Community Health Group's Response to California's Dual Eligible Demonstration Request for Solutions

Presented By

Norma Diaz, Chief Executive Officer

Community Health Group

Request for Solutions Contact Person:

Ann Warren, Chief Regulatory and Legal Affairs

619-498-6516

February 24, 2012

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Toby Douglas, Director

Department of Health Care Services
Office of Medi-Cal Procurement
MS 4200

1501 Capitol Avenue, Suite 71.3041
P.O. Box 997413
Sacramento, CA 95899-7413

Re: California's Dual Eligibles Demonstration Project Request for Solutions (RFS)

Dear Mr. Douglas:

Community Health Group (CHG) is pleased to submit its application to become a participant in California's Dual Eligibles Demonstration Project.

CHG is comprised of two legal entities. CHG is the Sole Member of CHG Foundation. Both organizations are non-profit public benefit corporations. The purpose of both organizations is to provide comprehensive health care services on a prepaid basis by operating organized health maintenance and health care delivery systems. CHG provides health care services to members under the Healthy Families Program in the County of San Diego and portions of the County

of Riverside and to members eligible for Medicare and Medi-Cal in the County of San Diego under a Dual Eligible Special Needs Plan (D-SNP). CHG Foundation (dba: Community Health Group Partnership Plan) provides healthcare services under the California Medi-Cal Program in the County of San Diego. Both organizations are licensed by the State of California as a Health Care Service Plan pursuant to the Knox-Keene Health Care Services Act. Unless otherwise stated, both organizations are collectively referred to as "CHG" or "The Plan" in the Dual Eligibles Demonstration Project Application.

CHG has operated in San Diego County since 1982. Using a member-centered, cost-effective model of managed healthcare, CHG currently manages the care of over 139,000 Medi-Cal and Healthy Families members and D-SNP members that often require integration of services, including coordinating acute, behavioral health, substance use and long-term care services. CHG has been managing a D-SNP program and providing managed care services for the dual eligible population since January 1, 2008. In addition, CHG has extensive experience in managing quality healthcare services for the most vulnerable populations in San Diego County, including an established track record of providing high quality and cost effective care in an integrated care coordination model for members who have multiple and/or complex conditions.

Enclosed please find our responses to the Department of Health Care Services' (DHCS) Request for Solutions for California's Dual Eligibles Demonstration Project. We look forward to assisting the DHCS and the Centers for Medicare and Medicaid Services (CMS) to achieve optimal value and care for the dual-eligible beneficiaries in San Diego County.

CHG has made its best efforts to answer the RFS completely and according to your instructions. If for any reason we have made an omission or if you have any further questions or require additional information, please feel free to contact me or our RFS contact Ann Warren.

Sincerely,

Norma Diaz
Chief Executive Officer

California Dual Eligible Demonstration Request for Solutions Proposal
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Tab 1- Checklists

Applicant Name: Community Health Group T Date: February 24,

California Dual Eligible Demonstration Request for Solutions

Proposal Checklist

(Please Refer To Tab 5 for Table of Appendices)

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

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7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	x	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.	x	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	x	
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	x	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	x	
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	x	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	x	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	x	

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14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	x	
15	If Applicant is a limited liability company or limited partnership, it is in “active” standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	x	
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	x	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	x	

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	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	Four	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	No	CHG received a sanction in 2008 that was not significant. See Appendix #7
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	See Appendix #8a
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes	See Appendix #9
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	See Appendix #9
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	The plan anticipates adding: limited dental, vision, non-emergency transportation and worldwide emergency services.
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	The Director of County of SD HHSA who oversees: IHSS/Public Authority, AIS, Social Services, Behavioral Health and MSSP have provided a Letter of Agreement. See Appendix #26
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	The LOA to Work in Good Faith outlines the County of SD commitment to work with plans to engage in a formal agreement. See Appendix #26

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10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes	CHG has a signed MOA with County of San Diego Behavioral Health Services which will be updated as needed. See Appendix #27
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	CHG has contracts with Community Clinics which are actively participating in Home-Health Grant, Technology and CMMI Grant applications. See Appendix #28

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
2.2.1	Applicant will develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1, which stipulates the criteria in the RFS.	x	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	x	
5.1	Applicant will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.	x	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	x	
5.3.3	Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review. A detailed operational plan for beneficiary outreach and communication. An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.	x	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	x	

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6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	x	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	x	
7.8	Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	x	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	x	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	x	

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Tab 2 - Mandatory Qualification Requirements

Mandatory Qualification Requirements

All Applicants must certify the following.

1. Knox-Keene License

Applicants must have a current unrestricted Knox-Keene License showing authority to operate in the State in order to participate in this RFS. Applicants must provide a copy of a current Knox-Keene License and has no adverse actions with regard to enforcement, or quality management. COHS plans would not need to seek separate Medi-Cal Knox-Keene licensure for purposes of participating in the Demonstration. COHS plans are exempt from Knox-Keene licensure for Medi-Cal pursuant to Welfare and Institutions Code Section 14087.95.

CHG has current and unrestricted Knox-Keene Licenses, which reflect authority to operate in the State of California. (Please refer to Tab 1 – Request For Solutions (RFS) Proposal Checklist and Tab 5, Appendix #1, attached.)

2. Financial Condition

Existing Knox-Keene Licensed Applicants must be in good financial standing with DMHC. Applicants must submit a letter from DMHC demonstrating that the Applicant is in good standing with DMHC. DHCS reserves the right to request additional information in the event DMHC does not provide a qualified letter of good standing.

CHG is in good financial standing with the Department of Managed Health Care (DMHC).

See attached letter from DMHC. (Please refer to Tab 1 – RFS Proposal Checklist and Tab 5, Appendix #2, attached.)

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

There must be experience operating a D-SNP in each Demonstration county. Criteria for D-SNP experience will vary by type of county. All Applicants must provide responses to all SNP Model of Care Elements and Standards, as modified to reflect the Dual Demonstration Application (See Appendix C).

a. Two-Plan Model Counties

At least one of the Applicants must have experience in the last three years operating a D-SNP in that county. The other Applicant must certify that it will work in good faith to meet all the D-SNP requirements in that county the next year.

Please refer to sub-section C below.

b. County-Organized Health System (COHS) Counties

The Applicant must have experience in the last three years operating a DSNP.

Please refer to sub-section C below.

c. Geographic Managed Care Counties

At least one of the Applicants must have experience in the last three years operating a D-SNP in that county. All other County Applicants that do not have a D-SNP must certify that it will work in good faith to meet all the D-SNP requirements in that County in the next year.

San Diego County is a Geographic Managed Care County (GMC). CHG has successfully operated a Dual Eligible Special Needs Plan (D-SNP) in good standing with the CMS since January 1, 2008. (Please refer to Tab 1 – RFS Proposal Checklist and Tab 5, Appendix #3, attached.)

4. Current Medi-Cal Managed Care Plan

Applicants must have a current contract with DHCS to operate a Medi-Cal Managed Care contract in the same county in California as the proposed dual eligible site.

a. Two-Plan Model Counties

For Applicants in Two-Plan Model Counties, Applications will only be considered if both plans submit an individual Application.

Note: DHCS encourages cooperation and collaboration between local plans. Applications that demonstrate such collaboration will receive additional consideration.

Please refer to sub-section C below.

b. County-Organized Health System (COHS) Counties

For Demonstration site Applications in COHS Counties, only the current COHS may apply.

Please refer to sub-section C below.

c. Geographic Managed Care Counties

For Demonstration site Applications in Geographic Managed Care Counties, at least two entities with a current Medi-Cal managed care contract must apply for the Applications to be considered.

Note: DHCS encourages cooperation and collaboration between local plans. Applications that demonstrate such collaboration will receive additional consideration.

CHG possesses a current Medi-Cal contract with DHCS. Through the Healthy San Diego Collaborative, CHG is aware of at least three other Medi-Cal Managed Care Health Plans who are submitting applications. CHG is collaborating through Healthy San Diego and San Diego County's Aging and Independence Services' (AIS) Long Term Care Integration Project (LTCIP) with other health plans and stakeholders on the Dual Eligibles Demonstration Project. (Please refer to Tab 1 – RFS Proposal Checklist and Tab 5, Appendix #4, attached.)

5. Subcontracting

Applicants must work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.

CHG agrees to work in good faith to subcontract with other Dual Eligible Special Needs Plans (D-SNP) to ensure continuity of care. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

6. Countywide Coverage

Successful Applications will demonstrate ability to cover a county's entire population of dual eligibles, as required by their existing Medi-Cal contracts. To be

considered, Applicants must certify they will coordinate with relevant entities to ensure coverage of the entire county's population of duals. (Certain exceptions will be allowed in rural areas of large counties, as currently allowed by Medi-Cal managed care contracts.)

For both Medi-Cal and Medicare lines of business, CHG is able to cover San Diego County on its own and certifies it will coordinate with relevant entities as needed to ensure coverage of San Diego County's entire population of Dual Eligibles. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

7. Business Integrity

Applicants must demonstrate business integrity by:

Listing all sanctions, penalties and corrective action plans issued by Medicare

or a state of California government entity taken in the last five years, including information about the reason for the corrective action plan and the resolution. An action taken does not necessarily result in disqualification. (Include this list in an attachment. It will not count against the page limit.)

CHG had one sanction imposed by DMHC in connection with a 2008 claims audit. The sanction has been resolved and there are no other DMHC sanctions pending. (Please refer to Tab 1 – RFS Proposal Checklist for details of the 2008 sanction, and Tab 5, Appendix #7, attached.)

Certifying that they are not under sanction by Centers for Medicare and Medicaid Services within California.

CHG certifies that its entity is not under any sanctions by CMS within California. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

c. Certifying that it will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.

CHG certifies that DHCS will be notified within 24 hours of any future Medicare sanctions or penalties, should such sanctions or penalties occur. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

8. High Quality

Applicants must demonstrate a capability of providing for the health and safety of dual eligible beneficiaries. Applicants must list the most recent three years of all the following (Include this list as an attachment. This will not count against the page limit):

a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.

For Medi-Cal, CHG utilizes the DHCS-established quality performance indicators, specifically:

The external accountability set performance measures - Healthcare Effectiveness and Data Information Set (HEDIS),

Consumer Satisfaction Surveys – Consumer Assessment of Healthcare Providers Over/Under Utilization Monitoring, and

Quality Improvement Projects (QIPS).

(Please refer to Tab 1 – RFS Proposal Checklist for the most recent three years of Medi-Cal performance indicators and measurements, and Tab 5, Appendices #8a, attached.)

b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.

For the D-SNP, CHG uses the CMS quality performance requirements, specifically:

HEDIS,

CAHPS,

Health Outcomes Survey (HOS),

Model of Care (MOC),

Chronic Care Improvement Program (CCIP), and

QIPS.

(Please refer to Tab 1 – RFS Proposal Checklist for the most recent three years D-SNP performance indicators and HEDIS measurements, and Tab 5, Appendices #8b, attached.)

9. NCQA Accreditation

Applicants shall certify that they will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of their participation in the Demonstration.

CHG certifies that it is currently National Committee for Quality Assurance (NCQA) accredited and has been since 2002. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #9, attached.)

10. Encounter Data

Applicants must certify that they will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.

CHG certifies it will continue to provide complete encounter data as specified by DHCS to support the monitoring and evaluation of the Dual Eligible Demonstration Project. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

11. Americans with Disabilities Act and Alternate Format

Applicants must certify that they shall 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, and shall develop a plan to encourage its contracted providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review. More specific requirements will be included in future state guidance.

CHG certifies it will fully comply with the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provisions, including communicating information in alternate formats, and will develop a plan to continue to encourage its contracted providers to do the same. CHG also certifies that it will provide an operational approach to accomplish this as part of the Readiness Review. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

12. Stakeholder Involvement

Applicants must demonstrate a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the project. As such, Applicants must certify that 3 of the following 5 are true:

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

CHG has elected to certify compliance with items 3-5 below.

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).

CHG has elected to certify compliance with items 3-5 below.

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.

CHG certifies it has five letters of support from the community. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #12a, attached.)

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.

CHG certifies it has sought and accepted community-level stakeholder input into the development of the application. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #12b, attached.)

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

CHG conducted a focus group with stakeholders that included participation from the dual eligible population in the community. This focus group represented various age groups, including Seniors and Persons with Disabilities (SPD). The focus group discussion was designed to obtain input on benefits, communication preferences (i.e. website, newsletters etc.), perceived barriers/challenges to accessing services, and grievance processes. The outcome of the meeting was informative and comments will be taken into consideration during the implementation of the Dual Eligibles Demonstration Project.

Additionally, CHG has been actively participating in the San Diego County AIS LTCIP Stakeholder Meetings for the past 10 years which is now focused on the implementation of the Dual Eligibles Demonstration Project. This work team has been very instrumental in providing a forum for Managed Care Organizations (MCO) to collaborate with County Agencies and hold forums for stakeholder input. On February 14, 2012, the LTCIP held a Stakeholders Meeting to solicit feedback from stakeholders and for MCOs to share their vision of implementing a successful Dual Eligibles Demonstration Project. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #12c, attached.)

13. Attestation

DHCS may refuse to enter into a contract with a Applicant if any 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. Applicant shall certify that it has no such relationships with such a person.

CHG certifies it has no relationship with anyone who has been convicted of a criminal offense under Medicaid (Medi-Cal), or Medicare. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #13, attached.)

14. Corporations

Corporations must certify they are in good standing and qualified to conduct business in California.

CHG certifies that its entity is in good standing and qualified to conduct business in California. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #14, attached.)

15. Limited Liability Companies and Limited Partnerships

Limited Liability Companies and Limited Partnerships must certify that they are in "active" standing and qualified to conduct business in California.

This certification requirement does not apply to CHG.

16. Nonprofit Organizations

Non-profit organizations must certify their eligibility to claim nonprofit status.

CHG certifies that it is a non-profit organization. (Please refer to Tab 1 – RFS Proposal Checklist, and Tab 5, Appendix #16, attached.)

17. Past Business Practice

Applicants must certify they have a past record of sound business integrity and a history of being responsive to past contractual obligations.

CHG certifies that its organization has sound business integrity and a history of being responsive to past contractual obligations. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

18. Work plan and Deliverables Certification

The Applicant must certify that they are willing to comply with future Demonstration requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. In addition, the Applicant certifies that it will provide operational plans for achieving those requirements as part of the Readiness Review.

CHG certifies that it will comply with all future Demonstration requirements as specified by DHCS and CMS. CHG will provide operational plans for achieving the requirements for the California Dual Eligibles Demonstration Project as part of its readiness review. (Please refer to Tab 1 – RFS Proposal Checklist, attached.)

Tab 3 – Project Narrative

Section: Executive Summary

Community Health Group (CHG) is pleased to submit its response to the California Department of Health Care Services (DHCS) Request for Solutions (RFS) for the Dual Eligibles Demonstration Project to provide health care services to individuals eligible for Medicare and Medi-Cal benefits in San Diego County. We are a local, non-profit health plan that has served San Diego County's residents for the past 30 years. We currently serve over 139,000 members, of which over 2,000 are dual eligible members enrolled in its Medi-Cal plan, over 9,000 are Medi-Cal Seniors and Persons with Disabilities (SPD) members, and over 1,000 are Dual Eligible Special Needs Plan (D-SNP) members.

CHG views its participation in the Dual Eligibles Demonstration Project as a continuation of the products and services it provides to currently enrolled members. These products and services include but are not limited to: coordination of benefits, continuity of care and services, referral to home- and community-based alternatives, working with members who desire to self-direct their care, improving health processes, outcomes and patients' satisfaction and monitoring the provision of high quality and cost-effective care.

CHG will offer the full range of services covered by Medicare Parts C and D and Medi-Cal, behavioral health in coordination with the San Diego County Specialty Mental Health Plan, and Long-Term Supportive Services (LTSS), including: In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), long-term custodial care and the Multi-Purpose Senior Services Program (MSSP). In addition to the above products and services, CHG is evaluating the feasibility of offering the following add-on benefits: non-emergent transportation, worldwide emergency services, vision benefits, and a dental benefit to ensure a full-range of integrated services.

Members currently have access to an extensive Medi-Cal/Medicare provider network in San Diego County. The network includes a significant number of Primary Care Physicians (PCP) and specialists in addition to contracts with Federally Qualified Health Centers (FQHC), acute care hospitals, Long Term Acute Care Hospitals (LTACH) and Skilled Nursing Facilities (SNF). The Plan also has contracts with Independent Practice Associations (IPAs), has Memorandums of Agreement (MOA) with several San Diego County Health and Human Services Agencies (HHSA), and has a MOA in place with the San Diego County Specialty Mental Health Plan.

The Plan is constantly expanding its partnerships with San Diego County agencies and anticipates executing additional MOAs with the San Diego County Behavioral Health Plan, San Diego County Aging and Independence Services (AIS), IHSS, San Diego County Public Authority, San Diego County Public Health Services, MSSP and providers in San Diego County to ensure the full integration of all covered benefits for Dual Eligible members.

CHG is excited and is 100% dedicated to working with DHCS and the Centers for Medicare and Medicaid Services (CMS) to successfully transition a high-risk population into managed care and therein demonstrate that it is possible to provide coordinated and seamless care using a beneficiary-centered delivery model to improve the quality of care, reduce institutional care, enhance home- and community-based services and to accomplish all of the above in a cost effective manner.

Application

Section 1: Program Design

Section 1.1: Program Vision and Goals

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

CHG is organized as a local, non-profit health plan and has served dual eligible beneficiaries in San Diego County for the past 30 years. Over the years, CHG has consistently maintained the largest Medi-Cal market share in San Diego County. CHG currently serves dual eligible members in its Medi-Cal plan as well as Medi-Cal only SPD members. The Plan coordinates the physical, social and behavioral health needs of its dual eligible members and works closely with providers, Community-Based Organizations, San Diego County Behavioral Health Plan and Healthy San Diego stakeholders to ensure proper coordination and access to care.

Enrollment in CHG's D-SNP began in January 1, 2008 through a contract with CMS. The Plan's historical experience with this population positions it well for participation in DHCS' Dual Eligibles Demonstration Project.

Question 1.1.2

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

CHG's Mission Statement states "Community Health Group is a health plan that is dedicated to improvement and maintenance of health for our members to help them achieve optimum health while demonstrating Exceptional Service and competency in serving diverse populations." Given its Mission, CHG believes the

goals of the Dual Eligibles Demonstration Project are closely aligned. To ensure that excellent service is provided, CHG has recruited and trained a dedicated San Diego-based Member Services staff who is available 24 hours a day/7 days a week to assist members and ensure they receive the care and community services they need. CHG's staff works hard to remove barriers to care for its members while ensuring they receive exceptional customer service in the process. CHG's mission has always been and continues to be dedicated to serving San Diego County beneficiaries and is built around the needs of this population. CHG is committed to its members and the community it serves. Through participation in the Dual Eligibles Demonstration Project, CHG will be able to improve care coordination and integrate the full range of services to meet the needs of members.

Question 1.1.3

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

CHG has specifically designed its program to align with the DHCS goals for the Dual Eligibles Demonstration Project. It is critical to allow members to be active participants in their care and to maximize their ability to remain in their homes and community. CHG's care management team, including its Behavioral Health Program Manager, member services and clinical staff work together to meet each member's health, social, psycho-social and behavioral health needs. The Plan's Interdisciplinary Care Team (ICT) works together with the member and provider network to develop care plans to address members' specific clinical needs. The ICT works closely with community-based programs and services to address the full needs of each member. Being a local health plan allows CHG staff to be out in the community, and to interface with hospitals and facilities where our members receive their care. This approach allows for direct member interaction with our ICT and for timely access to needed care. Through our multi-level care networks, CHG is able to ensure that members receive the appropriate care at the appropriate

time and level of facility. Through the Dual Eligibles Demonstration Project, CHG's goal will be to increase availability and access to home- and community-based alternatives and to retain members in the community and out of institutions.

Section 1.2: Comprehensive Program Description

The Application must:

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

CHG serves and proposes to serve the entire San Diego County as a participant in the Dual Eligibles Demonstration Project. DHCS has reported there are approximately 75,000 dual eligible beneficiaries in San Diego County. CHG is poised and ready to coordinate care for all of the dual eligible beneficiaries that select or are assigned to our Plan on or after January 1, 2013.

CHG's total membership as of December 2011 was over 139,000 members. This included over 2,000 dual eligible members who voluntarily enrolled in our Plan of whom over 1,000 are enrolled in CHG's D-SNP. It also includes over 9,000 SPDs who are only eligible for Medi-Cal. CHG is proposing to include the full range of services covered by Medicare Parts C and D and Medi-Cal. This will also include Long Term Care (LTC), Behavioral Health in coordination with the San Diego County Specialty Mental Health Plan, IHSS, CBAS, and MSSP.

CHG will provide services to new dual eligible members through its extensive network of providers and facilities which are culturally competent and experienced in serving both Medi-Cal and Medicare beneficiaries. CHG will

continue to expand its partnerships with the San Diego County Behavioral Health Agency, IHSS, San Diego County Public Authority and other key community advocates and health care providers as needed to fully serve the health care and social needs of the dual eligible population.

CHG will implement the dual eligible program using the identified core benefit package from DHCS/CMS to offer its members. These core benefits will include medical, behavioral health and substance use services, pharmacy, LTSS, MSSP, LTC and other home- and community-based services. CHG is evaluating the feasibility of offering additional add-on benefits to its members for this product. Such benefits may include: non-emergent transportation, worldwide emergency services, vision benefit, and a dental benefit. CHG will coordinate the provision of benefits to members through collaboration with our medical management department and provider network. CHG will work closely with its provider network to ensure they are educated on the benefits offered to members in this product. Additionally, CHG will work with members to ensure they are educated on the benefits that are afforded to them.

Question 1.2.2

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

CHG will coordinate the provision of benefits and manage the program as a single benefit package under the Dual Eligibles Demonstration Project. All reporting will be integrated to capture all benefits and costs for this new line of business.

Question 1.2.3

Describe how the program is evidence-based.

As a National Committee for Quality Assurance (NCQA) accredited health plan that contracts with DHCS and CMS, CHG’s internal structure and processes are

based on prevailing standards of practice and evidence-based guidelines as demonstrated in the following areas:

The Clinical Quality Improvement Committee (CQIC) has adopted evidence-based guidelines based on scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert opinion, in the absence of professional standards. Guidelines are adopted from recognized sources or involve board-certified practitioners from appropriate specialties in the development or adoption process. CHG distributes the guidelines to the appropriate network practitioners after adoption.

CHG uses objective, measurable criteria for making utilization management decisions that are based on sound clinical principles and processes and reasonable medical evidence. CHG bases utilization management decisions on program-specific criteria and guidelines (such as Medi-Cal guidelines and Medicare National Coverage Determinations (MNCD)), Milliman Health Care Guidelines, and guidelines issued by professional and governmental organizations.

CHG has developed a formal process, under the direction of its Technology Assessment Committee, to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefit plans to keep pace with changes and to ensure that members have access to safe and effective care. The Technology Assessment Committee is chaired by CHG's Chief Medical Officer (CMO) and includes contracted and credentialed clinicians for primary and specialty care (including behavioral health) as well as several members of CHG's clinical staff. Other clinicians and external experts are asked to participate as necessary.

CHG's automated care management system and process incorporate evidence-based criteria to guide care managers through the assessment and ongoing management of members.

Question 1.2.4

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

CHG's program is designed to enhance care coordination and communication with members and improve quality of care through a seamless transition and integration of needed health care services. CHG recognizes that many dual eligible members will have significant and complex needs that necessitate comprehensive care management. CHG's care management program addresses the complex needs of its members through:

Comprehensive Risk Assessments,

Care coordination,

Management of care transitions,

Disease Management for members with: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Diabetes to address effects of health disparities, and co-morbidities, Health Education to modify risk factors, and Multiple Admissions Program: targets members with a chronic condition and two or more hospital admissions.

CHG also incorporates findings from the Plan's Group Needs Assessment (GNA) to address health disparities and health education needs in a culturally sensitive manner.

Through effective utilization management of all the services listed above, CHG is able to positively impact the effect of multiple co-morbidities, favorably modify risk factors, and improve the overall quality of care.

Question 1.2.5

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

CHG's dual eligible program includes components that qualify under the federal Health Home Plans SPA. CHG envisions that one of the three Health Home models, specifically a team of health care professionals who are linked to a designated provider, is consistent with CHG's Model of Care (MOC) for dual eligibles.

In a recent survey of health plans, conducted by Mercer on behalf of DHCS, CHG described current processes for comprehensive care management, care coordination, health promotion, care transitions across the health care continuum, individual and family support services, referral to community and social support services, and the use of health information technology. The exercise of completing the survey provided an opportunity for CHG to become familiar with the requirements of a Health Home Plan and served as a validation of CHG's readiness to participate. It is also apparent that the requirements of the Health Home Plans SPA and the Dual Eligibles Demonstration Project share a significant common ground.

The standards for health homes is to promote a "whole-person" approach to care that assesses the need for clinical and non-clinical services; the provision of those services in a coordinated plan of care; the coordination and provision of preventive and health promotion services; mental health and substance use services; transitional care across settings; chronic disease management; individual and family support; and LTSS, is completely aligned with CHG's MOC.

Additionally, the Health Home and Dual Eligibles models rely on the use of health information technology to improve care coordination across the care continuum. Given the alignment of the care models, both sets of members would be managed in the same manner. CHG will develop a mechanism to distinguish and track members who meet the criteria for Health Home services from other dual eligibles for reporting purposes.

Question 1.2.6

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

CHG anticipates the primary challenges to the successful implementation of the program include the following:

Lack of Historical Clinical Data – To effectively integrate this new population into managed care, complete and accurate historical clinical data from the fee-for-service (FFS) environment from both CMS and DHCS will be needed. CHG's experience with the integration of the SPD population from FFS into managed care highlights the value of receiving the historical clinical data. This data will allow for a seamless transition and the identification of conditions that were continuity of care issues before the transition. CHG believes the receipt of this data will contribute greatly to the success of the

Demonstration and CHG will pursue the acquisition of this data, if selected as a Demonstration participant. If access to the historical data is not possible, CHG will work closely with beneficiaries, their families and current providers of these services to coordinate their transition into managed care.

Integration of LTSS – IHSS, CBAS, long-term custodial care in nursing facilities, and MSSP services have traditionally been carved out of managed care. CHG will use the initial period of the Demonstration to educate ourselves on how these services are authorized and provided. The Demonstration requires CHG to assume

the financial risk for providing services which are currently being provided through a FFS system by providers with whom CHG has no previous contractual relationship. As part of CHG's oversight responsibility, the authorization process and delivery of services will be monitored, learned, and evaluated during the first year of the Demonstration as provided by the San Diego County or other facilities via a contract/MOA with CHG.

Although CHG has established strong ties and relationships with the provider community, local government, community-based organizations, the local advocacy agency, and other managed Medi-Cal health plans operating within the Healthy San Diego collaborative to help mitigate some of the risks, DHCS and CMS will need to allow CHG (and all plans) enough flexibility to modify existing arrangements, starting in year two, to ensure achievement of program and cost containment goals over the term of the Demonstration period.

Utilization, Cost Data and Adequacy of Funding – It is imperative that CHG have a thorough and complete understanding of the historical utilization and cost trends of the dual eligible population, especially as it relates to LTSS. This information needs to be provided at the earliest possible date so CHG has enough time to conduct a proper analysis and develop a financial plan to ensure a successful outcome. The risks associated with LTSS are significant enough to warrant a timely sharing of data. Capitation rates must also be provided early in the demonstration planning process so CHG can determine if funding levels will be adequate to support the inclusion of proposed add-on benefits, and consideration of increased staffing levels and other program changes that will be needed.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

The Applicant must:

Question 2.1.1

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

CHG will provide seamless coordination between medical care and LTSS to keep members living in their homes and communities for as long as possible as outlined by the following process:

Care Management needs for newly enrolled members will be assessed in accordance with DHCS-approved procedures for risk stratification and risk assessment for SPDs using available FFS data, self-assessment questionnaires, and CHG's Health Risk Assessment (HRA) tool.

Once the risk assessment has been completed, CHG's ICT will develop and implement an individualized, person-centered care management plan to meet the member's continuing health care needs which include referrals to appropriate LTSS.

CHG staff will coordinate members with access to LTSS through the local Aging and Disability Resource Center (ADRC), which is the gateway for accessing LTSS in San Diego and contracts with LTC facilities.

CHG care management staff will follow the member, track the progress of the LTSS referral and document outcomes in CHG's care management module.

CHG staff is currently working with the AIS administration to:

develop a training program for their resource center staff to better understand managed care

develop a training program for CHG staff to better understand the full scope of services offered through AIS, and

develop processes to streamline referrals from CHG to the resource center to ensure collaboration and coordination of services for plan members.

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

CHG has included a Letter of Agreement to Work in Good Faith from Nick Macchione, MS, MPH, FACHE, Director of the HHSA for San Diego County. (Please see Tab 5, Appendix #26, attached.) CHG will work to obtain contracts with the following San Diego County Agencies:

HHSA

County of San Diego Public Health

County of San Diego Public Health Authority

County of San Diego Behavioral Health Services

In addition to existing San Diego County agency relationships, CHG has identified Intermediate Care Facilities (ICF) in CHG's network (providers located in San Diego County as potential candidates for addition). Reimbursement may include, but not be limited to: discounted FFS, or capitation models for each LTSS provider type and value based purchasing incentives.

CHG has identified the following licensed LTC facilities in San Diego County[1]: three LTACHs, 90 SNFs, two ICFs, one ICF-Developmentally Disabled (DD), 19 ICF-

[1] CA Dept. of Public Health, Health Facilities, Consumer Information System, Long Term Care Facilities

Developmentally Disabled Nursing (DDN) and 75 ICF-Developmentally Disabled Habilitative (DDH).

Medi-Cal – CHG is currently contracted with the following LTC facilities:

LTACHs 2 of 3

SNFs 36 of 90

Medicare – CHG is currently contracted with the following LTC facilities:

LTACHs 2 of 3

SNFs 18 of 90

CHG will solicit contracts with LTC facilities to ensure adequate Dual Eligible coverage.

Question 2.1.3

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

CHG will continue to use the HRA tool to identify enrollees in need of medical care and LTSS and standardize tools for specific medical care and LTSS as defined by the following process:

A member's medical care need(s) will continue to be assessed following DHCS approved procedures for risk stratification and risk assessment for SPDs using available FFS data, self-assessment questionnaires, and CHG's HRA tool.

CHG's HRA tool will be modified to include specific LTSS criteria as specified by the various support programs under the LTSS category. CHG has initiated discussions with local LTSS providers to simplify the documentation of all programs and develop a standard tool that will summarize key findings.

Member needs will be assessed and stratified. All pertinent findings will be summarized and included in CHG's revised HRA tool.

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

CHG has experience working with LTSS providers. CHG has existing SNF contracts (36 Medi-Cal and 18 Medicare) and will develop contracts with other LTC facilities as needed. We have reached out to several Adult Day Health Care (ADHC)/CBAS centers and begun developing relationships for integration of these services to CHG effective July 1, 2012. Additionally, CHG has been an active participant with the AIS LTCIP for over ten years with membership including many home- and community-based providers.

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

CHG currently has the capacity to engage in the provision of integrated care for members in LTC facilities through the Plan's current care management processes. CHG will also recruit the staff with the necessary skill levels to help serve this population in the most appropriate manner.

CHG's transition plan (when appropriate and clinically indicated) to transition members out of various institutional settings is based on the members' health/social status and level of care needed as assessed at the time of the

transition. Levels of care are determined by reviewing members' clinical records and applying evidenced-based standard clinical guidelines.

In 2009, CHG implemented a special program focusing on care management to members with key chronic conditions and multiple co-morbidities. Care management strategies focus on maximizing alternatives to the acute care setting and providing extensive home care and other outpatient supportive services. This program will be used when members are able to be transitioned from an institutional setting back into the community, as clinically appropriate.

One of the resources available to CHG in monitoring and assessing these members is access to the Electronic Health Record (EHR) of CHG's preferred contracted network of SNFs. CHG makes every effort to access EHRs or hard copy records of all institutions to evaluate and direct members to non-institutional care settings.

CHG ensures that members receive the appropriate level of care by applying care management strategies focused on:

Member adherence with or capability of adhering to treatment plans,

Ensuring timely access to PCPs and other specialty providers,

Ensuring access to preventive health care,

Access to disease management and health education services to assist members on self management of chronic conditions and medication reconciliation.

Section 2.2: IHSS

The Applicant must:

Question 2.2.1

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

IHSS consumers retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select who else participates in their care planning.

County IHSS social workers will use the Uniform Assessment tool and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams.

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

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

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

A process for working with the County IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.

CHG certifies its intention to develop a contract with the County of San Diego to provide IHSS services to those beneficiaries who are enrolled with the Plan, effective January 1, 2013. For the first year, CHG agrees to allow eligible IHSS beneficiaries to select, hire,

fire, schedule and supervise their own care provider; allow San Diego County IHSS social workers to perform in-home assessments and utilize procedures established by federal and state laws and regulations; allow the San Diego County IHSS Agency to increase hours if/when it is determined that additional hours will avoid unnecessary institutionalization; and allow payment to such providers to be paid by the State Controller's Case Management, Information and Payrolling

System (CMIPS) program. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Question 2.2.2

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

CHG will work closely with the San Diego County IHSS Agency in 2012 to develop an appropriate monitoring and oversight plan to be implemented effective January 1, 2013, to include:

Development of CHG referral and authorization policies and procedures.

Formation of a Joint Operating Committee (JOC) to review operational issues, identify process enhancement opportunities and determine education and training needs.

Based on the results of CHG's monitoring and oversight activities in 2013, and after actively participating in regular JOC meetings with the County IHSS Agency staff, CHG will determine what changes, if any, are needed in years two and/or three to maximize operational efficiency and reduce cost.

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

CHG will work with the local San Diego County Public Authority to implement a care coordination model to include the following components:

Referral guidelines for initial and extension of services will be in accordance with current processes based on current IHSS home assessments.

Authorization guidelines for initial and extension of services will be based on current processes and as necessary to ensure the health and safety of the member.

Care Coordination of LTSS for plan members.

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

CHG will partner to work with the local San Diego County Public Authority to provide IHSS worker training. San Diego County Public authority will offer provider/worker training to a voluntary group of participants using six-week National Caregiver Training Program modules. Modules cover topics including:

Infection Control

How to Care for Someone on Bed Rest

Personal Care

Tub Baths and Showers

Vital Signs

How to Manage Medications

Safe Wheelchair Use

Nutrition

Taking Care of the Caregiver

Fall Prevention

Fire Safety

CHG's partnership with the San Diego County Public Health Authority and a local community based program will include development of training curricula to address the needs of patients with dementia and Alzheimer's. CHG has begun discussions with staff from the George Glenner Alzheimer's Centers, a network of adult day programs who for over 30 years, have served patients with Alzheimer's, Parkinson's and other forms of dementia and memory impairment. Center staff has agreed to assist CHG in developing curricula and providing staff training as needed.

A plan for coordinating emergency systems for personal attendant coverage.

In 2013, CHG will work closely with the San Diego County IHSS Agency to develop a plan for coordinating emergency systems for personal attendant coverage.

Based on the results of CHG's monitoring and oversight activities in 2013 and after actively participating in regular JOC meetings with the County IHSS Agency staff, CHG will determine what changes, if any, are needed in years 2 and/or 3 to maximize operational efficiency, increase quality of care and reduce costs.

Section 2.3: Social Support Coordination

Applicants must:

Question 2.3.1

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

CHG certifies that it shall establish and maintain an operational plan for connecting beneficiaries to social supports that include clear evaluation metrics. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Question 2.3.2

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

CHG will continue to assess the need for and assist beneficiaries in connecting to community social support programs that support living in the home and in the community as outlined by the following process:

Newly enrolled members will continue to be individually assessed utilizing DHCS approved procedures for risk stratification and risk assessment for SPDs, available FFS data, Member Evaluation Tool (MET), and CHG's HRA risk assessment tool.

Once the individual risk assessment has been completed, the case is reviewed during weekly case rounds by the ICT.

An individualized, person-centered care management plan is developed by the care management team to satisfy the member's continuing health care needs, to include referrals to appropriate community social support programs, Meals on Wheels, energy assistance programs, CalFresh, and services for those beneficiaries with intellectual and developmental disabilities.

Members shall also be assisted by CHG's Member Services Department (available to members 24 hours a day/7 days a week). Member Services representatives have been trained to direct members in need of social, health and disaster services to 2-1-1 San Diego through a warm transfer. 2-1-1 San Diego is a free resource and information hub that connects people throughout the county to over 6,000 community services through a stigma-free, confidential, 24/7 phone service and a searchable online database. CHG's Behavioral Health Program Manager was one of the original founders of 2-1-1 San Diego and remains active in promoting 2-1-1 San Diego among CHG's provider community.

Question 2.3.3

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

CHG has a well established relationship in place with the local ADRC. The local ADRC has provided training to CHG's staff and providers. CHG's members are referred to the ADRC based on need(s) identified through the risk assessment process. CHG's member and provider web pages contain a link to the ADRC's web site.

Question 2.3.4

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

In 2011, CHG led a county-wide effort to train various behavioral health independent care facilities, the Senior Alliance and Downtown Senior Center, on the transition of SPD members into managed care. The trainings focused on how to navigate the healthcare system and the importance of coordinating services with their clients' health plan. The Senior Community Collaborative is a group of leaders serving seniors with services ranging from housing, meals, home adaptation, transportation, and in home assistance. The Downtown Senior Center provides daily activities and has a 200 unit housing program. These educational programs will continue in 2012 and throughout the demonstration period.

CHG plans to continue working closely with staff at the different senior centers, LTC facilities, and with the AIS Unit and with the local 2-1-1 San Diego program to develop and implement processes to coordinate care for members living in these

facilities. 2-1-1 San Diego keeps and up to date listing of all facilities and programs serving seniors. Our Behavioral Health Program Manager is the only health plan representative asked to serve on their Health Leadership Advisory Board.

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

The Applicant must:

Question 3.1

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

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

CHG identifies and coordinates treatment for all behavioral health services in the same manner. CHG's behavioral health program, which currently serves over 23,000 Healthy Families members and over 1,000 D-SNP members, includes treatments for both substance use and mental illness. Screening occurs through the care management process and/or by the member's PCP. Members may also self-refer. Once the need is identified, CHG assists the member to obtain a timely appointment with the most appropriate provider within CHG's contracted network. The contracted provider completes the initial evaluation and sends a treatment plan to CHG. The treatment plan summary is forwarded to the member's PCP to ensure coordination of care. CHG's Behavioral Health Program Manager is part of the ICT and works closely with care management staff to further facilitate care coordination. When a member or guardian expresses the need for an immediate appointment, CHG routinely arranges same-day evaluations. Additionally, CHG's practice is to schedule same-day appointments upon discharge from an in-patient setting.

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

CHG identifies and coordinates treatment for all behavioral health services in the same manner. CHG's behavioral health program, which currently serves over 23,000 Healthy Families members and over 1,000 D-SNP members, includes treatments for both substance use and mental illness. Screening occurs through the care management process and/or by the member's PCP. Members may also self-refer. Once the need is identified, CHG assists the member to obtain a timely appointment with the most appropriate provider within CHG's contracted network. The contracted provider completes the initial evaluation and sends a treatment plan to CHG. The treatment plan summary is forwarded to the member's PCP to ensure coordination of care. CHG's behavioral health program manager is part of the ICT and works closely with care management staff to further facilitate care coordination. When a member or guardian expresses the need for an immediate appointment, CHG routinely arranges same-day evaluations. Additionally, CHG's practice is to schedule same-day appointments upon discharge from an acute setting.

Question 3.2

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

CHG employs a full-time, dedicated, Behavioral Health Program Manager who has managed CHG's behavioral health program since 1993, prior to specialty mental health being contractually carved out by DHCS. Additionally, CHG has a contracted Psychiatrist and licensed clinical Psychologist available 24 hours a day/7 days a week. The Behavioral Health Program Manager works closely with the Contracting Department to maintain a network of practitioners to meet the needs of CHG's members. He is actively involved in the behavioral health and substance use

community and with Community-Based Organizations and is a resource to the care management staff in coordinating member's physical and mental health as well as in addressing any social issues. Additionally, CHG has contracted with a Behavioral Health Consultant, who is a licensed Psychologist, and is responsible for the overall clinical direction of all behavioral health services provided by CHG. The Behavioral Health Consultant is actively involved in implementing the behavioral health aspects of CHG's Utilization Management program including setting policies, participating in credentialing, reviewing potential denials and participating in Utilization Management, Clinical Quality Improvement, Credentialing and Technology Assessment Committees. Additionally, CHG has identified a physician who is board certified in Family Medicine and Psychiatry with extensive Geriatric Psychiatry experience who will serve as our Psychiatric Consultant throughout the Demonstration Project and beyond. The Psychiatric Consultant is actively involved in our Pharmacy and Therapeutics and Behavioral Health Committees and will assist in enhancing our Behavioral Health Program to better serve the needs of the dual eligible members.

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

Care coordination between physical and behavioral health occurs through CHG's ICT. CHG's Behavioral Health Program Manager is an integral member of the ICT. The ICT, under the direction of CHG's CMO, also includes care managers, utilization management staff, a member services representative, a pharmacist, and a community and preventive services staff member. A member's behavioral health needs are included in care discussions. When members are referred to a contracted behavioral health provider, CHG forwards the treatment plan summary to the member's PCP upon receipt.

Question 3.4

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

CHG maintains a Behavioral Health Advisory Committee that includes the San Diego County Mental Health Clinical Director, a psychiatric registered nurse, therapists, Psychologists, a representative from the local health advocacy agency and, CHG's health services staff. This committee, co-chaired by CHG's CMO and Behavioral Health Program Manager, establishes the strategic direction and recommends policy decisions relating to CHG's Behavioral Health Program, including care coordination between physical and behavioral health. CHG will invite consumers to participate in this committee and will provide transportation to facilitate participation.

Section 3.2: County Partnerships

Applicants must:

Question 3.2.1

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

During the first year of the Demonstration, CHG will provide the scope of behavioral health services through its contracted behavioral health network of providers as defined by its D-SNP contract. Beneficiaries with a serious mental illness or chronic substance use disorders will be referred to the San Diego County Specialty Mental Health Plan to provide services that are traditionally not part of

the Medicare scope of services such as targeted care management, rehabilitation services, crisis intervention, adult residential and crisis residential treatment services, and psychiatric health facility services. The current signed MOA with the San Diego County Mental Health Plan will be expanded to include dual eligible beneficiaries and will stipulate care coordination with CHG and contracted PCPs.

Over time, but no later than January 1, 2015, CHG intends to have a contractual relationship with the San Diego County Specialty Mental Health Plan to intensify the care coordination process and will include financial arrangements and incentives that promote shared accountability for coordination and achieving set performance objectives. CHG has a strong track record in working with behavioral health providers, as evidenced by a CHG conducted behavioral health provider satisfaction survey. In 2011, CHG received a 98% satisfaction rating. CHG will continue to work with the San Diego County Specialty Mental Health Plan to facilitate effective collaboration needed to achieve our improved integration goal.

CHG is well-positioned to manage a full range of behavioral health services for dual eligible beneficiaries. CHG's behavioral health program currently serves its D-SNP members and, prior to the State's carve-out of specialty mental health in 1998, CHG managed comprehensive behavioral health services for its Medi-Cal members. This extensive expertise with both Medicare and Medi-Cal will serve dual eligible members well.

Question 3.2.2

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

In 1998, CHG signed a MOA with the local San Diego County Health and Human Services Agencies Mental Health Plan Behavioral Health Administration. As a

function of the MOA, CHG assigned a liaison, the Behavioral Health Program Manager, to work closely with San Diego County Behavioral Health Services. The MOA details services to be provided by the Plan and services provided by San Diego County Behavioral Health Services. Additionally, CHG is the only Medi-Cal managed care plan that has a contract with San Diego County Behavioral Health Services for the Healthy Families line of business. This contractual relationship provides CHG with direct experience in working with San Diego County Behavioral Health Services. CHG meets with the San Diego County Behavioral Health Services administrators, contracted providers, and Optum Health, their Administrative Services Organization (ASO), on a regular basis. CHG will build on these existing relationships to address services for the seriously and persistently ill, including appropriate payment mechanisms.

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

CHG's Behavioral Health Program Manager has chaired and continues to chair the Healthy San Diego Behavioral Health Work Team since its inception in 1998. All Medi-Cal Managed Care and D-SNP plans participate. This forum will be used to develop standardized criteria for identifying beneficiaries' care coordination needs.

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

The Healthy San Diego Behavioral Health Work Team has developed a Coordination of Care protocol that includes guidelines for use. These tools will be used to identify and remove barriers and promote the exchange of information across systems. Multiple training sessions will be conducted targeting physical and behavioral health providers. CHG's current process with its D-SNP members

includes coordination between physical and behavioral health providers 100% of the time. Upon receiving behavioral health services, CHG staff forwards a case summary to the medical provider. Pertinent medical information is also shared with the behavioral health providers on an as needed basis. CHG intends to implement this process for members who enroll under the Dual Eligibles Demonstration Project.

Section 4: Person-Centered Care Coordination

The Applicant must:

Question 4.1

Describe how care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, and 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.

CHG defines a person-centered approach as a set of approaches designed to assist someone to maximize their independence and quality of life. The model is used most often as a life planning tool to enable individuals with disabilities to increase their personal self-determination and improve their own independence. CHG will continue to coordinate care through a person-centered approach for the wide range of medical conditions, disabilities, and functional limitations, intellectual and cognitive abilities among dual eligibles as outlined by the following process:

Members will continue to be assessed in accordance with CHG's standard evidence based clinical guidelines and monitored through the care management program conducted throughout the continuum of care, including but not limited to the following points of contact: primary care, specialty care, elective hospital admissions, acute emergency admissions, post hospital discharge planning, medication management, behavioral health and substance use services, home health services, and referral to community-based services based on member needs.

Assessments are member-centered and provide all covered services. Needs will be addressed via a seamless approach following DHCS approved procedures for risk stratification and risk assessment using available FFS data, self-assessment questionnaires, and CHG's HRA tool.

Completed assessments are reviewed during weekly case reviews by CHG's ICT and an individualized, person-centered care management plan is then developed to meet the member's continuing health care needs, based on risk levels and urgency for health care services. CHG's ICT consists of our CMO, Director of Utilization Management Services, Director of Health Care Operations, Behavioral Health Program Manager, High Risk Care Management Registered Nurses, Preventive Services Coordinator, Corporate Quality Specialist and Member Services representation. Care management plans will continue to include necessary referrals to appropriate community social support programs serving the needs of patients with dementia and Alzheimer's disease, including those listed by the local 2-1-1 San Diego program, the San Diego Regional Center and other providers of care with expertise in serving members with functional and intellectual limitations.

Members' ongoing medical care needs are assessed in accordance with CHG's standard evidence-based clinical guidelines and throughout the continuum of care to ensure services are provided in the ideal facility to foster improvement of clinical outcomes.

Questions 4.2

Attach the model of care coordination for dual eligibles as outlined in Appendix C. This will not count against any page limit.

Please refer to CHG's MOC document as shown in Tab 4, Supporting Attachment C.

Questions 4.3

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

The PCP plays a pivotal role in care coordination as part of their primary care duties and responsibilities. PCPs are expected to coordinate primary and preventive care with care provided by specialists and services received through community-based agencies. PCPs also provide follow-up care when a member is discharged from the hospital or the Emergency Room (ER), and work with CHG's care management staff to facilitate care transitions.

Care coordination is a critical component of care management which helps to ensure that members receive needed services as determined by their health status. A member's PCP plays a key role in identifying the need and in coordinating referrals to specialty, ancillary, community-based, and other services. CHG's care management staff work closely with a member's PCP to coordinate transitions in care when needed.

CHG's primary care contracts require that PCPs designate a case manager to be the liaison with CHG's care management staff. CHG's Provider Manual further stipulates that PCPs are responsible for ensuring timely care coordination as part of their scope of primary care services. Each PCP receives a copy of the Provider Manual, which is also available on CHG's Provider Extranet. In addition to the manual, CHG invites PCPs and their case managers to participate in care management meetings where pertinent topics related to care management are discussed and shared. Care coordination is also included in the MOC curriculum.

CHG specialists also play an important role in the care coordination process through direct communication with the PCP and through active participation with CHG's care management staff and ICT.

CHG will monitor its providers' effectiveness in care coordination by tracking admission rates to long term custodial care and hospital readmissions using the Healthcare Effectiveness and Data Information Set (HEDIS) Plan All Cause Readmission measure. Outlier physicians will be provided with additional training by care management staff.

Section 5: Consumer Protections

Applicant must:

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

CHG certifies that it will comply with all consumer protections as described in the forthcoming Demonstration Proposal and Federal-State Memorandum of Understanding (MOU). (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 5.1: Consumer Choice

Applicant must:

Question 5.1.1

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

The primary goal of CHG's current enrollment process is to support the member's right to build a care team that addresses their individualized needs. Our Member Services staff is available 24 hours a day/7 days a week to support members in this function. If a member chooses an in-network PCP during the initial enrollment process, this choice is honored. If a member does not choose a PCP, one is assigned based on address, language spoken, age, etc. If the member does not agree with our assignment, CHG facilitates an immediate transfer to a new contracted provider during the new member welcome call or when the member calls to request a PCP change. CHG's process already provides members the opportunity to select the participants of their care team, including choice of in-network primary and specialty providers, pharmacies, family members, and other caretakers. If the member's choice of specialty provider is not within our network, we try to accommodate the request. CHG understands the importance of continuity of care for the members during this Dual Eligibles Demonstration Project. The Enrollment module of our Information System includes fields that allow us to track the member's choice of participants in their care team.

Question 5.1.2

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

Members are able to self-direct their care through the following processes:

Participating in their care management and care coordination,

Selecting their PCP,

Selecting their in-network obstetrical provider for pregnancy and gynecological services,

Selecting their specialty providers from the contracted network,

Deciding whether or not to participate in a relevant health education program,

Deciding whether or not to participate in a relevant disease management program,

Deciding whether or not to accept services or treatments recommended or offered to them by their physician(s) and health plan, If they are receiving IHSS services, the ability to hire and fire their IHSS workers,

Newly enrolled members have the right to request continuity of care with their previous physician if their physician is not contracted with CHG.

Section 5.2: Access

Applicant must:
Question 5.2.1

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

CHG certifies that during the readiness review process it will demonstrate compliance with the rigorous standards for accessibility established by DHCS (Please refer to Tab 1, Project Narrative Criteria Checklist, attached).

Question 5.2.2

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

CHG is committed to ensuring all members have the maximum accessibility possible under this program. CHG's program will ensure maximum accessibility utilizing the following approaches:

Physical accessibility – CHG ensures members have physical accessibility through several mechanisms. CHG completes the Physical Accessibility Review Survey (PARS) with all PCPs and high volume specialist offices, and members are notified of these results through the Plan's provider directory. CHG also collaborates with other health plans through the Healthy San Diego Facility Site Review Workgroup. Through this collaborative program Medi-Cal PCP accessibility is continuously monitored on a county-wide basis.

Community Accessibility – CHG ensures community accessibility through its 24 hours as day/7 days a week member services representatives. Community accessibility needs, once identified, are referred to the Member Services Department for follow up. CHG works closely with several Community-Based Organizations including 2-1-1 San Diego services. These services include programs such as Meals On Wheels, Calfresh, and other community support programs.

Documentation/Information Accessibility – Document/information accessibility is achieved through a variety of mechanisms, including but not limited to: (1) forms documenting initial and periodic assessments, (2) referral and authorization activities, (3) claims and encounter data submission evidencing the provision of

care, (4) tracking of all Member Services, Appeals and Grievance and Provider Services communications and interactions, (5) tracking and trending of timely access standards and any other data results, determined to be appropriate to ensure there is reasonable document/information accessibility throughout the demonstration project.

CHG also utilizes numerous on-line tools and provides access to educational materials and Plan information for members. Available tools include: large font format of member materials posted on the web, member newsletters, Physician Directory Search, TTY services, on-line formulary, health education link, and mobile storm (health education texts to members). CHG also connects with its providers and key community partners, including the San Diego Immunization Registry, and has EHR access to multiple providers. Providers access information through CHG's web site in the provider section which links them to provider alerts, newsletters, health education materials, clinical resources and CHG staff. Members have access to our web site for Health Education, Quality and Guideline resources, Grievance Forms, Provider and Hospital Search, Urgent Care Sites and a Privacy Statement.

Doctor/provider accessibility – CHG currently ensures doctor/provider accessibility through the Provider Relations Representatives who work with the applicable provider to remedy any identified issues and/or barriers to access. CHG also conducts "Mystery Shopper" calls on a regular basis as a way to monitor appointment access at PCP locations and to ensure appropriate after-hours availability. CHG also employs a site certification team who works with our provider network to assess compliance with all physical accessibility, community accessibility and provider accessibility regulations. This is monitored through both the Healthy San Diego facility site certification process and CHG's provider relations team during site visits.

Currently CHG monitors accessibility trends through the Member Services and Appeals and Grievances Departments. The Member Services Department and Grievance and Appeals Department track member complaints and trends by category. On a quarterly basis the Service Quality Improvement Committee (SQIC) reviews the top member complaints and implements corrective action plans when necessary. This information is then presented to the CQIC who, in turn, reports to the Board of Directors. Additionally, CHG reviews member responses to the physician accessibility questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and addresses any identified accessibility issues.

Question 5.2.3

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

CHG communicates information about accessibility levels to beneficiaries via its provider directory, CHG's website, member newsletters, and daily telephonic communications with its members. The Plan's provider directory and online physician finder tool include the most frequently used accessibility indicators, such as handicap access.

Section 5.3: Education and Outreach

Applicants must:

Question 5.3.1

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

CHG currently meets the communication needs of its members in the following ways:

CHG employs a bilingual staff in English and Spanish, and all Member Services staff is required to be fluent in English and one of our current Medi-Cal/Medicare threshold languages (Spanish, Vietnamese, and Arabic).

CHG contracts with the Language Line to provide over the phone interpretation in more than 140 languages, 24 hours a day/7 days a week.

CHG contracts with The African Alliance for face to face interpretation and Deaf Community Services for sign language interpretation.

CHG has purchased TTY software to communicate with our hearing-impaired members directly, implementation will occur within the next three months. This TTY software will replace our current contract with TTY.

CHG provides member materials in English and Spanish and all other threshold languages upon request. CHG will also provide member materials in Braille or audio format upon request. In addition, our members have the capability of changing the size of the font on our website to accommodate ease of reading.

CHG is in the process of purchasing Text to Speech (TTS) software and will begin implementation within the second quarter of 2012.

Question 5.3.2

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

CHG currently meets the cultural and linguistic needs to communicate with members in their own language through the Plan's Language Assistance Program (LAP). The purpose of the LAP is to ensure services, both clinical and non-clinical, are provided in a culturally competent manner and is accessible to all members, including those with Limited English Proficiency (LEP), limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

The LAP ensures that interpretation and translation services are easily accessible and available to members in threshold languages, at all points of contact, at no charge, without using minors or family members (unless requested by the member). All Language Assistance Services (LAS) are coordinated through Member Services and are available 24 hours a day. Currently, over 70% of CHG staff is bilingual in English and other languages. In addition, Member Services staff speaks English, Spanish, Vietnamese and Arabic. Nurses offering advice through the Plan's after hours Telephone Advise Nurse Program are also bilingual in English and Spanish and have access to the language line to assist with other languages when necessary.

Members are educated on the process to access LAS via our Evidence of Coverage (EOC), during new member welcome calls, when members contact Member Services staff for interpreter assistance, and when care is accessed and interpreter services are not readily available through the provider. If providers do not have their own arrangement for interpretation services, these are coordinated through CHG. CHG staff is trained on the Plan's LAP through annual staff trainings and a bulletin board which highlights how to access services. Additional training is provided to key staff that has direct contact with CHG members: Telephone Advice Nurse Program, Member Services and Health Care Services. PCPs are trained on CHG's LAP through various methods such as: provider manual, provider alerts, newsletters, new provider orientations and provider staff trainings.

CHG provides a wide array of culturally and linguistically appropriate health education services through an extensive, countywide network of health education and promotion providers which include hospitals, community health centers and Community-Based Organizations. Many services and health education materials are available in English, Spanish, Vietnamese, Arabic and other languages.

Since 1982, CHG has participated in the Healthy San Diego Collaborative with the other Medi-Cal managed care plans in San Diego County. Under the Healthy San Diego umbrella, the Health Education and Cultural and Linguistic Workgroup has conducted trainings on a number of topics, including the language access and cultural and linguistic requirements. The standard protocol at all trainings is to provide the "Interpreter Services Health Plan Contact Information Sheet." This resource for health care providers includes language assistance and contact information for each health plan.

On a quarterly basis, CHG monitors compliance with the provision of LAS by tracking utilization of services, member complaints and grievances and reporting findings through the SQIC. CHG is continually reassessing its linguistic and cultural needs and will implement improvements when needed. As the language requirements of our membership change, we will add the needed bilingual staff.

Question 5.3.3

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

A detailed operational plan for beneficiary outreach and communication.

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

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

CHG certifies that it will comply with rigorous requirements established by DHCS and will provide a detailed operational plan, an explanation of the different modes of communication for beneficiaries' visual, audio and linguistic needs, and an explanation of the Plan's approach to educating counselors and providers to explain the benefit package to beneficiaries in a way they can understand as part

of the Readiness Review. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 5.4: Stakeholder Input

The Application must:

Question 5.4.1

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

CHG's stakeholder engagement plan is already underway. The Plan has been participating in the AIS Long Term Care Integration Project (LTCIP) for close to ten years. Since the date of the release of the Dual Eligibles Demonstration Project RFS, this group's main focus has been stakeholder involvement. CHG has asked the LTCIP Stakeholder group to develop a subgroup to serve as the Consumer Advisory Stakeholder Group for this demonstration project and they have agreed. Stakeholders have been identified including consumers, health plans, AIS staff, the Chair of the Southern California local collaborative of CBAS Centers, San Diego County Behavioral Health Administration, and Advocates.

CHG has also participated in several AIS LTCIP Stakeholder collaborative meetings this year including January 30th, February 8th February 14th, and the AIS LTCIP Stakeholder Meeting held on February 14th. The February 14th meeting included health plans, IHSS, hospitals, CBAS,

advocates and consumers, Community-Based Organizations, community clinics, Behavioral Health and LTC representatives. These stakeholders were able to provide feedback during the application development to all participating health plans and county representatives.

On February 2nd, CHG conducted a focus group with participation from the Dual Eligible population in the community. This focus group represented various age groups along with SPDs. The focus group discussion was designed to obtain input on benefits, communication preferences (i.e. website, newsletters etc.), the perceived barriers/challenges to accessing services, understanding the program and services, and grievance processes. The outcome of the meeting was very informative and the comments will be taken into consideration during the implementation of the Dual Eligibles Demonstration Project.

CHG's stakeholder engagement plan for the balance of 2012 will involve ongoing participation with LTCIP, the Consumer Advocacy Group, attendance at DHCS and CMS collaborative meetings, and evaluation and implementation of focus group recommendations, as appropriate.

Question 5.4.2

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

CHG's stakeholder engagement plan started in 2011 and will extend throughout the three-year Demonstration period and will include the following components:

Proactive stakeholders' involvement, including participation with new focus groups of Dual Eligible members; ongoing participation on the LTCIP Stakeholders group; and participation in the Consumer Advisory Stakeholder Group

Sponsoring multiple county outreach and educational meetings to educate members and their advocates Active involvement of senior CHG staff, such as the Behavioral Health Program Manager, in program design and implementation activities

Partnering with the Consumer Center for Health Education and Advocacy/Legal Aid Society to provide support and guidance in the development of managed care awareness and cost containment activities

Conducting member surveys as necessary to ensure adequate education and training is available to members

Question 5.4.3

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

CHG has a well established Public Policy Committee which meets quarterly. This Committee includes consumers and a representative from the Consumer Center for Health Education and Advocacy/Legal Aid Society. The meeting is chaired by a CHG Board member and two other CHG Board members are routinely in attendance. This forum allows for direct stakeholder input to the CHG Board of Directors and staff. The Public Policy Committee, along with development of one or more JOCs, is expected to ensure meaningful stakeholder development and involvement throughout the demonstration project. Additionally, CHG will continue to work with the AIS LTCIP Stakeholder group and local Healthy San Diego health plans. Based on input from the stakeholders meetings, CHG will incorporate feedback as appropriate.

Section 5.5: Enrollment Process

The Applicant must:

Question 5.5.1

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

CHG supports a passive enrollment model inclusive of all eligible members who do not opt-out and are enrolled in the managed care program, but can choose to opt-out after an initial six-month period. This model provides all dual eligible beneficiaries an opportunity to participate in the new integrated care program and to access a wider range of services for a limited time. It provides beneficiaries a designated "trial period" to experience services with the guarantee of opting out. During this initial enrollment phase, CHG will also have an opportunity to demonstrate its "value" to the beneficiary, with the goal of CHG achieving a high retention rate. In this model, education/outreach programs will be necessary to ensure beneficiary understanding. CHG also supports a phased-in enrollment process over a 12-month period similar to the mandatory enrollment of SPDs with enrollment commencing on their birth month.

Question 5.5.2

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

During the enrollment of SPDs, CHG Member Services representatives worked closely with its newly enrolled members to educate them on managed care. Through the new member orientation call, as expected, the Plan's average call length was extended due to the need to answer member specific questions

regarding referrals, provider network, continuity of care, and formulary issues. We anticipate that additional time will be needed to properly orient our dual

eligible members. CHG will enhance member materials to meet the needs of its new dual eligible members. Feedback from the LTCIP Stakeholders group will be considered when developing Plan materials.

Question 5.5.3

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

To help ensure the success of the Demonstration Project, CHG will need access to information similar to the information provided during the SPD transition – that is, Medi-Cal FFS clinical data and self assessment information. In addition, to the extent available, some or all of the following information and cost of care data will be needed:

All CBAS nurse assessments, IHSS cost and case notes, case and progress summary notes from the centers for eligible members, outstanding Treatment Authorization Requests (TAR) and LTC placement information

Behavioral health utilization (to assist CHG in identifying members needing care within our network or those who would benefit from services through the San Diego County Specialty Mental Health Plan)

Medicare encounter and pharmacy data

Complete details of the current contractual arrangements with all IHSS and LTC providers. This information should include the current contractual rates paid by the State of California for these services along with a complete list of the contracted providers in San Diego County

Capitation rates must be provided early in the demonstration planning process. It is difficult to design additional benefits, determine staffing levels and properly plan for the transition of new members without the benefit of rate information. We respectfully request that rate discussions begin immediately after site and county selection.

Section 5.6: Appeals and Grievances

Applicants must:

Question 5.6.1

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

CHG certifies that it will fully comply with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 6: Organizational Capacity

The Applicant must:

Question 6.1

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

CHG has been operating successfully for the past 30 years. The guiding principles of the organization have always been to provide high quality and cost effective care to our members in San Diego County. Our health plan grew out of a FQHC background with a mission to provide culturally competent quality health care to our members. CHG is and has been NCQA accredited for more than ten years. In

2011, CHG tied for #1 as the best Medicaid Health Plan in California by *Consumer Reports*. CHG has the background, knowledge and community affiliations needed to meet any/all current and future member needs. Due to our traditional and safety net status and HEDIS scores we will receive the highest percentage of auto-assigned Medi-Cal membership in San Diego County during 2012.

CHG is the largest government-funded program health plan in San Diego County serving more than 139,000 total members among all of our lines of business, including over 2,000 dual eligible members who voluntarily enrolled in our plan, and over 1,000 Medicare D-SNP members. CHG believes the DHCS Dual Eligibles Demonstration Project mirrors the population we have historically served and continue to serve today. The Plan's focus will continue to be on providing culturally and linguistically sensitive services along with the provision of high quality and cost-effective health care services. CHG has demonstrated its knowledge and understanding of its members' population in San Diego County and works closely with community advocacy groups, providers and community service agencies that have traditionally served its members' needs.

CHG staff are active participants in several stakeholder committees at the local HHSA level including: Healthy San Diego's Joint Professional and Consumer Advisory Committee, Behavioral Health Work Team (CHG staff act as chairman), Regional Center Work Teams (CHG staff act as chairman), Health Education and Cultural Linguistic Workgroup, Facility Site Review Workgroup, Quality Improvement Sub-committee (CHG act as chairman), Health Plan Work Group (CHG act as co-chairman), and California Children's Services Work Group. These work groups allow the Plan to hear directly from the consumer, advocacy groups, county staff and other Medi-Cal health plan representatives. The information CHG receives from its community involvement allows the Plan to better serve the full needs of its current members.

CHG is governed by a nine-member Board of Directors. Our Chief Executive Officer (CEO) reports directly to the Board of Directors. Reporting to the CEO are the Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, Chief Regulatory and Legal Affairs Officer and Chief Information Officer. Participation in the Dual Eligibles Demonstration Project is seen as a company-wide endeavor starting with the Board of Directors. Internal monitoring and reporting will occur at the Executive and management levels through divisional reports. The Board will be updated on progress monthly through the CEO's monthly report to the Board of Directors, monthly Board of Directors meetings and Educational Programs Committee Meetings.

CHG is committed to recruiting the additional staff resources and expertise needed to succeed under this Demonstration Project. The Plan will use internal monitoring audits, HEDIS and CAHPS scores, provider satisfaction feedback, member services reports and utilization benchmarks to monitor the program.

Question 6.2

Provide a current organizational chart with names of key leaders.

CHG's current organizational chart, with names of key leaders, is attached. (Please refer to Tab 4, Supporting Attachment A.)

Question 6.3

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

The key to CHG's success is its leadership. CHG's CEO, *Norma Diaz, MBA*, has been with CHG for 30 years (since its inception) and in her current position since 2002. Ms. Diaz has a total of 36 years of health care experience and is joined by a seasoned senior management team with many years of managed care experience. Many other CHG employees, both in management and front-line staff, have had a long tenure with the Plan and have "lived through" the implementation of several extensive projects similar to the Dual Eligibles Demonstration Project from the inception phase through completion. The following will be key Executives in CHG's successful implementation of the Dual Eligibles Demonstration Project:

Bill Rice, CPA, Chief Financial Officer, has over 25 years experience in health care and has been with CHG for over seven years. He has overall financial responsibility of the organization, including meeting regulatory financial standards, revenue and cost controls, and financial reporting.

Edward D. Hutt, MD, MBA, Chief Medical Officer, has over 26 years experience in managing both Medicaid and Medicare membership and has been with CHG for over four years. He leads CHG's Health Care Services Department and has developed close working relationships with our provider community and health care facilities with multiple levels of care. Dr. Hutt's clinical team is actively engaged in discharge planning, care management and ensures that members are linked to community resources and necessary care across the continuum of care.

Mike McGarrigle, MBA, Chief Operating Officer, has over 20 years health care experience including Medicaid and Medicare and was most recently the Chief Operating Officer of Aetna in Philadelphia, PA. He will lead CHG's implementation of the Dual Eligibles Demonstration Project and will be supported by the entire CHG Executive and management team.

Ann Warren, MA, Chief Regulatory and Legal Affairs Officer, has over 25 years health care experience, including behavioral health, and has been with CHG for over 17 years.

Her role is to continue to represent CHG at state level meetings, as well as actively participate with CHG's CEO at California Association of Health Plans (CAHP) and Local Health Plans of California (LHPC) meetings. She will ensure that CHG remains current on all regulations and legislation impacting this program for full compliance.

Jonathan Tamayo, BS, Chief Information Officer, has 30 years experience in health care and has been with CHG for over 17 years. He is in charge of technical support, system configuration, enrollment, encounters, Electronic Data

Interchange (EDI) and new technologies that support CHG's programs.

Nora Pintado, MHA, Director of Health Plan Operations, has over 29 years of health care experience and has been with CHG for over 25 years. She has more than 20 years of experience in member service and advocacy matters. She has vast experience in the development and implementation of strategies to achieve member satisfaction and retention.

Martha Jazo-Bajet, RN, MPH, Director of Utilization Management Services, has been with CHG for 30 years and oversees utilization management, care management, and cultural and linguistic services. She was a founding member of Healthy San Diego and, for over 10 years, has been the chairperson of the Healthy San Diego Quality Improvement Sub-Committee.

Noreen Koizumi, PharmD, Director of Health Care Operations, has been with CHG for 30 years. In addition to her health care duties, she is responsible for the provision of pharmacy services to CHG's members. She manages CHG's contract with MedImpact Healthcare Systems, Inc., CHG's Pharmacy Benefits Manager of 18 years who has national expertise in providing Part D and Medi-Cal/Medicaid benefits.

Carole Anderson, RN, MEd, Corporate Quality Director, has over 40 years of health care experience and has been with CHG for over 18 years. She is responsible for the development and overall implementation of the organization's quality management program, including establishing organizational goals related to quality improvement strategies and activities, and recommending and implementing an organization-wide improvement approach/process.

George Scolari, Behavioral Health Program Manager**,** has been with CHG for 15 years. George managed CHG's behavioral health services program prior to 1998, when behavioral health was contractually carved out of CHG's DHCS contract. He continues to manage the behavioral health program for CHG's D-SNP and Healthy Families members.

Most of CHG's employees live and work in the San Diego community. As such, many CHG employees have developed professional, face-to-face relationships with providers, community clinics, hospitals, community-based organizations and local and state government agencies. CHG employees serve on committees, task forces, and boards of some of these organizations, and, in many cases, in leadership roles. This high level of community involvement will also help CHG to successfully implement and manage this Dual Eligibles Demonstration Project.

Question 6.4

Provide a resume of the Duals Demonstration Project Manager.

Please refer to Tab 4, Supporting Attachment B.

Question 6.5

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

CHG is governed by a very active and engaged nine-member Board of Directors. Board members are involved on a monthly basis through their various Board and Committee assignments. Day-to-day decisions are and will continue to be the responsibility of the CEO, Executive, and management staff, which includes active oversight and monitoring of work produced by managers, supervisors and staff.

On a functional level, the CEO and senior team will oversee development and implementation of all necessary changes to existing program policies, procedures and processes, as well as, staff recruitment, development of internal and external monitoring and oversight programs, participation with DHCS, CMS, local public agencies and other stakeholders, and such other program enhancements as are

needed to ensure successful implementation commencing on January 1, 2013 and throughout the term of the Dual Eligibles Demonstration Project.

Section 6.2: Operational Plan

Question 6.2.1

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

CHG is actively developing a formal work plan to ensure the successful implementation of the Dual Eligibles Demonstration Project commencing on January 1, 2013. The implementation will be under the direction of its COO, who in turn is supported by the CEO and experienced Executive and management team. Each operational area within CHG will play a critical part to the success of this implementation. The post implementation monitoring will include reporting from each department which will identify any critical components needing modification. CHG will build upon the knowledge and experience gained in the first year of operation and will highlight its outcomes through medical management utilization and cost, quality, member surveys, provider surveys and tracking of complaints and grievances. This will become the foundation upon which future program improvements will be introduced in years 2 and 3 of the Dual Eligibles Demonstration Project.

Until such time as the final work plan is in place, the following preliminary operational plan will serve as the controlling document:

Roles and Responsibilities of key staff for implementation:

Norma Diaz, MBA – Chief Executive Officer

Bill Rice, CPA – Chief Financial Officer

Mike McGarrigle, MBA – Chief Operating Officer

Jonathan Tamayo, BS – Chief Information Officer

Edward D. Hutt, MD, MBA – Chief Medical Officer

Ann Warren, MA – Chief Regulatory and Legal Affairs Officer

Paty Urbina – Human Resources Manager

Martha Jazo-Bajet, RN, MPH – Director of Utilization Management Services

Noreen Koizumi, PharmD – Director of Health Care Operations

George Scolari – Behavioral Health Program Manager

Nora Pintado, MHA – Director of Health Plan Operations

David Ritchie, BA – Director of Contract Administration

Francisca Chavez, MBA – Regulatory Affairs Manager/Compliance Officer

Upon selection as a Dual Eligibles Demonstration Project participant, CHG will immediately implement the following processes:

Continue with an internal pre-readiness assessment and activities to include training internally on LTSS, LTC, IHSS, CBAS, and MSSP. CHG has established partnerships including San Diego County agencies, advocates and other health plans as part of this new Dual Eligibles Demonstration Project. CHG had a very successful implementation with the mandatory enrollment of the SPD population. The success of this implementation was due to our proactive involvement with DHCS, San Diego County agencies, Healthy San Diego work teams, community advocates, key stakeholders and potential members.

Major Implementation tasks to include:

Human Resources – Staffing assessment and recruitment of needed staff.

Information Systems Configuration – Evaluation and assessment of needed upgrades or other tools to ensure proper internal and external reporting:

Electronic Testing Plan with DHCS/CMS (Eligibility, Encounters and FFS Utilization files, Capitation File) to ensure connectivity of data exchange.

Identification of State and Federal Reporting requirements – Confirmation with DHCS and CMS for all other types of reporting.

Evaluation of Provider Network adequacy – Secure additional provider contracts as needed.

Contract with County Agencies (AIS, San Diego County Public Authority, Behavioral Health, IHSS and others).

Update Policies, Procedures and Processes – Review and evaluate all policies, procedures and processes and modify as needed.

Continue participation in Stakeholder meetings - LTCIP, IHSS, LTSS and Behavioral Health.

Develop and implement training plans, to include:

Enrollment, Claims, Member Services, Provider Relations, Medical Management.

Develop internal and external communication plans, to include:

Internal – Employee communication – CHG will ensure all employees are trained and updated on a regular basis. This will be accomplished via monthly departmental staff meetings, employee newsletters, and Intranet updates.

External – Provider, Member and Advocate/Stakeholders – CHG will continue to work closely with our provider network to ensure a seamless transition for the members. CHG will continue to communicate through Provider Alerts, provider newsletters, face to face meetings, case managers meetings, and all standing committees that include providers. CHG will continue to send out member newsletters, complete outreach calls, keep its website up to date, meet regularly with the Public Policy Committee and with numerous advocates and Community-Based Organizations. Additionally, CHG will continue to play an active role with the AIS LTCIP Stakeholder group.

Review, assess and implement IS programs and other technology improvements, to include:

Enrollment Module – Membership accounting.

Provider Module – Reports provider participation along with providers' demographics and affiliations, and capturing languages membership capability.

Finance Module – Captures all provider claims payments.

Claims Module – Adjudication of all claims.

Phone System – Members' and providers' calls.

Care Management system – Providers' prior authorization requests and risk stratification.

Development of a detailed implementation schedule, to include all relevant tasks and timeliness by April 1, 2012 to ensure the Plan is 100% compliant as of January 1, 2013.

The Project Manager will monitor the progress of the Dual Eligibles Demonstration Project to ensure all tasks and deliverables of the work plan are met on time. Additionally, CHG will create a critical issues log to include: Reporting and Tracking:

Weekly Implementation Task Force Meetings

Operations Weekly Meeting

Monthly and Quarterly Reporting

Executive Leadership Meetings

Question 6.2.2
Provide roles and responsibilities of key partners.

CHG has established key partnerships in our Medi-Cal and D-SNP programs. CHG has oversight of all the vendors to ensure compliance with State and Federal regulations.

AIS – provides services to older adults, people with disabilities and their family members, to help keep clients safely in their homes.

Behavioral Health Services and Network – consisting of over 200 providers offering multiple behavioral health specialties and languages, providing both Mental Health and Substance Use services (overseen by separate County entities).

California Paratransit – for non emergency transportation.

HHSA – the Agency provides a broad range of health and social services, promoting wellness, self-sufficiency, and a better quality of life for all individuals and families in San Diego County.

IHSS – provides homemaker and personal care assistance.

Language Line Services – language assistance line.

Liberty Dental – offers basic dental services to our Medicare recipients.

MedImpact Healthcare Systems, Inc. – is the Plan's Pharmacy Benefits Manager administrator which is offered to both our Medicaid and Medicare enrollees.

Participating Physicians and Hospitals – consisting of all contracted physicians and specialists, hospitals, FQHCs, Home Health Agencies and Ancillary providers.

CHG has contracts with the following hospitals in San Diego County for Medi-Cal: Alvarado Hospital, Fallbrook Hospital, Palomar Hospital, Paradise Valley Hospital, Pomerado Medical Center, Rady Children's Hospital of San Diego, Scripps Mercy Chula Vista, Scripps Memorial Encinitas, Scripps Green Hospital, Scripps Memorial La Jolla, Scripps Mercy Hillcrest, Sharp Chula Vista Medical Center, Sharp Mary Birch Hospital, Sharp Memorial Hospital, Tri-City Medical Center. CHG contracts

with the following hospitals for our Medicare line of business: Alvarado Hospital, Fallbrook Hospital,

Palomar Hospital, Paradise Valley Hospital, Pomerado Medical Center, Rady Children's Hospital of San Diego, Scripps Mercy Chula Vista, Scripps Memorial Encinitas, Scripps Green Hospital, Scripps Memorial La Jolla, Scripps Mercy Hillcrest, and Tri-City Medical Center.

San Diego County Public Health Authority.

Vision Service Plan (VSP) – which offers basic eye exams and eye wear to both our Medicaid and Medicare members.

Question 6.1.3
Provide a timeline of major milestones and dates for successfully executing the operational plan.

Under the supervision of the Project Manager, the following is the timeline:

<u>April through June 2012 (Second Quarter)</u>

Implement weekly Dual Eligible Task Force Meetings for entire year

Identify Benefit configuration requirements and develop implementation of plan

Initiate Public Agency contracting – AIS, IHSS, CBAS, San Diego County Public Authority, San Diego County Behavioral Health Services

Update Marketing Plan

Continue meeting with Consumer Advocates/Stakeholders

Prepare and submit monthly progress reports to DHCS and CMS, as applicable

Develop staffing assessment and recruitment plan

Update CHG's website

July through September 2012 (Third Quarter)

Finalize Benefit Configuration Testing

Finalize Public Agency contracting

Develop Provider Communication plan

Begin testing of 820 ANSI, Enrollment and Utilization files with DHCS

Complete all updates to policies and procedures

Begin staff recruitment process

Continue to meet with Consumer Advocates/Stakeholders

Prepare and submit monthly progress reports to DHCS and CMS, as applicable

October through December 2012 (Fourth Quarter)

Load Enrollment files

Finalize hiring of new staff

Confirm all State reporting requirements

Complete training of all staff members

Implement Provider Communication plan

Initiate Provider staff training and education plan

Finalize and implement Member Communication plan

Continue Meeting with Consumer Advocates/Stakeholders

Prepare and submit monthly progress reports to DHCS and CMS, as applicable

Question 6.1.4

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

CHG certifies that it will report monthly to DHCS regarding the progress of implementation of the Dual Eligibles Demonstration Project. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 7: Network Adequacy

The Applicants must:

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

CHG continuously monitors its provider network in accordance with the following standards:

CHG uses the DHCS standard of 10 miles or 30 minutes to determine member geographic proximity to physicians.

CHG uses the CMS HSD 2013 tables to ensure adequate network coverage. In addition:

CHG tracks physicians' age restrictions

CHG's Contracting Department works with CHG clinical staff to identify any gaps in coverage for contract consideration.

CHG reports the findings to DHCS semi-annually for:

Over 500 Medi-Cal PCPs and over 300 Medicare PCPs (unduplicated)

Over 2,000 Medi-Cal specialists and over 1,000 Medicare specialists (unduplicated)

In addition, CHG also conducts on-site inspections of current and prospective PCPs to, in part, assess their ability to accommodate members with special needs. Disabled access indicators are included in the Medi-Cal Provider Directory.

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

Depending upon the type of provider, CHG may decide to use a mix of value based Pay for Performance (P4P) models in addition to traditional Medi-Cal/Medicare FFS, Case Rates, Daily Per Diems, DRGs, and other methodologies as may be appropriate. CHG currently uses HEDIS and member retention P4P incentives for PCPs and EDI incentives for providers.

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

In addition to offering contracts to selected providers at competitive rates, CHG may elect to design P4P incentives as a way to encourage providers and organizations to participate in the Demonstration project. A P4P methodology could be used for member retention, EDI record submission, ER utilization and HEDIS performance.

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

As currently offered to D-SNP members, CHG's MOC includes the following tools to assist the disabled, when appropriate:

Provider directories which include disability access symbols

PCP site disability access assessments via Healthy San Diego in collaboration with other health plans in San Diego County

Wheelchairs

TTY service linked to CHG's Member Services Department.

Home Physician visits

Home Health agency services:

High-Tech nursing

Medical Social Work

Respite Care

Physical Therapy (PT)/Speech Therapy (ST)/Occupational Therapy (OT)

Home Phlebotomy service

In-Home Infusion service

In-Home Diagnostic Imaging provider

In-Home Respiratory Therapy

Non-emergency transportation to healthcare providers

Language assistance, face-to-face and telephone

Braille printed and audio recordings

In-Home Health Education

Question 7.5

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

To the extent providers are actively working with Dual Eligibles, CHG may elect to offer LOAs or contracts with the addition of P4P incentives as a way to encourage those providers and organizations to participate in the Demonstration Project. P4Ps could include those we currently have in place for member retention, EDI record submission, ER utilization and HEDIS performance.

Question 7.6

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

CHG's integrated delivery system is currently comprised of services which can also supplement the LTSS program. The following providers (unduplicated) support CHG's network of over 500 Medi-Cal PCPs (over 300 Medicare PCPs), and over 2,000 Medi-Cal specialist physicians (over 1,000 Medicare specialist physicians) are supported by the following extended network, consisting of:

Supplemental In-Home Supportive Services In-Home Physician group.

Home Health agencies with High-Tech Nursing, Medical Social Workers, PT/OT/ST, Wound Care and Respite Aide.

In-Home Phlebotomy agency.

In-Home Infusion provider.

In-Home Diagnostic Imaging provider.

Durable Medical Equipment provider that includes equipment delivery to homes.

Home Hemodialysis provider.

Home Respiratory Therapy provider.

Supplemental Long Term Care Services:

SNFs.

Sub-Acute Nursing Facilities.

Hemodialysis centers.

LTACHs with Intensive Care Units (ICU), a surgery suite, Intubation and Dialysis.

Reference Laboratory.

Other Network Providers of Service:

Pharmacies subcontracted via Pharmacy Benefits Manager (PBM).

Diagnostic and Therapeutic Imaging Centers.

Health Education providers.

General acute hospitals throughout San Diego County.

Community Clinics countywide, including rural areas.

Hospice providers.

Independent Physician Association.

Language Assistance Providers, face-to-face and telephonic.

Specialty Laboratories, including Genetic and biotechnology testing.

Physical Therapy networks.

Ambulatory Infusion Center.

Vision Care network.

SMS Text provider for appointment/service reminders.

TTY service via CHG's Member Services Department.

Behavioral Health Providers.

Question 7.7

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

CHG certifies its provider network adequately meets the needs of all enrolled dual eligibles within the current scope of dual eligible benefits and will not be weakened by sub-contractual relationships. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Question 7.8

Certify that the plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

CHG certifies that Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks will be met 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 refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Question 7.9

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

CHG certifies that all Medicare Part D requirements (e.g., benefits, network adequacy) will be met and will submit formularies and Prescription Drug Event (PDE) data. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 7.2: Technology

The Applicant must:

Question 7.2.1

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

CHG utilizes various modes of technology in monitoring and providing quality of care. CHG developed and uses an automated customized care management system to document and track clinical and quality of care measures for members with high risk conditions. This system is currently used to meet all DHCS SPDs reporting criteria and also incorporates established standard evidence-based guidelines to improve quality of care and documentation. CHG's provider web

portal includes access to the following tools: HEDIS pop-up reminders that alert PCPs of missing services needed for members during eligibility verification; a direct HEDIS encounter submission portal that allows providers to directly submit missing data for these HEDIS measures; a module to directly enter CHDP encounters; on-line access to grievance and appeals filings; provider directory search; and a prior authorization portal which allows providers to submit referrals for authorizations with auto approval of specific requests. CHG also has access to TTY services for members with hearing impairment.

Additionally, CHG has web-based access to on-line look-up for immunizations through the San Diego Immunization Registry, and for lab results from our lab vendor Quest. CHG has direct EDI interfaces with various providers for claims payment and has electronic access to files from our vision services vendor VSP and our PBM MedImpact Healthcare Systems, Inc. Via provider EHR systems, care management staff has on-line access to our members' health information when admitted to certain area hospitals and providers and are working toward obtaining electronic access to all key providers serving our members countywide. Through our San Diego County Medi-Cal Managed Care Collaborative, Healthy San Diego, CHG is part of the Facility Site Review Work Team who utilizes and tracks site certification via an on-line module. Plans use on-line templates to document site review results, corrective action and full certification.

Many of our contracted providers are members of the San Diego County Medical Association who are working with their members to enhance electronic connectivity and assist physicians with meaningful use. The San Diego Council of Community Clinics is very engaged with member clinics, assisting them with EHR selection, implementation and meaningful use education and expertise. Additionally, a contracted IPA is working with their MSO to select an EHR and prepare for meaningful use, including expert on-site visits from their vendor who works with the provider offices to assist in their implementation and meeting meaningful use. CHG has also participated in provider training sessions from one of the chosen EHR vendors.

CHG is committed to partnering with other providers and IPAs on Health Initiatives during this Dual Eligible Demonstration Project to ensure patient safety, secure patient access to their personal health information and have the ability to share health information with providers of care. Currently the Plan continues to request remote access with other providers to align with the statewide health information exchange and technology infrastructure. CHG is committed to improving healthcare outcomes and reducing medical costs and will work with providers and stakeholders on integrating and synchronizing the planning and implementation of EHRs that will help our provider network meet the meaningful use criteria.

Question 7.2.2

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

CHG intends to utilize care technology for beneficiaries at very high risk of nursing home admission by focusing on members with key chronic conditions that may benefit from remote health vitals and activity monitoring. These services have the potential for improved outcomes. Chronic diseases to be considered include: CHF, Diabetes, COPD, and Hypertension.

Care technology services include timely transmission and remote interpretation of patient data for follow-up and preventative interventions by providers. This communication facilitates a productive interaction between the patient and their provider in order to achieve improved treatment results such as: improved recovery, better management of their diseases, improved quality of life and reduction in inappropriate ER or acute care services.

As CHG researches the variety of care technology programs, attention will be placed on key areas to ensure positive outcomes to include:

A process for accurate data collection in digital format,

An electronic medical record for data incorporation and remote transmission,

A set of protocols for distant data analysis,

A variety of communication tools to permit effective dialogue between patients and their providers, and

A system for automatically flagging and providing feedback for outlier data.

CHG is also exploring the feasibility of utilizing telehealth services through a contracted community health center that currently utilizes a telehealth program for key behavioral health conditions.

Question 7.2.3

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

CHG will work closely with our provider network on current technologies to meet the information exchange advances. CHG will collaborate with plan providers to research the use of Food and Drug Administration (FDA) approved tele-medicine options that are in full compliance with the interoperability standards.

CHG will examine the quality and cost impacts on specific vital Medicare and Medicaid services, and consider options to integrate the use of technology for members receiving IHSS and other home based LTSS. When this technology becomes affordable and generally available, providers may receive clinical information transmitted by phone or computer resulting in the following possible

outcomes: support for disease management programs and reduction in inappropriate ER costs. Attention will be given to researching physiologic tele-monitoring services that are home based and are easy to use by the patient, family and/or caregiver.

Examples of physiologic tele-monitoring services to be considered may include: body weight and blood glucose monitoring.

Section 8: Monitoring and Evaluation

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

Question 8.1

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

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

CHG currently collects and analyzes data on enrollee satisfaction, self reported health status and access to care results from a variety of sources including:

Enrollee satisfaction-CAHPS survey,

Self reported health status-Health Outcomes Survey (HOS),

HEDIS chart reviews,

Access to care-grievance, appeals, member disenrollments, and requests to change PCPs.

CHG also conducts member interviews on targeted health education campaigns through plan members who participate in the plan's Public Policy Committee. CHG also conducts GNAs and identifies health education needs. Additionally, CHG

captures self-reported health status and access to care data through processes implemented during the transition of the SPD membership. CHG will continue to use the DHCS provided MET, FFS data and the Plan's tool to stratify member risk and identify members' health care needs. CHG will continue to conduct Initial Health Assessments (IHAs) to identify member needs proactively. Results of these reviews are reviewed by CHG's ICT for clinical/social/community identification of needs and shared with the members, their PCP and other providers of care as needed (such as LTSS providers).

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

CHG collects encounter data from multiple sources. These sources include claims encounter data, FFS claims data, state CBAS data, vision claims, pharmacy data, and lab data. All of the data is logged and tracked through multiple reports and logs with summary reports being reviewed on a scheduled basis. All of the data received by CHG is first processed through rigorous front end edits to ensure quality of data before being processed into the primary encounter data systems. Edit reports are sent back to our trading partners when discrepancies in the quality or timing of submission of the data is insufficient. Internal tracking of encounter data by trending the amount by each category by month are also used to determine patterns of submission by our trading partners.

External reports from our HEDIS vendor, DHCS and CMS are also used to set goals on improving the process to meet the required quality measures and standards. All the data is sorted and organized in a data warehouse and reported to each of the respective regulatory agencies. Medi-Cal encounter data is sent monthly using the DHCS format and CHG has demonstrated a consistent error rate of less than one percent (1%) based on feedback reports provided by DHCS.

Over the past few years, CHG's HEDIS scores have steadily improved as a result of CHG's efforts to work with providers. Activities included outreaching to members to ensure compliance with needed services, correct documentation of services provided, and improvement in encounter data submission. CHG has also been proficient in reporting Medicare encounter data by developing and utilizing a custom Risk Adjustment Processing application to send diagnoses clusters to CMS. CHG has increased its capture of relevant diagnoses through the strict adherence to quality measures and the use of this application. CHG will continue to review all of its data processes to ensure quality at all levels as we strive to achieve excellence in all HEDIS measures.

CHG participated in the DHCS SB 208 Workgroup as a health plan participant. CHG, along with other stakeholders, provided feedback on the new contract requirements related to encounter data. CHG continues to work in collaboration with DHCS on this project and provide ongoing input.

CHG has successfully reported PDE data and will continue to report to CMS as required. CHG's PDE rejection rate for contract year 2011 was six hundredths of one percent. Working closely with its contracted Pharmacy Benefits Manager, CHG has maintained a PDE rejection rate of less than one percent every year since it was first awarded a D-SNP in January 1, 2008.

Condition-specific quality measures

CHG tracks condition-specific quality measures through HEDIS and NCQA standards. CHG has a dedicated Total Quality Integration Management team comprised of representatives from all departments dedicated to data collection, analysis and outcome review with the focus of improving health care outcomes. This information is also reported through the CQIC for recommendations and clinical interventions. CHG tracks chronic diseases through the Plan's disease

management program. Members with chronic diseases (i.e., COPD, CHF, Asthma and Diabetes) are tracked and receive targeted intervention based on the severity of their illness and clinical need.

Question 8.2

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

CHG reports on beneficiary outcomes by collecting and analyzing data based on the enrollment data received from DHCS and CMS on the following member demographic characteristics: age, gender, ethnicity, language, disability or functional status (for new SPD members only), and GNA information. Specific examples of this type of reporting are demonstrated in our reporting of age and gender specific HEDIS measures, such as the Use of Appropriate Medications for People with Asthma, Breast Cancer Screening, and Cervical Cancer Screening.

Question 8.3

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

CHG certifies that it will meet all evaluation and monitoring requirements, once made available by DHCS. (Please refer to Tab 1, Project Narrative Criteria Checklist, attached.)

Section 9: Budget

The Applicant must, pending further rate development:

Question 9.1

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

For true integration of services for the Dual Eligibles Demonstration Project electronic data exchange is critical. Funding for connectivity for all providers who serve Dual Eligible beneficiaries is critical to ensure the most effective and efficient care is provided to the member. There are many traditional and safety net providers serving these beneficiaries that do not have the resources to implement the technology that is available. Funding for EHR, telemedicine, in-home monitoring and other such services could improve the health outcome and reduce the full cost of care. CHG would encourage DHCS to actively pursue funding for the above technology services in 2012 so they can be integrated into the Dual Eligibles Demonstration Project by mid to late 2013.

Tab 4 - California Dual Eligible Demonstration Request for Solutions Proposal Supporting attachments Table of Contents

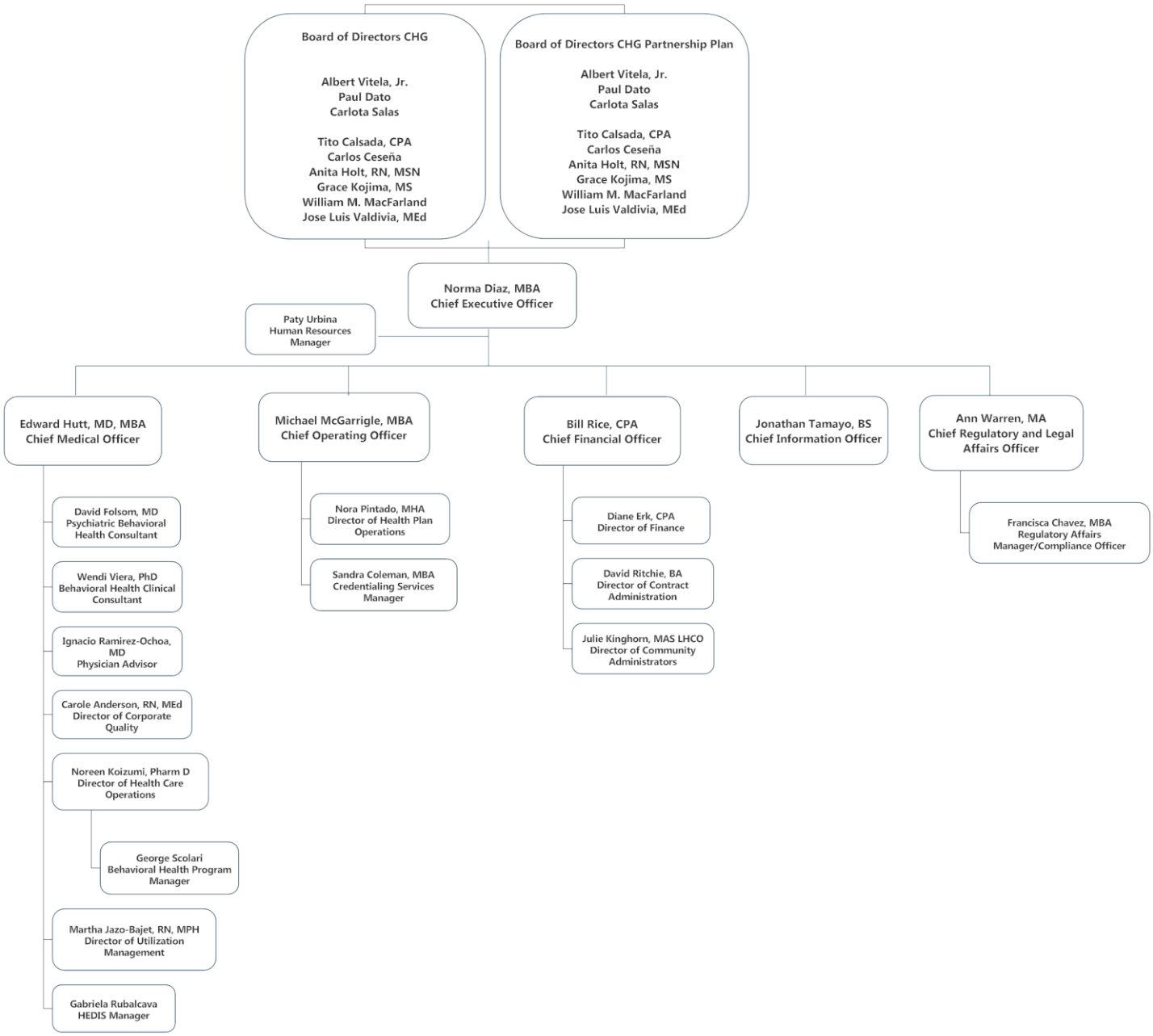
California Dual Eligible Demonstration

Request for Solutions Proposal

Supporting attachments Table of Contents

SUPPORTING ATTACHMENTS **TAB 4**

Organizational Chart



B. Duals Demonstration Project Manger's

Michael McGarrigle

1515 Second Street #U208

Coronado, CA 92118

(484) 477-7939

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SUMMARY OF QUALIFICATIONS

20+ years of professional insurance experience.

20 years of experience in Medical Claims, Call Centers and Operations.

16 + years of experience managing large operation teams including maintaining performance metrics. Supervised up to 200 direct / indirect reports.

Excellent team player. Works well with management, IT and operation personnel.

Excellent written and oral communication abilities, easily relating with clients, brokers, reinsurers.

Proven organizational abilities, frequently volunteering time and services for a variety of professional commitments and activities.

Superior time management skills, prioritizing time effectively to guarantee all tasks and implementations are successfully completed.

Skilled negotiator, always ensuring cost effective and efficient operations.

Diligent and creative in coordinating outside presentations, events, etc.

Thorough knowledge and understanding of medical codes, health insurance codes, and medical terminology (ICD-9 codes and CPT codes).

PROFESSIONAL EXPERIENCE

Community Health Group, Chula Vista, California, PA

Chief Operating Officer, (1-12 to current)

Responsible for oversight of operations for the Medi-Cal and CommuniCare Advantage (HMO-SNP) products servicing over 139,000 members

Responsible for Claims, Member Services, Credentialing and Marketing Departments.

Responsible for planning, directing, organizing controlling and evaluating implementation strategic and tactical plans to ensure sounds operations.

Responsible for leading weekly operations meetings with all departments to ensure all departments are operational

Oversight of ensuring all contractual requirements are met for both CMS (Center for Medicare & Medicaid Services) and DHCS (Department of Human Services) contracts

Participate in the development of the organizational budget, strategic and operational plans and risk management activities

Aetna Better Health & Aetna Better Health Kids (Aetna), Philadelphia, PA

Chief Operating Officer (12/09 – 12/11)

Responsible for implementation for the Pennsylvania Medicaid Operations servicing over 70,000 Medicaid recipients along with operations of the Aetna CHIP program (27,000 members)

Responsible for Training, Compliance, Credentialing, Appeals, Member Services, Provider Relations and Outreach, Encounters and Information Technology

Oversight for all delegated vendors –March Vision, Dentaquest and ESI Pharmacy

Coordination of all Audits – Department of Public Welfare, Department of Health, Department of Insurance

Responsible for Finance and Operational reports weekly, monthly and quarterly to State Regulators

Participating in Senior Leadership Quarterly Business Reporting (QBR), Medical Claims Management (MCM), and Management Operating Reporting (MOR)

Delaware Physicians Care, Inc. (Aetna), Newark, DE

Director – Provider Relations, Credentialing and Provider Appeals (12/2006 – 12/2009)

Directed a Provider Representatives team responsible for a statewide network of physicians, behavioral health practitioners, and hospitals, serving 105,000 Medicaid members for the State of Delaware

Managed a Credentialing team which is responsible for ensuring all network providers credentialing to meet NCQA standards

Oversaw the Provider Appeals team to ensure appeals are handled within timeframes established by State guidelines

Team lead for EQRO, HEDIS, and NCQA Audits

Developed a Provider Loyalty Program to improve provider satisfaction scores. Demonstrated year over year improvements in score.

Coventry Health Care, Newark, DE

Director - Commercial & Medicaid Claims and Customer Service (9/2004-12/2006)

Managed a claims operation of 200 associates who process Commercial and Medicaid claims for membership of 625,000 with an $8 million annual budget

Responsible for all internal and external audits for the health plan including HIPAA, HEDIS, SAS 70 and SOX Audits.

QTC Management, Philadelphia, PA

Team Manager, Veteran Affairs Compensation (6/2004 – 9/2004)

Managed a department of 40 associates processing Veteran Affairs Compensation claims under Government contract.

Responsible for ensuring contractual agreement to meet quality, timeliness and customer service requirements.

Independence Blue Cross, Philadelphia, PA

Manager, Medicare Government Operations (6/2000 – 6/2004)

AmeriHealth 65, Personal Choice 65, Security 65 Products

Consistently met or exceeded both the Centers for Medicare and Medicaid Services (CMS) goals and Independence Blue Cross (IBC) internal goals for claims processing timeliness and quality.

Claims Supervisor (1/1998 to 6/2000)

Supervised 35 Claims Analysts

Provident Indemnity Life Insurance Company, Norristown, PA

Medical Claims Supervisor (4/96 to 1/98)

CIGNA Corporation, Philadelphia, PA

Senior Reinsurance Claim Specialist (3/93 –3/95)

First Health, Inc., Exton, PA

Reinsurance Auditor (3/95- 4/96)

Senior Claims Analyst (6/90 - 3/93)

EDUCATION

Neumann University, Aston, PA

Bachelor of Arts, May 1990

Major: Communications; Minor: English

Philadelphia College of Osteopathic Medicine, Philadelphia, PA

Masters of Science, December 2003

Major: Organizational Development and Leadership

C. Model of Care

Community Health Group

SNP Model of Care

Elements and Standards

As modified to reflect the Dual Demonstration Application

Introduction

Community Health Group (CHG) is a health plan that is dedicated to the improvement and maintenance of health for its members to help them achieve optimum health while demonstrating exceptional service and competency in serving diverse populations. In the spirit of its mission, CHG realizes that a vulnerable segment of its community, those who are dually eligible for Medicare and Medicaid (Medi-Cal), have extensive healthcare needs that may not be fully addressed in a fee-for-service environment. CHG's model of care serves as a roadmap and a guide to achieve its goals and mission as applied to the dual eligible recipients in San Diego County.

Targeted Population

The populations targeted for California's Dual Eligibles Demonstration project are individuals with both Medicare (Parts A, B, and D coverage) and Medi-Cal. The "dual eligibles" are low-income individuals who are elderly or are disabled and have extensive health care needs. Dual eligible beneficiaries are more likely than non-dual-eligible beneficiaries to be under 65-disabled. Forty-one percent of dual-eligible beneficiaries nationwide are under 65-disabled, compared with 11 percent of the non-dual eligible population.[2]

California has approximately 1.1 million people enrolled in both Medicare and Medi-Cal, of which over 75,000 reside in San Diego County. Seventy-one percent (71%) of dual eligibles in California are 65 and older and most have multiple, co-occurring conditions.[3] Additionally, many have limitations to perform activities of daily living (ADL), e.g., bathing and dressing. Twenty-nine percent of dual eligibles nation-wide have impairments in three to six ADLs.[1]

Dual eligibles are more likely to suffer from cognitive impairment and mental disorders, and they have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease than do non-dual Medicare recipients.[1] Additionally, 19% of dual eligible beneficiaries live in an institution, as compared to 3% of the non-dual-eligible population.[1]

Needs of the Targeted Population

In addition to assessing the needs and developing customized care plans specific to each member, CHG has and will continue to enhance services, resources, care management tools and initiatives to meet the needs of its population. The infrastructure of this care delivery model is focused on specifically addressing the socio-economic, cultural and linguistic, and disease-related needs of the membership. Also of importance are the issues that arise from lack of coordination of care between providers, especially between physical and behavioral health.

The majority of the dual eligible beneficiaries have multiple chronic illnesses with varying levels of disease progression and acuity, the inability to care for themselves, and a lack of family and/or in-home support. As a result, CHG has enhanced the core offerings, such as its disease management programs, to meet

specific needs of the dual eligible members. For example, some members with COPD may have a difficult time with increased physical activity. As a result, CHG has implemented a telephonic group health education/support group with a respiratory therapist. This allows members to participate from the comfort of their own homes and allows for social interaction with others with COPD while educating members about their disease. Smoking cessation classes are offered in the same fashion.

Members with multiple chronic illnesses are frequently admitted to the hospital. Members with three or more admissions as a result of a chronic disease (vs. acute diagnoses) within a 12-month period are automatically enrolled in CHG's Multiple Admitters Program (MAP). MAP members receive intensive care and disease management services and proactive planning to address member needs prior to discharge (e.g., discharge medications delivered to the member's home or to the member while the member is still at the hospital or health education in the member's home).

The majority of the members will receive their care, including initial health assessments and primary care visits, in their PCP's office. However, the lack of transportation and mobility is also a barrier for some members to visit their primary care physicians. CHG intends to provide a transportation benefit as it does for its Medicare dual eligible special needs (D-SNP) members. Despite the transportation benefit, some members will not seek care until they are acutely symptomatic. Therefore, as medically indicated, CHG will provide, based on a potential need identified by a CHG Case Manager, an initial health assessment in members' homes by a physician to assess not only a members' health status and needs, but also their level of family support, safety issues in the home, and to identify any other issues that may affect their health and well-being. CHG has also found that when members do not have a permanent home or when they may be embarrassed about their home situation, conducting an assessment

in a neutral

place (such as a coffee shop) is an effective alternative.

Goals and Objectives

The goals and objectives of CHG's model of care are to:

Improve access to essential services such as medical, mental health, LTSS, and social services;

Measurable Outcomes:

CHG staff will make, at a minimum, three attempts to contact 100% of new members to conduct an initial health risk assessment (which includes an evaluation of a member's medical, behavioral health, and social services needs) and coordinate necessary follow-up care within 90 days of enrollment.

Improve access to affordable care;

Measurable Outcomes:

By 2014, increase the follow-up after Hospitalization for Mental Illness (FUH) by 3% over the baseline year of 2013.

Improve coordination of care through an identified point of contact;

Measurable Outcomes:

CHG will attempt to contact 100% of newly enrolled dual eligible members to provide a "welcome call" which notifies the member of their assigned PCP and how to access services.

Improve seamless transitions of care across health care settings, providers, and Home and Community-Based Services (HCBS);

Measurable Outcomes:

For planned and unplanned transitions from one level of care to another, share the sending setting's care plan with the receiving setting within one business day of notification of the transition, 90% of the time.

Improve access to preventive health services;

Measurable Outcomes

By 2014, increase CHG's HEDIS effectiveness of care measures (adult BMI assessment, breast cancer screening, care for older adults, and glaucoma screening) by 3% over the baseline year of 2013.

Improve access to HCBS;

Measurable Outcomes:

CHG will attempt to ensure completion of an initial health assessment of 100% of newly enrolled dual eligible members which includes an evaluation of the need for HCBS.

Assure appropriate utilization of services;

Measurable Outcomes

By 2014, decrease the HEDIS Plan All Cause Readmission (PCR) measure by 1% over the baseline year of 2013.

Improve beneficiary health outcomes (specify Medicare Advantage Organization (MAO) selected health outcome measures).

Measurable Outcomes

By 2014, reduce the custodial long term care admission rate by 1% over the baseline year of 2013.

By 2014, decrease the number of poorly controlled diabetics (as defined by the HEDIS Comprehensive Diabetes Care measure) by 3% as compared to the baseline year of 2013.

By 2015, increase the number of members who rate their general health above "fair" as compared to the baseline year of 2013.

CHG's Corporate Quality Department conducts quantitative analysis for evaluating the effectiveness of the model of care and the achievement of the established goals. Responsibility for oversight, accountability for monitoring, evaluation and qualitative analysis lies with the Director Corporate Quality and the Chief Medical Officer (CMO).

The ongoing evolution and improvement of the model of care is the responsibility of the CMO. If goals are not met in the expected timeframe, the established quality improvement process is followed to determine appropriate actions to be taken. The analysis of the model of care quality measures is completed by the Corporate Quality department with input by the Clinical Quality Improvement Committee. A corrective action plan and evaluation process is recommended by the Clinical Quality Improvement Committee. Any service-related issues are brought to the Service Quality Improvement Committee for discussion and input. Final recommendations for corrective action are presented to the Corporate Quality Improvement Committee for review and approval.

Staff Structure and Care Management Roles

Administrative Functions

Most of the administrative functions within CHG are housed within the Operations Division. Under the direction of the Chief Operating Officer (COO), the Operations Division is responsible for marketing, enrollment and eligibility, member services, credentialing and claims administration. All of the aforementioned functions are performed in-house; CHG does not use a contractor for these services or brokers for marketing.

The Member Services Department is staffed 24 hours a day, 7 days a week and is available and equipped to assist members and providers with any questions, including eligibility and benefit verification. CHG does not use an automated phone tree; every call is answered by a live person. CHG maintains high standards for its call center. Calls are routinely monitored and call center metrics are continuously tracked. Member Services staff speaks English, Spanish, Vietnamese, and Arabic and accesses a language translation service and a TTY line when needed. The Member Services Department disseminates written plan information to members and advocates, and informs and educates members on services and benefits. While every CHG employee receives annual customer service training in MAGIC® (Make a Great Impression on the Customer), CHG's Member Services Representatives receive more intensive training at more frequent intervals. In the near future, CHG will be implementing an interactive voice response (IVR) system to place calls to members regarding preventive services and other messages regarding their health and wellness.

Enrollment and disenrollment processing is done within the Member Services Department by individuals specifically designated and trained to work with dual eligible members. The enrollment and disenrollment processes are audited by the Member Services Auditor/Trainer. This individual works closely with staff to maintain accurate enrollment and eligibility files and to ensure that Member Services staff follows established policies and procedures.

Claims are processed under the direction of the Director of Operations by a Claims Department with expertise in processing Medicare and Medi-Cal claims. CHG has the capability to receive and adjudicate claims electronically. Approximately 99% of claims are processed and adjudicated within seven working days of receipt with an accuracy rate of 99%.

Clinical Team

CHG performs utilization, case, and disease management functions in-house. These functions are carried out by a team of licensed and non-licensed personnel working under the clinical direction of the *CMO*, who is board-certified in family practice, is a fellow of the American College of Utilization Review Physicians and the American College of Medical Quality, and holds an unrestricted California medical license.

CHG's internal registered nurse (RN) case managers, under the direction of the *Director of UM Services,* cover three areas within the continuum of care:

Outpatient Case Managers (RNs, Level II Reviewers) review and authorize requests for services that cannot be approved by non-clinical (Level I) reviewers using established protocols. Outpatient case managers ensure that members are referred to the appropriate contracted facilities and providers and ensure that all

specialty referral services are provided under the direction or concurrent agreement of the member's primary care practitioner. As part of their review, Outpatient Case Managers identify members with high risk diagnoses and refer them to the High Risk Case Managers for follow up. They also coordinate requests for care outside of the referral network with the primary care practitioners, if necessary.

Concurrent Review Nurses (RNs) conduct on-site review of the care rendered to hospitalized members to assess admission or continued stay using medical criteria for acute hospitalization. These case managers coordinate discharge plans with the member (and their families or care representatives as appropriate), attending physician, and hospital case managers in order to facilitate a seamless transition to lower levels of care, when clinically appropriate and safe. They refer members with on-going case management needs to the high risk case managers and coordinate any necessary post-discharge outpatient referral and/or follow-up care with the outpatient case managers.

High Risk Case Managers (RNs) address the needs of members who have been hospitalized at least once for chronic or recurring conditions or who have been determined to be high risk based on a stratification process. The objective of these case managers is to prevent hospitalization by maximizing outpatient modalities, such as prompt referral to specialists, quick access to primary care, medication management, health education, and home health.

In addition to the Utilization and Case Management staff, CHG's healthcare services team includes:

Associate Medical Director, who holds an unrestricted California medical license and is board-certified in Family Practice, is responsible for reviewing requests for

services that do not meet clinical review criteria and may initiate the modification or denial of services. The Associate Medical Director provides clinical guidance to the case managers and support staff. He is also contracted to conduct initial health assessment visits.

Personal Care Coordinator works closely with members, their families, Primary Care Physicians (PCPs), specialists and community-based resources to facilitate the individualized plan of care. CHG's Personal Care Coordinator understands the benefits available to each member, and can facilitate the optimal use of those benefits, including facilitating transportation services. The Personal Care Coordinator conducts an orientation call with every member and schedules an initial health assessment/exam as well as the annual health assessment, if there is none on record by the PCP. Members are encouraged to contact their Personal Care Coordinator if they have any questions regarding their benefits and care.

Behavioral Health Services Program Manager is actively involved in the behavioral health and substance abuse community and with community-based organizations and is a resource to the case management staff in coordinating members' physical and mental health, as well as addressing any social issues, and is available 24 hours a day, seven days a week.

Behavioral Health Psychiatric Consultant is a physician who is board-certified in family medicine and psychiatry. He is actively involved on CHG's Pharmacy and Therapeutics and Behavioral Committees and will assist in enhancing CHG's Behavioral Health Program to better serve the needs of the dual eligibles.

Behavioral Health Consultant, a licensed psychologist, is responsible for the overall clinical direction of all behavioral health services provided by CHG. She is actively involved in implementing the behavioral health aspects of CHG's utilization management (UM) program including setting policies, participating in credentialing, reviewing potential denials, and participating in the UM, Clinical Quality Improvement, Credentialing, and Technology Assessment Committees.

Director of Health Care Operations provides administrative direction to the UM Program and clinical and operational direction to the pharmacy services program. As a pharmacist, she is actively involved in ensuring the integration of drug therapy with all aspects of medical and behavioral health, participates in case rounds, and serves as a resource to the case managers.

Community and Preventive Services Staff work closely with clinical staff to maintain and refer members to a contracted health education network. Health education contractors submit their curricula prior to being granted a contract by CHG. The curricula are based on recognized national standards and guidelines must be consistent with CHG's clinical practice guidelines and protocols and include education on self-management techniques. Community and Preventive Services Staff also assist the High Risk Case Manager in implementation, tracking and follow-up of various components of the care plan.

CHG is prepared to add both administrative and clinical staff to meet the program goals, secure quality outcomes for members, and to fulfill the regulatory requirements of the Demonstration Project. CHG will evaluate options to use services through contracted providers and vendors versus hiring staff internally. For example, CHG currently uses social workers through contracted home health agencies on an as needed basis. As the need for this service increases based on membership, CHG will determine whether it would be best to bring this service in-house.

Administrative and Clinical Oversight

CHG's Human Resources Department verifies licensing and conducts a background check on all new hires and verifies on-going licensing on all licensed staff. Staff competency is assessed by their immediate clinical supervisors, and, ultimately, the CMO. Each staff member receives an annual evaluation by their supervisor.

As an NCQA-accredited health plan with contracts with the State of California and CMS, CHG reports a full complement of Healthcare Effectiveness Data and Information Set (HEDIS) measures and carries out several activities and interventions geared towards the improvement of care and services provided to our members. Through this process, CHG measures provider use of clinical practice guidelines and the appropriateness and timeliness of services provided. The HEDIS Manager is responsible for the process of collecting, analyzing, and reporting CHG's HEDIS measures.

The Director of Corporate Quality is responsible for conducting a quality improvement program which targets improving quality measures based on our HEDIS scores, CAHPS survey, HOS survey and other initiatives.

Under the direction of the Director of Health Care Operations, CHG monitors and evaluates our Utilization Management (UM) program to assess the fairness, consistency, and promptness of our UM decisions and appropriateness of utilization. The monitoring process includes a review of claims and utilization data (including pharmacy) as well as the evaluation of any complaints and appeals related to the UM process, assessment of trends, implementation of actions to

correct identified problems, mechanisms to communicate actions and results to appropriate staff and practitioners, and evaluation of any corrective action plan and measurements of performance.

Interdisciplinary Care Team (ICT)

CHG's ICT consists of key stakeholders described within our care model. Team members were selected based on the extent to which they can contribute to the development, implementation, and assessment of a realistic and actionable individualized care plan. Team members and their roles are listed below:

CMO – serves as a resource to determine the medical needs of the member; determines the clinical appropriateness of treatment based on established evidence-based clinical guidelines and standards

Director of UM Services – oversees the ICT review process; ensures that the process remains sound and that each team member works interdependently to complete their part of the care plan; also serves as a clinical resource

High Risk Case Manager – is responsible for coordinating the care plan with the personal care coordinators and preventive services staff and is the primary contact with the member once a care plan has been established; reviews the care plan with the member (and family members where applicable), PCP and other providers, and members of the care team to ensure that the care plan is addressing the member's needs; monitors the provision of services to ensure follow-up and seamless transition of care across settings and providers; recommends changes to the care plan based on feedback from the member and other stakeholders or when members' needs change

Behavioral Health Services Manager – is the behavioral health and substance abuse resource on the team; is responsible for managing members' behavioral health care and for care coordination with medical team members; and serves as the team resource for community-based services

Member Services Trainer/Auditor – is the Member Services and benefit resource on the team; assists team in maximizing and coordinating members' benefits; coordinates members' transportation benefit; works with members and contracted vendor to schedule and install home-adaptive equipment; is also a resource for community-based services

Community and Preventive Services Specialist – works closely with the High Risk Case Manager to coordinate the care plan and to identify appropriate preventive and health education programs/classes to address members' needs; serves as the disease management resource on the team

Health Care Applications Coordinator – coordinates the case review process under the direction of the Director of UM Services; tracks and records members that have been reviewed by the ICT by date and risk stratification and maintains a tickler file of when cases are to be re-reviewed by the ICT; disseminates ICT reports to team members

Corporate Quality Specialist – serves as the diagnoses coding specialist on the team; provides information obtained from file reviews conducted at the PCP offices as a result of diagnoses validation and annual health assessment audits.

Director of Health Care Operations – as a pharmacist, is the team resource on pharmacy services and drug therapy; serves to integrate drug therapy with all aspects of medical and behavioral health; coordinates the care plan with the medication therapy management program

PCPs – are provided with a copy of the health risk assessment and are invited to participate in person or by teleconference during ICT case conferences when their

patients are discussed. Any information or input provided by the PCP to the High Risk Case Manager is discussed during the case conference if the PCP is not able to participate.

Participation of the beneficiary is facilitated through the case management staff in coordination with the High Risk Case Manager. The case management staff reviews the care plan with the member (and family members where applicable) and recommends changes to the care plan based on feedback from the member and other stakeholders or when members' needs change. Beneficiaries may also participate through their PCPs.

The ICT meets weekly at a regularly scheduled day and time to review new and existing cases, stratify the level of acuity, develop, assess and modify care plans. The Health Care Applications Coordinator determines the case review "docket" for each meeting. New cases are scheduled for review after the completion of the initial health assessment (IHA). The Health Care Applications Coordinator gathers all information that is available for each the member – the IHA report, medical and pharmacy claims data (many members were previously CHG members prior to qualifying for Medicare), any customer service calls received by Member Services, and diagnosis codes received by CMS upon enrollment. The team reviews the cases, assigns risk stratification, determines components of the care plan, and determines when the care plan should be re-reviewed. After the review, the Health Care Applications Coordinator scans all documents (by member) into a designated electronic folder and updates the case review log.

Existing cases are included on the case review docket as they are due for review. The Health Care Applications Coordinator provides team members with a copy of the documents from the initial case review along with a summary of any available

updated information. ICT members are responsible to be prepared to provide an update on their areas of the care plan and to provide any new information obtained. After the team reviews the existing cases, re-assigns or confirms risk stratification and updates the care plan and follow-up, the Health Care Applications Coordinator scans all new documents into the member's file and updates the case review log.

Provider Network

CHG's care model is designed to provide a framework for an integrated and comprehensive system of care in which the patient-primary care physician (PCP) relationship is central. CHG's primary care network consists of over 500 Medi-Cal PCPs (over 300 Medicare PCPs), 15 Medi-Cal community clinic organizations (12 Medicare) and group practices and independent practice associations throughout San Diego County. Contracted community clinics include federally qualified health centers and look-alikes in San Diego County. These clinics comprise a major component of the traditional and safety net provider network in the county and provide a complement of services to at-risk dual eligibles. In addition to the PCP (who in some instances may be a specialist) and the support staff in the primary care home, CHG's contracted network of facilities, medical and behavioral health specialists, ancillary providers, and allied professionals are able to address the medical needs of our members.

In addition to 17 Medi-Cal contracted acute-care hospitals (12 Medicare) throughout the county, CHG's network includes sub-acute facilities that provide medical "step-down" and rehabilitative care, long term acute care facilities, skilled nursing facilities (SNFs), dialysis centers, free-standing diagnostic centers,

laboratory services, home health agencies, and durable medical equipment providers. Highly cultivated partnerships with key facilities allow CHG's case managers to effectively transition members to sub-acute facilities that are able to meet specialized needs such as ventilation, post-surgery rehabilitation, wound and infusion care, cardiac and post-stroke rehabilitation.

CHG's Medi-Cal specialty network includes over 2,300 physicians (over 1,800 Medicare Specialists) throughout the county, representing all major specialties and sub-specialties necessary to meet the needs of members. CHG has also established processes to provide care by non-contracted providers when care cannot be safely and appropriately rendered within the network. CHG's Contracts Department meets regularly with case management staff to discuss network needs (based on services and geographic location) and to discuss any issues that may arise with contracted providers and vendors.

CHG also maintains a contracted behavioral health network of over 200 behavioral health providers. These providers include many different behavioral health specialists and are able to provide services in many languages. The behavioral health network includes contracts with three licensed mental health professionals to provide care in the members' home, if necessary. The behavioral health system ensures that members discharged from a psychiatric admission are seen on an outpatient basis by a contracted licensed behavioral health provider on the same day of discharge. CHG has also contracted with the local chapter of the National Alliance on Mental Illness (NAMI) to provide a "warm line" designed to give members someone to talk to and complement other behavioral health treatment.

CHG has a contracted county-wide health education network of over 20 providers to provide culturally-sensitive and linguistically appropriate health education services to our members. Classes are available throughout the county and some

classes are available telephonically to address the needs of members who have difficulty with or upon ambulation. A contracted health education provider is able to conduct in-home health education sessions. These in-home sessions not only provide access to members who are unable or unwilling to attend classes but also provide another opportunity to assess the member's home environment and support system. This is important especially with diseases such as asthma, where triggers in the home may contribute to exacerbations that could negate the positive effects of a care plan.

CHG contracts with Outcomes, a medication therapy management (MTM) vendor. Outcomes contracts with pharmacies within CHG's contracted pharmacy network to provide MTM services to dual eligible special needs members. Pharmacists at contracted pharmacies complete an on-line training module. In addition to pharmacists at network pharmacies, Outcomes contracts with pharmacist consultants who are able to provide services outside of a store environment.

CHG also contracts with physicians to perform comprehensive assessments of members in their home, if indicated. These assessments include the completion of an initial or annual health assessment questionnaire, a review of medications, an environmental assessment to determine any safety issues, and an interview with the member and family members to identify any other issues that may affect the health and well-being of the member.

No later than July 1, 2012 (or as soon as DHCS allows us to do so), CHG will contract with DHCS-approved/certified Community-Based Adult Services (CBAS) centers to provide services to meet the needs of the most vulnerable clients. In

areas of the County where CBAS centers are not available, CHG is prepared to provide beneficiaries with services encompassed by the CBAS centers to help the beneficiary maintain independence and avoid institutionalization.

No later than January 1, 2013, CHG will contract with San Diego County's Aging and Independent Services (AIS) to provide In-Home Supportive Services (IHSS) and Multi-Purpose Senior Services Program (MSSP) benefits as authorized under the same process used under current state law in year one of the Demonstration. The contractual relationship in future years will be based on future guidance from DHCS and any other changes agreed to by CHG and AIS.

CHG intends to contract with appropriate entities throughout the County to provide long term skilled, intermediate, and custodial care to meet the needs of its membership. CHG will consult DHCS' Health Facilities Consumer Information System to determine contracting options in San Diego County.

CHG credentials every contracted provider and facility according to NCQA standards. The credentialing process incorporates provider and member grievances, issues identified through sentinel quality monitors and site certification for PCPs and high volume specialists. PCPs and high volume specialists must undergo and meet the requirements of a site review prior to seeing members and must be reviewed every three years thereafter. The site certification process includes a review of the physical facility as well as a review of medical records practices.

The PCP functions as the primary gatekeeper and is responsible for determining and requesting the services that a member needs. CHG's High Risk Case Manager,

based on the care plan, may suggest alternatives to the PCP, but the PCP determines the needed care.

The PCP follows CHG's established processes to refer members to appropriate services. When necessary, the High Risk Case Manager or Personal Care Coordinator will assist in the referral process. Members at risk for non-compliance or for failing appointments receive reminder calls by the Personal Care Coordinator and transportation is also arranged when necessary. The Personal Care Coordinator follows up with the member to ensure that the visit occurred and requests a copy consultation reports, results, etc. This is incorporated in members' case files and reviewed by the ICT at the next scheduled review. The ICT reviews the new information and modifies the care plan accordingly. If rendered care appears to be inappropriate or inconsistent with established evidence-based clinical practice guidelines and nationally recognized protocols, the Chief Medical Officer contacts the PCP to discuss the case. All care received throughout the healthcare continuum is coordinated between the PCP and CHG's UM and/or case management staff.

The appropriateness and quality of the care provided to CHG members is assessed on a case-by-case basis as mentioned above. Care provided to CHG members is also assessed on an aggregate basis using HEDIS measures. Using the HEDIS platform, CHG obtains reports of members who have not received recommended services or who have received services that are inappropriate. CHG addresses these issues broadly through practitioner and/or member interventions. For example, a targeted mailing or telephone outreach campaign may be directed to all diabetics who have not received an annual eye exam.

CHG uses objective, measurable criteria for making utilization management decisions that are based on sound clinical principles and processes and

reasonable medical evidence. CHG bases utilization management decisions on program-specific criteria and guidelines (such as Medi-Cal guidelines and Medicare National Coverage Determinations), Milliman Health Care Guidelines, and guidelines issued by professional and governmental organizations.

CHG's care plan templates for members with chronic conditions incorporate evidence-based clinical practice guidelines and nationally recognized protocols. For example, routine testing and exams based on the American Diabetes Association guidelines are incorporated within the care plan for diabetics.

Furthermore, the Clinical Quality Improvement Committee has adopted evidence-based guidelines based on scientific evidence; or on professional standards, in the absence of scientific evidence; or on expert opinion, in the absence of professional standards. Guidelines are adopted from recognized sources or involve board-certified practitioners from appropriate specialties in the development or adoption of clinical practice guidelines. CHG distributes the guidelines to the appropriate network practitioners after adoption, at least every two years, and when updates are made between the biennial distributions.

Model of Care Training for Personnel and Provider Network

Initial and annual model of care training is provided to Health Care Services staff during new employee orientation/training sessions and during regularly scheduled department meetings. Training to providers is conducted during provider case management meetings and through written communication

(Provider Alerts and Physician Newsletters) which are also posted on the Provider Extranet.

Employees and providers attending face-to-face trainings sign an attendee list and complete a training evaluation form. To facilitate and increase the training participation rate of practitioners, CHG plans to collaborate with other San Diego managed Medi-Cal plans through the geographic managed care collaborative (Healthy San Diego). The overwhelming majority of CHG's contracted providers are also contracted with at least one other D-SNP. Offering combined training in collaboration with the other health plans creates an incentive for providers to attend the training; by attending one training session, he/she would satisfy the requirements of all contracted health plans. CHG envisions the combined training to cover the general principles common to all SNP care models (required factors) while spending some time addressing any characteristics unique to specific plans. Just as the Health San Diego collaborative currently publishes the *HSD Plan Partner Card* (a one-sheet reference containing the names of the Plan liaisons with contact information, pertinent plan information such as member/customer service phone numbers, PBM contact information, and formulary web access information of each of the managed Medi-Cal plans operating in San Diego County as well as a listing of Medi-Cal drugs that are commonly "carved-out" of the GMC contracts), a similar reference will be created to assist providers in managing their members with each health plan.

After the joint health plan training(s) have been conducted for each year, CHG will reach out to providers to provide training by posting training material on the provider extranet which will create an electronic training record. Providers will

receive continuous reminders until they complete the on-line training. Large primary care sites may request on-site training sessions through CHG's Provider Relations Department.

CHG's Director of Healthcare Operations is responsible for the oversight of the model of care training. The Director of Healthcare Operations provides administrative direction to CHG's utilization and case management programs, is a member of the ICT, and is well-versed in all aspects of CHG's model of care.

Personnel or practitioners who miss face-to-face training meetings will be contacted and rescheduled for make-up training sessions. Personnel or practitioners who have not attended the training session are referred to the MOC training material on the Provider Extranet

Health Risk Assessment (HRA)

CHG's HRA tool is used to conduct both the initial assessment and annual reassessment. The tool assesses the following:

Member demographics

Family and caregiver support and resources

Life planning activities (e.g., advanced directives)

Medical and behavioral health history and current assessment of existing conditions, including

Review of systems

Medical, psychosocial, functional, and cognitive status/needs

Current medications

Activities of daily living, including:

Pain assessment

Social activities

The initial health assessment (IHA) is conducted within 90 days of enrollment using CHG's HRA tool and process established for expediently processing assessments with the mandatory SPD enrollment. To conduct the risk assessment, CHG staff makes a minimum of three attempts to contact members. Member Services staff mails a letter to all members immediately upon enrollment to notify them of the risk assessment process and to encourage them to take advantage of the benefit. A copy of the HRA tool is included with the letter as well as directions on how to schedule the assessment and plan contact information. Each member receives an initial phone call by a Member Services representative. The risk assessment process is included in the "welcome call" script made to all new members. The second and any subsequent phone call(s) is made by designated Member Services staff to inform members of the benefit of completing the assessment and will either conduct the non-clinical portion of the assessment at the time of the call or schedule a future date and time for the assessment. The assessment may be conducted directly with the member or the member's designated representative. Once Member Services completes the non-clinical portion of the assessment, the case is forwarded to Case Management staff for completion of the assessment and to develop the individualized care plan.

Annual health risk reassessments are conducted within one year of the last assessment by the member's PCP or as described above using the HRA tool. Upon completion of the IHA, the member is scheduled for review by the ICT. The Health Care Applications Coordinator distributes a copy of the completed IHA and a file containing all information that CHG may have about the member to the members of the ICT. This includes diagnoses or encounter data provided by CMS and/or DHCS, information provided by the member on a Member Evaluation Tool (MET) or Health Information Form (HIF), a history of any referrals, services received, hospitalizations, contact with case management staff, paid claims, prescription activity, calls to and by Member Services, and eligibility history (some members may have had previous eligibility in CHG's Medi-Cal only or D-SNP plans). The members of the ICT use this information, along with the risk assessment tool, to identify and stratify the health care, social, and supportive needs of the member and to create the framework of and recommendations for the individualized care plan or plan of care (POC). The primary goal of the POC is to maximize the ability of the member to remain at his/her home and community with appropriate services and supports in lieu of institutional care.

In the event that CHG is unable to reach a member to conduct an IHA, the Health Care Applications Coordinator creates a file of any information that CHG may have collected about that member and the file is reviewed by the ICT. The ICT determines whether further action should be taken to contact the member. If this is the case, the case management team will employ best efforts and try to establish contact with the member. If the ICT determines that the member appears to have no evident risk at the time of the review, the member's file will be closed until the annual review, or when the member receives a service that triggers a review – e.g., hospitalization.

A copy of the health risk assessment is mailed or faxed to the PCP. The High Risk Care Manager or Personal Care Coordinator communicates the proposed POC based on the stratification results of the risk assessment to every member. A copy of the POC is also mailed to the member. The results of the risk assessment are referenced during the discussion of the care plan. The High Risk Case Manager makes follow-up calls with the PCP to coordinate care/treatment as necessary based on clinical need.

Individualized Care Plan

The members of the ICT create the framework of and recommendations for the individualized plan of care (POC). The POC is person-centered and solidified during the discussion between the High Risk Case Manager or case management staff and the member, his/her family members or care representatives. The medical conditions, disabilities, functional limitations, intellectual and cognitive abilities, including those who can self-direct care and those with dementia and Alzheimer's disease, are considered when formulating the plan. The agreed upon POC is then mailed to the member. A copy of the POC is also faxed to the PCP and, as the member's medical home, the PCP has the opportunity to modify the POC based on his/her clinical judgment.

The POC addresses the member's current needs and potential needs over time based on the health risk assessment. The POC sets goals and objectives, lists specific services and benefits that are planned to meet the specific needs of the member, incorporates preferences for care, addresses barriers to care, sets schedules for follow-up and communication with the member, and incorporates outcome measures. Appropriate resources and tools are identified to address various aspects of the member's care, such as maximizing benefits (such as

transportation), community-based resources (such as In-Home Supportive Services and Meals-on-wheels), identifying appropriate network providers (such as home-based visits for members who are unable to leave their homes and hospice care for members near the end-of-life) and CHG's established programs (such as health education/wellness classes and disease management programs). The quantity and level of the services and resources included in the POC are dependent upon the intensity of the member's needs and risk stratification.

Care Coordination

CHG's case management staff works with the member and PCP to coordinate all needed medical, behavioral, and social services identified to meet the needs of the member. The PCP plays a pivotal role in coordinating primary and preventive care with care provided by specialists and through community-based services.

Care is also coordinated as a member transitions from one level of care to another throughout the healthcare continuum. Transitional care coordination includes pre-service assessments prior to targeted orthopedic surgeries; ongoing inpatient level of care monitoring; transitioning of care to long term acute or custodial care facilities, to skilled nursing, and intermediate care facilities; in home visitation within 24 hours of hospital discharge, if indicated; discharge medications delivered to the member or member's home prior to or soon after discharge, when necessary; and timely follow-up appointments with the PCP after discharge from the hospital and the emergency room for targeted members.

The ICT pays special attention to members identified who are frail, disabled, have end-stage renal disease, are near the end-of-life or who have multiple and complex chronic conditions. Frailty represents a state of age-related physiologic vulnerability resulting from impaired reserve and a reduced capacity to respond effectively to stressors. The manifestations of frailty include weight loss, weakness, fatigue, inactivity, and decreased food intake. In addition, signs of frailty include decreased muscle mass, balance and gait abnormalities,

deconditioning, and decreased bone mass. These clinical characteristics have been shown to be highly predictive of a range of adverse outcomes clinically associated with frailty, including decline in function, institutionalization, and mortality.[4]

Disabled members include individuals with physical impairment, sensory impairment, cognitive disorder, or mental disorder. In-home supportive services, Meals on Wheels, and other resources are arranged for members without adequate family or care-giver support. Visits in the member's home by a medical, psychiatric, or health education professional may be arranged for members who are unable or unwilling to leave their homes. Life planning activities are addressed with all members and hospice care is also discussed with members near the end-of-life. The ICT ensures that members with end-stage renal disease are under the care of a nephrologist, are set-up for dialysis, and to receive necessary pharmacotherapy. The POC is determined as to whether or not the member is a transplant candidate. Members with multiple and complex chronic conditions are enrolled in CHG's disease management program, are referred to an intensive, specialty health education program, and are targeted for a comprehensive medication review.

CHG's case management staff incorporates the recommendations by the ICT in the individualized POC. The finalized care plan is brought back for review by the ICT before the first scheduled review only when it differs significantly from the original recommendations made by the team. The POC is reviewed and revised, at a minimum, on an annual basis and as a change in the member's health status is identified. During the annual or scheduled review, the ICT evaluates the POC to determine whether all planned care and services have occurred. Potential barriers

are addressed and incorporated in the subsequent revision of the care plan. The initial POC as well as any changes to the POC are communicated to the member by the High Risk Case Manager or Personal Care Coordinator.

POCs and risk assessments are scanned and saved electronically in a shared network drive that is accessible to the ICT, Health Care Services, and Member Services staff. The files are maintained in accordance with industry practices, corporate policies and procedures to safeguard from destruction and secure according to Health Insurance Portability and Accountability Act (HIPAA) security standards. All CHG health care services staff that interact with or has anything to do with the member's care document pertinent information into CHG's case management module. This application allows all members of the healthcare team to document their case notes in a single, electronic case file. Member Services notes are also imported in the electronic case file.

The PCP receives a faxed copy of the initial POC from the case management staff and he/she receives periodic updates, either by fax or via telephone call, when there is a revision to the care plan. The High Risk Case Manager or Personal Care Coordinator communicates revisions to the POC to the member and ICT as necessary.

Communication Network

CHG communicates with Plan providers, members and regulatory agencies in various methods. Being a local health plan, CHG employees live and work in the community that they serve. Many CHG employees have developed professional, face-to-face relationships with providers, community clinics, hospitals,

community-based organizations and local and state government agencies. CHG employees serve on committees, task forces, and boards of some of these institutions. CHG's CMO routinely visits network providers and CHG's Concurrent Review Nurses conduct review on-site at the hospitals. Provider Relations staff conducts provider orientation training and visits primary care physician offices on a regular basis. Face-to-face training with providers and their staff is conducted in their individual offices, at CHG, or via web conferencing, when necessary.

CHG has standing committees which include network physicians (primary care and specialists), mid-level practitioners, and pharmacists. These include the Clinical Quality Improvement Committee, the Credentialing Sub-Committee, the Utilization Management Committee, the Technology Assessment Committee, the Pharmacy and Therapeutics Committee, and the Behavioral Health Advisory Committee. CHG also maintains a Public Policy Committee (which reports directly to the Board of Directors), comprised of members, a community-based organization representative, a member from the Consumer Advocacy Department of the local Legal Aid Society, and three (3) members of the Board of Directors. All of these standing committees provide a forum for communication in addition to the business conducted. In addition to the standing committees, CHG holds regularly scheduled meetings and trainings with providers and/or their staffs. When the need arises, focus groups are conducted with members and/or providers to solicit opinions and feedback.

All CHG members receive a welcome call from the Member Services Department upon active enrollment. The welcome call covers the member's benefits, how to access services, provides contact information, and other topics geared to assist members. Members have access to Member Services staff, 24 hours a day, seven days a week. CHG does not use automated phone trees in the call center; calls are answered by a live person. All Member Services staff is bi-lingual in one of the

Medi-Cal threshold languages for San Diego County which include: English, Spanish, Vietnamese, and Arabic. CHG accesses a translation service as well a TTY line, when necessary. Member Services Representatives acts as the member's liaison on many levels. Members may also come to CHG's physical location to meet with Member Services staff.

CHG has a web site with specific areas targeted to members, providers, and the public in general. The web site contains plan and benefit information, a provider network search feature (including hospitals, urgent care, and diagnostic centers), health education information and preventive guidelines, drug formularies, plan contacts, documents and information required by contractors, regulatory and accreditation agencies, useful resources and links, and on-line tools for providers and members. Members have the capability of completing and submitting an electronic grievance form. CHG maintains a secured provider portal which allows physicians to log-in and check member eligibility, submit electronic authorization requests, look up the status of submitted claims, and to submit specific encounter data electronically, such as electronic Child Health and Disability Prevention Program (CHDP) submissions and HEDIS-specific encounters.

CHG communicates with members and providers through printed materials. CHG's Provider Manual is available to providers in print as well as electronically through the web portal. Member and provider newsletters are published and Provider Alerts (fax notices) are used to target specific topics as applicable. Letters are also sent directly to members and physicians when it is the best mode of communication for the message to be relayed.

CHG dedicates specific staff to enhance communication with providers, members and regulatory agencies. This staff participates in weekly Operations Team

meetings along with key representatives in all departments within the organization. As it is decided that information must be communicated to members, providers, and regulators, the Operations Team decides what communication vehicle(s) is/are best suited for the message, assigns responsibility to communicate the message, and the timeline for the communication to occur. This allows all key stakeholders to be informed about specific messages that will be communicated to members, providers, and regulatory agencies and ensures that the message is consistent across all mediums and to all parties. This, in turn, ensures that CHG's Member Services and Provider Relations staffs are well-prepared to field any questions that may result from any particular message. At a state level, CHG staff are active participants in the DHCS MMCD CEO, CMO and Pharmacy Director meetings, CMS user call-in and trainings, and ICE committees. At a local level, CHG is active on numerous stakeholder meetings and leads several Healthy San Diego work groups to ensure the plan is fully aware of pertinent issues. These networking interfaces allow CHG to ensure we are effectively communicating with providers, members and regulatory agencies.

CHG maintains electronic copies of all communication issued to members, providers, and regulators. Electronic files are maintained in secure files that are backed up daily. Minutes are recorded to preserve a record of proceedings from weekly Operations Team meetings and standing committees and are also maintained in electronic files. Communication with members is documented in the electronic Customer Service or Case Management modules.

CHG's Service Quality Improvement Committee (SQIC) oversees the monitoring and evaluation of communication effectiveness. The SQIC, in turn, reports to the Corporate Quality Improvement Committee and, ultimately, to the CHG Board of Directors. The SQIC is comprised of key staff from all departments. Each

department is responsible for monitoring and reporting aspects of their processes that have an impact on customer (member and provider) service to the SQIC. Member Communication evaluation is conducted through the Public Policy Committee. Communication effectiveness to members is also monitored through member complaints and grievances, through CAHPS survey results (Health Plan Materials/Customer Service domains), and CHG's Public Policy focus groups. The effectiveness of communication with providers is evaluated through the annual Provider Satisfaction Survey and direct feedback from providers.

Care Management for the Most Vulnerable Subpopulations

CHG's health risk assessment (HRA) tool is designed to identify the most vulnerable subpopulations – the frail, disabled, members near the end of life, and members having multiple and complex chronic conditions. These members are determined to be of highest risk by CHG.

CHG's High Risk Case Managers actively manage the most vulnerable members with their PCPs and coordinate the following, when applicable:

Care rendered in the most appropriate setting (e.g., home or facility) and at the most appropriate care level (e.g., acute, sub-acute, custodial).

Members without adequate family or care-giver support are referred to In-home Supportive Services (IHSS), Meals on Wheels, and other resources.

Community-Based Adult Services Center.

Medi-Cal waiver programs, such as Acquired Immune Deficiency Syndrome (AIDS) Waiver, Multipurpose Senior Services Program (MSSP), Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD), Assisted Living Waiver (AlW), and In-Home Operation Waiver (IHO).

Visits in the member's home by a medical, psychiatric, or health education professional may be arranged for members who are unable or unwilling to leave their homes.

Prescription delivery services.

Life planning activities are addressed with all members and hospice care is also discussed with members near the end-of-life.

The ICT ensures that members with end-stage renal disease are under the care of a nephrologist, are set-up for dialysis, and receive necessary pharmacotherapy.

Members with multiple and complex chronic conditions are enrolled in CHG's disease management program, are referred to an intensive, specialty health education program (which may be conducted in the members' home), and are targeted for a comprehensive medication review.

An example of the services provided to its most vulnerable beneficiaries is illustrated by the following case. L.C. is a CHG member with asthma, COPD, CHF, and diabetes with lymphedema. She is also morbidly obese with multiple hospitalizations. CHG's High Risk Case Manager arranged home health services, treatments at a lymphedema clinic, arranged for necessary DME, and arranged for specialty health education provided by a respiratory therapist (RT). The RT did an in-home environmental assessment, noted that the carpets were primary asthma triggers, and immediately facilitated the removal of the carpets with the member's permission. The RT made frequent visits to assist member with her CPAP and nebulizer (and supplies), provided education on proper medication and equipment use, educated her family, and gained the member's trust to the point that member called the RT before experiencing an exacerbation of her asthma/COPD. The High Risk Case Manager coordinated the care between the RT and PCP, and together with the RT, ensured that the member kept her PCP

appointments and picked up medications. Because of the RT's frequent face-to-face contact with the member, the RT was able to alert the High Risk Case Manager when there was a problem with the member, e.g., when the member was not using her lyphedema bandages.

CHG anticipates that the most vulnerable dual eligible members will also have access to planned additional benefits for all dual eligible members.

Performance and Health Outcomes Measurement

CHG will evaluate the model of care by determining whether the goals have been achieved. Many of the established goals are HEDIS measures. Non-HEDIS based goals will be evaluated using internal reports from the case management system and utilization reports generated from the data warehouse. The review of CHG's performance as compared to the measurable model of care goals and associated analyses are incorporated into the established Quality Improvement and Utilization Management processes.

The following table will be used in the evaluation process:

Goal	Data Source	Outcome Measure
Improve access to essential services such as medical, mental health, LTSS, and social services	Report from CHG's Case Management Module following report format developed for the seniors and persons with disabilities (SPD) reports	CHG staff will make at a minimum of three attempts to contact 100% of new members to conduct an initial health risk assessment (which includes an evaluation a member's medical, behavioral

Goal	Data Source	Outcome Measure
		health, and social services needs) and coordinate necessary follow-up care within 90 days of enrollment.
Improve access to affordable care	HEDIS measure/methodology; baseline for this population to be established in 2013 with improvement to be measured in 2014	By 2014, increase the follow-up after Hospitalization for Mental Illness (FUH) by 3% over the baseline year of 2013.
Improve coordination of care through an identified point of contact	Report from CHG's Enrollment Module	CHG will attempt to contact 100% of newly enrolled dual eligible members to provide a "welcome call" which notifies the member of their assigned PCP and how to access services.
Improve seamless transitions of care across health care settings, providers, and HCBS	Report from CHG's health care services correspondence module/application	For planned and unplanned transitions from one level of care to another, share the sending setting's care plan with the receiving setting within one business day of notification of the transition, 90% of the time.

Goal	Data Source	Outcome Measure
Improve access to preventive health services	HEDIS measure/methodology; baseline for this population to be established in 2013 with improvement to be measured in 2014	By 2014, increase the rate CHG's HEDIS effectiveness of care measures (adult BMI assessment, breast cancer screening, care for older adults, and glaucoma screening) by 3% over the baseline year of 2013.
Improve access to HCBS	Report from CHG's Case Management Module	CHG will attempt to complete an initial health assessment of 100% of newly enrolled dual eligible members which includes an evaluation of the need for HCBS.
Assure appropriate utilization of services	HEDIS measure/methodology; baseline for this population to be established in 2013 with improvement to be measured in 2014	By 2014, decrease the HEDIS Plan All Cause Readmission (PCR) measure by 1% over the baseline year of 2013.
Improve beneficiary health outcomes (specify Medicare Advantage Organization (MAO) selected health	Report to be developed from data loaded in CHG's data warehouse HEDIS	By 2014, reduce the custodial long term care admission rate by 1% over the baseline year of 2013.

Goal	Data Source	Outcome Measure
outcome measures)	measure/methodology; baseline for this population to be established in 2013 with improvement to be measured in 2014 Report to be developed from data housed in CHG's Case Management Module or the Health Outcomes Survey (HOS)	By 2014, decrease the number of poorly controlled diabetics (as defined by the HEDIS Comprehensive Diabetes Care measure) by 3% as compared to the baseline year of 2013. By 2015, increase the number of members who rate their general health above "fair" as compared the baseline year of 2013.

CHG's Corporate Quality department provides quantitative analysis for evaluating the effectiveness of the model of care. HEDIS reports and results are tracked by CHG's internal Total Quality Integration Committee under the leadership of the HEDIS Manager. Reports obtained from CHG's data warehouse and Case Management Module are produced by CHG's Informatics Manager and Senior EDI Programmer Analyst, respectively.

CHG evaluates its model of care as part of its annual review of its quality improvement activities. Performance towards goal achievement, as well as other aspects of the care model, is reviewed. If goals are not met in the expected timeframe, CHG will follow its established quality improvement process, based on the quality improvement cycle, to determine appropriate actions to be taken. An

analysis of the model of care quality measures is completed by the Corporate Quality department with input by the Clinical Quality Improvement Committee and includes a review of potential barriers towards achieving expected outcomes. A corrective action plan is recommended by the Clinical Quality Improvement Committee. Any service-related issues are brought to the Service Quality Improvement Committee for discussion and input. Final recommendations for corrective action are presented to the Corporate Quality Improvement Committee for review and approval. Modifications may be made to the MOC if indicated by the results of the analysis.

All data, analysis, and documentation of the MOC review and all other quality improvement activities are stored electronically in the corporate computer system by the Corporate Quality Department. Documentation from the quality improvement program and its activities are available to CMS upon request and during onsite audits.

Oversight accountability for monitoring, evaluation and qualitative analysis to determine MOC effectiveness lies with the Director Corporate Quality and the CMO. The results are incorporated in CHG's annual Quality Improvement Report which is reviewed and approved by CHG's Clinical Quality Improvement Committee, CHG's Corporate Quality Improvement Committee, and, ultimately, CHG's Board of Directors.

CHG communicates improvements and changes via web announcements, internal training of staff, Provider Newsletters, Member Newsletters and direct outreach to primary care provider staff.

Tab 5 - Appendices

California Dual Eligible Demonstration Request for Solutions
Mandatory Qualifications
Table of Appendices

Appendix No.	Description	Cross Reference
1	Knox-Keene Licenses	RFS Checklist #1
2	Letter from DMHC	RFS Checklist #2
3	CMS – D-SNP Contract Approval	RFS Checklist #3
4	DHCS Contract	RFS Checklist #4
5	Blank – No Attachment	RFS Checklist #5
6	Geo-Access Maps – Medicare and Medi-Cal	RFS Checklist #6
7	DMHC Enforcement & Resolution Letters	RFS Checklist #7
8a	DHCS Performance Indicators	RFS Checklist #8.a.1, 8.a.2, 8.a.3, 8.a.4
8b	MA-SNP Quality Performance	RFS Checklist #8.b.1, 8.b.2, 8.b.3, 8.b.4, 8.b.5
9	NCQA Accreditation Certification	RFS Checklist #9
10	Blank – No Attachment	RFS Checklist #10
11	Blank – No Attachment	RFS Checklist #11
12a	Community Letters of Support	RFS Checklist #12
12b	Evidence of Stakeholder Input	RFS Checklist #12
12c	Focus Group Executive Summary	RFS Checklist #12
13	Report of Office of Inspector General regarding Criminal Offenses	RFS Checklist #13

Appendix No.	Description	Cross Reference
14	Secretary of State Business Entity Detail	RFS Checklist #14
15	Blank – No Attachment	RFS Checklist #15
16	Copy of IRS Letter/Non-Profit Status	RFS Checklist #16
17	Blank – No Attachment	RFS Checklist #17
18	Blank – No Attachment	See Application, Section 6.2 RFS Checklist #18

California Dual Eligible Demonstration Request for Solutions
Criteria for Additional Consideration
Table of Appendices

Appendix No.	Description	Cross Reference
19	Blank – No Attachment	RFS Checklist / #1A
20	Blank – No Attachment	RFS Checklist #2 See Appendix 7
21	Copy of HEDIS Results – Past 3 Years	RFS Checklist #3 See Appendix #8a
22	NCQA Accreditation Certification	RFS Checklist #4 See Appendix #9
23	NCQA Accreditation Certification	RFS Checklist #5 See Appendix #9
24	Blank – No Attachment	RFS Checklist #6
25	Blank – No Attachment	RFS Checklist #7
26	LOA – Work in Good Faith	RFS Checklist #8
26	LOA – IHSS	RFS Checklist #9 See Appendix #26
27	MOA – San Diego County Health & Human Services Agency	RFS Checklist #10
28	Letter from San Diego Council of Community Clinics	RFS Checklist #11

THIS LICENSE IS NOT TRANSFERABLE OR ASSIGNABLE

Department of Corporations

State of California

License

HEALTH CARE SERVICE PLAN

COMMUNITY HEALTH GROUP

File No. 993 0200

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

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

This license is granted upon the following condition:

(a) That subscribers and enrollees in the health plan be limited to Medi-Cal enrollees.

AJO:ja

Date: 8-30-85

(SEAL)

FRANKLIN TOM
Commissioner of Corporations

By Richard L. Camilli
RICHARD L. CAMILLI
ASsistant Commissioner

ORP LC

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

Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 322-6727
(916) 322-3968 Facsimile
tdunlap@dmhc.ca.gov

June 22, 2005

CHG FOUNDATION
COMMUNITY HEALTH GROUP PARTNERSHIP PLAN
740 Bay Boulevard
Chula Vista, CA, 91910

IN REPLY REFER TO: FILE NO: 933-0431

VIA ELECTRONIC AND U.S. MAIL

Re: Application for Licensure: CHG Foundation / Community Health Group Partnership Plan (DMHC Filing No. 2005-4370) Filed June 20, 2005.

Dear Mr. Garcia:

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

Enclosed is the license issued by the Department of Managed Health Care approving the terms of the above-referenced Application filed on June 20, 2005, proposing the licensure of CHG Foundation / Community Health Group Partnership Plan to operate the prepaid Medi-Cal programs currently operated by Community Health Plan (CHP) (Health Care Service Plan number 933-0200) in the counties previously approved for CHP.

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

Very truly yours,

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

Cc R. Michael Scarano Jr., Esq. Foley & Lardner LLP
Norma Diaz, CEO CHG Foundation

AM: for TD

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

NONTRANSFERABLE AND NONASSIGNABLE LICENSE
HEALTH CARE SERVICE PLAN

File No. 2005-4370
Application No. 2005-4382
S-05-1489

Licensee: CHG FOUNDATION / COMMUNITY HEALTH GROUP PARTNERSHIP PLAN
740 Bay Boulevard
Chula Vista, CA, 91910

IS HEREBY LICENSED AS A FULL SERVICE HEALTH PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICES ACT OF 1975, AS AMENDED ("ACT"), AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A FULL SERVICE HEALTH CARE PLAN TO OFFER SERVICES TO MEDI-CAL ENROLLEES WITHIN THE STATE OF CALIFORNIA IN THE COUNTIES PREVIOUSLY APPROVED FOR MEDI-CAL OPERATIONS OF COMMUNITY HEALTH GROUP (FILE NO.: 933-0200), SUBJECT TO THE PROVISIONS OF THE ACT AND THE IMPLEMENTING RULES OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE ADOPTED PURSUANT THERETO AND SUBJECT TO ANY CONDITIONS INCORPORATED HEREIN, AND SHALL REMAIN IN EFFECT UNTIL SUCH TIME AS THE LICENSE IS SUSPENDED OR REVOKED BY ORDER OF THE DIRECTOR OR IS SURRENDERED. THE LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

Dated: June 22, 2005
Sacramento, California

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

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

DEPARTMENT OF
Managed Health Care

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

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

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Bill Rice
Chief Financial Officer
Community Health Group
740 Bay Boulevard
Chula Vista, CA 91910

Re: Letter of Standing – Community Health Group

Dear Mr. Rice:

On February 10, 2012, you requested a letter regarding Community Health Group's ("CHG") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] CHG 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, CHG 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 CHG. 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 CHG and CHG 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 CHG was issued on November 20, 2007. There were no identified deficiencies from this Routine Medical Survey. The next Routine Medical Survey is scheduled to begin June 4, 2013.

[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: Ann Warren, Chief of Government Affairs, Community Health Group
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
Mike Punja, Division of Licensing
Barbara Yakin, Division of Financial Oversight

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

October 18, 2007

Ms. Norma Diaz
Chief Executive Officer
COMMUNITY HEALTH GROUP
740 Bay Blvd.
Chula Vista, CA 91910-5254

RE: 2008 Contract Application Approval **H7086**

Dear Ms. Diaz:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform COMMUNITY HEALTH GROUP that we are issuing your organization the enclosed Medicare Advantage contract effective January 1, 2008, through December 31, 2008. This contract is being issued based on our determination that your organization meets the eligibility requirements for a Medicare Advantage (MA) contract under the Social Security Act (SSA) and relevant federal regulations, the approval of your bid, and the receipt of your 2008 Benefit Attestation and other applicable contract addenda.

If your organization submitted an initial Prescription Drug Benefit application for 2008 and was found qualified to offer a prescription drug benefit under Part D of Title XVIII of the Social Security Act, your contract will include a Part D addendum, pursuant to 42 CFR §422.508, that governs the operation of the Part D benefits you will offer your enrollees. If your organization applied for and was found qualified to offer new 2008 Employer/Union-Only Group Waiver Plans (EGWPs) (i.e., "800 series" plan benefit packages), your contract will include the applicable EGWP addendum that governs the operation of these plans. Also, if your organization was approved to offer one or more special needs plan(s) (SNP), your SNP approval(s) is outlined in an attachment(s) to this letter.

This contract, along with the CMS regulations and policy guidance, articulates the mutual responsibilities of your organization and CMS under the Medicare Advantage program. Please review the contract carefully and notify your Central Office Plan Manager if you have any questions. This contract will renew annually unless non-renewed or terminated.

Please note that your contract with CMS consists only of the terms stated in the contract CMS provided to you and the benefit attestation as you downloaded it from HPMS. CMS does not consider statements made in a cover letter that you might have submitted with your Medicare contract, or mark ups to the contractual language, to be part of the agreement between CMS and your organization.

CMS will continue to provide MA and Prescription Drug Benefit program information (including information about your CMS Central Office and Regional Office contacts) to contracting organizations through the Health Plan Management System (HPMS) and the CMS website. It is imperative that you monitor both websites to stay current on program requirements and information. We further remind you to ensure that your organization's contact information in HPMS remains accurate, as that is our primary mechanism for contacting contracted organizations.

We look forward to working with you to serve the Medicare beneficiaries throughout your service area. If you have any questions, please contact your Central Office or Regional Office Plan Manager.

Sincerely,

David A. Lewis
Director,
Medicare Advantage Group

CC: San Francisco Regional Office

Enclosure(s):
SNP Attachment(s)
2008 Medicare Advantage Contract

HPMS

Bid 2009

Home

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Bid Reports 2009

Bid Status History Report

Contract Number: H7086
Organization Name: COMMUNITY HEALTH GROUP
Organization Type: Local CCP
Plan Type: HMO/HMOPOS

Plan ID *	Plan Name	Segment ID	Version	Trans. Type	Upload Date	Unload Date	Sent to DR Date	DR Approval Date	Bid Approval Date	Contract Approval Date	Plan Effective Date
001	CommuniCare Advantage	N/A	3	Renewal	08/20/08	08/20/08	08/20/08	09/02/08	09/02/08	09/17/08	1/1/2009

* Note: Employer-only plans are identified by plan ID numbers in the 800 and 900 series.

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Bid 2010

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Bid Reports 2010

Bid Status History Report

Contract Number: H7086
Organization Name: COMMUNITY HEALTH GROUP
Organization Type: Local CCP
Plan Type: HMO/HMOPOS

Plan ID *	Plan Name	Segment ID	Version	Trans. Type	Upload Date	Unload Date	Sent to DR Date	DR Approval Date	Bid Approval Date	Contract Approval Date	Plan Effective Date
001	CommuniCare Advantage (HMO)	N/A	3	Renewal	08/25/09	08/25/09	08/25/09	09/01/09	09/01/09	09/15/09	1/1/2010

* Note: Employer-only plans are identified by plan ID numbers in the 800 and 900 series.

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HPMS

Bid 2011

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Bid Reports 2011

Bid Status History Report

Contract Number: H7086
Organization Name: COMMUNITY HEALTH GROUP
Organization Type: Local CCP
Plan Type: HMO/HMOPOS

Plan ID *	Plan Name	Segment ID	Version	Trans. Type	Upload Date	Unload Date	Sent to DR Date	DR Approval Date	Bid Approval Date	Contract Approval Date	Plan Effective Date
001	CommuniCare Advantage (HMO SNP)	N/A	2	Renewal	08/23/10	08/23/10	08/23/10	09/01/10	09/01/10	09/08/10	1/1/2011

* Note: Employer-only plans are identified by plan ID numbers in the 800 and 900 series.

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Bid 2012

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Bid Reports 2012

Bid Status History Report

Contract Number: H7086
Organization Name: COMMUNITY HEALTH GROUP
Organization Type: Local CCP
Plan Type: HMO/HMOPOS

Plan ID *	Plan Name	Segment ID	Version	Trans. Type	Upload Date	Unload Date	Sent to DR Date	DR Approval Date	Bid Approval Date	Contract Approval Date	Plan Effective Date
001	CommuniCare Advantage (HMO SNP)	N/A	5	Renewal	08/09/11	08/09/11	08/09/11	08/23/11	08/23/11	09/06/11	1/1/2012

* Note: Employer-only plans are identified by plan ID numbers in the 800 and 900 series.

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

MAY 23 2011

Norma Diaz
Chief Executive Officer
CHG Foundation dba: Community Health Group Partnership Plan
740 Bay Boulevard
Chula Visa, CA 91910

Dear Ms. Diaz:

Enclosed for your records is your fully executed contract copy. Please include the DHCS contract number on all invoices and future correspondence related to this contract.

Contractor: CHG Foundation dba: Community Health Group Partnership Plan
Contract No.: 09-86155 A03 [Primary]

Please contact your contract manager, at the address below for program matters:

California Department of Health Services
Medi-Cal Managed Care Division
MS# 4408
P.O. Box 997413
Sacramento, CA 95899-7413

Sincerely,

Penny Farnell, Contract Manager/Analyst
Medi-Cal Managed Care Division

Enclosures

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

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

Agreement Number	Amendment Number
09-86155	A03
Registration Number:	

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

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

Contractor's Name (Also referred to as Contractor)
CHG Foundation, dba: Community Health Group Partnership Plan

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

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

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

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

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

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

All other terms and conditions shall remain the same.

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

CONTRACTOR

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
CHG Foundation, dba: Community Health Group Partnership Plan

By *(Authorized Signature)* ✍ [signature] | Date Signed *(Do not type)* 4-27-11

Printed Name and Title of Person Signing
Norma Diaz, Chief Executive Officer

Address
740 Bay Boulevard
Chula Vista, CA 91910

STATE OF CALIFORNIA

Agency Name
Department of Health Care Services

By *(Authorized Signature)* ✍ [signature] | Date Signed *(Do not type)* 5/3/11

Printed Name and Title of Person Signing
Tanya Homman, Chief, Medi-Cal Managed Care Division

Address
1501 Capitol Avenue, Suite 71.4.4006, MS 4400, P.O. Box 997413,
Sacramento, CA 95899-7413

CALIFORNIA
Department of General Services
Use Only

☒ Exempt per:
Welfare and Institutions Code section 14089.8(b)

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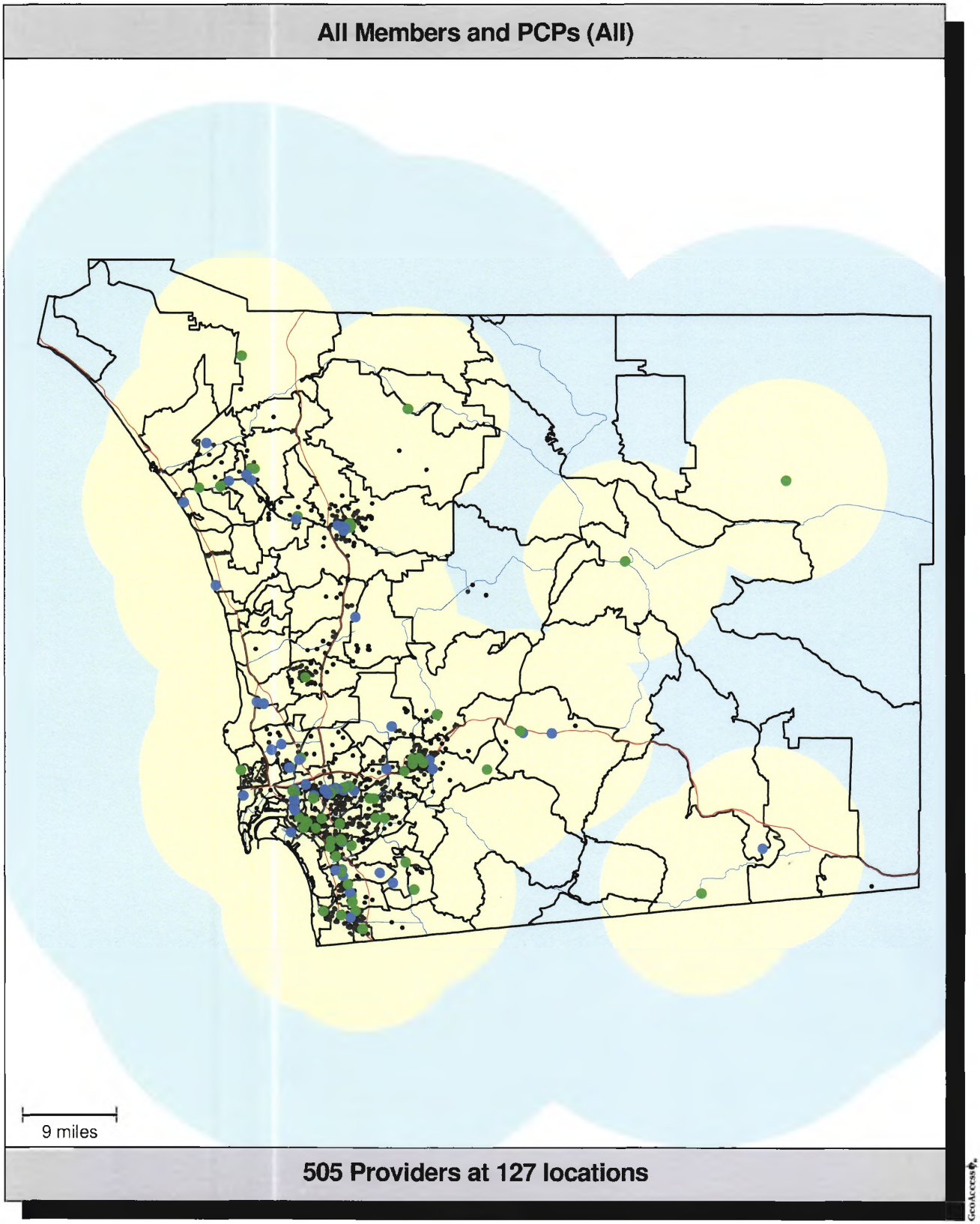
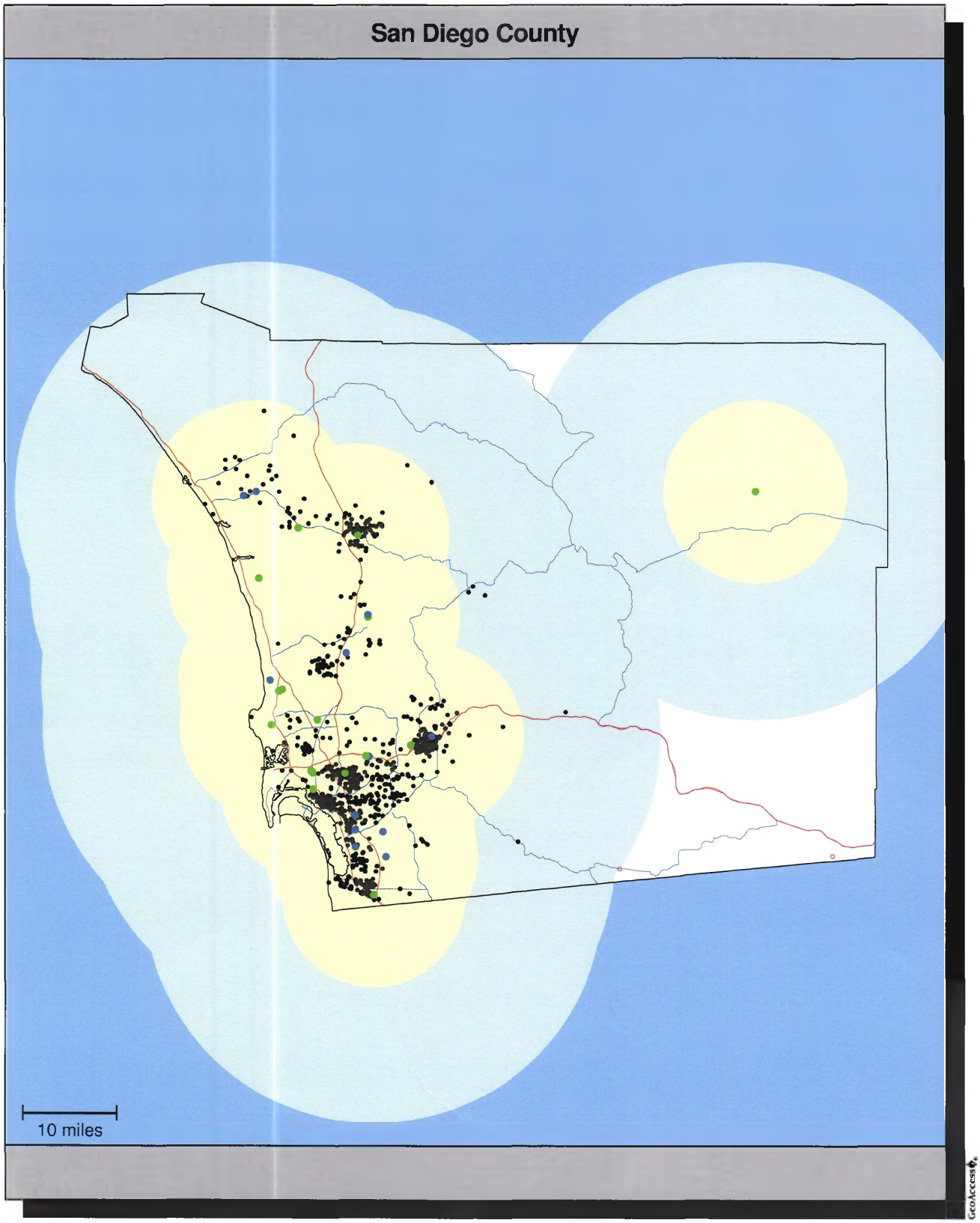
Medicare - San Diego County



- Members with access (949)
- Members without access (0)
- Single Provider locations (55)
- Multiple Provider locations (72)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

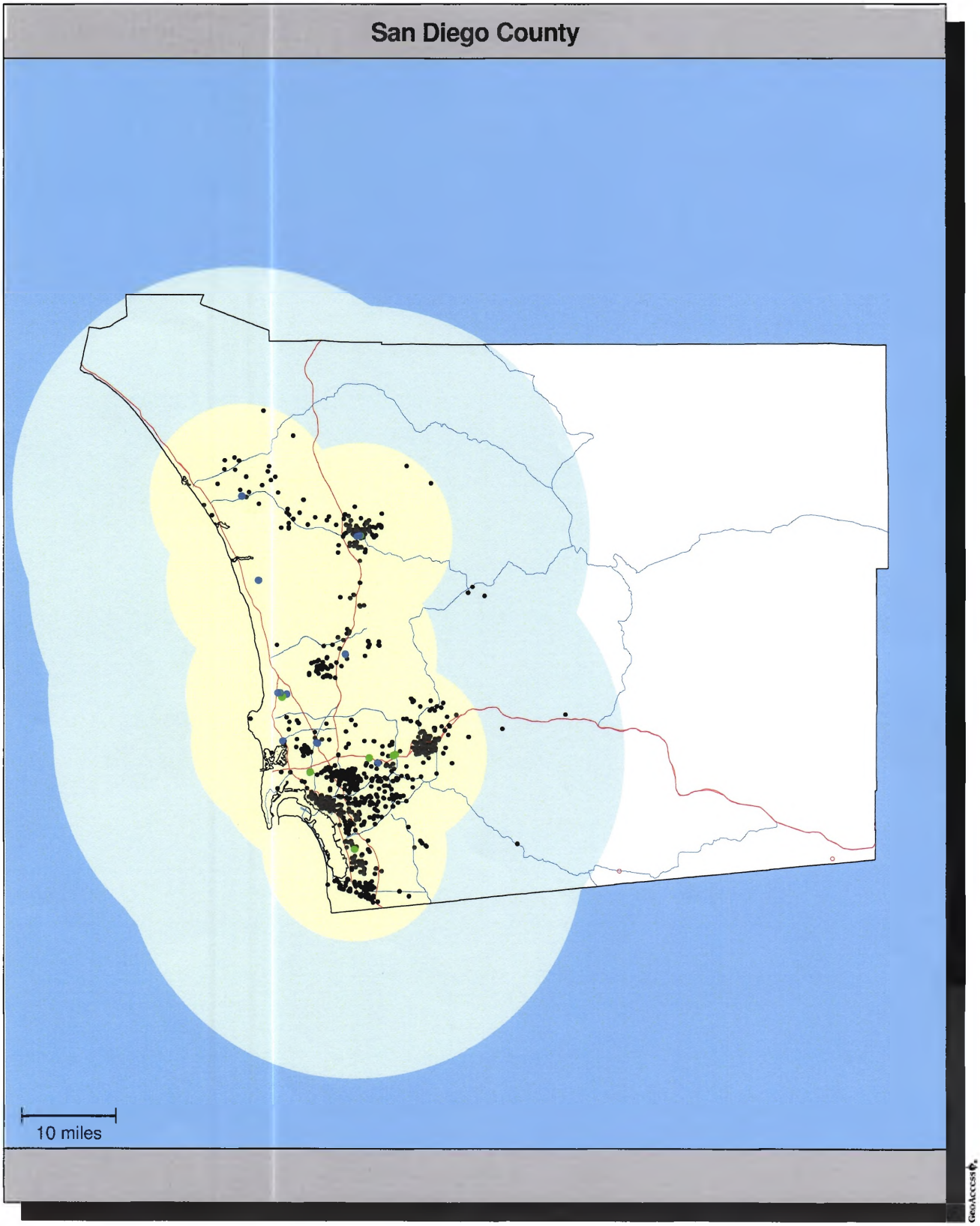
Medicare Specialists - CARDIO



- Members with access (946)
- Members without access (3)
- Single Provider locations (13)
- Multiple Provider locations (22)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

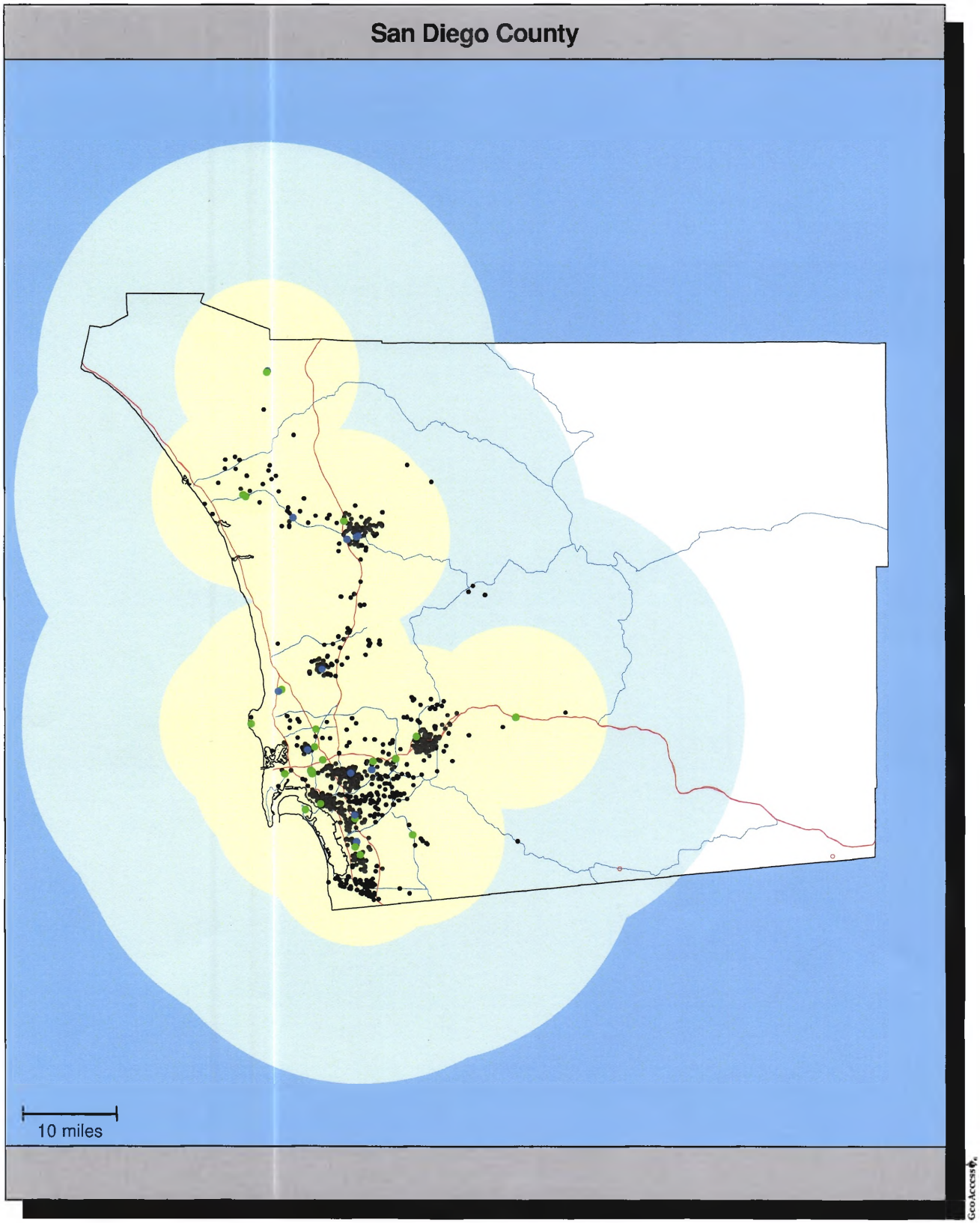
Medicare Specialists - ORTHO



- Members with access (946)
- Members without access (3)
- Single Provider locations (12)
- Multiple Provider locations (9)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

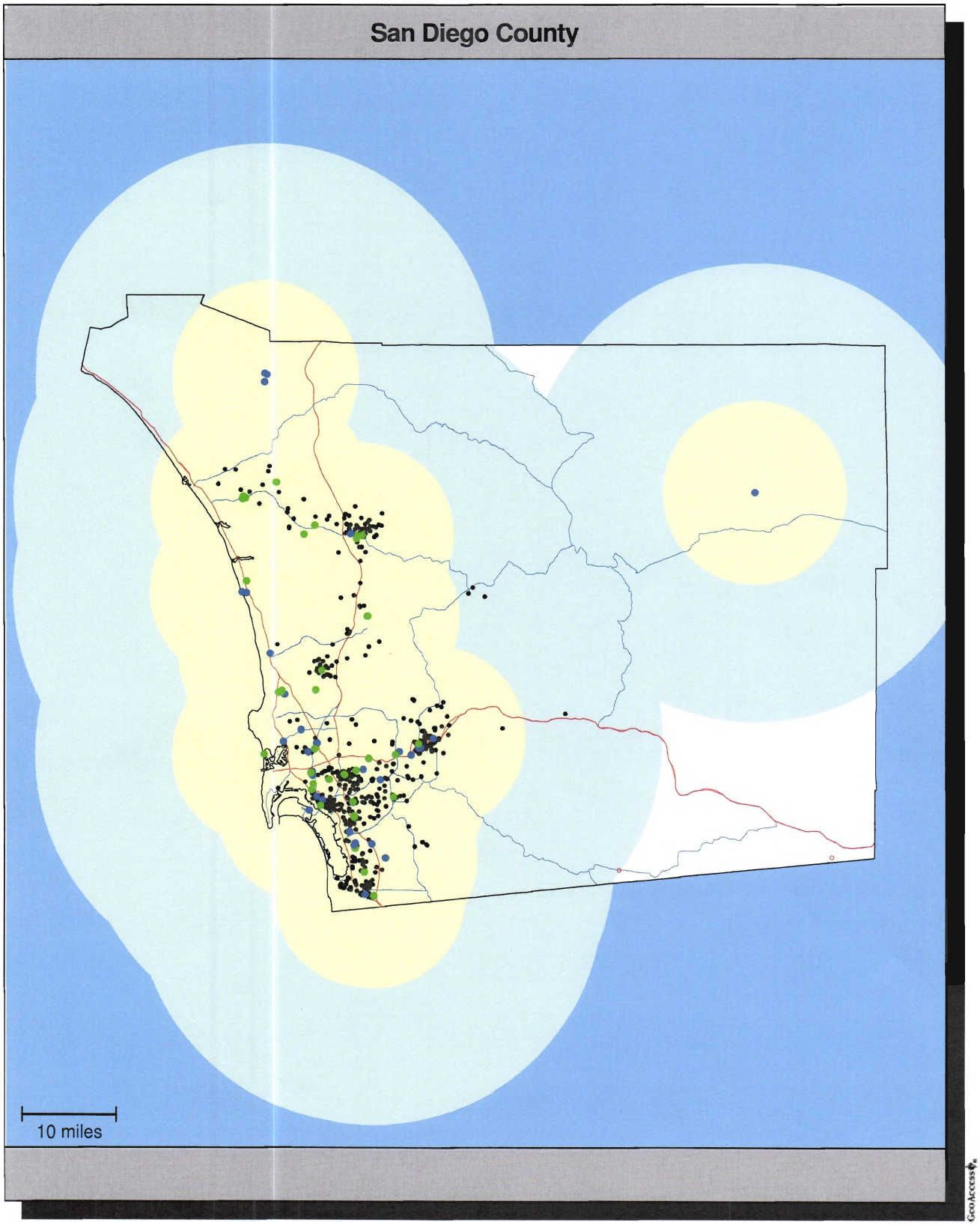
Medicare Specialists - OPTH



- Members with access (946)
- Members without access (3)
- Single Provider locations (13)
- Multiple Provider locations (26)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

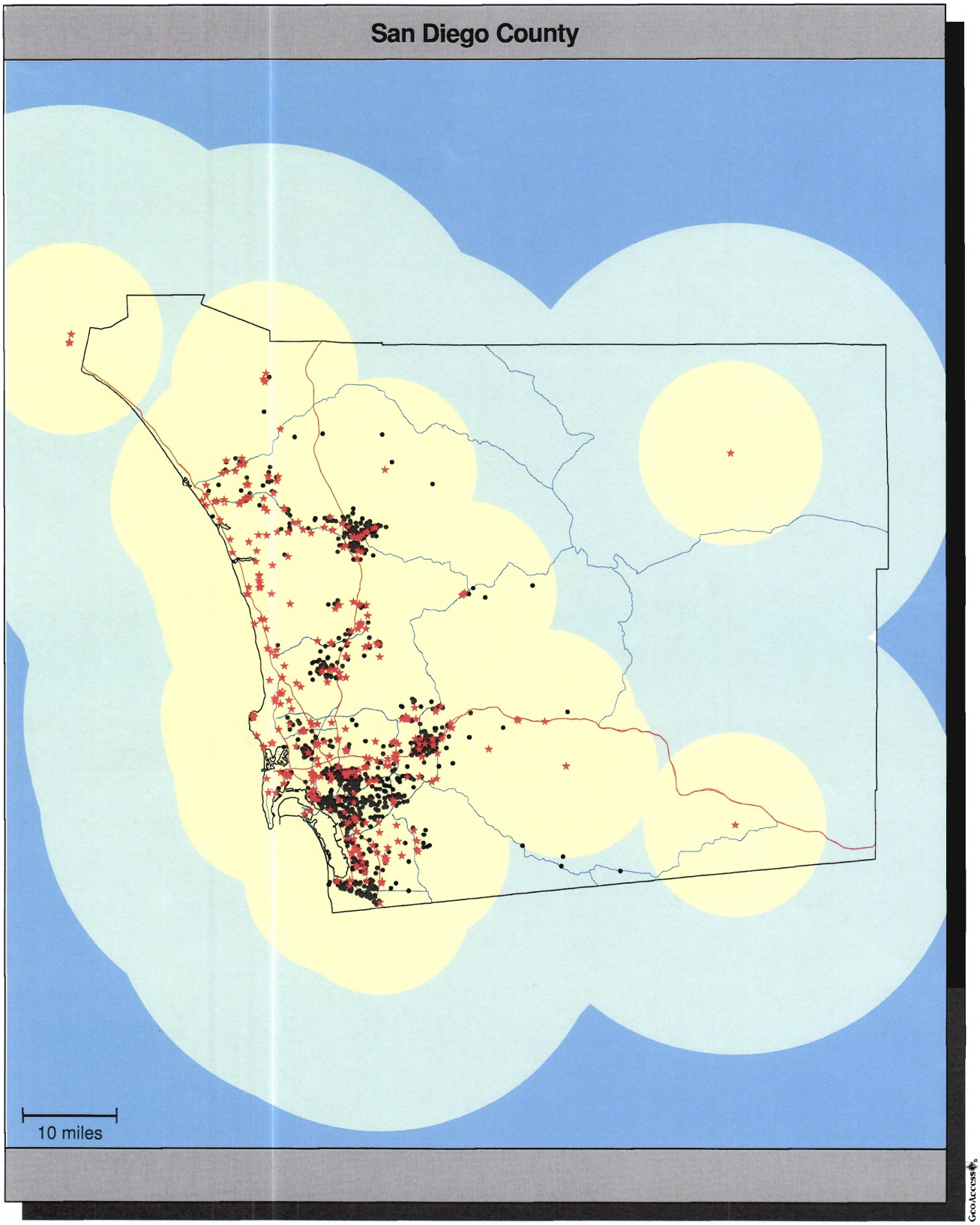
Medicare Specialists - OBGYN



- Members with access (516)
- Members without access (2)
- Single Provider locations (37)
- Multiple Provider locations (42)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

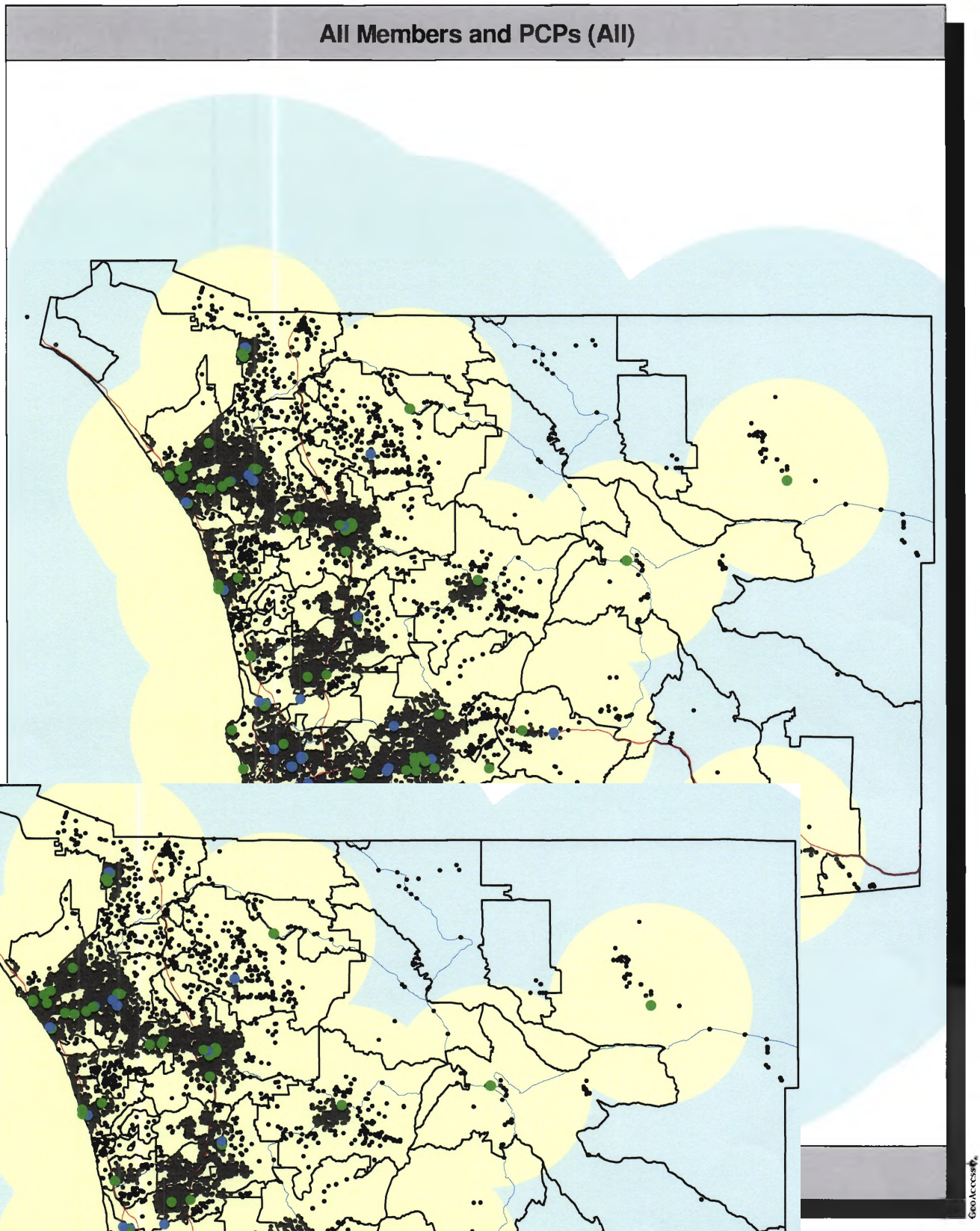
Medicare Pharmacies



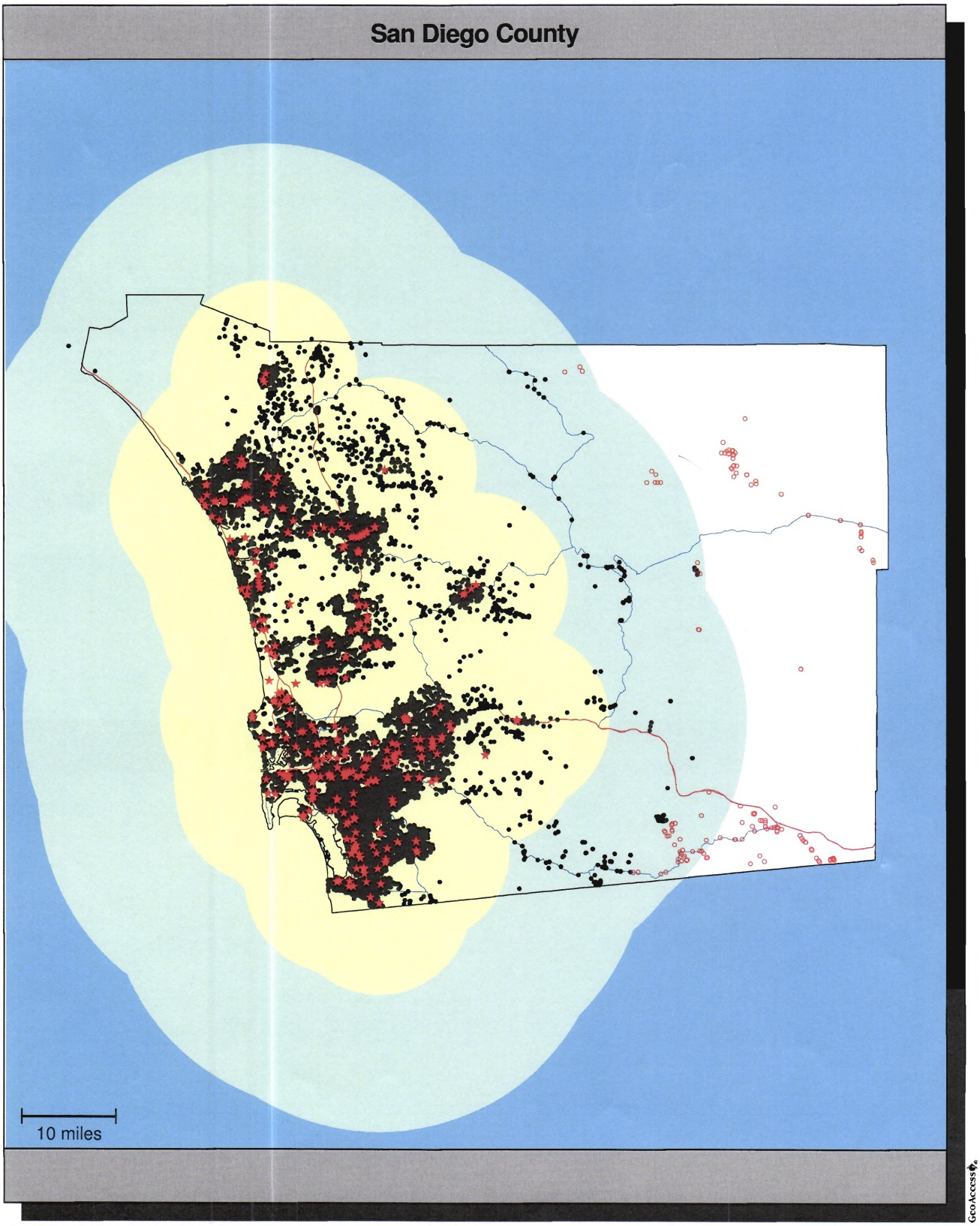
- ● Members with access (1,053)
- ○ Members without access (0)
- ★ Single Provider locations (391)
- ☆ Multiple Provider locations (3)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

Medi-Cal - San Diego County



Medi - Cal Pharmacies



- ● Members with access (114,036)
- ○ Members without access (397)
- ★ Single Provider locations (344)
- ● Multiple Provider locations (1)

Access standard: 1 in 25
- 10 mile radius
- 25 mile radius

Appendix 7

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
916-323-0435 -Phone
916-323-0438 -Fax
enforcement@dmhc.ca.gov

October 25, 2011

VIA FACSIMILE (619) 427-3108 AND U.S. MAIL

Francisca Chavez
Regulatory Affairs Manager
Community Health Group
740 Bay Blvd.
Chula Vista, CA 91910

RE: ENFORCEMENT MATTER NUMBER 08-357

Dear Ms. Chavez:

Enclosed, please find the Letter of Agreement for the above-referenced matter. Please sign and return the original Letter of Agreement, together with the Plan's check for 15,000, payable to the Department of Managed Health Care, to my attention at:

Department of Managed Health Care
Office of Enforcement
980 9th Street, Suite 500
Sacramento, CA 95814-2724

Please, do not forward the Letter of Agreement separately.

If you prefer forwarding the Letter of Agreement and check by overnight mail, and/or need signature confirmation, you may forward the documents to the Department's physical address as follows:

Department of Managed Health Care
Attention: Accounting Administrator
980 9th Street, Suite 500
Sacramento, CA 95814-2724

Please note, when forwarding funds to the Department's physical address, we require you specifically address the envelope to the attention of "Accounting Administrator." This will ensure prompt credit to the Plan's account. Mail sent to the Department's post office box is automatically received by our accounting unit. We encourage the Plan to utilize the post office box whenever possible.

Matter ID: 08-357
Doc. No.: 67265

Business Integrity Section does not count against page limit.

The Department of Managed Health Care has recently established a process by which Health Plans can pay DMHC invoices electronically. There is no cost to use this payment option. Information and instructions to sign-up are available at http://www.dmhc.ca.gov/hpp/, or you may contact the DMHC Accounting Office at 916-445-2282.

Payment should be received within ten (10) days of this cover letter. As you know, the Letter of Agreement will be posted to our public website (www.dmhc.ca.gov). If you have any further questions or comments, please do not hesitate to contact my office at 916-323-0435.

Cordially

Angela M. Lai
Staff Counsel
Office of Enforcement

AML:tbr

Enclosure: Letter of Agreement

cc: Accounting Office

Matter ID: 08-357
Doc. No.: 67265

Business Integrity Section does not count against page limit.

DEPARTMENT OF
Managed
Health Care

Edmund G. Brown Jr., Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
916-323-0435 -Phone
916-323-0438 -Fax
enforcement@dmhc.ca.gov

October 25, 2011

VIA FACSIMILE (619) 427-3108 AND U.S. MAIL

Francisca Chavez, Regulatory Affairs Manager
Community Health Group
740 Bay Blvd.
Chula Vista, CA 91910

RE: ENFORCEMENT MATTER NUMBER 08-357

LETTER OF AGREEMENT

Dear Ms. Chavez:

The Office of Enforcement of the Department of Managed Health Care ("the Department") has concluded its investigation of Community Health Group ("the Plan") concerning the above-referenced matter. This investigation concerned the Plan's failure to comply with Health and Safety Code section 1371 and 1371.35, and California Code of Regulations, title 28, sections 1300.71, 1300.71.38(a)(3), and 1300.71.38(a)(5). Specifically, the Department's routine examination of the Plan for the quarter ending March 31, 2008, revealed a number of significant deficiencies in the Plan's provider dispute resolution mechanism. Pursuant to the Department's authority under Health and Safety Code section 1386, the Department assessed an administrative penalty against the Plan in the amount of $15,000.

Community Health Group has acknowledged its failure to comply with the Knox-Keene Act in this matter and has agreed to pay the above administrative penalty. The Department agrees that execution of this Letter of Agreement and payment of the assessed penalty will settle this enforcement matter.

Cordially,

Debra L. Denton
Acting Assistant Deputy Director
Office of Enforcement

AML:aml

Accepted by COMMUNITY HEALTH GROUP

Dated: 10/27/11

NORMA DIAZ
CEO
Community Health Group

Matter ID: 08-357 / Doc. No.: 67259

Business Integrity Section does not count against page limit.

WELLS FARGO

Image

ORIGINAL CHECK HAS A COLORED BACKGROUND PRINTED ON CHEMICAL REACTIVE PAPER

Community HealthGroup

740 Bay Boulevard, Chula Vista, CA 91910
(619) 422-0422

WELLS FARGO BANK, N.A.
CALIFORNIA
www.wellsfargo.com

16-24/1220

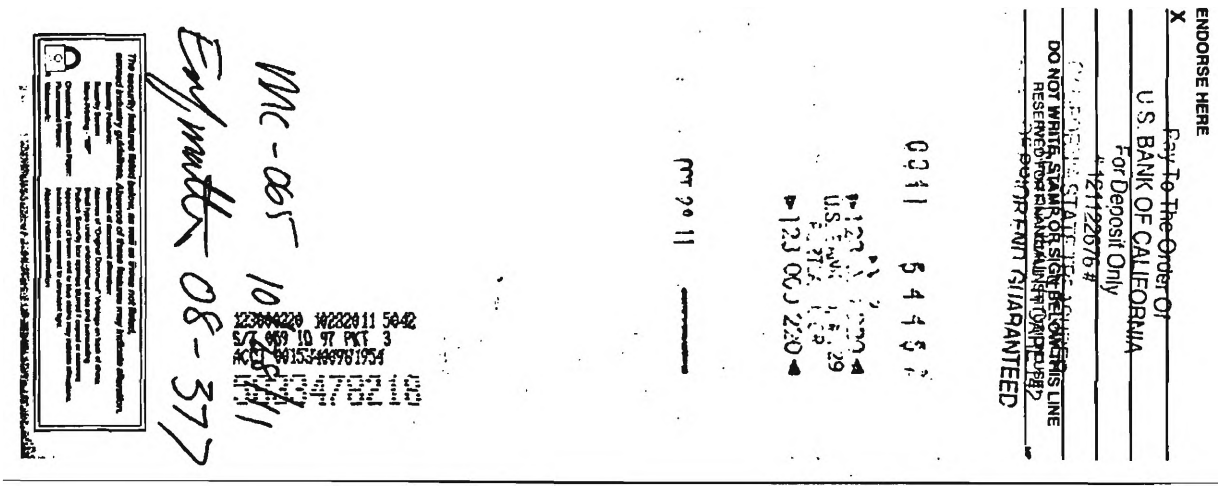
071496

DATE	CHECK NO.	AMOUNT
10/26/2011	71496	**$15,000.00

FIFTEEN THOUSAND AND XX / 100 Dollars

PAY TO THE ORDER OF
DEPARTMENT OF MANAGED HEALTH CARE
980 9TH STREET
SUITE 500
SACRAMENTO, CA 95814

VOID AFTER 120 DAYS



Business Integrity Section does not count against page limit.

Attachment 8.a.1
HEDIS 2009 – 2011 Final Data
Medi-Cal Measures

	2009	*2010*	*2011*
Adolescent Well-Care Visits	39.90%	36.98%	42.91%
Appropriate Tx for Children with URI	84.79%	90.34%	92.65%
Avoidance of Antibiotic Tx for Adults w/Acute Bronchitis	20.47%	23.24%	17.31%
Breast Cancer Screening	52.07%	55.93%	54.48%
Cervical Cancer Screening	65.94%	63.02%	65.21%
Childhood Immunization Status – Combo 3	77.37%	72.26%	78.10%
Comprehensive Diabetes Care – Eye Exam	46.61%	41.61%	52.31%
Comprehensive Diabetes Care – HbA1c Testing	79.83%	80.97%	88.08%
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	N/A	38.23%	53.28%
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	48.52%	44.03%	36.50%
Comprehensive Diabetes Care – Lipid Screening	77.74%	73.39%	84.67%
Comprehensive Diabetes Care – LDL-C <100 mg/dL	37.39%	26.45%	41.61%
Comprehensive Diabetes Care – Nephropathy Monitoring	73.39%	70.97%	77.37%
Comprehensive Diabetes Care – BP Control (<140/90)	N/A	59.03%	65.94%
Prenatal Care	76.40%	76.64%	79.08%
Postpartum Care	54.26%	52.07%	57.18%
Use of Imaging Studies for Low Back Pain	N/A	79.14%	77.75%
Weight Assessment & counseling for Nutrition & Physical Activity for Children/Adolescents - BMI Percentiles Total	N/A	38.44%	63.26%
Weight Assessment & counseling for Nutrition & Physical Activity for Children/Adolescents - Counseling for Nutrition	N/A	44.77%	69.83%
Weight Assessment & counseling for Nutrition & Physical Activity for Children/Adolescents - Counseling Physical Activity	N/A	34.55%	40.39%
Well Child Visit in 3rd, 4th, 5th & 6th Year of Life	75.91%	74.94%	74.95%

Attachment 8.a.2
Medi-Cal CAHPS 2009 – 2011 Final Data

CAHPS Adult Medi-Cal Summary

"Survey Attributes"

	2009	2010	2011
Sample Size	1755	1485	1755
Oversampling	30%	10%	30%
Ineligible Records	189	42	147
Non-response Records	1193	978	1057
Records Used	373	465	551
Response Rate	23.82%	32.22%	34.27%

"Composite Scores"

Not a Problem	2009	2010	2011
Getting Needed Care	2.1101	1.977	2.0451
Getting Care Quickly	2.2363	2.0683	2.1088
MDs Communicate Well	2.5228	2.3958	2.3845
Customer Service	na	2.2235	2.3317
Shared Decision Making - ***New***	2.494	2.4096	2.4473

"Ratings"

Rated as the Best	2009	2010	2011
All Health Care	2.2824	2.1087	2.2541
Personal Doctor	2.5479	2.3152	2.3371
Specialist Seen Most Often	2.5566	2.3657	2.4074
Health Plan	2.4494	2.1837	2.2296

"Global Proportions"

Always & Usually	2009	2010	2011
Getting Needed Care	69.33	65.99	68.09
Getting Care Quickly	72.89	66.29	70.36
MDs Communicate Well	85.02	83.07	82.08
Customer Service	na	73.69	74.04
Shared Decision Making - Definitely Yes - ***New***	60.68	56.32	58.14

CAHPS Adult Medi-Cal Summary

"Question Summary Rates"

	2009	2010	2011
Rate All Health Care - Best Possible	70.23	60.25	66.22
Best Personal Doctor Possible	80.84	70.91	71.10
Specialist Seen Most Often - Best Possible	83.96	76.87	73.33
Health Plan the Best Possible	78.09	63.95	66.54
Rate Overall Health - Excellent/Very Good	34.07	38.77	36.55
Ease of Getting Appointments w/Specialists	71.20	68.52	67.70
Ease of Getting Necessary Care, Test, or Treatment	67.47	63.45	68.47
Got Care Soon as Needed When Care Needed Right Away	74.17	68.09	73.68
Got Regular/Routine Appointment as Soon as Needed	71.60	64.50	67.03
Doctors Listen Carefully	85.71	84.81	83.06
Doctor Explained Things	85.25	81.11	82.47
Doctor Show Respect	87.61	88.19	85.44
Doctor Spend Enough Time With You	81.48	78.15	77.35
Doctor talked about specific things to do to prevent illness	52.87	na	
Personal doctor informed about care from other doctors	68.70	na	
Doctor talked about the pros and cons of each choice	63.03	60.56	59.38
Doctor asked which choice was best for member	58.33	52.08	56.91
Written Materials or Internet Provided Information or Help	na	na	na
Health Plan's Customer Service Provided Information or Help	na	65.14	68.27
Customer Service Treated Member w/Courtesy and Respect	na	82.24	79.81
Health Plan Forms Were Easy to Fill Out	93.02	91.76	94.14
Health Promotion & Education			52.56
Coordination of Care			68.05

CAHPS Child Medi-Cal Summary

"Survey Attributes"

	2009	2010	2011
Sample Size	2145	1815	2145
Oversampling	30%	10%	30%
Ineligible Records	345	22	200
Non-response Records	1283	1033	1155
Records Used	517	760	790
Response Rate	28.72%	42.39%	40.62%

"Composite Scores"

Not A Problem	2009	2010	2011
Getting Needed Care	2.1641	2.1692	2.2172
Getting Care Quickly	2.3364	2.2817	2.2769
MDs Communicate Well	2.5143	2.4693	2.5099
Customer Service	na	2.3878	2.4754
Shared Decision Making - ***New***	2.5335	2.5052	2.5349

"Ratings"

Rated as the Best	2009	2010	2011
All Health Care	2.4441	2.3819	2.4147
Personal Doctor or Nurse	2.6146	2.5468	2.5909
Specialist Seen Most Often	na	2.4554	2.622
Health Plan	2.6333	2.5531	2.5682

"Global Proportions"

Always & Usually	2009	2010	2011
Getting Needed Care	70.71	75.10	75.95
Getting Care Quickly	80.03	78.16	75.37
MDs Communicate Well	87.26	87.49	87.56
Customer Service	na	81.15	85.56

Definitely Yes	2009	2010	2011
Shared Decision Making - ***New***	64.31	60.52	64.08

CAHPS Child Medi-Cal Summary

"Question Summary Rates"

	2009	2010	2011
Rate All Health Care - Best Possible	77.33	75.95	76.59
Best Personal Doctor Possible	86.1	84.17	83.57
Specialist Seen Most Often - Best Possible	na	78.22	84.25
Health Plan the Best Possible	86.17	81.88	82.52
Rate Child's Overall Health - Excellent/Very Good	72.58	70.93	70.13
Got Care as Soon as Wanted When Needed Right Away	83.39	80.24	77.60
Got Regular/Routine Care Appointment as Soon as Needed	77.67	76.08	73.13
Ease of Getting Appointment w/Specialists	na	75.65	73.72
Ease of Getting Necessary Care, Tests or Treatment	72.73	74.55	78.17
Doctors/Health Providers Listen Carefully	90.07	91.90	90.83
Doctor Talked About Specific Things to Prevent Illness	51.38	na	
Doctors Explain Things	88.08	87.59	87.1
Doctor Talked about the Pros and Cons of each Choice	64.79	59.46	64.1
Doctor Asked Which Chose was Best for Member	63.83	61.59	64.06
Doctors Show Respect for What You Had to Say	93.73	94.05	93.36
Doctor Spend Enough Time With Your Child	77.15	77.43	78.94
Doctor Informed About Care from Other Doctors	72.52	na	
Customer Service Provided Information or Help	na	75.59	80.28
Customer Service Treated Member with Courtesy & Respect	na	86.72	90.85
Health Plan Forms were Easy to Fill out	95.91	95.64	97.62
Health Promotion & Education			59.92
Coordination of Care			70.86

Attachment 8.a.3

HEDIS Use of Services Measure: Ambulatory Care

	2009	2010	2011
Ambulatory Care - Surgery/Procedures/K	4.30	4.00	NR
Ambulatory Care - ED Visits/K	26.98	32.48	30.49
Ambulatory Care - Observation Room Stays/K	0.12	0.47	NR
Ambulatory Care - Outpatient Visits/K	255.76	279.80	274.97

2009 (CY 2008) DHCS Data Submission Tool - Medicaid Frequency of Selected Procedures

Procedure	Age	Sex	Number of Procedures	Procedures / 1,000 Member Months
Myringotomy	**0-4**	**Male & Female**	75	0.30
	5-19		28	0.05
Tonsillectomy	**0-9**	**Male & Female**	75	0.17
	10-19		28	0.09
Dilation & Curettage	**15-44**	**Female**	37	0.17
	45-64		15	0.30
Hysterectomy, Abdominal	**15-44**	**Female**	35	0.16
	45-64		17	0.34
Hysterectomy, Vaginal	**15-44**	**Female**	9	0.04
	45-64		13	0.26

DHCS Data Submission for Medi-Cal Managed Care Plans
2010 HEDIS Use of Services Measure:
Frequency of Selected Procedures for Measurement Year 2009

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Member Months
Back surgery	<20	Male	1	0.00248
		Female	0	0.00000
	20-44	Male	8	0.15634
		Female	8	0.05130
	45-64	Male	10	0.30836
		Female	15	0.27226
	65-74	Male	2	0.41841
		Female	0	0.00000
	75-84	Male	1	0.46425
		Female	0	0.00000
	85+	Male	0	0.00000
		Female	0	0.00000
Coronary angioplasty (PTCA)	<65	Male	13	0.02669
		Female	11	0.01829
	65-74	Male	1	0.20921
		Female	2	0.29291
	75-84	Male	1	0.46425
		Female	3	0.75339
	85+	Male	1	1.54321
		Female	1	0.83542
Cardiac catheterization	<65	Male	34	0.06981
		Female	40	0.06652
	65-74	Male	4	0.83682
		Female	5	0.73228
	75-84	Male	5	2.32126
		Female	2	0.50226
	85+	Male	2	3.08642
		Female	0	0.00000
Coronary artery bypass graft (CABG)	<65	Male	1	0.00205
		Female	2	0.00333
	65-74	Male	13	2.71967
		Female	1	0.14646
	75-84	Male	1	0.46425
		Female	0	0.00000
	85+	Male	1	1.54321
		Female	0	0.00000

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Member Months
Total hip replacement	<65	Male	1	0.00205
		Female	3	0.00499
	65-74	Male	0	0.00000
		Female	0	0.00000
	75-84	Male	0	0.00000
		Female	0	0.00000
	85+	Male	0	0.00000
		Female	0	0.00000
Total knee replacement	<65	Male	3	0.00616
		Female	17	0.02827
	65-74	Male	0	0.00000
		Female	2	0.29291
	75-84	Male	1	0.46425
		Female	1	0.25113
	85+	Male	0	0.00000
		Female	0	0.00000

DHCS Data Submission for Medi-Cal Managed Care Plans
2011 HEDIS Use of Services Measure:
Frequency of Selected Procedures for Measurement Year 2010

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Member Months
Back Surgery	20-44	Male	6	0.11
		Female	22	0.05
	45-64	Male	8	0.68
		Female	17	0.31
Bariatric Weight Loss Surgery	0-19	Male & Female	0	0
	20-44	Male & Female	5	0.02
	45-64	Male & Female	0	0
Lumpectomy	15-44	Female	25	0.1
	45-64	Female	22	0.4
Mastectomy	15-44	Female	5	0.02
	45-64	Female	3	0.05

2009 (CY 2008) DHCS Data Submission - Medicaid Inpatient Utilization-General Hospital/Acute Care

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
Total Inpatient					
<1	282	5.4	600	11.49	2.13
1-9	1289	3.34	1717	4.44	1.33
10-19	1409	4.28	2831	8.60	2.01
20-44	3732	19.99	8434	45.17	2.26
45-64	1346	17.06	4222	53.50	3.14
65-74	164	17.53	535	57.19	3.26
75-84	152	26.32	544	94.18	3.58
85+	46	31.04	195	131.58	4.24
Unknown	0		0		NA
Total	8,420	8.02	19,078	18.17	2.27
Medicine					
<1	164	3.14	426	8.16	2.60
1-9	238	0.62	390	1.01	1.64
10-19	141	0.43	265	0.81	1.88
20-44	476	2.55	1464	7.84	3.08
45-64	535	6.78	1685	21.35	3.15
65-74	64	6.84	208	22.24	3.25
75-84	72	12.47	276	47.78	3.83
85+	29	19.57	111	74.90	3.83
Unknown	0		0		NA
Total	1,719	1.64	4,825	4.60	2.81
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
Surgery					
<1	117	2.24	170	3.26	1.45
1-9	1049	2.71	1324	3.43	1.26
10-19	518	1.57	854	2.60	1.65
20-44	1098	5.88	2541	13.61	2.31
45-64	801	10.15	2507	31.77	3.13
65-74	100	10.69	327	34.96	3.27
75-84	79	13.68	262	45.36	3.32
85+	17	11.47	84	56.68	4.94
Unknown	0		0		NA
Total	3,779	3.60	8,069	7.68	2.14
Maternity					
10-19	750	2.28	1712	5.20	2.28
20-44	2158	11.56	4429	23.72	2.05
45-64	10	0.13	30	0.38	3.00
Unknown	0		0		NA
Total	2,918	4.91	6,171	10.38	2.11

2010 HEDIS Use of Services Measure: Inpatient Utilization-General Hospital/Acute Care (IPU) for Measurement Year 2009

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total Inpatient					
<1	306	7.04	666	15.32	2.18
1-9	957	2.35	1,439	3.54	1.50
10-19	1,485	4.32	2,889	8.41	1.95
20-44	3,894	18.80	9,448	45.61	2.43
45-64	1,397	15.96	4,221	48.23	3.02
65-74	177	15.25	664	57.20	3.75
75-84	148	24.12	565	92.08	3.82
85+	63	34.15	327	177.24	5.19
Unknown	0		0		0.00
Total:	8,427	7.61	20,219	18.25	2.40
Medicine					
<1	195	4.49	485	11.16	2.49
1-9	247	0.61	405	1.00	1.64
10-19	162	0.47	314	0.91	1.94
20-44	479	2.31	1,432	6.91	2.99
45-64	546	6.24	1,759	20.10	3.22
65-74	72	6.20	346	29.81	4.81
75-84	96	15.65	349	56.88	3.64
85+	34	18.43	188	101.90	5.53
Unknown	0		0		0.00
Total:	1,831	1.65	5,278	4.76	2.88
Surgery					
<1	109	2.51	167	3.84	1.53
1-9	705	1.73	1,019	2.51	1.45
10-19	561	1.63	864	2.52	1.54
20-44	1,057	5.10	2,641	12.75	2.50
45-64	838	9.57	2,405	27.48	2.87
65-74	105	9.05	318	27.39	3.03
75-84	51	8.31	213	34.71	4.18
85+	29	15.72	139	75.34	4.79
Unknown	0		0		0.00
Total:	3,455	3.12	7,766	7.01	2.25
Maternity					
10-19	762	2.22	1,711	4.98	2.25
20-44	2,358	11.38	5,375	25.95	2.28
45-64	13	0.15	57	0.65	4.38
Unknown	0		0		0.00
Total:	3,133	4.91	7,143	11.19	2.28

2011 HEDIS Use of Services Measure: Inpatient Utilization-General Hospital/Acute Care (IPU) for Measurement Year 2010

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total Inpatient					
<1	353	8.36	753	17.83	2.13
1-9	1,382	3.12	1,884	4.26	1.36
10-19	1,840	5.05	3,228	8.86	1.75
20-44	5,121	22.82	10,823	48.23	2.11
45-64	1,314	15.04	4,215	48.24	3.21
65-74	69	13.32	202	39.00	2.93
75-84	23	13.15	78	44.60	3.39
85+	12	35.71	107	318.45	8.92
Unknown	0		0		0.00
Total:	10,114	8.66	21,290	18.23	2.11
Medicine					
<1	242	5.73	552	13.07	2.28
1-9	261	0.59	480	1.09	1.84
10-19	150	0.41	292	0.80	1.95
20-44	559	2.49	1,453	6.47	2.60
45-64	502	5.75	1,781	20.39	3.55
65-74	29	5.60	102	19.69	3.52
75-84	12	6.86	37	21.15	3.08
85+	8	23.81	93	276.79	11.63
Unknown	0		0		0.00
Total:	1,763	1.51	4,790	4.10	2.72
Surgery					
<1	110	2.61	200	4.74	1.82
1-9	1,117	2.53	1,397	3.16	1.25
10-19	743	2.04	978	2.68	1.32
20-44	1,289	5.74	2,836	12.64	2.2
45-64	792	9.07	2,378	27.22	3
65-74	40	7.72	100	19.31	2.5
75-84	10	5.72	20	11.44	2
85+	4	11.9	14	41.67	3.5
Unknown	0		0		0
Total:	4,105	3.52	7,923	6.78	1.93
Maternity					
10-19	947	2.6	1,958	5.38	2.07
20-44	3,273	14.58	6,534	29.11	2
45-64	20	0.23	56	0.64	2.8
Unknown	0		0		0
Total:	4,240	6.27	8,548	12.64	2.02

2009 (CY 2008) DHCS Data Submission - Medicaid Outpatient Drug Utilization

Age	Total of Prescriptions	Avg. Cost of Prescriptions/ Per Member Per Month	Total Number of Prescriptions	Avg. Num. of Prescriptions/ Per Member Per Year
0-9	3778027.77	$8.61	144737	3.96
10-17	2454454.83	$8.77	74873	3.21
18-34	2329065.62	$14.49	87850	6.56
35-49	6199506.44	$56.94	163738	18.05
50-64	5226304.81	$115.45	141149	37.42
65-74	659302.14	$70.48	20121	25.81
75-84	266835.55	$46.20	9730	20.21
85+	46546	$31.41	1765	14.29
Unknown	0		0	
Total	$20,960,043.16	$19.96	643,963	7.36

2010 HEDIS Use of Services Measure: Outpatient Drug Utilization for Measurement Year 2009

Age	Total Cost of Prescriptions	Average Cost of Prescriptions/Per Member Per Month	Total Number of Prescriptions	Average Number of Prescriptions/Per Member Per Year
0-9	$5,131,132.72	$11.40	152,697	4.70
10-17	$3,813,190.04	$13.26	85,804	3.58
18-34	$4,242,559.24	$23.29	101,980	6.72
35-49	$10,153,817.27	$85.95	183,104	18.60
50-64	$9,839,017.77	$195.82	165,558	39.54
65-74	$1,857,872.01	$160.05	31,649	32.72
75-84	$736,154.06	$119.97	13,828	27.04
85+	$132,582.49	$71.86	2,736	17.80
Unknown	$0.00		0	
Total:	$35,906,325.60	$32.41	737,356	7.99

Attachment 8.a.4

DHCS Medi-Cal Quality Improvement Projects (QIPs) 2009 – 2011

QIP	*Year*	*Validation Scores*
Increasing Assessment, Diagnosis and Appropriate Treatment of COPD	2009	Percentage Score of Evaluation Elements Met - 84% Percentage Score of Critical Elements Met - 100% Validation Status - Met
	2010	Percentage Score of Evaluation Elements Met - 89% Percentage Score of Critical Elements Met - 100% Validation Status - Met
	2011	Percentage Score of Evaluation Elements Met - 92% Percentage Score of Critical Elements Met - 100% Validation Status – Met
Reducing Avoidable Emergency Room Visits	2009	Percentage Score of Evaluation Elements Met - 97% Percentage Score of Critical Elements Met - 100% Validation Status – Met
	2010	Percentage Score of Evaluation Elements Met - 87% Percentage Score of Critical Elements Met - 100% Validation Status – Met
	2011	Percentage Score of Evaluation Elements Met - 97% Percentage Score of Critical Elements Met - 100% Validation Status – Met
Increasing Follow-up to Positive Postpartum Screens	2009	Percentage Score of Evaluation Elements Met - 88% Percentage Score of Critical Elements Met - 100% Validation Status – Met
	2010	Percentage Score of Evaluation Elements Met - 90% Percentage Score of Critical Elements Met - 100% Validation Status – Met
	2011	Percentage Score of Evaluation Elements Met - 98% Percentage Score of Critical Elements Met - 100% Validation Status – Met

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Attachment 8.b.1
HEDIS 2009 – 2011 Final NCQA Adjusted Data
Medicare SNP Measures

	2009	2010	2011
Annual Monitoring of Patients on Persistent Medications	77.37%	74.29%	88.15%
Antidepressant Medication Management - Acute Phase	n/a	n/a	n/a
Antidepressant Medication Management - Continuation Phase	n/a	n/a	n/a
Care for Older Adults - Advance care Planning	7.00%	20.13%	44.04%
Care for Older Adults - Medication Review	55.00%	36.96%	78.10%
Care for Older Adults - Functional Status Assessment	17.00%	1.32%	43.80%
Care for Older Adults - Pain Screening	15.00%	3.30%	25.06%
Colorectal Cancer Screening	n/a	33.61%	46.25%
Controlling High Blood Pressure	56.28%	42.29%	58.23%
Follow-up After Hospitalization for Mental Illness - 7 Day	n/a	n/a	n/a
Glaucoma Screening in Older Adults	n/a	63.78%	62.86%
Medication Reconciliation Post-Discharge	30.81%	8.93%	23.83%
Osteoporosis Management in Women Who Had a Fracture	n/a	n/a	n/a
Persistence of Beta-Blocker Treatment After a Heart Attack	n/a	n/a	n/a
Pharmacotherapy Management of COPD Exacerbation - Corticosteroid	n/a	n/a	n/a
Plan all-Cause Readmissions			20.45%
Potentially Harmful Drug-Disease Interactions in the Elderly - Total	n/a	n/a	n/a
Falls + Tricyclic Antidepressants or Antipsychotics	n/a	n/a	n/a
Dementia + Tricyclic Antidepressants or Antipsychotics	n/a	n/a	n/a
Chronic Renal Failure + NSAIDs or Cox-2 Selective NSAIDs	n/a	n/a	n/a
Use of High-Risk Medications in the Elderly - One Prescription	29.78%	31.83%	32.55%
Use of High-Risk Medications in the Elderly - Two Prescription	5.14%	11.58%	9.60%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	n/a	n/a	n/a

Attachment 8.b.2
Medicare CAHPS 2011 Data

At-a-Glance
Community Health Group (H7086)

Scores are not case-mixed adjusted

Measures	n	Plan Summary Rate
Getting Needed Care	**108**	**49.9**
Easy to get appointment with specialist	96	49.0
Easy to get care, tests, treatment believed necessary	120	50.8
Getting Care Quickly	**143**	**42.5**
Getting care as soon as needed	83	61.4
Getting appointment as soon as needed	166	48.2
See doctor within 15 minutes of appointment time	179	17.9
Doctors Who Communicate Well	**165**	**76.2**
Explain things in a way you could understand	165	72.7
Listen carefully to you	163	80.4
Show respect for what you had to say	165	84.2
Spend enough time with you	166	67.5
Health Plan Customer Service	**71**	**56.1**
Got information or help needed	80	58.8
Treated you with courtesy and respect	81	69.1
Forms easy to fill out	52	40.4
Rating of Health Care Received	**212**	**47.2**
Rating of Doctor	**166**	**74.7**
Rating of Specialist	**88**	**64.8**
Rating of Health Plan	**213**	**56.8**
Easy to get medical equipment	52	44.2
Doctor followed up with test results	148	59.5
Personal doctor informed of specialist care	83	53.0
HEDIS Measures		
Influenza Vaccination *(% Yes)*	144	74.3
Pneumonia Shot *(% Yes)*	122	59.0
ASTQ *(% Yes)*	42	76.2
Getting Prescription Drugs	**181**	**73.9**
Getting medicines doctor prescribed	199	69.3
Filling prescriptions (pharmacy and mail)	163	78.5
Getting Information - Drug Coverage & Cost	**30**	**65.8**
Got information/help needed about RX drugs	30	63.3
Treated you with courtesy and respect	29	72.4
Got information about which medicines are covered	32	68.8
Got information about out-of-pocket costs	29	58.6
Rating of Drug Coverage	**209**	**62.7**
Recommend drug plan *(%Definitely Yes)*	205	63.4

Composite Score - Always; Questions Score - Always unless otherwise noted; Rating Score 9 + 10

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Attachment 8.b.3
Medicare Health Outcomes Survey (HOS)

2010 Cohort 13 Baseline Summary Scores Table
Mean Unadjusted and Adjusted PCS and MCS Scores
for Community Health Group – H7086, California, and HOS Total

	Unadjusted PCS Score (SD)	*Adjusted PCS Score (SD)*	*Unadjusted MCS Score (SD)*	*Adjusted MCS Score (SD)*
H7086	34.6 (10.7)	35.8 (6.4)	46.6 (11.6)	47.1 (4.0)
California	38.1 (12.1)	38.1 (6.7)	49.7 (11.8)	50.0 (4.6)
HOS Total	38.9 (12.4)	38.9 (7.0)	51.4 (11.4)	51.4 (4.5)

PCS – Physical Component Summary (Higher reflects better health status)
MCS – Mental Component Summary (Higher reflects better health status)
(SD) – Standard Deviation

2010 NCQA HEDIS Measures Table
Performance for Community Health Group – H7086, California,
CMS Region 9, and HOS Total

	MUI Discuss Rate	*MUI Treat Rate*	*PAO Discuss Rate*	*PAO Advise Rate*	*FRM Discuss Rate*	*FRM Manage Rate*	*OTO Testing Rate*
H7086	***NA***	***NA***	***56.9%***	***57.0%***	***46.2%***	***69.5%***	***45.3%***
California	56.5%	35.7%	54.2%	51.5%	34.0%	62.0%	60.9%
CMS Region 9	56.3%	35.3%	53.4%	49.0%	33.7%	60.9%	66.8%
HOS Total	58.1%	36.1%	52.5%	47.6%	32.4%	58.7%	69.6%

MUI – Management of Urinary Incontinence in Older Adults
PAO – Physical Activity in Older Adults
FRM – Fall Risk Management
OTO – Osteoporosis Testing in Older Women

Attachment 8.b.4

Guide to Completing the Medicare Advantage Quality Improvement Program (QIP) Project Reporting Template

Purpose

This document will provide Medicare Advantage Organizations (MAOs) with instructions on how to complete the Medicare Advantage Quality Improvement Project Reporting Template in order to help them meet the Centers for Medicare & Medicaid Services (CMS) requirements.

Background

Beginning January 1, 2006, Medicare Advantage Organizations (MAOs) are required to initiate one self-selected Quality Improvement Program project per year and to submit reports on these projects in advance of the MAO's routine CMS Audit. This reporting process replaces the submission of information via the web-based HPMS QAPI module. This reporting template must be used to submit information required by CMS in order to evaluate Medicare Advantage Quality Improvement projects.

MA Quality Improvement Project Reporting Template Structure

The Medicare Advantage (MA) Quality Improvement Project Report Template is organized into nine sections labeled A to I. Sections A to G address quality indicators on which MAOs are expected to report. Sections H and I inquire about delegation of the quality improvement project and lessons learned from the project.

General Instructions

- MAOs should submit a report for each project initiated since their last routine CMS audit, beginning with 2006.
- Provide information for all items under sections A through I using as much space as is necessary to provide detailed information.
- MAOs may submit additional supporting documentation along with the information in the reporting template.
- Questions about QIP project reporting can be submitted to the Medicare Advantage Quality Review Organization (MAQRO) via e-mail at maqro@optimalsolutionsgroup.com or via telephone on the MAQRO's Technical Assistance line at (866) 962-6826.

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Medicare Advantage Quality Improvement Project Reporting Template

Please refer to the enclosed Guide to Completing the Medicare Advantage Quality Improvement Project Reporting Template for general information on how to fill out this form.

A. Medicare Advantage Organization (MAO) Information

Provide all applicable information in this section. If an MAO is associated with several names, it is important to list them in the "*If applicable, other MAO Names*" field. Enter the City and Region Number for *CMS Regional Office.*

1. Medicare Advantage Organization Name:

   Community Health Group

   If applicable, other names associated with the MAO:
   CommuniCare Advantage

2. Medicare Advantage Contract Number(s): **H7086**

3. Multiple Contract Numbers are associated with this plan. Yes ☐ No ☒
   If yes, please explain:

4. MRT Number if applicable:

5. State: **California**

6. CMS Regional Office: **San Francisco**

7. CMS Regional Office Accounts Manager:

   Last name: **Kwok** First name: **Jullin**

8. Contact information for person responsible for completion of this report:

Last name: **Anderson** First name: **Carole** Middle initial: **A.**

Title: **Director Corporate Quality**

Phone: **619-498-6454** Fax: **619-407-4652** Email: **cander@chgsd.com**

B. QIP Project General Information

Enter Day, Month and Year for *Date of project initiation* and *Date of project completion or expected project completion.*

1. Title of Quality Improvement Project: **Improving the Annual Monitoring of Patients on Persistent Medications**

2. Date of project initiation: **July 1, 2010**

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3. Date of project completion or expected project completion: **June 30, 2013**

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

   No

5. Project Focus Area Type *[select all that apply and briefly describe]*

   ☒ Clinical Focus Area (i.e., prevention of acute/chronic conditions, treatment or care of acute/ chronic conditions, high-volume services, high-risk services, continuity/coordination of care).

   Describe: **The focus of the quality improvement project is to address medication management to prevent the harms associated with certain medications in the elderly. It identifies medications, as per HEDIS specification, that require annual blood tests to ensure patient safety and appropriate medication dosage.**

   ☐ Non-Clinical Focus Area (i.e., availability, accessibility, cultural competency of services, complaints, grievances, appeals).

   Describe:

6. Describe the target population for this QIP project. Clearly define the criteria for inclusion and any exclusion criteria for this target population. Indicate numerator and denominator criteria as well.

   The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Members who had an inpatient claim during the measurement year were excluded for this project.

C. Relevance of QI Project Topic to Medicare Population

1. Provide an explanation of why this QIP project topic is relevant to your MAO's Medicare population as well why the topic is of national importance. Describe the information used in making this determination, i.e., literature reviewed, comparisons with other MAOs, cost analyses, adverse events, HEDIS data, enrollee survey data, provider survey data, or external reviewer information. Describe the root causes of the problem that led to the development of the QIP project. Also describe how the topic is relevant, important, and developed with a strong QI process. Provide plan specific data to support any information provided.

Certain medications are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly. Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly.

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Monitoring of patients on high-risk drugs in the elderly also represents an opportunity to reduce the costs associated with the harm from medications (e.g., hospitalizations from drug toxicity) and encourage clinicians to consider safer, alternative medications.

Based on HEDIS 2010 specifications four hundred twenty-four (424) members qualify for this measure. The current total rating as noted are below NCQA's 25th percentile of 85%.

- **ACE Inhibitors/ARBS – 75.29%**
- **Digoxin – Small sample**
- **Diuretics – 76.07%**
- **Anticonvulsants – Small sample**
- **Total – 74.29%**

2. Describe your organization's prioritization process for selecting this specific topic:

During 2009 424 Medicare SNP members were included in this HEDIS measures. This represented 52.5% of the total Medicare SNP population of 807.

D. Quality Improvement Indicators

Provide all applicable information in this section. Clearly define quality improvement (QI) indicators. Demonstrate that these indicators are measurable and based on current clinical knowledge and describe how the data source and collection methodology are valid and reliable.

For each QI indicator you are submitting for this project, complete checkboxes and items 1 through 7 (copy and paste as many times as needed for multiple indicators). If HEDIS, CAHPS or HOS is checked, plans do not need to complete items #2 through #5 for the indicator.

☒ HEDIS (Administrative), Measurement Year: 2009
☐ HEDIS (Hybrid), Measurement Year:
☐ CAHPS, Measurement Year:
☐ HOS, Measurement Year:
☐ Other:

Indicator # 1:

1. Indicator name: **Annual Monitoring for Patients on Persistent Medications**

2. Numerator description: **The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.**

   - **Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)**
   - **Annual monitoring for members on digoxin**
   - **Annual monitoring for members on diuretics**
   - **Annual monitoring for members on anticonvulsants**
   - **Total rate (the sum of the four numerators divided by the sum of the four denominators)**

3. Denominator description: **The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year.**

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- **Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)**
- **Members on digoxin**
- **Members on diuretics**
- **Members on anticonvulsants**
- **Total members on listed drugs**

4. Inclusion criteria: **Members must be enrolled in Medicare SNP the entire measurement year.**
5. Exclusion criteria: **Members who had an inpatient claim during the measurement year were excluded for this project.**
6. Performance target: **All eligible members**
7. Rationale/justification for performance target: **Per NCQA's 'The State of Health Care Quality 2009' report Drugs that commonly require monitoring in outpatient settings accounted for over half of all unintentional drug overdoses that resulted in an emergency room visit.**

E. Data Sources and Collection Methodology

Provide all applicable information in this section.

(skip #1-4 if indicators used are from standard HEDIS, CAHPS and HOS collections)

1. Identify the sources of data utilized in quality indicators/measures in this quality improvement project:

☐ Medical records
☐ Claims or encounter data
☐ Complaints or customer service data
☐ Appeals
☐ Administrative – call center data
☐ Administrative – appointment/access data
☐ Pharmacy data
☐ Survey data (attach the survey tool and describe the sampling process, sample size, and the survey administration protocol. Provide response rates.)
☐ Other (list and describe):

2. Data collection cycle

☐ Once a year
☐ Twice a year
☐ Once a quarter
☐ Once a month
☐ Once a week
☐ Once a day
☐ Continuous
☐ Other (describe):

3. Data analysis cycle

☐ Once a year
☐ Twice a year
☐ Once a quarter
☐ Once a month
☐ Other (describe):

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4. Describe the baseline data collection methodology, collection periods, sampling, sample size, and efforts to assure reliability and validity.

5. Describe any changes in data collection methodology, collection periods, sampling, sample size, data sources, numerator and denominator definitions, inclusion and exclusion criteria or analysis that have occurred since the initiation of this project. Include a rationale for each change and an assessment of the impact of these changes on the quality improvement indicators.

   No changes in data collection.

F. Results

1. Complete the results table below with the measurement periods and results for each measurement cycle for each quality indicator for this project. Specify the year results were obtained in this section. Add additional rows for additional measurement cycles and indicators as needed. If applicable, copy and paste the table for each contract number in order to provide market-specific data at the contract level.

Contract number: **H7086**

	Measurement Period							
	Start Date (mm/dd/yy)	End Date (mm/dd/yy)	Eligible Population N	Number Excluded	Numerator	Denominator	Rate	Performance Goal Reached? (Y/N)
Indicator #1								
Baseline Measurement	**01/01/2009**	**12/31/2009**	**424**	**0**	**315**	**424**	**74.29**	**N**
Remeasurement 1								
Remeasurement 2								
Indicator #2								
Baseline Measurement								
Remeasurement 1								
Remeasurement 2								
Indicator #3								
Baseline Measurement								
Remeasurement 1								
Remeasurement 2								
Repeat rows for additional indicator(s) as needed								

1. Describe barriers (if any) to improving your quality indicators, and the strategies employed to overcome them (optional).

   - **Inadequate monitoring or follow up by prescribing physician**

High Quality Section does not count against page limit.

- **Health literacy barriers that lead to misunderstood health care instructions and follow-up by members.**

2. Describe improvements achieved (if any) in your quality indicators and how they impact the health outcomes and/or delivery of health care to your Medicare Advantage enrollees.

N/A – Baseline measurement

G. Interventions

1. Complete the intervention and intervention modification timetable below with the implementation date, duration, target group, staff/partners used in implementation, any barriers that the interventions were meant to address, and the participation rates for the intervention. In the *Intervention Description (or description of modification)* column, explain how the intervention addresses the issues identified as the focus of the QIP project. Include information about the individuals responsible for conducting the steps indicated for the interventions. Explain when and how these steps will be carried out. If applicable, copy and paste the table for each contract number in order to provide market-specific data at the contract level.

Contract number: **H7086**

Intervention Description (or description of modification)	Implementation Date	Duration OR Indicate if Ongoing	Target Group for Intervention	Staff/Partners in Implementation	Barriers Addressed by the Intervention	Percent/number of plan members who received the intervention
Identify members that have been prescribed ACE/ARBs, digoxin, diuretics, or anti-convulsants and have not received annual monitoring.	September 2010	Ongoing	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Provide member-specific lists of members who have not received annual monitoring to primary care physicians.	September 2010	Ongoing	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Provide comparative performance information on therapeutic monitoring for primary care	September 2010	Quarterly Updates	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Publish article in member newsletter regarding the importance of follow-up and monitoring when on continuing medications	December 2010	One Time	Members	Corporate Quality	Misunderstandding of health care instructions and follow-up by members.	

H. External Consultation and Delegation

Provide all applicable information in this section.

1. Did you seek consultation and/or technical assistance from the Quality Improvement Organization/ QIO in your State?

☐ Yes

High Quality Section does not count against page limit.

☒ No

1. (a) Indicate QIO involvement on this QI project (*select all that apply)*:

☐ Performance improvement project review
☐ Study design development
☐ Liaison with CMS
☐ Continuous quality improvement (CQI) training
☐ Data analysis
☐ Development, testing and training on electronic and/or paper abstraction tools
☐ Design and development of intervention materials (graphic design and printing)
☐ Dissemination of intervention materials (mailing to all physicians and/or beneficiaries)
☐ Facilitation of group collaborative projects (focus group, provider meetings)
☐ Brief consultation
☐ Collaborative project
☐ Other:

2. Did you seek consultation and/or technical Assistance from another organization outside of your QIO?

☐ Yes
☒ No

2. (a) Identify the organization:

2. (b) External consultation/technical assistance from other organization *[select all that apply]*:

☐ Performance improvement project review
☐ Study design development
☐ Liaison with CMS
☐ Continuous quality improvement (CQI) training
☐ Data analysis
☐ Development, testing and training on electronic and/or paper abstraction tools
☐ Design and development of intervention materials (graphic design and printing)
☐ Dissemination of intervention materials (mailing to all physicians and/or beneficiaries)
☐ Facilitation of group collaborative projects (focus group, provider meetings)
☐ Brief consultation
☐ Collaborative project
☐ Other:

3. Are any aspects of your organization's Quality Improvement Program delegated or outsourced? If so, list the delegated tasks and the contractor/delegated entity performing the tasks:

Not Delegated

3. (a) Explain how these delegated entities are monitored for compliance with Federal and State requirements and how often.

N/A

3. (b) Explain how these delegated entities are monitored for general quality assurance purposes and how often.

N/A

High Quality Section does not count against page limit.

I. Lessons Learned (Optional)

Provide all applicable information in this section.

1. State any "lessons learned" from conducting this QI project:

2. What system-level changes were made and/or planned as a result of this project:

3. What opportunities for future improvement were identified in the course of conducting this project:

High Quality Section does not count against page limit.

Attachment 8.b.5

Guide to Completing the Medicare Advantage Quality Improvement Program (QIP) Project Reporting Template

Purpose

This document will provide Medicare Advantage Organizations (MAOs) with instructions on how to complete the Medicare Advantage Quality Improvement Project Reporting Template in order to help them meet the Centers for Medicare & Medicaid Services (CMS) requirements.

Background

Beginning January 1, 2006, Medicare Advantage Organizations (MAOs) are required to initiate one self-selected Quality Improvement Program project per year and to submit reports on these projects in advance of the MAO's routine CMS Audit. This reporting process replaces the submission of information via the web-based HPMS QAPI module. This reporting template must be used to submit information required by CMS in order to evaluate Medicare Advantage Quality Improvement projects.

MA Quality Improvement Project Reporting Template Structure

The Medicare Advantage (MA) Quality Improvement Project Report Template is organized into nine sections labeled A to I. Sections A to G address quality indicators on which MAOs are expected to report. Sections H and I inquire about delegation of the quality improvement project and lessons learned from the project.

General Instructions

- MAOs should submit a report for each project initiated since their last routine CMS audit, beginning with 2006.
- Provide information for all items under sections A through I using as much space as is necessary to provide detailed information.
- MAOs may submit additional supporting documentation along with the information in the reporting template.
- Questions about QIP project reporting can be submitted to the Medicare Advantage Quality Review Organization (MAQRO) via e-mail at maqro@optimalsolutionsgroup.com or via telephone on the MAQRO's Technical Assistance line at (866) 962-6826.

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Medicare Advantage Quality Improvement Project Reporting Template

Please refer to the enclosed Guide to Completing the Medicare Advantage Quality Improvement Project Reporting Template for general information on how to fill out this form.

A. Medicare Advantage Organization (MAO) Information

Provide all applicable information in this section. If an MAO is associated with several names, it is important to list them in the "*If applicable, other MAO Names*" field. Enter the City and Region Number for *CMS Regional Office.*

1. Medicare Advantage Organization Name:

   Community Health Group

   If applicable, other names associated with the MAO:
   CommuniCare Advantage

2. Medicare Advantage Contract Number(s): **H7086**

3. Multiple Contract Numbers are associated with this plan. Yes ☐ No ☒
   If yes, please explain:

4. MRT Number if applicable:

5. State: **California**

6. CMS Regional Office: **San Francisco**

7. CMS Regional Office Accounts Manager:

   Last name: **Kwok** First name: **Jullin**

8. Contact information for person responsible for completion of this report:

Last name: **Anderson** First name: **Carole** Middle initial: **A.**

Title: **Director Corporate Quality**

Phone: **619-498-6454** Fax: **619-407-4652** Email: **cander@chgsd.com**

B. QIP Project General Information

Enter Day, Month and Year for *Date of project initiation* and *Date of project completion or expected project completion.*

1. Title of Quality Improvement Project: **Improving the Annual Monitoring of Patients on Persistent Medications**

2. Date of project initiation: **July 1, 2010**

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3. Date of project completion or expected project completion: **June 30, 2013**

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

   No

5. Project Focus Area Type *[select all that apply and briefly describe]*

   ☒ Clinical Focus Area (i.e., prevention of acute/chronic conditions, treatment or care of acute/ chronic conditions, high-volume services, high-risk services, continuity/coordination of care).

   Describe: **The focus of the quality improvement project is to address medication management to prevent the harms associated with certain medications in the elderly. It identifies medications, as per HEDIS specification, that require annual blood tests to ensure patient safety and appropriate medication dosage.**

   ☐ Non-Clinical Focus Area (i.e., availability, accessibility, cultural competency of services, complaints, grievances, appeals).

   Describe:

6. Describe the target population for this QIP project. Clearly define the criteria for inclusion and any exclusion criteria for this target population. Indicate numerator and denominator criteria as well.

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Members who had an inpatient claim during the measurement year were excluded for this project.

C. Relevance of QI Project Topic to Medicare Population

1. Provide an explanation of why this QIP project topic is relevant to your MAO's Medicare population as well why the topic is of national importance. Describe the information used in making this determination, i.e., literature reviewed, comparisons with other MAOs, cost analyses, adverse events, HEDIS data, enrollee survey data, provider survey data, or external reviewer information. Describe the root causes of the problem that led to the development of the QIP project. Also describe how the topic is relevant, important, and developed with a strong QI process. Provide plan specific data to support any information provided.

Certain medications are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly. Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly.

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Monitoring of patients on high-risk drugs in the elderly also represents an opportunity to reduce the costs associated with the harm from medications (e.g., hospitalizations from drug toxicity) and encourage clinicians to consider safer, alternative medications.

Based on HEDIS 2010 specifications four hundred twenty-four (424) members qualify for this measure. The current total rating as noted are below NCQA's 25th percentile of 85%.

- **ACE Inhibitors/ARBS – 75.29%**
- **Digoxin – Small sample**
- **Diuretics – 76.07%**
- **Anticonvulsants – Small sample**
- **Total – 74.29%**

2. Describe your organization's prioritization process for selecting this specific topic:

During 2009 424 Medicare SNP members were included in this HEDIS measures. This represented 52.5% of the total Medicare SNP population of 807.

D. Quality Improvement Indicators

Provide all applicable information in this section. Clearly define quality improvement (QI) indicators. Demonstrate that these indicators are measurable and based on current clinical knowledge and describe how the data source and collection methodology are valid and reliable.

For each QI indicator you are submitting for this project, complete checkboxes and items 1 through 7 (copy and paste as many times as needed for multiple indicators). If HEDIS, CAHPS or HOS is checked, plans do not need to complete items #2 through #5 for the indicator.

☒ HEDIS (Administrative), Measurement Year: 2009
☐ HEDIS (Hybrid), Measurement Year:
☐ CAHPS, Measurement Year:
☐ HOS, Measurement Year:
☐ Other:

Indicator # 1:

1. Indicator name: **Annual Monitoring for Patients on Persistent Medications**

2. Numerator description: **The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.**

   - **Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)**
   - **Annual monitoring for members on digoxin**
   - **Annual monitoring for members on diuretics**
   - **Annual monitoring for members on anticonvulsants**
   - **Total rate (the sum of the four numerators divided by the sum of the four denominators)**

3. Denominator description: **The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year.**

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- **Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)**
- **Members on digoxin**
- **Members on diuretics**
- **Members on anticonvulsants**
- **Total members on listed drugs**

4. Inclusion criteria: **Members must be enrolled in Medicare SNP the entire measurement year.**
5. Exclusion criteria: **Members who had an inpatient claim during the measurement year were excluded for this project.**
6. Performance target: **All eligible members**
7. Rationale/justification for performance target: **Per NCQA's 'The State of Health Care Quality 2009' report Drugs that commonly require monitoring in outpatient settings accounted for over half of all unintentional drug overdoses that resulted in an emergency room visit.**

E. Data Sources and Collection Methodology

Provide all applicable information in this section.

(skip #1-4 if indicators used are from standard HEDIS, CAHPS and HOS collections)

1. Identify the sources of data utilized in quality indicators/measures in this quality improvement project:

☐ Medical records
☐ Claims or encounter data
☐ Complaints or customer service data
☐ Appeals
☐ Administrative – call center data
☐ Administrative – appointment/access data
☐ Pharmacy data
☐ Survey data (attach the survey tool and describe the sampling process, sample size, and the survey administration protocol. Provide response rates.)
☐ Other (list and describe):

2. Data collection cycle

☐ Once a year
☐ Twice a year
☐ Once a quarter
☐ Once a month
☐ Once a week
☐ Once a day
☐ Continuous
☐ Other (describe):

3. Data analysis cycle

☐ Once a year
☐ Twice a year
☐ Once a quarter
☐ Once a month
☐ Other (describe):

High Quality Section does not count against page limit.

4. Describe the baseline data collection methodology, collection periods, sampling, sample size, and efforts to assure reliability and validity.

5. Describe any changes in data collection methodology, collection periods, sampling, sample size, data sources, numerator and denominator definitions, inclusion and exclusion criteria or analysis that have occurred since the initiation of this project. Include a rationale for each change and an assessment of the impact of these changes on the quality improvement indicators.

   No changes in data collection.

F. Results

1. Complete the results table below with the measurement periods and results for each measurement cycle for each quality indicator for this project. Specify the year results were obtained in this section. Add additional rows for additional measurement cycles and indicators as needed. If applicable, copy and paste the table for each contract number in order to provide market-specific data at the contract level.

Contract number: **H7086**

	Measurement Period							
	Start Date (mm/dd/yy)	End Date (mm/dd/yy)	Eligible Population N	Number Excluded	Numerator	Denominator	Rate	Performance Goal Reached? (Y/N)
Indicator #1								
Baseline Measurement	01/01/2009	12/31/2009	424	0	315	424	74.29	N
Remeasurement 1								
Remeasurement 2								
Indicator #2								
Baseline Measurement								
Remeasurement 1								
Remeasurement 2								
Indicator #3								
Baseline Measurement								
Remeasurement 1								
Remeasurement 2								
Repeat rows for additional indicator(s) as needed								

1. Describe barriers (if any) to improving your quality indicators, and the strategies employed to overcome them (optional).

   - **Inadequate monitoring or follow up by prescribing physician**

High Quality Section does not count against page limit.

- **Health literacy barriers that lead to misunderstood health care instructions and follow-up by members.**

2. Describe improvements achieved (if any) in your quality indicators and how they impact the health outcomes and/or delivery of health care to your Medicare Advantage enrollees.

N/A – Baseline measurement

G. Interventions

1. Complete the intervention and intervention modification timetable below with the implementation date, duration, target group, staff/partners used in implementation, any barriers that the interventions were meant to address, and the participation rates for the intervention. In the *Intervention Description (or description of modification)* column, explain how the intervention addresses the issues identified as the focus of the QIP project. Include information about the individuals responsible for conducting the steps indicated for the interventions. Explain when and how these steps will be carried out. If applicable, copy and paste the table for each contract number in order to provide market-specific data at the contract level.

Contract number: **H7086**

Intervention Description (or description of modification)	Implementation Date	Duration OR Indicate if Ongoing	Target Group for Intervention	Staff/Partners in Implementation	Barriers Addressed by the Intervention	Percent/number of plan members who received the intervention
Identify members that have been prescribed ACE/ARBs, digoxin, diuretics, or anti-convulsants and have not received annual monitoring.	September 2010	Ongoing	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Provide member-specific lists of members who have not received annual monitoring to primary care physicians.	September 2010	Ongoing	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Provide comparative performance information on therapeutic monitoring for primary care	September 2010	Quarterly Updates	Physicians	Corporate Quality Pharmacy Services Informatics Depart. Provider Relations	Inadequate monitoring or follow up by prescribing physician	
Publish article in member newsletter regarding the importance of follow-up and monitoring when on continuing medications	December 2010	One Time	Members	Corporate Quality	Misunderstandding of health care instructions and follow-up by members.	

H. External Consultation and Delegation

Provide all applicable information in this section.

1. Did you seek consultation and/or technical assistance from the Quality Improvement Organization/ QIO in your State?

☐ Yes

High Quality Section does not count against page limit.

☒ No

1. (a) Indicate QIO involvement on this QI project (*select all that apply)*:

☐ Performance improvement project review
☐ Study design development
☐ Liaison with CMS
☐ Continuous quality improvement (CQI) training
☐ Data analysis
☐ Development, testing and training on electronic and/or paper abstraction tools
☐ Design and development of intervention materials (graphic design and printing)
☐ Dissemination of intervention materials (mailing to all physicians and/or beneficiaries)
☐ Facilitation of group collaborative projects (focus group, provider meetings)
☐ Brief consultation
☐ Collaborative project
☐ Other:

2. Did you seek consultation and/or technical Assistance from another organization outside of your QIO?

☐ Yes
☒ No

2. (a) Identify the organization:

2. (b) External consultation/technical assistance from other organization *[select all that apply]*:

☐ Performance improvement project review
☐ Study design development
☐ Liaison with CMS
☐ Continuous quality improvement (CQI) training
☐ Data analysis
☐ Development, testing and training on electronic and/or paper abstraction tools
☐ Design and development of intervention materials (graphic design and printing)
☐ Dissemination of intervention materials (mailing to all physicians and/or beneficiaries)
☐ Facilitation of group collaborative projects (focus group, provider meetings)
☐ Brief consultation
☐ Collaborative project
☐ Other:

3. Are any aspects of your organization's Quality Improvement Program delegated or outsourced? If so, list the delegated tasks and the contractor/delegated entity performing the tasks:

Not Delegated

3. (a) Explain how these delegated entities are monitored for compliance with Federal and State requirements and how often.

N/A

3. (b) Explain how these delegated entities are monitored for general quality assurance purposes and how often.

N/A

High Quality Section does not count against page limit.

I. Lessons Learned (Optional)

Provide all applicable information in this section.

1. State any "lessons learned" from conducting this QI project:

2. What system-level changes were made and/or planned as a result of this project:

3. What opportunities for future improvement were identified in the course of conducting this project:

High Quality Section does not count against page limit.

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Community Health Group

Medicaid HMO

an accreditation status of

COMMENDABLE

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

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

August 29, 2011	*August 15, 2014*
DATE GRANTED	EXPIRATION DATE

May 27, 2011

Norma Diaz
Chief Executive Officer
COMMUNITY HEALTH GROUP
740 Bay Blvd.
Chula Vista, CA 919105254

Re: Conditional Approval of SNP Application
H7086 - COMMUNITY HEALTH GROUP - Dual-Eligible - Medicaid Subset - $0 Cost Share

Dear Norma Diaz:

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

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

Your Quality Improvement Program Plan passed.

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

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

Element 1	4
Element 2	11
Element 3	11
Element 4	10
Element 5	17
Element 6	12
Element 7	13
Element 8	17
Element 9	13
Element 10	7
Element 11	21
Total Points	136
Total Possible Points	160
Score	85.00%

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

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San Diego Regional Center
Serving Individuals with Developmental Disabilities in San Diego and Imperial Counties
4355 Ruffin Road, San Diego, California 92123 • (858) 576-2996 • www.sdrc.org

January 27, 2012

Norma Diaz
Chief Executive Officer
Community Health Group
Chula Vista, CA 91910

RE: Letter of Support for Community Health Group's Proposal for the Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Ms. Diaz:

On behalf of San Diego Regional Center we are pleased to offer our support and agree to serve as a reference for Community Health Group's (CHG) application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligible Demonstration Project. We understand that with this demonstration DHCS aims to promote coordinated care models that provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services dual eligibles need to maintain good health and a high quality of life.

Our organization has worked collaboratively with CHG since 1998 and has found CHG to be an excellent community partner. As a not-for-profit community based health plan CHG has been dedicated to serving Medi-Cal recipients for 30 years. Given the Plan's background and experience serving both Medi-Cal and Medicare Special Needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration.

San Diego Regional Center fully supports CHG's application to DHCS, and is happy to serve as a reference for its application. Please do not hesitate to contact me should you have any questions.

Sincerely,

Carlos Flores
Executive Director

East County Office
8760 Cuyamaca St., #100
Santee, CA 92071
(619) 596-1000

Imperial County Office
512 W. Aten Rd.
Imperial, CA 92251
(760) 355-8383

North County Office
1370 W. San Marcos Blvd #100
San Marcos, CA 92078
(760) 736-1200

South County Office
2727 Hoover Ave., #100
National City, CA 91950
(619) 336-6600

P.O. Box 421175 SAN DIEGO, CA 92142-1175 619-282-2232 ext. 207 kluton@heritageclinic.org

January 30. 2012

Norma Diaz
Chief Executive Officer
Community Health Group
Chula Vista, CA 91910

RE: Letter of Support for Community Health Group's Proposal for the Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Ms. Diaz:

On behalf of the San Diego Coalition for Mental Health, we are pleased to offer our support and agree to serve as a reference for Community Health Group's (CHG) application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligibles Demonstration Project. We understand that, with this demonstration, DHCS aims to promote coordinated care models that provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services dual eligibles need to maintain good health and a high quality of life.

Our organization has worked collaboratively with CHG since 1998 and has found CHG to be an excellent community partner. As a not-for-profit community-based health plan, CHG has been dedicated to serving Medi-Cal recipients for 30 years. Given the Plan's background and experience serving both Medi-Cal and Medicare Special Needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration.

The San Diego Mental Health Coalition fully supports CHG's application to DHCS and is happy to serve as a reference for its application. Please do not hesitate to contact me should you have any questions.

Sincerely,

Karen S. Luton
Chair

NEIGHBORHOOD HEALTHCARE
SERVING OUR COMMUNITIES AS A NONPROFIT SINCE 1969

January 24, 2012

NORTH REGION
RAY M. DICKINSON
WELLNESS CENTER &
MAIN ADMINISTRATION
425 N. Date St.
Escondido, CA 92025
(760) 520-8300
Dental Services
(760) 520-8350
Behavioral Health
(760) 520-8340
ESCONDIDO
460 N. Elm Street
Escondido, CA 92025
(760) 520-8100
WOMEN'S HEALTH
215 S. Hickory St. #212
Escondido, CA 92025
(760) 737-6900
GRAND AVE.
1001 E. Grand Ave.
Escondido, CA 92025
(760) 520-8200
PEDIATRICS &
PRENATAL
426 N. Date St.
Escondido, CA 92025
(760) 690-5900
PAUMA VALLEY
16650 Highway 76
P.O. Box 655
Pauma Valley, CA 92061
(760) 742-9919
Dental Services
(760) 742-0672
TEMECULA
41715 Winchester Rd. #200
Temecula, CA 92590
(951) 719-1414
WINCHESTER RD.
41715 Winchester Rd., #106
Temecula, CA 92590
(951) 694-9449

EAST REGION
ADMINISTRATION
1100 N. Magnolia Ave. #G
El Cajon, CA 92020
(619) 440-7616
EL CAJON
855 E. Madison Ave.
El Cajon, CA 92020
(619) 440-2751
LAKESIDE
10059 Vine St.
Lakeside, CA 92040
(619) 390-9975
Dental Services
(619) 390-9145

Norma Diaz
Chief Executive Officer
Community Health Group
Chula Vista, CA 91910

RE: Letter of Support for Community Health Group's Proposal for the Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Ms. Diaz:

On behalf of Neighborhood Healthcare, we are pleased to offer our support and agree to serve as a reference for Community Health Group's (CHG) application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligibles Demonstration Project. We understand that, with this demonstration, DHCS aims to promote coordinated care models that provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services dual eligibles need to maintain good health and a high quality of life.

Our organization has worked collaboratively with CHG since 1994 and has found CHG to be an excellent community partner. As a not-for-profit community-based health plan, CHG has been dedicated to serving Medi-Cal recipients for 30 years. Given the Plan's background and experience serving both Medi-Cal and Medicare Special Needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration.

Neighborhood Healthcare fully supports CHG's application to DHCS and is happy to serve as a reference for its application. Please do not hesitate to contact me should you have any questions.

Sincerely,

Tracy Ream

Tracy Ream
Chief Executive Officer

COUNCIL OF COMMUNITY CLINICS

January 24, 2012

Norma Diaz
Chief Executive Officer
Community Health Group
740 Bay Boulevard
Chula Vista, CA 91910

RE: Letter of Support for Community Health Group's Proposal for the Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Ms. Diaz:

On behalf of the Council of Community Clinics (CCC), we are pleased to offer our support and agree to serve as a reference for Community Health Group's (CHG) application to the Department of Health Care Services (DHCS) Request for Solutions for California's Dual Eligibles Demonstration Project. We understand that, with this demonstration, DHCS aims to promote coordinated care models that provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services dual eligibles need to maintain good health and a high quality of life.

Founded in 1977, CCC is a health-center controlled network consisting of 16 members operating over 100 clinical sites throughout San Diego, Imperial and Riverside Counties. CCC's mission is to represent and support community health centers in their respective efforts to provide access to quality, low-cost healthcare services.

Our organization has worked collaboratively with CHG since 1982 and has found CHG to be an excellent community partner. As a not-for-profit community-based health plan, CHG has been dedicated to serving Medi-Cal recipients for 30 years. Given the Plan's background and experience serving both Medi-Cal and Medicare Special Needs members, we believe it is well positioned to now serve the dual eligible population in this demonstration.

CCC fully supports CHG's application to DHCS and is happy to serve as a reference for its application. Please do not hesitate to contact me at (619) 542-4300 should you have any questions.

Sincerely,

Stephen R. O'Kane
Chief Executive Officer

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

PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
SAN DIEGO COUNTY

February 15, 2012

Letter of Agreement to Work in Good Faith:

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

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

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

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

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

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

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

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

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

Sincerely,

Albert G. "Bud" Sayles
Executive Director

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

Ann Warren

From: Schmitthenner, Brenda [Brenda.Schmitthenner@sdcounty.ca.gov]
Sent: Thursday, February 09, 2012 7:17 AM
To: Andrew Whitelock; Anglo, Leizyl; Ann Warren; Brown, Gretchen; Chin, Lauren; Fitzgerald, Debra; Fritz, Kimberly; Joseph Garcia; Harrison, Mary; Martha Jazo-Bajet; Jimenez, Barbara; Lewis, Marshall; Lopez, Rogelio; Mark R. Meiners Ph. D. (mmeiners@gmu.edu); Matovsky, Sabra; Michael Owens; Mike McGarrigle; Molzen, Vickie; Richard Bock; Rockwell, Jean; Santiago, Rene; Sayles, Albert; Schmeding, Ellen; Schmitthenner, Brenda; George Scolari; Smith, Pam; Steven Soto; Stout-Penn, Melissa; Teri Lauenstein; Thomas Dey; Thompson, Ann; Tim Schwab, M.D.; Yphantides M.D., Nick; Zaravia, Emily
Subject: FW: Documents distributed yesterday & brief meeting report
Attachments: Planning Committee List.xlsx; PA Services for Dual Pilots Draft 2-3-12 (2).docx; IHSS Process- San Diego 2-6-12.docx; Ltr of Agreement to work in good faith - County.pdf

Hi Everyone,

Thank-you all for coming yesterday – below are some brief notes reflecting our discussion:

In attendance: Tom Dey, Norma Diaz, Carol Edison, Kim Fritz, Mary Harrison, Rogelio Lopez, Sabra Matovsky, Mark Meiners, Mike McGarrigle, Michael Owens, M.D., Bud Sayles, Ellen Schmeding, Brenda Schmitthenner, George Scolari, Ann Warren, Emily Zaravia.

1. The group discussed the agenda for the upcoming stakeholder meeting as well as the time frames set aside for each of the discussion items. George S. indicated his willingness to discuss the "Establishment of an Advisory Committee" item as the health plans representative.
2. Some members of the group sat in on the Harbage Consulting call. Ellen noted that some key issues were shared that were relevant such as the repeated statements about this being the beginning of a lengthy discussion process between plans, stakeholders and the State on the design of this new system. Also shared by Harbage Consulting was feedback on the supplemental benefits (that there was a disconnect in the RFS – one section indicated that the supplemental benefits could not be established until the rate was known while another section asked plans to document what would be included as supplemental benefits). Harbage also indicated that plans could use their D-SNP model of care for care coordination but would need to update these keeping in mind 'innovation is key.' Also stated was that the additional guidance on IHSS would be provided via Trailer Budget Language and that workgroups would be formed to work on this issue over the course of the coming year.
3. New Trailer Bill language was just released on the "Coordinated Care Initiative." This language documents the goal for the State to expand the pilots from four to 10 and to roll out managed care for LTSS Medi-Cal funded benefits (IHSS, MSSP, CBA, SNF) in 20 counties beginning in Jan 2013. Page 9 (14146(b)(6) indicates that 'counties will continue to have a role in the assessment of beneficiaries for long term services & supports.' No other language was found that further specified what is being proposed for the county role. It appears that further trailer budget language may be in the works.
4. An addendum to the RFS was shared by Brenda and Kim (just received today). One key element was the change now indicating that 'demonstration sites are required to **coordinate** (not have plans to contract, utilize and pay for) community-based services that are not necessarily a plan benefit.... (page 10 of the RFS).
5. Lengthy discussion ensued regarding the level of training received by IHSS home care workers, especially around the issue of paramedical services, and the risk that might result to health plans with continuing to use this procedure for high risk individuals in need of these types of services.
6. The Public Authority and IHSS shared current program descriptions (attached) for use by the plans in discussing year one contracts with IHSS/PA.
7. The County letter from Nick Macchione was shared (Agreement to Work in Good Faith). Bud Sayles was asked to provide one from the Public Authority. The goal will be to complete this within the week and have it to the plans.

8. Bud shared information on consumer concerns with the group. Plans remain committed to including consumers in the steering committee in order to ensure that consumer needs are kept at the forefront as the planning process continues to evolve. It may help to send out an open letter to consumers to discuss the plans' goal to involve consumers. This may be an early issue for the Steering Committee (e.g., to identify ways to gather consumer & provider input).
9. The group began discussing the issue of care coordination – how this would work in the future. MSSP (care management program with AIS) is one of the LTSS programs to be integrated. AIS would like to participate in further discussion on the role for this important program in the new system design.
10. A request was made to shift topics in the coming weeks with the final application discussion to occur 2/14 at 8:30 and behavioral health coordination on 2/21 at 9:00. Ellen & Brenda asked to receive specific agenda topics for the 2/14 meeting ahead of time.

Thanks

Ellen Schmeding, MFT
Assistant Deputy Director
Aging & Independence Services, Health & Human Services
Ellen.Schmeding@sdcounty.ca.gov
5560 Overland Avenue, Suite 310, San Diego, CA 92123
(858) 505-6329
(858) 495-5080 (fax)
W-433

AIS: The leader in Advocacy, Information & Safety to foster dignity and enhance the quality of life for seniors and persons with disabilities.

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

Long Term Care Integration Project (LTCIP)

STAKEHOLDER MEETING

February 14, 2012

Please join us on **Tuesday, February 14, 2012** from **1:00 PM to 3:00 PM** for a LTCIP Stakeholder Meeting. The meeting will be held in the JA Training Room at the **Aging & Independence Services (AIS) Headquarters located at 5560 Overland Ave., Suite 310, San Diego, 92123.** There is two hour visitor parking behind the building and also on the first floor in the parking garage, which can be accessed from Farnham Drive. Please contact Cindy Vogel at (858) 514-4652 or **cindy.vogel@sdcounty.ca.gov** if you have any questions about the parking or need directions.

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

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

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

In January, the Department of Health Care Services (DHCS) released the Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project final Request for Solutions (RFS). The RFS will be used to select pilot sites. The selection criteria reflect DHCS' aim to rebalance care away from institutional settings and into the home and community. The RFS promotes coordinated care models that provide seamless access to the full continuum of medical, social, long-term, and behavioral supports and services dual eligibles need to maintain good health and a high quality of life.

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

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

LTCIP Meeting Agenda- February 14, 2012

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

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

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

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

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

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

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

- Consumer Center for Health Education and Advocacy
- County In-Home Supportive Services (IHSS)
- County Behavioral Health Services
- Program of All-Inclusive Care for the Elderly (PACE)
- Community Based Adult Services (CBAS)
- Senior Alliance
- United Domestic Workers (UDW)
- Hospital Association of San Diego and Imperial County
- Community Clinics
- AIS Aging Services (ADRC)
- Skilled Nursing Facility
- Consumers (up to 3)
- San Diego Regional Center
- Access to Independence
- Health Plans
- IHSS Public Authority

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

CHG's DUAL ELIGIBLE (MEDICARE/MEDI-CAL) FOCUS GROUP EXECUTIVE SUMMARY

OVERVIEW

On February 2, 2012, Community Health Group hosted a focus group with nine dual eligible (Medicare/Medi-Cal) beneficiaries. The purpose of the focus group was to elicit feedback from participants and identify perceived barriers to care or customer satisfaction.

REQUEST FOR SOLUTIONS (RFS) FOR DUAL ELIGIBLES DEMONSTRATION PROJECT

The information gathered from this focus group was from actual Medicare/Medi-Cal beneficiaries who will be eligible to participate in the Dual Eligible Demonstration Project.

METHODOLOGY

1. The composition of the focus group was as follows:

GENDER	
MALE	FEMALE
2	7

AID CATEGORY	
AGED	DISABLED
2	7

AGE GROUP		
21-40	41-60	61 & Over
3	4	2

2. The group moderator worked with participants who provided feedback on ten questions regarding benefits and service. In addition, their input regarding CHG's newsletter and use of Interactive Voice Response (IVR) technology was sought.

KEY MESSAGES FROM THE GROUP

The following were the most relevant messages from participants:

1. Respect, honesty, and support from the Plan and its providers are key to a successful Plan/Member relationship.

2. Clear, simple explanations on how to navigate managed care are a must. Plan employees and providers should not assume that healthcare jargon is common knowledge.

3. The authorization process is perceived as a barrier to care; this concept is foreign to fee for service patients.

4. Written communications need to be succinct and easy to understand. Lengthy documents, such as the Member Handbook, are usually "thrown in the trash."

5. Using IVR technology to disseminate information or promote healthcare campaigns was a welcomed idea.

NEXT STEPS

As we prepare to increase our enrollment of dual eligible recipients, we will need to concentrate efforts to ensure that member satisfaction and understanding of Plan benefits and services is in the forefront of our decisions and infrastructure.

Community Health Group

CHG's Compliance Officer, checks the Office of Inspector General's (OIG) "Excluded Individual" list for new hires and for regular employees quarterly to ensure no one reflects on excluded list. CHG certifies it has no relationship with anyone who has been convicted of a criminal offense under Medicaid (Medi-Cal), or Medicare.

Enclosed is an example of the OIG report.

Appendix 14

Business Entity Detail

Data is updated weekly and is current as of Friday, February 10, 2012. It is not a complete or certified record of the entity.

Entity Name:	CHG FOUNDATION
Entity Number:	C1871324
Date Filed:	04/01/1994
Status:	ACTIVE
Jurisdiction:	CALIFORNIA
Entity Address:	740 BAY BLVD
Entity City, State, Zip:	CHULA VISTA CA 91910
Agent for Service of Process:	NORMA DIAZ
Agent Address:	740 BAY BLVD
Agent City, State, Zip:	CHULA VISTA CA 91910

* Indicates the information is not contained in the California Secretary of State's database.

- If the status of the corporation is "Surrender," the agent for service of process is automatically revoked. Please refer to California Corporations Code **section 2114** for information relating to service upon corporations that have surrendered.
- For information on checking or reserving a name, refer to **Name Availability**.
- For information on ordering certificates, copies of documents and/or status reports or to request a more extensive search, refer to **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.
- For descriptions of the various fields and status types, refer to **Field Descriptions and Status Definitions**.

Modify Search **New Search** **Printer Friendly** **Back to Search Results**

Business Entities (BE)

Online Services
- **Business Search**
- **Disclosure Search**
- **E-File Statements**
- **Processing Times**

Main Page

Service Options

Name Availability

Forms, Samples & Fees

Annual/Biennial Statements

Filing Tips

Information Requests (certificates, copies & status reports)

Service of Process

FAQs

Contact Information

Resources
- **Business Resources**
- **Tax Information**
- **Starting A Business**
- **International Business Relations Program**

Customer Alerts
- **Business Identity Theft**
- **Misleading Business Solicitations**

Business Entity Detail

Data is updated weekly and is current as of Friday, February 10, 2012. It is not a complete or certified record of the entity.

Entity Name:	COMMUNITY HEALTH GROUP
Entity Number:	C1074270
Date Filed:	05/28/1982
Status:	ACTIVE
Jurisdiction:	CALIFORNIA
Entity Address:	740 BAY BLVD
Entity City, State, Zip:	CHULA VISTA CA 91910
Agent for Service of Process:	NORMA DIAZ
Agent Address:	740 BAY BLVD
Agent City, State, Zip:	CHULA VISTA CA 91910

* Indicates the information is not contained in the California Secretary of State's database.

- If the status of the corporation is "Surrender," the agent for service of process is automatically revoked. Please refer to California Corporations Code **section 2114** for information relating to service upon corporations that have surrendered.
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INTERNAL REVENUE SERVICE
DISTRICT DIRECTOR
2 CUPANIA CIRCLE
MONTEREY PARK, CA 91755-7406

DEPARTMENT OF THE TREASURY

Date: AUG 01 1994

CHG FOUNDATION
C/O COMMUNITY HEALTH GROUP,
ATTN: JAN FRATES
740 BAY BLVD.
CHULA VISTA, CA 91910

Employer Identification Number:
33-0586911
Case Number:
954138044
Contact Person:
RANDY HOWARD
Contact Telephone Number:
(213) 725-7002

Accounting Period Ending:
Dec. 31
Foundation Status Classification:
170(b)(1)(A)(vi)
Advance Ruling Period Begins:
April 1, 1994
Advance Ruling Period Ends:
Dec. 31, 1998

Dear Applicant:

Based on information you supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3).

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably expect to be a publicly supported organization described in sections 509(a)(1) and 170(b)(1)(A)(vi).

Accordingly, during an advance ruling period you will be treated as a publicly supported organization, and not as a private foundation. This advance ruling period begins and ends on the dates shown above.

Within 90 days after the end of your advance ruling period, you must send us the information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, we will classify you as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, we will classify you as a private foundation for future periods. Also, if we classify you as a private foundation, we will treat you as a private foundation from your beginning date for purposes of section 507(d) and 4940.

Grantors and contributors may rely on our determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you send us the required information within the 90 days, grantors and contributors may continue to rely on the advance determination until we make a final determination of your foundation status.

If we publish a notice in the Internal Revenue Bulletin stating that we will no longer treat you as a publicly supported organization, grantors and

Letter 1045 (DO/CG)

contributors may not rely on this determination after the date we publish the notice. In addition, if you lose your status as a publicly supported organization, and a grantor or contributor was responsible for, or was aware of, the act or failure to act, that resulted in your loss of such status, that person may not rely on this determination from the date of the act or failure to act. Also, if a grantor or contributor learned that we had given notice that you would be removed from classification as a publicly supported organization, then that person may not rely on this determination as of the date he or she acquired such knowledge.

If you change your sources of support, your purposes, character, or method of operation, please let us know so we can consider the effect of the change on your exempt status and foundation status. If you amend your organizational document or bylaws, please send us a copy of the amended document or bylaws. Also, let us know all changes in your name or address.

As of January 1, 1984, you are liable for social securities taxes under the Federal Insurance Contributions Act on amounts of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the private foundation excise taxes under Chapter 42 of the Internal Revenue Code. However, you are not automatically exempt from other federal excise taxes. If you have any questions about excise, employment, or other federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Internal Revenue Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Donors may deduct contributions to you only to the extent that their contributions are gifts, with no consideration received. Ticket purchases and similar payments in conjunction with fundraising events may not necessarily qualify as deductible contributions, depending on the circumstances. Revenue Ruling 67-246, published in Cumulative Bulletin 1967-2, on page 104, gives guidelines regarding when taxpayers may deduct payments for admission to, or other participation in, fundraising activities for charity.

You are not required to file Form 990, Return of Organization Exempt From Income Tax, if your gross receipts each year are normally $25,000 or less. If you receive a Form 990 package in the mail, simply attach the label provided, check the box in the heading to indicate that your annual gross receipts are normally $25,000 or less, and sign the return.

If you are required to file a return you must file it by the 15th day of the fifth month after the end of your annual accounting period. We charge a penalty of $10 a day when a return is filed late, unless there is reasonable cause for the delay. However, the maximum penalty we charge cannot exceed

$5,000 or 5 percent of your gross receipts for the year, whichever is less. We may also charge this penalty if a return is not complete. So, please be sure your return is complete before you file it.

You are not required to file federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, we will assign a number to you and advise you of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

If we said in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help us resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Richard R. Orosco
District Director

Internal Revenue Service
District Director

Department of the Treasury

Date: JAN 13 1983

Employer Identification Number:
95-3766170
Internal Revenue Code
Section 501(c)(4)

Accounting Period Ending:

Form 990 Required: ☒ Yes ☐ No

Person to Contact:
I. Hill
Contact Telephone Number:
(213) 688-4889

Community Health Group
4004 Beyer Boulevard
San Ysideo, California 92073

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from Federal income tax under the provisions of the Internal Revenue Code section indicated above.

Unless specifically excepted, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) for each employee to whom you pay $100 or more during a calendar year. And, unless excepted, you are also liable for tax under the Federal Unemployment Tax Act for each employee to whom you pay $50 or more during a calendar quarter if, during the current or preceding calendar year, you had one or more employees at any time in each of 20 calendar weeks or you paid wages of $1,500 or more in any calendar quarter. If you have any questions about excise, employment or other Federal taxes, please address them to this office.

If your purposes, character, or method of operation change, please let us know so we can consider the effect of the change on your exempt status. Also, you should inform us of all changes in your name or address.

The block checked at the top of this letter shows whether you must file Form 990, Return of Organization Exempt from Income Tax. If the Yes box is checked, you are only required to file Form 990 if your gross receipts each year are normally more than $10,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law provides for a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late, unless there is reasonable cause for the delay. This penalty may also be charged if a return is not complete. So, please make sure your return is complete before you file it.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Internal Revenue

(over)

Code. If you are subject to this tax, you must file an income tax return on Form 990-T. In this letter we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in Code section 513.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, a number will be assigned to you and you will be advised of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

Because this letter could help resolve any questions about your exempt status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

H. W. Smith

District Director

**For tax years ending on and after December 31, 1982, organizations whose gross receipts are not normally more than $25,000 are excused from filing Form 990. For guidance in determining if your gross receipts are "normally" not more than the $25,000 limit, see the instructions for the Form 990.

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Please refer to RFS Checklist 8.

See Appendix 8a and 8b.

Please refer to RFS Checklist 9.

See Appendix 9.

Please refer to RFS Checklist 9.

See Appendix 9.

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NICK MACCHIONE, FACHE
DIRECTOR

DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

County of San Diego

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

February 8, 2012

Letter of Agreement to Work in Good Faith:

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

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

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

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

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

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

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

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

Sincerely,

NICK MACCHIONE, MS, MPH, FACHE
Director

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

HEALTHY SAN DIEGO

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

11.0 MENTAL HEALTH PLAN (MHP)

11.1 BACKGROUND

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

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

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

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.2 Liaison (MHP & Plan Responsibilities) (continued)	update the MOA as necessary. The MHP Liaison will be responsible for communicating suggestions for MOA changes to the MHP leadership and Plan Liaison. The MHP will also communicate MOA changes to the State Department of Mental Health and MHP providers. At the discretion of the MHP, the Liaison may represent the MHP in the dispute resolution process. The MHP will assist and provide the Plan with the phone numbers of its beneficiary and provider services and support programs that provide liaison services.	liaison services. With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, Plan member, clinical, or other pertinent information will be shared between the Plan and the MHP and its providers for coordination of care.
11.3 Ancillary Mental Health Services	The MHP will provide hospital based ancillary mental health services, other than routine services, to Plan members when medical necessity criteria are met. Ancillary services, are included in the per diem rate and may include but are not limited to electro-convulsive therapy (ECT).	The Plan will arrange ancillary services for the MHP members when medically necessary. The Plan will direct contracting providers to cover ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.
11.4 Clinical Consultation and Training	The MHP will provide and make available to Plan Providers clinical consultation and training, including consultation and training on psychotropic medications to meet the needs of a beneficiary whose mental illness is not being treated by the MHP. The MHP will include consultation on medications to Primary Care physician for Plan members on medications whose mental illness is being treated by the PCP. Clinical consultation between the MHP and the PCP will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by the MHP to the PCP on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the PCP.	The Plan will direct contracting providers to provide clinical consultation and training to the MHP or other providers on physical health care conditions and on medications prescribed through Plan providers. The Plan will direct contracting providers to arrange clinical consultation to the MHP or other providers of mental health services on a member's physical health condition. Such consultation will include consultation by the PCP to the MHP on medications prescribed by the PCP for a Plan member whose mental illness is being treated by the MHP.
11.5 Confidentiality of Medical Records	The MHP will arrange for appropriate management of a member's care, including the exchange of medical records information with a member's other healthcare providers or	The Plan will arrange for appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers or

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.5 Confidentiality of Medical Records (continued)	providers of specialty mental health services. The MHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.	providers of specialty mental health services. The Plan will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization by the member. The Plan will not release any information pertaining to a member's physical or mental health treatment without a signed release from the member and a signed written statement by the requester describing the information requested, its intended use or uses, the length of time during which the information will be kept before being destroyed or disposed of, and a statement that the information will not be used for other purposes and will be destroyed within the designated timeframe. The timeframe may be extended, provided that the Plan is notified of the extension, the reasons for the extension, and additional intended uses and the expected date that the information will be destroyed. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.
11.6 Diagnostic Assessment	The MHP will evaluate and triage plan members and when authorized will provide specialty mental health services to the Plan members who meet Specialty Mental Health Criteria. The MHP will evaluate a member's symptoms, level of impairment and focus of intervention to determine if a member meets medical necessity criteria for specialty mental health services. When medical necessity criteria is met, the MHP will arrange for an appointment with the appropriate provider. When medical necessity criteria is not met, the MHP staff may refer the member back to the	The Plan or its subcontractors will arrange and pay, at the Medi-Cal rate, for appropriate medically necessary assessments of Plan members to identify co-morbid physical and mental health conditions, to: • Rule out general medical conditions causing psychiatric symptoms • Rule out mental disorders and/or substance-related disorders caused by a general medical condition. • Identify and treat those general medical conditions that are causing or exacerbating psychiatric symptoms. The PCP will be advised to identify and/or treat non-disabling psychiatric conditions that may be responsive to primary care, i.e. mild to moderate

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.6 Diagnostic Assessment (continued)	MHP staff may refer the member back to the referring PCP, notify the Plan and/or refer the member to community resources as appropriate. Individual mental health providers may arrange for records transfer by direct communication with the referring physician.	responsive to primary care, i.e. mild to moderate anxiety and/or depression or more serious mental health conditions if stabilized on medication or other physical health based treatment, if within the scope of practice of the member's PCP. The member's PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the member to specialty physical health care for such treatment.
11.7 Emergency Services & Care – Emergency Room Facility Charges and Professional Services	The MHP will be responsible for the facility charges resulting from the emergency services and care of a Plan member whose condition meets the MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay. The MHP will cover and pay for the professional services of a mental health specialist, subject to submission of a valid claim with appropriate documentation, provided in an emergency room to a Plan member whose condition meets the MHP medical necessity criteria or when the mental health specialist services are required to assess whether the MHP medical necessity is met. Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition does not meet the MHP medical necessity criteria will be assigned as follows: Payment for professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal fee-for-service system, and not the responsibility of the MHP.	The Plan will cover at the Medi-Cal rate the facility charges resulting from the emergency services and care of a Plan member, whose condition meets the MHP medical necessity criteria, when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility. The Plan will cover at the Medi-Cal rate all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose conditions meets the MHP medical necessity criteria. Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition does not meet MHP medical necessity criteria will be assigned as follows: The Plan will cover at the Medi-Cal rate the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.8 Home Health Agency Services	The MHP will notify the Plan of members who need home health services or who are receiving home health services through the Home and Community Based Services Waiver Program (HCBS) or the In-Home Supportive Services Program (IHSS). The MHP will pay for medically necessary specialty mental health services solely related to the included mental health diagnoses, or if the MHP determines a Plan member requires necessary Specialty Mental Health Services The MHP is not responsible to provide or arrange for Home Health Agency Services as described in Title 22, Section 51337.	The Plan will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHS. A homebound Plan member is a patient who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relative short duration, e.g., for a short walk prescribed as therapeutic exercise. The Plan is not obligated to cover home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a Plan member. For example, the Plan would not be obligated to cover home health agency services for the purpose of medication monitoring when those services are not typically medically necessary or for a patient who is not homebound. Home health agency services prescribed by Plan providers to treat mental health conditions of Plan members are the responsibility of the Plan.
11.9 Hospital Outpatient Department Services	The MHP will be responsible for the payment of specialty mental health services provided by hospital outpatient departments, which are credentialed as MHP group providers for Plan members who meet medical necessity criteria for specialty mental health services. Hospital outpatient services will be reasonably available and accessible to Plan members.	The Plan will cover at the Medi-Cal rate professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contract with its subcontractors and the Department of Health Services (DHS). Separately billable outpatient services related to *electroconvulsive therapy, such as anesthesiologist services* are the contractual responsibility of the Plan.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.10 Laboratory, Radiological, and Radioisotope Services	Laboratory, radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the MHP, *except* when provided as hospital based ancillary services and are included in the per diem. Medi-Cal beneficiaries may obtain Medi-Cal covered laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP. The MHP will coordinate with laboratory, radiological, and radioisotope and Plan as appropriate to assist beneficiaries in receiving laboratory, radiological, and radioisotope services, prescribed through the MHP including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedure. Information will be disseminated to the MHP providers primarily through provider meetings conducted by the MHP staff.	The Plan will be responsible for covering at the Medi-Cal rate medical necessary laboratory, radiological, and radioisotope services described in CCR Title 22, Section 51311. The Plan will cover at the Medi-Cal rate laboratory services to Plan members who require the specialty mental health services of the MHP or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis and treatment of Plan member's mental health condition. The Plan will also cover at the Medi-Cal rate services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan will coordinate these services with the member's specialty mental health provider.
11.11 Medical Transportation Services (Emergency and Non-Emergency)	The MHP is responsible for medical transportation services when the transportation is required to transfer an enrollee from one psychiatric inpatient hospital to another psychiatric inpatient hospital, or to another type of 24-hour care facility, when such transfers are not medically indicated. (i.e., undertaken with the purpose of reducing the MHP's cost of providing services.)	The Plan will cover at the Medi-Cal rate all medically necessary emergency and non-emergency medical transportation services for Plan members including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services. The Plan will cover at the Medi-Cal rate medically necessary non-emergency medical transportation services, when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP, when authorization is obtained.
11.12 Medical Necessity Criteria for Specialty Mental Health	The MHP will provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.	Beneficiaries whose diagnoses are not included in the applicable listing of MHP covered diagnoses may obtain mental health services through the Medi-Cal fee-for-service system under applicable provisions of Title 22, CCR, Division 3, Subdivision 1 (MMCD Policy Letter 00-01 Rev., page 16).

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.12 Medical Necessity Criteria for Specialty Mental Health (continued)	Medical necessity criteria, is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. The MHP will accept referrals received through beneficiary self-referral or through referral by another person or organization.	Plan members whose mental health diagnoses are covered by the MHP, but whose conditions do not meet the program impairment and intervention criteria, are not eligible for mental health care under the Medi-Cal fee-for-service program. These beneficiaries are eligible for care from a primary care or other physical health provider. The Medi-Cal fee-for-service system will deny claims from mental health professionals for such beneficiaries.
11.13 Nursing Facility Services	The MHP will provide medically necessary specialty mental services, typically visits by psychiatrists and psychologists who are credentialed by the MHP in a skilled nursing facility.	The Plan will arrange for nursing facility services for members who meet the Plan's medical necessity criteria for the month of admission, plus one month. The Plan will arrange for disenrollment from the managed care program if the member needs nursing services for a longer period of time. Skilled nursing facility services with special treatment programs for the mentally disordered are covered by the Medi-Cal fee-for-service program. These services are billed to the Medi-Cal fee-for-service system using accommodation codes 11, 12, 31, and 32, for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs). The Plan is responsible for these services in accordance with the terms of the Plans contract for coverage of long term care.
11.14 Pharmaceutical Services and Prescribed Drugs **(Out-Of-Plan Services)**	The MHP is not responsible to cover and pay for pharmaceutical services and prescribed drugs, including all medically necessary Medi-Cal psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services, which is included in the per diem rate. The MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist beneficiaries in receiving prescription drugs prescribed through the MHP, including, ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. The MHP will utilize the existing services of the Plan's laboratory or the services of the Plan's contracted laboratory providers, as needed in connection with the administration	The Plan will cover at the Medi-Cal rate pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, ***except*** when provided as inpatient psychiatric hospital based ancillary services or otherwise excluded under the Plan contract. The Plan will cover at the Medi-Cal rate psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions. A Plan may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.14 Pharmaceutical Services and Prescribed Drugs **(Out-Of-Plan Services)** (continued)	and management of psychotropic medications. Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD Policy Letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal Fee-For-Service system whether these drugs are provided by a pharmacy contracting with the plan or by a fee-for-service pharmacy provider.	Application of utilization review procedures should not inhibit a Plan member's access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan will ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. The Plan will not cover prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists; unless, these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited. Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD Policy Letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal Fee-For-Service system whether these drugs are provided by a pharmacy contracting with the plan or by a fee-for-service pharmacy provider.
11.15 Psychiatric Acute Inpatient Hospital Services	The MHP will be responsible for medically necessary psychiatric inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c). Psychiatric Inpatient Hospital Services for a fee-for-service Medi-Cal hospital will include in the per diem rate: • Routine hospital services • All hospital based ancillary services. Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal hospital will include: • Routine hospital services • All hospital based ancillary services, and • Psychiatric inpatient hospital professional services. The MHP will utilize the Plan contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for Plan members unless otherwise covered by the hospital's per diem rate.	The Plan will cover and pay at the Medi-Cal rates for all medically necessary professional services to meet the physical health care needs of the Plan members who are admitted to the psychiatric ward of a general acute hospital or a free standing licensed inpatient psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations. The Plan is not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.16 Physician Services	The MHP will not be responsible to provide or arrange and pay for physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, Psychiatrist Services, even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205.	The Plan will cover at the Medi-Cal rate physician services related to the delivery of outpatient mental health services, which are within the PCPs scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses, whose conditions do not meet the MHP medical necessity criteria. The Plan is not required to cover physician services provided by Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapist, or other specialty mental health providers. When medically necessary, the Plan will cover at the Medi-Cal rate physician services provided by Specialists such as Neurologists.
11.17 Provider Network and Member Education	The MHP will credential and contract with sufficient numbers of licensed mental health professionals to maintain a MHP provider network sufficient to meet the needs of the Plan members. The MHP will continually monitor the MHP provider network to ensure beneficiary access to quality mental health care. The MHP will assist the Plan in arranging for a specific MHP provider when the Plan is unable to locate an appropriate mental health service provider for a Plan member. The MHP will also assist the Plan to develop and update a list of provider or provider organizations to be made available to Plan members. Any updates to the list will be provided to the Plan upon request.	The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental health services as required by contract. Each Plan is contractually obligated to assist Plan members needing specialty mental health services, whose mental health diagnoses are covered by the MHP or whose diagnoses are uncertain, by referring such members to the local MHP. If a member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the member to an appropriate resource in the community, if known to the Plan, that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or other appropriate local provider or provider organization. The PCP will request assistance from the MHP whenever the PCP is unable to arrange for an appropriate MHP provider for a Plan member. The PCP will initiate a referral to the appropriate MHP provider or provider organization as recommended by the MHP. For those services that do not meet the MHP medical necessity criteria, a copy of the referral will be kept in the member's referral chart.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.17 Provider Network and Member Education (continued)		The Plan will collaborate with the MHP to develop and maintain a list of providers or provider organizations to be made available to Plan members.
11.18 Referrals	The MHP will accept referrals from the Plan staff, Plan providers and Plan Medi-Cal members for determination of MHP medical necessity. When medically necessity criteria are met, the MHP will arrange for specialty mental health services by a MHP provider. In the case of self-referrals or referrals from providers other than the member's PCP, in which the planned specialty mental health services involves a MHP psychiatrist, the MHP will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information. When medically necessity criteria are not met, or if it is felt that the member's mental health condition would be responsive to physical health care based treatment, the MHP will refer the member back to the Plan and the referring physician with the assessment results, diagnosis, need for service and/or recommendations for an appropriate provider to treat the member's symptoms. The MHP will encourage its providers to coordinate care with member's primary care provider. These referrals will be made through a referral form to assist in providing referrals to providers, provider agencies, or other sources of care for services not covered by the MHP. The MHP will encourage providers to secure the HSD Physical and Mental Health Care Coordination Form and guidelines (see attached). Referrals may include a provider with whom the member already has a patient-provider relationship, or a provider in the area that has indicated a willingness to accept referrals. This will include but is not limited to a Federally	The PCP will maintain responsibility for physical healthcare based primary mental health treatment, which includes: • Basic education, assessment, counseling, and referral and linkage to other services for all beneficiaries. The PCP will refer to the MHP for an assessment and appropriate services when: • An assessment is needed by the MHP to confirm or arrive at a diagnosis. • Mental health services other than medications are needed for a beneficiary with a diagnosis included in the responsibilities of the MHP. After the PCP's diagnostic assessment, the Plan or PCP will refer those members whose psychiatric condition would not be responsive to physical health care, to the MHP to determine if MHP medical necessity criteria are met. In the event a member does not meet the MHP criteria, the MHP will inform the Plan and PCP. The Plan will arrange for primary mental health services within the member's PCP's scope of practice. The Plan will encourage its providers to use the HSD Physical and Mental Health Care Coordination Form and guidelines (see attached). When the MHP informs the Plan and PCP that a member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, the Plan will refer for primary mental health services within the member's PCP's scope of practice.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.18 Referrals (continued)	Qualified Health Center (FQHC), a Rural Health Clinic, an Indian Health Clinic, or Indian Clinic. The MHP is not required to ensure a member's access to physical health care based treatment or to treatment from licensed mental health professionals for diagnoses not covered by the MHP. When the MHP has provided specialty mental health services and has determined that the member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, the MHP will refer the member back to the Plan and referring physician with the assessment and treatment results, diagnosis, need for ongoing service and recommendations for an appropriate provider to treat the member's symptoms. The MHP will utilize the Plan's referral authorization form and with the member's consent will inform the PCP of services provided and/or medications prescribed. The MHP will attempt to coordinate information with the member's other health care providers and ensure that contact with the Plan is made.	
11.19 Resolution of Disputes	The MHP will provide a resolution of dispute process in accordance to Title 9, Section 1850.505, Chapter 11. When the MHP has a dispute with the Plan that cannot be resolved to the satisfaction of the MHP, concerning the obligations of the MHP, or the Plan, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOA as described in Section 1810.370, the MHP may submit a request for resolution to the State Department of Mental Health (DMH). A request for resolution by either agency will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be	The Plan will provide a resolution of dispute process in accordance to CCR Title 9, Section 1850.505, Chapter 11 and the Medi-Cal contract between the Plan and the State Department of Health Services (DHS). When the Plan has a dispute with the MHP that cannot be resolved to the satisfaction of the Plan, the Plan may submit a request for resolution to the DHS. A request for resolution by either agency will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy including any disputed services that have or are expected to be

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.19 Resolution of Disputes (continued)	services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the MHP and the Plan will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process or any similar process offered by the Plan or to request a fair hearing. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP has determined that treatment would not be within the PCP's scope of practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.	services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the agency receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days, or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the Plan and the MHP will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the Plan's beneficiary problem resolution process or any similar process offered by the MHP or to request a fair hearing. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP has determined that treatment would not be within the PCP's scope of practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.20 Service Authorizations	The MHP will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the MHP for services that meet MHP medical necessity criteria. This will be done through the MHP access programs. Services will be rendered according to the MHP responsibility. MHP staff will be available to assist in coordinating care, including service authorizations. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.	The Plan and its subcontractors will authorize medical assessment and/or treatment services in accordance with the Medi-Cal contract with the State DHS. Plan staff will be available to assist in coordinating care and obtaining appropriate service authorizations. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.
11.21 Services Excluded from Coverage	The MHP will not be responsible to provide or arrange and pay for the following services: • **Medi-Cal services, that are not specialty mental health services,** • **Prescribed Drugs, and** • **Laboratory, Radiological, and Radioisotope services except** when provided as hospital-based ancillary services and included in the per diem. • **Medical Transportation Services, except** when the purpose of the medical transportation service is to transport a beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP. • **Physician Services**, that are not psychiatric services even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205. • **Out-of-State Specialty Mental Health Services except** when it is customary practice for a California beneficiary to receive medical services in a border community outside the State. • **Specialty Mental Health Services,** provided by a hospital operated by the department or the State Department of Developmental Services.	The Plan is not responsible to arrange and cover the services listed below to its members in accordance to the MOA and as contractually required. • **Medi-Cal Services**, that are specialty mental health services. • A copy of the drugs excluded from Plan coverage should be included as part of this MOA package. The drug list can be found as an enclosure to the MMCD Policy Letter 00-01.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.21 Services Excluded from Coverage (continued)	• **Specialty Mental Health Services,** provided to a beneficiary eligible for Medicare, prior to the exhaustion of the beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRG) when the DRG reimbursement covers administrative day services according to Medicare (Part A). • **Specialty Mental Health Services,** provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent that specialty mental health services are covered by the Medi-Cal Managed Care Plan. • **Psychiatric Inpatient Hospital Services,** received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a). • **Medi-Cal Services,** that may include specialty mental health services as a component of a larger service package as follows: 1. **Psychiatrist and Psychologist Services,** provided by adult day health centers. 2. **Home and Community Based Waiver Services** 3. **Specialty Mental Health Services,** authorized by the CCS program to treat CCS eligible beneficiaries. 4. **LEA Services** 5. **Specialty Mental Health Services,** provided by FQHCs, Indian Health Centers, and Rural Health Clinics. 6. **Home Health Agency Services** Beneficiaries whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Div.3, Subdivision 1.	
11.22 Services for the Develop-mentally Disabled	The MHP will refer members with developmental disabilities to Regional Centers for covered services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. When	The Plan's PCPs will refer members with developmental disabilities to Regional Centers for psychiatric and non-medical services such as respite care, out-of-home placement, supportive living services, etc, if such services are needed.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
11.22 Services for the Develop-mentally Disabled (continued)	appropriate, the MHP will inform the Plan, its delegated entity, and the PCP of such referrals.	
11.23 Specialty Mental Health Services Providers and Covered Specialty Mental Health Services (EPSDT)	The MHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 with full scope Medi-Cal is eligible for EPSDT supplemental services. If these criteria are met, the MHP will be responsible for arranging EPSDT supplemental mental health services provided by specialty mental health professionals. The MHP will pay for EPSDT supplemental services that are part of the member's specialty mental health treatment. If EPSDT supplemental mental health services or MHP medical necessity criteria are not met, the MHP will refer children who have a CCS eligible condition requiring specialty mental health services to their PCP for a referral to CCS. When the MHP determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, the MHP will refer the child to the PCP for treatment of conditions within the member's PCP's scope of practice. The MHP will provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205 and 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. The MHP will not be required to provide or arrange for any specific specialty mental health service, but, will ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as required or applicable. The MHP will provide specialty mental health services only to the extent the beneficiary is eligible for those services, based on the beneficiary's Medi-Cal eligibility under Title 22.	The Plan will assist the MHP and members by providing links to known community providers of supplemental services.

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

FINAL 06/12/03

COUNCIL OF COMMUNITY CLINICS

February 14, 2012

Dear Ann;

Let me share with you some of the innovations that the Council of Community Clinics is developing for our member health centers. We are working closely with our 16 member health centers in developing innovative solutions to prepare for health care reform in 2014.

One of these projects is the Central San Diego Health Home Collaborative which is funded by the Tides Foundation. The goal of the Collaborative is to transform the health of Central San Diego residents by enhancing the capacity of the safety net system to expand access to care, improve quality of care and patient and population health outcomes, and demonstrate cost saving through an integrated network of care supported by health information exchange and payment reform. The partners include Community Health Group, Scripps Mercy Hospital, UCSD Medical Center, La Maestra Community Health Center, Planned Parenthood of the Pacific Southwest, San Diego Family Care and San Diego American Indian Health Center.

Working together these partners represent the key components needed to develop and implement health homes and an integrated system of care for low income and underserved patients in the region. Project activities will also support the work that many primary care providers and safety net partners are doing to prepare for health care reform and implement provider of choice initiatives in their practice settings. Trainings will also focus on creating a Health Coach in each primary care setting to work with patients and their care teams in a proactive manner to ensure that the patients care is consistent and ongoing.

We are very proud of our partnership with Community Health Group.

Sincerely,

Stephen R. O'Kane
Chief Executive Officer

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