr. Donald reported that she had attended the consulting session with Ingenix, the consulting firm that was hired to devise a plan for the Star System to improve our quality ratings. The payment structure that we receive from CMS over the coming years will be dependent on the quality ratings that the health plan has. The rating system is from 1 star to 5 stars. We are currently rated at a 3 star plan. Maya mentioned that starting in 2012 we will be able to get additional funding based on improvement of our ratings. Starting at 3 stars you get additional funding of a bit over 1%. At 4 stars the plan will get additional 4% and 5 stars we would get additional 5%. Most plans are at 3 star categories. There are around 5 plans in the country that are 5 stars and around 20 that are 4 stars. The vast majority are 3 stars though there are

1

February 16, 2011 minutes of the Quality Assessment and Improvement Committee

DRAFT

QUALITY ASSESSMENT AND MPROVEMENT COMMITTEE
Wednesday, February 16, 2011 – 6:00 p.m.
Peninsula Medical Center
1501 Trousdale Drive
El Camino Room
Burlingame, CA 94010

AGENDA ITEM: 4.6
DATE: April 13, 2011

~ Meeting Summary ~

Members Present: Drs. Maria Osmeña, Nancy Morioka-Douglas, Dorothy Vura-Weis, Ellen Sullivan, Susan Ehrlich, Raymond Jajeh, Stephen Scheifele; Barbara Erbacher

Member Excused: Eric S. Perez

HPSM Members Present: Mary Giammona, M.D., Evelyn Charriez, Fiona Donald, M.D., Denise Gurgens

HPSM Member Excused: Maya Altman

Guest: HPSM Health Educator, Mara Bravo

1.0 Call to Order
Meeting called to order at 6:00 p.m.

2.0 Approval of Minutes
December 8, 2010 Meeting minutes approved

3.0 Approval of Agenda
Agenda was approved as presented.

4.0 Old Business—None

5.0 New Business

5.1. Update on CMS STAR System - Dr. Giammona reported that we have a new Health Educator, Mara Bravo, and she will be working on a number of programs that will help us raise our Star rating. Medicare has now decided that it will grade us and pay us not on risk assessment but on how we are doing in quality and they will determine how we are doing by the Star rating. There are many different areas where they will be counting our stars. Some of them are related to HEDIS, self reported measures that the members are asked and pharmacy data that is sent. Our Quality department has been designated to improve a number of the HEDIS ratings. We have selected the ones that we think we can improve upon the most. The main one is a group of Diabetes measures. Other measures are Breast Cancer Screening and Rheumatoid Arthritis.

5.2. Projects to consider - Mara reported that she has researched member-focused initiatives dealing with educational resources which were stand-alone, but she thought that they would work better if they were joined with other projects. One of these measures would be a Diabetes program similar in structure to the weight management of the Shapedown program. The providers could refer the member directly to this program. Another component would be a provider toolkit. Some of

March 3, 2011 minutes of the Consumer Advisory Committee

AGENDA ITEM: 4.4

DATE: April 13, 2011

HEALTH PLAN OF SAN MATEO
CONSUMER ADVISORY COMMITTEE MEETING
Meeting Summary
Thursday, March 3, 2011 – 12:00 p.m.
HPSM Board Room
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Members Present: Susy Castoria, Barbara Erbacher, Ed Kiryczun, Mary Pappas, Katy Rhoades, Tricia Vinson

Members Excused: Judy Garcia, Teresa Guingona Ferrer, Blaise Menez, Bruce Taylor, Lois Glover, Alison Mills

Staff Present: Maya Altman, Rob Fucilla, Daisy Lu, Mary Giammona, M.D., Edda Policar, Liliana Ramirez, Rosie Rivera, Sylvia Sharma, Scott Slayton, Jose Santiago, Carolyn Thon.

Guest: Selena Polston

1. **Call to Order**
   Katy Rhoades called the Consumer Advisory Committee meeting to order at 12:05 p.m. The Consumer Advisory Committee members introduced themselves.

2. **Public Comment/Communication**
   There was no public comment.

3. **Approval of Agenda**
   The agenda was adopted as presented.

4. **Approval of Meeting Summary for December 3, 2010**
   The Committee approved the meeting summary with one correction:
   Item 5.2, Nurse Advice Line is averaging 24 calls per *day*.

5. **Group Needs Assessment Survey**
   Daisy Liu and Liliana Ramirez provided the CAC a copy of a draft Assessment Survey which will be sent to members late March or early April. They asked the CAC to provide them with feedback and any changes/additions to the survey.

6. **Presentation of Focus Group Findings**
   Selena Polston provided the group with a written report of her findings prior to the meeting and she also gave a PowerPoint presentation on the findings of the focus groups which were conducted in July through October 2010.
   Ms. Polston facilitated 17 focus groups which included 128 members of the CareAdvantage, Medi-Cal and Healthy Kids programs.

   - 70% of the members were female and 30% male; 50% were between the ages of 65-84; the ethnic breakdown was: 43% Asian/Pacific Islander, 18% White, 35% Latino, and 4% African American.

10. Care Management for the Most Vulnerable Subpopulations

a. Describe how the MAO identifies its most vulnerable beneficiaries

HPSM defines vulnerable beneficiaries as those members with diagnoses or clinical conditions that place them at highest risk; with disabilities such as mental illness, a developmental disability, or some other physical or mental disability; and/or with complex psychosocial circumstances. As a Dual Eligible Special Needs Plan, a high proportion of HPSM's membership is considered vulnerable under this definition.

HPSM uses a variety of sources to identify its most vulnerable beneficiaries, including the following:

- Internal data sources, such as a health risk assessments, HCC risk scores, claims, encounters, utilization, pharmacy information, and results of predictive modeling;
- HPSM staff and contractors who often come into contact with members in the field or via phone;
- Network physicians, pharmacies, and other providers; and
- Referrals from community partners and agencies.

Overall, analyses show that the majority of SNP members have one or more chronic conditions, with the average risk score the member population reaching 1.35 per year. Approximately 44 percent have a mental illness diagnosis, 43 percent have diabetes, 28 percent are disabled under the age of 65, and 7 percent have developmental disabilities. Also, 47 percent are 75 years old or older, indicating a population that is or will soon be frail and facing end of life considerations.

Identification of High Risk Members Using Clinical Criteria

The defining variables for the plan's high risk and most vulnerable beneficiaries include:

- Predictive modeling algorithm for proactive identification of members- (Predictive Modeling Overview included as Appendix A.)
- RAPS/HCC score greater than 5.0
- ED visits >= 6 in past 9 months
- Hospital Recidivism list >= 3 admissions within past 9 months
- 2 or more multiple chronic diseases- CHF, DM, or COPD and /or a member in a Senior or person with disability aid code. (SPD)
- A diagnosis of ESRD
- Heath Risk Assessment (HRA) risk stratification algorithm methodology in identification of high risk members from individual comprehensive assessment (encompasses the entire population)

- Those at end of life managed by LTC clinical management team operating in nursing facilities with high volume of SNP members
- Members experiencing a care transition and identified via the dare transition process as requiring post acute care management
- Other sources of members potentially at risk for care transitions include clinical pharmaceutical reports including but not limited to those on 3 or more medications and have 2 or more chronic illnesses, members on combination drug therapy where there is a potential drug to drug adverse interaction

Through a compilation of data sources, the HPSM Senior biostatistician identifies members who are potentially high risk for a care transition who meet one or more of the above criteria noted. Data sources include, claims data, medical authorization data, pharmacy data, the Ingenix predictive model utilizing a diagnosis related grouper and pharmacy related grouper modeling, and stratification of member subjective initial health assessments which is required of all CareAdvantage SNP members. A high risk member list/spreadsheet is generated and refreshed monthly from the compilation of data sources and definition noted. This high risk member list is disseminated to the HPSM Nurse Case Managers for potential enrollment in HPSM's Care Coordination program. In addition, nursing case management has direct access to a web-base SAS report that identifies members who have a history of excessive ED utilization and hospital recidivism. This web- base SAS report includes but is not limited to an outline of each individual's ED and hospital utilization history, diagnosis, pharmaceutical history, and primary care assignment. A list of CareAdvantage members with two or more chronic conditions and on 3 or more chronic disease drugs is also analyzed monthly as potentially high risk for care transitions and eligible for the plan's care management program. The member high risk identification process is outlined in the HPSM's High Risk Identification Policy (UM-20), which is included as Appendix B.

Predictive Modeling

In 2010, HPSM implemented a predictive modeling algorithm for proactive case identification of high risk members. Predictive modeling indicators include previous hospitalizations, emergency room usage, and diagnosis information. Results of the predictive modeling are coupled with the results from the initial, annual, and/or comprehensive health assessment, as appropriate, in order to ensure that the individuals' care plans correctly reflect their risk level.

The predictive model algorithm is reviewed for continuous quality improvement to improve algorithm outcomes. The model algorithm last update revision was in August 2010. The performance of the model was assessed by calculating c statistics (or area under ROC curve) as well as sensitivity, specificity, and positive predictive value (PPV) for different cutoff points of the predicted risk in terms of percentages. The final model was created using logistic regression. The discriminatory power of our model was c= 0.72.

Monthly Care Management reports are generated that include identification of high risk members through the predictive model. This model serves as a tool to the plan to proactively

identify high risk members and the ability to provide proactive care management interventions that help maintain members in the least restrictive care setting, improvement in quality of care and health status.

Members identified through this monthly Care Management report are assigned a Nurse Case Manager to assess appropriateness for entry into HPSM's Care Coordination program. Nurse assessment includes outreach to the member, education about election into the program, and comprehensive assessment and individualized care planning, as appropriate.

High risk members are enrolled into HPSM's Care Coordination program. Individuals may be identified as high risk in a number of ways, including (but not limited to) hospitalization, admission into a nursing facility, ER utilization, PCP referral, predictive modeling, and self reporting through the initial and annual health risk assessment.

Once enrolled into HPSM Care Coordination program, a qualified Care Coordination Case Manager will conduct a comprehensive assessment via telephone. This assessment delves into members' demographic characteristics as well as their medical, cognitive, functional, and psychosocial needs.

Examples of Data Driven Strategies for Identification of Vulnerable Populations

- Predictive Modeling Memo Methodology Memo (included as Appendix A)
- HPSM's Procedure UM-20 outlining identification of high risk members for case management (included as Appendix B)
- HPSM recently initiated a High Utilizers Group (HUG) pilot to test an inter-disciplinary team-based care management model for HPSM high utilization SNP patients. As part of this project, the HPSM data analytics team identified the 200 highest utilization patients, based on recent utilization, HPSM risk adjustment score, and the other factors described above. The interventions related to HUG are described later in this section.

Examples of Other Methods for Identification of High Risk Subpopulations

In addition to the strategies described above, HPSM staff and contractors are also valuable sources for identification of vulnerable populations and members requiring additional attention. Listed below are descriptions of these methods and multiple examples:

- San Mateo County Behavioral Health and Recovery Services (BHRS) is the provider of Medicaid funded services for mentally ill members and subcontracts with HPSM to organize and provide Medicare funded services for HPSM SNP members. BHRS has multiple methods for identifying the highest risk members. One example is the ACCESS team, which connects people to the appropriate level of mental health and substance abuse treatment services. The well publicized ACCESS hotline is an important source for identification of vulnerable SNP members. HPSM clinical staff

collaborates closely with BHRS via regularly scheduled meetings and ad hoc case conferences to provide appropriate and coordinated mental health and medical care for mentally ill members. BHRS, with the help of HPSM, two years ago started a specialized clinic focusing on developmentally delayed consumers with behavioral issues (the Puente Clinic), many of whom are HPSM SNP members. This clinic provides another source for identifying especially vulnerable DD members in need of additional attention.

- HPSM employs two Nurse Practitioners as part of HPSM's Long Term Care Clinical Management program, which systematically manages provision and continuous improvement in the quality and service care provided to members in nursing facilities. Working with an HPSM physician who specializes in Gerontology, these staff also identify particularly vulnerable members.

- HPSM's contracted physicians are another source for identification of vulnerable populations, particularly physicians located at the extensive system of public hospital clinics (San Mateo Medical Center or SMMC). One SMMC clinic, the Ron Robinson Senior Care Center, sees many SNP patients and is particularly active in identifying vulnerable members in need of care management. HPSM is also helping start another SMMC clinic focusing on care for developmentally delayed consumers, called Esperanza. Once this clinic starts operations in 2011, it will be another critical identification and referral source for vulnerable members.

- HPSM employs a Care Transitions Nurse who focuses her attention on SMMC, the public hospital, ensuring appropriate transitions for inpatients. Working collaboratively with SMMC staff, she identifies vulnerable patients who require care transition management and coaching. SMMC is a major inpatient facility for HPSM SNP members.

- HPSM contracts with a UCSF physician whose expertise is primary care for developmentally disabled patients. She provides care in group homes where many HPSM SNP members with DD live. Dr. Kripke is a critical source for identifying especially vulnerable beneficiaries.

- HPSM employs a nurse who specializes in and has long experience in care for the developmentally disabled population. Out in the field visiting group homes for DD patients or in constant contact with her former employer, the regional agency responsible for providing a wide range of social services and housing services for DD consumers, she identifies particularly vulnerable DD members in need of additional care management services.

- HPSM NP staff and physician contractors also perform comprehensive physical assessments, targeting those individuals who data show have not accessed medical services in some time. Through these assessments, individuals in need of more

comprehensive service and care management have been identified, for example, home bound members, mentally ill members, etc.

- HPSM utilization review nurses assigned to the Medicaid program work in all the local hospitals. In the course of conducting concurrent reviews, they often encounter HPSM dual eligible SNP members as well, and are therefore important sources for identification of vulnerable patients in need of care management, especially for care transitions.

- A Nurse Advice Line contractor, covering all HPSM members assigned to SMMC, provides a weekly log of calls reviewed by SMMC's Medical Director, who flags SNP members who may need additional attention.

- HPSM contracted pharmacies, particularly the subset of independent pharmacies, are also critical sources for identification of vulnerable members. A few local pharmacies see a high volume of HPSM mentally ill members, provide additional services, and communicate about problem issues to HPSM staff. Other local independent pharmacies have been particularly active in the medication therapy management program and have identified vulnerable members through this program (see the case example for Franco at the end of this section).

- Hospital discharge planners are encouraged to contact HPSM as early in the admission process as possible, to help HPSM identify those vulnerable members who need care transition management.

- HPSM has a dedicated customer service unit for its SNP. These Care Navigators specialize in customer service for elderly and disabled members, and can spend the extra time needed to deal with complex SNP member issues. They are also an important source for identifying vulnerable members who need care management, and work closely with HSPM's SNP Care Coordination unit. Care Navigators enter notes into the call logs that can be accessed by Care Managers, or speak directly to care management staff who are all located by design near each other on the same floor.

- HPSM's SNP customer service unit also conducts outreach events at sites throughout our service area. Held at senior congregate living centers, nursing facilities, and other locations, these events inform members and their families about their benefits and the SNP program. Members often self report that they need additional assistance at these events as well.

Finally, HPSM staff work closely with community partners that also are critical sources for identification of vulnerable populations and high risk members. A few examples of these partners include:

- San Mateo County Aging and Adult Services (AAS), a local agency responsible for providing social support services to the aging and disabled population, including information and referral, adult protective services, and personal care services. HPSM staff work closely with this agency's staff to identify SNP members in need of care management. For example, we have found that the personal care services for SNP members arranged by AAS is not always well integrated into a member's care plan, so we have identified high utilizers who also receive personal care services through AAS as part of the HUG pilot cited above.

- Golden Gate Regional Center (GGRC), which provides social service support for individuals with developmental disabilities. Individuals are assigned to case managers who assist in creating and implementing individualized program plans that identify developmental goals and objectives, as well as strategies for meeting those objectives. HPSM staff collaborates closely with GGRC staff to identify SNP DD members who need additional care management for their medical and mental health needs.

b. Describe the add-on services and benefits the MAO delivers to its most vulnerable beneficiaries

Add-on services and benefits for HPSM's most vulnerable SNP beneficiaries are described below. These services and benefits include:

- Care coordination and complex care management for high risk and most vulnerable members;
- Care transitions management, including the services of a Care Transitions Coach;
- Long Term Care Integration, in development for 2012 to ensure greater access to long term supports and services for SNP members at risk or at near risk of nursing home placement;
- Physician home visiting services;
- Assignment to a patient-centered medical home (Ron Robinson Senior Care Center);
- Clinical management in long term care facilities;
- Medication Therapy Management;
- Additional services for disabled populations;
- Dedicated customer service for vulnerable SNP members
- Medicare and Medicaid benefit and eligibility coordination and advocacy
- Add-on benefits such as transportation, dental, vision and zero co-payments for generic drugs.

Care Management for High Risk Members

Care Coordination

For individuals who meet criteria for participation in HPSM's Care Coordination Program, HPSM conducts comprehensive care coordination activities. These activities include:

- Prospective, concurrent, and retrospective review of each case, based on medical condition, diagnosis, and age, to identify eligibility for programs like behavioral health, GGRC, or AAS described above.
- Coordination of individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services, and preventive services on a case-by-case basis to facilitate the achievement of realistic treatment goals.
- Completion of a comprehensive assessment to achieve a baseline understanding of the members' health status upon enrollment in the Care Coordination program.
- Assessment of the appropriateness of the individualized care plan in light of any changes in the member's health status since the most recent care plan was developed, and coordination with an Interdisciplinary Care Team (ICT) to update the plan as needed.
- Development of specific timelines to monitor, evaluate, and reassess the members' health status and the appropriateness of the individualized care plan in order to make changes to the plan.

Both the Director of Health and Provider Services and the Medical Director conduct oversight of the Care Coordination functions, including through direct case review when required, and through review of care coordination reports on a quarterly basis to determine referral patterns and utilization of appropriate community resources and specialty programs.

Complex Care Management

Complex care management uses proactive care management principles. High risk members are identified through a predictive model and health risk assessment screening tools. Complex/high risk care management programs focus on providing well coordinated community-based services, including limiting gaps in care between inpatient and outpatient and community-based services. The framework of the care management programs address the complexity of the healthcare system and the difficulty our member's encounter navigating the health care system- Limited ability to access services negatively affects health status. Goals of our care management programs include a) improving quality of care, b) improving member satisfaction and c) promoting the provision of medically appropriate care through a multidisciplinary, comprehensive approach in a cost effective manner. For our dually eligible population, CareAdvantage, each member receives a health risk screening assessment annually. In addition to the member's subjective health risk assessment screening tool, a comprehensive assessment is performed on high risk medically complex members. The

integration of the comprehensive assessment with the health risk assessment screening tool serves as a basis in development of individualized care plans. Individualized care coordination interventions are documented in a relational database that fosters centralized information and standardization. Care management interventions are developed in conjunction with the member and include a point of contact at the plan responsible for communications with the member. The health risk assessment screening is communicated with the member's primary care physician. Collaboration and coordination of care with the primary care physician is an integral component of the care management program.

Complex Care Management/ Care Coordination Activities include the following:

- Comprehensive health risk assessments are performed for each CareAdvantage member and high risk Medi-Cal members. This tool is the foundation of the case management process. Assessment and data gathering includes but is not limited to member demographics, primary care physician and specialty physician care information, living status, hospitalization and ED utilization, a review of physiological health systems, past medical history, a medication history and medication regimen, medication therapy management eligibility, social/emotional status, functional status/disability rating, activities of daily living assessment, exercise assessment, fall risk, community resource utilization and assessment, and primary care giver assessment, durable medical equipment (DME) and medical supply assessment and a needs assessment summary.

    - The clinical history documents the members' health status, clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history and current and past medication.
    - Activities of daily living evaluate the members' functional status related eating, bathing, walking, toileting, and transferring.
    - Mental health status evaluates the members' mental health status, including psychosocial factors and cognitive functions such as ability to communicate, understand instructions and process information about their illness.
    - Cultural and linguistic needs include an assessment of cultural and linguistic needs, preference or limitations.
    - Caregiver resources are evaluated to assess family involvement in the care plan and the caregiver potential for burn-out.
    - Life planning assessment addresses life planning issues such as living wills/ advance directives/ durable power of attorney.
    - A benefit assessment is also conducted.

- Individualized care plans are developed from the findings and analysis of the comprehensive health risk assessments.
- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under and over utilization of services,

continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.

- Ensuring that members have access to the appropriate care and service within their health plan benefits and consistent with accepted standards of medical practice.
- Retaining the ultimate responsibility for the determination of medical necessity for HPSM members and ensuring that authorization requests are handled efficiently according to HPSM UM timeliness standards.

Care Management and Linkage with Community Partners

For individuals with specialized needs, including individuals with developmental disabilities, individuals at risk of institutionalization, or individuals with behavioral health or substance abuse problems, HPSM ensures linkages to the appropriate health and social service providers, including Golden Gate Regional Center, Aging and Adult Services, and Behavioral Health and Recovery Services.

HPSM staff members participate in standing meetings with each of these agencies in order to ensure that high-level policy, programmatic, and operational considerations are addressed to best meet the clinical and social service needs of affected members. In addition, HPSM may conduct ad hoc case management/care coordination meetings to address the unique needs of individual members.

Examples of Specific Care Management Activities for Vulnerable Beneficiaries

1. As described in 10.a., HPSM recently initiated a High Utilizers Group (HUG) pilot to test an inter-disciplinary team based care management model for especially vulnerable HPSM SNP members. HPSM and its community partners secured funding from the Gordon and Betty Moore Foundation for this pilot, which focuses in particular on vulnerable members who see private primary care physicians in the community and also receive personal care services through San Mateo County's Aging and Adult Services Program. These individuals are at particular risk for institutional care. The interdisciplinary teams will include staff from Aging and Adult Services, Behavioral Health and Recovery Services, the PCP, and HPSM Care Management staff. The member and the personal care worker (if the member agrees) will also be invited to join the team. The pilot will be evaluated using a control group. Measured outcomes include 1) improved quality outcomes for pilot participants, as demonstrated by maintained or improved physical function and health-related quality of life (HRQL); and 2) reduced utilization, as demonstrated by a significant decrease in hospitalizations and emergency department visits. A summary of the pilot plan is included as an attachment.

2. HPSM care management staff participates in a weekly "Lower Level of Care" meeting at the public hospital, together with staff from County Behavioral Health and Aging and Adult Services. The goal is to help particularly vulnerable and difficult to place patients transition from the hospital to more appropriate settings.

See the case example below for Donna S., a SNP member who received complex care management services from HPSM.

Complex Care Management Success Story: Donna S.

- Patient background
  - 56 year old woman weighing more than 500 pounds, with complex medical needs (e.g., heart failure, respiratory failure, ulcers).
- Circumstances
  - Nursing facilities refused to accept her due to her weight. She could not care for herself and had no family support.
  - She had many hospitalizations and visits to the Stanford emergency room over a six month period.
- HPSM Care Coordination staff
  - Worked with county departments to maximize services, including more in home services and meals on wheels (with a weight reducing diet).
  - Arranged home health services
  - Convinced primary care provider to make home visits until the Plan's physician in-home visiting program was in place.
  - Helped patient obtain in-home mental health counseling
  - Outreached to the community church for volunteers to provide home visits for socialization and check-ins.
  - Obtained medical equipment for in home use, including a bariatric bed, scooter, and lift chair.
- Results
  - Due to increase in physical mobility and weight loss, member can now take Redi-Wheels to attend community activities and keep her appointments with specialist physicians.
  - Hospitalizations and visits to the ER have been dramatically reduced.
  - Member now has the proper support to live successfully at home

Care Transitions

The intent of the care transition model is to improve health care outcomes and reduce re-hospitalization risk when members encounter a care transition. Members experiencing a care transition from an acute care setting to home or to a skilled nursing facility are identified and followed by the nurse case manager through the continuum of care. The nurse case manager serves as a point of contact to the member and the member's health care team. For each care transition, the nurse case manager also initiates communication to the member's primary care physician. The primary goal of the nurse case manager is to support the member and the

member's healthcare team to ensure appropriate communication and benefit coordination occur in a timely manner.

HPSM's Care Coordination Team consists primarily of on-site Nurse Case Managers (NCM) at each facility and Care Coordination Technicians (CCT) that provide follow-up support to members' Interdisciplinary Care Team. The following sections describe how these activities are coordinated, as detailed in HPSM's Care Transition Policy.

Managing Transitions

Each Nurse Case Manager identifies planned transitions by maintaining timely review and tracking of all elective admissions assigned to their respective facility through daily hospital/SNF census reports, daily hospital/SNF admitting face sheets, and approved elective inpatient procedure treatment authorization requests.

NCMs follow patients/members experiencing a care transition through the continuum of care to ensure a smooth transition of care from one setting to the next. As part of the NCM's review, the NCM ensures that discharge instructions, a discharge summary, and/or transfer summary from the transferring facility is provided to the receiving setting. The NCM ensures that communication has taken place between the sending and receiving facility within one business day of notification of the transition and that this is appropriately documented in the patient's HPSM record on the plan's care transition form.

The Care Coordination Technician works closely with the NCM to ensure notification to the member's usual practitioner of the patient's admission and discharge from one setting to another, and documents necessary communication and care transition elements to ensure that it is part of the member's health record at HPSM.

Supporting Members through Transitions

For all transitions from any setting to another, the NCM becomes the member's point of contact for the transition and provides the member with the "Nurse Case Manager for Transition of Care" letter to the member so that the member has the NCM's contact information. The NCM is available to the member to address any questions or concerns the member may have during the transition process.

The NCM is also available to discuss the member's health status and any changes to care planning with the member or responsible party and continually reviews the member's chart at the facility and works collaboratively with the facility's case management and/or interdisciplinary team to support the member/responsible party through the transition until member is discharged from the facility.

Members' discharged from a facility to home receive follow-up phone calls 7-10 days after discharge from facility to ensure the member receives timely and appropriate follow up to the

primary care physician and that ancillary healthcare services are received. All interventions that take place during transitions are documented on the Care Transition form in the member's health record at HPSM.

Identifying Unplanned Transitions

CCTs review hospital and SNF census reports/documentation daily for all transitions. CCTs may also be notified of admissions and discharges by hospital/SNF face sheets that are faxed to HPSM by the facility notifying of member admission, on-site NCM notification or facility notification, and authorizations that are faxed to HPSM requesting authorization for inpatient elective admissions.

For admissions, the CCT notifies the member's usual practitioner by sending "HPSM Provider Notice of Admission" letter to the practitioner's office. For discharges, the CCT notifies the member's usual practitioner by sending "HPSM Provider Notice of Discharge" letter. Letters of notification are sent to the practitioner within one to two days from admission/discharge date. All communication is noted on the Care Transition form.

CCTs provide post-discharge follow-up communication with members to ensure delivery of any necessary services, including DME, home health, follow-up physician visits, transportation, and that the member's access to timely health care services is maintained. Communication beyond the scope of the CCT, such as specific health question, issues, or concerns and care coordination services are referred to the NCM for additional follow-up. It is the responsibility of the NCM to address questions, concerns or issues that a member or caregiver has until it is resolved. The NCM documents all telephonic contact made with member/caregiver and interventions completed on the Care Coordination Database.

Care Transition Coaching

HPSM has implemented Dr. Eric Coleman's model for Care Transitions at the County public hospital (SMMC), selected as the primary facility because some of the most vulnerable SNP patients are at this institution. A dedicated nurse, who has undergone training in the Coleman model, works collaboratively with SMMC clinical staff to select candidates for this intervention. This nurse serves as the coach for the patients who are recruited. These patients are introduced to the four pillars of the Coleman model, receive the intervention of the home visit and follow-up phone calls, and are thus empowered to take charge of their self care and health care management. This Care Transitions program is also being evaluated under a grant from the Gordon and Betty Moore Foundation to help us determine how to better implement this program successfully. So far, we have increased the number of patients enrolled in this program by almost 300% over the past 4 months.

Long Term Care Integration

HPSM is developing a long term care integration program for 2012. The goals of this program are to provide greater access to and delivery of person-centered care in a fragmented system; provide greater access to long term services and supports to maintain members at home or in appropriate community settings; and reduce rates of institutionalization, especially nursing home admissions. To accomplish these goals, we are developing an integrated acute, long term care, and home and community based service system that 1) adopts proper incentives to encourage greater utilization of services to prevent or delay nursing home placement; and 2) promotes greater efficiency by providing services in less restrictive settings in lieu of nursing home placement. The program will focus on SNP members who are at greatest risk of nursing home institutionalization, or are expected to be at risk in the near future. HPSM is working with the State of California to obtain the necessary federal Medicaid waivers to implement this program in 2012.

In- Home Physician Program

The In-Home Physician program is a system of care that provides 24/7 access to in-home physician visits for the plan's most medically vulnerable and complex members. This program supports proactive cost management and enhanced medical care by treatment through a home delivery system by optimizing care in the home. The services that In Home Physician program provides include:

- 24/7 patient access to a visiting physician.
- Regularly scheduled in- home and facility visits and anytime as needed.
- Coordinated care with primary care physicians, specialists, and the plan's nurse Care Manager.
- Clinical and pharmacy management.
- Education to the patient about their medical conditions and anticipated outcomes.

Assignment to a Patient Centered Medical Home

Some of the most vulnerable SNP members are assigned to Ron Robinson Senior Care Center (RRSCC), a specialized outpatient clinic based within San Mateo County' public hospital and clinic. RRSCC provides its own interdisciplinary care to older adults in San Mateo County, including physical health, mental health, social services support, and wellness education all in one location. Appointment times are as long as necessary and the Center also offers home visit options. Senior Center staff also has begun providing services to HSPM SNP members in congregate living situations.

Long Term Care Clinical Management

In 2010, HPSM initiated a clinical management program for SNP members residing in long term care facilities, based on the Evergreen model. This is a critical add-on service for some of

our most vulnerable members, those residing in nursing facilities. To conduct this program, HPSM employs a part-time physician with expertise in gerontology, two nurse practitioners, and a nurse case manager. HPSM clinical staff has targeted those nursing facilities with high numbers of SNP members residing, largely in custodial care. The program goals are to improve quality of care for HPSM's SNP members and reduce unnecessary hospitalizations and visits to the ED. In addition, HPSM clinical staff focuses on ensuring each member and their caregiver has had the opportunity to consider the end of life choices they prefer and specify them on a form such as California's Physician Orders for Life Sustaining Treatment (POLST) form. HPSM staff work closely with patients' primary care providers and facility medical directors to implement the program. HPSM staff conducts at least annual comprehensive assessments of HPSM SNP members, round at targeted facilities on a regular basis to monitor patient status, and provide training on areas such as geriatric syndromes, POLST, etc., for facility staff. We aim to intervene early with facility staff to resolve medical issues before they escalate to a point where a hospital admission or ED visit is required. For example, if a CareAdvantage patient appears to be running a low-grade fever, HPSM's nurse practitioner is called, under the program's agreement with the patient's PCP, to come and examine the patient. She could order a urinalysis; if it is abnormal, she could order antibiotics (if consistent with the patient's end of life wishes) immediately. If coupled with dehydration, an IV could be started in most of the LTC facilities contracted with HPSM. In this way, the program is able to prevent hospitalizations that otherwise would likely occur. Staff is also developing reports for PCPs and facility medical directors to inform them of hospitalizations and ED visits that appear to have been preventable.

Medication Therapy Management

Medication Therapy Management (MTM) is the analytical, consultative, educational and monitoring services provided by pharmacists to CareAdvantage SNP members in order to facilitate the achievement of positive therapeutic and economic results from medication therapy. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address mediation needs, and provide healthcare to plan members in a cost-effective manner. Health Plan of San Mateo contracts with the vendor, Outcomes, to administer MTM services. MTM services include comprehensive medication review (CMR), prescriber consultations, member compliance consultations, and member education and monitoring.

Comprehensive medication review is performed annually. During the CMR, the pharmacist will review the member's prescription and nonprescription medication, vitamins, minerals, herbal products, and dietary supplements for potential interactions. As part of the review, the pharmacist will provide a master medication list for the member to bring to future office visits. Prescriber consultations assist physicians and other prescribers to coordinate care and resolve potential medication- related complications. Participating MTM pharmacists consult the plan's formulary to assist members in selecting the most cost-effective and clinically appropriate medications. Member compliance consultations assist members with compliance issues. MTM pharmacists monitor plan members for compliance with prescribed medications. When an

overuse, underuse, or administration issue is identified, the pharmacist will educate the member on the importance of compliance and monitor the member to ensure that compliance improves. Member education and monitoring is performed when a member is prescribed a new medication therapy or experiences a change in therapy. MTM pharmacists monitor the member for improvement in reportable symptoms, the occurrence of the side effects and compliance with therapy.

Please refer to the Medication Therapy Management case example below for an example of the effectiveness of this service for vulnerable HPSM SNP members.

MTM Success Story: Franco

85-year-old "Franco" of San Francisco used to visit his pharmacist only occasionally. Then came the visit that saved his life.

Health Plan of San Mateo (HPSM)/CareAdvantage provides medication therapy management (MTM) services through the pharmacies that provide care for the health plan's members. The MTM services provided by Anchor Drugs include blood pressure readings for members at each pharmacist visit. When Franco sat down for the first time in several weeks to have his blood pressure checked, Richard Jajeh, PharmD, found that it was severely elevated.

"The patient was in hypertensive urgency," Pharmacist Jajeh recalls. "But he had only very slight symptoms and was unaware of the life-threatening situation."

The lack of severe symptoms created a dangerous dilemma. Franco needed immediate care but refused the pharmacist's strong advice to go immediately to the emergency room. "He didn't feel well, but he wasn't feeling much worse than he felt the day before. This is why they call hypertension the silent killer."

Franco, whose first language is Spanish, felt that he lacked language skills needed at the hospital. "The emergency room would be inconvenient and scary for him as well as potentially expensive," the pharmacist recalls. "These are the kinds of fears he had: Am I going to be able to communicate? How am I going to get there? I don't have any money – how will I pay for it?"

Without treatment, Franco could have soon faced the consequences: stroke, heart attack, multi-organ failure and even death.

Instead, with Franco's consent, Jajeh called Franco's doctor and recommended an immediate blood pressure lowering therapy using amlodipine. Franco visited the doctor the next day and obtained his prescription.

Amlodipine is a low cost drug that Franco received free, through his pharmacy benefit provided by Health Plan of San Mateo/CareAdvantage. Without this intervention, he could have soon faced expensive dialysis, life support, round-the-clock cardiac care or a long stay at a nursing home.

His pharmacist poses an obvious question: "How do you put a value on a man's life? You have a man who's walking up and down the street with a smile on his face. How do you put a number to that?"

"Medication-related complications similar to the one described in this story are repeated many times every day," says Jessica Frank, PharmD, Director of Clinical Services for Outcomes Pharmaceutical Health Care®, whose company contracts with health plans to provide MTM programs, including Health Plan of San Mateo/CareAdvantage. "Pharmacists have documented services that range from improving the quality of care for patients to avoiding potentially life-threatening situations."

Franco visits his pharmacy every day now. "He brings us sweets every day," says Jajeh. "Latino sweet bread, he offers it in his kindness and in his realization of what's happened."

"We really encourage him to walk, a block here, a block there. The idea is to keep him mobile."

Jajeh and fellow pharmacist Richard Rodriguez provide pillboxes for Franco. "We fill up his pillboxes for him so that he's taking the medications properly – morning, afternoon, evening. This is standard protocol for us." We have the philosophy that we will provide MTM services to the best of our abilities, and the results will one day speak for themselves."

Barrie Cheung, Pharmacy Services Manager at Health Plan of San Mateo, is pleased that the health plan provides for MTM services for their members. "HPSM believes the dollars invested in a MTM program is a great benefit for our CareAdvantage membership to help them with their difficult medication regimens and general health issues."

Add-on Services for Disabled Members

HPSM has developed additional services for SNP members with disabilities, including the examples listed below:

- Contracting with a physician from the University of California at San Francisco (UCSF) Medical School to provide primary care to SNP DD members living in group homes. Dr. Kripke specializes in care for the adult DD members.
- Hiring a dedicated nurse for DD members.
- Helping develop specialized DD clinics at San Mateo County Behavioral Health and at a County hospital outpatient clinic.
- Working with a community organization to develop a specialized training program for mammography providers working with disabled women.

In 2007 and 2008, HPSM worked with the State of California and local agencies to transition 51 DD clients who had lived at the Agnews Developmental Center for more than twenty years to group homes closer to their families in San Mateo County. Many joined HPSM's SNP in the process. HPSM's development of a specialized network for this group of members was critical for the success of this deinstitutionalization effort.

Dedicated Customer Service for Vulnerable Members

Members who are monolingual or who speak English as a second language often have more difficulty accessing health services, thereby making them among our more vulnerable SNP members. To address this issue, HPSM has developed a specialized customer service unit with

staff that speaks languages most represented by our SNP membership, including staff fluent in Tagalog, Mandarin, Cantonese, Russian, and Spanish. We also have a language line interpreter service for all other languages, as well as special phone services for deaf or hard of hearing members. All HPSM staff and providers, including care management staff, physicians, and physician office staff, employ these tools in serving SNP members.

Medicare and Medicaid Benefit and Eligibility Coordination and Advocacy

All of the CareAdvantage SNP membership is dually eligible for both Medicare and Medicaid, and all members are required to have Medicaid through HPSM as a condition for eligibility. As such, HPSM coordinates benefits for members between the two programs and is able to do so in a manner that is virtually transparent to members. Members use the same identification card to access services under either their Medicare or Medicaid benefits. Benefits are also described in a comprehensive, all-inclusive fashion in the member informing materials, such as the Summary of Benefits and the Evidence of Coverage. In addition, HPSM is able to authorize and pay for services under Medicaid without having to wait for verification of Medicare payment or denial, enabling members to access services as quickly as possible. Because HPSM also tracks utilization of services across both the Medicare and Medicaid programs, HPSM staff ensures that members receive the most-appropriate care across both programs without duplication of services.

Experience with the SNP program has shown that one of the greatest challenges is ensuring continuity of care for members who lose Medicare or Medicaid benefits temporarily. HPSM tracks member eligibility for the Medicare and Medicaid programs to ensure that members can remain eligible for the SNP CareAdvantage program. Churning on and off Medicaid has been a particular systemic problem that can lead to gaps in coverage, which can be very harmful for vulnerable beneficiaries with chronic conditions. HPSM has employed the following strategies to address this problem:

- HPSM has staff dedicated to tracking eligibility and proactively informing members of lapsed Medicaid eligibility; in 2010, HPSM staff resolved 830 cases in which a member had lost or was at risk of losing Medicaid eligibility. This would have meant loss of Special Needs Status requiring disenrollment from the Plan.
- Staff works with SNP members and the County Human Services Agency, the local agency responsible for Medicaid eligibility, to facilitate timely renewal of Medicaid eligibility;
- Dedicated staff works with the local Medicaid eligibility agency to highlight cases that need immediate attention and to monitor agency staff to ensure follow through;
- HPSM leadership meets on a regular basis with the San Mateo County Human Services Agency leadership to recommend strategies for improving systemic Medicaid eligibility and redetermination processes for SNP members.

- HPSM contracts with the local Legal Aid Society to provide individualized attention and advocacy for SNP members with especially complex eligibility issues, such as Medicaid share of cost requirements.

Below are case examples that demonstrate the administrative complications and the lengths HPSM staff go to ensure eligibility and care continuity for our SNP membership. This is a critical add-on service for HPSM SNP members.

Medicare and Medicaid Eligibility Coordination and Advocacy Case Example #1: Ms. G

Ms G. is 81 years old and homebound. Ms. G. has been continuously eligible for SSI/SSP cash benefits. In September 2008, Ms. G. lost her Medicare Part A benefit because her Medicare Savings Program (QMB) was discontinued when she moved from another county to San Mateo County; her QMB was not picked up by the San Mateo County Social Services Agency and therefore lapsed.

Notifications were sent to Social Services in September 2008, February 2009, January 2010 and April 2010. Social Services claimed there was nothing they could do about this inter-county transfer. From May 2010 through July 2010, eight calls were made to the State's Medi-Cal Ombudsman's Office to correct the error. Not one call was returned.

Finally in January 2011, HPSM referred the member to the San Mateo County Legal Aid Society. Legal Aid filed for a State Hearing. Social Services agreed to settle the case prior to the hearing, agreeing that Ms. G. was QMB eligible retroactive to September 2008. However, in their attempt to correct the case record, Social Services entered a beginning date of January 1, 2011 and they are now unable to correct the case history. As a result of this nearly three year effort, Ms G. has her Part A restored retroactive to 1/1/2011 but remains uncovered by Part A from 9/2008 through 12/2010.

HPSM has kept Ms. G on its SNP because her loss of Part A was due to an administrative error; however, due to a Social Services error in reinstating the retroactive QMB, the Health Plan lost Medicare capitation for many months.

Medicare and Medicaid Eligibility Coordination and Advocacy Case Example #2: Ms. A

A conserved dual eligible beneficiary (who has been enrolled in our SNP since 1/1/2006) lost full-scope Medi-Cal in July 2010. HPSM found out about her loss of Medi-Cal in August 2010; the member's 6 month period of deemed continued eligibility began on 9/1/2010 and continued through 2/28/2011. The member's conservator was sent a series of letters indicating that the member would be disenrolled as of 3/1/2011.

The member did not get Medi-Cal eligibility restored during the 6 month period and was disenrolled as of 3/1/2011. On 3/15/2011, the local Social Services Agency determined that she was full-scope Medi-Cal retroactive to 7/1/2010. Since the member was already disenrolled from the SNP, we had to tell the conservator to re-enroll her client in the Plan. The conservator did re-enroll the member but the enrollment is not effective until 4/1/2011 because the enrollment was received on 3/17/2011.

The member now has a 1 month gap in coverage during which time she is FFS Medicare; as of 3/18/2011, CMS had not automatically assigned her to a PDP. Since she needed medications, we told her pharmacy to go through the LI NET program. The pharmacy did not know about the LI NET program so HPSM provided the information to the pharmacy to ensure the beneficiary did not experience a gap in medication.

Add- on Benefits

HPSM's benefit package includes the supplemental benefits described below.

- Transportation (Taxi Rides)—HPSM's members are eligible for up to fifty (50) free one-way taxi rides (or 25 roundtrips) to medical, dental, or vision appointments per calendar year. This is a critical add on benefit for vulnerable SNP members who need regular and consistent care yet often have difficulty getting transportation to medical appointments.

- Dental Services—California's Medicaid program eliminated coverage for adult dental care in 2008. Therefore, HPSM's comprehensive dental coverage, including preventive and restorative dentistry, oral surgery, root canals, dentures, partials, crowns and bridges, is critical for the health of vulnerable SNP members.

- Vision Services—California has also eliminated coverage for many adult vision services under Medicaid. HPSM SNP members may receive an eye exam every 2 years, glaucoma screening, and eye care services from an optometrist and ophthalmologist. Vision services include one free pair of eyeglasses with frames or contact lenses ($125 cap every 2 years). This benefit is critical for prevention of falls and other trauma related to vision.

- Copayments—HPSM benefits include zero copayments for generic drugs. This is an important benefit for ensuring members are compliant with pharmacy regimens. We have found that copayment requirements, especially for mentally ill members or members in need of multiple prescriptions for their chronic conditions, can be a significant barrier to quality care outcomes. Many vulnerable members simply cannot afford multiple copayments, no matter how low.

11. Performance and Health Outcome Measurement

a. Describe how the MAO will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.)

HPSM collects data continuously, analyzes it regularly, reports on it at periodically and acts on it strategically in order to evaluate the performance and health outcome measures of our CareAdvantage Model of Care's stated goals, as well as the Model of Care (MOC) overall. We do this using a variety of internal tools as well as externally-validated studies. Details of these steps in the evaluation of our performance and outcome measurements and MOC are provided below.

Under the direction of the Medical Director, the Model of Care is analyzed and evaluated. As explained in more detail below, this occurs in various settings, (e.g., Medical Management meeting, Quality Management Oversight Committee, and so forth), when different aspects of the Model of Care are the focus of review. However, the overall responsibility for the evaluation of the Model of Care rests with the Medical Director, as the Director of HPSM's Quality Program.

1. Collection of Data

HPSM uses a variety of data sources in order to gather the information necessary to evaluate the Model of Care and its performance and outcome measures. We have extensive data systems for managing the demographic, health service, and financial information related to our enrolled members. We use our central claims processing, eligibility, and provider management systems, as well as several ancillary SAS, SQL, and Microsoft Access databases, including the Care Coordination database.

Data in these systems come from various sources, including but not limited to:

- Member enrollment forms
- Member surveys and assessments, including the annual Health Risk Assessment (HRA) and Comprehensive Assessment
- Member notifications of changes in status
- CMS reports
- Provider contracts
- Claims and encounter submissions and payment, which provide member and provider-specific service and cost data
- Lab, radiology, and pathology data feeds
- Authorization processes
- Grievance and appeals processes

Data from these systems enable demographic analysis, as well as analysis of members' health status as reflected by reported diagnoses. In addition, claims data are used to track cost and utilization for the CareAdvantage line of business. They also provide the data used to determine whether or not HPSM has met its goals and objectives under the CareAdvantage MOC.

Samples of Data

Grievance and Appeals Quarterly Report

Line of Business	1st Qtr 2010		2nd Qtr 2010		3rd Qtr 2010		4th Qtr 2010	
	Grievances	Appeals	Grievances	Appeals	Grievances	Appeals	Grievances	Appeals
CareAdvantage	26	26	27	32	45	27	33	32
Medi-Cal	22	36	20	28	15	25	18	22
Healthy Families	0	0	0	0	0	0	0	0
Healthy Kids	0	0	0	0	0	0	0	0
HealthWorx	2	2	1	1	0	1	1	3
ACE	13	16	29	11	23	10	9	8
Sub-totals	63	95*	77	76*	83	51	61	68
Grand Totals	**158***		**153***		**134***		**129***	

Authorization Data Report

1st Quarter - 2nd Quarter 2010 Trend Summary

CA Inpatient Admits

Quarters 2010	CareAdv Total Admits--1124
Quarter One	578
Quarter Two	546

Care Advantage Hospital Medical Admission by Percentage
Reporting 1st Quarter - 2nd Quarter 2010

SETON MEDICAL, 42.01%
PENINSULA, 19.47%
STANFORD, 10.41%
SAN MATEO, 10.14%
OTHERS, 6.97%
KAISER, 1.33%
CALIFORNIA, 1.84%
SEQUOIA, 7.59%

HPSM conducts weekly audits of the claims and encounter data using specialized software that tracks appropriate billing – and therefore data reporting – practices of submitting physicians. HPSM also conducts medical record review of inpatient medical records to ensure that DRG billing is accurate. In addition, HPSM's data systems are backed up on a daily and weekly basis, with backups stored off-site for disaster recovery purposes.

HPSM also utilizes data collected by external sources, including the following nationally-validated studies:

- CAHPS. HPSM participates in the Consumer Assessment of Health Plans and Systems (CAHPS) survey every year to determine the level of members' satisfaction with and ease of using the CareAdvantage plan. CAHPS survey responses are used to identify areas that need improvement with respect to the member experience.
- HEDIS. Each year, HPSM measures performance for important aspects of care for our members using the HEDIS® (Healthcare Effectiveness Data and Information Set) methodology. HPSM studies measures, including SNP-specific measures, as directed by CMS.
- HOS. Every year, HPSM participates in the Medicare Health Outcomes Survey (HOS), which measures outcomes for members of Medicare Advantage plans based on a survey of 1200 plan members. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. HPSM reviews the results of our HOS studies to identify plan strengths and weaknesses in the management of members' care, as well as to identify areas for further intervention.
- NCQA SNP Evaluation. HPSM participates in the annual CMS/NCQA evaluation of Special Needs Plans, which includes review of structure and process measures, as well as review of SNP-specific HEDIS measures. The goal of the evaluation is to measure the quality of care provided by SNPs.

2. Analysis of Data

Each of the data sources listed above is utilized as applicable to monitor the Model of Care goals to determine how well HPSM is performing in achieving the goals. This information is the basis, in large part to evaluate the MOC overall. A description is given for each of the goals below to explain with examples of how such analysis takes place. Then, how this information is used for a general evaluation of the MOC overall is presented.

- By June 30, 2012, hospitalizations for our CareAdvantage members who have been case managed by our care coordinators will be reduced by 15%; and by December31, 2012, hospitalizations for this group will have been reduced over the year by 30%.

- This goal uses a number of the data sources listed above. Our internal health statisticians match hospitalization (utilization) claims data with member data from the Care Coordination data base over the time period in question. They do the same type of matching with a comparable time period prior to the care coordination intervention. They analyze the findings and do statistical tests of significance, to determine if there is a difference, and if this difference is statistically significant. To control for regression to the mean, they will also look at the CareAdvantage membership as a whole in the same way (analyzing for changes in hospital utilization—perhaps this was a really healthy year with very little flu or pneumonia for all our members, and the intervention of our care coordinators was superfluous vs. in spite of a very challenging health year for everyone, our intervention helped keep our highest risk members stable and out of the hospital). These measures will be monitored regularly, but will be reported every 6 months.

- By June 30, 2012, ED visits for our CareAdvantage members who have been case managed by our care coordinators will be reduced by 10%; and by December31, 2012, ED visits for this group will have been reduced over the year by 20%.
  - This goal uses a number of the data sources listed above. Our internal health statisticians match ED visit (utilization) claims data with member data from the Care Coordination data base over the time period in question. They do the same type of matching with a comparable time period prior to the care coordination intervention. They analyze the findings and do statistical tests of significance, to determine if there is a difference, and if this difference is statistically significant. To control for regression to the mean, they will also look at the CareAdvantage membership as a whole in the same way (analyzing for changes in ED visit utilization). They will look at the major reasons for ED utilization, compare these reasons between the intervention group receiving care coordination services and the CareAdvantage population as a whole, and look to determine if anything out of the ordinary (e.g. like the H1N1 epidemic) might be influencing findings as well. These measures will be monitored regularly, but will be reported every 6 months.

- In 2013, the CareAdvantage HEDIS scores for the diabetes measures that are part of the HPSM Pay for Performance program (HbA1c testing, HbA1c <8%, LDL-C testing, LDL-C < 100, Retinal eye exam, Attn for nephropathy) will each increase by 2%.
  - A tremendous amount of HPSM data is used for HEDIS data submission annually. HPSM contracts with a HEDIS certified vendor for chart abstraction and data analysis; however, one of our quality nurse specialists participates as well, and our senior health statistician is a critical component of preparing the data, analyzing preliminary administrative rates, evaluating initial hybrid rates as they are collected, reviewing supplemental data files to be submitted and so forth. During the active data HEDIS collection phase, we analyze chart

abstraction data as it comes in, to see where additional hits might be found, targeting our known providers of specific services (e.g. endocrinology, nephrology, and so forth), so there is ongoing data analysis in a real time manner. In the off-season, after the results are finalized, the quality team analyzes findings in detail, looking at each measure, seeing where hits were missed, where additional supplemental data could be provided in administrative format to decrease gaps in data for the next year, and strategizing what quality improvement projects will be implemented to increase whatever area needs changing (e.g. member screening, better control etc).

- Our fourth measurable goal for our model of care is that CareAdvantage members who receive HPSM care coordination services will demonstrate that, for at least 25% of members, quality of life will be the same or better, as documented on one of the assessment tools they respond to over the course of the subsequent year (e.g. if the intervention starts on January 1, 2012, the improvement will be documented by December31, 2012).
  - The data sources needed for analysis in this goal will include those such as the annual Health Risk Assessment, comprehensive assessment and Health Outcomes Survey tools, as well as the Care Coordination database. Each HPSM member who receives intensive care coordination services, identified in the Care Coordination database, will be matched with any/all of the three tools as they come in. In discussion with the clinical team, specific questions are identified that represent quality of life measures on each tool. . If necessary, for those members that might have results on more than one tool in the year following the start of the intervention, the statistical team will develop a composite score. Either way, as a composite or individually, this is what will be tracked and analyzed regularly, and reported annually; it is on a rolling basis per member, but will be a summary for the members served in the past calendar year for reporting.

The results of these four specific measurable goals are key components of determining how well HPSM's MOC has served our CareAdvantage members. Each of the elements of the MOC beyond the measurable goals, e.g. identifying the target population, ensuring the staff structure is appropriate to support the MOC, the provider network in place is adequate, the staff and provider training on the MOC is appropriate, the HRA and the ICP are designed correctly to meet the needs of the members, the communications network in place supports the MOC sufficiently, and that the care rendered for our most vulnerable subpopulations is tailored in a sensitive way to meet their needs, is reflected in these four goals and their outcomes. For example, the target population is demonstrated in potentially an increased risk of hospitalizations and ED visits (goals 1 and 2); so are our vulnerable subpopulations. Seeing how these groups are impacted by any improvements in our first two goals can help us understand how well the MOC is doing overall. Another example is goal 3, improvement in HEDIS scores. Since 43% of our CareAdvantage population has diabetes, this goal impacts both our targeted population and a vulnerable subpopulation. Appropriate quality team staff

is needed to carry out the initiatives and P4P program to achieve this goal. The senior health biostatistician is another key staff in this endeavor.

Example: At a minimum, the Model of Care will be reviewed quarterly at the Senior Managers' Meeting where the CareAdvantage program is highlighted. While the CareAdvantage Project Specialist leads the CA program review monthly for the Sr. Mgrs' meeting, during this MOC quarterly review, the Medical Director will lead the meeting. In addition, the Senior Health Statistician, and any key quality department staff (e.g. the Associate Medical Director, the health educator in charge of the diabetes quality initiative, etc), will also attend. During these quarterly reviews, each component of the MOC will be assessed. Some may just be touched upon, e.g. Element 3 (Staff Structure), unless a notable problem has been identified. Others, in contrast, such as the goals, the ICP and ICTs, the communication plan, and so forth, will be highlighted. Brief presentations by key staff will outline how the element is functioning, whether or not any barriers to success have emerged, and data available will be examined. The Sr. Managers will provide input on how the MOC is meeting its stated goals, offer recommendations about improvements, or areas to be further analyzed, and so forth. This is how ongoing review and analysis will ensure the MOC is kept on track.

3. Reporting of Results

Each of the goals listed above has a specific time frame for reporting of results. Goal 1, reduction of hospitalizations, and goal 2, reduction of ED visits, are both to be reported at 6 month intervals, at June 30 and December 31, 2012. Goal 3 and Goal have annual reporting time frames; goal 3 is by calendar year, and will be reported when the HEDIS results come out (generally late summer of the reporting year—2013 in this case) and goal 4 is an annual basis.

The goals and their results will be reported in multiple ways. All results will be reported to the core MOC analysis group of the senior health statistician, the medical directors and the Director of Health and Provider Services. The results will also be reported to the following teams via meetings described in further detail in factor c (who) and factor e (oversight) below.

- Medical Management Review Team—meets monthly
- Quality Management Oversight Team—meets monthly
- CareAdvantage Meeting of Senior Managers—meets monthly; will discuss performance measures at least twice a year after analysis—July, January
- Senior Managers' Meeting—meets weekly—can bring up any CareAdvantage MOC issue ad hoc as needed
- Quality Improvement Projects and Initiatives—meets monthly
- San Mateo Health Commission—meets monthly; quality issues reported quarterly
- Physician Advisory Group (PAG)—meets bi-monthly; comprised of 10 physicians from HPSM provider network—mostly primary care, some specialists (common types); serves as physician "focus group", particularly for quality projects and initiatives

- Quality Assessment and Improvement Committee (QAIC)—meets quarterly, comprised of physicians, other health professionals, community members, who are interested in quality issues and evaluation; more analytic than PAG, purpose is to help interpret analytic data, evaluate quality, performance and outcome measures, give feedback/help strategize when barriers identified.
- Consumer Advisory Committee (CAC)—meets quarterly, given regular quarterly report, provides consumer/member feedback on quality, performance and outcome measures/issues.

The above meetings are also the venues for reporting of the overall MOC evaluation. Any areas where success has occurred or improvement is needed are identified to these groups, and action steps are designed as needed, including modifying specific aspects of the MOC as necessary, to achieve better outcomes for our CareAdvantage members.

Example: in addition to the example above (under analysis), where Sr. Managers will specifically be apprised on a regular basis about the status of analysis of the MOC, the results of the MOC will be reported to various groups, depending on what is found, and what is needed. For example, if problems are identified in any performance aspect related to the goals, and these involve quality issues, then the quality department will be mobilized by having the MOC results and problem areas discussed at the Quality Improvement Projects and Initiatives (QIPI) meeting. Here, MPH-trained health educators, led by the Medical Director, along with the Associate Medical Director, Quality Program Nurses, the P4P Project Specialist and the Senior Health Statistician, examine data and develop ideas in depth about programs related to quality improvement. Any steps related to the 4 goals would be discussed, developed and planned for implementation at the QIPI meeting and also would get good feedback from our provider network advisors on the Quality Assessment and Improvement Committee. Challenges related to aspects of the Model of Care involving Care Coordination would be discussed at the Medical Management Review team, Sr. Managers' meeting or an ad hoc meeting involving the Medical Director, the Assoc. Medical Director and the Director of Health and Provider Services. Issues that need the input of the physician provider network, especially regarding new care coordination initiatives, would go to the Physician Advisory Group. The members of this group are very vocal about telling us whether a new tool for diabetes is something they would use in the office, or that they would give to their patients to use, etc. Any of these meetings would be excellent venues to announce improvements or positive outcomes as a result of our efforts. We would especially want to alert the Consumer Advisory Committee about these findings, and also hear if their consumer groups have any feedback about how to further improve the work we are doing with our MOC.

4. Taking Action

For each of the measurable goals above, HPSM key staff (see Factor b) will review the goals and compare the results to the outcomes expected. We anticipate that we have established goals that are realistic and attainable. We have reviewed these goals with the key staff

involved in leading the teams working with the members, physicians and external partners integral to achieving these goals. However, we do know that sometimes goals are not achieved as hoped. If this occurs, HPSM will do a root cause analysis and implement the Deming model for improvement, promulgated by the Institute for Healthcare Improvement. This model encourages one to (1) identify the barriers that impeded the ability to meet the objective, (2) determine strategies for overcoming the barriers; (3) establish a work plan for implementing the strategies, including specific action items and timelines and (4) implement the work plan. The following provides some examples of actions that we will take, in concurrence with this model, if each goal is not met in the timeframes outlined above; it should be noted that the input and feedback of each of the groups/committees noted above will be obtained as part of the development of an action plan:

1. What if hospitalizations are not reduced by 15% by June 30, 2012, or 30% by December 31, 2012?

    i. The first step HPSM will take in the root cause analysis (RCA) is to see if there has been some problem with data collection. Did we get all the members? All the hospitals? Were the numbers unexpectedly small or large? Did something skew the data unexpectedly (like another H1N1 epidemic)? Did one or two members impact the data adversely? If so, what happens if we remove just those few members? These are the kinds of analysis we will do to see if the data is the issue.
    ii. Next, was there an issue with the intervention? Was there a staffing issue during the large part of the intervention period? Loss of staff? New or less trained staff? And so on. Were there problems with the intensity of intervention vs. intensity of need? Were the frailest members needing services, and even though services of high quality were rendered, was there nothing that could be done to prevent many of the hospitalizations? This piece would of course be done with medical director input, sampling of chart reviews, staff interviews, etc., particularly with the on-site staff.
    iii. Was there some improvement, but only in a certain group of patients? Were patients of a certain PCP, or at a certain hospital, or from LTC, etc, the outliers in hospitalization? These subsets would be looked for as part of the analysis. Then, perhaps a separate intervention might need to be developed to target a specific group beyond the general group initially identified.
    iv. Was the initial goal realistic? Were we too ambitious with our highest risk members, in thinking they could be stabilized as outpatients considering their co-morbidities, or did we miss something that needed to have an intervention first, etc?
    v. These would be the type of steps we would take as a team in performing a RCA of the problem if the goal to reduce hospitalizations is not met in the expected time frame.

2. What if ED visits are not reduced by 10% by June 30, 2012, or 20% by December 31, 2012?

   i. The first step HPSM will take in the root cause analysis (RCA) is to see if there has been some problem with data collection. Did we get all the members? All the EDs? Were the numbers unexpectedly small or large? Did something skew the data unexpectedly (like another flu epidemic)? Did one or two members impact the data adversely by having a large number of ED visits? If so, what happens if we remove just those few members? These are the kinds of analysis we will do to see if the data is the issue.
   ii. Next, was there an issue with the intervention? Was there a staffing issue during the major part of the intervention period? Loss of staff? New or less trained staff? And so on. Were there problems with the intensity of intervention vs. intensity of need? Were the frailest members needing services, and even though services of high quality were rendered, was there nothing that could be done to prevent many of the ED visits? Were the symptoms the patients developed of such severity that they would be sent to the ED by any reasonable clinician or lay person? This piece of analysis would of course be done with medical director input, sampling of chart reviews, staff interviews, etc., particularly with the on-site NCM staff.
   iii. Was there some improvement, but only in a certain group of patients? Were patients of a certain PCP, or from LTC, etc, the outliers here? E.g. were patients of one PCP always being sent to the ED vs. seen in the office? These subsets would be looked for as part of the analysis. Then, perhaps a separate intervention might need to be developed to target a specific group beyond the general group initially identified.
   iv. Was the initial goal realistic? Were we too ambitious with our highest risk members, in thinking they could be stabilized as outpatients considering their co-morbidities, or did we miss something that needed to have an intervention first, etc?
   v. These would be the type of steps we would take as a team in performing a RCA of the problem if the goal to reduce ED visits is not met in the expected time frame

3. What if our 2013 HEDIS scores for the six diabetes measures reflected in our P4P program do not improve by 2% as expected?

   i. If our 2013 HEDIS scores do not improve as expected, each one will be examined to see which did not meet the 2% improvement mark. A root cause analysis will be done for each one, but this is not quite as helpful as in other goals, since each is a hybrid measure, and contains only 411 members per item. Some will overlap with the same members; some will not.
   ii. Because of the small number of members in each hybrid measure, it is difficult to make a case for each PCP re: how well he or she did on a particular HEDIS measure, especially if he/she is in a smaller practice, since having 2 or 3 members chosen doesn't make much of a pattern necessarily. Therefore, although we can prepare provider HEDIS report cards with the HEDIS data, with the assistance of our HEDIS vendor, this may not be as helpful to the provider as we would like.
   iii. For this reason, we are developing, and plan to roll out soon (when the vendor is ready), comparison reports for our P4P providers on all of these diabetes measures, comparing

the provider's results for all of his/her HPSM patients on all six measures to colleagues in their specialty, and the hospital they attend at. For our CareAdvantage HEDIS measure goal's analysis and follow-up, we will pull out just their Medicare members, and see how they did. This can provide the PCP with a more realistic picture of how many of their CareAdvantage members are getting their annual recommended tests, and even more importantly, how many are meeting goals for HbA1c and LDL-C.

iv. For PCPs who are not performing well, we will focus our outreach to assist them in recalling their members to, at a minimum, get their annual tests. We will also intensify member outreach so that members who may be less compliant with PCP recommendations for testing, medication or diet will be encouraged with reminders and incentives to attend classes, get their lab work, pick up their medications and so forth.

v. By following the lab results that we have access to, we can monitor our success monthly. This may not be exactly equivalent to HEDIS, as it is not a random sample, but it will give us a picture of how the plan is doing overall with our CareAdvantage members and their diabetes testing parameters. Then we can continue to intervene in specific areas if we repeatedly find we are not improving as we expect.

4. What if our follow-up assessments show that our members' quality of life/perception of health status is not improved by 25% one year after the intervention?

    i. Of all of the goals we are measuring for our Model of Care, this one is perhaps the most tenuous, since it is the most subjective. However, because our model of care is for our patients, and its heart is to serve the patients, improvement of patient quality of life/perception of health status is a significant concern that we want to demonstrate.
    ii. Throughout our interaction with patients and their caregivers, we expect our care coordinators to check in with members, to ensure the members' needs are being met, that all questions are being answered, and that the services the care coordinators are providing are being rendered in a culturally and linguistically sensitive way. Nevertheless, as noted above, we recognize that while these services may be of help, many other factors contribute to a patient's sense of quality of life/perception of health status. A RCA of this measure, if results demonstrate that quality of life/perception of health status is not maintained or improving for at least 25% of the intervened group, as expected, would need to look at an array of the above factors.
    iii. A key factor in the analysis of this measure, if it does not reach the expected goal, will be to see if there are subgroups that meet what we expected. Does the outcome change by diagnosis? By hospitalization or other service usage? By PCP? And so forth.
    iv. In addition, while overall quality of life/perception of health status may not be maintained or improved, we might also find that certain aspects of quality of life/perception of health status were met, and for which the intervention was directly responsible. These could be aspects such as reduction in stress about their diagnosis, or more peace about end of life issues, for example. Any of these findings would be informative and important to help tailor the intervention further.

5. Likewise, each of the MOC elements will be examined, as outlined below.

    i. Has the CareAdvantage population changed? Do we need to change or modify the definition of our target population? Perhaps there has been an influx of a new subgroup, e.g. another ethnic group that has moved into the county, or a new series of homes (e.g. for seriously mentally ill or developmentally disabled people) have opened, leading to an alteration in the target group or the subpopulations of vulnerable members.
    ii. Have there been key changes in staffing? Have significant staff involved in the development, implementation or evaluation of the MOC changed positions? If so, how has that influenced the success of the MOC? How has that impacted the training of new staff or providers on the MOC?
    iii. What is the status of the provider network? Is access to PCPs and specialists for CareAdvantage members still adequate? Have grievances increased in this area? What are Provider Representatives hearing? Have there been extreme changes in the State or Federal budget or other high level policy decisions that impact our providers directly (e.g. SGR, wholesale provider reimbursement cuts, etc) that have influenced provider participation in the CareAdvantage program? Has HPSM's communication network been able to address these issues for providers, members and the public adequately? If not, how has this influenced the outcome of our MOC?
    iv. How have the results of the HRAs and the subsequent ICPs and ICTs (for high risk members, as applicable) served our members? Has the outreach approach been successful in achieving increasing and adequate member participation at each level (HRA, ICP, ICT)? At each check-in with care coordinators in any program, do members express satisfaction with their ICPs and ICTs? If not, why not? How can these processes be improved to increase member participation and member satisfaction?

All the above issues, and similar ideas, will be examined by the senior clinical and scientific analytic leadership on at least an annual basic as part of the evaluation of the MOC.

Example: If our data collection, analysis and reporting identify that our members and physicians are not happy with the way our Model of Care is collecting and using health risk assessment (HRA) data, then we will need to address this issue. We will need to first find out what the problem is—are the members refusing to do the HRA tool? If so, why—because we are gathering some of the data in our comprehensive assessment tool via telephone, and it feels redundant? Because they are not interested in completing the form annually? Because they think this is information that the plan does not need, only their doctor does? And so forth. Then, we will have to develop some solutions to these concerns, particularly if a large (greater than 1%) number of members have these same concerns. Perhaps we can develop the tool so that the member only needs to mark the areas with any changes. Or we can have the document come from the physician instead of the plan, etc. We can brainstorm with our pertinent committees to help us with addressing this issue, including the Consumer Advisory Committee, and even use focus groups if necessary, to see what solutions the members might

come up with. In addition, we can work with CMS to see what they might suggest, since this is a mandated process, and other plans across the country may have faced the same problem.

The physicians, in turn, may not be happy with receiving copies of all their patients' HRA tools. They may complain that they are not useful, they don't reflect what the patient's true condition is, and they are a pain to have to file, or scan into their EMR. If this occurs, we can go to our two advisory groups with external physician members for their input. Perhaps we can explain the project better in future waves of the mailings of the HRA tools. We might be able to have an article in the provider newsletter that addresses MD concerns, or even have an open meeting where they can come to ask questions. We can also consider incentives, if the work of the HRAs becomes too burdensome for some of our physicians with many patients. Further, we can explore alternative means of having the HRAs sent to the physician offices rather than via mail, so that they could be more readily put into patients' charts.

Both of these examples are types of actions we would be able to consider taking. They would be developed through the meetings outlined in earlier examples in this factor; then these potential solutions would be brought to the committees and groups for discussion, input and feedback that represent the applicable stakeholders, so that true improvement in the process and thus in the MOC could be achieved.

b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.)

1. Data Collection

At HPSM, many of the data sources identified in "factor a" are automated. Member demographic and eligibility data comes daily from the State of California, for example. HPSM has arranged that almost all major contracted hospitals send us automated laboratory data feeds monthly. Most large providers submit electronic claims.

In contrast, other key data sources are completed one-on-one with members. A nurse care coordinator performs the care coordination comprehensive assessment by phone with members. The member Health Risk Assessment (HRA), Health Outcomes Survey (HOS) and CAHPS are completed on paper (sent by mail) and if not received, are done over the phone with contracted vendors. HEDIS is done via automated (administrative) data and chart abstraction with on-site nurses during the specified HEDIS season by contracted vendors and HPSM trained staff. For overall MOC evaluation, as noted above, similar data sources are utilized, both automated and one-on-one. In addition, provider network data is both automated (kept in HEALTHsuite electronic database) and updated one-on-one e.g. when providers call with address changes to Provider Representative or during re-credentialing updates to the Credentialing Specialist triennially. Staff updates and training sign-in sheets are kept in human resource files and databases and so forth.

A variety of means is used for data collection used for evaluation of the Model of Care (MOC).

2. Analysis

HPSM's informatics team does the bulk of data analysis for HPSM's CareAdvantage MOC. This team is comprised of a senior health statistician and data analysts who specialize in SAS as well as research and analytic skills to compare and contrast data in a healthcare environment.

- The Senior Health Statistician is especially qualified for her health-related job as she is a nurse by training, who transitioned into informatics after getting a Master's degree and training in health research. She has worked in statistical research at HPSM for 11 years, and been the leader of scientific analysis at HPSM for the last seven of those years.
- The team's four Data Analysts are also key members of HPSM's scientific research team. Three of these staff have Master's degrees in statistics, and all have worked in this field for 2 to 5 years.

Multiple staff in the HPSM leadership, Health Services and Quality Departments use the analysis received from the scientific team to interpret the results of the performance measurements as well as the overall MOC evaluation. This occurs through meetings such as the Medical Management Review meeting. This meeting, chaired by the Medical Director, includes the CEO, Finance Director, Medical Director, Director of Health and Provider Services, controller and senior financial analysts, is held monthly. During this meeting, trends in hospitalization and ED usage, including reports on programs such as the MOC, are reviewed, goals and results are examined, and action items to address any shortcomings are developed. The quality team looks at the progress of such issues as the HEDIS measures. This is done in ad hoc meetings with key quality department staff including the medical directors, health educators, Pay for Performance (P4P) project specialist and quality improvement nurse specialists as data results become available. In addition, all these people, along with the senior health statistician and the quality administrative staff meet monthly in the Quality Improvement Projects and Initiatives (QIPI) meeting to review each quality program and project, assess progress, determine where results are not meeting expectations, and take action steps of change to improve the projects and programs as needed. Then these actions are subsequently reviewed for their results, in accordance with Deming's model of "plan, do, study, act, so that the projects are regularly modified where needed as a result of their evaluation. For the measurable goal of quality of life/perception of health status, in addition to review at the two previously-mentioned meetings, analysis occurs at the regular Care Coordination bi-weekly meetings.

At this meeting, one of the medical directors, the Director of Health and Provider Services, the nurse care coordinators and social worker review the periodic findings reported by the informatics team as a result of the compilation of information from the various pertinent member assessments. If performance measures are not meeting expectations, and one of the reasons is due to staffing lags (for example, not enough comprehensive assessments are being done), this can be addressed at the meeting, and action taken to improve this process. If

multiple performance measures are lagging, this will be brought for analysis to the weekly Senior Managers meeting, where each department director, along with the CEO, Finance Director, Director of Systems Improvement and Medical Director, attends. If just quality department measures are lagging, these can be discussed at the monthly Quality Management Oversight Committee (QMOC), where the Senior Managers attend along with quality department staff. Both of these forums allow a time where attendees can help analyze as a group whether additional resources are needed to address the unmet performance goals, and work together to determine strategies and a timeline for how to improve the progress of the activities, reporting timeframes and so forth. Each of these groups will also review the overall MOC evaluation as well. A focus on the performance measurement is to be expected, since as explained above, the performance goals have been chosen since they reflect all the elements in the MOC. However, each MOC element is also reviewed at least annually, and any specific element of the MOC that is problematic is also analyzed, its results interpreted, and an action plan for improvement according to the Deming model will developed for it, as well.

As documented in Element 3, the staff noted above are well-qualified to carry out the tasks of analysis and performance improvement needed to ensure the CareAdvantage MOC is continually improving, with key staff described below as follows:

- The Medical Director has worked at HPSM for 5 years. She is an MD, and also has an MPH. She is board certified in pediatrics and board eligible in preventive medicine including public health. Her preventive medicine as well as her pediatrics training included a major emphasis on the preventive health model and the importance of primary care. She has worked in the care of seniors and persons with disabilities for the past 23 years, and in quality improvement for the past 13 years. Her quality improvement work includes national recognition as a clinical leader at a CMS contracted quality improvement organization.
- The Health and Provider Services Director is a Master's prepared clinical nurse specialist who is also a public health nurse. She has worked as a leader at HPSM for over 5 years, and in the county health department before that. She is an expert in case management and care coordination, having developed and taught in this area for over 10 years. In addition to nursing, her BS is in computer systems, giving her expertise to develop systems tools such as the comprehensive assessment tool and work with DSS to develop the HRA.
- The Associate Medical Director—Health Services and Quality is board certified in Internal Medicine with a subspecialty certification in Rheumatology. She has worked in quality improvement for the past 10 years, including as an Associate Medical Director at a CMS contracted quality improvement organization. She has worked at HPSM for the past 4 years. This knowledgeable physician is often the medical lead for the internal ICT, and her expertise in chronic illness is integral to the team's understanding of its CareAdvantage patients who are seniors and/or persons with disabilities.
- All the Nurse Case Managers in the CareAdvantage program are RNs, who have practiced in the hospital, office, home health, developmentally disabled intermediate care facility or long term care setting for 2-20+ years. They are well versed in member

assessments, motivational interviewing, care coordination, development of ICPs, being part of an ICT and serving as the advocate for members so that the MOC they are implementing can come to life for the best outcome of the member.

- The HPSM Social Worker has a Medical Social Work degree, has been working in her field for 4 years, and brought experience working for a specific vulnerable subpopulation (Chinese elderly) to HPSM, when she joined 2 years ago. Her focus on meeting the social service needs of our CareAdvantage members has made her an integral part of the ICT team.
- Each Health Educator and the P4P Project Specialist is Master's prepared in Public Health. They have from 2 to 10 years of experience in putting their training that emphasizes preventive care, healthy eating, activity and access to health care into action on behalf of the members served by HPSM. Because of their expertise in quality improvement, each staff is involved in leading a number of quality improvement projects and initiatives based on HEDIS goals, including diabetes, and is skilled at working directly with both members and providers to ensure outstanding outcomes so that the members' health status can continue to improve.
- The Quality Nurse Specialists, both RNs, have over 10 years of physician office based nursing experience that is essential when they perform on-site office reviews for quality assurance. Their training and experience helps HPSM determine if an office/physician should be credentialed/recredentialed; if, after chart review, evidence-based guidelines are being met, and how is each component of the provider network that they review functioning, so that this information can be considered, as part of the MOC evaluation.
- The CareAdvantage Project Specialist, who has a Master's degree in Business Administration, is an expert in project management, project coordination and business workflow. She helps coordinate the management of project improvement efforts such as the overall evaluation of the MOC. She serves as the facilitator of action steps, ensuring timeframes are met, reports are submitted on time and in the correct format, etc. She has worked for HPSM for 3 years.

3. Reporting on Performance Measures

As noted above, the informatics staff, in particular the senior health statistician and her team of data analysts are the first level of reporting on HPSM's MOC performance measures, after they have completed their analysis. This information is shared with the appropriate teams responsible for the interventions of the measures. These include the Care Coordination unit nurses, the Director of Health and Provider Services, the medical directors, the quality department health educators, the P4P project specialist, quality improvement nurse specialists, finance staff and the Senior Managers at HPSM, including the CEO and the Finance Director. For selected projects, contracted vendors may have a role in reporting (e.g. HEDIS measures, HRA results) as well. Each of these assigned HPSM staff takes the information, works with it individually and/or as a group, according to their job expectations, to determine next steps for change, as needed (see above).

4. Acting on Reported Results

As described above, often the individual or group responsible for performing some aspect of the data analysis in the evaluation of the HPSM's MOC is also the staff relied upon to take the next step, if necessary, and develop a strategy for improvement as a result of the reported findings. In general, there is a core group of staff involved in all aspects of performance measure analysis and strategic development, including the overall evaluation of the MOC. These are the Medical Director, Associate Medical Director-Health Services and Quality, Director of Health and Provider Services and the Senior Health Statistician and the CareAdvantage Project Specialist. Then, additional staff are brought in to add breadth and resources so that robust solutions are developed and implemented. For example, for measures addressing quality of life/perception of care and health assessments, selected Care Coordination Unit nursing staff are involved in developing next steps. Staff who are part of the Long Term Care Clinical Management Team, in particular the Associate Medical Director-Long Term Care, are involved in measures addressing reduction of hospitalizations and ED visits. Quality Department staff, including all the health educators, quality improvement nurse specialists, and the P4P project specialist, take part in strategic development of HEDIS-related performance measures and associated quality improvement projects and initiatives. These are examples of how additional staff are mobilized along with the core group at HPSM to continuously work on the evaluation of the MOC and take action when results indicate that performance and outcome measures are not yielding the level of success HPSM had anticipated. Senior managers are involved, as well, in helping to develop strategic solutions, as well as provide constructive feedback (such as at the monthly QMOC meeting) on new/revised initiatives prior to implementation.

c. Describe how the MAO will use the analyzed results of the performance measures to improve the model of care (internal committee, other structured mechanism, etc.)

As noted above, HPSM follows the Deming model of process improvement. We apply our MOC interventions, quality improvement projects and initiatives that we have described, collect data and analyze the data to determine the results of what we have done. Our overarching goal, aligned with the Mission of HPSM, is to ensure high quality and preventive services for our members. The specific goals of our MOC are the ways we aim to do this. In factor b, above, the ways that each performance goal will be analyzed and approached to develop an improvement plan, starting with a root cause analysis, are described in detail. These issues are addressed there for the overall MOC elements, as well. Here, we describe some additional steps that we will take to evaluate the overall MOC, as well.

After we have analyzed and reported the results of our activities, determined what worked and what didn't, and planned the steps of change needed to do better as necessary, we also plan an overall review of the entire MOC. This is to be done as follows:

- Once a month, a Senior Managers' meeting is dedicated to the CareAdvantage program. In this meeting, any pertinent issues related to this line of business are discussed; for example, the status of the current bid, any recent HPMS notices, any

outstanding RAPS items, and so forth. Because of a relatively flat leadership matrix (e.g. both the Medical Director and the Director of Health and Provider Services are on the Senior Management team), any urgent clinical or programmatic issues can be raised for discussion at any Senior Management weekly meeting, or at the monthly QMOC meeting.

However, HPSM also specifically plans as a structured mechanism that, on a quarterly basis to have the MOC as a standing item on the CareAdvantage program agenda. This component of the CareAdvantage program agenda would be led by the Medical Director. While the overall MOC evaluation is done once a year, and the performance measurement goals are reviewed as part of multiple meetings reviewing all other quality goals, as described in factor b, above, these four meetings will be where, at a minimum, the MOC is reviewed with all elements in mind:

- o At each of these meetings, the current status of the MOC is to be reviewed.
- o Any concerns or issues, especially regarding performance measures and goals, or anything regarding the ongoing MOC evaluation, are to be discussed at these meetings. However, these meetings will encompass a much broader viewpoint than merely the MOC goals.
- o These meetings will also review the MOC document/program as a whole. Each segment of the MOC will be examined. Any concerns, or areas in need of revision, will be identified. Updating assignments will be made, and changes will be discussed before adoption.

- In this way, the MOC, as a dynamic document, will be reviewed and updated on a regular basis.
- The following is a case study example to show how this process would be applied:
  - o At the January 2012 Senior Managers' meeting focused on the CareAdvantage program, when the MOC status is assessed, and each element is reviewed, it is possible that a new vulnerable subpopulation will have become the responsibility of HPSM's CareAdvantage program. These might be dual eligible (Medi-Cal/Medicare) members who are seniors or persons with disabilities living in San Francisco who become frustrated with the new state process that will mandate them joining one of the two Medi-Cal managed care plans in San Francisco County. Because a number of these people find it less expensive to live "across the border" in San Mateo County anyway, we may see a notable sized group of them move into northern San Mateo County cities and automatically become eligible for HPSM. Because of the supplemental benefits offered under CareAdvantage, including 50 health-related taxi rides, vision and dental services, a good proportion of these dual eligible people are likely to enroll in CareAdvantage.
  - o If this increase in new CareAdvantage members happens suddenly, rather than gradually, it could disrupt the MOC processes. Thus, internal staffing might not have the capacity to absorb a sharp increase in care coordination calls, need for ICPs, more demand for ICTs, etc., internally (elements 2,4,8), as well as

potentially putting an unexpected strain on HPSM's provider network (element 5), overall member access to services (element 2) , and so forth. This could also impact our performance on all of our measurable goals (element 2), such as reducing hospital admissions and ED visits because if there is less provider access, and less availability of care coordinators for intensive case management services, patients will more likely fall through the cracks and end up with their illnesses advancing rather than having prevention optimized. Without good coordination with and support for our providers along with our members, improvements in our HEDIS scores for the comprehensive diabetes measures will decrease. And with members suffering these adverse health outcomes, it is unlikely that quality of life scores can be expected to improve, as outlined in our goal 4.

- As these changes for the worse are identified for the MOC elements, the Senior Managers would recognize that improvement actions need to be designed and implemented. General ideas would be discussed, and a timeline (e.g. follow up at the next monthly CareAdvantage discussion) would be set. Then a workgroup, consisting of the core group of staff involved in all aspects of CareAdvantage performance measure analysis and strategic development, including the overall evaluation of the MOC, as outlined above, would be charged with developing an action plan and next steps. These are the Medical Director, Associate Medical Director-Health Services and Quality, Director of Health and Provider Services, the Senior Health Statistician and the CareAdvantage Project Specialist.
- Using the Deming model of improvement, action steps would be designed, tests of change implemented, the results would be collected and studied, reported back to the Senior Managers, and if improvement is demonstrated, continued steps in this direction would be approved. Resources needed to support continued improvement and support the services required to build a better MOC would be authorized at the Senior Managers level, as that meeting includes the CEO and Finance Director.
    - During this time period, some actions might include hiring a temporary additional Provider Services Representative to help increase recruitment of physicians into the provider network so that capacity can be increased rapidly until a better equilibrium is met. An additional care coordinator position could be filled, since the increased membership would be likely to remain after enrollment. Review and modification of the health educators' work load might also be necessary, so that more effort can be devoted to the diabetes project. These efforts could be followed after three months, and six months, to see if these changes have brought needed improvements and stabilizations to the problems seen in the MOC elements. Monthly reports to the Senior Managers will keep them informed about the effects of these efforts.
- Once the MOC elements are demonstrated to be back on track, reporting will lessen until it is back to the twice a year regular reporting cycle. However, more

intense follow-up can again be triggered whenever decreasing outcomes might indicate it is again necessary.

Example: in addition to the descriptions and examples above, where Sr. Managers will specifically be apprised on a regular basis about the status of the MOC, its evaluation, any challenges, and so forth, the results of the MOC evaluation will be reported to various groups, depending on what is found, and what is needed, in order to get input, feedback, recommendations and steps for solutions to improve the MOC. For example, if problems are identified in any performance aspect related to the goals, and these involve quality issues, then the quality department will be mobilized by having the MOC results and problem areas discussed at the Quality Improvement Projects and Initiatives (QIPI) meeting. Here, MPH-trained health educators, led by the Medical Director, along with the Associate Medical Director, Quality Program Nurses, the P4P Project Specialist and the Senior Health Statistician, examine data and develop ideas in depth about programs related to quality improvement. Any issues related to the MOC measurements, goals, or other quality improvement issues would be discussed, developed and planned for implementation at the QIPI meeting and also would get good feedback from our provider network advisors on the Quality Assessment and Improvement Committee (QAIC). The QAIC committee in particular, has been established with members who represent a cross-section of quality expertise, including from public health, the public hospital, private providers with quality interest and training, the quality leader from our local integrated care system (Kaiser), and a consumer with quality interest. Challenges related to aspects of the Model of Care involving Care Coordination would be discussed at the Medical Management Review team, Sr. Managers' meeting or an ad hoc meeting involving the Medical Director, the Assoc. Medical Director and the Director of Health and Provider Services. Issues that need the input of the physician provider network, especially regarding new care coordination initiatives, would go to the Physician Advisory Group. The members of this group are very vocal about telling us whether a new tool for diabetes is something they would use in the office, or that they would give to their patients to use, etc. If members are dissatisfied with a particular effort, such as the use of the Health Risk Assessment tool, we would bring this to the Consumer Advisory Committee to hear if any of these members have any feedback about how to further improve the work we are doing with our MOC, what might be more acceptable for members, and so forth. In these ways, with the Medical Director as the lead in this effort, HPSM would explore any avenue as guided by its internal quality staff, senior leadership, external provider and consumer advisors, to find reasonable and feasible ways to improve its MOC so that it can best serve its CareAdvantage members.

d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.)

Each element of the Model of Care (MOC) is documented and ultimately brought together, primarily in an electronic format. HPSM has invested in a software system called "Compliance

360 (C 360)." This program allows for the filing for all sorts of related policies and procedures (P&P), contracts and analyses in one centralized database for the company, eliminating the need for each employee to keep their own copy of a policy or procedure. This approach allows the company to have one reference point for the most current copy of a document, eliminating confusion about who has the most recent version. This system also allows grouping and linking of documents, so that anything related to one program (e.g. the quality department) can be sorted in one area.

To the extent possible, HPSM plans to keep the P&Ps, MOC, and other related documents in C 360 and associated files. In this way, for example, anyone who needs to access the performance measures and outcomes of the MOC evaluation will be able to go to the MOC, and find the performance measures in a linked document easily, in a convenient manner.

The following information is also maintained on an ongoing basis to document and preserve the evidence that HPSM's MOC is active and effective:

- Meeting agendas and minutes—for each of the meetings held where the MOC, its performance goals and outcome measures, and overall evaluation are discussed, such as QMOC, Medical Management Review, Care Coordination Meeting, QIPI and Senior Managers' CareAdvantage monthly meetings, etc, agendas are created and minutes are kept.
- Policies and Procedures—All P and Ps related to the quality department, the care coordination unit, the long term care clinical management program, etc., are documented in C-360, updated annually at a minimum, and cited where applicable for the MOC
- MOC contracted data analyses—each contracted vendor results, summary report and/or analyses including HEDIS, HOS, CAHPS and HRA are received monthly to annually and collected in a data files related to C-360. These are used to prepare analyses that are reported in the minutes of the various meetings referred to above.
- MOC internal data analyses—all internal data analyses related to MOC performance and outcome measures and overall MOC evaluation are examined and discussed in the meetings cited above. Any analytic reports (e.g. graphs, data reports, etc) are included as part of the meeting minutes and included electronically or scanned in, depending on the data source of the report, in order to have a complete version of the meeting documents.
- MOC overall evaluation reports—any overall summary reports of the MOC evaluation are presented at the monthly CareAdvantage meeting of the Senior Managers. As noted above, this meeting has an agenda and minutes, and is the one meeting of the company that routinely focuses specifically on HPSM's CareAdvantage program. Any reporting documents summarizing the MOC evaluation presented here is entered into the meeting minutes and made part of the scanned documents memorializing the meeting that are kept in the file on CareAdvantage on the company's shared file.

Further examples of how these documents are used are as follows:

- o Copies of any of these documents are shared upon request with state and federal regulators.
- o They are used as references when doing comparative analyses of projects used to evaluate the success of the MOC over time.
- o They also serve to help document information that may assist with additional MOC projects in the future.

Case Study Example (beginning): the CareAdvantage Project Specialist makes notes of the key points of the monthly Sr. Managers' meetings where CareAdvantage issues are discussed. She will also do so at the quarterly meetings where the Model of Care is the main topic of discussion. If, for example, the Medical Director has, as a topic for that meeting's agenda, that there is a concern with the MOC's effectiveness because, after two years of our vendor achieving a 68% response rate with the High Risk Assessment (HRA) tools, they have only averaged 56% over the last 5 months; then, the Sr. Manager's group would discuss what the vendor has done so far to examine (root cause analysis) what might be the cause of the significant change—is it due to a change in staffing, methodology, demographics of recipients, and so forth. Everything discussed, including whether or not the HRA vendor is teleconferenced in to get their side of the story, would be documented in the Project Specialist's notes. These notes would be available in hard copy for the perusal of anyone looking through binders of the summaries of each meeting. They would also be available electronically in the company shared file for the Sr. Managers' meeting on CareAdvantage, and also e-mailed to all the attendees. Any comparable step in the evaluation of the effectiveness of the MOC would be handled in a similar fashion. (continued with next factor)

e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.)

The two people having the primary responsibility for monitoring and evaluating the model of care for effectiveness are the Medical Director and the Health and Provider Services Director.

The Medical Director at HPSM has a unique role in oversight of the MOC. Not only is she is a member of the core clinical group responsible for MOC problem solving, but she is a physician (MD) trained in quality methodology (with a Master's in Public Health). She directs the Quality Department and is also part of the Senior Management team; thus, she has an integral role in ensuring that the overall MOC evaluation is occurring as well as that the staff under her leadership is doing their part in strategic implementation. The Medical Director chairs a number of the key evaluation meetings: Medical Management Review, QMOC and QIPI. By having direct access to monthly data reports about hospitalization presented at the Medical Management Review meeting, ready access to ED visit information from the senior health statistician at QIPI, and HEDIS data results during the HEDIS process through the daily work of the quality department, the Medical Director is able to provide ongoing oversight as well as report broadly and discuss results, potential barriers and possible solutions through

appropriate team root cause analysis at the multiple meetings that occur with other oversight leaders at HPSM. This provides significant strength of HPSM's work in oversight, analysis, reporting and design/implementation of action steps in the evaluation of our CareAdvantage MOC.

- As noted earlier in factor b, above, The Medical Director has worked at HPSM for 5 years. She is board certified in pediatrics and board eligible in preventive medicine including public health. Her preventive medicine as well as her pediatrics training included a major emphasis on the preventive health model and the importance of primary care. She has worked in the care of seniors and persons with disabilities for the past 23 years, and in quality improvement for the past 13 years. Her quality improvement work includes national recognition as a clinical leader at a CMS contracted quality improvement organization.

The Director of Health and Provider Services is the other key staff who has core problem solving responsibilities for the CareAdvantage performance and outcome measures and the overall MOC evaluation, and is also a leader in oversight as part of the Senior Management team. As director of the CareAdvantage Care Coordination unit, she is a Master's prepared nurse with notable expertise in the Case Management model. She has developed the comprehensive assessment, led the team that developed the HRA used by our contracted vendor, and thus has an integral role in ensuring that the overall MOC evaluation is occurring as well as that the staff under her leadership is doing their part in strategic implementation. The nursing authorization unit is also under her direction, as are databases collecting information on frequent hospital admissions and ED visits. By having ready access to these data sets, the Director of Health and Provider Services is able to provide ongoing oversight as well as report broadly and discuss results, potential barriers and possible solutions through appropriate team root cause analysis at the multiple meetings that occur with other oversight leaders at HPSM.

This provides significant strength of HPSM's work in oversight, analysis, reporting and design/implementation of action steps in the evaluation of our CareAdvantage MOC.

- As explained in factor b, above, the Health and Provider Services Director is a Master's prepared clinical nurse specialist who is also a public health nurse. She has worked as a leader at HPSM for over 5 years, and in the county health department before that. She is an expert in case management and care coordination, having developed and taught in this area for over 10 years. In addition to nursing, her BS is in computer systems, giving her expertise to develop systems tools such as the comprehensive assessment tool and work with DSS to develop the HRA.

The Medical Director and Director of Health and Provider Services work with three other staff as key partners in the core group at HPSM responsible for evaluating the effectiveness of the MOC. These staff are:

- The Associate Medical Director (AMD)-Health Services and Quality
    - This AMD has an integral role in evaluating the effectiveness of the MOC because of her work on many levels. She is often the physician on the internal

ICTs; along with the Medical Director she interacts directly with physicians on the PAG and QAIC. She is active participant in the planning and implementation of root cause analyses (RCA) and the Deming model of improvement when performance measures don't produce the desired results

  - As outlined in factor b, The Associate Medical Director—Health Services and Quality is board certified in Internal Medicine with a subspecialty certification in Rheumatology. She has worked in quality improvement for the past 10 years, including as an Associate Medical Director at a CMS contracted quality improvement organization. She has worked at HPSM for the past 4 years. This knowledgeable physician is often the medical lead for the internal ICT, and her expertise in chronic illness is integral to the team's understanding of its CareAdvantage patients who are seniors and/or persons with disabilities.

- The Senior Health Statistician
  - Because the effectiveness of the MOC could not be evaluated without data and analysis, both of which depend in large part on the work of the Senior Health Statistician and her team, this staff is critical to any evaluation performed on the MOC. In addition, the years of experience in working with HPSM's data, and her understanding of the nuances of the various claims fields, make our Senior Health Statistician particularly indispensible as the initial analysis, and any RCA is done for poor outcomes. Her recommendations for the "why" of findings, and places to look for potential hypotheses, which are the next steps we take in our quality improvement projects for sub-performing elements or goals, are also very valuable contributions.
  - As indicated in factor b, the Senior Health Statistician is especially qualified for her health-related job as she is a nurse by training, who transitioned into informatics after getting a Master's degree and training in health research. She has worked in statistical research at HPSM for 11 years, and been the leader of scientific analysis at HPSM for the last seven of those years.
- The CareAdvantage Project Specialist
  - Any evaluation of a program's effectiveness relies on someone to facilitate the tasks, timelines, completion of action items, etc., as well as contribute insight and ideas to the planning of necessary quality improvement projects. That is why the CareAdvantage Project Specialist is such a key partner in the oversight of the MOC review. She keeps each aspect of the evaluation project on track; makes sure no element is overlooked; ensures all the necessary data and documents are available. These skills are critical for a smooth, timely review and completion of the annual MOC and performance measures evaluation.
  - As shown in factor b, The CareAdvantage Project Specialist, who has a Master's degree in Business Administration, is an expert in project management, project coordination and business workflow. She helps coordinate the management of project improvement efforts such as the overall evaluation of the MOC. She serves as the facilitator of action steps, ensuring timeframes are met, reports are submitted on time and in the correct format, etc. She has worked at HPSM for 3 years.

The next level of oversight for the MOC evaluation is HPSM's Senior Managers Team. This team, which includes the CEO, Finance Director, Medical Director and Director of Health and Provider Services as discussed above, also includes the Directors of Outreach and Member Services, MIS, Compliance and Regulatory Affairs, Human Resources, and Systems Improvement. Each of these leaders brings unique perspectives to the oversight of the MOC evaluation. For example, the Director of Outreach and Member Services has an important view on member responses, based on her and her staff's experience every day dealing with hundreds of calls; this information is helpful when looking at low member response to assessment tools, or poor member compliance. Another example is the MIS Director. He knows the details of claims data, eligibility data, etc, and how that might impact our HEDIS rates in ways the quality team might not suspect. Thus, when a RCA involving administrative results is discussed, his perspective about how to troubleshoot a barrier regarding accurate data collection is indispensible. In turn, each of these leaders helps provide oversight re: keeping the evaluation on track, but also assists in addressing barriers or other problems that may arise when the MOC performance and outcome measures as well as all the elements in the overall MOC are analyzed and reported as part of the evaluation process.

HPSM's Finance Director is also an important part of the oversight team that monitors and evaluates the CareAdvantage MOC. As a key leader at HPSM, and the officer responsible for all claims activities as well as HPSM's financial work, he is especially attuned to issues involving member utilization, data validity, provider incentives and so forth. He, too, takes an active part in questioning the status of projects, analyzing reports and results, etc., on the Medical Management Review committee, QMOC and the CareAdvantage meeting of Senior Managers, as well as any other Senior Managers' meeting where such issues are raised. When action items are developed, his staff are key team members in follow-through. Thus, he looks for results at subsequent meetings according to the timeframes his staff has agreed to.

The general oversight of HPSM activities, including for the MOC evaluation, belongs to the CEO, who exercises this role as the leader of the Senior Management team. She takes an active part in questioning the status of projects, analyzing reports and results, etc., on the Medical Management Review committee, QMOC and the CareAdvantage meeting of Senior Managers, as well as any other Senior Managers' meeting where such issues are raised. When action items are developed, she expects follow-through, and looks for results at subsequent meetings according to timelines initially set.

At HPSM, the group having ultimate oversight for the monitoring and evaluation of the Model of Care (MOC) effectiveness is HPSM's Health Commission. This group is essentially HPSM's Board of Directors. Because HPSM is a publicly-insured plan started by San Mateo County resulting from a federal waiver, our Board of Directors is called the San Mateo Health Commission or Health Authority. San Mateo County's governing body, the Board of Supervisors (BOS), appoints all members. There are eleven members on the Commission, 2 who are members of the BOS, 4 who represent providers, 2 who represent members, 1 who represents the business community, and the county manager.

The Commission meets monthly in an open public session, and is updated quarterly about quality issues, and the status of performance on quality initiatives including, when applicable, the MOC outcome measures. The Commission is a very engaged board, and members do not hesitate to ask questions about quality programs, why things are or are not happening, where projects are moving, etc.

As the above description demonstrates, there are many levels of staff, up to the governing board, interested and responsible for the effectiveness of HPSM's CareAdvantage MOC. The reason that the MOC is established with review up to the highest levels of authority at our plan is clear: we want to make sure that everyone in key leadership positions is aware of how we are doing in our service to our members. This is how we are all held accountable, so that our members are assured of getting the highest quality care we can provide.

Case Study Example (continued from factor d, above): The Medical Director has received the report that was collected by the CareAdvantage Project Specialist from the HRA vendor about the significant decrease in response rate by members. She calls an internal meeting with the Health and Provider Services Director, the Project Specialist and the Senior Health Statistician to look at the raw data the vendor has sent. The group meets, and notes that the data demonstrate an apparent drop off in the number of HRA surveys sent out during the first three months of the year. It is unclear why. The Senior Health Biostatistician (SHB) agrees to look into that. For the following two months, it looks like the rate has increased so that in the fifth month the response rate was back up above 60%. It was still below the previous average of 68%, though. The team decides to call the vendor's lead scientist to see if there was any change that they could attribute the rate slip to. They have another meeting, during which the lead scientist is called, and he and his assistant lead both attend. They report that they and their team have tried to identify what might have changed to have caused such an apparently abrupt and severe reduction in the response rate for the HRA, especially since it had seemingly steadied after over a year of use. They also had noted the decrease in the number of surveys sent out, and found that it was due to the number of new CareAdvantage members on their lists from HPSM for those three months. The SHB acknowledged that she would be researching that to see if, somehow, the new member enrollment had dropped, or there had been a glitch in passing the new member info to the vendor.

The vendor also stated that they had analyzed the earlier received data, and the lowest response group was English speakers. The lead scientist commented that, ironically, in the months with the fewer new members enrolled, the ones that were enrolled were almost all English speakers. In the subsequent two months were members were increasing, these primarily consisted of Tagalog and Russian speakers, who were the most compliant in returning the surveys. That is why, in his opinion, the numbers were again climbing. Thus, the group had another issue to tackle—how to improve the response rate of the English-speaking CareAdvantage members to the HRA survey tool. They planned another meeting with the vendor experts to discuss recommendations of steps they could put into place to help with that effort. The Health and Provider Services Director also mentioned that, at least for the group of

respondents who was receiving care coordination services, her staff could remind them to return the survey when they got it. The group decided that any contact with a member—when they called member services, when they got the member newsletter, when they called for health education materials, and so forth—would be a time when they could get a reminder about the HRA survey. Each of these reminders would reinforce the importance of the survey, and if they hadn't received their annual survey as yet, the members would be primed to complete it when it did arrive. The group agreed to meet after their action items were completed and to continue to follow up on the response rate. The next meeting was set so they could see the status of the issue within a month.

As can be seen from this case study example, the lead people involved in the evaluation of the MOC step up and take action when the results indicate that any aspect of the MOC is not performing to the level expected.

f. Describe how the MAO will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.)

When improvements to HPSM's Model of Care (MOC) occur, HPSM believes both internal and external stakeholders deserve to be told. We have multiple ways we communicate these findings. These include the following:

- Notice to all HPSM employees via e-mail from the CEO
- Notice on the HPSM web site
- Article in the quarterly HPSM member newsletter
- Article in the bi-annual HPSM provider newsletter
- Announcement or presentation at various stakeholder meetings, including HPSM's San Mateo County Health Commission, Physician Advisory Group, Quality Assessment and Improvement Committee, Consumer Advisory Committee
- Other media approaches, as applicable.

The process for notification would be as follows:

- o When an improvement is identified, it is likely to be noted by one of the core group members (Medical Director, Health and Provider Services Director, AMD-Health Services and Quality, Senior Health Statistician, CareAdvantage Project Specialist)
- o Examples could be that the improvement may be in one of the MOC elements, such as expansion of needed specialties in the provider network, additional new services or benefits, increased access, new programs and specialized ICTs, etc.

- Other examples could be that the improvement may be in one of the MOC performance measures and outcomes, such as goal one or two—reductions in hospitalizations or ED visits for our high risk members receiving intensive case management; or goal 3 HEDIS comprehensive diabetes scores may have increased as much or more than we expected; or the quality of life of high risk members receiving intensive case management services may have improved as much or more than our goal.
- Once the improvement is identified and confirmed, it is shared with the Senior Managers team. A communications plan is discussed and developed there, and includes one or more of the notice types listed above. Depending on how widespread the work to achieve the improvement is (e.g. a large number of providers, agencies etc, vs. only internal staff, a specific subpopulation of members), the notification will involve more widespread public information as well as notice to the involved providers.
- The results are shared with the Health Commission either for discussion, or at a minimum, as an information item.

A case study of what we would do can be shown by a special project we are working on that impacts element 10, special subpopulations.

We have identified a health disparity between our CareAdvantage women with disabilities and those who have no disabilities and breast cancer screening. We have heard from community experts that a lot of the women not getting mammograms as recommended are women with developmental disabilities and serious mental illnesses, in addition to those with physical disabilities. Therefore, we submitted a proposal, and were awarded a grant to provide a special training workshop and technical assistance for mammography technologists and breast screening center schedulers, on how to better serve these special populations. Our goal is to get each center to commit at least two appointments per week for women with disabilities (these need to be longer than typical appointments, so they need to set aside special times). We are also combining the provider training and commitment with dedicated marketing outreach to this vulnerable population, focused on letting them know that now there are centers trained and ready just for them to meet their needs. We have specific target goals for increased mammograms overall for our women with disabilities as a result of these efforts.

If we attain these goals, it would be a remarkable achievement for the entire community. In addition to writing newsletter articles for our members and providers, as well as placing them on our website, we would definitely want to make presentations about these findings to the Health Commission and other community groups. These could include the Commission on Disabilities, as well as local community groups working with or representing the vulnerable subpopulations particularly of the seriously mentally ill and the developmentally disabled. This would hopefully help spread the message about these services as well as report the quality improvement results we have achieved.

Additionally, we would want to get press coverage of our results. Each of the providers that made the commitment to train their technologists and schedulers, and opened their appointment schedule to accommodate women with disabilities would be acknowledged publicly. Not only would it be important to thank them, but this would also hopefully make more providers aware of the issue, and interested in wanting to do the same thing at their facility. And most importantly, all the publicity would hopefully also make more women with disabilities have increased awareness that they need mammograms too, and that there are places they can go that make getting this test easier. This would be the best aspect of the achievement overall.

As far as timelines for reporting on MOC improvements, any findings are reported at the next meeting following the determination of the improvement. For example, if a meeting occurs quarterly, the finding would be reported at the next quarterly meeting following the determination or release of the finding.

Sample of Community Announcements and Publications

In addition to the verbal announcements, and publications in meeting minutes, as outlined above, the following are examples of community publications with more widespread distribution where announcement would be made.

- The following is a press release HPSM sent to local media after we became the number one Medicaid managed care plan in the nation for immunizations based on HEDIS data. We would release something similar to announce an improvement in rates of mammography for typical vs. disabled women based on HEDIS data.

The Health Plan of San Mateo (HPSM) Media Release

healthy is for everyone

For Immediate Release
Jan. 24, 2011

Contact: R. Russell Hoyle
Director of Marketing
650-616-2020
russell.hoyle@hpsm.org

Local Health Plan Tops Nation in Child Immunizations

South San Francisco, Calif.—The Health Plan of San Mateo (HPSM), San Mateo County's community health plan for Medi-Cal and other publicly funded health coverage programs, now has the nation's highest rate of child members immunized on five important measures, according to the 2010 rankings of the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a performance measurement tool of the National Committee on Quality Assurance (NCQA), used by more than 90% of America's health plans.

HPSM's number one scores are for the measles, mumps and rubella vaccine (MMR) with 98.3% children immunized, the chickenpox vaccine (VZV) with 98.3% immunized, pneumococcal conjugate vaccines (93.43% immunized), tetanus and accellular pertussis (DTaP) with 92.21% immunized, and other multiple vaccines (Combo 3) with 87.35% children covered.

"As a pediatrician and a mother, I believe an investment in childhood immunizations should be a foundation and focus of any health plan and any community," said Dr. Mary Giammona, HPSM's medical director. "Protecting our children's health is an investment in our future."

HPSM's successful child immunization program consists of fliers, direct-mail reminder postcards, and $15 Target gift card incentives (courtesy of San Mateo County's First 5 Program). HPSM health educators also work with the San Mateo County Health System to assist plan physicians in using a county created immunization registry, helping the plan and physicians track which children need follow-up to get fully immunized. Materials are provided in both English and Spanish, and HPSM has bilingual staff to ensure questions are answered in the member's primary language. HPSM staff members also speak Chinese, Tagalog, and Russian, and use a phone interpreter service for other languages.

"At HPSM, we fight every day to ensure our members receive high quality care," said CEO Maya Altman. "But the real honor goes to our partner hospitals, providers, and the staff who support them. It is their professionalism and dedication that show in these results. I'm happy in the knowledge that together we're helping so many families get the quality care they need."

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-more-

We fight to make a difference in our community.
701 Gateway Blvd. Suite 400 South San Francisco, CA 94080

The following is an article in HPSM's provider newsletter about a successful summit we sponsored to provide end-of-life education for our physician network. Any improvements we would make in our MOC program would be written about in this manner, likely as an article coming "From the Desk of the Medical Director…" since she is the lead of the MOC.

health matters MD

Health Plan of San Mateo Provider Newsletter Winter 2009

From the Desk of the Medical Director

Why Providers Are Key to End-of-Life Care

Gary Lee, M.D., palliative care medical specialist from Santa Clara Valley Medical Center, was the keynote speaker at Health Plan of San Mateo's End-of-Life Summit in June.

Talking about end-of-life issues with patients usually doesn't come easily: Who has the time? It seems awkward. What do you say, especially to patients from different cultures? Then, before you know it, Mrs. Jones is 98, in a nursing home with dementia, still full code—and we never talked to her about what she wanted before this time came.

In June, Health Plan of San Mateo (HPSM) facilitated the End-of-Life Summit, which was generously funded by the California HealthCare Foundation and clinically sponsored by San Mateo Medical Center, the San Mateo County Medical Association, Seton Medical Center and Stanford Geriatric Medical Education Center.

Participants heard a superb keynote speech by Gary Lee, M.D., palliative care medical specialist from Santa Clara Valley Medical Center. Other expert speakers led informative sessions about spirituality and end-of-life care, cultural issues, and tips for incorporating end-of-life discussions into private practice, including how to use the POLST (physician orders for life-sustaining treatment) form.

Key points about end-of-life talks

They are not about giving up or death. It is best to avoid using this phrase and wording. They are talks about what gives meaning to a person's

more on page 3

In this Issue:

2 Get help meeting your patients' linguistic needs

3 Go paperless! Access your reports online

4 HPSM's Medi-Cal Nursing Facility Benefit

Any improvements in the MOC would also be highlighted on the launch page (home) of our web site. Here is the screen shot of our current home page, where the latest current issues of importance are highlighted (see News and Announcements):

Appendices

A. Predictive Modeling Overview *(applicable to Element 10, Factor A)*

B. P&P UM-20: Case Identification of High Risk Members for Case Management *(applicable to Element 10, Factor A)*

C. High Utilizers Group (HUG) Work Plan *(applicable to Element 4, Factor A)*

D. HPSM Communications Survey 2010 *(applicable to Element 9, Factor D)*

E. HPSM Website Usability Study *(applicable to Element 9, Factor D)*

F. Health Risk Assessment Tool *(applicable to Element 7, Factor A)*

G. CR-02 Recredentialing of Physicians, Non-Physician Medical Practitioners, Mid-Level Clinicians, and HIV/AIDS Specialists *(applicable to Element 5, Factor B)*

H. CR-07 Denial, Reduction, Suspension, or Termination of Practitioner Status *(applicable to Element 5, Factor B)*