



**CONTRA COSTA HEALTH PLAN
RESPONSE TO CALIFORNIA'S
DUAL ELIGIBLE DEMONSTRATION
REQUEST FOR SOLUTIONS**

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Executive Summary

Contra Costa Health Plan (CCHP) is the oldest County-sponsored Federally Qualified Health Maintenance Organization (HMO) in the country. CCHP is an integral entity within the Contra Costa County Health Services Department and has nearly 40 years of collaboration with the County Public Hospital and Federally Qualified Health Center (FQHC) Ambulatory Health Center, as well as the Public Health, Mental Health, and Substance Abuse Divisions within the Health Services Department.

CCHP now proposes to operate a Dual Eligible Demonstration pilot project in Contra Costa County as this pilot offers the opportunity to implement the integrated model of health care and social services in the direction which we have been jointly working for over 15 years. In becoming a pilot, we will finally be able to realize the vision of the Aging and Long Term Care Integration (ALTCI) Project we undertook, under the auspices of AB 1040, in partnership with the Aging and Adult Services (AAS) Bureau of the Contra Costa County Employment and Human Services Department (EHSD). We were forced to put this vision on hold in 2006 because of lack of State support for our model which proposed to use interdisciplinary medical and social work care management to integrate

health care and Home and Community Based Services (HCBS) into a seamless service delivery system.

We believe that this pilot project offers the opportunity to develop a coordinated system of care that will result in better health outcomes for the dual population, allowing them to attain optimal levels of personal independence and thereby reducing unnecessary use of emergency room care, hospitalization, and nursing home placement. Under the pilot, it will be possible to rebalance their care by offering enhanced access to home and community-based alternatives to more costly and less desirable acute care and institutional long term care under an integrated funding model.

This pilot project anticipates enrolling about 80% of the 22,000 duals residing in the county over the course of calendar year 2013. CCHP and its contracted Contra Costa Regional Medical Center (CCRMC) and Health Centers already care for 42% of the current duals in Contra Costa County. There are only two other Special Needs Plans (SNPs) in Contra Costa County. Health Net and Kaiser. Health Net has a current enrollment of less than 1,000 SNP members. Kaiser has a current enrollment of 3100 SNP members in Contra Costa County. Together, Kaiser and Health Net represent 78% of duals in this county.

Key partners in implementing this pilot will be CCRMC and its eight FQHC clinics; the secondary contracted primary care and specialty and community FQHC network (CPN); the Behavioral Services Division of the County Health Services Department, which operates the homeless, mental health and substance abuse programs; the Aging and Adult Services (AAS) Bureau of the County Employment and Human Services Department, which administers both the In Home Supportive Services (IHSS) and Area Agency on Aging (AAA) programs for the county; Rehabilitation Services of Northern California (RSNC), operator of the Multipurpose Senior Services Program (MSSP), two newly credentialed Community Based Adult Services (CBAS) sites in the county (with MSSP), and the California Community Transitions (CCT) Program; and the Alzheimer Center of the East Bay, operator of the third CBAS site in Contra Costa County.

In addition, we have initiated a Contra Costa Coordinating Council encompassing a broad continuum of home and community based service providers to partner with CCHP in improving the dual population's access to long-term services and supports throughout the county. Kaiser, Blue Cross, and Health Net are recent additions to this Coordinating Council and have expressed interest in collaborative arrangements with CCHP to serve this population. Also, CCHP will formally expand its relationships with

existing county government appointed advisory bodies under a Dual Pilot Project, i.e. the Managed Care Commission (MCC) which already includes a dual member representative, Advisory Council on Aging, IHSS Public Authority Advisory Committee, and with behavioral health consumers to assure that stakeholders and consumers are actively involved in oversight of the planning, implementation, and ongoing operation of the pilot project.

Section 1: Program Design

Section 1.1: Program Vision and Goals

1.1.1 CCHP has a nearly 40-year experience as a Federally Qualified HMO and a California Knox-Keene licensed managed care plan and has provided choice as the local initiative in a two-plan Medi-Cal model plan with three networks. CCHP currently provides care to 88% of the Medi-Cal members enrolled in managed care in Contra Costa County. CCHP provides further choice within its Health Plan of three distinct Provider Networks: the CCRMC and its eight FQHC clinics, a separate Community Provider Network (CPN) consisting of multiple contracted primary care and specialty providers, and four community FQHC providers with separate sites across the county, as well as a third sub-capitated network with Kaiser Permanente.

CCHP provides 24/7 Advice Nurse services to both of its direct networks to assist members with health care advice linkages to appropriate care levels and referrals for both Urgent Care and Emergency Room care. CCHP members assigned to Kaiser receive 24/7 Advice Nurse services from Kaiser.

CCHP has served duals who voluntarily chose to enroll throughout its long history. More specifically, we have five years' experience serving duals as a Medicare Advantage (SNP) from 2007 through 2011 and

through their voluntary enrollment into the Medi-Cal plan administered by CCHP. Additionally, CCHP has successfully enrolled 91% of the Contra Costa County Seniors and Persons with Disabilities (SPDs) since June 2011.

During the five years that CCHP operated its SNP, there was an average of 165 dual eligibles enrolled in the program. CCHP met all of the care management standards required for serving that population and our Structure and Process measures were approved by NCQA. Our Model of Care, as well as our Quality Improvement Plan and Chronic Care Improvement Plan, were approved by CMS. The financial risk of serving so few members in the SNP program with several outliers and CMS refusal to allow small SNPs to qualify for higher rates under the Star Program proved finally risky and led to our decision to terminate the SNP contract effective January 1, 2012. It is anticipated that the much larger number of duals to be enrolled passively in the pilot will mitigate the financial risk we experienced for the much smaller voluntary enrollment in our SNP. There are currently approximately 3,160 duals voluntarily enrolled in CCHP for their Medi-Cal benefits. There are an additional 6,000 duals currently being treated by CCHP's contracted health partners, CCRMC and Ambulatory Health Centers.

1.1.2 The core mission statement of Contra Costa Health Plan with its County Health Department is that it cares for and improves the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems. The motto of CCHP is to provide “a culture of caring.”

Contra Costa County has a complicated framework of medical, mental health, substance abuse and public health programs that care for predominately low-income and uninsured people and to insure overall community health standards are monitored and met. Contra Costa Health Plan is one of seven divisions comprising Contra Costa Health Services (3,000 employees) which also include: Contra Costa Mental Health, Contra Costa Public Health, Contra Costa Regional Medical Center and Health Centers, Alcohol and Other Drug Services, Contra Costa Environmental Health, Contra Costa Hazardous Materials, and Contra Costa Emergency Medical Services.

Over 15 years ago, we initiated joint planning efforts with the Aging and Adult Services Bureau of the county to develop a health and social service coordinated model of care to better serve low-income seniors and persons with disabilities. Under the auspices of AB 1040 we jointly developed an Aging and Long Term Care Integrated model of care with the

involvement of a broad cross-section of community stakeholders, both consumers and service providers. We presented this model of care to the State in 2005-2006, but we were not successful in garnering the necessary administrative and legislative support to implement this model of care. The Duals Demonstration Pilot now offers us the opportunity to proceed to implement our earlier vision.

We anticipate that over time, the coordinated care system of the pilot project will result in better health outcomes for duals allowing them to attain their maximum level of personal independence thereby reducing incidences of emergency room care, hospitalization, and nursing home placement. The pilot will make it possible to rebalance their care by offering home and community based alternatives to more costly acute care and institutional long term care. The emphasis on streamlined and joint funding and passive enrollment under managed care allows this vision to become a reality.

1.1.3 Based upon our many years of planning and experience in delivering health care to the duals population, CCHP is committed to the overall goal of the Dual Eligible Demonstration Project to create a coordinated health, behavioral health, and social service delivery system providing consumer-centered care that will provide both improved health

outcomes and a better quality of life for those enrolled in the program. CCHP has established Health Risk Assessments, risk stratification to case management and care coordination as well as access to 24/7 Advice Nurse services for all of its 108,000 patients. These health interventions have been established with the Medi-Cal dual diagnosis population, the SNP population for duals, and the participants in the county's Low Income Health Program (LIHP) which CCHP administers. Therefore, this pilot will be able to achieve the following outcomes:

- Improve continuity of care and services by using care management to coordinate both medical and social benefits and access to care.
- Maximize consumers' ability to remain living in their own homes and in community settings, avoiding unnecessary institutional care by providing access to appropriate services and supports.
- Increase the availability and access to home and community based services for the duals thereby reducing the occurrence of acute care episodes and incidences of institutional long term care placement.

- Maximize the ability of consumers to self-direct their care, participate in decision-making regarding their care options, and receive high quality care
- Streamline health processes and improve care coordination and timely access to care leading to increased consumer satisfaction.
- Optimize the use of Medicare, Medi-Cal, and other State and County resources by making CCHP, as a single entity, responsible for overall care coordination.

Section 1.2: Comprehensive Program Description

1.2.1 Based upon our experience with both the TANF, SPD and CBAS populations, we estimate that between 80% and 90% of the dual eligible population not currently enrolled in an SNP in the county will enroll into the pilot under passive enrollment with an opt-out feature. There are currently 3,160 duals enrolled in CCHP and an additional 6,000 duals already being treated by CCRMC and its Health Centers. This would result in a total dual enrollment of between an approximately 12,000 individuals by the end of 2013. We would be responsible for providing access to the full spectrum of both Medicare and Medi-Cal health care benefits including long-term custodial care in Nursing Facilities, MSSP, CBAS, IHSS, mental

health, and substance abuse services throughout the entire county. Thus 42% of duals are already aligned with CCHP. Kaiser, as a sub-capitated provider, has expressed interest in collaborating with CCHP and their current SNP members. Health Net as the other SNP in Contra Costa County has also indicated a willingness to work directly with CCHP and its SNP members.

Health care services will be delivered through expansion of existing contracts and agreements with the Contra Costa Regional Medical Center in Martinez and its eight neighborhood clinics, which comprise a broad network of primary care physicians and medical specialists in a publicly operated setting administered by the County Health Services Department; and our secondary network CPN which includes a comprehensive array of private primary care providers (PCPs), medical specialists, community FQHC clinics, hospitals, and other ancillary health care providers. Prescription drugs will be provided through the expansion of our current Pharmacy Benefit Management contract. Also, we will maintain and expand our contractual relationship with 33 skilled nursing facilities in all geographic regions of the county to ensure an adequate supply of beds for duals. We would provide the supplemental benefit of worldwide emergency

care and are considering providing enhanced non-emergency transportation as a benefit.

We are expanding our existing Care Management unit of nurses and social workers to manage and coordinate the full spectrum of medical care and long term services and supports. We are collaborating by contracting a portion of the care management of home and community based services to Rehabilitation Services of Northern California (RSNC) given their extensive experience providing MSSP, ADHC, and Community Transition services in Contra Costa County. CCHP will also expand its care tradition, where we have managed a Part D Program for the five-year SNP for duals. CCHP will also expand its Coleman Model Care Transitions Intervention Program (CTI) with two of our largest hospitals to assure appropriate medication and follow-up care for hospital-discharged patients at high risk for hospital readmission and avoidable Emergency Room use. CCHP will also expand its Emergency Room Intervention Program where we send patients showing several avoidable Emergency Room visits by use of the New York Algorithm of Preventable Emergency Room letters explaining their care alternatives and using them to contact our 24/7 Advice Nurse Program.

CCHP is contracting with RSNC for the delivery of CBAS at its Antioch and Pleasant Hill sites for duals residing in eastern and central Contra Costa County and with Guardian Day Health and CBAS for west County. We will expand the contract for MSSP services for duals throughout the county to assure delivery of intensive case management and waived services to duals at significant risk of placement in skilled nursing facilities but still able and willing to reside at home with this assistance. This will also ensure access to Community Transition services countywide for duals potentially able to leave skilled nursing facilities.

As a county government agency, CCHP will develop interdepartmental agreements with both the Aging and Adult Services Bureau (AAS) of the County Employment and Human Services Department (EHSD) and with the IHSS Public Authority for delivery of IHSS to eligible duals. Aging and Adult Services social workers will continue to perform assessment and authorization of IHSS; however this process will be coordinated with CCHP care management staff to ensure that the IHSS authorization is congruent with the overall care plan for the individual consumer. The agreement with the Public Authority will acknowledge its ongoing role in recruiting, screening, enrolling, training and paying

providers based upon the negotiated collective bargaining agreement with the union representing the providers.

Moreover, the agreement with AAS will also recognize that agency's role as the Area Agency on Aging (AAS) for the county and will clarify procedures for assuring access for the dual members to the comprehensive array of home and community based services provided by that agency and its subcontractors under the Older Americans Act and Older Californians Act, i.e. information and assistance; congregate and home delivered meals; legal services; home visiting; home chore registry; social day care; health insurance counseling and advocacy; long term care ombudsman; and family caregiver support. Also, the agreement with AAS will incorporate working procedures for duals accessing Adult Protective Services administered by that agency. Collaboration with the County's 211 Resource Program and Crisis Line for more information for duals is also beginning for this pilot.

Similarly, an intradepartmental agreement will be expanded with the Division of Behavioral Health of the Contra Costa County Health Services Department for delivery of mental health and substance abuse services. This agreement will outline the collaborative coordinated care system currently being developed in partnership with the CCRMC and Ambulatory

Health Centers and will specify how dual consumers with mental health and substance abuse service needs will access necessary treatment and care. Interdisciplinary care planning and coordinated care management will be developed between the CCHP Care Management unit and Behavioral Health staff. Three separate pilots of Behavioral Health Integration are currently occurring between Mental Health and the Ambulatory Health Centers. These pilots are currently being evaluated prior to expansion in 2012.

In consultation with AAS Independent Living Resources of Solano and Contra Costa Counties, and the Independent Living Center (ILC) serving Contra Costa County, we will mutually determine the feasibility of developing an Aging and Disability Resource Center service delivery model from the existing information and assistance services already being provided by those agencies to both the elderly and adults with disabilities.

1.2.2 CCHP has been in operation as a county operated health maintenance organization for nearly 40 years and has extensive experience operating capitated managed care programs. We have offered prepaid Medi-Cal benefits since 1972 and have provided fee-for-service Medicare benefits since 1978. We had a SNP for five years from 2007 – 2011. We have a fiscal infrastructure in place that can readily be adapted

to further integrate Medicare and Medi-Cal funding for duals. We pay our own claims and maintain a large database for funding and utilization management.

1.2.3 The empirical evidence underlying the integrated model of care to be implemented in this Dual Eligible Pilot has shown, in both California and across the country, that this integrated model offers both financial incentives and a care management structure that is capable of diverting health care resources away from more expensive emergency care, hospitalization and nursing home care to less costly home and community based services. Inclusion of institutional skilled nursing care in the capitated rate for the pilot will create a fiscal incentive to shift care to such services as IHSS, CBAS, social day care, home visiting, chore services, and home health care whenever they are an appropriate alternative. The capitated model will make it possible to enhance the scope of HCBS, making it more possible to encourage family caregivers to continue providing care in the home environment. Moreover, to the extent the pilot program is successful in promoting effective self-care among members and appropriate use of primary care physicians while reducing episodes of emergency care, hospitalization, and unnecessary SNF placement, the resulting savings in Medicare and Medi-Cal funding will make available

additional resources to expand alternative HCBS and enhance care management, health care education, and outreach activities to the dual eligibles. The utilization of the EPIC System Electronic Health Record (EHR) for both CCRMC, health clinics and CCHP will provide an easier tool for providers to utilize evidence-based guidelines in care practices.

1.2.4 The care management component of this integrated care model will promote the ability of members to manage their own self-care to the greatest extent possible. CCHP will use a both a self-screening tool and the Health Risk Assessment tool currently being used by Case Management staff for the SPD and SNP populations to identify dual eligibles at risk of medical problems and/or inappropriate emergency care, acute hospital care or nursing home placement. In addition, Case Management staff will utilize risk stratification to review individual diagnoses and prior utilization patterns to identify high-risk individuals, e.g. members of historically underserved groups; members of groups with identified health disparities; members suffering from multiple co-morbidities and serious chronic conditions. Data reviewed includes the following:

- Monthly RAPS (claims) data reports.
- Monthly enrollment data of new members into the CCHP plan.
- Monthly pharmacy data reports.

- Review of discharge summaries received from CCRMC.
- Lab data collected during the Health-Risk Assessment process.
- Weekly collaborative CM/UM case conferences with CCHP Medical Director for concurrent review of admissions/discharges at community hospitals.

Members identified as high-risk will receive a comprehensive assessment to determine their personal strengths and limitations and to develop a care plan to provide appropriate medical care and to offer access to those LTSS and HCBS which can assist in mitigating the impact of their medical conditions and in living as independently as possible. Their care plans will promote members' self-empowerment to the greatest extent possible in order to maintain or increase their independence and avoid episodes of unnecessary health care intervention. CCHP staff will contact the member within 90 days and perform a health screening exam. Three times during the first two weeks after new enrollment notification, CCHP will attempt to contact the member by telephone no less than once a week. If the Health Plan is unable to contact the member during the first two weeks, subsequent efforts to contact the member are performed weekly. If CCHP is unable to contact the new member by phone by the 45th day after enrollment notification, CCHP will send a written communication to the

member, informing the member to contact the Health Plan. Attempts to contact the member will be documented on the Health Risk Screening form and kept by the Health Plan.

Once the health information is collected, a nurse will screen all completed forms and if needed, forward a copy of the form to appropriate staff if follow-up needed, such as enroll in disease management, or explore the need for complex case management. In addition, a copy of the assessment will be sent to the primary care provider.

1.2.5 CCHP believes that they can easily utilize their existing Case Management resources, and contracts with MSSP and IHSS to meet the requirements of the Health Home soon to be offered to HMOs in California. This model integrates well with the Medical Homes already in place with the majority of the contracted primary care providers with CCHP. Under authority of Sec. 1945 of the Social Security Act (Section 2703 of the Patient Protection and Affordable Care Act-ACA), California will consider submitting a State Plan Amendment for CMS approval to engage in a Health Home care model. As of this date, California has applied for and received a CMS planning grant to explore the Health Home state option. CCHP believes that in the event California participates in this model, we can utilize our existing managed care plan in Contra Costa County to assist

in the statewide implementation of this model. Consultants to the state have already identified the Managed Care Delivery System as one of seven potential Health Home model options. They have further identified a “Dual-Eligible” sub-option to the Managed Care Option that efficiently aligns with the Dual Pilot project. CCHP’s extensive history and experience as a Medical plan and SNP would assist in meeting the goals of enhancing integration and coordination of care, creating person-centered systems of care improving outcomes, care experiences, and overall value.

1.2.6 Among the major challenges facing this pilot program is uncertainty over whether the rate development process will result in appropriate risk adjustment for the actual population of dual eligibles to be served. It will not be possible for Contra Costa County and CCHP to accept the financial risk for this integrated model unless the capitation rate and methodology are adequate. The funding for the pilot must provide adequate financial resources to build the type of comprehensive care management infrastructure necessary to perform the complex assessment, care planning, monitoring and evaluation tasks that are critical to successfully caring for the duals.

In order for CCHP to assume the financial risk and ultimately sign a contractual agreement with DHCS and CMS to operate a pilot program, it is

essential that DHCS provide, in a timely fashion, the detailed data needed to project potential financial risk. CCHP needs to receive recent cost utilization and demographic data from Medi-Cal, Medicare, and IHSS for the dual eligibles residing in Contra Costa County including risk profiles, diagnoses, chronic conditions, medical providers, LTSS usage, including skilled nursing and waiver programs, age distribution, and residential ZIP codes. We will need to carefully review and analyze this data to determine that an eventually agreed upon capitation rate will not put CCHP and Contra Costa County Health Department in an unacceptable financially risky position.

The short timeline for pilot implementation is also particularly challenging. Extensive pre-implementation activities including education and outreach to potential members, providers, caregivers and community stakeholders will all need to be accomplished by the end of calendar year 2012. We have already set in motion a wide variety of collaborative efforts with our key partners and other community stakeholders to begin these efforts. We have met with a cross-section of essential LTSS providers and, as a result of that session, established a Coordinating Council of service providers that has begun convening to organize pre-implementation activities. We have also met with leading community advocates for seniors

and persons with disabilities, i.e. the Managed Care Commission, the County Advisory Council on Aging, and the Access to Care Stakeholders Group. We just met with the Contra Costa County Health Integration Committee of both County Mental Health and community mental health and substance abuse agencies to discuss further collaborative efforts at Behavioral Health integration with primary care and the needs of duals. We will be scheduling additional meetings with other advocacy bodies including the IHSS Public Authority Advisory Committee, city committees on aging, caregiver support organizations, labor union representatives, and others. Also, we will be working with the Health Insurance Counseling and Advocacy Program (HICAP) to assure that their corps of counselors will be knowledgeable about the pilot project when they assist dual eligibles in making their decisions about participating in the pilot. Conversations about collaboration with both Kaiser and Blue Cross have begun but need further state guidance on sub-contracted models with other community SNPs.

Moreover, the ability of CCHP to obtain needed HCBS for the duals will be particularly challenging in the current political environment when many of those service providers have experienced major program reductions in recent years due to Federal, State, and local government budget reductions. Rebuilding and expanding their service delivery

capabilities will take time as CCHP gradually shifts expenditures for the duals from skilled nursing and acute care to HCBS. The collaborative working relationship that has already begun with our key partners, County AAS, Rehabilitation Services of Northern California, and Guardian Adult Day Care will, in part, focus on determining how these agencies can work with the pilot project to enhance access to their home and community based services i.e. area agency on aging services, IHSS, adult protective services, CBAS, MSSP, and Community Transition Care.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

2.1.1 The Case Management and Utilization Management Units of CCHP currently authorize and coordinates health care for members within established guidelines. For the Duals Pilot, these guidelines will be expanded to include facilitating access to and/or authorizing purchase of LTSS as well as conventional Medicare and Medi-Cal health care services. Case managers will be responsible for facilitating communication with medical team members and other agencies and community based organizations serving the dual members. The integrated care management model requires active coordination and communication among the Case Management staff, the member, caregivers, family members, community based service providers, the primary care physician and other health care practitioners. Shared decision-making is an important element of integrated case management and already incorporated in our CCHP Case Management procedures.

Monitoring the outcomes of the authorized care plan across a variety of care settings will require coordination among many professionals and agencies. Case managers must have access to direct care provider information across the continuum of medical and HCBS providers. CCHP will create a system for collecting data and monitoring the effectiveness

and quality of HCBS being delivered to the duals under individual care plans. In addition, guidelines will be established for triggering reassessments and care plan revisions when there are substantive changes in the dual member's physical condition, functional abilities, or social environment. Such a monitoring system is an important element in being able to intervene promptly to avoid and/or minimize episodes of inappropriate or unnecessary emergency room care, hospitalization, or skilled nursing care.

2.1.2 CCHP has developed a formal contracting relationship with the three CBAS agencies in our county and will be expanded to include duals and MSSP services currently co-located with one of the CBAS agencies. That process will be used as a model for the Dual Pilot's need to be able to contract for a broad range of HCBS, possibly including such services as personal care, transportation, personal security devices, family caregiver respite, chore work and home repair/modification, social day care, meal delivery, or assistive devices. Collaboration with RSNC, the MSSP agency in our county, will be helpful in modeling contracts upon existing MSSP vendor agreements and reimbursement rates for purchase of HCBS.

2.1.3 As noted earlier, CCHP has developed three Health Risk Assessments (HRAs) for the Low Income Health Plan (LIHP), SPD and

SNP population's members. Health Risk Assessments currently in use when enrolling SPDs into CCHP, will be utilized in the Duals Pilot Project to identify high-risk individuals in need of a comprehensive assessment. This comprehensive assessment process will be built upon the guidelines developed in 2005 under the ALTCl project. Those guidelines specify that the best assessment is one that provides the maximum amount of relevant information in the least invasive and duplicative manner and which builds upon assessment information already collected by other programs. This assessment information needs to be readily available to the PCP and other clinical practice team members, to the dual member himself or herself, and to their families, as appropriate under HIPAA guidelines soon after enrollment and ongoing. One of the key assignments of our forthcoming Coordinating Council of service providers will be to consider methodologies for streamlining and/or consolidating the assessment tools currently in use for the various LTSS and health care programs that they administer for working with the pilot project.

The assessment process should identify the member's strengths and limitations so that effective and appropriate interventions can be delivered to prevent or delay functional decline and institutionalization. Both initial and ongoing reassessments must be comprehensive and facilitate clinical,

behavioral, social service, and member self-care interventions. It must consider the interrelationship between the physical, psychological, social, and supportive conditions in the member's environment.

The assessment tool must facilitate the development of a care plan. The assessment and care planning process would include not only the CCHP case manager and member but, guided by the member's preferences, encompass the broader care community, including community based service providers, the PCP, medical home teams, caregivers, and family members as appropriate. The goal of the process is to create a care plan that wraps HCBS around medical services in a seamless system of care. This process will also be utilized in the Health Home.

2.1.4 CCHP currently contracts with 33 SNFs in Contra Costa County as well as two acute rehabilitation facilities. Additionally, our case managers collaborate with board and care homes, Meals on Wheels, IHSS and the new CBAS agencies to refer and assist in the development of care plans for fragile members. We have included periodic consultation with the County Ombudsman for SNF contracting input.

2.1.5 CCHP is developing a plan to hire nurse practitioners with physician oversight to provide care to patients in SNFs to prevent unnecessary deterioration of medical care, E.R. visits or hospitalizations.

These nurse practitioners will consult with the SNFs and refer back to CCHP Case Management to assist with discharge planning for patients able to move to lower levels of care or back to a home setting. The case manager will coordinate referrals to other community partners such as IHSS, MSSP, and CBAS.

Section 2.2: IHSS

2.2.1 SEE CERTIFICATION CHECKLIST

2.2.2 IHSS is by far the largest and most readily available HCBS for which many dual consumers are eligible because of their functional limitations. Thus, it is essential that the pilot project, during its second and third year of operation, work towards implementation of a care coordination model integrating the IHSS program into the overall case management process through exploration of the following options:

- Screening dual members requesting or referred to IHSS services for possibly needing a comprehensive assessment of their health and social situation in order to avoid unnecessary episodes of emergency care, hospitalization, or skilled nursing care.
- Including the IHSS social worker assessment as part of a more comprehensive assessment of the member's social and health situation.

- Authorizing IHSS hours as part of a continuum of services specified in a comprehensive care plan developed through a collaborative interdisciplinary team process encompassing both social work and health care perspectives.
- Providing alternative personal care options for dual members who are not able to direct their IHSS care provider due to mental or physical illness, diminished mental capacity such as dementia or Alzheimers, or undue influence.
- Develop tools to monitor the quality of personal care being provided to dual members under the IHSS program and identify areas requiring improvement.
- Address the identified quality issues by undertaking a collaborative planning process with the Public Authority, Public Authority Advisory Committee, and IHSS provider union representatives to develop training curricula and create incentives for care providers to enhance their skills and abilities, especially for dealing with IHSS duals suffering from dementia as well as other issues identified in quality reviews.
- Identify the possibility of training resources (including possible development of career ladder opportunities) for IHSS providers

being made available from multiple CMS Innovation Challenge Grant proposals submitted by SEIU, County Health Services, and the County Welfare Directors Association to CMS and currently under review.

- In collaboration with the Public Authority registry identify alternative personal care resources in emergency situations such as bridging the gap when IHSS has not yet been authorized but a dual member is facing imminent discharge from the hospital or when an existing provider is temporarily or permanently unavailable on short notice before an appropriate independent provider replacement can be identified and enrolled.

Section 2.3: Social Support Coordination

2.3.1 SEE CERTIFICATION CHECKLIST

2.3.2 The CCHP Care Management unit is familiar with the full range of HCBS in Contra Costa County available to the dual population. The care planning process will include referral to local community programs that provide services to duals. CCHP case managers will refer dual members in need of these services to the individual service providers, for programs for which they are either eligible and/or able to purchase themselves. This range of services includes CalFresh (Food Stamps); congregate and home

delivered meals; Food Bank grocery assistance; social day care; paratransit; home visiting and tele-care telephone reassurance; home chore registry; housing and respite care; legal assistance; assistive technology assistance; and independent living skills counseling.

2.3.3 Partnership with the AAS Information and Assistance Program, Independent Living Resources and the Contra Costa Crisis Center 211 line will be essential for keeping the Case Management staff informed about service availability and changes to the HCBS service system in the county. There is no Aging and Disability Resource Center (ADRC) in operation in Contra Costa County. However, as part of the implementation process for the Dual Pilot, CCHP will collaborate with the above programs to determine how their existing staff can work together with CCHP Case Management staff to provide more intensive counseling to dual members in need of in-depth assistance regarding access to available aging and disability resources in the community.

2.3.4 CCHP currently partners with the Homeless Program in Public Health, including sharing utilization data. We have added representatives from the Public Health Homeless Program, SNF, Assisted Living and Board and Care Association, and the Housing Authority to our Contra Costa Coordinating Council for further strategic planning and collaboration.

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

3.1 The Contra Costa Health Department has previously committed to the integration of Behavioral Health with Primary Care. The three divisions of Mental Health, Substance Abuse, and Homeless merged into one Division in 2011. Currently, there are three separate pilots now in the evaluation stage of Mental Health integration with Primary Care. The first two pilots involve different methods for improving both access and integration of Mental Health into Primary Care.

- 1) Co-location with Psychological Interns (Wright Institute) into Primary Care has existed for the past year. Referrals from PCPs to these Behaviorists occur with shared data access.
- 2) Co-location of psychiatrists are occurring as “warm hand-offs” within a Primary Care setting.

These professionals also provide consultation liaison work for the PCPs on co-morbid conditions and particularly for medication management. Additional collaboration between the Ambulatory Care Chief and Mental Health regarding shared screening tools are under development.

3.1 The third pilot currently in process has established a nurse practitioner in the County Mental Health Clinic for the seriously and persistently mentally ill. The nurse practitioner works on the medical issues

with this vulnerable population, who have previously only been willing to seek care for their mental health issues.

3.2 CCHP will continue the partnership already established with the Director of Behavioral Health and Homeless Program. Recruitment of other geriatricians with Behavioral Health experience has been successful and will continue with the Contra Costa Ambulatory Health Centers.

3.3 The Medical Homes are being expanded at the County Ambulatory Health Centers and the contracted FQHCs with the CCHP CPN network are hiring behaviorists (often social workers or marriage and family counselors) to support the Medical Home. These developments all include co-location and multidisciplinary care teams with PCPs, nurse practitioners, RNs, dieticians, and health educators.

3.4 The Contra Costa Coordinating Council will also include representatives from Mental Health and Substance Abuse. Additional discussion has already occurred with the CCHP Managed Care Commission which includes a dual member representative, Mental Health Integration Committee, and the Executive Committee of the Council on Aging, who will all provide input to the pilot development.

Section 3.1: County Partnerships

3.1.1 The third pilot currently in process has established a nurse practitioner in the County Mental Health Clinic for the seriously and persistently mentally ill. The nurse practitioner works on the medical issues with this vulnerable population, who have previously only been willing to seek care for their mental health issues.

The nurse practitioner works under the medical direction of the Ambulatory Health Chief to assist in chronic condition management and medication compliance issues. Data is shared between the Ambulatory Care chart and Mental Health for coordinated patient care. This pilot involves collaboration between the County Ambulatory Centers, County Department of Managed Mental Health and Department of Substance Abuse Services.

3.1.2 The above pilot resulted from a joint grant proposal to Calmend between CCHP and Mental Health, which funded the Nurse Practitioner model. All three of the pilots described in 3.1 and 3.1.1 are being evaluated by the contracted agency Resources Development Associates under a separate Blue Shield grant written by CCHP to assess models of Behavioral Health Integration with primary care. The CEO for CCRMC, Ambulatory Care Chief, and Director of Behavioral Health will develop expansions of successful pilots in 2012-2013. These models post-

evaluation will be modified and expanded. The implementation of EPIC, an EHR (July 2012), will simplify many of the challenges for patient identification, data exchange and care coordination. CCHP and its case managers will also be moving to EPIC in July 2012 so that care coordination across all entities will be enhanced. This new EHR will increase the care coordination now occurring between CCHP Case Management and Mental Health Case Management in monthly meetings for Medi-Cal and dual members of CCHP.

Section 4: Person-Centered Care Coordination

4.1 CCHP is committed to creating a person-centered care coordination model for the Duals Pilot. The assessment and care planning process will be focused upon the individual health and social situation of the Duals Pilot member. Care plans will authorize and/or recommend a set of available interventions and services that meet the unique needs of the member and that maximize his/her ability to live as independently as possible in the community.

In this person-centered care model, the care management team must have the capability to comprehensively assess care needs stemming from medical conditions, physical disabilities, functional limitations, intellectual limitations, mental illness, substance abuse, and cognitive limitations due to dementia or Alzheimer's disease. As part of its assessment, the care team must gather information about the living situation of the individual and determine how his/her social environment may impact his/her health care situation. The care management team must be personally knowledgeable about or have ready access to professional staff familiar with the full range of local services and resources that are available to meet the unique needs of each person being served.

For those dual members suffering from Alzheimer's disease, dementia, or other physical or mental conditions that impair their cognitive

ability to fully participate in the assessment and care planning process, CCHP will work with appropriately designated trustworthy family members or other personal representatives of the member to speak on behalf of their personal needs and preferences. Moreover, care plans for members with impaired cognitive ability must take into account the need for frequent ongoing monitoring to minimize identified risks of abuse, neglect, or exploitation. CCHP Case Management staff currently conduct HRAs and use risk stratification to identify patients upon enrollment to focus enhanced care coordination with patients and caregivers to meet their needs.

4.2 SEE ATTACHMENT #2 THE MODEL OF CARE COORDINATION FOR DUAL ELIGIBLES (AS OUTLINED IN APPENDIX C)

4.3 The multiple Federally Qualified Health Centers, which either exist in the County clinics or in the contracted CPN network, already refer to Case Management and Advice Nurse Services at CCHP. All of the CCHP providers, including those at the sub-contracted Kaiser network, currently receive the HRAs from the CCHP Care Unit upon enrollment. Additionally, they receive the Case Management Care Plan and care communication occurs between the PCPs and the case managers for patients under Case Management.

Further Medical Home and Health Home development will result in additional training, data exchange and care team participation.

Section 5: Consumer Protections

5.1 SEE CERTIFICATION CHECKLIST

Section 5.1: Consumer Choice

5.1.1 As part of the enrollment process into CCHP, each new dual member will receive an enrollment packet with the list of PCPs available under the two provider networks offered, i.e. CCRMC Network or the CPN. Members are free to choose their PCP's from those lists. Those new members who do not choose will be assigned to providers they have used in the past to the extent that utilization information is available. New members who are in the midst of specialized treatment with a provider who is outside the CCHP provider network will be allowed to continue with their current provider for a limited period of time provided that provider agrees to accept CCHP reimbursement rates. This process includes time for physician recruitment to CCHP.

CCHP refers patients upon medical criteria to numerous specialists. There is significant specialist choice within each of the three networks as appropriate.

The assessment process will offer the dual member the opportunity to specify personal representatives, caregivers, and service providers he/she would like to participate in assessment and care planning.

5.1.2 It will be assumed that members will be a full participant in the assessment and care planning process and will be self-directing their HCBS care unless the assessment process determines that the member lacks the capability to assume those responsibilities. The care planning process will provide the necessary information and explanatory detail to members for them to be full participants in that undertaking. Where there is a choice of service providers available, members will be given the option of selecting from among them.

For those members who choose not to participate in the care planning process and for those found to have physical, mental, or cognitive limitations which impair their ability to participate in care planning or to self-direct their care, Case Management staff will seek to find appropriate surrogates (e.g. family, caregivers, or service providers) to assume those roles on the members' behalf.

Section 5.2: Access

5.2.1 SEE CERTIFICATION CHECKLIST

5.2.2 CCHP performs ongoing management of Provider Networks and monitors routine and urgent accessibility to care. We conduct the DHCS Enhanced FSR (Facility Site Review) in the credentialing process of

all PCPs. Physical and Disability access accommodation are rated as part of that contracting process.

5.2.3 This physical and disability access accommodation information is shared and provided to members through both hard copy and electronic Provider Directory Access.

Section 5.3: Education and Outreach

5.3.1 Contra Costa Health Plan will ensure effective communication with the dual beneficiaries by publishing all written communications at a 6th grade reading level. After enrollment in the health plan, beneficiaries will receive an Evidence of Coverage and Disclosure Form (EOC). The EOC and Disclosure Form will be written as stipulated in Title 28, CCR, Sections 1300.51 (d) Exhibit T and U and Title 22, CCR, Section 53881.

All written communications will be translated into the identified threshold and concentration languages in large-size print, Braille and audio format. These alternate formats will be made available upon request. The Member Services Guide will ensure Members' understanding of the health plan processes and ensure the Member's ability to make information health decisions. The Guide will constitute a fair disclosure of the provisions of the covered health care services. It shall meet the requirements contained in the Health and Safety Codes, Section 1363 and Title 289, CCR, Section

1300.63 (a) as to print size, readability, and understandability of text. Written materials will be submitted to DHCS and CMS for approval prior to use.

All electronic information and technology will comply with section 508 Federal Criterion. Telecommunications products such as voice mail, auto-attendant, and interactive voice response telecommunications systems shall be usable by TTY users with their TTYs.

5.3.2 CCHP has completed extensive training with all contracted providers on the linguistic, cultural and physical needs required to care for the SPDs and duals. A database has been established by CCHP upon enrollment (REAL) which identifies the race, ethnicity and language used by the member verbally and their preferred written language. This database is shared with the providers throughout the County Ambulatory Care Centers. Well-developed translation service access is also available through HCIN, which includes certified translators and video monitors for them in exam rooms as well as Language Line contractors for phone translation. Providers have already received training for physical and disability access with SPDs in written, video and presentation formats.

5.3.3 SEE CERTIFICATION CHECKLIST

Section 5.4: Stakeholder Input

5.4.1 Our stakeholder engagement plan will build upon the long history of stakeholder engagement CCHP and AAS pursued during the many years of planning the ALTCl project under the auspices of AB 1040. During the decade-long period of 1996-2006, a broad cross-section of consumer member representatives, service provider organizations, and health care and social service professionals participated in advisory committee meetings, public forums, and program design committees to provide input and feedback regarding the design of an integrated model of both health care and social service long term care for the County.

In preparation for the development of this Dual Demonstration proposal, CCHP convened a meeting of key service providers in January 2012 to provide an overview of the Dual Demonstration Pilot and to begin a collaborative process of identifying the respective roles of each agency in the implementation of the project. The participants invited included representatives of the Area Agency on Aging, IHSS, future CBAS programs, Independent Living Resources Center, Meals on Wheels, crisis centers, residential care, skilled nursing, ombudsmen, and CCHP Case Management. As a result of that meeting, we have established a Contra Costa County Coordinating Council of service providers comprised of health care, aging, disability and behavioral health professionals which

have been meeting to begin working on implementation issues for the Dual Demonstration Pilot.

In addition, CCHP staff made presentations to the County Managed Care Commission (January 2012) whose membership includes consumer representatives as well as health care professionals, to the County Advisory Council on Aging Executive Committee (February 2012), and to the Access to Care Stakeholders Group (February 2012) regarding the opportunities offered by the Duals Demonstration Request for Solutions and to discuss future opportunities for stakeholder involvement in the project design.

The stakeholder engagement plan for the pilot will necessitate creation of a Pilot Project Advisory Committee by July 1, 2012, under the umbrella of the existing Managed Care Commission which oversees CCHP. This proposed Advisory Committee would have as its core membership representatives from key County Board of Supervisors-appointed advisory bodies, i.e. the Managed Care Commission, the Advisory Council on Aging, and the IHSS Public Authority Advisory Committee, all of which have members who are duals themselves and whose members are recognized as important advocates for the dual population of the County. Behavioral health professionals and consumer

representatives will also be invited to participate on this advisory committee. This body would likely meet on a monthly basis during the run-up and early implementation phases of the pilot. This advisory body could be a useful sponsor of public meetings to gather broader stakeholder input regarding design and implementation issues.

5.4.2 After the initial start-up months of the pilot project, this proposed Advisory Committee would meet bi-monthly or quarterly. After the initial start-up period for the pilot is over, this Advisory Committee would sponsor periodic public meetings to report to the public regarding achievements of the pilot and for receiving public and consumer feedback on a regular basis.

The Coordinating Council of providers would be the major vehicle for assuring a platform for provider stakeholders to provide input and feedback regarding ongoing operations of the pilot project. It can provide the venue for developing collaborative solutions regarding operational problems and issues that will inevitably arise during pilot implementation. It will focus on overall project operational issues as well as on addressing the need for improvements in the availability of HCBS for the dual population. It would continue to meet monthly or bi-monthly depending upon the volume of issues needing to be discussed. It will set up working subcommittees or

task groups to focus on specific service delivery issues identified as the pilot project proceeds.

5.4.3 CCHP has long worked with the MCC as its Health Plan advisory body and has extensive history and experience in consulting that body for consumer and stakeholder input regarding the operations of the health plan. In working with a pilot project advisory committee and the Coordinating Council of service providers, CCHP would apply the same principles of meaningful stakeholder involvement that have been followed with the MCC. Both of these entities would serve as vehicles for receiving public input regarding all aspects of pilot project, including program operations, benefits, access to services, grievances, and consumer protections.

Section 5.5: Enrollment Process

5.5.1 Unlike some other regions of the state, the SPD enrollment in Contra Costa County for CCHP has enrolled over 8,000 SPDs since June 2011, with only 15 patient complaints in eight months. This represents 90% of the eligible SPDs in Contra Costa County during this time period. We would expect to follow a similar process for enrolling the duals into this proposed pilot on a monthly basis. As the proposal specifications allow for no more than a one year roll-out of enrollment, we would recommend

enrolling one-twelfth of the duals each month beginning January 2013 based upon birth month. This process allows HRAs, PCP assignment and continuity of care issues to be resolved quickly with a manageable population.

We are pleased that the proposal specifications provide for passive enrollment with a voluntary opt-out, thereby likely assuring that there will be adequate enrollment numbers to make the pilot financially viable. Duals should be notified 90 days before their scheduled enrollment date of the benefits available to them under the pilot and would be informed that they will be enrolled in the project unless they inform the state within 30 days that they choose to remain in fee-for-service or want some other option available to them, e.g. PACE which will remain carved out as a unique benefit in this county.

For purposes of ensuring adequate time for full implementation of case management care plans for duals with complex health and social needs, we would like to avail ourselves of the option to lock-in enrollment for six months before duals are able to disenroll from the pilot. The overall accuracy and applicability of evaluation findings regarding the quality and impact of the pilot will be greatly enhanced if we have a minimum of six months of utilization and satisfaction data for most enrollees. Under this

enrollment model, duals would be free to leave the pilot and choose some other option available to them after the sixth month following their enrollment. This six-month lock-in also allows time for physician recruitment to CCHP for their continuity of care.

5.5.2 Learning from the experience of the enrollment of the SPD population into managed care during 2011-12, CCHP believes there needs to be a longer period of time made available for performing the HRAs of incoming dual enrollees. If the State assigns the duals to the health plan at least 60 days prior to their actual enrollment, then their prior utilization information needs to be forwarded to CCHP no later than 45 days before their actual enrollment date. This time frame will make it possible to initiate the assignment of their PCP, the authorization of ongoing medical care, and the HRA process well in advance of enrollment, thereby assuring a relatively smooth transition of the duals to the pilot. Given that we are aware of the complexity of medical and social issues faced by a significant number of the duals, it is critical that the State make every effort to make this information available to CCHP in this proposed time frame.

Also, realizing the additional complexities of the choice decision being faced by duals in whether or not to opt out of the pilot, we plan to provide detailed information about the Pilot Project to the Health Insurance

Counseling and Advocacy Program (HICAP) operated by the County Aging and Adult Services. The decades of experience of their program staff and volunteers in counseling and advocating on behalf of Medicare recipients and their sterling reputation as disinterested experts and advocates will make them a valuable resource to duals wanting assistance in making their decision regarding participation in the pilot. HICAP has the capability to meet with potential enrollees on an individual basis to help explain in detail the positives and negatives of deciding whether to opt out of enrollment into the Duals Pilot.

5.5.3 DHCS reporting requirements need to be mainstreamed and not duplicative or contradictory in timeframes with our CCHP reporting requirements. Based upon the SPDs and CBAS mandates into managed care, that streamlined process should be enhanced.

Section 5.6: Appeals and Grievances

5.6.1 SEE CERTIFICATION CHECKLIST

Section 6: Organizational Capacity

6.1 Contra Costa Health Plan has served the health needs of county residents for nearly 40 years. It was the first Federally qualified, State licensed, county sponsored health maintenance organization in the United States. In 1973, CCHP became the first county sponsored health plan to offer Medi-Cal managed care. In 1976, we were the first county operated HMO to serve Medicare consumers. In the 1980's we began serving county employees, businesses, individuals and families. In 2006, we were chosen as the lead agency for the Health Care Coverage Initiative in Contra Costa County, thereby serving thousands of low-income uninsured county residents. CCHP operated a D-SNP for five years from 2007-11. Beginning June 2011, we have enrolled approximately 1,000 SPDs monthly into Medi-Cal managed care (averaging 90% of all eligible duals in the county). Also, we estimate that 3,160 of the 22,000 dual eligibles residing in the county are enrolled in CCHP. Additionally, 6,000 duals are currently receiving care at CCRMC and the Health Centers. This population will most likely wish to enroll at CCHP to maintain continuity of care.

CCHP is a Knox-Keene licensed plan and currently has over 108,000 members, as well as recipients of the Low Income Health Plan (LIHP) almost 90% of whom are low-income. Thus, CCHP has extensive experience providing managed health care to low-income persons of all

ages and is well positioned to serve the duals. Moreover, as noted previously, the extensive planning undertaken to develop an Aging and Long Term Care Integration model of care under AB 1040, the experience of providing D-SNP care management over a five year period, and the ongoing successful enrollment of the SPD population has well prepared CCHP to put in place the system of care management and coordination for duals necessary for implementation of the demonstration pilot.

Moreover, during the crisis of the past year resulting from the elimination of Medi-Cal Adult Day Health Care (ADHC) services and transition to the forthcoming Community Based Adult Services, CCHP senior leadership and care management staff have collaborated very closely with the two agencies that operate the three ADHC sites in our county. We have met with those two agencies, Rehabilitation Services of Northern California and Guardian Adult Day Health Care, on a regular basis to coordinate case management services to assure a smooth transition of their clientele into managed care and to provide access to alternate services for those former ADHC clients who will not qualify for the new CBAS program. CCHP has brought the two ADHC providers together with the County IHSS program and the Area Agency on Aging to identify alternative service options for those not eligible for CBAS. This

collaborative experience over the past six months has laid the foundation for developing a Coordinating Council of service provider agencies as part of our implementation plan for the Duals Pilot. CCHP enrolled 95% of all eligible ADHC members in this County during October and November 2011.

As a division of the Contra Costa County Health Services Department, CCHP will receive and manage the capitation dollars from Medi-Cal and Medicare for the Pilot Project as it already does for tens of thousands of its currently enrolled Medi-Cal members as well as Healthy Family members. The Chief Executive Officer of CCHP provides executive leadership reporting to the Director of the County Health Services Department.

CCHP is ultimately responsible to the Contra Costa County Board of Supervisors. The Board has appointed a CCHP Joint Conference Committee consisting of two of its five members, the Medical Director and CEO of CCHP, and two County Regional Medical Center physicians to monitor CCHP activities. In addition, the Board has appointed a Managed Care Commission of consumers' members, medical professionals, and other community representatives to serve in an advisory capacity to the Board of Supervisors to CCHP oversee operations. CCHP has both a

longstanding Local Initiative Health Plan serving the low-income population of the county and the LIHP as well as providing commercial populations including county employees, private employers, and individuals. CCHP has the necessary infrastructure in place to manage all of the complexities of a capitated program including enrollment, quality assurance, consumer complaints and grievances, and finance.

6.2 SEE ATTACHMENT #3 CURRENT ORGANIZATIONAL CHART WITH NAMES OF KEY LEADERS

6.3 The CEO of CCHP, Patricia Tanquary, has extensive experience in leadership in managed care, case management, partnership with multiple providers and SNF management having been both a hospital and health plan administrator at Kaiser at CCHP.

Patricia Tanquary has been the Chief Executive Officer of the Contra Costa Health Plan since April 2007, directing and managing the activities of the Contra Costa Health Plan. She, as part of the inter-divisional management team, assists in the planning, development and administration of the health programs and management activities of the Health Services Department and Contra Costa County. Ms. Tanquary has been very involved with giving input into Health Care Reform with Local

Health Plans of California (LHPC) and Association for Community Affiliated Plans (ACAP) organizations.

Ms. Tanquary served as the Deputy Executive Director for the Health Plan for the two years 2005–2007.

Prior to being recruited to Contra Costa, Ms. Tanquary spent 18 years with Kaiser Permanente. She served as Director of Member Services for Northern California and then as Hospital and Health Plan Administrator for Kaiser Hospital at San Rafael.

She became the Continuing Care Leader for Kaiser at three Kaiser hospitals – Redwood City, Santa Clara, and San Jose – where she initiated Case Management for high-risk populations, which included social work and RN case managers in teams with geriatric nurse practitioners rounding in contracted skilled nursing facilities throughout the South Bay.

Ms. Tanquary then moved to manage Statewide Divisional Provider Contracting, which led to her becoming the Director of National Provider Contracting for all Kaiser regions. Her team provided and managed national contracts that accounted for regional size and model variations.

Ms. Tanquary had previously been the Associate Administrator for French Hospital and Health Plan in San Francisco for five years assisting

them in implementing one of the four first Medicare Risk Demonstration Projects by CMS.

She spent four years teaching social work and health courses and managed the undergraduate social work internship program at San Diego State University. This work included surveying the Foster Care Program in San Diego County.

Ms. Tanquary has a Masters in Social Work from San Diego State University and both a Masters in Public Health Administration and a Doctorate in Social Welfare from U.C. Berkeley.

The consultant to CCHP, Bob Sessler, is a very experienced leader in Aging and Adult Services both at Contra Costa County and has been a leader in HCBS and the needs of the elderly at both state and national levels.

Bob Sessler retired as Director of the Aging & Adult Services Bureau of the Employment and Human Services Department for Contra Costa County. Overseeing a combined budget of over \$100 million and a staff of approximately 350 including six division offices, as well as the IHSS Public Authority, Mr. Sessler, as a consultant to the Contra Costa Health Plan, brings over 27 years of experience working within the aging network. He has worked in all levels of area agency on aging activities including

provider of direct client services, advocacy, coordination, contracts administration, planning and Area Agency on Aging director.

In 1967 Mr. Sessler graduated with a B.A. from Stanford University, having concentrated his studies in history, sociology and psychology. In 1984 he earned his Masters in Public Administration from California State University, Hayward. He also attended the University of Southern California Andrus Gerontology Center, the University of Colorado National Leadership Institute on Aging, the Bay Area Social Service Consortium (BAASC) Executive Development Institute, and the Senior Executive Program.

Mr. Sessler began his career in the late 1960's as a Social Worker in Los Angeles County and in the 1970's for Contra Costa County. From 1976 through 1989, he worked for the Contra Costa County Office on Aging beginning as an Information and Referral Coordinator, then a Program Specialist and later as a Planner/Assistant Director. In 1989, Bob was promoted to the position of Director of Contra Costa's then existing Office on Aging. Upon the restructuring of the County's social service agencies, Bob became manager of the newly formed Aging & Adult Services and was formally named the director of the new stand-alone bureau in 1989.

Mr. Sessler has been active in many state and national social service organizations. He is currently President of the California Area Agency on Aging association, is presently on the Board of Directors for the National Association of Area Agencies on Aging, and is President of the Board for Contra Costa County Meals on Wheels, Inc., a non-profit fundraising entity.

As Program Director of the Aging & Adult Services Bureau, Mr. Sessler administered a wide variety of services to the residents of Contra Costa County. Programs within the Bureau provide varied services for the aged and adult disabled such as: County's Area Agency on Aging, In Home Supportive Services, Medi-Cal, Adult Protective Services, Multipurpose Senior Services Program, Linkages (a program to connect clients with community support services), Long Term Care Integration, Providing Assistance to Caregivers in Transition (PACT), LPS Conservatorship, Health Insurance Counseling and Advocacy Program (HICAP), Senior Peer Counseling, Senior Legal Services and Senior Transportation programs. Additionally, Mr. Sessler supervised the County's Non-Assistance Food Stamps Program and the In Home Supportive Services Public Authority.

CCHP intends to hire an experienced pilot project manager under the direction of the CEO and CCHP consultant.

The current leadership in Case Management at CCHP, CBAS/MSSP leaders and IHSS leaders are also very experienced in their respective fields with commitment to further collaboration between county and community agencies.

6.4 Duals Demonstration Project Manager

Provide staffing assistance to the Contra Costa Coordinating Council meetings.

Direct reports to CEO of Contra Costa Health Plan (CCHP)

- a. Provide consultation to the Health Plan's Executive Committee with regard to determining goals and directing implementation plans for the Dual Demonstration Project;
- b. Provide consultation to the Health Plan's Administrative Coordinating Committee with regard to implementation of Executive Committee goals and management issues raised to the Executive Committee;
- c. Provide consultation to the Health Plan's Coordinating Committee with regard to regulatory issues;
- d. Provide consultation to the Health Plan's Benefits Committee with regard to dual enrollee benefits to ensure compliance with regulatory agencies;

- e. Provide consultation to the Health Plan's Care Management Unit with regard to complying with legal requirements and issues affected dual enrollees.
- f. Consult on Pharmacy Administration and advice on set-up system for Part D pharmacy compliance with crossover Medicaid drug coverage;
and
- g. Provides consultation to members of stakeholder group for Dual Pilot.

Under general supervision, performs staff analysis and administrative duties within limited guidelines requiring creativity, wide discretion and in-depth program knowledge and administrative experience. Assignments require provision of administrative support for one major program which may require the supervision of professional staff and some discretion in personnel matters. Required decisions may carry a significant consequence of error. Responsibility for management of a total program or conducting a complex special research and analysis assignment may be required. Position will report to the CEO of Contra Costa Health Plan and to associated staff and programs will be required.

Minimum Qualifications:

Education: Possession of a baccalaureate degree from an accredited college or university with a major in Business Administration, Public

Administration, Hospital Administration, Welfare Administration, Finance or a closely related field.

Substitution for the required academic major: Either one (1) year of full-time (or the equivalent of full-time) experience performing administrative duties in a health service agency or program, or possession of a Master's degree in Business Administration, Public Administration, Hospital Administration, Welfare Administration, Finance or a closely related field may be substituted for the academic major.

Experience:

At least 18 months full-time (or the equivalent of full-time) experience performing administrative duties in a health service agency or program is required.

OR

Possession of a Master's degree in Business Administration, Public Administration, Hospital Administration, Welfare Administration, Finance or a closely related field may be substituted for one (1) year of the required experience.

Knowledge, Skills and Abilities:

Knowledge of:

- Accepted principles and practices of health care administration
- The organization and work of various hospital departments and outpatient clinics
- Federal, State and County Codes, laws, rules and regulations applicable to “Dual” population
- Principles and practices of management and supervision

Ability to:

- Gather and analyze data
- Interpret and apply rules, regulations and laws
- Supervise the work of others
- Establish and maintain effective working relationships with others
- Prepare clear and concise reports and correspondence

Typical Tasks:

- Plans, organizes and directs a major health care program to include determining program goals and the activities necessary to reach those goals, establishing program policies and procedures,

supervising professional and clerical program staff providing services in a number of locations, developing and controlling the program budget, and coordinating program activities at a number of sites

- Develops and monitors policies and procedures to insure compliance with all legal mandates and to ensure the control of quality of staff and service delivery
- Advises and consults with community advisory boards or interest groups regarding management and program activities

Section 6.1: Operational Plan

6.1.1 PRELIMINARY OPERATIONAL PLAN FOR CALENDAR YEAR 2013

- Inform appropriate CCHP staff and provider networks of revised benefits available to dual eligibles under the pilot program and conduct training sessions for staff and providers most directly impacted.
- Enroll approximately 1000 dual eligibles monthly based upon our experience with the SPD enrollment choice history.
- Send new enrollees welcome letters explaining access to 24-hour Advice Nurses, prescription drug procedures, and various membership issues.

- Send out Explanation of Coverage (EOC) for the Duals Pilot to enrollees along with their membership identification cards, plan handbook, and provider directory.
- Case Management Unit will complete the Health Risk Assessment Process for high-risk duals and PCP assignment at least 45 days after to enrollment providing that the State sends us the list of enrollees in a timely fashion.
- Meet monthly with Coordinating Council to develop referral relationships, standardization/coordination of assessment tools, care planning consultation, identify service gaps, etc.
- Meet monthly with Pilot Project Advisory Committee to gather input from consumer representatives regarding implementation issues.
- Schedule quarterly meetings in conjunction with the Pilot Project Advisory Committee, Advisory Council on Aging, and IHSS Public Authority Advisory Committee to get consumer feedback regarding pilot project implementation from those various constituencies.

6.1.2 Roles and Responsibilities of Key Partners

Contra Costa County Regional Medical Center/Health Centers:

provide primary care and specialist care at its Martinez central location and eight neighborhood clinics throughout the County; emergency care; in-patient care; and provide Community Transition Initiative services through its discharge planning staff coaching patients to provide an optimal level of self-care upon return home to avoid unnecessary or inappropriate readmissions. The CCHP CTI nurse will also assist with home visit transition services following discharge for high-risk patients.

Community Provider Network: provide primary care and specialist care through independent community physicians and contract clinics; provide emergency care and in-patient care at contracted hospitals; John Muir Medical Center will provide community transition services (CTI) coaching discharged patients in self-care techniques to avoid unnecessary or inappropriate readmissions.

Lifelong Medical Care: provide primary care with geriatricians including end-of-life care and dementia care. Lifelong will also provide consultation to CCRMC and the Ambulatory Health Centers on Geriatric team care for duals.

Aging and Adult Services Bureau, Contra Costa County Employment and Human Services Department: assess duals for In Home Support

Services (IHSS) and authorize hours of care; process payroll for IHSS providers; coordinate with CCHP care managers access to Area Agency on Aging information and assistance, supportive services, nutrition programs, family caregiver services, and health insurance counseling and advocacy; coordinate with CCHP care management regarding Adult Protective Services.

In-Home Services Public Authority: recruit, screen, enroll, orient, and train.

IHSS providers; maintain registry of potential IHSS providers; conduct collective bargaining with union representing IHSS providers for wages and benefits.

Rehabilitation Services of Northern California: provide CBAS to duals residing in central and east Contra Costa; provide MSSP services to duals countywide; provide California Community Transition services countywide for duals residing in skilled nursing who wish to move back into the community; may assist CCHP care management with such activities as monitoring and follow-up of duals who at medical risk.

Guardian Adult Day Care: provide CBAS services to duals residing in west Contra Costa; may assist CCHP care management with monitoring

and follow-up of duals who are at medical risk; may provide countywide non-emergency transportation for duals.

Behavioral Health Division, County Health Services Department:
provide public mental health and substance abuse services to eligible duals in coordination with primary care physicians and CCHP Case Management staff. Homeless care and Respite care coordination will also occur in consultation with CCHP.

6.1.3

On January 1, 2013:

- Contracts in place with enlarged network of community physicians.
- Revised pharmacy benefits management contract in place.
- Contract in place with RSNC for MSSP, CBAS, and Community Transitions.
- Contract in place with Guardian for CBAS.
- Intradepartmental agreements in place with Aging and Adult Services and IHSS Public Authority.
- Expanded intradepartmental agreement in place with Division of Behavioral Health.

- Enroll approximately 1000 duals on the first of each month through December 2012.
- Ongoing recruitment of additional community physicians.
- Monthly meetings of Coordinating Council of HCBS Providers.
- Monthly meetings of Pilot Project Advisory Committee.
- Bi-monthly meetings of the Managed Care Commission.
- Quarterly meetings of Joint Conference Committee of the County Board of Supervisors.

Quarterly public meetings in collaboration with County Advisory Committees representing seniors and persons with disabilities.

6.1.4 SEE CERTIFICATION CHECKLIST

Section 7: Network Adequacy

7.1 CCHP has a total of 3293 contracted PCPs and specialists providing care in two networks. Those members accessing care at Kaiser are served by additional PCPs and specialists.

Physician recruitment and retention are continuous efforts. In preparation for the SPDs, CCHP sent letters to many community physicians and made presentations with the Alameda/Contra Costa Medical Society across the county. We utilized the Continuity of Care provisions to provide outreach to all providers at the time of enrollment, agreeing to either limited or full contract status.

7.2 CCHP has successfully utilized Fee-For-Service (FFS) Claims payment to limit risk to smaller providers and ensure 100% encounter data compliance. We further use Panel Management Incentives to pay incentives beyond rates for serving an increased number of enrollees. We are currently adjusting these rates to accommodate increased care needs of the SPDs and duals.

7.3 CCHP has a history of paying providers slightly higher than Medi-Cal FFS rates and paying Medicare for the duals enrolled in the SNP, which would continue under this pilot and will attract additional providers not currently under the CCHP CPN network.

7.4 The DHCS-Enhanced FSR (Facility Site Review) tool and training will continue to be utilized to ensure sufficient accessibility for desirable beneficiaries.

7.5 New enrollment with six new Community FQHCs occurred in 2011 for the SPDs and voluntary duals, which will also offer more experienced care for the duals.

Lifelong Medical Care now provides clinics with several geriatricians and geriatric social workers. This FQHC will also serve as a consultant to CCHP, CCRMC and the Health Centers in further development of similar capacity.

Additional conversation with Kaiser and Health Net are occurring for sub-capitation to their SNP members in Contra Costa County.

7.6 CCHP has established a seven-year contracted relationship with our Pharmaceutical Benefits Manager (PBM), PerformRx. They have developed a sophisticated 340B Program, and a Part D Medi-Cal and Medicare Program for the SNP with CCHP. We participate in their National Pharmacy and Therapeutic Committee for formulary compliance with all regulators. They have consistently demonstrated knowledge, ability and skill in working with managed care with all populations and particularly the duals.

7.7 SEE CERTIFICATION CHECKLIST

7.8 SEE CERTIFICATION CHECKLIST

7.9 SEE CERTIFICATION CHECKLIST

Section 7.1 Technology

7.1.1 CCHP, as a Health Plan, as well as CCRMC and all eight FQHC Clinics, are migrating to the EPIC Electronic Health Record (HER) System on July 1, 2013. All providers, the County Hospital, Advice Nurses, CCHP Case Managers, Member Services Referral, Utilization Management and Quality staff will be able to communicate as part of the same electronic system and patient health record. A component of this system allows for a web portal for the contracted providers to check eligibility, receive and reply to electronic medical information, and send electronic consultative reports back. These reports will become part of the patient electronic record. An additional feature is one where patients can have e-mail communication with their PCP through a secure site. This feature will be utilized by our members assigned to Kaiser. It improves care coordination, timely access, as well as decreasing unnecessary visits. Electronic claims will also enhance provider payment.

7.1.2 CCHP has initiated a Care Transition Intervention (Coleman Model) in two of its major contracting hospitals. The Coleman Model,

developed at the University of Colorado, Denver, is the framework for the Care Transitions Intervention (CTI) program at CCHP. The program is designed to improve the continuity of care as clients transfer from one facility to another (i.e. from the hospital to home) and reduce the risk of readmissions.

During a four-week program, clients admitted to CCRMC with complex care needs and their family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

The coach's job is to:

1. Give clients a complete understanding of all the aspects of their care; answer questions from the client and family and/or caregivers as they arise;
2. Assist client in understanding what brought them to the hospital and help them develop a viable health care plan for the future;
3. Make sure that pre- and post-hospital medications are coordinated;
4. Provide non-judgmental emotional support;
5. Promote self-sufficiency;

6. Provide tools and coaching needed to empower the client to take charge of their condition and future healthcare needs.

The intervention focuses on four conceptual areas, referred to as The Four Pillars™:

1. Medication self-management: patient is knowledgeable about medications and has a medication management system.
2. Use of a dynamic patient-centered record: patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient or informal caregiver manages the PHR. This record is kept at the patient's home for patient and caregiver use.
3. Primary Care and Specialist Follow-Up: patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
4. Knowledge of Red Flags: patient is knowledgeable about indications that their condition is worsening and how to respond.

Additionally, CCHP case managers and the CCRMC hospital social workers are working with AAS to create a volunteer program of retired

social workers and nurses to visit families in the home during a hospital stay to assist in the development of a rapid patient transition care plan, which prevents SNF stays where appropriate. Those patients in the SNF will receive care by nurse practitioners who can utilize the EPIC EHR System to have appropriate medical data. The SNFs will also have access to the provider web portal for data exchange.

7.1.3 CCHP is also working with its contracted CPN network as they pursue meaningful use. All of the FQHCs are implementing an EHR system called Next Gen. These providers will also have EPIC provider portal website access for improved patient data exchange. Additionally, they are intending to implement an electronic communication tool with patients and their PCPs in 2013-2014.

Nationally, the Next Gen and EPIC systems are discussing future data links, which will improve clinical data exchange.

Section 8: Monitoring and Evaluation

8.1 CCHP currently provides Health Risk Assessments for the SPDs and voluntary duals and will continue to do so under the Dual Pilot. These HRAs are mailed to patients for self-reported health status and are completed by Care Coordination staff utilizing additional utilization data.

We have a long history of conducting annual patient satisfaction surveys with all the members served: Medi-Cal, SNP, Healthy Families, LIHP, and Commercial. We intend to conduct patient satisfaction surveys with the Dual Pilot as well. Timely access to care is monitored currently with both provider and patient self-reporting input.

CCHP has nearly 100% encounter data reported due to a FFS claims system and internal database. CCHP has met all SNP requirements for uniform encounter data with Part D through its PBM and data is uploaded daily. Encounter data for new covered services will be added through the claims adjustment process to this same internal database. County Mental Health and Substance Abuse data systems are planning to be linked with the EPIC System, which will complete the EHR for patients served by both systems of care.

Specific condition-specific quality measures will be added to the HEDIS data tracking currently in place with all Medi-Cal members. CCHP has participated with the risk-adjustments utilized by CMS with its SNP

members. However, no risk-adjusted mortality data has been shared by DHCS or CMS with us yet for the Duals Pilot.

8.2 CCHP has an integrated database which has allowed us to report beneficiary outcomes including age, race, ethnicity, gender, language, geography, and disease by network for comparison. These reports' capabilities will be enhanced by the EPIC System, which will include Health Plan and clinical data.

Medi-Cal Performance Rates

HEDIS Rates have been generally increasing year over year. The average gain from 2010 to 2011 was almost four points per indicator. Fourteen of the twenty-one were above the Medi-Cal mean. Three exceeded the High Performance Level (90th %ile) and none were below Minimum Performance level (25th %ile).

Final HEDIS Rates (audited) 6/15/2011

CCHP Medicaid	2008 CCHP Final	2009 CCHP Final	2010 Final	2011 FINAL	2011 RMC	2011 CPN	2011 Kaiser	2011 MPL ¹
BMI %ile calculated for children			18.49%	61.07%	65.61%	60.87%	78.57%	13.00%
Nutrition counseling given for children			49.15%	58.88%	68.15%	50.00%	82.14%	34.30%
Physical activity counseling for children			38.44%	46.47%	50.32%	33.70%	78.57%	22.90%
*Yearly well child visit 3-6 yr.	66.46%	77.37%	74.70%	78.82%	78.24%	79.41%	79.59%	65.90%
*Yearly adolescent well visits	38.9%	47.45%	38.69%	40.63%	34.09%	44.54%	54.17%	38.80%
*Combo 3 immunizations	80.00%	82.48%	77.13%	87.16%	90.61%	76.19%	77.42%	63.50%
No antibiotics for Acute Upper Resp. children	91.95%	93.64%	92.76%	93.29%	94.48%	89.78%	98.68%	82.10%
*First trimester prenatal	80.25%	83.45%	84.67%	81.75%	83.74%	71.43%	86.25%	80.30%
Postpartum visit 21-56 days	61.48%	68.13%	68.13%	67.40%	67.89%	55.95%	77.50%	58.70%
No imaging for lower back pain		87.02%	87.14%	88.64%	85.43%	93.80%	92.96%	72.00%
Breast cancer screening	47.60%	43.68%	56.19%	57.39%	53.13%	47.84%	79.52%	46.20%
*Cervical cancer screening	69.70%	67.88%	69.34%	70.62%	63.08%	73.42%	86.08%	61.00%
Diabetes Eye Exam 2 yrs.	52.6%	53.47%	48.54%	49.09%	55.18%	31.58%	49.06%	41.40%
Diabetes screening LDL-C	77.90%	79.38%	78.65%	77.74%	73.48%	75.44%	93.40%	69.30%
Diabetes LDL <100	42.10%	42.20%	40.69%	40.69%	36.89%	30.70%	63.21%	27.20%
*Diabetes HbA1c testing	82.0%	83.03%	85.40%	86.86%	86.59%	81.58%	93.40%	76.00%
Diabetes HbA1c(>9%) [lower is better]	38.0%	42.15%	31.75%	33.94%	34.76%	40.35%	24.53%	>53.4
Diabetes HbA1c (<8%)		49.09%	52.55%	56.57%	57.32%	51.75%	59.43%	38.70%
Diabetes Nephropathy screen or treatment	81.20%	82.30%	86.5% ³	89.23%	94.51%	70.18%	93.40%	72.50%

Diabetes BP <140/90		56.20%	53.1% ³	55.11%	52.44%	44.74%	74.53%	53.50%
Avoidance of antibiotics in adults with acute bronchitis	37.50%	32.50%	31.87%	29.56%	23.15%	35.82%	40.74%	19.70%

Measures calculated solely by administrative data are in bold

* Auto assignment default algorithm measures

¹ Minimum Performance Level=last year's 25th %ile, below which an improvement plan is required

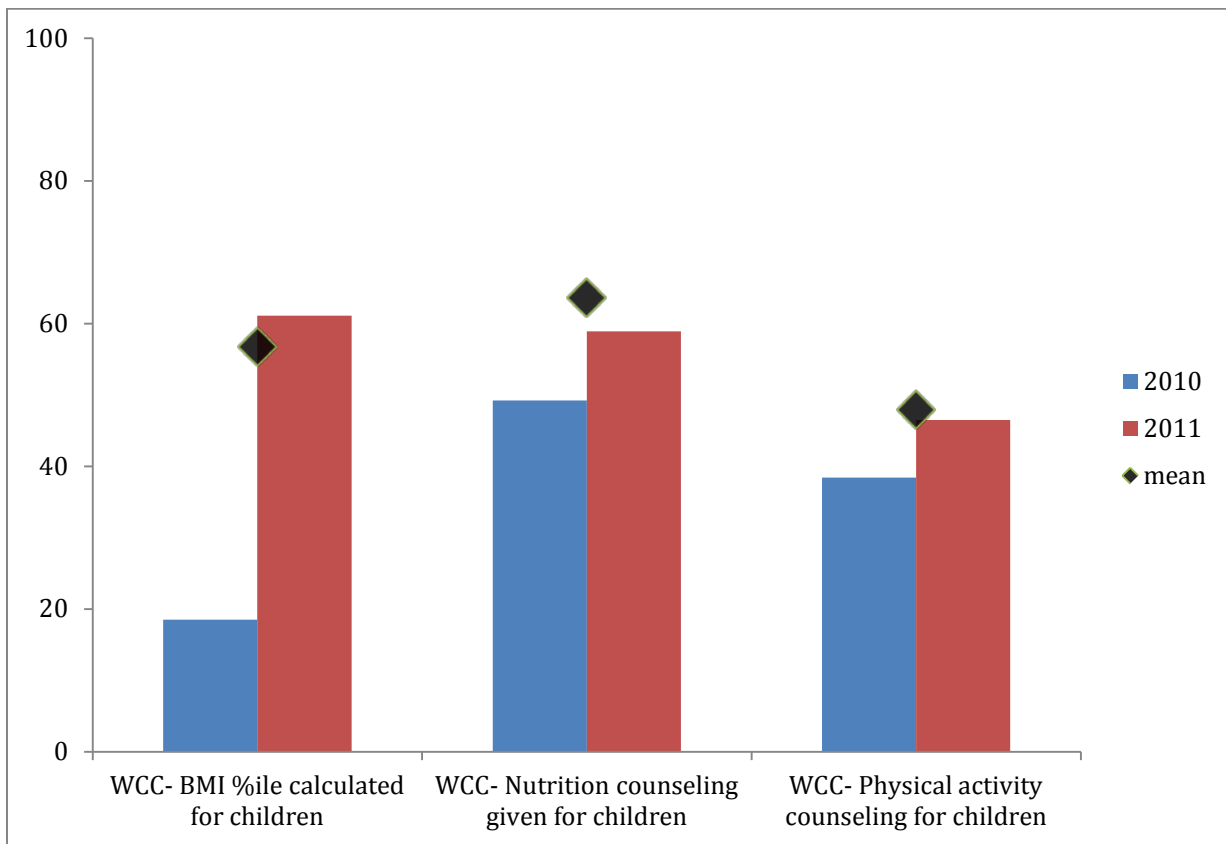
² High Performance Level=2010 90th percentile

³These measures without MPL/HPL defined for 2010



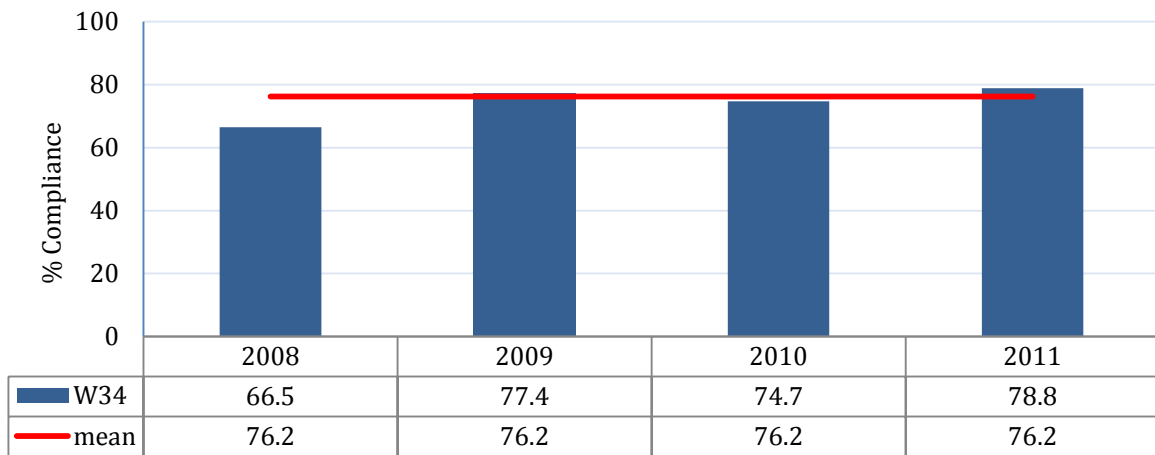
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)

The percentage of members 3-17 years old, continuously enrolled with no more than a one month gap in coverage, who had at least one outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: 1) a BMI percentile or BMI percentile plotted on a BMI-for-age growth chart, unless the member is 16-17 years old for whom a BMI value is acceptable. 2) Counseling for nutrition, and 3) counseling for physical activity or referral for physical activity counseling.



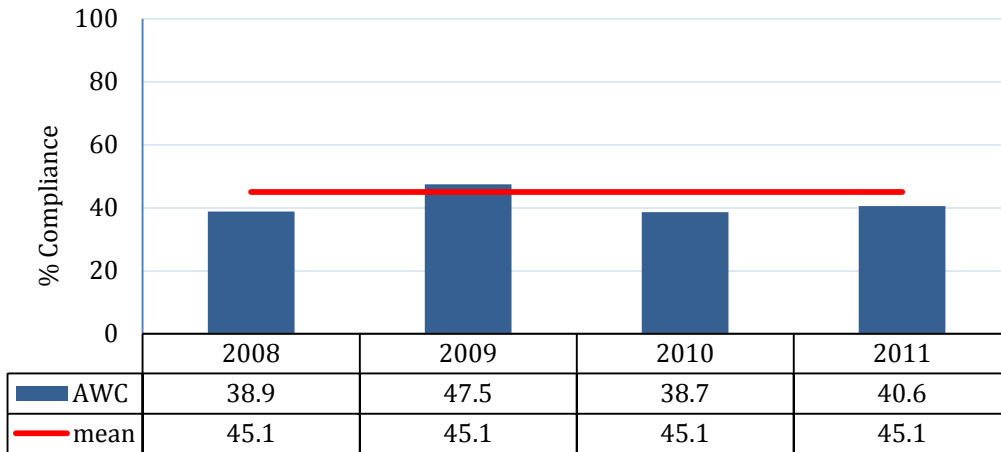
Well Child visits in the Third, Fourth, Fifth, and Sixth years of Life (W34)

The percentage of Medi-Cal members who were three, four, five, or six years of age, and continuously enrolled during the measurement year who received one or more well visits with a primary care provider in during the measurement year.



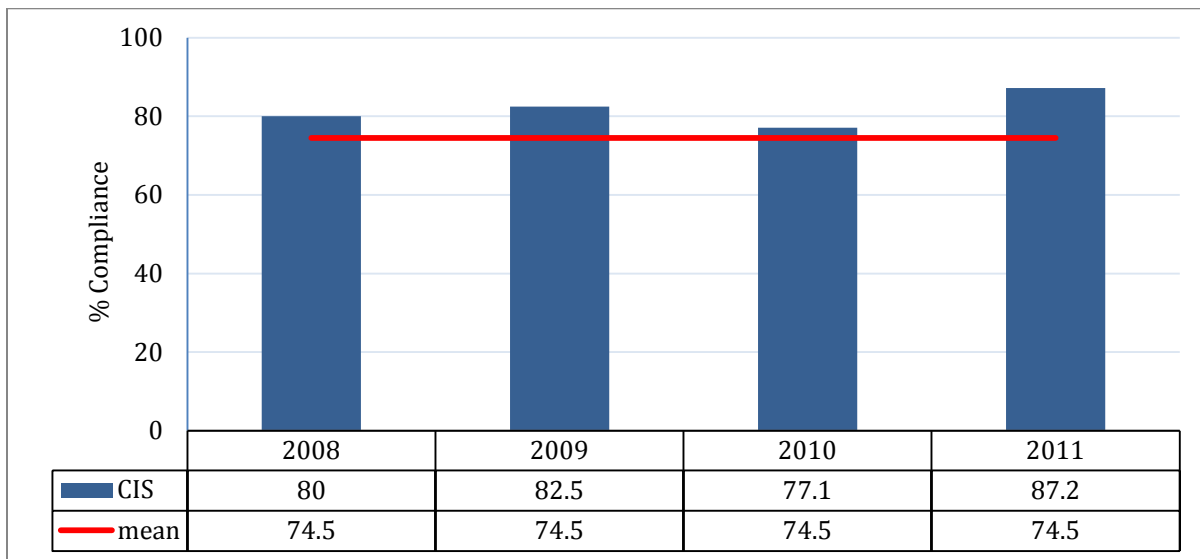
Adolescent Well-Care visits (AWC)

The percentage of Medi-Cal members who were 12-21 years of age, with no more than a 45 day gap in coverage during the measurement year, who had at least one comprehensive well-care visit with a primary care practitioner or and OB/GYN practitioner during the measurement year.



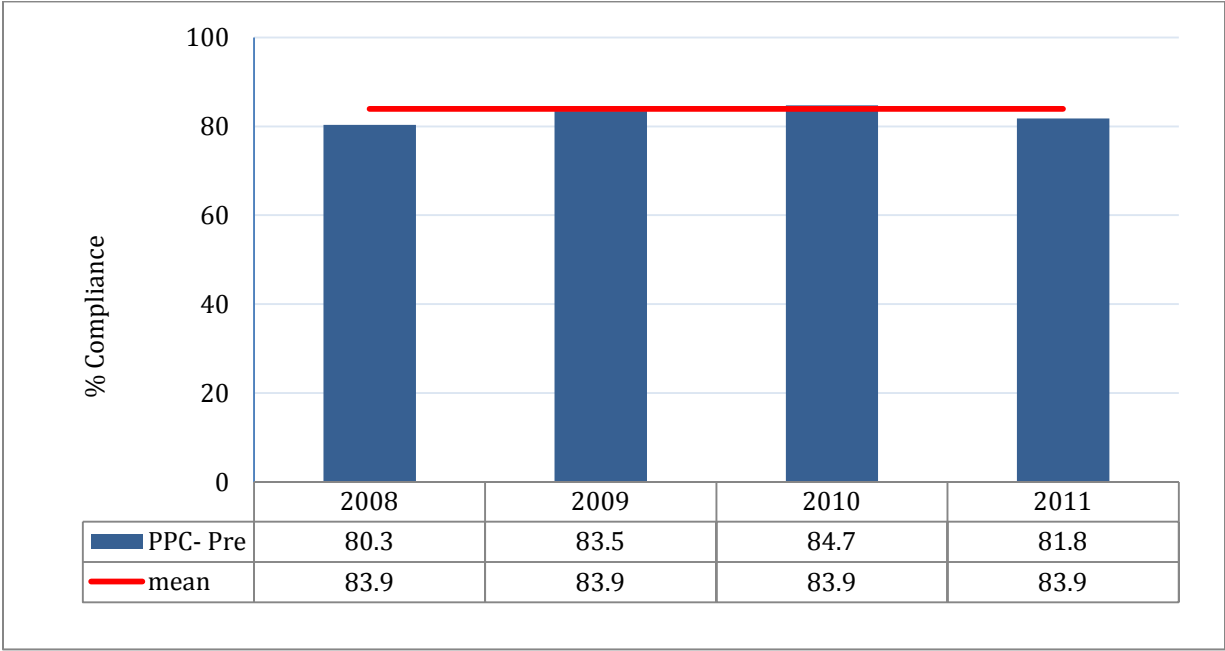
Childhood Immunizations Status (CIS)

The percentage of children continuously enrolled 12 months prior to the child's second birthday, who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate by their second birthday.



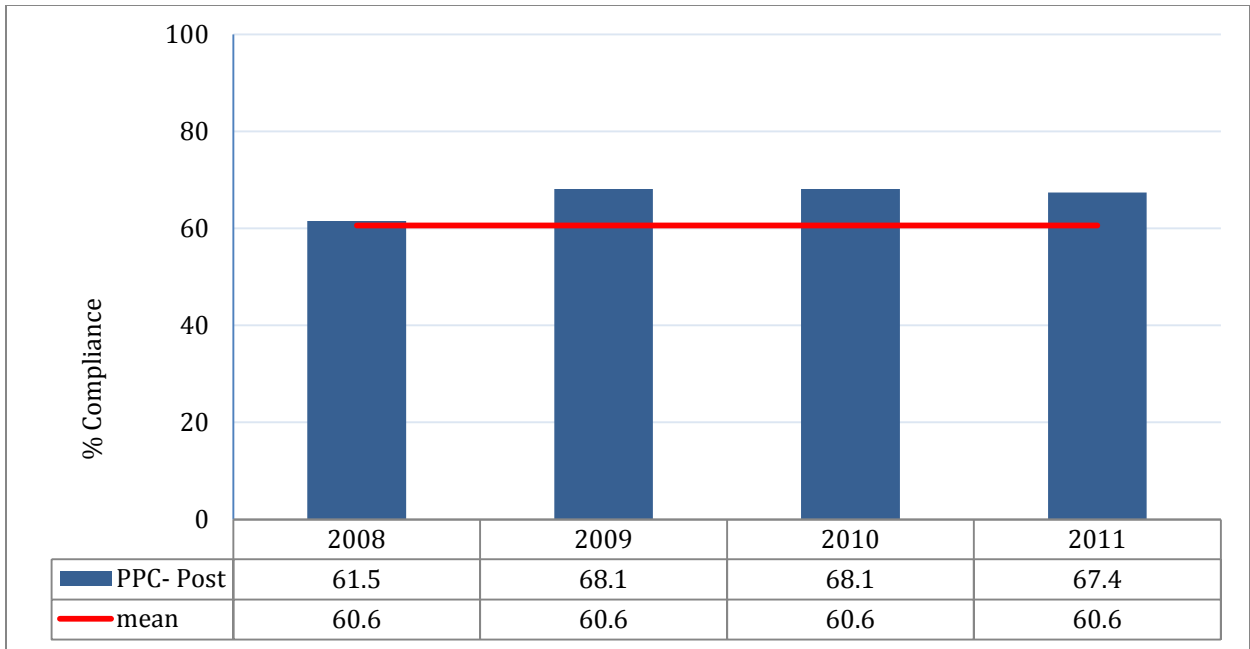
Timeliness of Prenatal Care (PPC- Pre)

The percentage of deliveries that received a prenatal care visit in the first trimester *or* within 42 days of enrollment in the health plan. Continuous enrollment requirement is 43 days prior to delivery through 56 days after delivery.



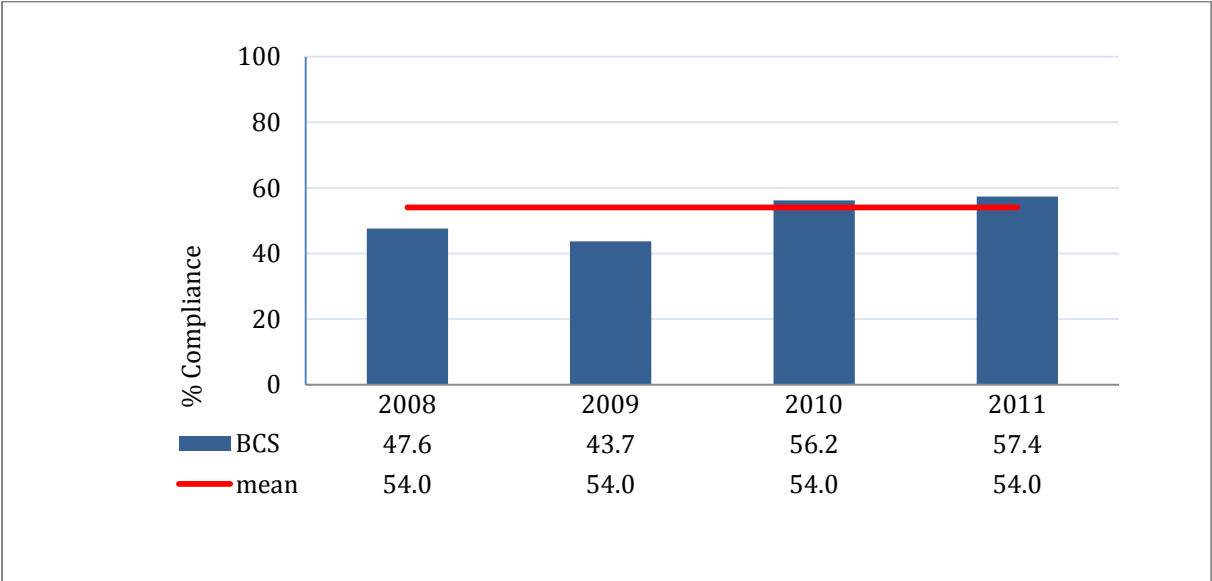
Postpartum Care (PPC-Post)

The percentage of deliveries that had a postpartum visit on or between 21-56 days after delivery. (three to eight weeks postpartum).



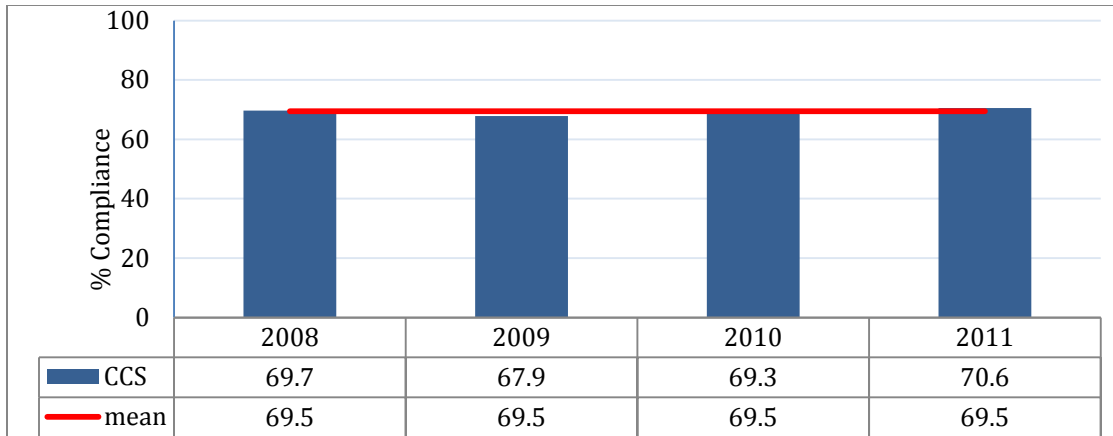
Breast Cancer Screening (BCS)

The percentage of women 40-69 years of age who had a mammogram during the measurement year or year prior to the measurement year (two-year span) and were continuously enrolled for both years.



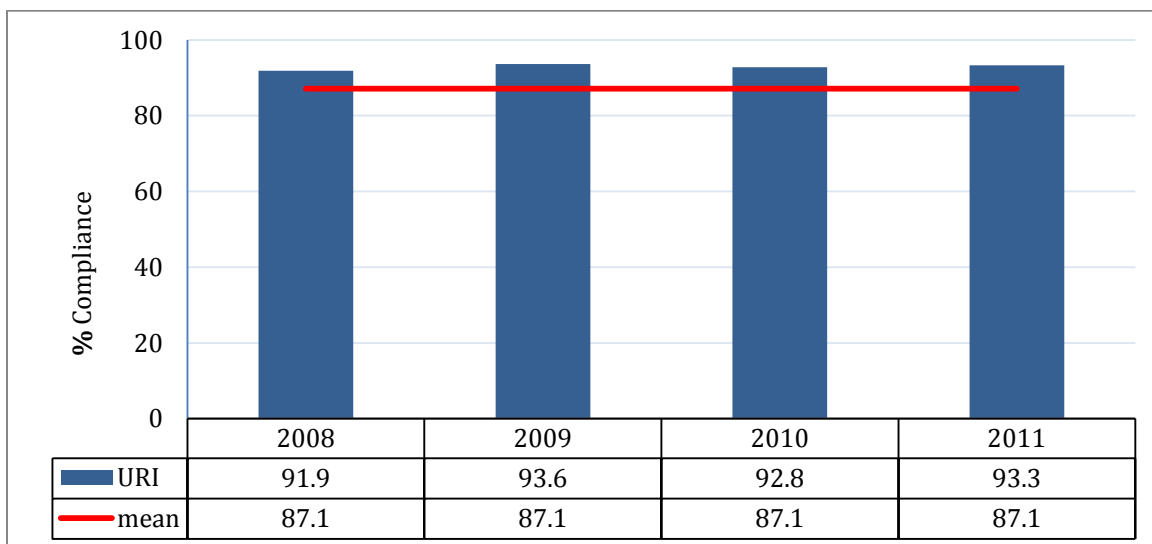
Cervical Cancer Screening (CCS)

The percentage of women 21-64 years of age continuously enrolled for the measurement year, who received one or more pap tests during the measurement year or the two years prior to the measurement year (three-year span).



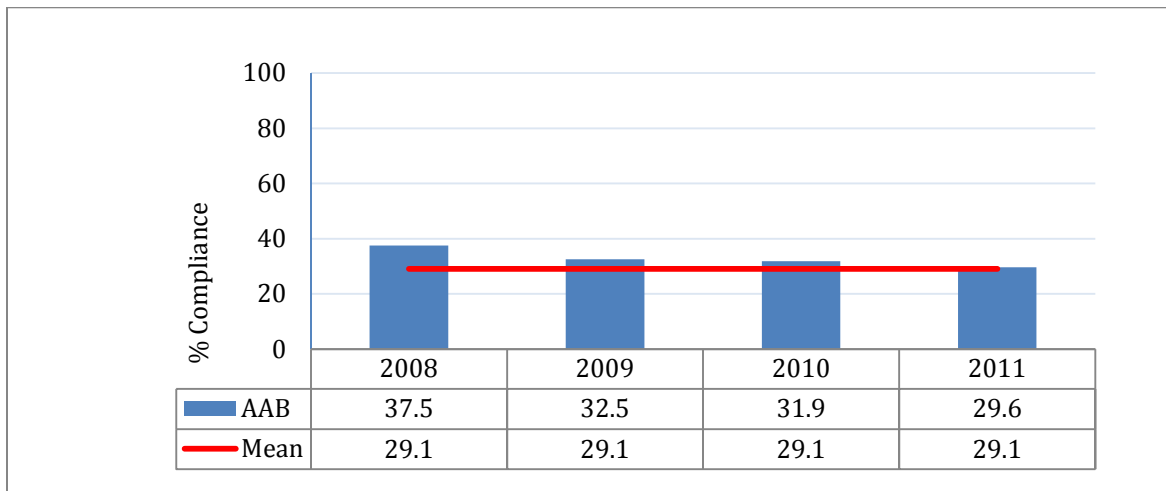
Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of children 3 months – 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or within three days after the episode date.



Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis (AAB)

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the episode date. A higher rate is better.



Comprehensive Diabetes Care (CDC)

This set of eight indicators measure process and outcome related to the care of patients aged 18-75 with type 1 and type 2 diabetes, continually enrolled for the measurement year and in some cases two years.

Retinal Eye Exam- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal exam performed in the year prior to the measurement year.

LDL Testing- An LDL-C test performed during the measurement year with the result documented in the medical record.

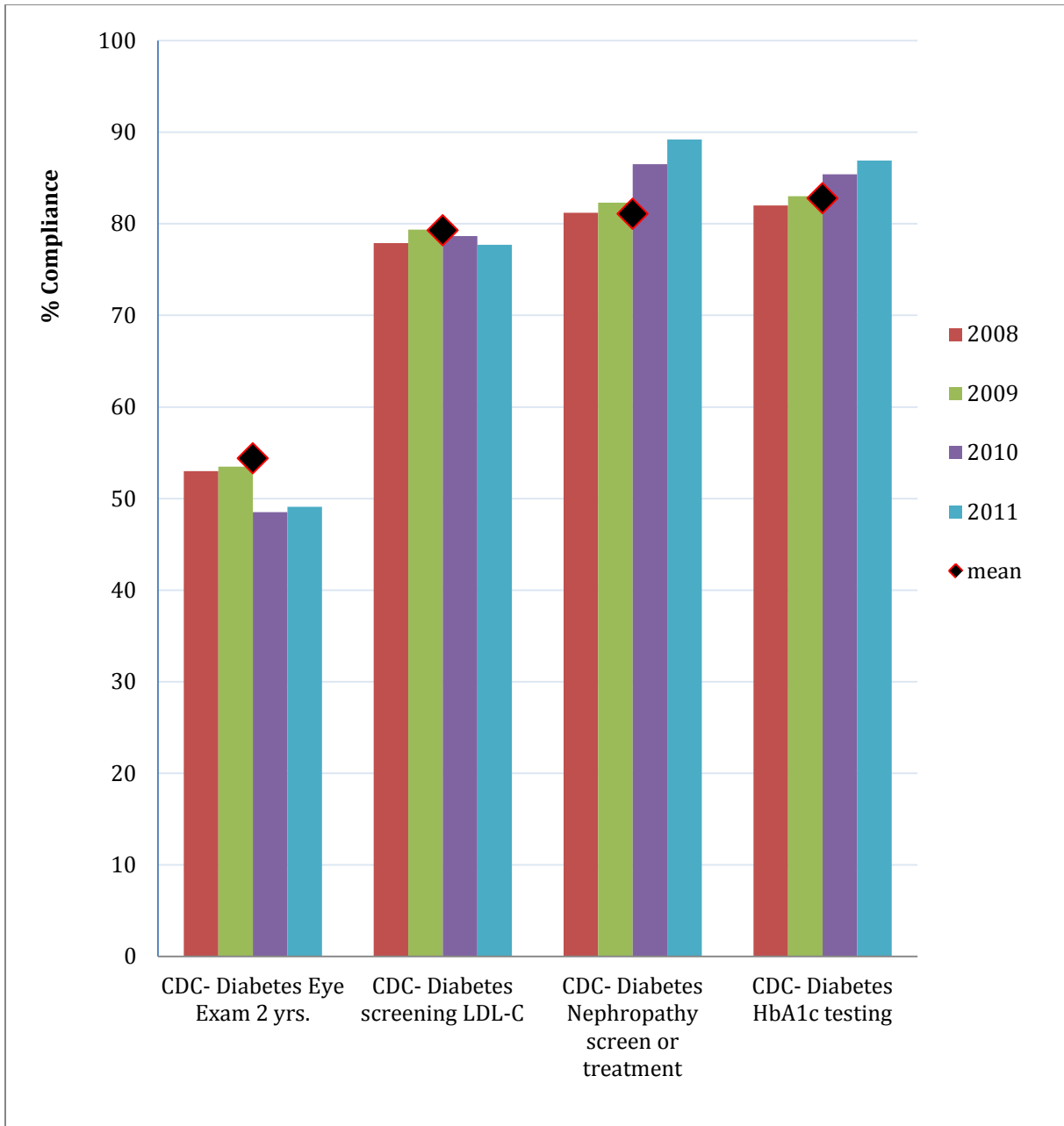
Nephropathy screening- Screening for nephropathy or evidence of nephropathy or nephropathy treatment in the medical record. This measure requires annual screening regardless of past results.

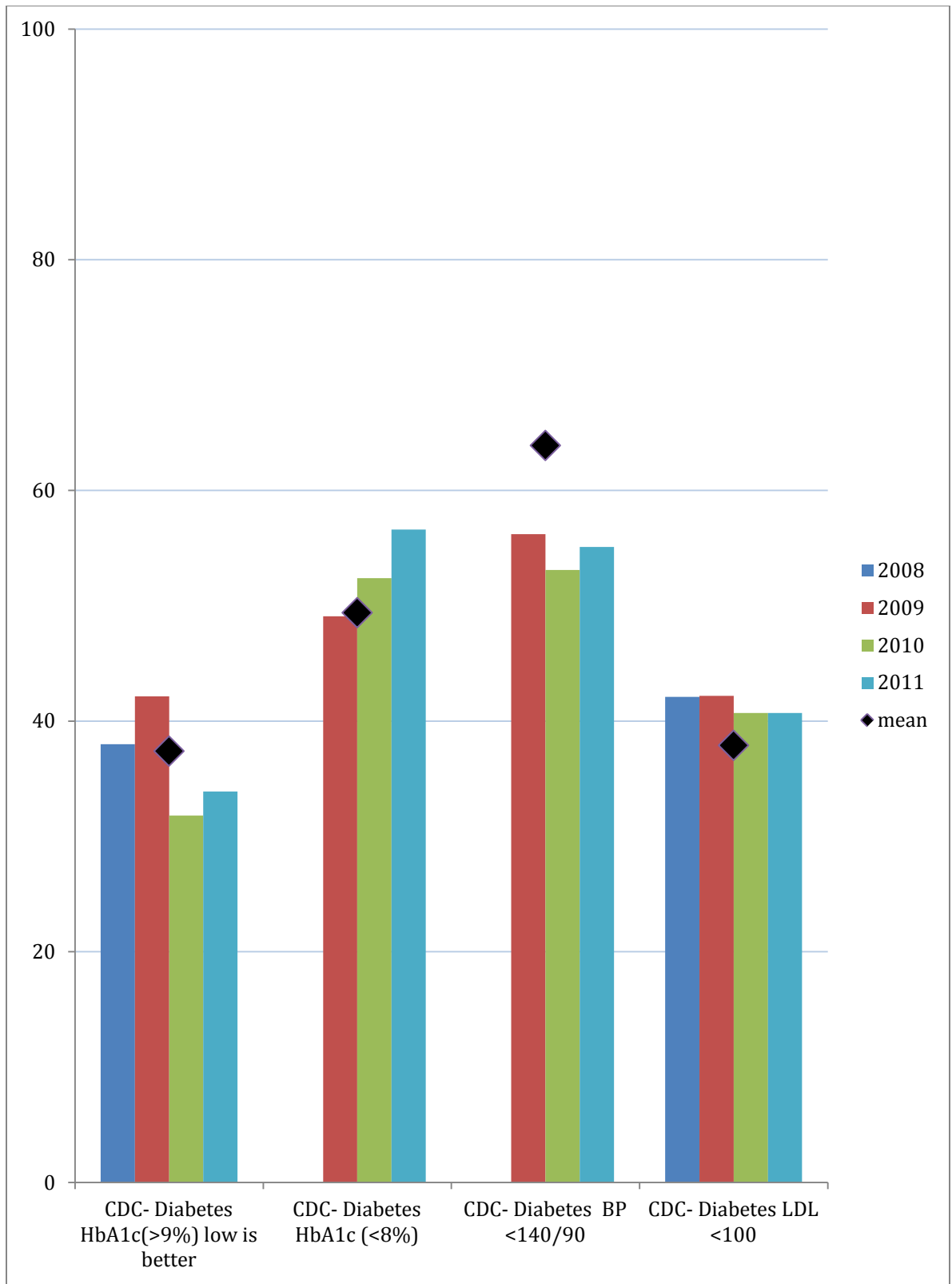
HbA1c Testing- One or more HbA1c tests performed during the measurement year with a result documented in the medical record.

HbA1c Level-Two rates are measured: **>9%**, where a lower score is better, and **<8%**, where a higher score is better. If there is no record of the test in the measurement year, it is counted against us in the >9% rate.

Blood Pressure < 140/90-The most recent outpatient reading. Both systolic and diastolic rates must be below the standards to pass. If there is no reading on record for the measurement year, the case counts against us.

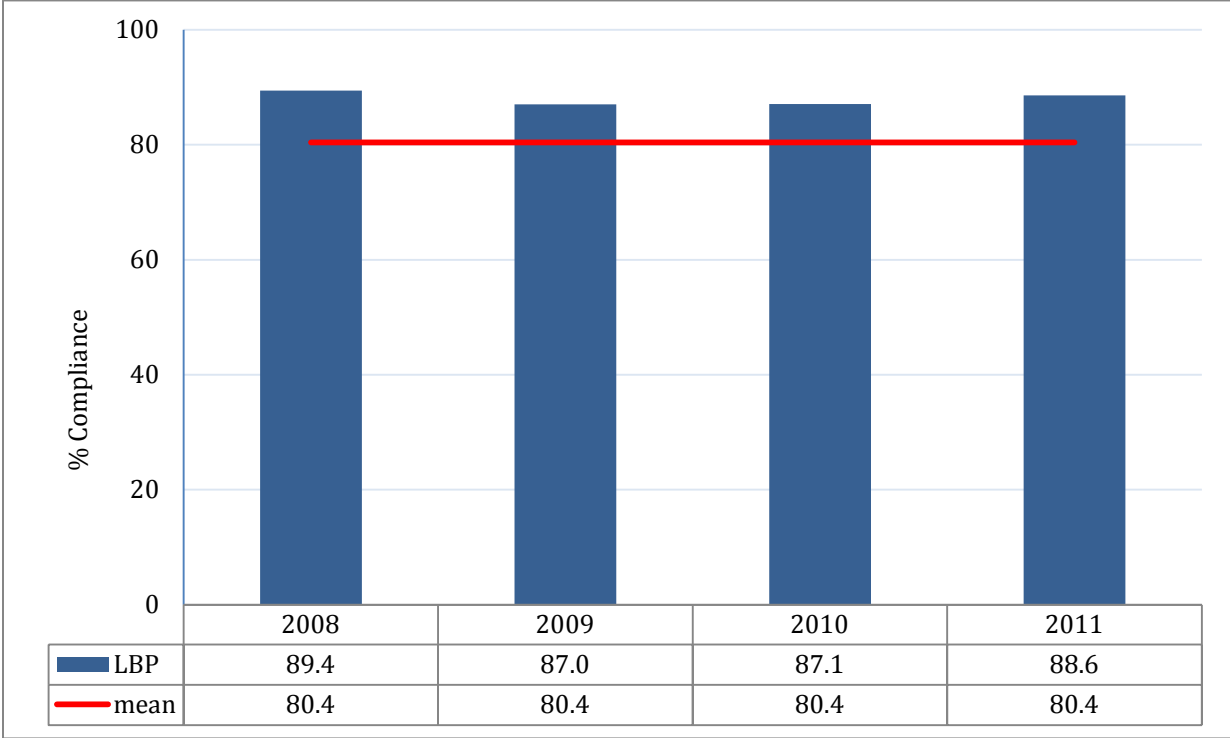
LDL level <100-Most recent LDL cholesterol level. If there is no such test on record for the measurement year, it counts against us.





Lower Back Pain (LBP)

The percentage of adult members 18-50 years, with no gaps in enrollment, who had an outpatient encounter with a primary diagnosis of lower back pain who did not have an imaging study within 28 days of the diagnosis.



8.3 SEE CERTIFICATION CHECKLIST

Section 9: Budget

9.1 CCHP will have completed the migration to EPIC with the County Hospitals, all of the Ambulatory Health Centers and Public Health by July 2012. The linking from EPIC to County Mental Health is planned as Phase II in early 2013.

EPIC Care Link (web portal) will connect to the contracted providers and contracted community FQHCs for ease in medical record sharing. Electronic Health Record linking between the Next Gen system for FQHCs and EPIC will enhance EHR sharing. However, the IHSS, CBAS, MSSP, and community SNFs all use entirely different systems. Infrastructure support for creating IT linkage between these social care providers to the medical care providers is crucial. Information Technology linkage requires expensive IT programming and potential upgrading for which neither CCHP nor these community agencies have funding. This linkage could greatly ease the team Patient Assessment process across multiple agencies, increasing timelines and reducing travel time of providers for participation in patient assessment and coordinated patient care.

Secondly, training funding for IHSS workers, Meals on Wheels drivers, and volunteers to enhance their critical problem identification skills for inclusion into the patient care assessment and care team is sorely needed to complete the goals of this Dual Pilot Project.

Thirdly, funding for transportation drivers of Meals on Wheels vans with frozen food could greatly increase the size of duals who could remain in their homes safely with essential nutrition needs met. Currently, Meals on Wheels in Contra Costa has been unable to expand due to lack of volunteers capable of delivering small meals. The economy, cost of fuel, and aging volunteers has sorely diminished their expansion capabilities. This added transportation funding with frozen food truck purchase would greatly increase the dual population under this Pilot Program.

Attachments

List of Attachments

DUALS DEMO RFS ATTACHMENTS

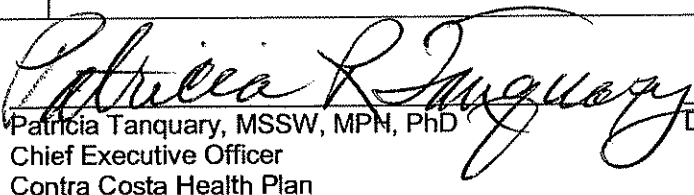
1. PROPOSAL CHECKLIST
2. MODEL OF CARE COORDINATION FOR DUAL ELIGIBLES AS OUTLINED IN APPENDIX C OF RFS
3. CURRENT ORGANIZATIONAL CHART WITH NAMES OF KEY LEADERS
4. LETTER OF GOOD STANDING FROM DMHC
5. LIST OF SANCTIONS/PENALTIES FROM MEDICARE OR THE STATE IN PAST 5 YEARS
6. ALL DHCS ESTABLISHED QUALITY PERFORMANCE INDICATORS FOR MEDICAL MANAGED CARE PLANS, INCLUDING BUT NOT LIMITED TO MANDATORY HEDIS REQUIREMENTS
7. ALL MA-SNP QUALITY PERFORMANCE REQUIREMENTS, INCLUDING BUT NOT LIMITED TO HEDIS REQUIREMENTS
8. DOCUMENTATION DEMONSTRATING LOCAL STAKEHOLDER INVOLVEMENT
 - VERIFICATION THAT DAVID THAYER IS A DUAL MEMBER ON MCC
 - REFER TO PROJECT NARRATIVE SECTION 5.4.1 RE: PILOT PROJECT ADVISORY COMMITTEE
 - LETTERS OF SUPPORT FROM COMMUNITY STAKEHOLDERS
 - DEBBIE TOTH
 - PETER BEHR
 - ETTA MAITLAND
 - DAVID THAYER
 - CORY POHLEY
 - REFER TO PROJECT NARRATIVE SECTION 5.4.1 RE: COMMUNITY STAKEHOLDER INPUT INTO PROPOSAL
 - REFER TO PROJECT NARRATIVE SECTION 5.4.1 RE: NARRATIVE OF ACTIVITIES SEEKING COMMUNITY INPUT. PACKETS FROM MCC MEETING ON 1/25/12, COMMUNITY STAKEHOLDER MEETING ON 1/27/12, ADVISORY COUNCIL ON AGING MEETING ON 2/1/12,

AND DR. WALKER'S STAKEHOLDER ACCESSS
MEETING ON 2/2/12

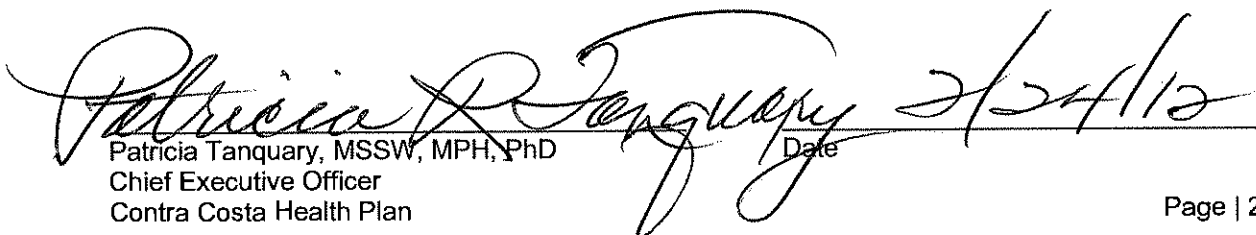
9. LETTERS OF SUPPORT FROM COUNTY OFFICIALS
 - JOE VALENTINE
 - DR. BRUNNER
 - CHARLES ANDERSON
 - CYNTHIA BELON
 - SUZANNE TAVANO
10. DRAFT AGREEMENT WITH IHSS
11. SIGNED AGREEMENT WITH MENTAL HEALTH

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check Box to certify "YES"	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.	X	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	X	ATTACHMENT #4
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	X	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	N/A	
4	Applicant has a current Medi-Cal contract with DHCS.	X	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	X	
6a	Applicant will cover a county's entire dual eligible population either on its own or through partnerships of agreed-upon geographic divisions with other applicants.	X	
6b	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of dual eligibles.	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	ATTACHMENT #5
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	X	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	X	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.	X	ATTACHMENT #6
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	X	ATTACHMENT #7
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	X	


2/24/12
 Patricia Tanquary, MSSW, MPN, PhD Date
 Chief Executive Officer
 Contra Costa Health Plan

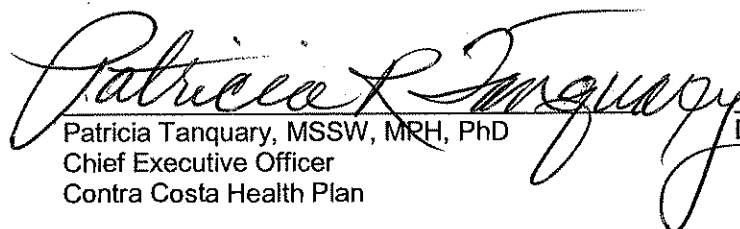
	Mandatory Qualifications Criteria	Check Box to certify "YES"	If no, explain
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	X	
11	Applicant will fully comply with all state and federal 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	ATTACHMENT #8
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	X	
14	Applicant is a corporation and it is in good standing and qualified to conduct business in California.	N/A	CCHP IS A COUNTY GOVERNMENT AGENCY
15	Applicant is a limited liability company or limited partnership and is in "active" standing and qualified to conduct business in California.	N/A	CCHP IS A COUNTY GOVERNMENT AGENCY
16	Applicant is a non-profit organization and is eligible to claim nonprofit status.	N/A	CCHP IS A COUNTY GOVERNMENT AGENCY
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	



 Patricia Tanquary, MSSW, MPH, PhD
 Chief Executive Officer
 Contra Costa Health Plan

Date

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	5 YEARS	2007-11
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	X	
3	Do the Plan's three -years of HEDIS results indicate a demonstrable trend toward increasing success?	X	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	PENDING	IN PROGRESS
5	Has the Plan received NCQA certification for its D-SNP Product?	N/A	CCHP NO LONGER HAS A D-SNP
6	How long has the Plan had a Medi-Cal contract?	SINCE 1973	
7	Does the plan propose adding supplemental benefits? If so, which ones?	YES, PERSONAL ADVISOR	INTERNATIONAL EMERGENCY COVERAGE; NON-EMERGENCY TRANSPORTATION
8	Did the Plan submit letters from County officials describing their intent to work together in good faith on the Demonstration Project? From which agencies?	YES	SEE ATTACHMENT #9
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	YES	SEE ATTACHMENT # 10
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	YES	SEE ATTACHMENT #11
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?	X	LIFELONG MEDICAL CARE; REHABILITATION SERVICES OF NORTHERN CALIFORNIA; GUARDIAN ADULT DAY HEALTH CARE


 Patricia Tanquary, MSSW, MRH, PhD
 Chief Executive Officer
 Contra Costa Health Plan


 Date

#	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. <ul style="list-style-type: none"> o A detailed operational plan for beneficiary outreach and communication. o An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. o An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand. 	X	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	X	
6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	X	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	X	
7.8	Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	X	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	X	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	X	



 Patricia Tanquary, MSSW, MPH, PhD Date: 2/24/12

 Chief Executive Officer

 Contra Costa Health Plan

CCHP Model of Care

1. Description of the Target Population

Members served by this program are potentially underserved residents in the community who are frail, elderly, disabled and/or have multiple chronic illnesses who frequently need additional information and support regarding access to health care services. Services include care coordination and referral to community resources with the goal of allowing the member to live in the least restrictive environment possible with the highest level of quality of life.

2. Measurable Goals

a. Describe the specific goals including:

- **Improving access to essential services such as medical, mental health, and social services; CCHP strives to increase communication and coordination among the plan, the providers and the member. In doing so, the member will be better empowered to utilize the spectrum of accessible services available in a managed care plan.**
- **Improving access to affordable care: Because the member's care is being managed, we can better assist the member in identifying medically necessary care and at the same time coordinate care in such a way to lower costs and provide more efficient services for the member's care.**
- **Improving coordination of care through an identified point of contact (e.g., gatekeeper); Each member is assigned to a Personal Advisor during their first 90 days of membership. This Personal Advisor acts as an identified point of contact to guide the member through our plan. CCHP will measure the total number of members that receive an Advisor.**
- **Improving seamless transitions of care across healthcare settings, providers, and health services; CCHP is part of an integrated health care system run by the county of Contra Costa. As such, we may avail ourselves to better transitions of care than other plans. These transitions will appear seamless to the member.**
- **Improving access to preventive health services; As stated above, allowing the member to better understand plan offerings and striving to increase communication among all providers will allow the member to improve their ability to benefit from basic preventive services and in turn will lead to better outcomes in member health. HEDIS measures will allow CCHP to measure these goals.**
- **Assuring appropriate utilization of services; CCHP is fully staffed with a knowledgeable Utilization Management Department that coordinates decisions with Case Management and all aspects of the health plan. As such, we assure that services are properly utilized which in turn ensures efficiency and guards against fraud, waste and abuse.**

- Improving beneficiary health outcomes (specify MAO selected health outcome measures); **CCHP is committed to measuring health outcomes and utilizing the results of such measurements to improve our systems and services. CCHP reports all Medi-Cal required measures. These measures are subject to change annually depending on requirements specified in the memo for each identified benefit year.**

Beginning in 2012, CCHP is also reporting all NCQA accreditation HEDIS measures and will conduct annual CAHPS surveys.

CCHP also evaluated our previous dual-eligible SNP with the NCQA newly SNP Structure & Process Measures including these three major groupings:

- **Complex Case Management**
- **Improving Member Satisfaction**
- **Clinical Quality Improvements**

Below are the NCQA set of HEDIS measures:

<u>Measure</u>	<u>Medicaid</u>	<u>Medicaid Accreditation</u>
Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life	✓	
Adolescent Well-Care Visits	✓	
All-Cause Readmissions – Statewide Collaborative QIP Measure	✓	
Ambulatory Care (Outpatient visits, Emergency Department visits)	✓	
Annual Monitoring for Patients on Persistent Medications (Total Rate)	✓	✓
Antidepressant Medication Management (Both Rates)		✓
Appropriate Testing for Children With Pharyngitis		✓
Appropriate Treatment for Children With Upper Respiratory Infection		✓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓	✓
Breast Cancer Screening		✓
Cervical Cancer Screening	✓	✓
Childhood Immunization Status (Combination 2)		✓
Childhood Immunization Status (Combination 3)	✓	
Children & Adolescents' Access to Primary Care Practitioners	✓	
Chlamydia Screening in Women		✓
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)		✓
	✓	✓

Comprehensive Diabetes Care (Eye Exam, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)		
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)		✓
Controlling High Blood Pressure		✓
Follow-Up After Hospitalization for Mental Illness (7 – Day Rate Only)		✓
Follow-Up for Children Prescribed ADHD Medication (Both Rates)		✓
Immunizations for Adolescents	✓	
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only)		✓
Prenatal and Postpartum Care (Both Rates)	✓	✓
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	✓	
Use of Appropriate Medications for People With Asthma (Total Rate)		✓
Use of Imaging Studies for Low Back Pain	✓	✓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		✓

b. Describe the goals as measurable outcomes and indicate how MAO will know when goals are met

- Each of the goals specified above can be measured by definable outcomes. For instance, regular meetings are held to evaluate network adequacy and to analyze whether there is any particular need to increase a specialty provider. If found to be the case, reports are available showing network composition for providers that can be measured against a benchmark.
- **Monthly Network Monitoring Report.** Data is gathered from CCHP's Provider Maintenance Information System (PMIS). PMIS contains data supplied by CCRMC Medical Staff Office and CCHP. This report shows open and closed panels for PCP's for RMCN and CPN. This report also shows raw data for Specialists in both networks formatted to show by East, West or Central County.
- **Quarterly Geo-Access Report** showing numbers of PCP and Specialists in each county region.
- Both the Monthly Network Monitoring Report and the Quarterly Geo-Access Report are reviewed at CCHP's Contract Strategy Meeting for access and network capacity issues. Semi-Annually, these reports are reviewed at CCHP's Quality Council. Any issues related to special care needs may be communicated to the Quality Director or UM Director and subsequently communicated to the Compliance

Subcommittee for action and follow-up.

- **See attached policies UM15.004- Specialist Referrals, UM15.027- Second Medical Opinion, and UM15.028- Standing Referrals for Specialist for detailed information regarding CCHP's policy for providing specialist services in circumstances when the medical needs of the member require expertise beyond that of the Primary Care Provider (PCP). These policies also explain how CCHP will provide and/or authorize medically necessary second opinions to an appropriately qualified professional and CCHP's policy for providing standing referrals to members with chronic conditions requiring ongoing specialty care.**
 - **Improvement in access is also a measurable outcome. If there are grievances or complaints regarding access, these will be logged in our Service Excellence Tracking System. Any decrease in complaints and/or grievances regarding access would be a measurable outcome.**
 - **Utilization Management also tracks an array of measures that allow the plan to measure the scope of functions provided under UM.**
 - **Goal: 100% of members will be assigned a Personal Advisor within 30 days of enrollment. Case Management Manager runs a report monthly of enrollment date, date Personal Advisor assigned and percentage of members meeting this goal.**
 - **Goal: 100% of members will be provided information regarding Advance Directives. Case Management Manager reviews monthly report which includes**
 - **Member statement of whether or not they have an Advance Directive**
 - **Date Advance Directive information was mailed to member**
 - **Date Member mailed a copy of the Advance Directive to the Health Plan**
- c. Discuss actions MAO will take if goals are not met in the expected time frame
- **Once a defined goal is developed with an expected time frame, a benchmark will exist. Any goals that do not meet expected time frames will be collected and reported to the plan's Quality and Compliance Units for further corrective action.**
 - **Goal: Personal Advisor Assignment: Report is run monthly. Case Management Manager will assign a Personal Advisor to any member who did not initially meet this goal. In addition, staff re-education will be provided.**
 - **Goal: Advance Directive: Report is run monthly Outbound call will be made to any member who was not asked about an Advance Directive in the first 30 days of enrollment. In addition, staff re-education will be provided.**
3. Organization of Staff
- a. Identify the specific employed or contracted staff to perform **administrative** functions (e.g., process enrollments, verify eligibility, process claims, etc.)
- **CCHP uses a Member Maintenance Unit (MMU) headed by our Member Maintenance Unit Manager that processes enrollments,**

and verifies eligibility. MMU also works in conjunction with our California Life and Health Insurance licensed Sales and Outreach Manager for online applications and other methods of enrollment.

- **Claims processing is performed by our Business Services Unit headed by our Business Service Manager and delegated claims functions are performed by our PBM for Part D.**

b. Identify the specific employed or contracted staff to perform **clinical** functions (e.g., coordinates care management, provide clinical care, educate beneficiaries on self-management techniques, consult on pharmacy issues, counsel on drug dependence rehab strategies, etc.)

- **A multi-disciplinary team approach proves to be a highly efficient and effective means of utilizing personnel resources without compromising client care and overall satisfaction. Our team includes Registered Nurses, Social Workers (LCSW and MSW), Member Services Counselors and Medical Record Technicians. The first point of contact for members are specially trained member services counselors known as Personal Advisors. A Registered Nurse then addresses episodic health and/or social services concerns. If more complex care coordination is needed over an extended period, a referral is made to the Case Managers for the comprehensive follow up.**

- **Personal Advisor: The Personal Advisor's role is to facilitate a smooth transition to the Plan and provide information and support regarding access to health care services, where to call when the member has medical questions, and to answer benefit questions during the first 90 days of enrollment. Personal Advisors can assist with linking members to community resources for transportation assistance, food and housing. They also facilitate establishment of a Medical Home by making initial health appointments with new PCP as necessary.**

- **Assessment Nurse: California licensed Registered Nurse/California licensed Public Health Nurse. For new members in CCHP, the Personal Advisor will contact the member and perform a health screen. Once the health information is collected, a nurse will make a follow-up call to the member to identify and address any clinical concerns.**

- **RN and Social Worker Case Managers: California licensed Registered Nurses and Masters Prepared Licensed Clinical Social Worker (LCSW) Case Managers coordinate individualized services for members whose needs include ongoing assistance with coordinating health care services. The Case Managers work collaboratively with all members of the healthcare team, including Discharge Planners at the affiliated hospitals and Utilization Management staff at the Health Plan.**

- **Manager of Case Management Services: Bachelor of Science Prepared Registered Nurse, California licensed RN/Public Health Nurse, Certified Case Manager.**

- **Medical Record Technicians: Clerical Support.**

- **Manager of Pharmacy Services: California licensed Pharmacist**

▪ **Health Plan Medical Director: California licensed Physician**

c. Identify the specific employed or contracted staff to perform **administrative and clinical oversight** functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.)

- **CCHP's Provider Relations Department headed by the Provider Relations Manager is responsible verifying licensing and competency for providers. They meet regularly in Credentialing Committee and participate in the Quality Committee. Our Quality Department headed by our Director of Quality Management reviews encounter data for appropriateness and timeliness of services. Our Pharmacy Director regularly reviews pharmacy claims reports and our UM Manager reviews utilization data and ensures proper use of clinical practice guidelines. All clinical actions are under the direction of CCHP's Medical Director. All clinical units are also represented in the Plan's Compliance meeting that meets twice a month and reports to the Director of Compliance.**
- **Contra Costa Health Plan's Executive Committee is ultimately responsible for oversight of all administrative and clinical activities. The Executive Committee consists of the CEO, COO, Medical Director, Compliance and Government Relations Offices and a Community Consultant.**

4. Interdisciplinary Care Team (ICT)

a. Describe the composition of the ICT and how the MAO determined the membership

- **Contra Costa Health Services is the safety-net healthcare system for Contra Costa County. Contra Costa Health Plan is one of seven divisions comprising Contra Costa Health Services which also includes: Contra Costa Mental Health, Public Health, Regional Medical Center and 8 FQHC clinics as well as our Alcohol and Other Drug Services. All members are assigned a Medical Home in one of our 8 clinics throughout the County. Medical Home assignments are determined by geography and member preference.**
- **At the Plan level the ICT includes nurses, social workers, pharmacist, Medical Director and Personal Advisors. At the clinic level, the ICT includes the Primary Care Physician is the primary point of contact. Other team members present at the clinics include Registered Dietitians, Physical, Occupational and Speech Therapists, Medical Social Workers and Mental Health Providers.**
- **ICT includes community based organizations as appropriate and may include:**
 - **Coordination of skilled and/or custodial care services with Skilled Nursing Facility (SNF) case managers/discharge planners. This includes coordination with SNF for discharge planning to the least restrictive residence for the member including but not limited to board and care, assisted living or home with family.**
 - **Coordination and collaboration with In-Home Support Services (IHSS).**
 - **Coordination with Community Based Adult Services (CBAS) for screening to determine the appropriateness of an individual for**

participation in the CBAS program. Enhanced Case Management Services (ECM) will be provided to CCHP members who have been screened and deemed ineligible for CBAS but meet the guidelines for ECM. ECM will be provided telephonically and in person by either a CCHP case manager or through special case management contracting with CBAS agencies within the service area.

- Describe how the MAO will facilitate the participation of the beneficiary whenever feasible
 - **The Health-Risk assessment is completed telephonically with the assessment nurse and member and/or caregiver. During the HRA process the nurse discusses, using motivational interviewing skills, the member's personal health and wellness goals. These goals are included in the care plan which is mailed to both the ICT via the Primary Care Provider and the member as a health planning tool.**
 - **Beneficiaries are contacted by the Personal Advisor at least twice a month during the first 90 days to determine changes and updates to their goals and care needs.**
 - b. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.)
 - **The completed Health Risk Assessment, member reported medication list for reconciliation and the individualized care plan initiated by the assessment nurse at the Health Plan is mailed to the Primary Care Provider. The ICT and PCP use the care plan to make decisions regarding referrals to rehab, and other specialty services. It also provides information to the clinic ICT regarding service coordination that has already occurred at the ICT Health Plan level.**
 - **Since the Health Plan and Clinics are part of the same Health Services framework, information can be easily shared via secure email. In 2012 the entire Health Services department will have implemented the EPIC electronic medical record. Health Plan Case Management, Utilization Management and clinics will all be charting on the same record.**
 - **At least annually, the Health Risk Assessment and care plan is reviewed with the member and PCP by the Health Plan assessment nurse. Adjustments to the care plan are made and shared with the ICT. Face-to-face meetings are conducted with the Health Plan Case Manager, member and clinic ICT when requested by any member of the team, including the member.**
 - **Documentation of written and telephonic communication is kept at the Health Plan in an Access database. Written correspondence is mailed to the Primary Care Provider for inclusion in their permanent records.**
5. **Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols**
- a. Describe the specialized expertise in the MAO's provider network that corresponds to the target population including facilities and providers (e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.)
 - **The existing Contra Costa Health Plan network already has expertise in disease management and Medicaid because CCHP has a history of serving dual eligible populations that consist of those who have CCHP for Medi-Cal and fee-for-service Medicare. This**

includes a comprehensive network of primary care providers and specialists in all clinical areas throughout Contra Costa and neighboring counties. This clinical expertise found in our network providers will allow CCHP to continue to focus on populations we are experienced in serving. ~~Our SNP plan will also afford us the continued opportunity to gain experience on how to tailor benefit packages to fit the needs of specific populations, such as the dually eligible, and to target marketing and services toward dual-eligible beneficiaries.~~

- **The Personal Advisor/Case Manager model ensures continuity of care between a multitude of providers due to the complexities of coordinating benefits between their Medi-Cal, Medicare and Medicare Pharmacy plans that may be particularly challenging for the frail/disabled beneficiaries. In addition, beneficiaries with multiple chronic illnesses receive through our programs complex medical care coordination by Registered Nurses and Social Workers.**
 - **Near end of life: When elected by the member, Contra Costa Health Plan (CCHP) coordinates hospice services for members with terminal conditions. Members who elect hospice services are referred to the Case Management Unit. The member is assigned to a Case Manager. The Case Manager shall assist the member with the coordination of continued medical care, including the continuation of established patient-provider relationship to the extent possible. (Policy CM16.003 Hospice Services)**
- b. Describe how the MAO determined that its network facilities and providers were actively licensed and competent
- **CCHP regularly conducts credentialing activities and monitors providers for disciplinary actions, suspensions, etc., which may require action.**
 - **The provider and pharmacy networks are the same for all plans offered through Contra Costa Health Plan. Health services will be available throughout Contra Costa County. Members will also have access to pharmacies through CCHP's arrangement with PerformRx. All providers from the member's chosen network will be available to CCHP's members using normal referral procedures from their PCP, or by self-referral for certain services.**
 - **CCHP is actively recruiting physicians that were identified as Fee for service providers in data sent from the State in late 2010. Letters were sent out to those these providers in January 2011.**
- b. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.)
- **Contra Costa Health Plan (CCHP) Utilization Management (UM) Unit is responsible for managing the utilization of services and ensuring high**

quality, appropriate, and timely services for its' members by following medical necessity guidelines established by the Health Plan and/or utilizing written clinical criteria/guidelines established by nationally recognized organization that are approved by the Quality Council.

The Health Plan does not require an authorization or a primary care provider (PCP) referral for the following services as long as coverage is included in the member's benefit package and rendered by a contracted, in-network Health Plan provider:

1. Acupuncture Services
2. Chiropractic Care
3. CT, DEXA Scan (for members ≥ 65 y/o with no previous DEXA in the last 2 years), ECHO, EEG, MRA, MRI, Pulmonary Function Test, Thyroid Scan
4. Emergency treatment¹ (*see footnote*)
5. Global outpatient OB care: thirteen (13) visits in eleven (11) months²
6. GYN services²
7. Mammograms (no more than one every 12 months)
8. Optometry services (For Medi-Cal members: CCHP limits coverage to diagnostic, ancillary and supplement procedures used to evaluate the visual system). *Please note: Orthopedics and pleoptics are not covered. Additionally, a second eye exam with refraction within 24 months is covered only when medically necessary.*)
9. Outpatient Psychotherapy Services (member can self-refer to the Mental Health Authorization Unit). For Medi-Cal members: Outpatient mental health services within the PCP's scope of practice are covered by CCHP. Other mental services for Medi-Cal enrollees are carved out; refer to County Mental Health Division)
10. Preventive Services
11. Sensitive Services^{2,3}: Includes family planning services, which are provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Also, initial HIV testing and counseling, treatment for rape, and abortion. *Please refer to Attachment A for exceptions and limitations*
12. Services by the PCP
13. X-rays and Ultrasound (limited to 2 OB ultrasounds; unlimited if requested by perinatologist)

¹For emergency treatment, stipulation regarding "contracted, in-network Health Plan provider" do not apply.

²For exceptions and detailed guidelines refer to Sensitive Services/OB/GYN grid, Attachment A. Medi-Cal members do not need prior authorization for sensitive services from non-contracted/non-network providers.

³Minor Consent Services: Members under eighteen (18) years old may get certain services, considered sensitive services, without parental approval. These services include:

- HIV testing and counseling;
- Pregnancy testing and other pregnancy-related services;
- Family planning services;
- Treatment for sexual assault, including rape and sexually transmitted diseases; and
- Outpatient mental health for 12 y/o or older who are mature enough to participate intelligently and either (1) there is danger of serious

Services Requiring Prior Authorization

Prior authorization is required for services requested by and/or for non-contracted, non-network providers, specialized, unusual or elective services. Examples of services requiring prior authorization for CCHP members include:

1. **Cardiac and pulmonary rehabilitation**
2. **DME and oxygen**
3. **Dental-medical services related to dental services that are not provided by dentists or dental anesthetists (refer to applicable EOC for detailed information)**
4. **Elective/scheduled inpatient admissions including obstetrics and hospice**
5. **EMG, NCS, ENG**
6. **Experimental/Investigational services**
7. **Genetic or DNA testing**
8. **Hearing aid**
9. **Hemo and peritoneal dialysis (not required for Senior Health, Medicare Crossover, or Medi-Cal enrollees)**
10. **Home health services, including home infusion therapy, SNF, or rehab center**
11. **PET and total body scans**
12. **Non-contracted or non-network providers, except if emergency services or sensitive services for Medi-Cal members is required**
13. **Non-reusable medical supplies**
14. **Mental health-psychiatrist (carved out for Medi-Cal enrollees, refer to County Mental Health Division)**
15. **Organ transplant evaluation**
16. **Out-of-area services**
17. **Outpatient surgery and facility based procedures (except those listed previously)**
18. **Prosthetics, orthotics, appliances, and braces**
19. **RAST or MAST testing**
20. **Referral of PCP to self for special services (e.g., surgery, OB care)**
21. **Subspecialty services or specialized programs such as Child Development Center, Pain Clinic, Weight Loss Clinic, Healthy Eating Active Lifestyle (HEAL) at CHO, or Sleep Lab, etc.**
22. **Specialist provider beyond 2 initial visits**
23. **Rehabilitation services beyond 2 initial visits, which includes physical, occupational and speech therapy**
24. **Tertiary care centers, e.g. UCSF, UC Davis**

Refer to either the CCHP Procedure/Services-Prior Authorization Request (PA001) form or the HP200-7 for other services requiring prior authorization.

The requesting physician completes a PA001 and faxes the form to the Authorization Unit at (925) 313-6058 when additional visits and/or treatments are required or when requesting a procedure, which requires prior authorization. The requesting provider must submit the medical justification for the requested service. All efforts are made to make a determination within 5 business days, but shall not

exceed a total turnaround time of 28 calendar days from the receipt of original routine authorization request (refer to policy UM 15.015a for turnaround time for urgent requests). The request is reviewed by the UM staff for appropriateness, which includes:

- 1) **Diagnosis and ICD-9 code**
- 2) **Requested services**
- 3) **Procedure**
- 4) **History and physical and pertinent clinical findings**
- 5) **Symptoms and significant physical findings**
- 6) **Test and lab results already performed**
- 7) **Purpose of the referral**
- 8) **Availability of service/procedure within assigned provider network**

The UM staff uses InterQual, Apollo, Medi-Cal, Medicare, established Health Plan guidelines, and/or other approved criteria (refer to policy UM15.002 for detailed information) along with the member's clinical condition, diagnosis, and requested treatment plan to determine medical necessity. If the request meets medical criteria, written notice of the approval is issued to the provider and member within 2 business days of the determination. In addition, the provider receives a verbal or fax transmittal notice within one day of the approval decision if the request was urgent.

If the UM staff does not initially receive sufficient supporting documentation to make a decision on a routine authorization request, the Health Plan contacts the requesting provider no less than twice, during the 28-day timeperiod to obtain additional information. If the Health Plan does not receive the requested information, the Health Plan makes a decision based on available information for a turnaround time not to exceed 28 days. For unfavorable decisions related to insufficient clinical information, the requesting provider can resubmit the authorization request with additional medical information and the 28-day timeperiod begins again.

Health Plan Authorization Representatives (aka: Medical Records Technician) have the authority to approve some authorization requests that have established guidelines and are noted on the CCHP Services Requiring HPAR Review grid and briefly outlined in the UM Program Description. Services such as inpatient, home health and/or infusion services, rehabilitation services, and skilled nursing facility admissions are referred to UM Nurses for clinical review. Requests that do not meet criteria are forwarded to the Medical Director or as designated, Physician Medical Consultant for final determination (see UM Program Description, Level of Authority section for more information).

To allow for the decision-making process, the requesting provider needs to submit non-emergent service requests to the Authorization Unit no less than five business days before the anticipated service date. Regardless of whether the PCP made the initial referral for a member, the Medical Director still has the authority to modify or deny continued services.

Occasionally, during the prospective and concurrent review process, the UM staff identifies at risk, high risk, and/or high dollar members. The UM staff refers these members to the Case Management Unit to assess the member's need and, if

appropriate, provide case coordination activities such as frequent contact, communication, resources, and feedback to the member, PCP, specialist, and other involved health care entities.

If an authorization request is urgent, the requesting provider receives a verbal notice within one day of the determination, followed by a written notice to both the member and provider within two business days. A decision to deny or modify an authorization request related to medical necessity is only made by the Medical Director or as designated, Physician Medical Consultant. If appropriate, the Medical Director will suggest alternatives to the requested service. When necessary, the Medical Director may assemble a panel of independent experts to assist in this determination.

If the Medical Director denies or modifies a request, the requesting provider is initially notified by phone or via fax transmittal. Within 2 days of an authorization denial or modification, written notification is sent to the member and provider, which includes a clear and concise explanation of the reason for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity along with a copy of member and provider appeal rights.

Please refer to policy #UM 15.015a for communication timeliness guidelines.

CCHP has a process for retention of prior authorization records, including Notice of Actions. This process is described in CCHP's Administrative Policy #1.031- Records Retention Policy.

Out of Plan Providers

In the event a medically necessary service is not available within the member's network or within the Health Plan provider network, the PCP may request a referral for the member to a non-participating provider. The PCP needs to obtain authorization from the Health Plan UM Unit and/or Medical Director before making a referral to a non-participating provider. It is the policy of the Health Plan not to authorize out-of-plan consultations and services if those same services are available through participating Health Plan providers. However, the Medical Director will consider such requests on a case-by-case basis. On a retrospective basis, Quality Council may review the frequency of requests for non-participating providers and actions taken by the Medical Director to determine if long-term interventions are necessary.

- CCHP's UM Department is the gatekeeper that determines which services beneficiaries will receive. All decisions are made with input from Case Management and subject to review.
- c. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.)
- Upon notification of a hospital or skilled nursing facility (SNF) unplanned admission, an admission review and as appropriate, a screening for discharge plans will be performed by the Health Plan Utilization Review

Nurse. The admitting facility should attempt to notify the Health Plan via telephone or fax transmittal of the admission face sheet on the day of or the following business day of the admission.

- For planned admissions of members, the Authorization Unit notifies the assigned CCHP case manager when the request for service has been approved. The case manager will confirm with the requesting provider that the plan of care has been sent to the receiving provider and ICT before admission. CM will contact the member, as part of the ICT, to assist as necessary.
- The Authorization Unit notifies the ICT via the Primary Care Provider (PCP) via fax transmittal or voice mail message within 2 business days of notification from the admitting facility of the members admission to acute and/or skilled nursing facility.
- When a member is hospitalized in a non-delegated facility, the CCHP UM Nurse reviews the stay and functions as the case manager. When the member is hospitalized in a skilled nursing facility (SNF), the member's Case Manager (CM) is assigned to follow the case and coordinate post-SNF services. The UM or CM Nurse can contact and consult with the attending physician and the ICT to determine discharge needs.
- Our delegated hospital (Contra Costa Regional Medical Center) provides care transitions services via their Transitions RN program and communicates directly with the ICT members via telephone. In addition, CCHP is in the process of implementing the "Coleman Care Transitions Intervention Model" which includes a post-discharge home visit and telephone transitions support.
- Screening the member for post hospital care by the facility case manager or discharge planner needs to begin as soon as the member is admitted to the hospital, or at the time of pre-scheduled elective admission review by the UM Nurse. In collaboration with the attending physician, patient/family and facility case manager or discharge planner, arrangements for medically necessary skilled nursing facility admission (if not concurrently in a SNF), home health care, outpatient follow-up visits or other needs are coordinated within benefit limitations. The facility case manager or discharge planner is the main contact person for the member and their family. The Health Plan UM or CM nurse stays in contact with the facility discharge planner to assure discharge plans are in place and appropriate for each member while considering the medical condition, disease process, family situation, available benefits, and community resources.
- For members, the assigned case manager acts as the liaison for the member, family, practitioners and other healthcare providers, including hospital, SNF, home health, etc.
- Upon acute hospitalization, if the member has a case manager, he or she will be notified of the member's admission. If the UM Nurse newly identifies a member that may benefit from outpatient Case Management services, a referral is made to Case Management (CM) unit. The UM Nurse shall complete a CM Referral Form and document in the computer system that a referral has been sent to CM. A copy of the CM Referral Form is retained the member's file. In addition to the admission notification, the CM unit is notified when a member is discharged to the next level of care, which may include, SNF, home health, custodial care, rehabilitation, etc. The Health Plan CM will communicate with the

member/family regarding the care transition process and ongoing treatment plans.

- Upon identification that a member needs SNF care, the acute hospital case manager or discharge planner will coordinate the transition to the SNF and **provide the member's plan of care within one business day of the admission** and will include at minimum a problem list, medications, allergies, advance directive, physical/cognitive function and provider contact information. The transition from SNF to the next level of care is coordinated by the SNF Case Manager and may include coordinating the following:
 - Discharge home with home health or outpatient services.
 - Assisting the member with making financial arrangements for continued care in the SNF.
 - Determining linkage to alternative financial and community resources, i.e. Medi-Cal, Medicare, long-term care insurance, in-home support services, or Providing Assistance to Caregivers in Transition (PACT).
 - Identifying members who may potentially exhaust his/her SNF benefits while hospitalized in the SNF and collaborate with the member, family, and SNF to implement a plan of action that focuses on, as much as possible, providing continuity of care.
 - SNF admission directly from home is coordinated by the CCHP assigned CM who acts as the primary point of contact for the facility CM, PCP, member and family during the transition.
 - CM will discuss with member and/or family what their goals are, care needs identified, wishes and the process of SNF placement.
 - CM will obtain from PCP the SNF order, history and physical, medication list, etc (i.e. care plan) and forward to the receiving SNF **at least 1day before admission**.
 - CM will follow up with facility CM and member/family within 1 week of the transition to identify any additional transition coordination needs.
- d. Describe how the MAO assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to MAO Medical Director for review, etc.)

Contra Costa Health Plan (CCHP) draws and follows recommendations from a number of nationally recognized sources in the development of clinical authorization guidelines and the application of criteria in the decision-making process. These recommendations and guidelines are used to evaluate the medical necessity for preventive care, admissions, outpatient surgeries, diagnostic and therapeutics, and ancillary services, such as durable medical equipment, orthotics, and prosthetics. Quality Council (QC) approves the following organizations and resources for the Utilization Management Department and Provider Network to use in the decision-making process (as listed in preferred usage order):

- State Department of Health Care Services-DHCS (Medi-Cal)*- *Medi-Cal product line*
- Noridian Administrative Services-DMERC Region D*- *Medicare and*

commercial product lines

- **Center for Medicare/Medicaid Services (CMS)*- Medicare and commercial product lines**
- **Health Plan established clinical authorization guidelines***
- **Apollo guidelines or InterQual Intensity of Service and Severity of Illness Criteria***
- **Aetna Clinical Policy Bulletins (http://www.aetna.com/cpb/cpb_alpha.html)***
- **Health Net Medical Policies (<https://www.healthnet.com/>)**
- **Blue Cross of California Clinical Utilization Management Guidelines (http://www.bluecrossca.com/shared/noapplication/f0/s0/t0/pw_a088663.pdf)**
- **National Guideline Clearinghouse (http://guidelines.gov/resources/guideline_index.aspx)**
- **Contra Costa County Health Services' Approved Electronic Library Web-Based Resources**
- **American Academy of Pediatrics (<http://pediatrics.org>)**
- **National Institute for Health (<http://www.nih.gov/>)**
- **American Medical Association Practice Parameters**
- **National Committee for Quality Assurance**
- **Joint Commission Accreditation for Hospital Organizations**

**See APPLICATION of Criteria and Guidelines section for specifications.*

In addition, other statistical data and resources are considered that may influence the frequency of review and revision of guidelines include: admits/1000, bed days/1000, visits/1000, under and over utilization of services, and any standards or goals published by professional organizations and approved by QC prior to use.

DEVELOPMENT of Clinical Criteria or Guidelines

In consultation with providers from the Contra Costa Regional Medical Center and/or Community Provider networks, CCHP UM department will aggregate data to review diagnoses, analyze treatment plans, identify practices, and research established standard of practice parameters that demonstrate consistent positive outcomes. These practices will be used to establish authorization and utilization review guidelines.

On an annual basis, the QC will review, approve, and recommend revisions to the application of criteria and guidelines. Documentation of above activities is noted in the Committee minutes.

UTILIZATION of Criteria or Guidelines by Participating Providers

Participating providers will be notified by CCHP that Health Plan established guidelines, InterQual, Medi-Cal, and Medi-Care criteria are the primary sources for the decision-making process. CCHP review guidelines are available to providers and applicable to all utilization activities.

UTILIZATION of Criteria or Guidelines by Regional Medical Center Network (RMCN) Provider

Upon approval by the Health Plan's Quality Council, RMCN providers may choose to use criteria and guidelines established by their organization for utilization review activities. These review criteria and guidelines are reviewed by the Health Plan prior to assignment of CCHP members to the RMCN, and annually thereafter.

APPLICATION of Criteria and Guidelines

The consistency of applying approved criteria and guidelines are measured at all levels of delegation via periodic concurrent review by supervisory staff, Utilization Management rounds, or periodic audits of determinations made by using these criteria.

In general, guidelines used in the decision-making process (prospective, concurrent and retroactive reviews and determinations) are as follows:

For hospital admission review (emergency room admissions, concurrent stay and retroactive review):

1. InterQual

For elective admissions, specialty care referrals, outpatient and ancillary services:

1. Based on enrollee's product line:
 - a. Medi-Cal guidelines for Medi-Cal enrollees
 - b. Medicare guidelines for Medicare and commercial enrollees, and for Medi-Cal enrollees when Medi-Cal guidelines do not exist or are nonspecific, such as DME, orthotic and prosthetic
2. Established Health Plan clinical authorization guidelines when Medi-Cal and Medicare guidelines are nonexistent or nonspecific
3. Apollo or InterQual guidelines when #1 and #2 are nonexistent or nonspecific
4. If the above sources do not have authorization guidelines specific to the requested service, CCHP follows guidelines established by nationally recognized sources listed in subheading, "Source of Criteria and Guidelines". However, for the services specified below, the Health Plan follows:
 - a. Aetna Clinical Policy Bulletins
(http://www.aetna.com/cpb/cpb_alpha.html) for:
 - i. Breast reduction/mammoplasty
http://www.aetna.com/cpb/medical/data/1_99/0017.html
 - ii. Genetic testing and/or counseling
http://www.aetna.com/cpb/medical/data/100_199/0140.html
 - iii. Neuropsychological testing
http://www.aetna.com/cpb/medical/data/100_199/0158.html
 - b. American Academy of Pediatrics Recommendation for Treatment of Child and Adolescent Overweight and Obesity, Suggested Staged Approach to Weight Management for Children and Adolescents,
http://pediatrics.aappublications.org/cgi/content/full/120/Supplement_4/S254 for:
 - i. Child and adolescent weight management

If guidelines or criteria do not exist, literature search for evidence-based, best practice standards shall apply. The Health Plan may use product-line specific Industry Collaboration Effort (ICE) Pre-Service Denial and Modification Reasons to compose denial and modification reasons.

- As explained above, CCHP has experience serving a variety of populations and our provider network has already been in

existence to serve dual eligible populations in Contra Costa Health Plan. Examples of pertinent clinical expertise used to meet the needs of frail/disabled beneficiaries or those with chronic illnesses, or those near the end of life include R.N. driven case management, disease management including asthma and diabetes, and psychiatric referrals programs. We have 24-hour Advice Nurse service available to all members. Our network also has contracted DME providers with certified fitters to help those in this particular population. Other specific providers offering expertise to these populations include contracted SNFs and Hospices for those requiring subacute and end of life services. Speech and Physical therapy services are also available. All services are coordinated through Case Management and specifically, the Personal Advisor who ensures continuity of care between a multitude of providers and specialties and due to the complexities of coordinating benefits for a frail population. Some of the tools providing information for evaluation include the following:

- **Monthly Network Monitoring Report.** Data is gathered from CCHP's Provider Maintenance Information System (PMIS). PMIS contains data supplied by CCRMC Medical Staff Office and CCHP. This report shows open and closed panels for PCP's for RMCN and CPN. This report also shows raw data for Specialists in both networks formatted to show by East, West or Central county.
- **Quarterly Geo-Access Report** showing numbers of PCP and Specialists in each county region.
- Both the Monthly Network Monitoring Report and the Quarterly Geo-Access Report are reviewed at CCHP's Contract Strategy Meeting for access and network capacity issues. Semi-Annually, these reports are reviewed at CCHP's Quality Council. Any issues related to special care needs may be communicated to the Quality Director or UM Director and subsequently communicated to the Compliance Subcommittee for action and follow-up.

Clinical guidelines are reviewed at Quality Council and communicated to providers through meetings with our network providers for both our Community Provider Network and our Regional Medical Center Network. They are also publicized in provider newsletters, on the Internet and Health Services Intranet sites. The Health Plan's Quality Director also sits on a joint Quality Committee with our Regional Medical Center where issues such as protocols and clinical guidelines can be discussed and implemented.

Through our new Epic electronic health information system, we will produce quarterly reports of adherence to clinical protocols. In addition, we evaluate adherence to best practices annually through HEDIS measures.

6. **Model of Care Training for Personnel and Provider Network**
 - a. Describe how the MAO conducted initial and annual model of care training including training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.)

Trainings are completed via face-to-face interaction using power point presentations and handouts and going forward e-learning modules developed by CCHP Leadership Team. In addition, quarterly all staff meetings are conducted

by the Health Plan's Chief Executive Officer and includes review and updates to the Model of Care.

b. Describe how the MAO assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.)

Section 10 of the Contra Costa Health Plan Staff Orientation Manual describes the Staff Development and Training mandates for all Health Plan employees. Going forward, e-learning modules will automatically track compliance and notification to the responsible manager.

c. Describe who the MAO identified as personnel responsible for oversight of the model of care training

Attendance in these trainings is directly linked to the staff member's annual performance review and salary considerations. Noncompliance with mandated trainings is documented in the performance review.

d. Describe what actions the MAO will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.)

The responsible manager is required to assure all of his/her staff has completed the MOC training. Personnel will be reminded in writing and in person that the training is mandatory and non-compliance will result in disciplinary action including withholding scheduled salary increases until completed.

Once a year, issues are reviewed with all staff. The Model of Care is also reviewed and any changes are communicated to operations, specifically Provider Relations. For 2012, CCHP will be evaluating the inclusion of the Model of Care specifics into our Provider Manual. The Provider Manual with updates and amendments are disseminated by Provider Relations staff. Proof of dissemination is available via attendee lists and signed acknowledgments. CCHP will identify the Case Management and Provider Relations Staff as designated personnel responsible for assuring that providers are trained on the Model of Care.

Contra Costa Health Plan holds regular Leadership Forum meetings where various Plan issues are discussed and where issues regarding Plan implementation and operations are shared with staff. In turn, management holds regularly scheduled meetings with each unit's staff. Documentation of updates/trainings are included in those minutes. In addition to this meeting, CCHP has the Compliance Fraud Subcommittee that meets twice a month to train managers on various operational issues. Also, as part of CCHP's internal audits system, the Compliance Officer works with all departments to ensure that staff understand specific CMS requirements and uses the internal auditing system as an educational tool. In the event that it is discovered that a provider is not provided access to the Provider Manual, Provider Relations will work with Compliance to remedy the situation. The following policies have also been discussed and shared with the Case Management Unit.

- **Policy CM16.015 SNP CM Program Description**
- **Policy CM16.006 Identification of Special Status SNP Members**
- **Policy CM16.017 Health Risk Assessment Screening**

- **Policy GHC23.002 Personal Advisor**
- **Power Point presentation at Staff trainings for Personal Advisor Role and completion for Health Risk Assessment Tool**

7. Health Risk Assessment

a. Describe the health risk assessment tool the MAO uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial, functional, and cognitive needs, medical and mental health history, etc.)

- **The HRA includes the following elements:**
 - **Life planning (i.e. living will/advance directive)**
 - **Language/communication preferences**
 - **Living environment including support systems and DME needs**
 - **Healthcare providers including PCP, Specialists, Pharmacy, dentist, etc**
 - **Current linkages to community resources**
 - **Medication List**
 - **Inmunization records if available**
 - **Activities of Daily Living status**
 - **Home Safety assessment and education**
 - **Historical data including ED visits and admissions**
 - **Medical Diagnoses**

b. Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary (e.g., initial assessment within 90 days of enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary, etc.)

- **Upon notice of a newly enrolled member, Contra Costa Health Plan (CCHP) will contact the new enrollee and perform a telephonic health screening within the first 90 days of the notification.**
- **The purpose is to identify health-related issues that can affect efforts made by the Health Plan to facilitate a smooth transition onto Contra Costa Health Plan. Additionally, the telephonic health screening enables the Health Plan to verify demographic information, establish a point-of-contact with the new member, and identify care coordination needs, such as the need for case management or disease management.**
- **For new members in CCHP's plan, CCHP Personal Advisor will contact the member within 90 days and perform a health screen using the attached Health Risk Screening form. Three times during the first two weeks after new enrollment notification, CCHP will attempt to contact the member by telephone no less than once a week. If the Health Plan is unable to contact the member during the first two weeks, subsequent efforts to contact the member are performed weekly. If CCHP is unable to contact the new member by phone by the 45th day after enrollment notification, CCHP will send a written communication to the member, informing the member to contact the Health Plan. Attempts to contact the member will be documented on the Health Risk Screening form and kept by the Health Plan.**
- **Reassessments are completed annually based on the quarter for which the previous assessment was completed. Reassessment forms are mailed to the member. If the assessment is not returned, the RN will attempt to contact the member telephonically to complete.**

c. Describe the personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.)

- **Once the health information is collected, a Registered Nurse will screen all completed forms and if needed, forward a copy of the form to appropriate staff if follow-up needed, such as enroll in disease management, or explore the need for case management. In addition, a copy of the assessment will be sent to the primary care provider.**

d. Describe the communication mechanism the MAO institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification, secure electronic record, etc.)

- **A copy of the Health Assessment and individualized care plan is sent to the Primary Care Provider along with a letter from the RN describing her interventions to date.**
 - **The completed Health Risk Assessment, member reported medication list for reconciliation and the individualized care plan initiated by the assessment nurse at the Health Plan is mailed to the Primary Care Provider. The ICT and PCP use the care plan to make decisions regarding referrals to rehab, and other specialty services. It also provides information to the clinic ICT regarding service coordination that has already occurred at the ICT Health Plan level.**
 - **Since the Health Plan and Clinics are part of the same Health Services framework, information can be easily shared via secure email. In 2012 the entire Health Services department will have implemented the EPIC electronic medical record. Health Plan Case Management, Utilization Management and clinics will all be charting on the same record.**
 - **At least annually, the Health Risk Assessment and care plan is reviewed with the member and PCP by the Health Plan assessment nurse. Adjustments to the care plan are made and shared with the ICT. Face-to-face meetings are conducted with the Health Plan Case Manager, member and clinic ICT when requested by any member of the team, including the member.**

8. Individualized Care Plan

a. Describe which personnel develops the individualized plan of care and how the beneficiary is involved in its development as feasible

- **At the Health Plan, our multi-disciplinary team including Registered Nurses, Social Workers (LCSW and MSW), Member Services Counselors and Medical Record Technicians all contribute to developing the care plan. However, the first point of contact for members are specially trained member services counselors known as Personal Advisors. A Registered Nurse then addresses episodic health and/or social services concerns with the member's involvement. If more complex care coordination is needed over an extended period, a referral is made to the Case Managers for the comprehensive follow up. These discussions become part of the individualized plan of care. The Health-Risk assessment is completed telephonically with the assessment nurse and member and/or caregiver. During the HRA process the nurse discusses the member's personal health and wellness goals. These goals**

are included in the care plan which is mailed to both the ICT via the Primary Care Provider and the member as a health planning tool. Other ICT members may make additions to the care plan as necessary.

b. Describe the essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc)

- The Personal Advisor will complete the assessment form, including race/ethnicity, language/communication, computer access, living environment, Activities of Daily Living (ADL's) and Durable Medical Equipment (DME) but not diagnosis section. They will begin composing the care plan. They will inform the member to expect a follow-up call from a nurse to collect clinical information and answer any clinical questions they may have. The assessment form is then given to the Assessment Nurse, who will contact the member in order to complete the medical portion of the form as well as any information not obtained through any of the above processes. The RN is responsible for reviewing and completing the care plan.

Care Plan essential elements from the health-risk assessment include:

- Family/caregiver support systems
- Activities of daily living deficits
- Living environment and home safety considerations
- Current or necessary DME requiring authorization/reauthorization
- Need for primary care or specialty care appointments
- Linkages to community resources such as Regional Center, Adult Day Healthcare, mental health, home health, substance abuse, In Home Support Services (IHSS), hospice
- Assistance with medication management
- Advance Directive/End of Life planning

The care plan includes specific interventions and expected outcomes as well as a target date for achievement of the goal.

d. Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the interdisciplinary care team (ICT), beneficiary whenever feasible, and other pertinent specialists required by the beneficiary's health needs; reviewed and revised annually and as a change in health status is identified, etc.)

- The Case Management Manager, along with other members of the multidisciplinary team (including but not limited to the case manager, PCP, rehab services, medical specialty providers, member/caregiver) may review and revise the care plan as frequently as appropriate for the member. The care plan is reviewed by the ICT and updated at least annually upon completion of the annual reassessment.

d. Describe how the plan of care is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and beneficiary either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.)

- Each plan of care is kept on a shared drive that is secured and backed up daily by our IS department.

In 2012 the entire Health Services department will have implemented the EPIC electronic medical record (EMR). All members of the ICT will be able to

access the individualized care plan on a shared EMR. Revisions and updates will be immediately available to the rest of the ICT.

- e. Describe how the plan of care and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers

As noted above, the care plan will be on a shared EMR that is used by the ICT at the Medical Home clinic and the MAO. Team members are responsible for communicating to the beneficiary any revisions they have made to the care plan.

- **All members are assigned a Personal Advisor (PA). PA's initiate the first part of a telephonic health-risk screening assessment, which includes demographics, race/ethnicity and languages spoken at home, the language in which they prefer their medical services and written materials and any communication barriers. Also addressed are financial barriers, living environment, support systems, medical equipment and devices in the home, current services that may need transition or coordination, visit history with healthcare providers and current level of assistance required for activities of daily living. Once immediate issues are addressed, the assessment is forwarded to a Registered Nurse to complete the clinical portion. The nurse will answer clinical questions and report all findings to the Primary Care Provider by written communication as well as telephonically for urgent issues. An integral part of the clinical assessment is medication reconciliation. A list of medications as reported by the member is collected and forwarded to the PCP for review of accuracy. The nurse is available to provide education based on the PCP's response. Referral to a Case Manager may be made at any time.**
 - **A minimum of one follow-up call per month will be made to the member during the first 90 days of enrollment to assist in scheduling Health Center Clinic appointments, answer benefit questions including pharmacy and research as necessary and identify new or ongoing medical or psychosocial concerns that require intervention.**
 - **All care plan revisions are communicated directly to the member and Case Management staff will communicate changes to providers as necessary.**

9. Communication Network

- a. Describe the MAO's structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.)
- **CCHP's structure for communication includes a combination of internet based email system as well as face-to-face meetings to supplement telephonic communication and regular mail.**
 - **Contra Costa Health Services will be fully functional with the EPIC EMR in 2012. This will allow for electronic communication between ICT members in real time.**
 - **Face-to-Face ICT meetings as needed are available on-site at either Contra Costa Regional Medical Center, one of the 8 FQHC clinics or at the Health Plan.**
 - **Monthly telephonic or face-to-face meetings are scheduled with our Health Services Mental Health Division to review mental health concerns of our members.**

- c. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies
 - **CCHP's Managed Care Commission (MCC) is the principal advisory board to the Health Plan. The Commission meets with The Plan bimonthly and includes as members no less than one Medi-Cal subscriber, one Medicare subscriber, one commercial subscriber, one person sensitive to medically indigent healthcare needs, one physician-noncontracting, one other provider-noncontracting, no less than 9 at-large noncontracting members, the Director of Health Services, the CEO of Contra Costa Health Plan and a member of the County Board of Supervisors. The Model of Care is presented annually to the MCC for review and input.**
 - **Community Coordinating Council meets no less than quarterly to collaborate with community based organizations (CBO's) to better meet the needs of our members. Council members include, but are not limited to, CCHP Case Management Manager and CEO, representatives from IHSS, Meals-on-Wheels, skilled nursing facilities, Board and Care community, CBAS centers, Independent Living Resources, disability-rights community.**
 - **CCHP's web site is available to all providers, beneficiaries, public and regulatory agencies.**
 - **Our communication network allows providers, beneficiaries and the public to facilitate communication with the plan. Regulatory agencies may also avail themselves to this communication network.**
- c. Describe how the MAO preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.)
 - **All aspects of written communication such as written minutes, newsletters etc., are kept on a shared drive that is secured and backed up daily by our IS department. Other types of communication are kept pursuant to current record retention policies including three years in hard-copy form and seven years in electronic form.**
 - **All written communication between the CCHP Case Managers and the member or providers is saved electronically and also hard copy in the Case Management department.**
 - **The Manager of Case Management keeps minutes of all staff meetings both electronically and hard copy.**
- d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness
 - **Health Plan staff have daily responsibility to monitor and evaluate the effectiveness of the plan's communication network. Problems that are identified are referred to the appropriate technical staff technicians for remedy.**
 - **Contra Costa Health Plan's Executive Committee is ultimately responsible for oversight of all communication avenues and their effectiveness. The Executive Committee consists of the CEO, COO, Medical Director, Compliance and Government Relations Officer and a Community Consultant.**

10. Care Management for the Most Vulnerable Subpopulations

- a. Describe how the MAO identifies its most vulnerable beneficiaries
- **All of the pilot's members are dual eligible. By definition, they are all in the most vulnerable category of seniors or persons with disabilities.**
 - **Enrollment Application will be sent to the Case Management Department upon enrollment by the Membership Maintenance Department.**
 - **All members are assigned a Personal Advisor (PA). PA's initiate the first part of a telephonic health-risk screening assessment, which includes demographics, race/ethnicity and languages spoken at home, the language in which they prefer their medical services and written materials and any communication barriers. Also addressed are financial barriers, living environment, support systems, medical equipment and devices in the home, current services that may need transition or coordination, visit history with healthcare providers and current level of assistance required for activities of daily living. Once immediate issues are addressed, the assessment is forwarded to a Registered Nurse to complete the clinical portion. The nurse will answer clinical questions and report all findings to the Primary Care Provider by written communication as well as telephonically for urgent issues. An integral part of the clinical assessment is medication reconciliation. A list of medications as reported by the member is collected and forwarded to the PCP for review of accuracy. The nurse is available to provide education based on the PCP's response. Referral to a Case Manager may be made at any time.**
 - **A minimum of one follow-up call per month will be made to the member during the first 90 days of enrollment to assist in scheduling Health Center Clinic appointments, answer benefit questions including pharmacy and research as necessary and identify new or ongoing medical or psychosocial concerns that require intervention.**
 - **Monthly utilization/claims data is reviewed by the Pharmacy Director and Manager of Case Management to identify members who have multiple co-morbidities or are high utilizers of services as an indication that they are vulnerable for hospitalization or decline in health status.**

b. Describe the add-on services and benefits the MAO delivers to its most vulnerable beneficiaries

- **Personal Advisor 90 days: The goal of the Personal Advisor program is to provide personalized assistance to all new members during their first 90 days of enrollment.**
- **Smoking Cessation classes and Rx are made available to help reduce exposure to heart and lung disease caused by smoking.**
- **Health Education and nutrition materials.**
- **Emergency services covered Worldwide: this is a highly desirable benefit that allows these members to freely travel outside the original Medicare service area and still retain medical coverage.**
- **Routine Physical 1 per year: As a MAO, CCHP believes in preventive medical care and routine physicals help doctors to diagnose and test for medical problems before they exacerbate.**
- **No prior hospital stay required for SNF coverage.**
- **Transportation**

- **CBAS or enhanced case management for those not meeting CBAS criteria**
- **Health Education**
- **Complex Case Management**
- **Beneficiaries near the end-of-life:**
 - **Telephonic and written education and assistance regarding Advanced Healthcare Directives in both English and Spanish**
 - **Assigned to a dedicated hospice case manager who will coordinate with contracted hospice agency for care.**

11. Performance and Health Outcome Measurement

- a. Describe how the MAO will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.)
 - **Case Management receives monthly pharmacy data, Risk Adjustment Processing results and a SNF report every week. Using these informational sources, Case Management will evaluate the Model of Care and make adjustments as appropriate, not to exceed annually.**

- b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.)
 - **Annually or more frequently as necessary, the Manager of Case Management along with the Director of Quality and Director of Compliance will review and evaluate the model of care to ensure that it is current and reflective of all new requirements.**
 - **Model of Care Review Committee will meet annually in January to review from the previous year all utilization data, HEDIS results, referrals made to specialty services and other case management activities on both a member and Plan level. The analysis also includes all transitions of care activities and their effectiveness. Committee members include:**
 - **CEO**
 - **Quality Director**
 - **Case Management Manager**
 - **Analysis and Reporting Manager**
 - **Compliance Officer**
 - **RN certified risk adjustment reviewer/coder**
 - **Director of Advice Nurse Unit**
 - **Plan Medical Director**
 - **FQHC Chief of Ambulatory Care Services**
 - **Manager of Provider Relations**

- c. Describe how the MAO will use the analyzed results of the performance measures to improve the model of care (e.g., internal committee, other structured mechanism, etc.)
 - **After reviewing appropriate performance measures, the Director of Quality will report any analyzed results that may be indicative of opportunity for improvement in CCHP's model of care. Identified opportunities for change will first be discussed at Quality Council, and subsequently brought to the Compliance Committee for review with the Director of Compliance.**
 - **Recommendations from the above committees will be incorporated into the Model of Care by the Manager of Case Management, Quality Manager and**

Provider Relations Manager, all of whom will be responsible for staff/provider training and implementation.

- d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.)
 - **If an evaluation of the model of care is deemed necessary, all changes will be documented through numeric identification of the appropriate version so that changes may be documented for tracking purposes. The effectiveness of any change will be tracked by the Manager of Case Management in an electronic format as determined by Case Management and reported to the Director of Compliance upon the annual re-submission of the Model of Care and Quality Improvement Program.**
 - **All data collected and all subsequent analysis will be recorded via an Excel or other spreadsheet during the annual review by the MOC Review Committee. All documents relating to the evaluation of the MOC will be kept on the Health Plan's secure shared drive for future reference and review.**
- e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.)
 - **Oversight responsibility will be shared between the Manager of Case Management, Director of Quality and Director of Compliance. Responsibility for evaluation will require feed-back from all members of the multidisciplinary team to be analyzed by the aforementioned parties.**
- f. Describe how the MAO will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.)
 - **One of the most important pieces of the program is the enhanced communication between the Health Plan and the Primary Care Provider. Initially, the Health Plan Assessment Nurse sends a detailed letter to the PCP describing issues identified during the assessment process, actions she has taken to date, a copy of the medication list as understood by the client for medication reconciliation, as well as the entire Health-Risk assessment for review. This process has been invaluable in streamlining service coordination and improving satisfaction for both member and PCP.**
 - **Once assigned, the Case Manager shall be in contact with each client's Primary Care Physician (PCP) on admission to the program and on a regular basis thereafter. Frequency of contact to be determined by the severity of the illness and the complexity of Case Management required**
 - **All changes to the MOC will be presented annually to the Managed Care Committee (see description in element 9b) for their review. This will assure that all stakeholders are aware of the changes and have an opportunity to provide input into the MOC and review process.**

Any improvements in the Model of Care can be communicated to the Provider Relations Unit who in turn can announce these changes in a Provider Newsletter, bulletin or other appropriate announcement, including face-to-face plan/provider meetings as appropriate.

Contra Costa Health Plan

Case Management

Title: Hospice Services

Policy #: CM 16.003

Origin Date: 7/18/07

Author: Florence Chan, RN, Director of Auth/UM/CM
Laurie Crider, RN, CM Supervisor

Revised:

Author:

Reviewed: 2/20/2009, 2/2012

Author: Laurie Crider, RN, CM Manager

Applies to:

- | | | | |
|--|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> All | <input type="checkbox"/> BHC | <input type="checkbox"/> Commercial | <input type="checkbox"/> Healthy Families |
| <input checked="" type="checkbox"/> Medi-Cal | <input type="checkbox"/> Medicare | <input type="checkbox"/> N/A | <input type="checkbox"/> Other State Sponsored |

Regulatory/Accreditation:

- | | | | |
|------------------------------|---|-------------------------------|--------------------------------|
| <input type="checkbox"/> CMS | <input checked="" type="checkbox"/> DHS/MMCD 7014 | <input type="checkbox"/> DMHC | <input type="checkbox"/> MRMIB |
| <input type="checkbox"/> N/A | <input type="checkbox"/> Other | <input type="checkbox"/> URAC | |

Units:

- | | | |
|--|--|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Advice Nurses | <input type="checkbox"/> All Staff |
| <input type="checkbox"/> Business Services | <input type="checkbox"/> Authorization/CM/UM | <input type="checkbox"/> Health Ed/Cultural Ling. |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Member Services | <input type="checkbox"/> Planning, Survey, Reg Affairs |
| <input type="checkbox"/> Provider Affairs | <input type="checkbox"/> QM/QI | |

OPS Council Approval Date & Sign Off : 11/26/2007

POLICY & PURPOSE

When elected by the member, Contra Costa Health Plan (CCHP) shall provide hospice services for members with terminal conditions. Members who elect hospice services are referred to the Case Management Unit. The member is assigned to a Case Manager. The Case Manager shall assist the member with the coordination of continued medical care, including the continuation of established patient-provider relationship to the extent possible. Additionally, the assigned Case Manager shall ensure medically necessary covered services unrelated to the terminal illness are covered.

PROCEDURE

Hospice care will be coordinated with a contracted hospice agency and, concurrent review/utilization review performed by a CCHP Case Manager to ensure the following are met:

1. Members are informed that hospice services are available via member materials. In addition, providers are informed by the Provider Relations Department via provider manual, provider education and periodic bulletins.
2. Requests for hospice care will be accepted from PCP, Specialty Physician or Hospice agency with a physician's certification that the member has a terminal illness and a member "election" of such services is submitted on an appropriate hospice election form.
3. And election period shall consist of two periods of 90 days each and an unlimited number of subsequent periods of 60 days each. An individual's voluntary election may be revoked or modified at any time during an election period.
4. No prior authorization is required for outpatient hospice care. However, CCHP requires timely notification from our contracted hospice providers of any admission to hospice services.
5. Prior authorization is required for general inpatient care. CCHP will respond to prior authorization requests within 24 hours by the Case Management Unit during business hours and by the Advice Nurse Unit during non-business hours.

6. A CCHP Case Manager will be assigned to the member to coordinate hospice and non-hospice related services.
7. Members with a terminal condition covered by CCS will be informed that election of hospice will terminate the child's eligibility for CCS services.
8. Concurrent review and coordination of hospice care in a skilled nursing facility (SNF) will be ongoing regardless of the length of stay and will not affect eligibility. Admission to a SNF while under hospice services does not affect the member's Health Plan enrollment eligibility.
9. Hospice services will consider the enrollee and the enrollee's family and include, but are not necessarily limited to the following:
 - i. Skilled nursing services
 - ii. Physical, occupational or speech therapy
 - iii. Medical social services under the direction of a physician
 - iv. Home health aide and homemaker services
 - v. Medical supplies and appliances
 - vi. Drugs and biologicals
 - vii. Physician Services
 - viii. Dietary/nutrition counseling
 - ix. Counseling, including bereavement, grief and spiritual counseling
 - x. Continuous home nursing care for as much as 24 hours a day during a period of crisis, and only as necessary to maintain the patient at home.
 - xi. Respite care provided on an intermittent, non-routine and occasional basis for up to five days at a time
 - xii. Short-term inpatient care for pain control or chronic symptom management which cannot be managed in the home setting
 - xiii. Any other item or service for which payment may otherwise be made under the Medi-Cal program.
 - xiv. Interdisciplinary team care
 - xv. Active utilization of volunteers in the delivery of hospice services

CONTRA COSTA HEALTH PLAN

Case Management

Title: Identification of Special Status Contra Costa Health Plan Members Policy #: CM16.006

Origin Date: 1/23/2007
Reviewed: 2/20/09
Revised: 2.2012

Author: Laurie Crider, RN, Case Management Supervisor
Author: Laurie Crider, RN, CM Manager
Author: Laurie Crider, RN, CM Manager

Applies to:

- Medi-Cal
 BAC
 Medicare
 State Sponsored
 Commercial
 All
 N/A

Regulatory / Accreditation:

- Department of Managed Care
 Other Reg. References:
 HCFA
 NCQA
 DHS:
 N/A

Units:

- Administration
 Business Services
 Marketing
 Provider Affairs
 Advice Nurses
 Care Management
 Member Services
 Quality Management
 All Staff
 Health Ed/Cultural Living
 Planning, Survey, Reg. Affairs
 Auth/Utilization Management

OPS Council Approval Date & Sign Off 1/29/2007 BIM/CFS

POLICY and PURPOSE

The purpose of this policy is to describe the process that Contra Costa Health Plan (CCHP) will follow to track, monitor and report all CCHP members with a CMS Special Status designation. Special Status designation includes those CCHP members who have elected hospice care, are diagnosed with End Stage Renal Disease (ESRD), or are institutionalized in a Skilled Nursing Facility (SNF), intermediate care facility, psychiatric hospital or unit, rehabilitation hospital, long-term care hospital or swing-bed hospital.

PROCEDURE

Identification

1. Enrollment Application will include a question, which addresses institutional status and ESRD diagnosis.
2. Initial telephonic Member Health Risk Assessment will include questions, which address hospice care, ESRD and institutionalization.
3. Utilization Management will report to Case Management any member discharged from the hospital to an institution or to home or institution with hospice care.
4. Case Management will educate CCHP staff about the importance of timely notification (day of admission) to CCHP of admissions of all CCHP members to their facility.

Tracking

1. Case Management will provide concurrent review of all members in CCHP or Hospice care.
2. Case Management will receive on a weekly basis from Performance Measurement Unit (PMU) a report recording all authorizations for Skilled Nursing Facility (SNF), intermediate care facility, psychiatric hospital or unit, rehabilitation hospital, long-term care hospital or swing-bed hospital, hospice and ESRD (dialysis). This report will track for 30-day residency requirement as required and reportable to CMS for institutionalized members.

Reporting

1. Case Management will report to Membership Maintenance unit (MMU) on the day of identification any member residing in an institution, has elected hospice care or diagnosed with ESRD. MMU has the responsibility of reporting to the appropriate regulatory agency.

CONTRA COSTA HEALTH PLAN

Case Management

Title: Contra Costa Health Plan Case Management Program

Policy #: CM 16.015

Origin Date: 4/2008
Revised: 1/1/2011, 2/2012

Author: Laurie Crider, RN-CM Supervisor
Author: Laurie Crider, RN-CM Manager

Applies to:

- | | | |
|--|--|-------------------------------------|
| <input checked="" type="checkbox"/> Medi-Cal | <input checked="" type="checkbox"/> Medicare | <input type="checkbox"/> Commercial |
| <input checked="" type="checkbox"/> BAC/HCCI/MCE | <input type="checkbox"/> State Sponsored | <input type="checkbox"/> All |

Regulatory / Accreditation:

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> Department of Managed Care | <input type="checkbox"/> HCFA: | <input type="checkbox"/> DHS: |
| <input type="checkbox"/> Other Reg. References: | <input type="checkbox"/> NCQA | <input checked="" type="checkbox"/> N/A |

Units:

- | | | |
|--|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Advice Nurses | <input type="checkbox"/> All Staff |
| <input type="checkbox"/> Business Services | <input checked="" type="checkbox"/> Case Management | <input type="checkbox"/> Health Ed/Cultural Living |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Member Services | <input type="checkbox"/> Planning, Survey, Reg. Affairs |
| <input type="checkbox"/> Provider Affairs | <input type="checkbox"/> Quality Management | <input type="checkbox"/> Auth/Utilization Management |

OPS Council Approval Date & Sign Off 4/2008 BIM/CFS

POLICY

The Contra Costa Health Plan (CCHP) Case Management (CM) program provides specialized Case Management Services to all CCHP members.

PURPOSE

The purpose of the CM Program is to ensure that CCHP members receive comprehensive high quality, well-coordinated care and service. The program is focused on the delivery of cost-effective, appropriate health and social services for members with complex and chronic care needs. Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate services, which may be delivered on an ongoing basis. Case Management is performed through a process of telephonic assessment and review, and, as required, complemented with in-home visits.

This program is directed at coordinating resources and creating individualized care plans to meet the member's unique medical and psychosocial needs.

GOALS

The primary goals of the program are to:

- Enhance the quality of life of the client
- Provide support and advocacy to member and provider
- Obtain timely information on high-cost clients
- Decrease fragmentation of care
- Promote cost-effectiveness
- Improve client and provider satisfaction
- Meet regulatory and accreditation requirements

SCOPE:

Case Managers facilitate individualized services for members whose needs include ongoing assistance with coordinating health care services to achieve optimum wellness. The Case Managers work collaboratively with all members of the healthcare team, including Discharge Planners at the affiliated hospitals and Utilization Management staff at the Health Plan. The Case Management Manager is responsible for oversight of program activities and reports to the Director of Utilization Management who reports to the Medical Director and Quality Council.

CM staff provides all clients, community providers, Health Plan employees and other health service providers with high quality professional service, which include:

- Adherence to the confidentiality rules and regulations set forth by the Contra Costa Health Services Department. Department policy shall be distributed to each employee upon hire and annually by performance evaluation.
- The privacy and confidentiality of all clients and staff shall be respected in all medical and personal matters.
- Equal treatment to all clients, without regard to socioeconomic status, race, religion or cultural background.

The effectiveness of the Case Management Program depends on the ability to identify CCHP members who will benefit from the CM process. Cases are identified through the following:

- Monthly RAPS (claims) data reports
- Monthly enrollment data of new members into the CCHP plan
- Pharmacy data reports monthly
- Review of discharge summaries received from Contra Costa Regional Medical Center
- Lab data collected during the Health-Risk Assessment process
- Weekly collaborative CM/UM case conferences with CCHP Medical Director for concurrent review of admissions/discharges at community hospitals

All CCHP members are eligible for the CCHP Case Management Program, which includes a Personal Advisor, for the first 90 days of enrollment in order to receive an Initial Health Risk Assessment and provide assistance with care coordination as they transition to their new health plan. In addition, referrals will be accepted at any time from the following:

- Contracted primary care providers and specialists (instructions included in Provider Manual)
- CCHP Advice Nurse Unit
- Contra Costa Regional Medical Center and Community Hospital discharge planners
- Referrals from member or family members (Case Management member brochure mailed to all CCHP Members)
- Utilization Management/Authorization Unit Nurses and staff
- Health Services Department Disease Management Programs

Guidelines for referral to CCHP case management may include, but not limited to:

- Frail elderly*, disabled, those with multiple chronic illnesses and those in need of end-of-life care.
- Medical non-adherence (e.g., two or more missed appointments, misuse of medications, poor dietary adherence)
- High utilization of ED visits (e.g., two visits in three months)

- Over/under utilize of medically necessary services
- Frequent hospital admissions (same or different diagnosis) and readmissions (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year)
- Referral for clinical assessment of benefit exception and substitution appropriateness.
- Psychosocial high risk factors resulting in significant negative health outcomes
- Cognitive changes as evidenced by significant fluctuations in memory, mood, personality or behavior by the geriatric client
- Unstable medical conditions warranting closer monitoring (e.g., uncontrolled diabetes, exacerbating asthma, COPD, CHF)
- Complex or chronic medical condition, including those which affect multiple organ systems and/or which require ongoing complicated therapy (e.g. transplants, cancer, ESRD)
- Clients requiring assistance following a particular medical regime (e.g., pre-surgical)
- Self-care deficits requiring one-to-one or group health education to promote well-being
- Coordination of skilled and/or custodial care services at a Skilled Nursing Facility (SNF). This includes coordination with SNF for discharge planning to the least restrictive residence for the member including but not limited to board and care, assisted living or home with family.
- Coordination of In-Home Support Services (IHSS) including oversight of quality of care provided by the IHSS provider.
- Screening to determine the appropriateness of an individual for participation in the Community Based Adult Services (CBAS) program. Enhanced Case Management Services (ECM) will be provided to CCHP members who have been screened and deemed ineligible for CBAS but meet the guidelines for ECM. ECM will be provided telephonically or in person by either a CCHP case manager or through special case management contracting with CBAS agencies within the service area.

* Elderly person with multiple medical problems, difficulty with mobility and self-care as well as problems with memory, mood and ability to cope. May lack social support network.

OBJECTIVES:

The CM program intends to accomplish the following:

- Coordinate cost-effective services
- Facilitate care which is easily accessible with no access barriers as related to the member's available benefits
- Apply benefits appropriately and coordinate with health plan staff to flex benefits
- Promote early and intensive treatment intervention in the least restrictive setting
- Provide accurate and up-to-date information to providers regarding member evaluations and progress toward goals
- Create individualized treatment plans which are revised as the member's healthcare needs change
- Utilize multidisciplinary clinical, rehabilitative and support services.
- Arrange broad spectrum appropriate resources for members
- Deliver highly personalized case management services
- Grant adequate attention to member satisfaction
- Uphold strict rules of confidentiality and protect member rights and encourage member responsibility
- Encourage collaborative collegial approaches to the case management process

PROCESS:

(Also see Policy # GHC23.002-Personal Advisor and CM16.017-CCHP Health Risk Assessment)

1. Manager will assign new CCHP members to a Personal Advisor.
2. The Personal Advisor will complete on the assessment form demographics, provider information, historical data and immunizations information. The Personal Advisor will also print the current medication list and include it as a separate attachment along with assessment.
3. The Personal Advisor then calls the member to welcome him/her using the CCHP Health Risk Screening and Welcome Script. The Personal Advisor will complete the assessment form, including race/ethnicity, language/communication, computer access, living environment, Activities of Daily Living (ADL's) and Durable Medical Equipment (DME) but not diagnosis section. They will inform the member to expect a follow-up call from a nurse to collect clinical information and answer any clinical questions they may have.
4. The assessment form is then given to the CCHP Assessment Nurse, who will contact the member in order to complete the medical portion of the form as well as any information not obtained through any of the above processes.
5. Based on risks identified, the Assessment Nurse Case Manager will develop an individualized care plan with input from the member, Personal Advisor and Primary Care Provider. The completed health-risk assessment form and care plan will be forwarded to the Primary Care Provider within 90 days of enrollment.
6. The CCHP Case Manager will refer to other CCHP, CCHS and community programs and resources as appropriate. At the end of the 90-day period, the CCHP Case Manager may refer the member to the Complex Case Management Unit for ongoing Case Management services as necessary.
7. The Personal Advisor will provide ongoing follow up on all non-clinical issues identified during the welcome call and will respond to the member in a timely manner:
 - a. Benefit questions
 - b. Systems questions
 - c. Pharmacy questions
8. The Personal Advisor will send a close letter to the member one week before the end of the 90-Day period. The letter includes contact information for Advice Nurse unit, Member Services, Pharmacy, Authorizations, appointment unit for County Clinics and CCHP Sales & Marketing department. A member brochure for the Complex Case Management Program is also included.
9. Reassessments are completed annually based on the quarter for which the previous assessment was completed. Reassessment forms are mailed to the member. If the assessment is not returned, the RN will attempt to contact the member telephonically to complete.

Origin Date: 5/15/06

Authors: Florence Chan, Director of UM

Ellen Lent-Wunderlich, RN, Clinical Operations Officer

Revised: 12/18/2006, 1/29/2007

Author: Laurie Crider, RN, Case Management Supervisor

Reviewed: 2/20/09

Author: Laurie Crider, RN, CM Manager

Applies to:

 Medi-Cal Medicare Commercial BAC State Sponsored All N/A

Regulatory / Accreditation:

 Department of Managed Care HCFA: DHS: Other Reg. References: NCQA N/A

Units:

 Administration Advice Nurses All Staff Business Services Care Management Health Ed/Cultural Living Marketing Member Services Planning, Survey, Reg. Affairs Provider Affairs Quality Management Auth/Utilization Management

OPS Council Approval Date & Sign Off 1/29/2007 BIM/CSF

POLICY

Upon notice of a newly enrolled member, Contra Costa Health Plan (CCHP) will contact the new enrollee and perform a telephonic health screening within the first 90 days of the notification.

PURPOSE

The purpose is to identify health-related issues that can affect efforts made by the Health Plan to facilitate a smooth transition onto Contra Costa Health Plan. Additionally, the telephonic health screening enables the Health Plan to verify demographic information, establish a point-of-contact with the new member, and identify care coordination needs, such as the need for case management or disease management.

PROCEDURE

For new members in CCHP, CCHP staff will contact the member within 90 days and perform a health screen using the attached Health Risk Screening form. Three times during the first two weeks after new enrollment notification, CCHP will attempt to contact the member by telephone no less than once a week. If the Health Plan is unable to contact the member during the first two weeks, subsequent efforts to contact the member are performed weekly. If CCHP is unable to contact the new member by phone by the 45th day after enrollment notification, CCHP will send a written communication to the member, informing the member to contact the Health Plan. Attempts to contact the member will be documented on the Health Risk Screening form and kept by the Health Plan.

Once the health information is collected, a nurse will screen all completed forms and if needed, forward a copy of the form to appropriate staff if follow-up needed, such as enroll in disease management, or explore the need for case management. In addition, a copy of the assessment will be sent to the primary care provider.

Reassessments are completed annually based on the quarter for which the previous assessment was completed. Reassessment forms are mailed to the member. If the assessment is not returned, the RN will attempt to contact the member telephonically to complete.

Title: Personal Advisor

Policy #: GHC23.002

Origin Date: 4/23/2007 Author: Laurie Crider, RN, Case Management Manager
Revised: 2.2012 Author: Laurie Crider, RN, Case Management Manager
Revised: Author:
Reviewed: Author:

Applies to:

All BHC/HCCI/MCE Commercial Healthy Families
 Medi-Cal Medicare N/A Other State Sponsored

Regulatory/Accreditation:

CMS DHS DMHC MRMIB
 N/A Other URAC

Units:

Administration Advice Nurses All Staff
 Business Services Authorization/CM/UM/GHC Health Ed/Cultural Ling.
 Marketing Member Services Planning, Survey, Reg Affairs
 Provider Affairs QM/QI

OPS Council Approval Date & Sign Off: 5/14/2007

POLICY

Upon enrollment into the Contra Costa Health Plan (CCHP), each member will be assigned a Personal Advisor to provide a welcome call and assistance with the transition to his or her new plan.

PURPOSE

The Personal Advisor's role is to provide information and support regarding access to health care services, where to call when the member has medical questions, and to answer benefit questions during the first 90 days of enrollment.

ROLE

1. Complete health risk assessment using computer systems and call script
2. A minimum of one follow-up call per month will be made to the member to assist in scheduling Health Center Clinic appointments and answer benefit questions, including pharmacy; research as necessary.
3. Provide information & resources to members re: non-emergency transportation to appointments
 - a. Go on-line to agency web sites to plot a fixed transit route to and from appointments or give member web site if they have computer access
 - b. Provide phone # or applications for Para-transit provided by county transportation agencies (Tri-Delta, County Connection, West-Cat)
 - c. Para-Transit with Private Companies (Pro-Transport, Medic Mobile, etc.): Refer to Case Management if member states they cannot use public-transit.
4. Use translation services appropriately and educate member in alternative communication services (i.e. California Relay/TTY/TDD).
5. Refer to CM/DM programs as appropriate via Assessment Nurse.
6. Educate member about accessing member services, advice nurse unit and appointment unit.
7. Send close letter to member one week before end of 90 days.

PROCEDURE

1. Case Management Manager will assign new CCHP members to a Personal Advisor.
2. Three times during the first two weeks after new enrollment notification, Personal Advisor will attempt to contact the member by telephone no less than once a week. If the Personal Advisor is unable to contact the member during the first two weeks, subsequent efforts to contact the member are performed at least weekly. If the Personal Advisor is unable to contact the new member by phone by the 45th day after enrollment notification, he/she will send a written communication to the member, informing the member to contact the Health Plan. Attempts to contact the member will be documented on the Health Risk Screening form or other appropriate computer database and kept by the Health Plan.
3. The Personal Advisor will complete on the assessment form demographics, provider information, historical data and immunizations information collected from the enrollment form, Meditech, PCIS, SETS, ALUS and QicLink computer systems. The Personal Advisor will also print the current medication list from PCIS and include it as a separate attachment along with assessment.
4. The Personal Advisor then calls the member to welcome him/her using the CCHP Health Risk Screening and Welcome Script. The Personal Advisor will complete the assessment form, including race/ethnicity, language/communication, computer access, living environment, Activities of Daily Living (ADL's) and Durable Medical Equipment (DME) but not diagnosis section. They will inform the member to expect a follow-up call from a nurse to collect clinical information and answer any clinical questions they may have. The assessment form is then given to the Assessment Nurse, who will contact the member in order to complete the medical portion of the form as well as any information not obtained through any of the above processes.
5. The Personal Advisor will follow up on all non-clinical issues identified during the welcome call and will respond to the member in a timely manner:
 - a. Benefit questions
 - b. Systems questions
 - c. Pharmacy questions
6. The Personal Advisor will send a close letter to the member one week before the end of the 90-Day period. The letter includes contact information for Advice Nurse unit, Member Services, Pharmacy, Authorizations, appointment unit for County Clinics and CCHP Sales & Marketing department.

Health Risk Screening Form Contra Costa Health Plan

DEMOGRAPHICS			
Last Name:		First Name/MI:	
Birth Date:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Member ID:
Address:			Previous plan:
Life Planning: Living Will/Adv Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No Information Mailed: <input type="checkbox"/> Yes <input type="checkbox"/> No Copy Received: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Phone Numbers: Home: Cell: Work: Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently employed <input type="checkbox"/> Not currently employed Employer: Employer Address:			
Emergency Contact Name/Relationship: Phone Numbers:			
Race/Ethnicity: (check all that apply)	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Native American	<input type="checkbox"/> Other: _____
		<input type="checkbox"/> Asian	<input type="checkbox"/> Multicultural
			<input type="checkbox"/> decline
Do you speak another language at home? Y N	If yes, what language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Tagalog <input type="checkbox"/> Russian <input type="checkbox"/> Farsi <input type="checkbox"/> Cantonese <input type="checkbox"/> Other:		<input type="checkbox"/> Needs Interpreter
In what language do you prefer to receive your medical services? _____		In what language do you prefer to receive your written materials? _____	
Communication	<input type="checkbox"/> Sign Language <input type="checkbox"/> TTY (Phone for the deaf) <input type="checkbox"/> Braille		
Do you have access to a computer? [] Yes [] No		Member's email address:	
If yes, would you like to receive information online/via email?			
ALLERGIES	Medication/Food: <input type="checkbox"/> None known		
Living Environment	[] House: levels 1 2	[] SNF	[] Board/Care
	[] Apartment	[] Homeless	[] Assisted Living
			[] Custodial
Lives with	[] Spouse/Partner [] Family [] Alone: part-time assistance		
	[] Alone: no assistance		
Equipment at home	[] Cane/Walker [] Manual Wheelchair [] Electric Wheelchair		
	[] Oxygen [] Ramp [] Other:		
	Vendor: _____ Rental or Purchased _____		
Case Management	Do you have a case manager at CCHP or through other source? Name: _____ Source: _____		

PROVIDERS				
Providers	Name	City	Phone	Last Visit
PCP				
Specialist and specialty type				
Pharmacy				
Eye				
Dentist				
Current Services	<input type="checkbox"/> MSSP <input type="checkbox"/> Linkages <input type="checkbox"/> Regional Center <input type="checkbox"/> Adult Day Care/Health Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Home Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/> IHSS <input type="checkbox"/> Hospice <input type="checkbox"/> Other:			

Member Name: _____

MEMBER SELF-EVALUATION OF HEALTH
How would you currently rate your overall health? 1(great) 2(very good) 3(good) 4(not good) 5(poor)
Do you sometimes have trouble remembering to take your medicines or keep appointments? Yes No

HISTORICAL DATA (In past 12 months)			
Type of Visit	# Visits	Last Visit	Details
ED Visits without admission			
Acute admissions			
Readmissions within 30 days			
Specialty Physician Visits			
PCP			

DIAGNOSES						
CATEGORY	DISEASE					Alert
Respiratory	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Asthma	<input type="checkbox"/> Smoker	<input type="checkbox"/> Congestive heart failure	
	<input type="checkbox"/> COPD	<input type="checkbox"/> Other				
Circulatory	<input type="checkbox"/> Heart Disease (heart attack)	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Deep Vein Thrombosis (blood clot)	
	<input type="checkbox"/> Swollen feet/ankles	<input type="checkbox"/> Other				
Digestive	<input type="checkbox"/> Colitis	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Frequent heartburn (GERD)	
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Other		
Endocrine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Obesity	<input type="checkbox"/> Nutritional Deficiency	
	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Other				
Genitourinary	<input type="checkbox"/> Problems with urination	<input type="checkbox"/> UTI (bladder infections)	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> PID (pelvic inflammatory disease) Female	<input type="checkbox"/> Urostomy	
	<input type="checkbox"/> Other					
Nervous System	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Seizures	<input type="checkbox"/> Paraplegic or Quadraplegic	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Other	
Musculoskeletal	<input type="checkbox"/> Frequent or severe pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disk or Joint Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Amputation body part:	
	<input type="checkbox"/> Other					

Materials Provided:		
Referral to CCC Fall Prevention Program	Yes	No (why not)

Date: Phone contact attempted: _____
Date: Phone contact attempted: _____
Date: Phone contact attempted: _____
Date: Letter Sent: _____

Personal Advisor: _____

Person completing form: Advisor: _____ RN: _____

Date assessment done: Advisor: _____ RN: _____

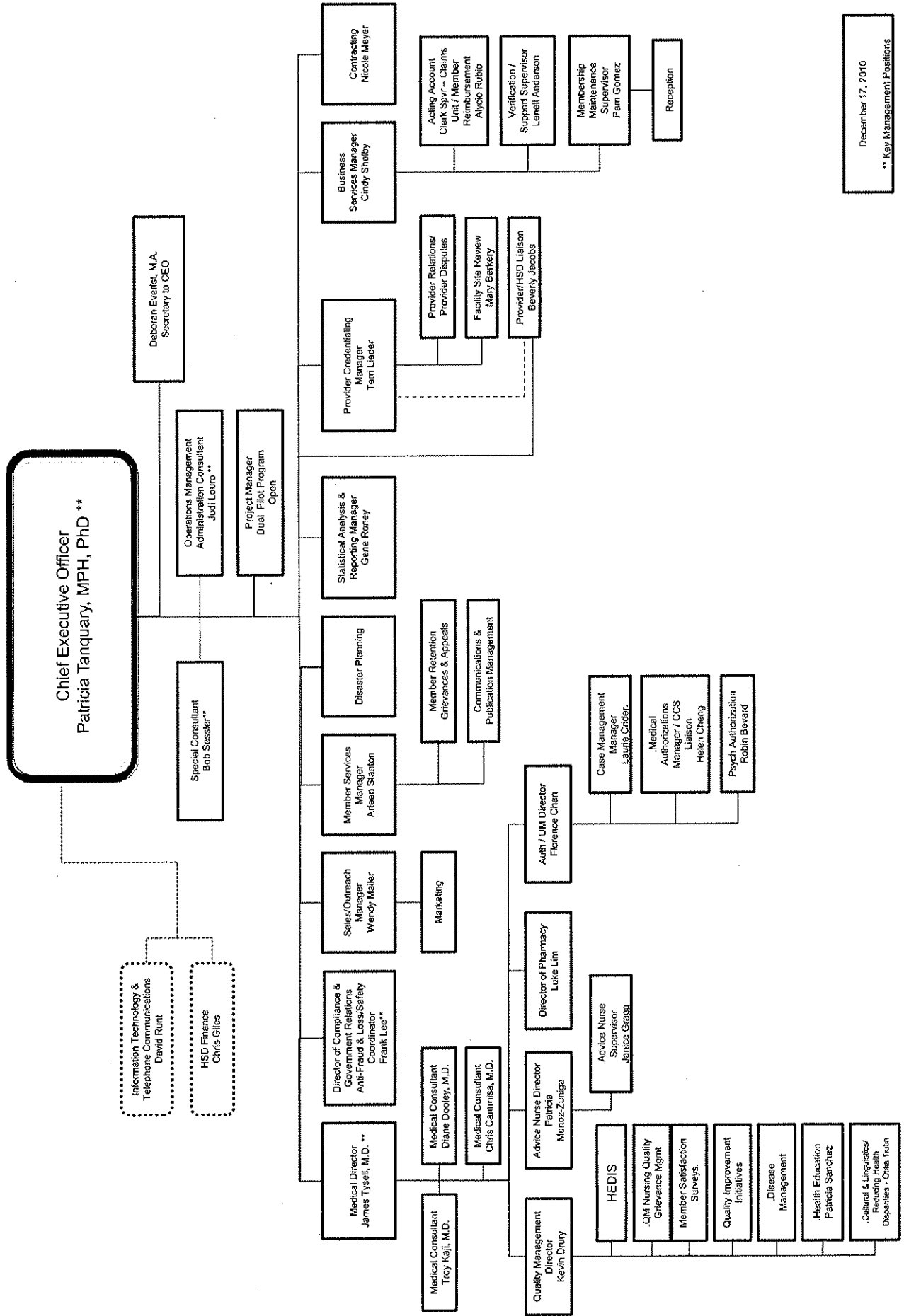
Date sent to RN: _____

Date assessment sent to PCP: _____

Referral to: Case Management Disease Management

CCHP ORGANIZATION CHART

Leadership & Functions 2011



December 17, 2010
** Key Management Positions

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Frank Lee, J.D.
Director of Compliance and Government Relations
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

Re: Letter of Standing – Contra Costa County Medical Services

Dear Mr. Lee:

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

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

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.

The Division of Plan Surveys (“DPS”) shows that the last Routine Medical Survey Report for CCCMS was issued on July 22, 2010. The Routine Medical Survey did not identify any deficiencies. The next Routine Medical Survey is due by February 20, 2013.

Please contact me with any questions or concerns.

Sincerely,



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

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Bill Prather, Division of Licensing
Tom Chan, Division of Financial Oversight

5

Contra Costa County Medical Services (d.b.a. : Contra Costa Health Plan)

Org. Type

Health Plan

Action Date

07/08/2011

Penalty

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Violation #

1300.76(a)	Failure to have and/or maintain required level of tangible net equity (TNE)
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Contra Costa County Medical Services (d.b.a. : Contra Costa Health Plan)

Org. Type

Health Plan

Action Date

08/14/2007

Penalty

\$3,600.00

Violation #

1371	Failure to pay claims timely/to pay interest on late claims/to include fee for failing to include interest
1300.71.38(f)	Failure to issue written determination explaining resolution within 45 working days
1300.71.35(1)(A)&(B)	Incorrect calculation of interest



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

DATE: JAN 31 2011

MMCD All Plan Letter 11-002
(Supersedes APL 10-001)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM
REQUIREMENTS FOR 2011

PURPOSE

This Medi-Cal Managed Care Division (MMCD) All Plan Letter clarifies the Quality and Performance Improvement Program requirements for Medi-Cal managed care health plans for 2011. All Medi-Cal managed care health plans are contractually required to report annual performance measurement results, participate in a consumer satisfaction survey, and conduct ongoing quality improvement projects (QIPs).

Not all of the requirements presented below are applicable to specialty health plans (AHF Healthcare Centers, Family Mosaic Project, and SCAN Health Plan) or prepaid health plans (Kaiser PHP in Marin County). For these health plans, requirements are noted where applicable, but health plans should refer to their contracts for further information.

REQUIREMENTS

1. External Accountability Set Performance Measurement Requirements

- a) All Medi-Cal managed care health plans must submit annual scores for the required External Accountability Set (EAS) performance measures. With the exception of the specialty health plan Family Mosaic Project, the Department of Health Care Services (DHCS) currently requires all contracted health plans to report selected Healthcare Effectiveness Data Information Set (HEDIS®) measures in order to comply with the EAS reporting requirement. DHCS requires the Family Mosaic Project to report on two performance measures developed specifically for that health plan. (See Attachment 1.)

- b) All contracted health plans must submit to an annual on-site EAS compliance audit, currently referred to as the "HEDIS Compliance Audit™," except for the Family Mosaic Project. This audit is a two-part process consisting of an information systems capabilities assessment, followed by an evaluation of an organization's ability to comply with HEDIS audit specifications. The HEDIS audit methodology was developed by the National Committee for Quality Assurance (NCQA) and is used to assure standardized quality performance measure reporting throughout the health care industry. The Family Mosaic Project must undergo a performance measure audit of its two (2) internally-developed measures.
- c) All health plans must use DHCS's selected contractor for the HEDIS Compliance Audit. The Health Services Advisory Group (HSAG) is DHCS's current External Quality Review Organization (EQRO) contractor, and will perform the 2011 HEDIS audits. HSAG may subcontract with one or more independent auditors licensed by the NCQA to conduct some of the HEDIS audits. These audits are paid for by the State.
- d) For the 2011 reporting year, DHCS made no changes to the required HEDIS measures from the previous year. However, it should be noted that the Department will introduce new measures for the 2012 reporting year to support performance measurement related to the implementation of mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities, as required by Welfare and Institutions Code Section 14182 (as added by Stats.2010, c. 714 (SB 208) § 20). These new measures may be HEDIS measures, other standardized measures, and/or Department-developed measures and will be chosen after consultation with contracted plans and input from the EQRO and other stakeholders during 2011.
- e) Attachment 1 lists all 11 HEDIS measures required for reporting year 2011 (i.e., measurement year 2010) for full-scope health plans, as well as those which were required for the previous year. Note that some measures have multiple indicators. Attachment 1 also includes the two HEDIS or other performance measures to be reported by each specialty and prepaid health plan. These measures have been agreed upon between DHCS and each health plan as appropriate for each health plan's membership. The required measures for reporting year 2011 were communicated to all contracted health plans via e-mails from MMCD's Plan Management Branch on September 21 and 22, 2010, and from Rita Marowitz, Chief of MMCD's Program Data and Performance Measurement Section on September 23, 2010.

- f) Each health plan (any model type) must report to the EQRO the results on all the performance measures required of that health plan, while adhering to HEDIS or other specifications for the reporting year. Each health plan must submit preliminary results to the EQRO by June 1, 2011, to allow for sufficient auditor review before rates are finalized.
- g) All health plans must calculate and report HEDIS rates at the county level unless otherwise approved by DHCS. Current exceptions to this requirement were approved many years ago for health plans operating in Riverside and San Bernardino counties and the County Organized Health System (COHS) plans operating in Monterey and Santa Cruz counties and in Napa, Solano, and Yolo counties. When existing health plans expand into new counties, if enrollment exceeds 1,000 members as of July of a given calendar year, health plans are required to report separate HEDIS rates for each county. DHCS does not intend to approve new combined county reporting of HEDIS measures if a health plan has 1,000 or more members in any new county.
- h) Each contracted health plan will calculate its scores for the required performance measures, and these scores will be confirmed by the EQRO or its subcontractor and reported to DHCS.
- i) Health plans must meet or exceed DHCS-established Minimum Performance Levels (MPLs) for each required HEDIS measure. The 2011 MPL for each required measure is the 25th percentile of the national Medicaid results for that measure as reported in the most current edition of NCQA's *2010 Audit Means, Percentiles, and Ratios* at the time the EQRO provides the annual HEDIS rates to DHCS.
- j) DHCS adjusts the MPLs each year to reflect the 25th percentile of the national Medicaid results for each measure. The percentiles are drawn from the most current edition of NCQA's *Audit Means, Percentiles and Ratios* at the time the EQRO provides HEDIS rates to DHCS.
- k) For each measure that does not meet the established MPL or is reported as a "Not Report" (NR), the health plan must submit an Improvement Plan (IP) within 60 days of being notified by DHCS of the measures for which IPs are required. For example, a health plan with HEDIS scores falling below the MPL for two of the required measures must submit two IPs – one for each measure.
 - Health plans must submit the required IPs to DHCS using the *HEDIS Improvement Plan Submission Form* (Attachment 2). The most current

version of this form is provided to each health plan at the time DHCS notifies the plans of the measures for which IPs must be submitted and the due date.

- The IPs are submitted to DHCS at gipsmail@dhs.ca.gov, the address established by MMCD's Performance Measurement Unit for this purpose.
 - Health plans serving multiple counties under a single contract may submit an IP that addresses more than one county if the health plan's scores fell below the MPL for the same measure in more than one county covered by that contract. However, in the IP the health plan must discuss how it will address the targeted population in each county.
 - Plans are not subject to the MPL in the first year scores are reported for a newly required measure as this score is considered the baseline score. Therefore plans do not have to submit an IP if a score for a new measure is below the MPL. These first-year scores will be reported in the annual aggregate report with an acknowledgement that these are baseline scores that are not subject to the MPL.
- l) DHCS will publicly report the audited HEDIS or other performance measurement results for each contracted health plan, along with the Medi-Cal managed care program average, the national Medicaid average, and the national commercial average for each DHCS-required performance measure.
- m) DHCS establishes a High Performance Level (HPL) for each required performance measure and publicly acknowledges health plans that meet or exceed the HPLs. The 2011 HPL for each required measure is the 90th percentile of the national Medicaid results for that measure as reported in the 2010 edition of NCQA's *Audit Means, Percentiles and Ratios*.

2. Under/Over-Utilization Monitoring

- a) Health plans are required to report rates for selected HEDIS Use of Services measures for the monitoring of under and over-utilization. For 2011, the selected Use of Services measures are listed in Attachment 3 and include:
- *Frequency of Selected Procedures* –Procedures selected for reporting year 2011 are: back surgery, bariatric weight loss surgery, lumpectomy, and mastectomy.
 - *Inpatient Utilization: General Hospital/Acute Care* – Includes utilization of acute inpatient services in various categories

- *Ambulatory Care* – Includes outpatient visits and emergency department visits.
- b) Health plan processes for arriving at Use of Services rates are not audited, but the rates for these measures are reported to the NCQA-certified auditor performing the HEDIS audits under the direction of DHCS's EQRO. These Use of Services rates are for internal use and are not publicly reported. In future years, MMCD may include these measures in the HEDIS audits, may modify the selected measures, may establish benchmarks, and/or may begin publicly reporting the results.

3. Consumer Satisfaction Surveys

- a) The next Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for both adults and children will be administered by the EQRO in 2012.
- b) In years when the CAHPS surveys are administered, results will be reported by the EQRO for each health plan at the county level. County-level reporting allows the DHCS, contracted health plans, and other stakeholders to better understand how member satisfaction and health plan services varies in individual counties.
- c) Although specialty and prepaid health plans are not required to participate in the CAHPS survey, these health plans are required to conduct a member satisfaction survey at least every other year and to provide DHCS with results specific to the health plan's Medi-Cal managed care members. Each specialty health plan must provide DHCS with a copy of the survey instrument and the survey calculation/administration methodology, so that the EQRO may evaluate them for compliance with both federal and contract requirements.

4. Quality Improvement Projects

Number of QIPs Required

Full-scope health plans are required to conduct and/or participate in two QIPs – the Department-led statewide collaborative and *either* an internal QIP (IQIP) or a health plan-led small group collaborative (SGC) QIP. Health plans holding multiple Medi-Cal managed care contracts are required to conduct two QIPs for each contracted entity.

Specialty and prepaid health plans also are required to conduct two QIPs, but are not required to participate in the Department-led statewide collaborative QIP. For these

health plans, the two QIPs usually will be IQIPs, although health plans may request approval to participate in a SGC appropriate to their member population.

Both IQIPs and SGCs must be approved by DHCS and validated by the EQRO in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements for performance improvement projects. Full-scope health plans that contract with DHCS after the current statewide collaborative begins will be required to participate in a SGC or to develop an IQIP in place of their participation in the statewide collaborative after the plan has been operational for one year, subject to DHCS approval.

Requirements for QIPs

Title 42, CFR, Section 438.240(b)(1) requires that QIPs “be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable affect on health outcomes and enrollee satisfaction.”

- a) In order to demonstrate significant and sustained improvement, each health plan is required to provide the following information in the QIP status reports and the QIP final report:
- A quality indicator baseline result followed by subsequent measurement results for the same quality indicator during and after implementation of improvement interventions. Note that sustained improvement is demonstrated when two consecutive re-measures result in a statistically significant improvement.
 - Tests of statistical significance calculated on baseline and repeat indicator measurements. For example, a health plan might use a P value of less than 0.05 as the threshold for statistical significance.
 - Prospective identification of indicator goals. Existing benchmarks should be strongly considered when establishing indicator goals. DHCS recommends that indicator goal(s) be based on the following sources in order of precedence: benchmarks of performance, a DHCS-specified goal, or a well-defined goal submitted in advance by the health plan. If a benchmark or DHCS-specified goal is not used, the health plan must provide justification for the chosen goal(s).
- b) QIPs may be based on HEDIS measures, although this is not required. Under such circumstances, health plans must adhere to the HEDIS specifications in

place at the time the QIP proposal is approved by DHCS and validated by the EQRO. If, during the course of the QIP, HEDIS specifications change for the QIP's HEDIS measure, DHCS and the EQRO, in collaboration with the health plan, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by DHCS.

- c) QIPs typically last 12 to 36 months, and use of the Rapid Cycle Improvement approach is expected when feasible. Health plans wishing to conduct a QIP beyond 36 months must get approval from DHCS.
- d) If desired, health plans serving multiple counties under a single contract may submit a QIP that addresses the same improvement topic in more than one county, provided the targeted improvement is relevant in more than one county covered by that contract. However, the QIP proposal and subsequent status reports must specifically address the targeted population in each county included in the QIP by submitting county-specific data and results for the following QIP activities:
 - Sampling methods
 - Data collection procedures
 - Assessment of improvement strategies
 - Data analysis and interpretation of study results
 - Assessment for real improvement
 - Assessment for sustained improvement

The above QIP activities and others are documented by health plans on the *QIP Summary Form* and validated by the EQRO.

- e) The *Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans* explains the CMS requirements for QIPs and how the EQRO validates plan QIPs for compliance with the federal requirements. This guide was updated as of November 2010 to reflect changes and enhancements to the validation process, including instructions and requirements for documenting an improvement topic in multiple counties. The *QIA Guide* is available on the DHCS website at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>.

Approval and Validation Process for QIP Proposals and Status Reports

All QIP proposals and status reports must be submitted on HSAG's *QIP Summary Form* or *QIP Summary Form for Multi-Counties*. The forms are available to health plans on HSAG's File Transfer Process (FTP) site. (Note: All current Medi-Cal managed care

health plans already have identified FTP users who have been assigned user names and passwords by HSAG in order to access each health plan's specific folder. To establish additional user profiles or remove previous users, health plan staff should contact Denise Driscoll at DDriscoll@hsag.com.)

- a) Health plans first submit QIP proposals to MMCD for approval. Once MMCD has approved the topic of the QIP proposal, MMCD forwards the proposal to the EQRO for validation. Once a health plan's QIP proposal is fully approved and validated, the health plan must submit status reports at least annually or according to a timeline agreed upon by the health plan, MMCD, and the EQRO.
- b) QIP proposals, both for IQIPs and SGCs, should be sent to qipmail@dhs.ca.gov, the e-mail address established by MMCD's Performance Measurement Unit for submission of QIP proposals and status reports.
- c) Within approximately one month of receiving a QIP proposal, MMCD will send the health plan either an approval of the QIP or a request for further development. Once a proposal is approved by MMCD, staff will forward it to the EQRO for validation and notify the health plan that the QIP's validation process has begun. The EQRO will send validation results to both the health plan and to MMCD and may request modifications to the health plan's proposal before final validation that the health plan's QIP proposal is in compliance with both DHCS and CMS requirements.
- d) Health plans must send baseline reports (if not included in the proposal), annual status reports, and final reports for all QIPs directly to the EQRO via HSAG's FTP site with a "cc" to qipmail@dhs.ca.gov.
- e) Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, health plans must submit a new QIP proposal to MMCD as described above.
- f) Attachment 4 presents an overview of QIP requirements in table form.

KEY CONTACTS

If you have questions or concerns about the information in this letter, please contact the following individuals via e-mail according to your area of concern:

- General questions about MMCD's quality and performance improvement program requirements: Helen MacDonald, Chief, MMCD Performance Measurement Unit, at Helen.MacDonald@dhcs.ca.gov

- HEDIS MPLs and HPLs and the submission of HEDIS Improvement Plans: Helen MacDonald at Helen.MacDonald@dhcs.ca.gov
- HEDIS 2011 audit requirements and QIPs validation process: Jennifer Lenz, Associate Director of EQRO Services, HSAG, at jlenz@hsag.com
- The current statewide collaborative QIP on reducing avoidable ER visits: Rose Recostodio, Nurse Consultant, MMCD Medical Policy Section, at Rose.Recostodio@dhcs.ca.gov.
- Required QIPs, the submission of QIP proposals and status reports, and QIP due dates: K.A. Corley (Corley), Associate Governmental Program Analyst, MMCD Performance Measurement Unit, at K.A.Corley@dhcs.ca.gov.

Performance measurement and quality improvement are important aspects of the Medi-Cal managed care program. The partnership between MMCD, its contracted health plans, and the EQRO results in ongoing improvement of the quality of care and services provided to Medi-Cal beneficiaries. We look forward to continuing this positive relationship.

Sincerely,



Tanya Homman, Chief
Medi-Cal Managed Care Division

Attachments (4)

**REQUIRED HEDIS MEASURES FOR FULL-SCOPE PLANS:
REPORTING YEARS 2010 and 2011**

<i>HEDIS Reporting Year 2010¹</i>	<i>HEDIS Reporting Year 2011²</i>	<i>Notes re: 2011 Measures</i>
Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life*	Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life*	Hybrid measure Used for Auto Assignment
Adolescent Well-Care Visits*	Adolescent Well-Care Visits*	Hybrid measure Used for Auto Assignment
Childhood Immunization Status – Combo 3*	Childhood Immunization Status – Combo 3*	Hybrid measure Used for Auto Assignment
Appropriate Treatment for Children with Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection	Admin measure
Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care* • Postpartum Care	Prenatal & Postpartum Care (2 indicators): • Timeliness of Prenatal Care* • Postpartum Care	Hybrid measure Prenatal indicator used for Auto Assignment
Use of Imaging Studies for Low Back Pain	Use of Imaging Studies for Low Back Pain	Admin measure
Breast Cancer Screening	Breast Cancer Screening	Admin measure
Cervical Cancer Screening*	Cervical Cancer Screening*	Hybrid measure Used for Auto Assignment
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	Hybrid measure
Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing* • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Comprehensive Diabetes Care (8 indicators): • Eye Exam (Retinal) Performed • LDL-C Screening Performed • LDL-C Control (<100 mg/Dl) • HbA1c Testing* • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Medical Attn. for Nephropathy • Blood pressure control (<140/90 mm Hg)	Hybrid measure HbA1c Testing indicator used for Auto Assignment
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Admin measure
7 Hybrid & 4 Admin measures+	7 Hybrid & 4 Admin measures+	

* Measures used for the Auto Assignment default algorithm.

+ Hybrid measures require both administrative data and medical record review, while Admin measures require only administrative data.

¹ Reflects data from January 1, 2009, through December 31, 2009.

² Reflects data from January 1, 2010, through December 31, 2010.

REQUIRED PERFORMANCE MEASURES FOR SPECIALTY & PHP PLANS: 2011

AHF Healthcare Centers

- Colorectal Cancer Screening
- Controlling High Blood Pressure (*new for 2011*)

Family Mosaic Project

- *Inpatient Hospitalizations*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who have a mental health admission to an inpatient hospital facility during the measurement period.
- *Out-of-Home Placements*: The percentage of Medi-Cal managed care members enrolled in Family Mosaic who are discharged to an out-of-home placement during the measurement period.

Kaiser PHP in Marin County

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection

SCAN

- Breast Cancer Screening (*new for 2011*)
- Persistence of Beta-Blocker Treatment After a Heart Attack

**MEDI-CAL MANAGED CARE DIVISION
HEDIS IMPROVEMENT PLAN SUBMISSION FORM**

Plan Name: _____

HEDIS Measure: _____

MMCD "Minimum Performance Level" (MPL): _____

County:	Plan's 2010 Score for Measure:

1. Performance Standard and Goal

Briefly describe your plan's performance goal for this measure, including the target score your plan hopes to achieve in the next two reporting years (2011 and 2012).

2. Plan for Improvement

Briefly describe the overall plan for improved performance for this measure. Include a description of the strengths and opportunities for improvement. This may include improvement suggestions for the following year, such as modifications to goals and objectives, newly established goals and objectives, changes in methodology due to an unforeseen nuance, or other changes that will enhance the program in the short and/or long term.

3. Barriers and Challenges

Report the internal and/or external barriers, issues and/or factors that impacted the HEDIS result, identifying the reasons that:

- Improvement was not made or sustained for reporting year 2010;
- Goals could not be reached in reporting year 2010; and/or
- Study, project or intervention could not be completed in time to affect the reporting year 2010 score.

Note: Internal barriers are often associated with lack of a particular resource. Once identified, barriers often become opportunities for improvement for the following year or next remeasurement cycle.

4. Repeat Improvement Plan

If your plan has been previously required to submit an Improvement Plan for this measure for more than two consecutive years, please describe how your plan has applied previous lessons learned to the development of this Improvement Plan and how this IP differs from previous IPs or why it does not.

5. Improvement Plan Grid

List the interventions your plan will use to improve performance for this measure. Indicate whether the intervention is new (N) or continued (C) from a previous IP.

Item	Interventions	New (N) or Continued (C)	Anticipated Completion Date	Responsible Person(s)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Name and title of person completing this HEDIS Improvement Plan

Date

Name and title of person in plan approving this HEDIS Improvement Plan

Date

**REQUIRED USE OF SERVICES MEASURES FOR FULL-SCOPE PLANS:
REPORTING YEAR 2011**

In the 2011 reporting year, Medi-Cal managed care health plans (with the exception of specialty and prepaid health plans) are required to submit HEDIS rates for measurement year 2010 for the HEDIS Use of Services Medicaid measures listed below:

1. Frequency of Selected Procedures – This measure summarizes the number and rate of various frequently performed procedures. For Medicaid members, plans report the absolute number of procedures and the number of procedures per 1,000 member months by age and sex. The following indicators are reported:
 - a) Back surgery
 - b) Bariatric Weight Loss Surgery
 - c) Lumpectomy
 - d) Mastectomy

2. Inpatient Utilization: General Hospital/Acute Care – This measure summarizes utilization of acute inpatient services in the following categories: total inpatient, medicine, surgery, and maternity. The following data are reported for each category:
 - a) Discharges
 - b) Discharges/1,000 member months
 - c) Days
 - d) Days/1,000 member months
 - e) Average length of stay

3. “Ambulatory Care” – This measure summarizes utilization of ambulatory services for the following indicators, all expressed per 1,000 member months by ages:
 - a) Outpatient visits
 - b) Emergency Department visits

Note: Results for these measures are reported to the EQRO consistent with HEDIS technical specifications and in a format designated by DHCS. However, these measures are not included in the EQRO's audit process.

MMCD QUALITY IMPROVEMENT PROJECT (QIP) REQUIREMENTS: 2011

	Internal QIP (IQIP)	Small Group Collaborative (SGC)	Statewide Collaborative (SWC) QIP
Required number of plans	One	At least <u>four</u> health plans (Proposals for SGCs with fewer plans require justification & must be approved by MMCD.)	All contracted plans (except specialty plans)
Required meetings	NA	Health plans expected to work collaboratively to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices. <ul style="list-style-type: none"> Plans must conduct at least <u>one meeting each quarter each year for this purpose.</u> At least one staff member from each participating plan must attend each meeting (in person or by telephone). The designated MMCD contact for the SGC from MMCD's Medical Policy Section should be invited to meetings. 	MMCD will organize meetings <u>at least quarterly</u> each year to work collaboratively with health plans to review progress, provide insights on overcoming barriers, share specific interventions & tools, adopt process and system changes, & establish best practices.
Data reporting	As specified in the approved/validated IQIP proposal	<ul style="list-style-type: none"> The SGC must, <u>at a minimum</u>, collect and report baseline data and then annual re-measurement data for two consecutive years. At the end of the second re-measurement, subsequent re-measurements and continuation of the SGC will be evaluated jointly by MMCD and the health plans involved in the SGC. 	Determined by agreement between MMCD and plans & specified in the approved & validated SWC QIP proposals submitted by each plan. Note: The next annual status reports are due 10/29/10. Submit to: qip@mail@dhs.ca.gov
Objectives and indicators	As indicated in the approved/validated QIP proposal	Plans must work on the same measurable objectives and use the same performance measure indicators. These performance measures may be process or outcome measures as applicable to the specific collaborative ¹ .	
Methodology for measuring improvement	As indicated in the approved/validated QIP proposal	Plans must measure improvement toward the outcome or process objectives using the same measurement methods ² to compare post-intervention to baseline and to compare results across plans.	

¹ Acceptable: "All plans in this SGC will increase diabetes screening rates for HbA1C, LDL, and eye exams by 10%." Unacceptable: "Plan A will increase HbA1C screening rates, while Plan B will decrease mean HbA1C levels."

	Internal QIP (IQIP)	Small Group Collaborative (SGC)	Statewide Collaborative (SWC) QIP
<i>Interventions</i>	As indicated in the approved/validated QIP proposal	At least some interventions must be the same or similar across plans. ³ Other interventions may differ across plans.	
<i>Evidence-based interventions</i>	If evidence-based interventions exist, it is preferable that they be applied. In addressing topics for which evidence-based interventions do not exist, a plan (for IQIPs) or plans (for SGCs & the SWC QIPs) may try other interventions based on community standards, best practices, etc. to see what works with their plan model and/or their provider and membership populations.		
<i>Intermediate process measures</i>	Plans may use different intermediate process measures ⁴ based on the specific interventions being implemented. These process measures should be collected (but not necessarily reported to MMCD) more frequently than the outcome measures to guide "course corrections" in the Plan-Do-Study-Act (PDSA) cycles or the rapid cycle improvement process.		
<i>Timing of re-measurement</i>	Re-measurement of quality indicators after baseline should be performed after implementation of improvement interventions and over comparable time periods. Note: sustained improvement is demonstrated when two consecutive re-measures result in statistically significant improvement.		
<i>Use of goals</i>	Goals, as specified by MMCD and found in industry standards, or defined in advance by the health plan, should be prospectively identified. The plan's quality indicator results should be compared with the stated goals. For example, a goal might be to reduce the performance gap (the percent of cases in which the measure failed) by at least 10 percent.		
<i>Use of HEDIS measures</i>	QIPs may be based on HEDIS measures. When QIPs are HEDIS-based, health plans must adhere to the HEDIS specifications in place at the time the QIP proposal is approved & validated. If the HEDIS specifications change during the course of the QIP, MMCD and the EQRO, in collaboration with the health plan, will evaluate the impact of the changes. Any change in methodology for trending QIP performance must be approved by MMCD.		
<i>Statistical testing</i>	Tests of statistical significance should be calculated between baseline and repeat indicator measurement periods. For <u>example</u> , a health plan might use a P value of less than .05 as the threshold for statistical significance.		
<i>Duration</i>	QIPs typically last 12 to 36 months. Use of the Rapid Cycle Improvement approach is expected when feasible.		

² Acceptable: "All plans in this SGC will measure HbA1C screening rates by chart review." Unacceptable: "Plan A will measure HbA1C screening rates by chart review, while Plan B will measure HbA1C screening rates by a survey of its physicians."

³ Acceptable: "All plans in this SGC will participate in a joint training and will establish a diabetes registry. Plan A will also use group visits, while Plan B will improve linkages to community resources." Unacceptable: "Plan A and B do not plan to implement similar interventions. Plan A will conduct training and will establish a diabetes registry, while Plan B will conduct group visits and will improve linkages to community resources."

⁴ Acceptable: "Plan A will track number/percent of provider practices using group visits, while Plan B will determine the percent of patients referred to ophthalmologists."

	Internal QIP (IQIP)	Small Group Collaborative (SGC)	Statewide Collaborative (SWC) QIP
<i>Format for submission of proposals and reports</i>	<p>All QIP proposals and reports must be submitted using HSAG's QIP Summary Form.</p> <ul style="list-style-type: none"> Initial proposals are first submitted to MMCD for approval and then submitted to the EQRO for validation. Once a QIP proposal is approved, status reports must be submitted at least annually and in accordance with the timeline agreed upon by the health plan(s) and MMCD. 		
<i>Submission of QIP proposals</i>	<p>Submit proposals for IQIPs & SGCs on HSAG's QIP Summary Form to gipsmail@dhs.ca.gov. When a proposal is approved, MMCD will forward the approved proposal to the EQRO for validation. Proposals are approved only after the EQRO certifies that it has passed validation requirements.</p>	<p>Submit proposals for the SWC on avoidable ER visits on HSAG's QIP Summary Form to: gipsmail@dhs.ca.gov. When a proposal is approved, MMCD will forward the approved proposal to the EQRO for validation. Proposals are approved only after the EQRO certifies that it has passed validation requirements.</p>	
<i>Submission of QIP status reports</i>	<p>Submit baseline reports (if not included with proposal), annual status reports, and close-out reports to the EQRO via HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov.</p>		<p>Submit baseline reports (if not included with the proposal), annual status reports, and close-out final reports to the EQRO to HSAG's FTP site with a "cc" to gipsmail@dhs.ca.gov.</p>
<i>Submission of new proposal after close-out of QIP.</i>	<p>Within 90 days of receiving EQRO notification that a final closing QIP report has been validated and meets requirements, plans must submit a new QIP proposal to the MMCD.</p>		<p>Generally, within 90 days of receiving EQRO notification that a final closing QIP report has been validated, plans are to submit new proposals for the next SWC. However, the MMCD will determine the specific time frame for plans to submit new SWC proposals.</p>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

DATE:

TO: Medicare Advantage and §1876 Cost Contracts Quality Contracts, and Medicare Compliance Officers

FROM: Danielle R. Moon, J.D., M.P.A., Director,
Medicare Drug & Health Plan Contract Administration Group
Cynthia G. Tudor, Ph.D., Director,
Medicare Drug Benefit and C & D Data Group

SUBJECT: 2012 HEDIS®, HOS and CAHPS® Measures for Reporting by
Medicare Advantage and Other Organization Types

OVERVIEW

This memorandum contains the Healthcare Effectiveness Data Information Set (HEDIS®) measures required to be reported by all Medicare Advantage Organizations (MA organizations or MAOs) and other organization types in 2012. It also includes information about which contracts are required to participate in the Medicare Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). Sections 422.152 and 422.516 of Volume 42 of the Code of Federal Regulations (CFR) states that MA contracts must submit performance measures as specified by the Department of Health & Human Services (DHHS) Secretary and the Centers for Medicare & Medicaid Services (CMS).

HEDIS® 2012 Requirements

In 2012 (the reporting year), the National Committee for Quality Assurance (NCQA) will collect data for services covered in 2011 (2011 is the measurement year). NCQA publishes detailed specifications for HEDIS® measures in *HEDIS® 2012, Volume 2, TECHNICAL SPECIFICATIONS*.

All HEDIS® 2012 measures must be submitted to NCQA by 11:59 p.m. EDT on **June 15, 2012**. Please note that late submissions will **not** be accepted. If an organization (contract/plan) submits HEDIS® data after June 15, 2012, they will automatically receive a rating of one star for the required HEDIS® measures for the data that are updated on Medicare Plan Finder (in the fall of 2012). MA ratings affect MA quality bonus payments.

Contracts with 1,000 or more members enrolled as reported in the July 2011 Monthly Enrollment by Contract Report (at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/MEC/list.asp#TopOfPage>) must collect and submit HEDIS® summary data to CMS. Closed cost contracts are required to report HEDIS® regardless of enrollment closure status. Any organization which reports HEDIS® summary data must also report patient-level data to the designated CMS contractor. More information on the patient-level data submission will be forthcoming in a separate memorandum.

MAOs and other organization types meeting CMS' minimum enrollment requirements for the reporting year of 2011 must submit audited, summary-level HEDIS® data to NCQA. Table 1 indicates which organization types need to report HEDIS®, CAHPS® and HOS data.

Table 1: 2012 Performance Measure Reporting Requirements

2012 Performance Measure Reporting Requirements				
Organization Type	CAHPS®	HEDIS®	HOS	HOS-M
1876 Cost	✓	✓	✓	✗
Chronic Care	✗	✗	✗	✗
Employer/Union Only Direct Contract PFFS	✓	✓	✓	✗
HCPP-1833 Cost	✗	✗	✗	✗
Local CCP	✓	✓	✓	✗
MSA	✓	✓	✓	✗
National PACE	✗	✗	✗	✓
PFFS	✓	✓	✓	✗
Regional CCP	✓	✓	✓	✗
RFB PFFS	✓	✓	✓	✗
RFB Local CCP	✓	✓	✓	✗

✗ = Not required to report

✓ = Required to report

During the measurement year, if your Health Plan Management System (HPMS) contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS® data for all members of the contracts involved. If a contract status is listed as a conversion in the measurement year, the contract must report if the new organization type is required to report.

In 2012, CMS will continue collecting audited data from all benefit packages designated as Special Needs Plans (SNPs) that had 30 or more members enrolled as reported in the February 2011 SNP Comprehensive Report (at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp#TopOfPage>).

In HEDIS® 2012, the submission of HEDIS® measures in the Utilization and Relative Resource domain (formerly called the Use of Services domain) is subject to change as CMS moves to submission of audited data for CMS Part C and D reporting requirements.

MAOs that are new to HEDIS® must become familiar with the requirements for data submissions to NCQA, and make the necessary arrangements as soon as possible. All information about the HEDIS® audit compliance program is available at <http://www.ncqa.org/tabid/204/Default.aspx>.

If a Contract has multiple SNP plan benefit packages (PBPs), the Contract is required to submit the SNP-specific information for each PBP. SNP-only Contracts are also required to meet the MA HMO requirements.

In 2012, Preferred Provider Organization (PPO), Private Fee-For-Service (PFFS) and Medical Savings Account (MSA) plan types must report the HEDIS® measures listed for which an “X” is included in Table 2. When a required measure allows the hybrid method to be used for data collection, plans may choose that method. If a required measure offers only the hybrid method for data collection, plans must use that method (e.g., *Controlling High Blood Pressure*). The hybrid method is now allowed for the *Colorectal Cancer Screening* measure for PPOs.

MA organizations and §1876 Cost Contracts should refer to this memorandum for CMS reporting requirements, rather than to the NCQA website or any other third-party source. The reporting requirements are summarized in Table 2. For further information on HEDIS®, including the SNP-specific HEDIS® measures, please email HEDISquestions@cms.hhs.gov.

Table 2: HEDIS® 2012 Measures for Reporting by Organization Types

HEDIS® 2012 Measures for Reporting		MA HMO, MSA, PFFS, E-PFFS & PPO Contracts	\$1876 Cost Contracts	SNP* PBPs
<i>Effectiveness of Care</i>				
ABA	Adult BMI Assessment	X	X	
BCS	Breast Cancer Screening	X	X	
COL	Colorectal Cancer Screening	X	X	X
GSO	Glaucoma Screening in Older Adults	X	X	X
COA	Care for Older Adults (SNP-only measure)			X
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	X	X	X
PCE	Pharmacotherapy Management of COPD Exacerbation	X	X	X
CMC	Cholesterol Management for Patients With Cardiovascular Conditions	X	X	
CBP	Controlling High Blood Pressure	X	X	X
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	X	X	X
CDC	Comprehensive Diabetes Care ¹	X	X	

Table 2: HEDIS® 2012 Measures for Reporting by Organization Types

HEDIS® 2012 Measures for Reporting		MA HMO, MSA, PFFS, E-PFFS & PPO Contracts	\$1876 Cost Contracts	SNP* PBP's
ART	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	X	X	
OMW	Osteoporosis Management in Women Who Had a Fracture	X	X	X
AMM	Antidepressant Medication Management	X	X	X
FUH	Follow-up After Hospitalization for Mental Illness	X	X	X
MPM	Annual Monitoring for Patients on Persistent Medications	X	X	X
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly	X	X	X
DAE	Use of High-Risk Medications in the Elderly	X	X	X
MRP	Medication Reconciliation Post-Discharge (SNP-only measure)			X
HOS	Medicare Health Outcomes Survey	X	X	X*
FRM	Falls Risk Management (collected in Medicare Health Outcomes Survey)	X	X	X*
MUI	Management of Urinary Incontinence in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X*
OTO	Osteoporosis Testing in Older Women (collected in Medicare Health Outcomes Survey)	X	X	X*
PAO	Physical Activity in Older Adults (collected in Medicare Health Outcomes Survey)	X	X	X*
FSO	Flu Shots for Older Adults (collected in CAHPS)	X	X	
MSC	Medical Assistance With Smoking Cessation (collected in CAHPS)	X	X	
PNU	Pneumonia Vaccination Status for Older Adults (collected in CAHPS)	X	X	
<i>Access /Availability of Care</i>				
AAP	Adults' Access to Preventive/Ambulatory Health Services	X	X	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	X	
CAB	Call Abandonment	X	X	
CAT	Call Answer Timeliness	X	X	

<i>Health Plan Stability</i>				
TLM	Total Membership	X	X	
<i>Utilization and Relative Resource Use**</i>				
FSP	Frequency of Selected Procedures	X	X	
IPU	Inpatient Utilization - General Hospital/Acute Care	X	X	
AMB	Ambulatory Care	X	X	
MPT	Mental Health Utilization	X	X	
IAD	Identification of Alcohol and Other Drug Services	X	X	
ABX	Antibiotic Utilization	X	X	
PCR	Plan All-Cause Readmissions	X		X
<i>Health Plan Descriptive Information</i>				
BCR	Board Certification	X	X	X
ENP	Enrollment by Product Line	X	X	
EBS	Enrollment by State	X	X	
RDM	Race/Ethnicity Diversity of Membership	X	X	
LDM	Language Diversity of Membership	X	X	

¹ HbA1c Control <7% For a Selected Population is not required for Medicare contracts.

* Contracts with exclusively SNP plan benefit packages – see also specific HOS requirements in this memorandum.

** 1876 Cost Contracts do not have to report the inpatient measures if they do not have inpatient claims.

2012 HOS and HOS-M REPORTING REQUIREMENTS

Plans that Must Report HOS

The following types of MA Organizations, with Medicare contracts in effect on or before January 1, 2011, are **required** to report the Baseline HOS in 2012, provided that they have a minimum enrollment of 500 members:

- All Coordinated Care Plans, including health maintenance organizations (HMOs), local and regional PPOs and contracts with exclusively SNP plan benefit packages;
- Continuing cost contracts that held §1876 cost contracts with open enrollment;
- PFFS plans;
- MSA plans; and,
- Employer/Union Only Direct Contract PFFS plans.

In addition, all MA organizations that reported a Cohort 13 Baseline Survey in 2010 are required to administer a Cohort 13 Follow-up Survey in 2012.

To report HOS, all plans must contract with an NCQA-certified HOS survey vendor and notify NCQA of their survey vendor choice no later than **January 20, 2012**. You will receive further correspondence from NCQA regarding your HOS participation.

Optional HOS Reporting for FIDE SNPs

MAOs sponsoring fully integrated dual eligible (FIDE) SNPs may elect to report HOS at the FIDE SNP level to determine eligibility for a frailty adjustment payment, under the Affordable Care Act, similar to those payments provided to PACE programs. Voluntary reporting will be in addition to standard HOS requirements for quality reporting at the contract level.

Plans that Must Report HOS-M

The HOS-M is an abbreviated version of the Medicare HOS. The HOS-M assesses the physical and mental health functioning of the beneficiaries enrolled in PACE Programs to generate information for payment adjustment.

All PACE Programs, with Medicare contracts in effect on or before January 1, 2011, are required by CMS to administer the HOS-M survey in 2012, provided that they have a minimum enrollment of 30 members.

To report HOS-M, eligible plans must contract with the CMS-certified HOS-M survey vendor, no later than **January 20, 2012**. You will receive further correspondence from NCQA regarding your HOS participation.

For additional information on 2012 HOS or HOS-M reporting requirements, please email hos@cins.hhs.gov.

Contra Costa County Roster

Maddy

Managed Care Commission

	<u>Appointment Date</u>	<u>Term Expiration</u>	<u>Resignation Date</u>	<u>Statu</u>
<u>Seat Title</u> Medi-Cal Subscriber				
<u>Representatives</u> Thayer David	08/25/2009	08/31/2012		
<u>Seat Title</u> Medicare Subscriber				Vaca
<u>Representatives</u> Steinfeld Richard	08/19/2008	08/31/2011		
<u>Seat Title</u> Commercial Subscriber				
<u>Representatives</u> Kayser-Stange Roberta	08/25/2009	08/31/2012		
<u>Seat Title</u> Medical Indigent Needs				
<u>Representatives</u> Madrigal Eleanor M	03/15/2011	08/31/2013		
<u>Seat Title</u> Physician				Vaca
<u>Representatives</u>		08/31/2011		
<u>Seat Title</u> Other Provider				Vaca
<u>Representatives</u> Lautenberger, R.N. Joan	08/19/2008	08/31/2011		
<u>Seat Title</u> At-Large 1				
<u>Representatives</u> Sherman Mary	09/20/2011	08/31/2013		
<u>Seat Title</u> At-Large 2				Vaca
<u>Representatives</u> Garcia Michael	08/19/2008	08/31/2011		
<u>Seat Title</u> At-Large 3				Vaca
<u>Representatives</u>		08/31/2011		
<u>Seat Title</u> At-Large 4				
<u>Representatives</u> Harris Michael	03/15/2011	08/31/2013		
<u>Seat Title</u> At-Large 5				
<u>Representatives</u> Kalin Jeffrey	08/25/2009	08/31/2012		

Seat Title

At-Large 6

Vaca

Representatives

Ptaszynski Andre	11/18/2008	08/31/2011
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Seat Title

At-Large 7

Representatives

Shorter-Jones Debra	08/25/2009	08/31/2012
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Seat Title

At-Large 8

Representatives

Corvetto-Avancena Blanca	03/15/2011	08/31/2013
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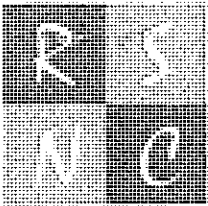
Seat Title

At-Large 9

Representatives

Brannon-Bazile Lucinda	08/25/2009	08/31/2012
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REHABILITATION
SERVICES *of*
NORTHERN CALIFORNIA

MT. DIABLO CENTER

ADULT DAY HEALTH CARE/ALZHEIMER'S DAY CARE & RESOURCE CENTER

A Not-For-Profit Corporation

Debbie Toth
Executive Director

February 8, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary,

I am writing to express my strong support of Contra Costa Health Plan's (CCHP) proposal to participate in California's Dual Eligibles Demonstration Project. Your leadership and the Plan's history of an exemplary SNP and involvement in the community you serve make CCHP an excellent candidate for this project.

When you approached me in March to discuss what we would do together to mitigate the negative impacts of the elimination of Adult Day Health Care on the frail population it serves, I was blown away. Being the first plan in the state of California to create a transition plan unique to Contra Costa and contract with nonprofit service providers in your community demonstrates your commitment to ensuring our population of seniors and persons with disabilities and our dual eligibles remain living in the community rather than costlier and less independent skilled facilities.

Through our agency's provision of Adult Day Health programs, the Multipurpose Senior Services Program and the California Community Transitions project, we are looking forward to working with you in providing a seamless and coordinated care system tailored to the individual needs of the people we serve. Rehabilitation Services of Northern California is a nonprofit mission driven agency that has been promoting the dignity and independence of people with disabilities and special needs since 1949. RSNC's Mt. Diablo Center was the 16th licensed Adult Day Health Care facility in California and is the state's first approved Community Based Adult Services (CBAS) provider. Our breadth of programs and history of providing quality health and social services will match beautifully with CCHP's commitment to providing the best and most integrated person-centered care.

SERVICE LOCATIONS

RSNC Executive Offices
490 Golf Club Road, Pleasant Hill, CA 94523
925.682.6343

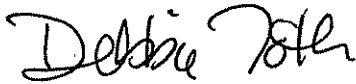
RSNC Multipurpose Senior Services Program
490 Golf Club Road, Pleasant Hill, CA 94523
925.682.6330

RSNC Bedford Center
1811 "C" Street, Antioch, CA 94509
925.778.4171

In addition to your efforts in community collaboration, I believe the size of Contra Costa County makes it an ideal location for a pilot project. Being the 11th largest county of dual eligibles in the state, we will be able to see how a mid-sized two plan county can work through creating the seamless system of care. As you know, Contra Costa health and social services have worked together for over fifteen years to create a long-term care integration project which looks very similar to the provision of services through the duals pilot project. Having that history of community collaboration and common purpose make our county the perfect place for this demonstration.

On behalf of the many seniors and persons with disabilities we serve, we are looking forward to working with you, CCHP, and our many community partners to make our health care system even better integrated, more cost-effective and completely comprehensive so our community can have coordinated bio-psychosocial care, better health outcomes and continued dignity and independence.

Sincerely,

A handwritten signature in cursive script that reads "Debbie Toth". The signature is written in black ink and is positioned above the printed name.

Debbie Toth

**Guardian Adult Day Health Center
3905 San Pablo Dam Road
El Sobrante, CA 94803
Phone: 510-669-1005
FAX: 510-669-1008**

February 6, 2012

**From: Peter H. Behr, Jr.
Administrator / Chief Financial Officer
510-669-1007 (Direct Line)**

Ms. Patricia Tanquary
Chief Executive Officer
Contra Costa Health Plan
595 Center Street
Suite 100
Martinez, CA 94553

Dear Ms. Tanquary:

This letter is written to support Contra Costa Health Plan's (CCHP's) proposal to participate in California's Dual Eligibles Demonstration Project. Guardian has served individuals eligible for both Medicare and Medi-Cal since 1994, and we are both well aware and strongly supportive of a coordinated system of care for this population.

We look forward to working with CCHP as part of a broad range of health care providers and social support services from across the county to create and provide a seamless continuum of care. We support the demonstration project's goal of rebalancing care for the duals away from expensive and avoidable institutionalization and towards a program of enhanced home and community based services.

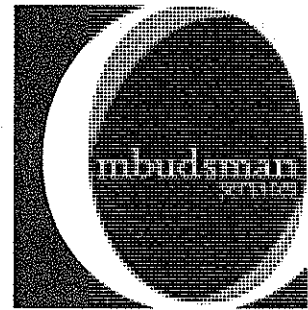
We look forward to working with, and as part of, a pilot program that will maximize the ability of the duals to maintain the best possible health and the highest possible quality of life. We plan to work actively and enthusiastically with CCHP and our fellow service providers to successfully implement this project.

Guardian welcomes the opportunity to help assure that Contra Costa County will be, and will remain, in the forefront of developing the long-needed integrated model for care for California's dually eligible seniors and people with disabilities.

Sincerely,


Peter H. Behr, Jr.

Ombudsman Services of Contra Costa
1601 Sutter Street, Suite A
Concord, CA 94520
PH: 925.685.2070
Email: <http://www.ccombudsman.org>



giving voice. empowering people.

February 8th, 2012

Ms. Patricia Tanquary, CEO,
Contra Costa Health Plan,
595 Center Street, Suite 100,
Martinez, CA 94553

Dear Ms. Tanquary,

I am writing in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. Our agency, Ombudsman Services of Contra Costa, serves many residents that are eligible for both Medi-cal and Medicare. We are keenly aware of the need for a coordinated system of care for our population and all individuals eligible for both Medi-cal and Medicare.

We look forward to working with CCHP and other health care providers and social service agencies from across the country in providing a seamless continuum of care. We support the goals of the pilot project to rebalance enhanced home and community-based services.

We support working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

Ombudsman Services welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed, integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,

A handwritten signature in cursive script that reads 'Etta Maitland'.

Etta Maitland
Executive Director



CONTRA COSTA CRISIS CENTER

February 8, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary,

I am please to submit this letter in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. As an agency that serves individuals eligible for both Medi-Cal and Medicare, we are well aware of the need for a coordinated system of care for that population. All of our adult services serve as a resource for dually eligible seniors and persons with disabilities residing in Contra Costa County. These include access to Contra Costa County's only suicide prevention hotline. Founded in 1963, our suicide hotline was one of the first of its kind in the United States. Today it's one of only 150 certified hotlines nationwide. All local calls to the two national suicide hotlines (800.SUICIDE and 800.273.TALK) are routed to us.

In addition, we answer special 24-hour hotlines for child abuse, elder abuse, homelessness, grief, and youth violence prevention and serve as the authorized 211 provider for Contra Costa County. 211 is the national, toll-free, three-digit phone number to call for information about local health and social services.

We look forward to working with CCHP and a broad range of health care providers and social supports and services from across the county in providing a seamless continuum of care. We support the goals of the pilot project to rebalance care for the duals away from avoidable institutionalized services and toward enhanced home and community-based services.

We support working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

Our agency welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,

Cory Pohley,
Interim Executive Director

P.O. Box 3364
Walnut Creek, CA 94598
925.939.1916 Office
800.833.2900 Hotline
925.939.1933 Fax
www.crisis-center.org

With

help

comes

hope.

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary,

I am writing in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. I am an individual that needs agencies that serve both Medi-Cal and Medicare, and am aware of the need for a coordinated system of care.


I need services that provide a seamless continuum of care. I support the goals of the pilot project to make sure that my care for my needs is away from avoidable institutionalized services and toward me staying in my home and community-based services.

I support working with a pilot program that seeks to maximize my abilities to maintain good health and a high quality of life. I will do whatever I can to help with this needed project.

Patricia, I welcome the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for people like me who are dually eligible seniors and persons with disabilities.

Thank you for this opportunity to show my support of Contra Costa Health Plan.

Sincerely,


IHSS ADVISORY COMMISSIONER

David Thayer
81 Pioneer Court
Oakley, CA 94561
925-625-0423

**MANAGED CARE COMMISSION
MINUTES FOR MEETING
On
Wednesday, January 25, 2012**

COMMISSIONERS PRESENT:

Joan Lautenberger, Chair
Jeff Kalin
Dave Thayer

Patricia Tanquary (ex officio)
Henry Tyson
Michael Garcia
Erwin Cho

COMMISSIONERS ABSENT:

Andre Ptaszynski
Eleanor Madrigal
Blanca Crovetto-Avancena

Michael Harris, O.D.
Debra Shorter-Jones
Richard Steinfeld

GUESTS: Frances Trant, Ken Cess, Windsor Health Care, Bob Sessler

STAFF: Wendy Mailer, Sales & Outreach Manager
Kevin Drury, Director of Quality Management
Deboran Everist, Secretary

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
1.0 Call to Order	The meeting was called to order at 4:05 p.m.	
2.0 Review Minutes	The minutes, due to a computer crash, will be reconstructed and attached with the next meeting minutes.	
3.0 Approval of Agenda	The agenda was approved with no corrections.	
4.0 Public Comment	The Public representative, Ken Cess, from Windsor Healthcare, works with the community clinic consortium and Director of Community Affairs and Finance and is particularly interested in #7.1 – Governor’s Budget Changes to Managed Care.	
5.0 Commissioner Comments	No comments.	Patricia Tanquary
6.0 Committee Reports	<u>Quality Assurance: Quality Management – Kevin Drury</u> The Managed Risk Medical Insurance Board honored the Quality Management group for the second year in a row for superior performance with our HEDIS measures that we submit every year. Out of 11 measures, 5 of the measures scored above the national commercial 90 percentile. We were 1 of 7 Healthy Families plans statewide to receive this honor and one of 2 local initiatives.	Kevin Drury

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
6.0 Committee Reports (continued)	<p>6.1 Group Needs Assessment Executive Summary</p> <p>A group needs assessments has been completed. Summary: Every few years for Medical and Healthy Families, we have to survey the membership and gather information on their needs - health education, language, cultural and linguistic needs. The cultural and linguistic services manager and health education manager prepare these plans and submit them</p> <p>In a survey, our members were asked if they were treated with respect, and they were. Members were also asked whether they preferred receiving their information via mail, email or website. Email is growing but not high enough to replace mail even though members using internet is growing and we try to keep the websites current and with useful information.</p> <p>We also like to know how to direct health education to our members. Health topics of most interest are healthy eating (54%), exercise (41%), healthy teeth (41%), weight loss (37%), diabetes, cholesterol, heart health (31%). CCHP frequently provides education on these topics in the Health Sense Newsletter and other means.</p> <p>Members have also been asked what they did in the last year to learn more about their health. Problems have been reported in getting information to stay healthy.</p> <p>The language preference of our members has shifted more to Spanish. We provide all of our communications in both English and Spanish. At this point there are no other threshold languages with a requirement to send out information in. .</p> <p>Our Quality Management team have added 2 action items to their work plan: 1) Providing more education on specific topics of interest that were noted; 2) Looking into purchasing additional media for those popular health topics, published in CDs and DVDs.</p> <p>We are also collaborating with CCRMC health centers to increase and advertise the amount of health education that they provide to our members. More families are being encouraged to attend health education programs.</p> <p>Regarding cultural and linguistic, we educate members on their right to have an interpreter at their medical appointment; monitor population for new threshold languages; share this information with Provider Relations so they can prioritize what language is most needed to recruit providers who can use the language in their offices; and we will try to identify ways we can increase health literacy.</p> <p><u>Comments by Patricia Tanquary</u></p> <p>The percentage of members who call our advice nurse line has increased by 23%. Marketing for the Advice Nurse is mainly handled on member's enrollment documents, on their ID cards.</p> <p>While we don't routinely send out information in other than English and/or Spanish, we have a very well developed interpreter network that can interpret documents in 26 different languages. Very few of the other Medical health plans in the State have their own Advice Nurses. Kaiser has had Advice Nurses for some time.</p>	Kevin Drury

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
<p>6.0 Committee Reports (continued)</p>	<p>Some other health plans are now starting to have Advice Nurses. Our county hospitals and clinics are starting to urge people to call the Advice Nurse more.</p> <p>6.2 Standing Reports</p> <p><u>6.2.1 MediCal Choice Rate</u></p> <p><u>Medi-Cal Choice Rate Local Initiative Health Plans vs. Blue Cross:</u></p> <p>There are 4 counties that are closely aligned to us in the sense that they are Local Initiative and are called 2-Plans Counties. That would be Contra Costa County Health Plan, Alameda, San Francisco and Santa Clara. The 2 plan model in these 4 counties was discussed.</p> <p>The Choice Rate graph shows us the choice rates that new MediCal beneficiaries have.</p> <p>According to the blue line of the graph, we tend to do much better than Blue Cross in attracting new members.</p> <p>CCHP usually has one of the highest default rates in California. The default formula is based on quality initiatives and kind of HEDIS. We did very well with Healthy Families and we have the highest default rate in the State of California for Healthy Families – 100%.</p> <p>We're higher than Blue Cross on every measure in the county at this time. Our providers are working really hard with our members. Our actual full enrollment is about 89% in this county of all people on MediCal.</p> <p><u>6.2.2 Enrollment Trend by Product Line</u></p> <p>This graph shows how our MediCal enrollment has grown between since December 2009 through December 2011. It is our fastest growing product line.</p> <p>6.2.3 CCHP Enrollment Trend Report for December 2011</p> <p>Our product lines are broken into 15 different categories. Overall our health plan has grown 12% in its membership from December 2010 to December 2011.</p> <p>In our MediCal program, our membership has grown 16% since December 2010. Section 1 shows the percentage of change in the Annual Change column.</p> <p>In Section 2, Medicare shows a loss because many of the plans are closed to enrollment although the Senior health plan is open now. Growth will be seen in the next program.</p> <p>OPEN ENROLLMENT As of December 2011 there was a 1% growth in the County Employee program.</p> <p>The IHSS, in-home supportive services has shown a decrease in membership. This is the direct result of many of the actions taken by the State of California in terms of reducing the number of people who are eligible for either getting the care or the number of people who are providers, who can then apply to become a provider and join us.</p> <p>We also manage a group of people under Uninsured Recipients. These are people who are qualified based on their FPL (federal poverty level) who have</p>	<p>Wendy Mailer</p>

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
6.0 Committee Reports (continued)	<p>qualified for a variety of different programs that are managed through the county</p> <p>We continue to see a large growth in that program and the various programs. There are so many people who are uninsured and fall into one of the segments of federal poverty. As a result of that, at the end of December, Contra Costa Health Plan was managing the health care needs of over 107,000 people. There were 20,000 at the beginning.</p> <p>6.2.4 Member Services – Grievances Report</p> <p>Considering the numbers just heard, and look at the aggregate of 78 overall grievances of approximately 100,000 people, the grievances numbers are very low.</p>	Arleen Stanton
7.0 Focus Topic	<p>7.1 Governor’s Budget Changes to Managed Care</p> <p>What the Governor and the State Department have in mind to expand managed care to other populations and services:</p> <p>When thinking of all of these new proposals, we recognize as much of the challenge this is. It’s also a compliment that the State, as well as the Feds, actually believe that, Managed Care can do a better job of coordinating and being responsible for connecting not just the medical care, but some of the social activities in the community</p> <p>What the State intends to do is to change and add major new benefits to come under Medi-Cal Managed Care. The 3 benefits for right now are, Adult Day Health Center (ADHC), skilled nursing care and Long term care and In Home Supportive Services (IHSS). We have 189 new members that came from ADHC and will probably get more when it changes to CBAS <u>Community Based Adult Services</u> on 3/1/12.</p> <p>We are networking and contracting with those adult day health centers. For patients that don’t continue to get ADHC, they will transition into a new program call</p> <p>As of 3/1/12, no one will go into ADHC unless they’re in Managed Care. As of 7/1/12, the dollars for that care will be added as a major benefit to our <u>capitation dollars for the Health Plan. Then it will be our responsibility to manage the current and future.</u></p> <p>Bob Sessler came out of retirement and now works for us and helping us in the health plan to reach out and partner in new and different ways.</p> <p>The giving of these 2 benefits, the nursing home benefits, the State does intend that all of those benefits will be only under MediCal Managed Care. Individuals receiving those services will cease to receive them as a fee for service benefit, so they will have to choose CCHP or Blue Cross.</p> <p>With respect to IHSS the administration of the program, initially, will remain unchanged, but IHSS benefits will be included as part of the plan rates. The skilled nursing facility services, the department states that people who have been in the facility for more than 90 days on January 1, would not be immediately be enrolled into Managed Care. Enrollment will be deferred for 1 year. Others who haven’t been in nursing homes that long will begin to shift</p>	Patricia Tanquary

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
7.0 Focus Topic (continued)	<p>into Managed care.</p> <p>For the Public, Mr. Cess, it's important to note that the CEOs of the MediCal Managed Care plans had a 2-day meeting last week. We welcome and want to partner. In this county we have contracted with approximately 36 skilled nursing facilities. We have good working relationships with them and we will support an orderly staged enrollment of those who are dually eligible just like we did with the SPD populations. I believe in partnership, and that's what we will need to do to meet the needs of all members joining managed care in our County</p> <p>After speaking with the heads of our clinical areas, including Dr. Walker, the moment CCHP begins to have the nursing home benefits, which will also mean some people will be in boarding care homes, our intention is to have geriatric practitioners to partner to help the nursing home to avoid an unnecessary ER visit.</p> <p>The same is true with IHSS. Bob Sessler and Patricia Tanquary have already have had several meetings with partners in the county.</p> <p>The transition would occur so that IHSS would only become a benefit under Managed Care and not under FFS Medi-Cal as it is now.</p> <p>There will be a Community Meeting downstairs at the Health Plan at 10:30am, and have invited 2 of our large nursing homes, a large Board and Care home, Meals on Wheels, IHSS , the people who are now providing the ADHC in the adult health care services and, our case management staff</p> <p>We're preparing, things can change. It's just a question of how many laws will pass this year and maybe next year. If SEIU is content and believes this is a good thing, they will tell the legislators.</p> <p>Part of the issue for the Health Plan is making sure that we embrace the continuity of care for all of contracted partners who need to be part of our team.</p> <p>There are other major changes. One of those has to do with moving the dually eligible people (* those with Medicare as well as Medi-Cal) into Managed Care with a passive enrollment. This means people will have to choose a managed care plan in their county, try it for a 6-month period. If they don't like it, then they can "opt out" or disenroll.</p> <p>Choice is important. We're prepared as a plan to work with the State and we want to partner with Kaiser. Our commitment is to not destabilize continuity of care for these populations.</p> <p>Our mission is to provide coordinated health care coverage in the best way possible with good quality providers for the needy and safety network population, the poor.</p> <p>Part of the State Plan in enrolling the duals is a phase-in strategy. They want to start with the 8 to 10 largest counties in the State in the first year.</p> <p>We are applying to be one of those 8 to 10 counties to be part of the "dual" pilot that will be the beginning of January 2013. The State may not choose us but one way or the other, we will be prepared.</p>	

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
7.0 Focus Topic (continue)	We will be using this year to prepare with our community partners on how we are going to provide expanded coordinated care in a more comprehensive way with more partners.	
8.0 CEO's Report	<p>8.1 CEO Report – November 2011</p> <p>8.1.1 CCHP Successfully Enrolls Seniors and Persons with Disabilities (SPDs)</p> <p>We have been talking about the Managed Care Commission since before last June when we started to prepare to receive all the SPDs who were not dually eligible who were on MediCal Fee for Service and move them into Managed Care. The State decided a year ago that their goal for last year was to take this mini population that were receiving Medi-Cal in a fee for service mode and move them into managed care</p> <p>We need ongoing medical homes, Primary Care Providers and coordinate their care. CCHP has expanded our Community provider network, case management and our ability to reach out and make sure that as an SPD joins our plan, even if they're mandated, they still have a choice of Networks (*CPN, CCRMC or Kaiser).</p> <p>We've been tracking what's happening since last June. The population on the average was about 12,000 potential SPD members who live in this county and could choose CCHP or Blue Cross. Every single month we look at the people who chose us or who were defaulted. They seem to be averaging 900+ per month. On average, every month CCHP enrolls 90% to 91% of the potential eligible who lives in this county.</p> <p>As of January 2012, we have now enrolled 7,500 seniors and persons with disabilities. We've only had 7 grievances out of 7,500 people.</p> <p>Summary: Of our MediCal members 15%, which is close to 11,000 members, are now seen by Kaiser Permanente because they are allowed to remain in Kaiser if they were a Kaiser member in the previous 6 months.</p> <p>Of the 32% of SPD members, we found that they haven't been seen by our own data within our county clinic or Kaiser and they were assigned to the Community Provider Network.</p> <p>We found out which SPD members had been seen by Community Providers who were not yet contracting with CCHP. We've asked those providers to join our network, which many of them did, or at least they would agree to still see those few patients, even if they wouldn't join and become a full CCHP provider.</p> <p>We deliberately distributed those members to our various contracted providers by geographical design.</p> <p>SPD enrollment will end by May 2012.</p> <p>Bob Sessler added his comments to the report:</p> <p>One of the first things we're getting ready for is whatever the State rolls out from the dual population, the Medical/Medicare population. We'll be meeting with public and private agencies.</p>	Patricia Tanquary

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
<p>8.0 CEO's Report (continued)</p>	<p>Second, it's very important to get involved with the community advocate and talk to them about what the implications are for the County, the opportunities, and the challenges that are there, and idea of how IHSS and the aging services in the county will be able to cover under the umbrella of the dual process.</p> <p>We will also be reaching out to the independent living center where they work with disability community in the county and other advisory groups out there. Our business body may have to grow over time to represent the new constituency that will be serving.</p> <p><i>(Comments were added by David Thayer, a member.)</i></p> <p>"I always had help from my case manager and kept in touch with her, and told her what happened to me. I was not insured ever and I'm getting care."</p> <p>8.2 November and December FLASH REPORT</p> <p>The Flash News is attached. There is a lot of information about the SPDs in the first report. The second report talks about our move to EPIC. We acknowledge our staff team leaders who are spending almost 90% of their time trying to build a new electronic health record computer system named EPIC. Kaiser has long used EPIC as electronic medical records and has had the ability for patients to email their doctor. That is what partly what we're creating.</p> <p>A bigger creation for EPIC is to serve both the Health Plan, the County hospital and the County clinic, and we will be linking with mental health in the future as well to create a system that will communicate electronically more easily and we will also have a web portal for our contracted community doctors to be able to reduce the tendency on phone calls. Community providers will be able to look up eligibility, their claims and r referral status. We are also welcoming a system where our patients who receive their primary care within our county clinics, will be able to email their physicians. The answer to any access issues is not always to be given an appointment. It is a variety of mechanisms.</p> <p>There is also a joint pilot between our Advice Nurses and our clinic physicians. The pilot showed that we can reduce the number of appointments by giving callers the ability to talk with an Advice Nurse who will screen callers who wanted a same day appointment. IF the nurse is able to assist the caller then they are promised a 2-hour turnaround callback from a physician.</p> <p>The physician can actually meet the need of the caller many times. They can order a lab, change a prescription, order an x-ray and/schedule a visit if necessary.</p> <p>That pilot expands 2 days a week next month. By April we will be up to 3 days a week. We're just planting the seeds so you would want to come back to hear a lot more about this successful model because the world knows there are multiple ways to meet patients' needs.</p> <p>8.3 Finances</p> <p>This Financial Report on attachment 8.3.1. is based upon October financial projections for the year ending in June of this year. At the moment we're not projecting any deficits in Medicare, our commercial population, and MediCal.</p>	

ITEM # & SUBJECT	DISCUSSION	ACTION/WHO
9.0 Old Business	None.	
10.0 New Business	<p>10.1 – Commissioner Recruitment Status</p> <p>Pending the final vote by a quorum via email, we will pursue the application process to add Frances Trant as a Commissioner in our CCHP Commercial Subscriber seat.</p> <p>Joan read the resignation letter received from Andre Ptaszynski. The commission agreed to send him a letter thanking him for all of his service.</p> <p>The vote to accept the letter of resignation was unanimously.</p> <p>His letter will be forwarded to the Clerk of the Board to have the Member-at-Large #6 seat declared vacant.</p>	
10.0 New Business (continued)	<p>10.2 – Next Meeting</p> <p>The next meeting is March 21, 2012.</p>	
11.0 Correspondence and Information	None	
12.0 Adjournment	The meeting was adjourned.	

Approved

Date

MANAGED CARE COMMISSION

Wednesday, January 25, 2012

4:00—5:30 p.m.

**595 Center Avenue, Suite 200B
Martinez, CA 94553**

Minutes for Meeting

Unless otherwise indicated below, Contra Costa Health Plan—Community Plan, hereby adopts all issues, findings, or resolutions discussed in the meeting minutes for Contra Costa Health Plan’s Managed Care Commission, dated January 25, 2012, and attached herein.

Excepted Matters: None

COMMUNITY STAKEHOLDER MEETING

REGARDING CBAS AND COST PROPOSED EXPANSION BENEFITS INTO MANAGED CARE

JANUARY 27, 2012

FACILITATOR: PATRICIA TANQUARY, MSSW, MPH, PHD, CEO
BOB SESSLER, CONSULTANT

CONTRA COSTA HEALTH PLAN
595 CENTER AVENUE, SUITE 100
MARTINEZ, CA 94553



News Release

NUMBER: 12-01
FOR IMMEDIATE RELEASE
January 24, 2012

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STATE ANNOUNCES FINAL APPROVAL OF ADHC LAWSUIT SETTLEMENT AGREEMENT

SACRAMENTO – The U.S. District Court, California Northern District, today approved the California Department of Health Care Services' (DHCS) settlement agreement regarding the Adult Day Health Care (ADHC) lawsuit, *Darling, et al v. Douglas*. Under the settlement approved today, the ADHC program will be phased out and replaced on March 1, 2012, with the Community-Based Adult Services (CBAS) program, which will provide necessary medical and social services to individuals with intensive health care needs.

"We are pleased the court approved our settlement agreement that allows the state to provide key health services to the most vulnerable poor and disabled Californians in an efficient and fiscally responsible manner," said DHCS Director Toby Douglas. "The court's ruling supports the state's strong commitment to provide essential care and services to those most in need and helps keep them independent and in the community."

As a result of this fiscally responsible settlement, the state will achieve General Fund savings of \$25 million in 2011-12 and \$92 million in 2012-13.

Eligibility to participate in CBAS will be determined by state medical professionals on the basis of medical need, and the benefits provided will be coordinated with managed care plans. Those former ADHC participants who do not qualify for CBAS will be eligible to receive enhanced case management and other services through DHCS and managed care plans.

###



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

JAN 10 2012

Ms. Gloria Nagle, PhD, M.P.A.
Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare & Medicaid Services, Region IX
90 7th Street, Suite, 5-300 (5W)
San Francisco, CA 94103-6707

RE: California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment

Dear Ms. Nagle:

The State of California proposes to amend the Special Terms and Conditions (STC) of Waiver 11-W-00193/9, "California Bridge to Reform Demonstration," pursuant to STC paragraph 7. The proposed amendments would provide: an additional benefit to Seniors and Persons with Disabilities (SPD) who are enrolled in managed care under the terms of the demonstration project, and to those who are dually-eligible for Medicaid and Medicare (dual-eligibles); and a fee-for-service benefit for individuals in those counties that have not yet implemented managed care, and individuals who do not qualify for, or receive exemptions from, managed care.

The amendment would provide Community Based Adult Services (CBAS) to individuals who are Medi-Cal eligible, meet specified medical necessity criteria, and:

- Meet "Nursing Facility Level of Care A" (NF-A) or above; or
- Have a moderate to severe cognitive impairment, including moderate to severe Alzheimer's Disease or other dementia; or
- Have a developmental disability; or
- Have a mild to moderate cognitive disability, including Alzheimer's or dementia, and need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
- Have a chronic mental illness or a brain injury, and need assistance or supervision with either:

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- Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
- One need from the above list and one of the following: money management, accessing resources, meal preparation, or transportation.

For additional detail on these requirements, please see the attached Settlement Agreement, Sec. XI "Eligibility for CBAS Services" (Attachment A).¹

Many of these individuals have been receiving Adult Day Health Care (ADHC) services under the State Plan. However, that service has been eliminated from the State Plan, effective February 29, 2011. **We ask that CMS act on the requested amendment as quickly as possible so that affected individuals can transition from ADHC to CBAS without a gap in service.** The State is requesting that this waiver amendment have an effective date of February 29, 2011. In order to secure prompt approval of the amendment, the State is prepared to work with CMS and to provide whatever information CMS requires.

The Amendment would also provide Enhanced Case Management (ECM) for members of the Settlement class who are not eligible for CBAS. For additional detail about who is included in the Settlement Class, please see the attached Settlement Agreement, Sec. VII (Attachment A).

Proposed Amendments

Managed Care Services Provided to Beneficiaries

The Settlement Agreement and Draft CBAS Standards of Participation (SOPs) set forth the services provided to SPDs and dual-eligibles enrolled in a managed care system within the State, and a fee-for-service benefit for individuals in those counties that have not yet implemented managed care, and individuals who do not qualify for, or receive exemptions from, managed care. Beginning not sooner than July 1, 2012, California requests that Attachment N be amended to add the following:

¹A lawsuit was filed against the Department of Health Care Services (DHCS) challenging the elimination of the Adult Health Care (ADHC) benefit. The plaintiffs and DHCS jointly filed a signed settlement agreement on December 1, 2011, with the U.S. District Court for the Northern District of California to resolve the case. The Court preliminarily approved the settlement on December 13, 2011, and there is a hearing scheduled on January 24, 2012 to consider final approval of the agreement.

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Community-Based Adult Services (CBAS), as defined the attached Settlement Agreement and the attached CBAS SOPs (Attachment B).	Services not covered under the State Plan	<p>An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. Eligible beneficiaries are those that meet specified medical necessity criteria and:</p> <ul style="list-style-type: none"> • Meet "Nursing Facility Level of Care A" (NF-A) or above, and; or • Have a moderate to severe cognitive impairment, including moderate to severe Alzheimer's Disease or other dementia; or • Have a developmental disability; or • Have a mild to moderate cognitive disability, including Alzheimer's or dementia, and need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or • Have a chronic mental illness or a brain injury, and either: <ul style="list-style-type: none"> ○ need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; or ○ one need from the above list and one of the following: money management, accessing resources, meal preparation, and transportation. 	X	X	X

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Enhanced Case Management (ECM), as defined the attached Settlement Agreement (Attachment A).	Services not covered under the State Plan	<p>A service consisting of those "Complex Case Management" and "Person-Centered Planning" services as defined below, and including the coordination of beneficiaries' individual needs for needed long term care services and supports, whether or not covered under the Medical program, and periodic in-person consultation with the beneficiary and/or his or her designees. As used here:</p> <ul style="list-style-type: none"> • "Complex Case Management Services" means the systematic coordination and assessment of care and services provided to a subset of managed care enrollees in 2-Plan and GMC counties who require the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. • "Person-Centered Planning" is a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences; person-centered planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the individual member, as well as the member's functional level, support systems, and continuum of care needs. 	X*	X*	X*

[*] ECM is available only to non-CBAS-eligible members of the Settlement Class.

Populations Included in the Demonstration

Ultimately, the State intends for CBAS benefit to be available only to those individuals who, by mandate or by choice, are enrolled in a managed care plan, with exceptions based on unavailability of, ineligibility for, or exemptions from managed care. However, in light of the need for accelerated implementation of the CBAS program and the fact that managed care is being introduced for SPDs on a rolling basis over a 12 month period that began on June 1, 2011, the State requests that the following language be added to STC VIII.B (78) to address how the benefit will be provided during the managed care transition process:

- c. Community-Based Adult Services (CBAS) will be provided as follows, after July 1, 2012:

i. Delivery System.

- 1) **Counties That Have Implemented Managed Care:** CBAS will only be available to eligible individuals enrolled in managed care, except as set forth in (3) below.
- 2) **Counties That Have Not Yet Implemented Managed Care:** CBAS will be provided as fee-for-service benefits to all eligible individuals.
- 3) **Individuals Who Qualify For CBAS But Don't Qualify for, or who have been exempted from, Managed Care:** CBAS will be provided as fee-for-service benefits.

ii. **Payment.** Due to the accelerated implementation of the CBAS program, the current capitation rates will not reflect the addition of the CBAS service. Therefore, CBAS will initially be treated as a carved out service from the contracts and rates. The State will remain responsible for the service and will make payments for claims directly to the providers through the fee-for-service claims systems. No sooner than July 1, 2012, responsibility for the payment for these services will transition to the managed care plan and the payment will be built into the capitation rate through our actuarial rate determination, at which time the plans will be at risk for the payments and be required to make the payments.

Until its incorporation as part of the capitation rate, CBAS services will be reimbursed at least the rate described below minus 10%, except in exempted Medical Service Study Areas which will receive \$76.27. According to the Settlement, "Plans are required to reimburse CBAS Providers at the prevailing CBAS reimbursement rate per day."

HCPCS Code	Description	a. Rate *
H2000	Comprehensive multidisciplinary evaluation	\$ 80.08
S5102	Day care services, adult; per diem	76.27
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	64.83

Assessment. Beginning on March 1, 2012, CBAS shall be provided to individuals who are assessed to be eligible to receive CBAS services, as specified in the attached Settlement Agreement and Draft CBAS SOPs, individuals who have not yet been assessed by the Department of Health Care Services for eligibility for CBAS services, and individuals who have been determined to be ineligible for CBAS but for whom a care plan has not been developed and/or acted upon. Individuals who are determined to be ineligible for CBAS services will receive enhanced case management services – not CBAS services.

ADHC clients who do not meet CBAS eligibility criteria will receive information about their option to receive “Enhanced Case Management” and other services through DHCS or their managed care plan, as well as a notice informing them of the right to challenge the denial of CBAS eligibility. The ADHC center shall be asked to complete a Discharge Plan and provide a copy of the Discharge Plan to the Class Member and either DHCS or the managed care plan that serves the Class Member.

Managed care plans shall be required to include a social worker on their assessment team, either in-house or by contract. If the requested level of service is for continuation at the same level of service, the managed care plan may approve the request via a paper review of the level of service recommendation and any supporting documentation provided by the CBAS provider.

Any denial or reduction in a requested level of service shall occur only after a face-to-face review, using the process described in the Settlement Agreement, Section XI.A.3 (Attachment A).

Enhanced Case Management Services (ECM)

ECM will be provided to eligible individuals through managed care for those enrolled in managed care and through fee for services for those not enrolled in managed care. ECM is not available to the entirety of the SPD population, but rather only to those Settlement Class members who are not eligible for CBAS. The State requests that the following language be added to STC VIII.B(78) to address the inclusion of ECM in the SPD Benefits Package:

d. Enhanced Case Management Services (ECM) will be provided as follows:

i. **Delivery System.**

1. **For Individuals Enrolled in Managed Care:** ECM will be available through each eligible individual’s managed care plan.
2. **For Individuals Not Enrolled in Managed Care:** ECM will be provided as a fee-for-service benefit to all eligible individuals.

- ii. **Payment.** For those individuals who do not receive ECM through managed care, the State will remain financially responsible for the service. For those individuals receiving ECM through managed care, plans will be at risk for the payments and be required to make payments directly to ECM providers. Prior to July 1, 2012, the payment for ECM will be built into the monthly plan capitation rate through an actuarial rate determination.

Eligibility. Prior to March 1, 2012, as specified in the attached Settlement Agreement, ECM will be provided to individual members of the Settlement Class who have been assessed to be ineligible for CBAS services by the Department of Health Care Services.

Waiver Authority

We believe the existing waivers for freedom of choice, statewideness, and comparability can encompass the proposed amendment. To the extent necessary, we ask that our authority to operate under these waivers add the following sentence: "To enable the State to provide Community Based Adult Services to adults who are enrolled in managed care and, only in counties without a managed care plan or for those not eligible to enroll in managed care or who are granted an exemption from enrollment in managed care, on a fee-for-service basis."

Expenditure Authority

We ask that California be granted an additional expenditure authority to cover the CBAS services, which is not otherwise covered by the state plan.

Public Notice

As required by STC paragraph 7 and 59 Fed. Reg. 49249 (Sept. 27, 1994), these proposed changes have been shared publicly, as follows:

- On November 17, 2011, upon reaching settlement of the lawsuit that challenged the elimination of the ADHC optional benefit, DHCS issued a press release announcing the Settlement Agreement. See News Release, DHCS, State Announces Settlement of ADHC Lawsuit (Nov. 17, 2011), available at <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/11-07%20CBAS%2011-17-11.pdf>.
- On December 1, 2011, DHCS posted a copy of the Settlement Agreement on the DHCS website. See <http://www.dhcs.ca.gov/Documents/Darling%20v.%20Douglas%20Settlement%20Agreement.pdf>.

- On December 12, 2011, DHCS conducted a webinar for stakeholders to review the terms of the settlement agreement and respond to initial questions about CBAS implementation. Webinar material is available on the DHCS website. See http://www.dhcs.ca.gov/services/medi-cal/Documents/ADHC%20Transition/CBAS%20Stakeholder%20Webinar%2020111212_Final.pdf
- On December 13, 2011 and December 14, 2011, DHCS, in conjunction with the California Department of Aging (CDA), and ADHC center representatives, provided training for ADHC centers and the state nurses that will be conducting CBAS eligibility determinations per the settlement agreement, regarding CBAS eligibility requirements and the eligibility determination process. Training materials are available on the DHCS website. See <http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx>
- On December 29, 2011, DHCS and CDA released the CBAS provider application and the proposed CBAS SOPs to all ADHC center providers and DHCS stakeholders. These documents are available on the DHCS website. See <http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx>
- On January 4, 2011, DHCS and CDA held a webinar for stakeholders to discuss the CBAS provider application and proposed SOPs.

In addition, pursuant to the tribal consultation requirements of Section 1902(a)(73) of the Social Security Act, 42 U.S.C. § 1396a(a)(73), as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 § 5006(e)(2)(A)(iii), 123 Stat. 115, 505 (2009), California will solicit advice on these amendments from Federally recognized Indian tribes, Indian health programs, and Urban Indian organizations in the State. On December 15, 2011, DHCS held a telephone conference with tribal organizations to explain in detail how the State will provide CBAS services. There were no comments received during the 14 day comment period.

Analysis of Budget Neutrality

The State estimates that the cost of providing this service to the CBAS eligible population will be approximately \$916.60 per member per month in fiscal year 2011-12 and would increase each year by 3.16%. The State estimates that the cost of providing enhanced case management services to the non-CBAS eligible population will be \$10.00 per member month. This additional cost will not cause the State to exceed budget neutrality as the expenditures for the CBAS eligible population, under both with and without waiver components, are estimated to be the same. The State projects a significant savings related to the non-CBAS eligible population. An updated and revised budget neutrality analysis is attached as Attachment C.

CHIP Allotment Neutrality Worksheet

There is no need for a CHIP Allotment Neutrality Worksheet, since the proposed changes do not affect children.

Evaluation Design

The State proposes to modify its draft evaluation design to evaluate the health outcomes provided by the CBAS program. In addition, there are data collection, reporting, and quality assurance requirements that DHCS must meet as part of the Settlement Agreement. See Settlement Agreement, Sec. XVI "Data Collection, Reporting, and Quality Assurance."

Technical Amendments to Special Terms & Conditions

In addition to the amendments related to the CBAS program described above, DHCS has included in this amendment proposal two additional attachments with requested technical amendments to the Special Terms & Conditions (STC). The detail and justification for these amendments can be found in the attachments:

- Attachment D: Proposed STC technical amendments previously submitted through the technical correction process.
- Attachment E: Additional proposed STC amendment to STC 115 related to monitoring budget neutrality.
- Attachment F: Additional proposed STC amendment to STC 23 b. and f. related to the required Access Study and Plan.

Thank you for your assistance. If you have any questions, please contact Brian Hansen of my staff at (916) 440-7418. We are happy to assist you and your staff in any way as you review the changes we are proposing.

Sincerely,



Toby Douglas
Director

Attachments

PROPOSED 2012-13 HEALTH & HUMAN SERVICES BUDGET

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Below is a quick and preliminary summary based on excerpts from the official summaries, a conference call HHS held this evening, and conversations CAHP had with DHCS this afternoon. CAHP is working with DHCS on a process to answer health plan questions related to the budget proposal. This will likely include a call or meeting with DHCS managed care division and our members. Please stay tuned for more details.

By the way of background, Department of Finance has projected next year's deficit to be \$9.2 billion. In addition to the solutions presented in the budget, the Governor is also pursuing a tax proposal via the initiative process that would generate nearly \$7 billion in new revenue over five years. If voters reject the tax initiative, today's budget includes automatic triggers that would reduce spending on K-12, universities, the courts, and other programs by billions.

More documentation is expected from the various departments and agencies in the coming days. In the meantime, please let us know if you have any questions, comments, clarifications, or more information on the budget you wish to share.

MANAGED CARE TRANSFERS & EXPANSIONS

- **MOVE DUAL ELIGIBLES, INCLUDING IHSS BENEFICIARIES, INTO MANAGED CARE –** There are approximately 1.2 million duals. There are 423,000 IHSS beneficiaries and (by my math) approximately 360,000 of them are duals who will be transitioned into managed care under the proposal. Total estimated savings for the integration is \$678.8 million GF in 2012-13 and \$1B GF in 201-14. However, the savings will take time to realize. So, the budget proposes a provider payment deferral to accelerate savings into 2012. Saving is being banked based on anticipated reductions in hospital and nursing home costs.
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benefit. These will be integrated into managed care. With respect to IHSS, the administration of the program will remain unchanged but IHSS benefits will be included as part of plan rates. For skilled nursing facilities services, DHCS states that people who have been in a facility for more than 90 days on January 1, 2013 would not immediately be enrolled into managed care. Enrollment will be deferred for one year.

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Plans designed for Medicare beneficiaries residing in Contra Costa County. There are low or no co-pays for services with expanded benefits including dental coverage.

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Este programa de cobertura de salud es para residentes del condado sin seguro médico que cumplen ciertos requisitos de ingresos y de otro tipo de elegibilidad. Se ofrecen visitas al médico, atención preventiva, cobertura de recetas, y otros servicios a través de CCRMC y de la Red de Centros de Salud.

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Este es uno de los dos planes aprobados para beneficiarios de Medi-Cal sin costo en el Condado de Contra Costa. La inscripción es procesada por la agencia estatal *Health Care Options*. Para solicitar una forma de inscripción *Health Care Options*: llame al 1-800-430-4263.

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HFP es una opción de cobertura de salud, visión y dental, de bajo costo, que está auspiciada por el estado, para niños y jóvenes desde que nacen hasta que cumplen los 19 años. Está disponible para familias sin cobertura médica auspiciada por el empleador, y que no son elegibles para los beneficios completos de Medi-Cal.

Puede obtener ayuda para solicitar a algunos de estos programas a la oficina de mercadotecnia de CCHP. Llámenos al 1-800-211-8040 para obtener ayuda.



Somos una cultura de cariño

**COUNTY ADVISORY
COUNCIL ON AGING
EXECUTIVE COMMITTEE
PRESENTATION**

**REGARDING CBAS AND COST
PROPOSED EXPANSION BENEFITS
INTO MANAGED CARE**

FEBRUARY 1, 2012

**FACILITATOR: PATRICIA TANQUARY, MSSW, MPH, PHD, CEO
BOB SESSLER, CONSULTANT**

**CONTRA COSTA HEALTH PLAN
595 CENTER AVENUE, SUITE 100
MARTINEZ, CA 94553**



News Release

NUMBER: 12-01
FOR IMMEDIATE RELEASE
January 24, 2012

CONTACT: Norman Williams
(916) 440-7660
www.dhcs.ca.gov

STATE ANNOUNCES FINAL APPROVAL OF ADHC LAWSUIT SETTLEMENT AGREEMENT

SACRAMENTO – The U.S. District Court, California Northern District, today approved the California Department of Health Care Services' (DHCS) settlement agreement regarding the Adult Day Health Care (ADHC) lawsuit, *Darling, et al v. Douglas*. Under the settlement approved today, the ADHC program will be phased out and replaced on March 1, 2012, with the Community-Based Adult Services (CBAS) program, which will provide necessary medical and social services to individuals with intensive health care needs.

"We are pleased the court approved our settlement agreement that allows the state to provide key health services to the most vulnerable poor and disabled Californians in an efficient and fiscally responsible manner," said DHCS Director Toby Douglas. "The court's ruling supports the state's strong commitment to provide essential care and services to those most in need and helps keep them independent and in the community."

As a result of this fiscally responsible settlement, the state will achieve General Fund savings of \$25 million in 2011-12 and \$92 million in 2012-13.

Eligibility to participate in CBAS will be determined by state medical professionals on the basis of medical need, and the benefits provided will be coordinated with managed care plans. Those former ADHC participants who do not qualify for CBAS will be eligible to receive enhanced case management and other services through DHCS and managed care plans.

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Este es uno de los dos planes aprobados para beneficiarios de Medi-Cal sin costo en el Condado de Contra Costa. La inscripción es procesada por la agencia estatal *Health Care Options*. Para solicitar una forma de inscripción *Health Care Options*: llame al 1-800-430-4263.

Programa Healthy Families (HFP)

HFP es una opción de cobertura de salud, visión y dental, de bajo costo, que está auspiciada por el estado, para niños y jóvenes desde que nacen hasta que cumplen los 19 años. Está disponible para familias sin cobertura médica auspiciada por el empleador, y que no son elegibles para los beneficios completos de Medi-Cal.

Puede obtener ayuda para solicitar a algunos de estos programas a la oficina de mercadotecnia de CCHP. Llámenos al 1-800-211-8040 para obtener ayuda.



Somos una cultura de cariño

Managed Care and State Budget Changes

Presentation

by

Patricia Tanquary

February 2, 2012



CONTRA COSTA
HEALTH PLAN

A Division of Contra Costa Health Services

Programs and Services Impacted

1 Seniors and Persons with Disabilities (SPD) 4 In Home Supportive Services (IHSS)

2 Adult Day Health Care (ADHC) 5 Dual Eligible Pilots

3 2012 Governor's Budget 6 Healthy Families – AIM - MRMIP & PCIP

Seniors & Persons with Disabilities (SPD's)

- Effective June 2011, SPD's must join a managed care plan – CCHP or Blue Cross.
- CCHP enrolled 7461 as of February, 2012.
- CCHP contracted with additional Primary Care Providers and Specialists to improve access to SPD's and continuity of care.
- Members received Health Risk Assessments, Welcome Letters, and Nurse and Case Management assistance.
- Community Based Clinics (FQHCs) are assisting in caring for SPD's – LaClinica, Brookside, Lifelong Medical Care, and Axis.
- Expansion of clinics – more evenings & weekend appointments.

Adult Day Health Services (ADHC)

- This population was mandated to join Managed Care October, 2011. CCHP received 90% of eligibles in County.
- The State is changing this benefit to Community-Based Adult Services (CBAS) beginning March 1, 2012.
- State budget savings
 - \$25 Million FY 11/12 & \$92 Million FY 12/13.
- CBAS eligibility will be determined by CDHS and will cover necessary medical and social services for those with intensive health care needs.
- If ineligible for CBAS, patients will receive enhanced case management through managed care plans.

2012 Governor's Budget

- Mandate managed care for Medicare/Medi-Cal eligibles (Duals) effective 1/1/13 (Foster care excepted).
- Estimated 1.2 million individuals statewide, 22,000 in Contra Costa.
- Mandate Long Term Care (skilled nursing facilities) as Managed Care benefits only January 1, 2013.

In Home Supportive Services (IHSS)

- Move to Medi-Cal managed care beginning in 2012-13 year.
- Service hour reduction for 20% of recipients effective 4/1/12 (if approved by courts).
- Eliminates domestic and related services as benefits for IHSS beneficiaries in shared living arrangements including children – beginning 1/1/13 in phases through 2015.

Dual Eligible Pilots

- Mandate Duals into Managed Care with an opt out after 6 months.
- The 10-20 pilots will have contracts with Medicare, Medi-Cal and Managed Care to provide all benefits under both programs plus skilled nursing care, IHSS and CBAS care in a coordinated single managed care program.
- Selected Plans will initiate these 3 year pilots beginning January, 2013.

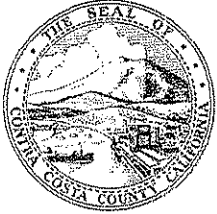
Healthy Families – AIM – MRMIP & PCIP

- Healthy Families
 - Rate reduction by 25.7% effective 10/1/12 to Medi-Cal Managed Care rate
 - Move to Medi-Cal beginning October, 2012 continuing over nine months.
- Access for Infants and Mothers (AIM)– move to DHCS 7/1/13.
- Major Risk Medical Insurance Program (MRMIP) eliminate 1/1/14.
- Pre-existing Condition Insurance Program (PCIP) eliminate 1/1/14 with Health Care Reform.
- Annual Open Enrollment for Medi-Cal.

Questions

Contra Costa County Employment & Human Services

Aging & Adult • Children & Family • Community Services • Workforce Development Board • Workforce Services



In partnership
with the
community,
we provide
services
that support
and protect
adults,
children,
families,
and the elderly,
and promote
personal
responsibility,
independence and
self-sufficiency.

February 14, 2011

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary:

I am writing in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. As an agency that serves individuals eligible for both Medi-Cal and Medicare, we are well aware of the need for a coordinated system of care for this population.

We look forward to working with CCHP and a broad range of health care providers and social supports and services from across the county in providing a seamless continuum of care. We support the goals of the pilot project to rebalance care for the duals away from avoidable institutionalized services and toward enhanced home and community-based services.

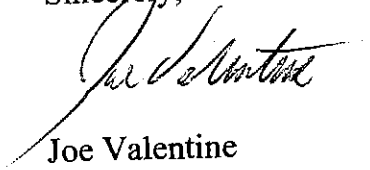
We endorse working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life. As the entity that manages In Home Supportive Services, the Aging & Adult Services Bureau is particularly interested in developing a model that assures IHSS clients maintain consumer choice and a level of support that allows them to remain safely and healthfully in the place of their choice. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

Joe Valentine
Director

Ms. Patricia Tanquary
Contra Costa Health Plan
February 14, 2011
Page Two of Two

Our bureau welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,

A handwritten signature in cursive script, appearing to read "Joe Valentine".

Joe Valentine
Director, Employment & Human Services

MC:sgb

cc: John Cottrell, Director, Aging & Adult Services
Maura Connell

WILLIAM B. WALKER, M.D.
HEALTH SERVICES DIRECTOR

WENDEL BRUNNER, M.D.
DIRECTOR OF PUBLIC HEALTH



CONTRA COSTA
PUBLIC HEALTH
597 CENTER AVENUE, SUITE 200
MARTINEZ, CALIFORNIA 94553
PH (925) 313-6712
FAX (925) 313-6721
WENDEL.BRUNNER@HSD.CCCOUNTY.US

February 22, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Doctor Tanquary,

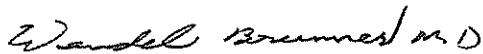
As Director of Public Health for Contra Costa County, I am writing in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. As an agency that serves individuals eligible for both Medi-Cal and Medicare, we are well aware of the need for a coordinated system of care to improve the health of that vulnerable population.

We look forward to working with CCHP and a broad range of providers of health care and social supports and services from across the county in providing a seamless continuum of care. The goals of the pilot project - to rebalance care for this at-risk population of Dual Eligibles away from avoidable institutionalized services and toward enhanced home and community-based services- are completely consistent with our mission as a Public Health program and have our full support.

We support working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

Our agency welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,



Wendel Brunner, PhD, MD, MPH
Director of Public Health
Contra Costa Health Services





Western Contra Costa
Transit Authority

February 6, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary,

I am writing to communicate Western Contra Costa Transit Authority's strong support for Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. As an agency that serves individuals eligible for both Medi-Cal and Medicare, we are well aware of the need for a coordinated system of care for that population.

We look forward to working with CCHP and a broad range of health care providers and social supports and services from across the county in providing a seamless continuum of care. We support the goals of the pilot project to rebalance care for the duals away from avoidable institutionalized services and toward enhanced home and community-based services.

We support working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

WCCTA welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,

Charles Anderson
General Manager



WILLIAM B. WALKER, M.D.
Health Services Director
CYNTHIA BELON, L.C.S.W.
Behavioral Health Services Director



CONTRA COSTA
BEHAVIORAL HEALTH
SERVICES
ADMINISTRATION
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5201
Fax 925/957-5156

February 22, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary,

I am writing in support of Contra Costa Health Plan's proposal to participate in California's Dual Eligibles Demonstration Project. As a Division of Contra Costa County Health Services, we serve individuals eligible for both Medi-Cal and Medicare, and are well aware of the need for a coordinated system of care for that population.

We look forward to working with CCHP and a broad range of health care providers and social supports and services from across the county in providing a seamless continuum of care. We support the goals of the pilot project to rebalance care for the duals away from avoidable institutionalized services and toward enhanced home and community-based services.

We support working with a pilot program that seeks to maximize the ability of the duals to maintain good health and a high quality of life through the development of coordinated services, efficient use of resources, and increased emphasis on preventive services and community-based care. We will work in good faith to collaborate with CCHP and our fellow service providers to successfully implement this project.

Contra Costa County Behavioral Health Services welcomes the opportunity to help assure that Contra Costa County will be in the forefront of developing this long needed integrated model of care for California's dually eligible seniors and persons with disabilities.

Sincerely,



Cynthia Belon, LCSW
Director of Behavioral Health Services

CB:jd



WILLIAM B. WALKER, M.D.
Health Services Director
SUZANNE TAVANO, PhD
Acting Mental Health Director



CONTRA COSTA
MENTAL HEALTH
ADMINISTRATION

1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156

February 22, 2012

Patricia Tanquary, CEO
Contra Costa Health Plan
595 Center Street, Suite 100
Martinez, CA 94553

Dear Ms. Tanquary:

I would like to submit this letter of support for the Contra Costa Health Plan's proposal to participate in California's Dual Eligible Demonstration Project. As the Contra Costa Mental Health Plan, we have enjoyed a long-standing formal relationship with the Health Plan which dates back to 1995. This partnership has supported the delivery of coordinated health and mental health services to enrolled Contra Costa Medi-Cal beneficiaries.

As you are aware, the Mental Health Plan already provides specialty mental health services to Medi-Cal/Medicare dual eligible beneficiaries. At our last estimate, approximately 18% of the adult mental health consumers we serve are in this financial category. It is with hope and anticipation that the Contra Costa Health Plan participates in the Dual Eligible Demonstration Project. This would facilitate the coordination of care and resources to Medi-Cal/Medicare beneficiaries. As we saw with enrollment of Medi-Cal beneficiaries into Managed Care, the reliance on multiple and extended periods of institutional care decreased and the community-based safety net of services increased, thereby supporting individuals in remaining in their home communities and in achieving goals of wellness and recovery. We anticipate the same positive results for the dual eligible population.

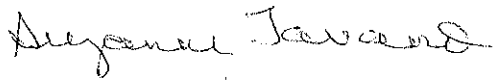
It will be a pleasure to join with the Contra Costa Health Plan and the large array of providers that form Contra Costa County's continuum of care in this demonstration project. Extending the many collaborative relationships established to better serve the Medi-Cal population to the Dual Eligible population should result in better treatment outcomes, improved general health, and increased support to consumers to live a full and rewarding life.



Patricia Tanquary
February 22, 2012
Page 2

We commit to work in a meaningful and productive manner with the Health Plan and all collaborating partners to achieve the goals and objectives of the demonstration project.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne Tavano".

Suzanne Tavano, BSN, Ph.D
Acting Mental Health Director
Contra Costa Mental Health Plan - Behavioral Health Division

DRAFT
INTERDEPARTMENTAL AGREEMENT
BETWEEN

IN HOME SERVICES PUBLIC AUTHORITY

AND

HEALTH SERVICES DEPARTMENT/CONTRA COSTA HEALTH PLAN

TERM: January 1, 2013-December 31, 2013

The two County departments agree to work collaboratively over the duration of this agreement to further the goals and objectives of the Dual Eligible Demonstration Pilot Project as specified in the tripartite contract between Contra Costa Health Plan, the California Department of Health Care Services, and the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services and incorporated herein by reference.

The two departments agree to the following in regards to the administration of the In Home Supportive Services (IHSS) program:

1. The Public Authority will conduct collective bargaining with the union elected to represent IHSS providers to determine the wages and benefits paid to the providers.
2. The Public Authority will utilize procedures according to applicable Federal and State laws and regulations under the Duals Demonstration Pilot Project.
3. The Public Authority will recruit, screen, orient, enroll, and train IHSS providers and refer them to consumers who request assistance finding a provider.
4. The Public Authority will coordinate with Contra Costa Health Plan Care Management staff to refer appropriate providers from its registry to IHSS consumers and other dual consumers in need of a provider.
5. CCHP will consult the Public Authority Advisory Committee for consumer and community feedback regarding the operations of the Duals Demonstration Pilot Project.

Jan Watson, IHSS Public Authority Executive Director

William Walker, M.D., Health Services Director

DRAFT

INTERDEPARTMENTAL AGREEMENT

BETWEEN

EMPLOYMENT AND HUMAN SERVICES DEPARTMENT/ AGING AND ADULT SERVICES BUREAU

AND

HEALTH SERVICES DEPARTMENT/CONTRA COSTA HEALTH PLAN

TERM: January 1, 2013-December 31, 2013

The two County departments agree to work collaboratively over the duration of this agreement to further the goals and objectives of the Dual Eligible Demonstration Pilot Project as specified in the tripartite contract between Contra Costa Health , the California Department of Health Care Services, and U. S. Department of Health and Human Services Center for Medicare and Medicaid Services and incorporated herein by reference.

The two departments hereby agree to the following in regards to the administration of the In Home Supportive Services (IHSS) program:

1. IHSS consumers will be able to select, hire, fire, schedule and supervise their IHSS care provider, participate in the development of their care plan, and select who else participates in their care planning.
2. Aging and Adult Services IHSS Social Workers will use the Uniform Assessment tool and Hourly Task Guidelines developed by the California Department of Social Services, authorize IHSS services, and participate with Contra Costa Health Plan Care Management staff and others in care coordination.

3. Aging and Adult Services IHSS Social Workers will utilize procedures according to applicable Federal and State laws and regulations under the Duals Demonstration Pilot Project.
4. In situations where additional IHSS hours or alternative personal care options may be needed to avoid unnecessary institutionalization of the consumer, CCHP Care Management staff and Aging and Adult Services IHSS Social Workers will work together to mutually arrive at a solution.
5. The State of California Controller's office will pay IHSS providers through the State of California's IHSS Case Management Information and Payrolling System (CMIPS) from payroll data provided by Aging and Adult Services IHSS payroll staff from time cards submitted by IHSS providers.

Joe Valentine, Employment and Human Services Director

William Walker, M.D., Health Services Director



Memorandum of Understanding
Contra Costa Health Plan
Contra Costa County Mental Health Program

Purpose:

Contra Costa Mental Health Program (CCMHP) agrees to provide mental health counseling to Contra Costa Health Plan (CCHP) Medi-Cal eligible enrollees.

Procedure:

- Eligible CCHP Medi-Cal enrollees may self refer for needed services by calling 1-888-678-7277, CCMHP Access Line
- Periodic meetings regarding service delivery will be held as needed or at least quarterly to review progress
- Member eligibility for CCHP Medi-Cal will be reviewed by CCMHP prior to delivery of mental health services
- CCHP members requiring psychiatric hospitalization will be referred to CCMHP for authorization and utilization review
- Mental Health documentation on patients receiving service will be made available to referring primary care provider

This document serves to assure availability of services.

Margaret J. Lewis, PhD
Contra Costa County Mental Health

March 14, 2011

Date

Judith Lowe
Contra Costa Health Plan

March 17, 2011

Date

3/17/2011

**MEMORANDUM OF UNDERSTANDING
BETWEEN
CONTRA COSTA HEALTH PLAN (CCHP)
AND
CONTRA COSTA MENTAL HEALTH PLAN**

DATE:

REV. DATE: 14 April 2003

CATEGORY	CONTRA COSTA MENTAL HEALTH PLAN	CONTRA COSTA HEALTH PLAN
LIAISON	<p>The CCMHP Liaison will coordinate activities with CCHP and will notify the CCMHP providers of the roles and responsibilities of the CCMHP liaison.</p> <p>CCMHP will meet with CCHP at least quarterly to resolve issues regarding appropriate and continuous care for members. CCMHP Liaison will be responsible for communicating suggestions for MOU changes to the CCMHP leadership and CCHP Liaison.</p> <p>At the discretion of CCMHP, the Liaison may represent CCMHP in the dispute resolution process.</p> <p>CCMHP will assist and provide CCHP with the phone numbers of its beneficiaries and provider services and support programs that provide liaison services.</p>	<p>The CCHP liaison will coordinate activities with the CCMHP and will notify its CCHP providers of the roles and responsibilities.</p> <p>The CCHP Liaison will meet with CCMHP at least quarterly to resolve issues regarding appropriate and continuous care for members. CCHP will be responsible for communicating suggestions for MOU changes to CCHP leadership and CCMHP Liaison. CCHP will also communicate MOU changes to the State Department of Health Services (DHS) and CCHP providers.</p> <p>At the discretion of CCHP, the Liaison may represent CCHP in the dispute resolution process.</p> <p>CCHP will provide CCMHP with the phone numbers of its member services, provider services, and support programs that provide liaison services.</p> <p>With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, CCHP member clinical, or other pertinent information will be shared between CCHP and CCMHP and its providers to ensure coordinate of care.</p>
ANCILLARY MENTAL HEALTH SERVICES	<p>When medical necessity criteria are met, CCMHP will provide hospital based ancillary services, which include but are not limited to electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI) that are received by a beneficiary admitted to a psychiatric inpatient hospital other than routine services.</p>	<p>CCHP will provide ancillary services to CCMHP members when medically necessary. CCHP will direct contracting providers to provide covered ancillary physical health services to CCHP members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.</p>
CLINICAL CONSULTATION AND TRAINING	<p>CCMHP will provide and make available clinical consultation and training, including consultation and training on psychotropic medications, available to meet the needs of a beneficiary whose mental illness is not being treated by CCMHP.</p> <p>CCMHP will include consultation on medications to CCHP member whose mental illness is being treated by CCHP.</p> <p>Clinical consultation between CCMHP and CCHP will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by CCMHP to CCHP on psychotropic drugs prescribed by CCMHP for a CCHP member whose mental illness is being treated by CCHP.</p>	<p>CCHP will direct contracting providers to provide clinical consultation and training to CCMHP or other providers on physical health care conditions and on medications prescribed through CCHP providers.</p> <p>CCHP will direct contracting providers to provide clinical consultation to CCMHP or other providers of mental health services on a member's physical health condition. Such consultation will include consultation by CCHP to CCMHP on medications prescribed by CCHP for a CCHP member whose mental illness is being treated by CCMHP.</p>

CATEGORY	CONTRA COSTA MENTAL HEALTH PLAN	CONTRA COSTA HEALTH PLAN
CONFIDENTIALITY OF MEDICAL RECORDS	<p>CCMHP 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 providers of specialty mental health services. CCMHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations.</p> <p>All identification and information relating to a member's participating in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member.</p> <p>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.</p>	<p>CCHP will facilitate appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers or providers of specialty mental health services. CCHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations.</p> <p>CCHP will not release any information pertaining to a member's 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, 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 CCHP is notified of the extension, the reasons for the extension, and additional intended uses and the expected date that the information will be destroyed.</p> <p>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.</p>
DIAGNOSTIC ASSESSMENT	<p>CCMHP will provide evaluation, triage, and when authorized, specialty mental health services to CCHP members whose psychological conditions would not be responsive to mental health or physical health care by their PCP.</p> <p>CCMHP 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.</p> <p>When medical necessity criteria is met, CCMHP will arrange for an appointment with the appropriate provider and will relay appointment information to the member. When medical necessity criteria is not met, CCMHP staff will refer the member back to the referring PCP, notify CCHP and/or refer the member to community service, as appropriate.</p> <p>Individual mental health providers may arrange for records transfer by direct communication with the referring physician, or will request records through the CCHP liaison.</p>	<p>CCHP will advise its contracting providers to furnish and CCHP will then pay for appropriate medical necessary assessments of CCHP members to identify co-morbid physical and mental health conditions to:</p> <ul style="list-style-type: none"> ■ 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. <p>The PCP will be advised to identify and treat non-disabling psychiatric conditions that may be responsive to primary care, i.e.: mild to moderate anxiety and/or depression, if within the scope of practice of the PCP.</p> <p>The member's PCP or appropriate medical specialist will be advised to identify and treat those general medical condition that are causing or exacerbating psychological symptoms, or refer the member to specialty physical health care for such treatment.</p>
EMERGENCY SERVICES & CARE - EMERGENCY ROOM FACILITY CHARGES AND PROFESSIONAL SERVICES	<p>CCMHP will be responsible for the facility charges resulting from the emergency services and care of a CCHP member whose condition meets CCMHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same</p>	<p>CCHP will cover and pay at the Medi-Cal rates for the facility charges resulting from the emergency services and care of a CCHP member, whose condition meets CCMHP medical necessity criteria, when such services and care do not result in the admission of the member for psychiatric</p>

CATEGORY	CONTRA COSTA MENTAL HEALTH PLAN	CONTRA COSTA HEALTH PLAN
	<p>facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.</p> <p>CCMHP will be responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room, when these services do not result in the admission of the member for psychiatric inpatient hospital services at that facility or any other facility.</p> <p>CCMHP will cover and pay for the professional services of a mental health specialist provided in an emergency room to a CCHP member, whose condition meets CCMHP medical necessity criteria or when the mental health specialist services are required to assess whether the CCMHP medical necessity is met.</p> <p>Payment for professional services of a mental health specialist required for the emergency services and care of a CCHP member with an excluded diagnosis, is the responsibility of the Medi-Cal fee-for-service system.</p>	<p>inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.</p> <p>CCHP will cover and pay at the Medi-Cal rates for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets CCMHP medical necessity criteria.</p> <p>CCHP will cover and pay at the Medi-Cal rates for the facility charges and the medical professional services required for the emergency services and care of a CCHP member whose condition does not meet CCMHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.</p>
HOME HEALTH AGENCY SERVICES	<p>CCMHP will notify CCHP 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).</p> <p>CCMHP will pay for services solely related to include mental health diagnoses, or for Specialty Mental Health Services determined to be necessary by the CCMHP.</p> <p>CCMHP is not responsible to provide or arrange for Home Health Agency Services as described in Title 22, Section 51337.</p>	<p>CCHP will cover and pay at the Medi-Cal rates for home health agency services prescribed by a CCHP provider when medically necessary to meet the needs of homebound members.</p> <p>A homebound CCHP member is a patient who is essentially confined to his home due to illness or injury. If ambulatory or otherwise mobile, member 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.</p> <p>CCHP is not obligated to provide 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 CCHP member. For example, CCHP would not be obligated to provide home health agency services for the purpose of medical monitoring when those services are not typically medically necessary, or for a patient who is not homebound.</p> <p>Home health agency services prescribed by CCHP providers to treat mental health condition of CCHP members are the responsibility of CCHP.</p>
HOSPITAL OUTPATIENT DEPARTMENT SERVICES	<p>CCMHP will be responsible for the payment of specialty mental health services provided by hospital outpatient departments, for CCHP members who meet medical necessity criteria for specialty mental health services hospital outpatient services will be reasonably available and accessible to CCHP members.</p>	<p>CCHP will cover and pay at the Medi-Cal rates for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and CCHP contract with his subcontractors and the DHS. Separately billable outpatient services related to electroconvulsive therapy, such as</p>

CATEGORY	CONTRA COSTA MENTAL HEALTH PLAN	CONTRA COSTA HEALTH PLAN
LABORATORY, RADIOLOGICAL AND RADIOSOTOPE SERVICES	<p>Prescribed drugs as described in Title 22, Section 51513 and laboratory radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the CCMHP, except when provided as hospital based ancillary services.</p> <p>Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice, and employed by or contracting with the CCMHP.</p> <p>CCMHP will coordinate with CCHP as appropriate, to assist beneficiaries in receiving laboratory services prescribed through the CCMHP, including ensuring that any medical justification of the services required for approval of payment to the laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedure.</p> <p>Information will be disseminated to the CCMHP providers primarily through quarterly provider meetings conducted by CCMHP staff. Secondly, targeted outreach will be extended to interested providers in the form of written communication and/or office visits to present a review of the claims process.</p>	<p>anesthesiologist services, are the contractual responsibility of CCHP.</p> <p>CCHP will be responsible for providing medically necessary laboratory, radiological, and radioisotope services described in Title 22, Section 51311.</p> <p>CCHP will cover and pay at the Medi-Cal rates for services to CCHP members who require the specialty mental health services by the CCMHP or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis and treatment of CCHP member's mental health condition.</p> <p>CCHP will also cover and pay at the Medi-Cal rates for services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. CCHP will coordinate these services with the member's specialty mental health provider.</p>
MEDICAL TRANSPORTATION SERVICES	<p>CCMHP will not be responsible for medical transportation services, except when the purpose is to transport a beneficiary from one psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24-hour facility because:</p> <ul style="list-style-type: none"> ■ The services in the facility to which the beneficiary is being transported will result in lower cost to CCMHP. 	<p>CCHP will cover and pay at the Medi-Cal rates all medically necessary emergency and non-emergency medical transportation services for CCHP members, including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services.</p> <p>CCHP will cover and pay at the Medi-Cal rates for medically necessary non-emergency medical transportation services, when prescribed for a CCHP member by a Medi-Cal mental health provider outside the CCHP, when authorization is obtained.</p>
MEDICAL NECESSITY CRITERIA	<p>CCMHP will provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries served by CCMHP, who meet specified medically necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.</p> <p>Medical necessity criteria, is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. CCMHP will accept referrals received through beneficiary self-referral or through referral by another person or organization.</p>	<p>Beneficiaries whose diagnoses are not included in the applicable listing of CCMHP covered diagnoses may obtain specialty mental health services through the Medi-Cal Fee-For-Services (FFS) system.</p> <p>CCHP members whose mental health diagnoses are covered by the CCMHP but whose conditions do not meet the program impairment and intervention criteria, are not eligible for specialty mental health care under the Medi-Cal FFS program. These beneficiaries are eligible for care from a primary care or other physical health care provider. The Medi-Cal FFS system will deny claims from mental health professionals for such beneficiaries.</p>

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<p>NURSING FACILITY SERVICES</p>	<p>CCMHP is not responsible for any nursing facility services. However, CCMHP will arrange and pay for all medically necessary specialty mental services (typically visits by psychiatrists and psychologists) in a skilled nursing facility.</p>	<p>CCHP will arrange and pay at the Medi-Cal rates for nursing facility services for members who meet CCHP's medical necessity criteria for the month of admission, plus one month. CCHP will arrange for disenrollment from the managed care program if the member needs nursing services for a longer period of time.</p> <p>Skilled nursing facility services with special treatment programs for the mentally disordered, are covered by FFS program. These services are billed to the FFS system using accommodations codes 11, 12, 31, and 32 for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs)</p>
<p>PHARMACEUTICAL SERVICES AND PRESCRIBED DRUGS</p>	<p>CCMHP 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.</p> <p>However, CCMHP is responsible for coordinating with pharmacies and CCHP as appropriate, to assist beneficiaries in receiving prescription drugs and laboratory services prescribed through CCMHP, 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.</p> <p>CCMHP will utilize the existing services of CCHP's laboratory or the services of CCHP's contracted laboratory providers, as needed in connection with the administration and management of psychotropic medications.</p>	<p>CCHP will cover and pay at the Medi-Cal rates for 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 CCHP contract.</p> <p>CCHP will cover and pay at the Medi-Cal rates for psychotropic drugs not otherwise excluded by their contract, which are prescribed by out-of-plan psychiatric providers for the treatment of psychiatric conditions.</p> <p>CCHP may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists.</p> <p>Application of utilization review procedures should not inhibit a CCHP member's access to prescriptions. If CCHP requires that covered prescriptions written by out-of-plan CCHP psychiatrists be filled by pharmacies in CCHP's provider network, CCHP will ensure that drugs prescribed by out-of-plan CCHP psychiatrists are not less accessible to CCHP members than drugs prescribed by network providers.</p> <p>CCHP will not cover and pay for 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 CCMHP to provide mental health services in areas where access to psychiatrists is limited.</p> <p>Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD policy letter, and for new psychotropic drugs classified as anti-psychotics and approved by the FDS, will be made through the FFS system whether these drugs are provided by a pharmacy contracting with CCHP or by FFS pharmacy providers.</p>

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PSYCHIATRIC INPATIENT HOSPITAL SERVICES	<p>CCMHP will be responsible for psychiatric inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c).</p> <p>Psychiatric inpatient hospital services for a FFS/Medi-Cal hospital will include:</p> <ul style="list-style-type: none"> ■ Routine hospital services ■ All hospital based ancillary services <p>Psychiatric inpatient hospital services for Short-Doyle/Medi-Cal hospital will include:</p> <ul style="list-style-type: none"> ■ Routine hospital services ■ All hospital based ancillary services, and ■ Psychiatric inpatient hospital professional services <p>CCMHP will utilize CCHP contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for CCHP members unless otherwise covered by the hospital's per diem rate.</p>	<p>CCHP will cover and pay at the Medi-Cal rate, all medically necessary professional services to meet the physical health care needs of CCHP 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.</p> <p>CCHP 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.</p>
PHYSICIAN SERVICES	<p>CCMHP 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.</p>	<p>CCHP will cover and pay at the Medi-Cal rates for physician services related to the delivery of outpatient mental health services, which are within the PCP's scope of practice, for both CCHP members with excluded mental health diagnoses and CCHP members with included mental health diagnoses, whose conditions do not meet the CCMHP medical necessity criteria.</p> <p>CCHP is not required to cover and pay for physician services provided to Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage, Family and Child Counselors, or other specialty mental health providers. CCHP will cover and pay for physician services provided by specialists such as Neurologists, when medically necessary.</p>
PROVIDER NETWORK AND MEMBER EDUCATION	<p>CCMHP will credential and contract with sufficient numbers of licensed mental health professionals to maintain a CCMHP provider network sufficient to meet the needs of CCHP members.</p> <p>CCMHP will assist with identification of CCMHP providers who have the capacity and willingness to accept CCHP reimbursement to serve the needs of CCHP members who do not meet the CCMHP medical necessity criteria and require services outside the scope of practice of the PCP.</p> <p>CCMHP will continually monitor the CCMHP provider network to ensure beneficiary access to quality mental health care. CCMHP will assist CCHP in arranging for a specific CCMHP provider when CCHP is unable to locate an appropriate mental health service provider for a CCHP member.</p>	<p>The coordination of Medi-Cal physical health care services and specialty mental health services is a dual CCHP/CCMHP responsibility. CCHP is responsible for arranging appropriate management of a CCHP member's care between CCHP and other care providers or providers of specialty mental health services as required by contract.</p> <p>CCHP will utilize the CCMHP to identify CCMHP providers who are willing to accept FFS payment, to provide services for CCHP members who do not meet CCMHP medical necessity criteria for CCMHP services and require services outside the scope of practice of the PCP.</p> <p>CCHP will request assistance from the CCMHP whenever CCHP is unable to arrange for an appropriate CCMHP provider for a CCHP member.</p>

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	<p>CCMHP will also assist CCHP to develop and update a list of provider or provider organizations to be made available to CCHP members. Any updates to the list will be provided to CCHP at the quarterly MOU meetings or as changes occur to the list.</p>	<p>CCHP will initiate a referral to the appropriate CCMHP provider or provider organization as recommended by the CCMHP. For those services that do not meet the CCMHP medical necessity criteria, a copy of the referral will be kept in the member's referral chart.</p> <p>CCHP will collaborate with the CCMHP to develop and maintain a list of providers or provider organizations to be made available to CCHP members. Amendments to the list will be provided to the CCMHP at the quarterly MOU meetings or as changes occur to the list.</p>
<p>REFERRALS</p>	<p>CCMHP will accept referrals from CCHP staff, CCHP providers and CCHP Medi-Cal members for determination of CCMHP medical necessity.</p> <p>Contra Costa Mental Health Plan (CCMHP will provide and maintain responsibility for:</p> <ul style="list-style-type: none"> ■ Medication treatment for mental health conditions that would not be responsive to physical health care based treatment and those conditions that do not meet CCHP medical necessity criteria. ■ Consultation services to CCHP providers, particularly PCPs about specialty mental health issues and treatments including medication consultation. ■ Medical induced reactions from medications prescribed by the CCMHP providers. <p>When medical necessity criteria are met, CCMHP will arrange for specialty mental health services by a CCMHP provider. In the case of self-referrals or referrals from providers other than the member's PCP, in which CCHP specialty mental health services involves a CCMHP psychiatrist, the CCMHP will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information.</p> <p>When medical necessity criteria are not met, or if it is felt that the member's mental health condition would be responsible to physical health care base treatment, the CCMHP will refer the member back to CCHP 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.</p> <p>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 CCMHP.</p> <p>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</p>	<p>CCHP will maintain responsibility for physical healthcare based primary mental health treatment, which includes:</p> <ul style="list-style-type: none"> ■ Basic education, assessment, counseling, and referral and linkage to other services for all beneficiaries. <p>CCHP will refer to the CCMHP for an assessment and appropriate services when:</p> <ul style="list-style-type: none"> ■ An assessment is needed by the CCMHP 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 CCMHP. ■ CCHP identifies mental health conditions not responsive to physical health care based primary mental health treatment. <p>After the PCP's diagnostic assessment, CCHP or PCP will refer those members whose psychiatric condition would not be responsive to physical health care, to the CCMHP to determine if CCMHP medical necessity criteria are met.</p> <p>CCMHP will inform CCHP and CCHP providers when a member does not meet the CCMHP criteria and will provide results of psychological assessment and treatment recommendations. CCHP will arrange for primary mental health services within the PCP's scope of practice.</p> <p>When CCMHP informs CCHP and the CCHP provider that a member's health condition has stabilized and maintenance of the condition would</p>

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	<p>willingness to accept referrals. This will include, but is not limited to, a Federally Qualified Health Center (FQHC), a Rural Health Clinic, an Indian Health Clinic, or an Indian Clinic. The CCMHP 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 CCMHP.</p> <p>When the CCMHP 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 CCMHP will refer the member back to CCHP 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.</p> <p>CCMHP will utilize CCHP's referral authorization form and with the member's consent, inform the PCP of services provided and/or medications prescribed. The CCMHP will attempt to coordinate information with the member's other health care providers and ensure that contact with CCHP is made.</p>	<p>be responsive to physical healthcare based treatment, CCHP will refer member for primary mental health services within the PCP's scope of practice.</p> <p>Some specialty mental health services will continue to be covered and provided through the Medi-Cal FFS program for a specified set of diagnoses specifically excluded from CCMHP responsibility.</p> <p>CCHP will use its referral authorization form and ensure that coordination and contact with the CCMHP is made. If a provider is not available to perform the needed service, the PCP, after obtaining prior authorization, will refer the member to an out-of-plan provider for services.</p>
RESOLUTION OF DISPUTE	<p>CCMHP will provide a resolution of dispute process in accordance to Title 9, Section 1850.505.</p> <p>When CCMHP has a dispute with CCHP that cannot be resolved to the satisfaction of CCMHP, concerning the obligation of CCMHP, or CCHP, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the CCMHP may submit a request for resolution to the State Department of Mental Health (DMH).</p> <p>A request for resolution by either department will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties.</p> <p>The request for resolution will contain the following information:</p> <ol style="list-style-type: none"> 1. A summary of the issue and a statement of the desired remedy, including any disputed 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. <p>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</p>	<p>CCHP will provide a resolution of dispute process in accordance to Title 9, Section 1850. 505, and the contract between CCHP and the DHS.</p> <p>When CCHP has a dispute with CCMHP that cannot be resolved to the satisfaction of CCHP concerning the obligations of CCMHP or CCHP under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, CCHP may submit a request for resolution to the DHS.</p> <p>A request for resolution by either department will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties.</p> <p>The request for resolution will contain the following information:</p> <ol style="list-style-type: none"> 1. A summary of the issue and a statement of the desired remedy, including any disputed 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. <p>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</p>

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	<p>statement of the party's position on the payment for services included by the other in its request.</p> <p>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.</p> <p>A dispute between CCMHP and CCHP 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.</p> <p>Nothing in this section will preclude a beneficiary from utilizing the CCMHP's beneficiary problem resolution process or any similar process offered by CCHP or to request a fair hearing.</p>	<p>statement of the party's position on the payment for services included by the other in its request..</p> <p>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.</p> <p>A dispute between CCHP and CCMHP 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.</p> <p>Nothing in this section will preclude a beneficiary from utilizing the CCHP's beneficiary problem resolution process or any similar process offered by CCMHP or to request a fair hearing.</p>
SERVICE AUTHORIZATIONS	<p>CCMHP will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the CCMHP for services that meet CCMHP medical necessity criteria. This will be done through CCMHP Access program or a CCMHP linkage agency. Services will be rendered according to the CCMHP responsibility.</p> <p>Emergency services will be provided in accordance with State and Federal laws and regulations. CCMHP case management staff will be available to assist in coordinating care, including service authorizations.</p> <p>If a dispute occurs between the member and CCMHP or CCHP, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.</p>	<p>CCHP and its delegated entities will authorize medical assessment and/or treatment services by providers who are credentialed by CCHP and contracted with a CCHP partner or delegated entity for covered physical health care services.</p> <p>CCHP and/or its delegated entities will authorize all inpatient and outpatient medical assessment, consultation and/or treatment services required for CCHP members and coordinate with CCMHP for those member receiving care from the CCMHP.</p> <p>CCHP case management staff will be available to assist in coordinating care and obtaining appropriate service authorizations.</p> <p>If a dispute occurs between the member and CCHP or CCMHP, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.</p>
SERVICES FOR THE DEVELOPMENTALLY DISABLED	<p>CCMHP will refer members with developmental disabilities to Regional Centers for psychiatric medical services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. When appropriate, the CCMHP will inform CCHP, its delegated entity, and the PCP of such referrals.</p>	<p>CCHP 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.</p>
SPECIALITY MENTAL HEALTH SERVICES PROVIDERS AND COVERED SPECIALTY MH SERVICES (ES PDT)	<p>CCMHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 is eligible for EPSDT supplemental services. If these criteria are met, the CCMHP will be responsible for arranging EPSDT supplemental services are part of the member's specialty mental health treatment.</p> <p>CCMHP will also provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Section 1820.205, or 1830.210 are met and when specialty mental health services are required to assess</p>	<p>CCHP will cover specialty mental health services related to mental health diagnoses that are not the responsibility of either the CCMHP or CCHP.</p> <p>When CCHP determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, CCHP will refer the child to the PCP for treatment of conditions within the PCP's scope of practice.</p> <p>Referrals to CCMHP for an appropriate linked program will be made for treatment of conditions outside the PCP's scope of practice; CCHP will</p>

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	<p>Whether the medical necessity criteria are met.</p> <p>If EPSDT supplemental services or CCMHP medical necessity criteria are not met, the CCMHP will refer children who have a CCS eligible condition requiring specialty mental health services to their PCP for a referral to CCS.</p> <p>Children who do not have a CCS eligible condition will be referred to their PCP with recommendations for mental health treatment.</p> <p>Hospitals not affiliated with CCMHP may provide psychiatric inpatient hospital services to Medi-Cal beneficiaries in emergency situations at FFS rates established regulation.</p>	<p>Assist the CCMHP and members by providing to known community providers of supplemental services.</p> <p>CCHP will also provide all medically necessary professional services to meet the physical health care needs of CCHP members admitted to a general acute care hospital, psychiatric inpatient hospital.</p>
<p>SERVICES EXCLUDED FROM COVERAGE</p>	<p>CCMHP will not be responsible to provide or arrange and pay for the following services:</p> <ul style="list-style-type: none"> ■ 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 hospitals operated by the State Department of Mental Health or Developmental Services. ■ Specialty Mental Health Services provided to Medi-Cal beneficiary eligible for 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 covered by the Medi-Cal Managed Care CCHP. ■ Psychiatric Inpatient Hospital Services, billable to FFS Medi-Cal, under 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 services package as follows: <ul style="list-style-type: none"> ○ Psychiatric and Psychological Services provided by adult day health centers ○ Home and Community based Waiver Services as defined in CCR Title 22, Section 51176. ○ Specialty Mental Health Services other than psychiatric inpatient hospital services, authorized by the California Children's Services (CCS) program to treat CCS eligible beneficiaries. ○ Local Education Services as defined in Title 22, CCR, Section 51190.4. ○ Specialty Mental Health Services, provided by Federally Qualified Health Centers, Indian Health Centers, and Rural 	<p>CCHP is not responsible to arrange and pay for the services listed below to its members in accordance to the MOU and as contractually required.</p> <ul style="list-style-type: none"> ■ Medi-Cal Services, that are specialty mental health services. <p>(A copy of "Drugs Excluded from CCHP Coverage" list should be included as part of this MOU package. The drug list can be found as Enclosure 2 to the MMCD policy letter #00-01)</p>

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	<p>Health Clinics.</p> <p>Beneficiaries who have an excluded diagnoses or may obtain specialty mental health services under applicable provisions of Title 22, Div.3, Subdivision 1.</p>	