IEHP Logo

IEHP's Application for

California's Dual Eligible Demonstration

Request for Solutions

For San Bernardino County

Submitted

February 22, 2012

IEHP Logo

February 22, 2012

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

Re: Dual Eligible Demonstration Project

Dear Mr. Douglas:

Inland Empire Health Plan (IEHP) is a not-for-profit, public health plan, serving over 540,000 members who are enrolled in Medi-Cal, Healthy Families, Healthy Kids, or our Medicare Special Needs Plan in Riverside and San Bernardino counties. Since 1996, we have consistently focused on our mission of providing quality, accessible, and coordinated healthcare for our community. This commitment has resulted in our decision to submit an application to the department's Request for Solutions for the Dual Eligible Demonstration Project.

Attached is our application for San Bernardino County, but the overall goal of our Dual Eligible Demonstration program is to provide coordinated, comprehensive healthcare services to the dual eligible population in both Riverside and San Bernardino counties.

For all future correspondence regarding this application, please contact:
Thomas Pham, Director of Marketing
P.O. Box 19026
San Bernardino, CA 92423-9026
Phone: 909-890-2176
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Thank you for giving us an opportunity to participate in this RFS process. Please contact me at (909) 890-2010 if you have any questions.

Sincerely,

Dr. Gilbert’s Signature

Bradley P. Gilbert, M.D., M.P.P.
Chief Executive Officer

CERTIFICATION

Applicant Name: Inland Empire Health Plan (IEHP) Date: February 22, 2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

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

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
			the Medicare or a state of California government entity in the last five years.
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	✓	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	✓	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. (Attachment C)	✓	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements. (Attachment D)	✓	
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	✓	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	✓	
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	✓	

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.		
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement. (Attachment E1 – E3)	✓	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	✓	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.		
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	✓	IEHP is organized as a Joint Powers Agency, not-for-profit organization.
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	✓	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide	✓	

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
	operational plans for achieving those requirements as part of the Readiness Review.		

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	5 years	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	Yes	IEHP has not received any sanctions or penalties taken by the Medicare or a state of California government entity in the last five years.
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes	
5	Has the Plan received NCQA certification for its D-SNP Product?	No	IEHP will make good faith effort to achieve NCQA Managed Care accreditation for its D-SNP product by the end of the third year of participation in the Demonstration.
6	How long has the Plan had a Medi-Cal contract?	16 years	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	IEHP intends to add Dental, Vision, and Transportation as supplemental benefits.

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? (Attachment F)	Yes	1. Riverside County Department of Mental Health. 2. Rolling Start, Inc. Center for Independent Living in San Bernardino County. 3. Community Access, Center for Independent Living Center in Riverside County.
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	We will work with the IHSS program to contract with the agency. We have an excellent relationship with both county IHSS programs. We have spoken with both agencies and they have assured they have no concerns about IEHP, rather about the impact about the proposed changes to county funds.
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health? (Attachment G)	Yes	
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligibles? Which groups?	Yes	The following groups have expressed interest in contracting with IEHP: North American Medical

			Management (NAMM)/PrimeCare, Desert Oasis Medical Group, Choice Medical Group, and EPIC Management/Beaver Medical Group

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

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

PROJECT NARRATIVE

Section: Executive Summary

Inland Empire Health Plan (IEHP) is the Local Initiative Medi-Cal managed care plan for Riverside and San Bernardino counties (known as "the Inland Empire"). Currently, we serve over 540,000 members including 50,000 Medi-Cal seniors and persons with disabilities (SPDs) and 10,000 dual eligibles. The Inland Empire has approximately 105,000 dual eligibles, with about 55,000 in San Bernardino County. We estimate that about 25,000 – 30,000 dual eligibles in San Bernardino County will be enrolled in our Dual Eligible Demonstration program after the Demonstration enrollment is complete. Since the dual eligibles can opt-out of Medicare managed care, some will likely access their Medicare through the fee-for-service (FFS) system. This application is for San Bernardino County, but the overall goal of our Dual Eligible Demonstration program is to maintain and improve the health outcomes of dual eligibles, who live in Riverside or San Bernardino County, and maximize their ability to live in the least restrictive environment of their choice. In order to achieve these goals, we will provide a complete continuum of integrated care in the Inland Empire that coordinates the total needs of a person along the care spectrum that includes preventive, primary, acute, behavioral health, long term care (LTC), and home- and community-based services (HCBS).

Our Demonstration program will be designed around the person-centered care approach. We will use the results from a comprehensive health assessment to develop individualized care plans to meet the total needs of dual eligible members across the care continuum. Our interdisciplinary care team includes a Medical Director, a clinical psychologist, a clinical pharmacologist, nurse care manager, licensed social worker, member's providers, member, member's caregiver, and community resource specialists (e.g., Independent Living Centers, Meals on Wheels, housing services, etc.) who will coordinate and manage all needed services.

Under our Demonstration program, our members will be able to self-direct their care. For example, they will be an integral part of the care team in the development of their personal care plan, or they can determine if their caregiver should be part of the care team. They will retain the right to hire and fire their In Home Support Services (IHSS) caregiver. Our dual eligible members will have the ability to live in the least restrictive and safe environment of their choice, instead of a facility.

Our consumer protection program will encompass all care delivery areas, such as (but not limited to) network adequacy (network size, provider capacity and timeliness of access), quality of care, consumer choice, customer satisfaction, and consumer representation through our Public Policy Participation Committee for

dual eligibles. Furthermore, we will ensure that all services are culturally and linguistically appropriate and physically accessible, to the extent possible.

During the development and implementation of our Demonstration program, we will collaborate and work with many entities including, but not limited to, Molina Healthcare, medical providers, county behavioral health departments, county social service agencies, IHSS Public Authorities, County Office on Aging, CBAS centers, and LTC facilities. Specifically, IEHP will work with Molina Healthcare in many areas, such as alignment on supplemental benefits, geographic coverage area, contracting approach with LTSS providers, sharing health risk assessment data for individuals who switch between health plans, and engagement with local entities that serve the dual eligible population. We will continue our partnership with over 300 organizations affiliated with the Inland Empire Disabilities Collaborative, such as Independent Living Centers, the Inland Regional Center, the Area Agency on Aging, Aging and Disability Resource Connection, and many other providers. We are also in discussions with health plans that offer a D-SNP plan in the Inland Empire for continuity of care purpose.

Section 1: Program Design

Section 1.1: Program Vision and Goals

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

Response: Since we commenced operations in September 1996, we have served thousands of dual eligible members who have voluntarily enrolled into our Medi-Cal plan. Prior to January 2006, we provided and coordinated Medi-Cal benefits and services for these dual eligible members including prescription, vision, and care coordination services while their Medicare remained with the FFS system. To provide better care coordination and blend Medicare and Medi-Cal benefits, we started a Medicare Advantage Special Needs Plan, called IEHP Medicare DualChoice (HMO SNP) in January 2007. Our D-SNP plan integrates all benefits of Medicare Part A and Part B, Medicare Part D Prescription Drugs, and Medi-Cal (except for LTC and HCB services), providing coordinated and seamless healthcare system to the dual eligible members. As of February 2012, out of 10,000 dual eligible members who are voluntarily enrolled in our Medi-Cal plan, 6,500 also have enrolled in our D-SNP plan for their Medicare and Medi-Cal benefits.

Most of our dual eligible members have multiple chronic conditions; many lack the ability to perform daily living tasks; and more than 30% of them have a

behavioral health condition. As a result, they see many healthcare providers for multiple medical conditions and take multiple medications. Generally, their medical utilization is more than 4-5 times the utilization of an adult Medi-Cal beneficiary who does not have a chronic disability. Therefore, care management is one of the key factors in improving the health outcomes of the dual eligibles.

We have developed and implemented a Model of Care (MOC) care management program and received a 3-year approval (which is the highest approval level) for this program from the Centers for Medicare and Medicaid Services (CMS). The goal of the MOC program is to provide and manage the delivery of specialized services and benefits for the dual eligible members by facilitating the coordination and integration of Medicare and Medi-Cal services. This is done by working with Primary Care Physicians, ancillary providers, caregivers and members to produce a timely, seamless and well-coordinated service delivery experience for the dual eligible members. This achievement is reached by employing an interdisciplinary team approach, which will assess, monitor and provide targeted interventions to this population. We will create a care coordination and care management model for our Demonstration Project by building upon our successes and lessons learned from the MOC care management program. We will expand the program appropriately to better integrate LTC, HCBS and social services to meet the total needs of a person. For example, we will

work to fully integrate the results from health assessments of IHSS, CBAS, MSSP, and other Waiver programs into the development of an individualized care plan. We also plan to include their IHSS caregivers in the interdisciplinary team and provide enhanced training programs to these caregivers.

Our D-SNP plan experience has helped us understand the barriers dual eligible members face when they access care. For example, the Inland Empire includes two of the largest counties in the nation with a public transportation system that is less than optimal in comparison to other adjacent counties. Therefore, we offer enhanced transportation benefits (including special transportation vans for persons with physical disabilies) for our D-SNP members. With a benefit package of 60 one-way trips a year with a 50-mile radius each way, our members can get to their medical providers for their needed services.

In addition to our experience in serving the dual eligible population through our D-SNP plan, we have significant experience in providing care to over 50,000 seniors and persons with disabilities (SPDs) who are enrolled in our Medi-Cal plan. Our historical data shows that about 20% of these individuals will gain Medicare eligibility in the near future because of “age-in” or “disability-in.” Since June 2011, the California Department of Health Care Services (DHCS) has mandatorily enrolled the SPDs who have Medi-Cal into managed care. Since the mandate, about 3,000 SPDs have enrolled with IEHP per month. We estimate that

the phase-in enrollment approach for this Demonstration Project will yield a similar enrollment volume. Therefore, our recent experience in providing care for a high volume of SPD members will help us significantly in this new project.

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

Response: Since we commenced operations as a health plan in 1996, we have consistently focused on our mission of organizing and providing quality, accessible, wellness focused and coordinated health care for our community. Therefore, DHCS's goal to provide coordinated services including health, behavioral health, LTC, HCBS services and social services for the dual eligible population is strategically aligned with IEHP's overall mission.

In addition, IEHP has a successful track record in providing quality and coordinated health care for seniors and persons with disabilities (SPDs). For example, in 2002 we introduced a comprehensive Disability Program that has helped us meet the needs of our SPD members. Members with a chronic illness, behavioral health issue, or physical disability can access many services including, but not limited to: coordination of care, sign language interpreters, Wellness Programs such as Living Well with a Disability program, and materials in alternative formats. Community involvement is also an important feature of the program. IEHP attends disability-related events, presentations, health fairs, and

sponsors the Disability Sports Festival and the Rolling Bears wheelchair basketball team. For employees, IEHP uses training and education, to build cultural competency and awareness of the disability community. This innovative program has also been instrumental in connecting regional organizations that serve the SPDs. In 2006, IEHP participated in the planning and development of the Inland Empire Disabilities Collaborative (IEDC). This cross-disability collaborative, launched as a networking tool and honored by the Disabilities Rights California (DRC), has built a strong local voice to promote equal opportunity and universal access for seniors and people with disabilities.

Our work in serving SPD members continued as we launched our D-SNP plan for dual eligible members in January 2007. With this program we provide coordinated care to over 6,500 dual eligible members. Furthermore, as a result of the SPD mandatory enrollment since June 2011, we now serve about 50,000 SPDs. We estimate that about 20% of this population will eventually gain a dual eligible status.

In summary, the Demonstration Project goals are consistent with our mission in providing coordinated care to this population. In addition, our successful track record in providing coordinated care for our dual eligible members, our well established disability programs for seniors and persons with disabilities and our partnerships with over a hundred community organizations that serve SPDs will

give us a major head start in the development and implementation of the Demonstration Project by January 2013.

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

Response: To meet the goal of coordinating benefits, access to care and improving continuity of care and services, IEHP will implement the following activities, but not limited to:

1) Integrate all Medicare and Medi-Cal covered benefits into a single benefit package so members can seamlessly navigate the program.
2) Integrate all Medicare and Medi-Cal covered benefits into a single benefit package to streamline the billing and reimbursement processes for the providers.
3) Designate a phone number for members to call in for all needed assistance or questions.
4) Expand our existing D-SNP Model of Care (MOC) Care Management program to include behavioral health, long term support services (such as IHSS, CBAS, MSSP, long-term custodial care in nursing facilities, etc.). The new Dual MOC program will encompass all services in the care continuum of preventive, primary, acute, behavioral health, long term care facilities, and home and community based services.

5) Conduct a comprehensive health risk assessment to develop an individualized care plan for each enrolled member by working with the member, caregiver (if authorized) and providers. This plan will be implemented and monitored on a regular basis to ensure its effectiveness and determine any improvement opportunities.
6) Utilize an interdisciplinary care team approach in assessing, monitoring and providing targeted interventions for the dual eligible members.
7) Improve care coordination through an identified point of contact by assigning members to a specific care management team or individual staff member (nurse, social worker, etc.). Depending on the level of medical needs, the member may be assigned to a Complex Case Manager for extensive and intense case management, a General Care Manager for care coordination, or a Care Coordinator for general assistance, such as answering basic questions about referral status, pharmacy status, benefits, etc. Members with primary behavioral health needs will be assigned to a licensed clinical social worker.
8) Coordinate with IHSS, CBAS, MSSP and other Medi-Cal Waivers programs in conducting health assessment, sharing data, and integrating them to become part of an interdisciplinary care team.

9) Create a Transition of Care team to actively follow up with members and their providers when a member moves from one level of care to another to ensure continuity of care and to prevent avoidable readmissions.
10) Build an online system where providers can view most of their patient's health records to improve their care delivery and treatment options.

To meet the goal of maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and support in lieu of institutional care, IEHP will implement the following activities, but not limited to:

1) Use integrated funding sources from Medicare and Medi-Cal to effectively optimize provider reimbursement and align program incentives for providers and members.
2) Coordinate and manage all of the medical, behavioral, social and rehabilitative services that our members need to preserve or restore their independence and to remain in their homes and communities of their choice.
3) Identify the IHSS recipients who have the greatest health care needs and are at most risk of entering a nursing home, and then conduct intensive health assessments by combining the county-based IHSS

assessment for determination of functional and mobility status with a broader health, social and psychological assessment.

4) Provide a wide scope of services to these IHSS recipients (who are at most risk of entering a nursing home) and other members at high risk, including care coordination through an interdisciplinary care team approach to reflect the total needs of a person.
5) Provide enhanced care coordination training to IHSS caregivers and integrate them to be part of an interdisciplinary team (if the dual eligible members and their caregivers agree to participate).
6) Use the principles from the Coleman Care Transitions Intervention (CTI) model for our Transition of Care program. This CTI model is a four-week process that encourages patients to take a more active role in their health care. Patients receive specific tools and skills that are reinforced by a "transition coach" who follows patients across settings for the first four weeks after leaving the hospital or nursing home and focuses on key components such as medication self-management, use of a patient-centered record that helps guide patients through the care process, Primary Care Physician and specialist follow-up, and patient understanding of "red flag" indicators of worsening condition and appropriate next steps.

7) Connect the dual eligible members, who will be transitioned out of a nursing home because of improvement in their health, to the community housing providers for affordable housing options.

To meet the goal of increasing availability and access to home- and community-based alternatives, IEHP will implement the following activities, but not limited to:

1) Through comprehensive health assessments and utilization data provided by DHCS, identify dual eligible members who may be eligible for IHSS, CBAS, MSSP or PACE program but have not yet enrolled, and then coordinate with applicable program agencies to establish their eligibility.
2) Work with all HCBS programs to ensure eligibility determination process is conducted within the timeliness performance standard.
3) Develop a health data warehouse to collect and share appropriate health information of the dual eligible members with the HCBS programs to assist in the determination of initial eligibility, on-going maintenance of eligibility and renewal of eligibility.

To meet the goal of preserving and enhancing the ability for consumers to self-direct their care and to receive high quality care, IEHP will implement the following activities, but not limited to:

1) Involve members in the development of their individualized care plan.
2) Allow their IHSS caregivers to become part of an interdisciplinary care team (if the members and caregivers agree to participate).
3) Retain members' right to hire, fire, and supervise their IHSS caregivers.
4) Preserve members' ability to choose to live in the least restrictive, safe environment of their choice, instead of living in a supervised care setting.
5) Preserve members' ability to choose their own Primary Care Physician and Care Team, and change to a new one who better fits their needs.
6) Maintain health education programs that allow Members to self-manage their condition, such as Diabetes self-management, Asthma self-management, Hypertension self-management, Living Well with a Disability, and many others.
7) Develop many simple print and online Self Guides on a variety of health topics, such as Diabetes (Attachment H), Asthma (Attachment I), and many others.
8) Offer an audio library on hundreds of health topics that members can access and listen to from the comfort of their own home.

To meet the goal of improving health processes and satisfaction with care, IEHP will implement the following activities, but not limited to:

1) Provide appropriate cultural and linguistic training to care providers and internal staff.
2) Utilize technology such as a secure online system that includes real-time eligibility status for dual eligible members, their health records and key health alerts to assist providers in the delivery of care.
3) Utilize technology to allow providers to view the status of a specialist referral, claims status, etc. to help them manage complicated health processes for better care treatment and coordination.
4) Monitor customer service on a monthly basis by analyzing the call types and call volume to the Member Services Department.
5) Review grievance and appeals reports on a monthly basis to identify any system issues and any common issues.
6) Provide multiple options for members to file grievance and complaints such as filing by phone, in writing, online, or email.
7) Develop a Public Policy Participation Committee (PPPC) for dual eligibles where they can give IEHP feedback on existing and new policies and their experience in getting care.

To meet the goal of improving coordination of care and timely access to care, IEHP will implement the following activities, but not limited to:

1) Maintain an interdisciplinary team that includes experts in all areas of the care continuum such as a Medical Director (a board certified physician), a behavioral health expert (a clinical psychologist), a clinical pharmacologist, LTSS managers, nurse care managers, licensed social workers, member providers, member, member caregiver, and community resource specialists (e.g., Regional Center, Independent Living Centers, Meals on Wheels, housing services, etc.) to coordinate and manage all needed services.
2) Improve care coordination through an idenfied point of contact by assigning members to a specific care management team or individual staff member.
3) Conduct member satisfaction surveys about their patient experience with the Care Team in providing care coordination services.
4) Ensure our provider network meets or exceeds all DHCS and CMS network adequacy requirements.
5) Conduct provider appointment availability audits to ensure our members can get care within current regulatory timeliness access standards.

6) Review incoming call volume and call types as well as grievance and complaint reports on a monthly basis to identify any access to care issues and develop targeted interventions as needed.

To meet the goal of optimizing the use of Medicare, Medi-Cal and other State/County resources, IEHP will implement the following activities, but not limited to:

1) Integrate all funding sources and develop a streamlined provider reimbursement system that eliminates the need to bill both Medicare and Medi-Cal.
2) Use the integrated funding sources to better align provider and member incentives that aim to maintain and improve the health outcomes of the dual eligible members and increase their quality of life in living in the least restrictive environment.
3) Streamline administrative processes, such as potential consolidation of health assessment conducted by a variety of agencies that administer the LTSS programs.
4) Develop a data warehouse to assist in the development and/or modification of a system of care that preserve and enhance the member's ability to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

5) Partner with multiple applicable state and county agencies to provide seamless and coordinated care to meet the total needs of dual eligible members. For example, we will work with the County Behavioral Health program to collect and share relevant health data about the dual eligible members, and integrate this data into the medical and LTSS system of care.

Section 1.2: Comprehensive Program Description

Question 1.2.1 Describe the overall design of the proposed program, including the number of enrollees, proposed partners, geographic coverage area and how you will provide integrated benefit package described above along with any supplemental benefits you intend to offer.

Response: The overall design of our proposed program includes the following components:

1) Number of enrollees

There are about 55,000 dual eligibles living in San Bernardino County. About 20% of this population is already enrolled in D-SNP plans, and 80% obtain their care through the FFS system. We estimate that about 25,000 – 30,000 dual eligibles in San Bernardino County will be enrolled in our Dual Eligible Demonstration program after the Demonstration enrollment is complete, with the following assumptions:

- DHCS will automatically transition all of our existing D-SNP members into our new Dual Eligible Demonstration program.
- DHCS will conduct a passive enrollment over a course of 12 months.

Since the dual eligibles can opt-out of Medicare managed care, some will likely access their Medicare through the fee-for-service (FFS) system.

2) Proposed Partners

IEHP will partner with Molina Healthcare in many strategic areas, such as alignment on supplemental benefits, geographic coverage area, contracting approach with LTSS providers, and sharing health risk assessment data for individuals who switch between health plans. IEHP and Molina Healthcare will also collaborate in the engagement of strategic partners and stakeholders in the development and implementation of our proposed programs for this Demonstration Project. Specifically, we will have joint meetings with the following entities when applicable, but not limited to:

- County Behavioral Health Departments
- County Social Service Agencies
- County Office on Aging

- County hospitals
- IHSS Public Authorities
- CBAS Centers
- Long term care facilities
- Inland Regional Centers
- Area Agencies on Aging
- Aging and Diabilities Resource Centers
- Independent Living Centers
- And many other critical agencies that affiliate with the Inland Empire Disability Collaborative (IEDC)

In addition, we are also in discussions with health plans that offer a D-SNP plan in the Inland Empire for continuity of care purpose when the Demonstration is implemented. With these strong partners, we will be able to provide comprehensive and coordinated services to dual eligible members.

3) Geographic Coverage Area

This application is for San Bernardino County, but IEHP and Molina Healthcare propose to provide integrated care for the Riverside and San Bernardino counties at the same time. Our geographic coverage area for San Bernardino County will include all current DHCS-approved Medi-

Cal mandatory enrollment zip codes. We assume dual eligibles who live in the current Medi-Cal voluntary enrollment zip codes will not be mandatorily enrolled in this Demonstration project. Instead, they will have an option to voluntarily enroll. In addition, those who live in the following Medi-Cal excluded zip codes in San Bernardino County will be excluded from the Demonstration Project enrollment:

92242 Earp	92364 Nipton
92267 Parker Dam	92366 Mountain Pass
92280 Vidal	93558 Red Mountain
92323 Cima	93562 Trona
92332 Essex	93592 Trona
92363 Needles	

4) <u>Our proposed delivery of the integrated benefit package</u>

Integrating Medicare and Medi-Cal benefits into a single benefit package will simplify the product for both providers and dual eligible members. From the consumer's perspective, this will facilitate a seamless experience in receiving their healthcare services. From the provider service perspective, it will provide a single consolidated set of benefits with a streamlined billing and reimbursement process. We will

provide all services of the care continuum through a coordinated, comprehensive delivery model as described below.

a) Medical Benefits

We will use our existing D-SNP delivery model with appropriate changes as outlined throughout our proposal to deliver the medical benefits of Medicare and Medi-Cal. Under this model, our dual eligible members will access their preventive care, primary care, acute care, inpatient services, prescription drugs, ancillary services, and many other services through our large provider network that includes over 3,000 providers in the Inland Empire. We plan to reach out and contract with many new providers who traditionally treat the dual eligible population. Our members will choose a primary care physician who will provide most preventive and primary care services, and will also refer members to other services if needed. Members will be allowed to choose a Specialist as their primary care provider if the Specialist accepts that role and can deliver all primary care and care coordination services needed by the member. Specialty and community based services will be coordinated through the plan's care management teams. For individuals who reside in intermediate care facilities or Board and Care homes, IEHP and Molina Healthcare will contract with the same providers to

deliver care in a home or residential facility when an individual's condition prevents them from accessing care in a community office or clinic setting.. To support our providers in delivering quality healthcare services to our members, we offer secure online services, such as real time eligibility, electronic health records, health alerts, behavioral health assessment, referral status, claims status, etc. We believe that offering access to our member's e-health record will help our providers deliver better care.

b) Behavioral Benefits

We will use our existing directly contracted behavioral health network that includes hundreds of behavioral professionals to deliver behavioral health benefits to our dual eligible members. Our members can self-refer or be referred by their primary care physician to a network provider. We will assess our network adequacy and will contract with new providers if needed to accommodate higher demand from the new population. We will utilize our existing written (MOU) relationship with the Riverside and San Bernardino County Behavioral Health Departments for behavioral health services, and care coordination for our members who utilize services within the county network. We will also utilize this existing relationship for reimbursement when plan

members access behavioral health services provided by the county. In addition, we have agreements with both County Behavioral Health Departments to have an IEHP dedicated liaison within each county Behavioral Health department to coordinate care. We have a secure online portal where our behavioral providers can submit their screening and assessment results and treatment plan. This gives the Primary Care Physician access to behavioral health services that their patients receive so they can coordinate their treatment more effectively. With this approach, we have fully integrated the behaviroal health providers into the medical delivery system.

c) Long Term Support Services (LTSS)

We will take a phase-in approach for the delivery and integration of LTSS into the medical and behavioral health system of care. For year 1 of the Demonstration Project, we will have a formal agreement with IHSS, MSSP and other Waiver programs that will stipulate the continued operation of these programs. Specifically, these programs will continue to be administered and operated by the same agencies with existing processes and procedures. The agreement will include a care coordination provision where IEHP will work with these programs to collect and share health assessment data to better serve the total

needs of the dual eligible member. Additionally, both IEHP and Molina Healthcare will work closely with the IHSS entities in both counties regarding reimbursement changes. Lastly, IEHP will use our existing skilled nursing and other supervised care facility network to provide long term care facility services for our dual eligible members. We will assess our network adequacy and will contract with new providers if needed to accommodate higher demand from the new population.

d) Care Coordination and Care Management

To deliver care coordination and care management services for the members enrolled in this Demonstration project, we will expand our existing D-SNP Model of Care (MOC) care management program. The goal of the MOC program is to provide and manage the delivery of specialized services and benefits for the dual eligible members by facilitating the coordination and integration of Medicare and Medi-Cal services. This is done by working with Primary Care Physicians, ancillary providers, caregivers and members to produce a timely, seamless and well-coordinated service delivery experience for the dual eligible members. Achievement is reached by employing an interdisciplinary team approach, which will assess, monitor and provide targeted interventions to this population. We will expand the program

appropriately to better integrate behavioral health services, LTSS and social services to meet the total needs of a person. For example, we will integrate the results from health assessments from IHSS, CBAS, MSSP, and other programs into the development of an individualized care plan.

e) Consumer Protection

Our consumer protection program will encompass all care delivery areas, such as (but not limited to) network adequacy (network size, provider capacity and timeliness of access), measurable quality of care (as determined by DHCS and CMS), consumer choice (ability to choose their PCP or Care Team), customer satisfaction (conducted by an independent entity like NCQA), ability for the consumer to self-direct their care, and consumer representation in the policy development and evaluation activities through our Public Policy Participation Committee for dual eligibles. We will also ensure that all services are culturally and linguistically appropriate and physically accessible. In addition, our members will have a designated phone number for all types of questions regarding their benefits. We will also ensure that our members get a responsive and clear grievance and appeals processes.

f) Plan Monitoring and Oversight of the Delivery of Care System

IEHP will use the rigorous oversight standards established by DHCS, CMS and NCQA (we are currently accredited by NCQA for the Medi-Cal program) to conduct plan oversight for the delivery of care by our sub-contracted providers. We will work with DHCS and CMS in the near future to get more guidance on the oversight policies and standards for all LTSS programs.

5) Supplemental Benefits

IEHP and Molina Healthcare agree that we intend to offer dental, vision and transportation as supplemental benefits for this Demonstration Project if the capitation rate offered to health plans is adequate for the cost of the entire program.

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

Response: We will manage the program within an integrated financing model by combining all Medicare and Medi-Cal benefits into one single "Dual Eligible Demonstration" benefit package. All funding sources from Medicare and Medi-Cal will be combined into a single revenue account designed for this program. We will not differentiate what services are treated as "Medicare" or as

"Medi-Cal" to the providers. This will create a consolidated system of care and service reimbursement for members and providers. We currently operate in this manner for our D-SNP program.

Question 1.2.3 Describe how the program is evidence-based.

Response: We use evidence-based approach to design and deliver our proposed program for the Demonstration Project. Following are few examples:

1) We use nationally recognized clinical criteria, Medicare and Medi-Cal benefit guidelines, and the IEHP Utilization Management Committee-approved guidelines in making decisions on medical and behavioral care.
2) We use the principles from the Coleman Care Transitions Intervention (CTI) model, based on the work of Eric Coleman, M.D., M.P.H., from the University of Colorado, for our Transition of Care program. This CTI model is a four-week process that encourages patients to take a more active role in their health care. Patients receive specific tools and skills that are reinforced by a "transition coach" who follows patients across settings for the first four weeks after leaving the hospital and focuses on key components such as medication self-management, use of a patient-centered record that helps guide patients through the care

process, Primary Care Physician and specialist follow-up, and patient understanding of “red flag” indicators of worsening condition and appropriate next steps. The role of the transition coach is “to coach not do”, so that patients develop improved capacity in these four domains. We plan to expand this model to include our members who would be transitioned out of a supervised care setting.

3) Our Model of Care (MOC) Care Management program is based on current Medicare-approved care coordination and care management guidelines. We received the highest level of approval, which is a 3-year approval, from CMS for our current D-SNP MOC program.
4) Our Formulary is developed and updated according to nationally recognized standards and Medicare and Medi-Cal benefit guidelines.

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

Response: The overall goal of our program is to maintain and improve the health outcomes of dual eligible members and maximize their ability to live in the least restrictive and safe environment of their choice, instead of living in a supervised care setting or facility. In order to achieve these goals, we will provide comprehensive and integrated care that supports the total needs of each individual

including preventive, primary, acute, behavioral health, long term care, and home and community based services.

Specifically, our program will improve access to care for the underserved by offering them a strong provider network with over 3,000 healthcare providers in the Inland Empire. Our goal is to meet or exceed DHCS and CMS network adequacy requirements in primary care, specialty care, behavioral health, pharmacy, outpatient and inpatient, nursing homes, and home- and community-based services (such as access to IHSS, CBAS, MSSP and other programs that they are eligible for). We have oversight procedures in place to ensure that our members get timely and quality care from our contracted providers. For example, we conduct an appointment availability study to determine if the appointment time is in compliance with current regulatory timeliness access standards. In addition, our program will connect the underserved population to many community-based social services to empower them to live independently in their home. Through the Inland Empire Disabilities Collaborative (IEDC) that includes over 300 organizations that serve the dual eligible population, we are able to pool resources and connect dual eligibles to the full-scope of services available in the Inland Empire.

Today we serve over 50,000 Medi-Cal seniors and persons with disabilities (including 10,000 dual eligibles). Most of our SPDs have multiple chronic conditions; many lack the ability to perform daily living tasks; and more than 30%

of them have a behavioral health condition. As a result, they see many healthcare providers for multiple medical conditions and take multiple medications. Generally, their medical utilization is more than 4-5 times the utilization of an adult Medi-Cal beneficiary who does not have a chronic disability. Navigating services from multiple healthcare and HCBS providers across a widespread geographic area can be a challenge and is often overwhelming. Therefore, care coordination and care management are the key factors in improving the health outcomes of dual eligible members. We believe care coordination that uses an interdisciplinary team approach with individualized care plans will allow us to work with members, their caregivers, and their providers to address all of their healthcare needs. The dual eligible members will no longer receive care through a fragmented delivery system that provides minimal or no assistance. Our care coordination services will ensure members receive timely services to prevent institutionalization or reinstitutionalization. It will also eliminate costly duplication of services and administrative functions. In addition, all providers on the care continuum will be able to see a complete picture of their patient's health and behavioral health condition, mobility and functional status, and individualized care plan. As a result, they will have a better treatment and care maintenance options for their patients. This system of coordinated care will help mitigate the challenges of dealing with multiple co-morbidities, and risk factors, while reducing overall

health disparities. As the end result, we will be able to maintain or improve the health outcomes and quality of life for the dual eligible population.

Question 1.2.5 Explain whether and how the program could include a component that qualifies under the federal Health Home Plans SPA.

Response: As an existing D-SNP plan, IEHP has extensive experience in coordinating and delivering the health care services to the dual eligibles and Medi-Cal SPD populations, particularly persons with multiple complex and chronic conditions like asthma, diabetes, heart disease, obesity, and mental conditions. IEHP plays a key role in the health home team concept by serving as the central "hub," monitoring the overall care delivery of our members. IEHP works closely with the member's primary care, specialty and behavioral health providers in coordinating components of the member's care, such as home health, transportation, and behavioral health. Doing so provides comprehensive care management, care coordination, chronic disease management, health education promotion, transitional care from inpatient to other settings, and referral to community and social support services when needed. IEHP's mixed model network, consisting of IPAs, directly contracted individual physicians and community clinics, is well positioned to launch health home/patient centered medical home activities.

While California is in the midst of the health home development planning stage and has not yet released health home guidelines to managed care organizations, IEHP has initiated groundwork activities to establish a solid understanding and foundation in support of the health home/medical home provider transformation process. IEHP currently has two provider health home/patient centered medical home pilots underway: (1) Through a Health Home Innovation Fund grant from the Community Clinics Initiative (Tides and The California Endowment), IEHP has partnered with the County of Riverside Community Health Agency (CHA), along with Health Team Works consultants, to help transform ten (10) CHA clinics to health homes over the next two years with the objective to achieve NCQA Patient Centered Medical Home (PCMH) Level 1 recognition, and (2) Through a FQHC Partnership Fund established by IEHP to support expansion of primary care access and capacity projects, we are working to facilitate patient centered medical home activities, including enhanced care coordination and open access in FQHC and FQHC lookalike clinics over a two year period. From these two pilot initiatives, IEHP will apply best practices and lessons learned in an effort to replicate the health home/medical home transformation processes across our entire provider network, including individual solo practice environments that may lack the resources and infrastructure needed to support medical home activities.

IEHP believes that early EHR adoption is the first step towards a solid foundation in the health home/medical home transformation process, linking health care services to our Members and facilitating communications between and among providers. IEHP in collaboration with San Bernardino County Medical Society and Riverside County Medical Association formed the local Inland Empire EHR Resource Center (IEEHRC) which is working to provide education, outreach and EHR implementation services to physicians in the Inland Empire with the goal to help physicians achieve meaningful use through successful EHR adoption. While approximately 100 contracted Primary Care physicians in the IEHP provider network are currently using an EHR system, with even fewer primary care physicians striving to achieve NCQA PCMH criteria, there is room for continued encouragement and support of our provider community in these areas. IEHP understands that the health home/patient centered medical home concept is based on the "whole-person" approach to care that identifies needed clinical and non-clinical services and support, and strongly encourages our provider community to adopt electronic linkages to start the medical home/health home process.

In response to the CMS Innovation Challenge opportunity, IEHP is gearing up to expand its successful Health Navigator program concept (community health worker model) beyond the age 0-5 child population, to target our D-SNP and Medi-Cal SPD members with chronic diseases and complex needs at high risk of

readmission with the primary goal to improve health outcomes, improve care transitions and prevent readmissions. In this expanded program concept, the Health Navigator would be teamed up with licensed RNs or social workers to conduct inpatient visits, home visits and follow up phone calls to promote continuity of care and connection back to the member's primary care physician (PCP). During the home visit the Health Navigators will facilitate medication management through the use of an evidence-based electronic medication management system. The medication management system includes electronic screening, with remote pharmacists conducting assessments, consultations, and follow-up with the member's PCP. The electronic system allows non-licensed individuals to facilitate medication reconciliation in the member's home. In addition, medication management will be conducted in advance of the PCP visit to reconcile medications from before and after hospitalization. The Health Navigators will also provide health care information, member education, and connections to needed resources, such as home health, nutritional support, and conduct in-home safety assessments. IEHP is confident these initiatives will help set a foundation for our provider network in preparation for California's health home guidelines

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

Response: Following are the primary challenges to successful implementation of the program and our proposals to mitigate these anticipated risks:

1) IEHP and Molina Healthcare have met with the IHSS county administration team and they have expressed concern about the future funding sources for the IHSS program when it is integrated in this Demonstration Project. This concern could be challenging for health plans and county IHSS program administration to reach a formal agreement before the program launch. Currently, the IHSS program has a complex funding mechanism where it receives funds from the state and the county. It is unclear at this point if the county funding contribution will be changed because of the full integration of IHSS into the Demonstration Project. We have an excellent relationship with both county social service agencies that manage the IHSS programs. Our Chief Executive Officer (CEO) has spoken with both county leaders of these agencies and they have assured him that they do not have concerns about IEHP, but rather about the impact of the proposed changes to county funds (See Attachment N and Attachment O).

2) IEHP agrees with DHCS that in the first year of the Demonstration, IHSS benefits will be authorized under the same process used under current state law. We understand that DHCS will issue more guidance for Year 2 and Year 3. In order to reach a formal agreement or contract with the county IHSS program before or by January 1, 2013, specific guidance or technical assistance will be needed from DHCS by June 2012.

3) The final RFS does not have details requiring program administration, and/or program eligibility for LTSS services. More guidance from DHCS on these issues will facilitate managed care plans' contracting efforts with applicable LTSS program administrators.

4) Similar to the SPD Medi-Cal mandatory enrollment, we expect to receive de-identified utilization and pharmacy data for this population preferably by June 2012. This will provide enough time to assess network adequacy and make necessary adjustments prior to January 2013. Once individuals start to enroll, we expect to receive identifiable data to use in conjunction with the results from our health assessment to develop an individualized care plan for each member. In addition, there were regulatory issues that prevented DHCS from sharing behavioral health and substance use data for the SPD mandatory enrollment

project. We request this data to be available for this Demonstration because it helps our efforts in fully integrating behavioral health into the medical and LTSS system.

5) Currently, inconsistencies exist between Medicare and Medi-Cal policies on key issues such as the Health Risk Assessment form, grievance and appeals, regulatory monitoring and oversight, marketing, outreach, and communication. We plan to mitigate these inconsistencies by developing uniform policies for both programs.

6) According to our experience serving mandatorily enrolled SPD members, many of them receive care with out-of-network providers or out-of-service area; and we expect a similar experience for the dual eligibles. IEHP will work diligently to reach out and contract with these non-contracted providers as they become identified. However, in some cases providers and members refuse to work within a managed care environment. Therefore, we expect that DHCS will assist in communicating the continuity of care policy and the Medical Exemption Request process to community providers prior to the implementation.

Section 2: Coordination and Integration of LTSS

Section 2.1: LTSS Capacity

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

Response: To provide seamless coordination between medical care and LTSS and to keep people living in their homes and communities for as long as possible, we will use an interdisciplinary care team approach. We will expand our existing D-SNP Care Team that now includes a Medical Director (a board certified physician), a behavioral health expert (a clinical psychologist), a clinical pharmacologist, nurse care managers, licensed social workers, member's providers, member, and community resource specialists. We will add an LTSS expert and potentially IHSS caregiver (if they agree to participate) to this Care Team to reflect the broader diversity of the needs of our members.

Navigating services from multiple healthcare, LTSS and HCBS providers across a widespread geographic area and across the care continuum can be challenging and often overwhelming. The Care Team will proactively help members get timely services to prevent institutionalization or reinstitutionalization.

In addition, we have a formal agreement with the Independent Living Centers to conduct in-home assessments for our SPD members and provide

independent living training services. We will expand this program if needed to accommodate a potential increase in demand.

As described later in the IHSS program section, we will also identify the IHSS recipients who have the greatest needs and are at risk of entering a nursing home. We will then conduct an intensive health assessment to evaluate their total needs in medical, psychological, social, mobility and functional status. By providing targeted and complete care coordination services to this population, we will be able to prevent avoidable admissions to an institutionalized setting.

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

Response: Currently under our D-SNP plan, we provide the skilled nursing facility (SNF) coverage for the first 100 days of SNF services. Therefore, we have existing direct contracts with Skilled Nursing Facilities and other types of long term care facilities. Our reimbursement arrangement with these facilities is based on a negotiated fee-for-service reimbursement methodology. We will continue this contractual relationship and reimbursement arrangement with these types of facilities. IEHP and Molina Healthcare will contract with the same facility-based providers to provide care for our members who stay at these facilities.

We also intend to contract with the county IHSS program and the IHSS Public Authority. However, IHSS has expressed concern over reimbursement changes as noted earlier in this application. For Year 1 of the Demonstration, as indicated in this RFS, the IHSS program will be operated and administered as it is today, except that IEHP and the IHSS program will collaborate in providing care coordination services to the IHSS recipients. For Year 2 and Year 3, we will reassess our contractual relationship options after we receive further guidance or technical assistance from DHCS about the IHSS integration.

For the CBAS program, IEHP is already working with DHCS and potential CBAS centers at this point to implement the newly created CBAS program according the ADHC Court Settlement. We have met with our local CBAs on multiple occasions to facilitate the transition. The CBAS program integration into managed care will be fully implemented by July 1, 2012.

We intend to contract with the Aging and Disability Resource Connection for their social and health care management for the MSSP dual eligible members. The reimbursement arrangement will likely be a “pass through” for Year 1 of the Demonstration. Future reimbursement arrangements for Year 2 and Year 3 will be assessed based on our Year 1 experience and any additional guidance from DHCS.

Question 2.1.3 Describe how you would use Health Risk Assessment Screening to identify enrollees in need of medical care and

LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.

Response: Our Model of Care (MOC) Team or a contracted vendor will ensure that all Demonstration Project members are contacted for a Health Risk Assessment Screening and enrolled in the MOC program. Because of the complexity of regulatory Medicare and Medi-Cal requirements and variations among LTSS programs, IEHP and Molina Healthcare support DHCS's effort in creating a uniform Health Risk Assessment Screening for all services on the care continuum.

We will use this standardized tool to assess medical, cognitive, functional needs and psychological status of members. We will make every effort to contact members to conduct the HRA within 45 days. We will use the initial risk stratification and the HRA responses as a foundation to develop an individualized care plan for each member. This individualized care plan will address the total needs of each member. The member and/or their caregiver are an integral partner in the development of this care plan. For more detailed information on our Health Risk Assessment Screening activity, refer to Attachment K, Appendix C: SNP Model of Care Elements and Standards.

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

Response: Our experience in working with the broad network of LTSS providers includes the following, but not limited to:

1) Since July 2011, we have engaged in many discussions with the Adult Day Health Care (ADHC) providers for the mandatory enrollment of ADHC members into managed care by an original deadline of October 1, 2011. During that period, we have engaged and partnered with the ADHC providers to ensure a smooth transition of their patients to IEHP. Under the recent ADHC Court Settlement guidance, we will continue to work with these ADHC/CBAS providers to integrate the CBAS program into managed care by July 1, 2012.
2) Since 2004, through the Inland Empire Disabilities Collaborative (IEDC), IEHP has collaborated with the Aging and Disability Resource Connection (ADRC) that administers the MSSP program, and also with over 300 organizations that serve seniors and persons with disabilities (SPDs). The common goal of IEDC is to share resources to better serve the SPDs across the health and social services spectrum.
3) We have already initiated meetings with Intermediate Care Facility (ICF) and Board and Care operations to discuss delivery of care,

payment issues and other aspects related to the current transition of SPDs, and the potential future transition of dual eligibles. These discussions have already led to a focused contracting effort to find providers who can provide care at the facilities.

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

Response: IEHP and Molina Healthcare will contract with the same institutional facility-based providers to deliver care for individuals living in institutional settings. These will include skilled nursing facilities, intermediate care facilities, and Board and Care homes. We have already hosted meetings for the latter two groups to discuss the possible transition of members. In fact, IEHP has existing contracts with these providers to provide care to our D-SNP members who stay at these facilities. We also have an existing contract with a vendor to provide mobile lab draws in facilities or homes when needed (Attachment J). A team of care managers will serve as a single point of contact for these members and/or their caretakers.

IEHP will track, monitor and identify patterns of institutional admissions. The results will be discussed in the quarterly Utilization Management

Subcommittee meetings for recommendations and interventions. Re-admissions are reviewed monthly and cases are forwarded to applicable teams – Care Management, Complex Case Management, Disease Management, Health Education and Quality Management – for further interventions. Our goal is to reduce avoidable admissions and re-admissions. If the goal is not met, IEHP will work collaboratively with the member's primary care physician, contracted facilities and our inpatient nursing staff to ensure appropriate application of clinical criteria and level of care.

For members who want to leave institutional settings and are medically safe to do so, IEHP will conduct the following activities, but not limited to, to ensure a medically safe transition:

1) We will use the principle from the Coleman Care Transitions Intervention (CTI) model for our Transition of Care program. This CTI model is a four-week process that encourages patients to take a more active role in their health care. Patients receive specific tools and skills that are reinforced by a "transition coach" (a nurse, social worker and/or community health worker) who follows patients across settings for the first four weeks after leaving the hospital and focuses on key components such as medication self-management, use of a patient-centered record that helps guide patients through the care process,

Primary Care Physician and specialist follow-up, and patient understanding of “red flag” indicators of worsening condition and appropriate next steps. The role of the transition coach is “to coach not do”, so that patients develop improved capacity in these four domains.

2) We will work with internal staff and selected vendors to provide care transition services to any member moving out of institutional settings. The goals are to ensure a medically safe transition, reduce institutional readmissions, and improve health outcomes. Specifically, services include:
   - Visits or telephonic contact with patients and/or their caregivers in the institutional setting
   - Visits with patients and/or their caregivers after discharge in the home
   - Series of post-discharge follow-up calls
   - Personal Health Record preparation
   - Medication record and discrepancy tool preparation
   - Post-discharge nutritional assessment
3) We will use our existing contract with Independent Living Centers to provide independently living training services to discharged members.

Section 2.2: IHSS

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

Response: Refer to the RFS Certification Check List.

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

- A proposed care coordination model with IHSS including, the referral, assessment, and care coordination process.
- A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including dementia and Alzheimer's disease.
- A plan for coordinating emergency systems for personal attendant coverage.

Response: Both IEHP and Molina Healthcare have met with IHSS and they are concerned with how the Demonstration will impact their county funding (see Attachment N and Attachment O). The IHSS program has a complex funding mechanism where it receives funds from the state and also the county. It is unclear at this point if the county funding contribution will be changed because of the full integration of IHSS into the Demonstration Project. Clear guidance or technical assistance from DHCS will help resolve this concern.

At this point, our plan for interaction with the IHSS program for Year 2 and Year 3 is to work with the IHSS program in both counties to explore the following actitivies:

1) Work with the IHSS program to develop a comprehensive health assessment that combines the county-based IHSS assessment for determination of functional and mobility status with a broader health, social and psychological assessment. The current IHSS program's assessment (by using the functional index rating scale and Hourly Task Guidelines) focuses on program eligibility and number of service hours needed for in-home domestic and personal care. It does not address the total needs of a person, whether medical, psychological, or social.
2) Utilize available medical, behavioral health and IHSS hours and functional status data to identify the IHSS recipients who have the greatest health care needs and are at most risk of entering a nursing home.
3) Use the new comprehensive health assessment to conduct health assessments on IHSS recipients who are at most risk of entering a nursing home.
4) Provide a wide scope of medical, psychological, and social services to these IHSS recipients, including enhanced care coordination through an

interdisciplinary care team approach to reflect the total needs of a person. These members will benefit from this approach because it responds to their total needs of the care continuum.

The IHSS program for all other IHSS recipients who are not identified as high risk of entering a nursing home will remain the same (as it is today) for the 3-year demonstration period. They can self refer, or their caregiver or program administration can refer them, for this intensive health assessment.

During the entire Demonstration project, the IHSS recipients will retain their right to hire, fire, and supervise their personal caregivers. We intend to explore the following options for the IHSS caregivers in collaboration with the IHSS program:

1) Provide additional training for the IHSS caregiver regarding care coordination skill.
2) Enhance the caregiver's role in the consumer's care after they complete a potential new professional training program.
3) Integrate the caregiver into the interdisciplinary care team (if the IHSS recipient and his/her caregiver agrees to participate).

We will work closely with our two county IHSS entities regarding reimbursement changes.

Section 2.3: Social Support Coordination

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

Response: IEHP certifies that we will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

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

Response: IEHP will assess and assist beneficiaries in connecting to social programs, such as Meals on Wheels, CalFresh, and others that support living in the home and the community through the Inland Empire Disability Collaborative (IEDC).

The IEDC consists of community/social organizations whose mission is to promote equal opportunity, universal access, and full participation of people with disabilities in all aspects of life. Launched as a networking tool, this unique initiative has led to the creation of new partnerships with organizations within Riverside and San Bernardino counties. As a result, seniors and people with disabilities have improved access to many services available to them. Once a fragmented set of services across a large geographic area, today it is a more

cohesive network of service providers who come together to provide the full continuum of services.

The IEDC was developed and launched by member agencies and brings together members from regional organizations, such as the Alzheimer's Association, Blindness Support Group, Braille Institute, San Bernardino County Dept of Aging and Adult Services, Fair Housing Council of Riverside, San Bernardino County Public Authority IHSS, Riverside County Office on Aging, and many more.

Through this partnership, IEHP and the IEDC connect dual eligible members to important services. For example, the Centers for Independent Living are members of the IEDC and provide self-advocacy training, assistive technology, housing information, independent living skills training, peer counseling, and personal care assistance. As a partner organization, IEHP can assist dual eligible members to connect to these valuable resources. In the development of the Dual Demonstration Project, the IEDC will foster new partnerships, allowing IEHP to further link dual eligible members to resources that improve quality of life.

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

Response: IEHP has well-established partnerships with the Riverside County Office of Aging, and the San Bernardino County Department of Aging and Adult Services through the IEDC. For example, IEHP's Disability Program Manager is a member of ADRC's Leadership Advisory Resource Team for Riverside County. By partnering with these agencies, IEHP can support the long-term care needs of dual eligible members. Additionally, through formal agreements with the Independent Living Centers in both counties, IEHP's dual eligible members can receive in-home independent living assessments and independent living skills training. This allows dual eligible members to live in their home and community for as long as possible, avoiding institutionalized settings.

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

Response: IEHP will use existing partnerships with housing providers, while building additional partnerships with senior housing, residential care facilities, and assisted living facilities. For example, IEHP has partnered with Fair Housing Council of Riverside, the Inland Fair Housing and Mediation Board, Ballard Rehabilitation Hospital, and Casa Colina Centers for Rehabilitation through the IEDC. Through these partnerships, IEHP will also enrich the MOC program by

including these housing specialists in ICT case conferences when housing is an issue. This will further advance our ability to holistically care for the needs of the dual eligibles.

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

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

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

Response: IEHP will provide seamless and coordinated access to the full array of mental health and substance use benefits covered by Medicare and Medi-Cal through an integrated, in-house Behavioral Health (BH) Program and through collaboration with the County Behavioral Health programs.

After significant long-term planning and development IEHP launched its in-house BH program in February of 2010. IEHP directly addresses the complex, interrelated health care needs of our members by integrating behavioral health care with physical health care and utilizing other departments and a specialized BH clinical team. Besides using the existing internal support structure, the BH program coordinates benefits and continuity of care services in partnership with Riverside

and San Bernardino counties. Our long standing Memorandums of Understanding (MOU) for Behavioral Health Services with both counties serve as an example of this local support and shared accountability. Specifically, IEHP received a letter of support for our participation in the Demonstration Project from Riverside County Mental Health Department; however due to similar funding concerns expressed by the San Bernardino IHSS program, the San Bernardino County Behavioral Health Department is unable to provide a letter of support at this time. Our MOUs have recently been revised to provide for an IEHP social worker to be co-located at each respective county mental health department. These imbedded positions intend to enhance coordination of care between IEHP and county behavioral health providers in both counties.

Launching our own Behavioral Health Program required IEHP to recruit and directly contract with BH providers, psychiatric hospitals, and Intensive Outpatient Programs (IOP) to provide more responsive care to dual eligible members. This direct “local” partnership with BH providers compliments our relationship with the two counties and allows IEHP to leverage incentives for improved access to appropriate care levels like outpatient mental health and substance abuse treatment services.

The BH program also integrates with the Model of Care (MOC) program, creating targeted BH interventions and hand-offs for high-risk populations,

including coordinating treatment for substance use and mental illness. For example, BH clinical experts are integrated into the Interdisciplinary Care Team (ICT), where complex member care plans are managed by a team of specialized participants, chosen dependent upon the members needs. Therefore, IEHP's MOC program and BH program have already integrated and will continue to expand for the purposes of the Demonstration project to incorporate LTC, HCB services, and social services.

Additionally, the BH program supports Member Services and the Health Navigator Program to ensure that non-clinical front-line staff has immediate access to in-house BH clinicians to handle crisis situations, suicidal members, and threatening callers. Through both departments, the BH program can assist members, who otherwise would not receive this specialized care.

Overall, the development of IEHP's BH program has been a success. It has connected BH providers and PCPs. For example, IEHP implemented an online claims and clinical reporting system designed to speed reimbursement while connecting BH specialists with the member's PCP, enabling meaningful coordination of care. After member approval, a common web-based coordination of care form is shared between the behavioral health provider and the primary care provider in both directions. After one year of operation in the first quarter of 2011, nearly 100% of the BH specialists are submitting Coordination of Care web forms

online to IEHP and 83.6% of these were passed onto the member's PCP (with the member's authorization). Another indication that coordination of care is working is seen in the 70% of PCPs who logged on and picked up these reports from the BH Specialists. To ensure member privacy, IEHP has set guidelines for sharing information, and all PCPs and BH specialists have unique login information. Therefore, only a member's provider can view all relevant medical information. As integration of LTC and other social services are implemented as part of the Demonstration Project, IEHP will make it a priority to establish privacy guidelines and facilitate secure information exchange across multiple systems and organizations. As an example, IEHP is actively engaged in training county behavioral health providers to use the web based coordination of care tool. Use of this web based tool by county providers will further support integration of behavioral and physical health care for IEHP Members. IEHP also actively supports ongoing initiatives in both counties to co-locate behavioral and substance abuse services in their county clinics. In San Bernardino they have co-located services in their Ontario clinic, and Riverside clinic they have implemented co-location pilots in selected Family Care Centers. IEHP will continue to work with the counties throughout the three year demonstration to develop additional measures of success, such as process improvements, coordination of care and services, cost savings, and improved healthcare outcomes.

Another notable integration project involves an FQHC clinic in Coachella Valley. In this instance IEHP has partnered with FQHC to bring a child psychiatrist to the clinic several days a month to provided integrated behavioral health services to IEHP Members.

Additionally, IEHP's BH team has increased access and utilization of outpatient BH services by removing barriers, streamlining access and educating members and providers about the expanded services IEHP now offers directly. Comparisons of utilization and financial data for 2009 (when a contracted sub-plan partner was providing BH services) and 2010 (when IEHP initiated BH operations) demonstrate that these objectives were achieved in the first year. For example, under Medicare DualChoice, the outpatient mental health utilization rate increased from 740.3 to 1,717.22, reflecting a 132% increase.. These numbers show that IEHP succeeded in expanding access to many additional members. For substance abuse, the utilization rate increased from 19.6 to 21.72, reflecting an 11% increase and the average number of member visits in substance abuse treatment increased from 1.8 to 2.5. This modest improvement in access and utilization of substance abuse treatment for the Medicare DualChoice members indicates that there are additional barriers, including substance abuse treatment avoidance, in this population that will require continued effort to overcome. IEHP will address these barriers and improve care for dual eligibles.

Furthermore, with direct administration over the BH program IEHP can respond to regulatory changes and new expectations promptly. For example, with the mandatory enrollment of seniors and people with disabilities (SPD), IEHP was required to screen 100% of these new members for mental health conditions. IEHP's integration of PHQ9, the mental health screening tool, into the Health Risk Assessment (HRA) process was quickly implemented and the BH team is actively triaging these members as they enroll. This nimble responsiveness to the growing expectation that health plans incorporate BH screening and treatment has enhanced IEHP's ability to respond to the many challenges that come with healthcare reform and reorganization, including the Dual Demonstration Project.

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

Response: IEHP has hired a full-time Clinical Director of Behavioral Health for clinical oversight and management of BH Program activities and staff of BH Specialists and BH Care Managers. The Clinical Director of Behavioral Health is a licensed doctoral level clinical psychologist in the State of California with behavioral health administrative experience. The BH Care Managers are licensed master level practitioners (LCSWs) and each have at least five years of post-master's clinical experience.

The responsibilities of the Clinical Director of Behavioral Health include: clinical oversight and direction; development and implementation of clinical policy for BH activities; participation in IPA BH activities, as necessary; review of BH criteria to ensure that protocols and BH personnel of IEHP follow rules of conduct; monitoring and oversight of BH activities performed by IEHP; coordination and continuity of care for members and oversight of the network of contracted BH specialists and facilities. This individual oversees triage and referral decisions and is available to the BH Care Managers to make final triage determinations.

The Chief Medical Officer and the Clinical Director of Behavioral Health also work with a contracted psychiatrist to provide clinical direction for psychiatric issues that are beyond the scope of practice or experience of the Clinical Director of Behavioral Health. The consulting psychiatrist provides valuable input in many ways:

1) Ongoing consultation to the Clinical Director of Behavioral Health and BH staff on clinical issues where psychiatric direction is indicated.
2) Participation in the BH Advisory Subcommittee to provide psychiatric direction for the development of BH policies and procedures, as well as to provide oversight for BH services provided by psychiatrists.
3) Provide ongoing direction regarding the appropriate use of psychotropic medications.

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

Response: To support co-location of services, IEHP has consistently supported initiatives to assist Federally Qualified Health Centers (FQHC) and other primary care providers to expand in the Inland Empire. For example, IEHP became one of seven California recipients of a $500,000 grant to transform county run health clinics in Riverside County into Health Homes. These health homes will add medical services and integrated systems of care to improve health outcomes among members. The two-year project will improve data exchange, technology and care coordination at 10 Riverside County Community Health Agency (RCCHA) health clinics representing more than 12,500 IEHP members. Furthermore, this project will help our members remain in their homes and communities with appropriate service and supports in lieu of institutional care. Another example involves IEHP's recent establishment of a $2,000,000 fund to assist FQHCs to expand and encourage migration to a multi-disciplinary model for clinic staffing. The multi-disciplinary staffing model is consistent with the Health Home concept of making major health services accessible in a convenient and familiar setting.

IEHP has a unique arrangement using a mixed reimbursement methodology for BH services with an FQHC in Riverside County. IEHP pays an all-inclusive flat rate per month as payment in full for its Healthy Families, Healthy Kids and

DualChoice members to receive Behavioral Health Services from a clinical Psychiatrist located on the Borrego clinic premises integrated with member's primary care providers, providing approx. 4 hours of direct clinical services per week. There is also a clinical Psychologist on site for member referral, reimbursed on a fee-for service basis. The onsite clinical BH providers are fully integrated with the primary care and case management team, and are able to evaluate member's BH needs and consult with the member's primary care provider for seamless continuity and reporting of clinical findings and treatment recommendations.

In addition, IEHP has dedicated staff who are co-located at each county Behavioral Health Department and also at the Inland Regional Center. This co-location approach allows us to provide better coordination of care to our dual eligible members.

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

Response: IEHP will include consumers and advocates on local advisory committees to oversee the care coordination partnership and progress towards integration as it has done for its Medi-Cal, Medicare DualChoice, and Healthy Families members through the Public Policy Participation Committee (PPPC) and

the Persons with Disabilities Workgroup (PDW). Direct member input has proven vital to improve the delivery of care and services, and will continue to be significant in caring for the dual eligible members. For example, IEHP will develop a dual eligible advisory committee to achieve meaningful input. This will provide a mechanism for structured input from IEHP dual members on how IEHP structure or operations impact their care delivery. This committee will preserve and enhance the ability for consumers to self-direct their care.

The PPPC for dual eligibles will include 30 dual eligible members and it will have many functions:

1) Members will review changes in policy or procedures.
2) IEHP will provide updates on state policies or issues that affect IEHP and its members.
3) Members will provide input on issues that impact them (i.e. marketing materials, IEHP website, the Evidence of Coverage, brochures, flyers, Health Education materials, advertisements, incentive ideas/items, etc).
4) Members can share experiences that will help IEHP improve how care is delivered;
5) Members will advise on educational and operational issues affecting groups who speak a primary language other than English.
6) Members will advise on cultural competency.

To ensure a forum that is relevant to dual members, membership will consist of 30 selected IEHP dual eligible members, along with key IEHP staff that include:

1) Chief Marketing Officer
2) Clinical Director of Behavioral Health
3) BH Care Managers & Specialists
4) Care Managers (MOC)
5) Disability Program Manager
6) Medical Director
7) Director of Marketing
8) Director of Member Services
9) Director of Community Outreach
10) Health Education Manager

The structure of the PPPC for the dual eligibles will be as follows:

1) Meet routinely at least quarterly.
2) Special meetings may be called at any time.
3) Meeting minutes will be recorded, transcribed, and approved by the committee.

Additionally, to provide a forum to discuss issues and ideas concerning care for members, IEHP will continue to hold Joint Operations Meetings (JOMs). JOMs allow IEHP to monitor plan administration responsibilities delegated to IPAs and

acute care hospitals, and may address specific quality, CM, UM, grievance, study results, or any other pertinent quality issues. They are also held with County Behavioral/Mental Department staff and are designed to address issues from an operational level.

To ensure advocates are involved in the planning, development, and implementation, IEHP will involve the Inland Empire Disabilities Collaborative (IEDC), a cross-disability collaborative of over 300 regional service providers who serve seniors and people with disabilities. The IEDC holds monthly meetings to share knowledge, resources, issues and concerns, and discuss how to better serve their members. To gather continuous feedback, IEHP will ask the IEDC to incorporate planning discussions into these monthly meetings.

IEHP is requesting that DHCS seeks approval from CMS to waive the current regulation against member stipends for advisory committees like the PPPC for dual eligibles. In order to help dual members attend the PPPC, such as transportation costs, IEHP would supplement their membership with a $50 stipend.

Section 3.2: County Partnerships

Question 3.2.1 Describe in detail how your model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders. In preparing the response, keep in mind that your system of care may evolve over time, relying more heavily on the County in Year 1 of the Demonstration.

Response: For dual eligibles severely affected by mental illness and chronic substance use disorder, IEHP will utilize existing partnerships with both Riverside and San Bernardino counties to refer these members to the appropriate level of care. For example, IEHP currently contracts for services provided by the Members Assertive Program Solution (MAPS) Community treatment team. The MAPS team provides wrap-around services and supportive case management services to individuals with severe mental health and/or substance abuse issues. The intent of the MAPS program is to stabilize frequent users of psychiatric services, maintain them in a community living environment, and decrease the frequency of hospitalization. Additionally, to extend additional mental health and chronic substance abuse services to dual beneficiaries, IEHP works with the Riverside County Mental Health Program and the San Bernardino County of Behavioral Health. The counties provide behavioral health services for Medi-Cal and Healthy Families members and in Riverside County the county also provides mental health services for Healthy Kids members. In all cases, IEHP works closely with the two counties to coordinate services. IEHP's online member health record and reporting systems to further integrate care at multiple levels.

To further engage with county behavioral health agencies, IEHP has hired or will be hiring two county liaisons, one in Riverside County and one in San Bernardino County. IEHP also has a third liaison at Inland Regional Center (IRC).

The IEHP Chief Medical Officer or designee works with liaisons from both counties to facilitate member access to specialized programs and/or services and to promote coordination and communication between specific county agencies, programs, and services. Reciprocal Liaison Lists with DPSS, Community Health Agency (including CCS and CHDP), Department of Mental Health in Riverside County and The Department of Public Health (including CCS and CHDP) and the Department of Behavioral Health in San Bernardino County are maintained by the Director of Health Administration and updated quarterly to identify key contacts for both IEHP and county personnel. These lists promote communication and facilitate coordination between IEHP and external organizations that also provide mental and physical health services. Furthermore, by providing additional coordination of care to community resources and optimizing current county services and programs, the liaisons allow IEHP to provide dual eligible members with the full continuum of care.

Question 3.2.2 Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015.

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

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

Response: IEHP has existing agreements with Riverside and San Bernardino counties for the provision of mental health and substance use services to the seriously and persistently ill. For example, IEHP has a Memorandum of Understanding (MOU) with both County Behavioral Health Departments for the provision of mental health services to Medi-Cal and Medicare DualChoice members. IEHP also has a MOU with Inland Regional Center (IRC) for care coordination services for eligible IEHP members, including Lanterman residents. Additionally, IEHP acts as a liaison with Riverside and San Bernardino counties for coordination of care of Healthy Families members and San Bernardino Healthy Kids under the Severely Emotionally Disturbed (SED) Program and Medi-Cal members receiving care through the County Behavioral/Mental Health Department.

IEHP will work with existing partners, such as county and other local hospitals, County Behavioral Health departments, county social services agencies, IHSS Public Authorities, County Office on Aging, CBAS centers, and LTC facilities to establish standardized criteria for identifying beneficiaries to target for care coordination. For example, using our web based claims and clinical reporting tool IEHP plans to connect behavioral health services with our internal BH clinical

team and MOC care management teams. Additionally, IEHP will use the Health Risk Assessment (HRA) results to identify those individuals who may benefit from inter-agency coordination.

Currently, to overcome barriers to exchange information across systems for purposes of care coordination and monitoring, IEHP has implemented an online clinical reporting system designed to connect BH specialists with the member's PCP and enable meaningful coordination of care. BH specialists conduct assessments and upload treatment plans. After approval from the member, these plans are stored in the member's health record and available for PCPs to download and review. IEHP is continuously training BH providers on the use of the clinical information tool, and working with leadership in both counties agencies to support and enable meaningful use.

Section 4: Person-Centered Care Coordination

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

Response: Person-centered care coordination allows beneficiaries to self-direct their care in order to meet their unique social and medical needs. This

requires improved understanding of the different needs of each population, improved care coordination, and partnerships with local support services. However, IEHP has shown throughout its history that it has the experience and know-how to care for these populations. For example, since 1996, IEHP has served seniors and people with disabilities (SPDs) who have a wide range of medical conditions, disabilities, functional limitations, and intellectual cognitive abilities. We understand their complex needs, and have the functional capacity to care for similar populations like the dual eligibles, whom IEHP has also served since 2007 through our D-SNP program.

To achieve the goals of person-centered care with the dual eligibles, IEHP will build upon the integrative activities and coordination of services existing in the IEHP Model of Care (MOC) Care Management Program. The MOC is a systematic healthcare delivery process, integrated and coordinated for the dual eligible members, such as the IEHP Medicare DualChoice (HMO SNP) members. The program is also for at risk members, such as seniors and people with disabilities (SPD), Health Management (HM) and Complex Care Management (CCM) program enrollees. Through a Health Risk Assessment (HRA) and Care Plan, IEHP can provide these members personalized care revolving around the member's needs. For example, IEHP MOC Care Management staff facilitate the coordination and integration of Medicare and Medi-Cal (Medicaid) services and

work together with practitioners, vendors, ancillary providers, caregivers, county agencies, county based organizations, and members to produce a seamless and well coordinated service delivery experience for dual eligibles and at risk members. Specifically, the MOC Care Management staff assists members in obtaining access to continuous care and services, including long term care services, coordination of health care issues, and connection to valuable community resources within a specialized provider network and county partners. To provide the best person-centered care approach for those individuals who cannot self-direct their care, the MOC Care Management staff works with the member's caregiver/family and physician who understand the member's medical and social service needs.

Additionally, the MOC Care Management Program utilizes local support for integrating medical care, long-term care, and home-and community-based services networks. For example, the MOC Interdisciplinary Care Team (ICT) provides a multi-disciplinary approach to assessing and monitoring the targeted population. The ICT strives to address multiple issues that affect this population (e.g. medical, behavioral health, psychosocial, cognitive, access and functional issues). For example, each beneficiary is assigned an ICT composed of IEHP staff, the Primary Care Physician, ancillary providers, specialty care providers, social workers, community based organization member, and etc. pertinent to the beneficiary's

specialized needs. The Care Management Nurse, in consultation with the Medical Director if necessary, determines additional membership. This may include:

- Members/member caregiver/IHSS caregiver/family
- Member providers (e.g. PCP/board certified specialists/nurse practitioner/ physician's assistant/mid-level provider)
- Care coordinators
- Community resources specialists (e.g. Inland Regional Center, County Independent Living Centers, Meals on Wheels)
- Restorative health specialist (physical, occupational, speech, recreation); registered dieticians/nutritionist; disease management nurses; health educators (preventive health/health promotion specialist)

For example, if a member is identified with behavioral health needs, the makeup of the ICT will include the member/caregiver, IEHP Medical Director, social worker, mental/behavioral health expert, nurse care manager, clinical pharmacologist, and other staff as needed. By personalizing each ICT to the beneficiary's need, IEHP can improve processes, coordination, and access to timely care, while allowing members to self-direct their care to improve quality of life.

Additionally, in order to facilitate the member's needs, the Care Manager will prescreen the member to ensure ICT meetings fulfill the following criteria:

ICT meetings held in member's primary language, through TTD/TTY, or through use of a language line interpreter if the language is not one of the company's threshold languages. Members and/or caregivers also work with the Care Manager to review the care plan and see if updates are required. Members may also request a new ICT or new members may be added according to their needs, allowing members to play an active role in his or her healthcare.

Furthermore, to assist members in all types of care settings and maximize their ability to remain in their homes and communities, the MOC program facilitates transition of care (TOC) through a TOC Nurse. This TOC Nurse coordinates the delivery of care across all healthcare settings, providers and services to assure continuity of care, and minimize risk of patient safety. For example, when a member moves from one care setting to another, such as home health care, acute care, skilled nursing facility, rehabilitation facility, the IEHP Care Management (CM) department will collaborate with the Utilization Management (UM) department to coordinate the delivery of care and direct how network providers and facilities will deliver services to members. The Care Manager will work with the facility discharge planner, social service staff, and Inpatient Nurse for a safe transition. The member's usual practitioner and ICT are also notified of any care setting transitions. IEHP's goal in this process is to help patients take a more active role in their health care by receiving specific tools and

skills by their TOC Nurse. These tools could include education on medication management, follow-up care, managed care education, involving family members and/or caregivers as support, all of which can help the member self-manage their health and transition to avoid readmission or institutionalization.

To monitor these transitions, IEHP has ongoing communication with facilities to monitor members' needs and the services provided to them. IEHP also works with its contracted facilities to ensure that members are receiving comprehensive quality care in the least restrictive setting.

Question 4.2 Attach the model of care coordination for duals as outlined in Appendix C.

Response: For the SNP Model of Care Elements and Standards see Attachment K.

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

Response: To ensure the providers in the IEHP network participate in care coordination, they are integrated into the care coordination process in several ways. For example, providers, specialists, ancillary providers, social workers, etc. who

are involved in the member's care are encouraged to participate on the Interdisciplinary Care Team (ICT). These providers are contacted to discuss specific dual member needs, working with IEHP staff, community based organizations, social workers, and the member. The provider network further collaborates with the ICT, assisting in the development of care plans, providing clinical consultation as needed and adhering to nationally recognized clinical practice guidelines.

Providers are also involved in the transition of care process that is initiated by a Transition of Care (TOC) Nurse. For example, the TOC Nurse will coordinate and facilitate the transition of care, educate regarding the delivery system, medicine reconciliation, and the importance of keeping follow-up appointments as directed by physician(s). The TOC Nurse will also notify the primary care physician (PCP) for all planned and unplanned admissions at the time of discharge.

Physicians can also go to IEHP's secure provider login on the IEHP website to track patient activity, such as preventive health requirements, medical, hospital, and behavioral health visits. The physician can also view the individualized care plans that IEHP has discussed with the member.

To ensure providers in the IEHP network meet the needs of our dual members, the IEHP Provider Services and Contract Departments assure that the provider and facility network have specialized clinical expertise pertinent in

delivering healthcare services to the targeted special needs population. These include, but are not limited to providers that coordinate the following:

- Assess, diagnose, and treat in collaboration with the interdisciplinary care team
- Conduct conference calls with the ICT, as needed
- Assist with developing and updating individualized care plans
- Provide long-term care
- Assist with conducting disease management programs
- Provide pharmacotherapy consultation and/or medication management clinics
- Conduct home visits for clinical assessment or treatment
- Conduct home safety assessment
- Provide home health services
- Provide home-based end-of-life care through hospice and/or palliative programs

To train, incentivize, and monitor providers who are not experienced in participating in care teams and care coordination, IEHP provides training throughout the year on the MOC program. Training may include face-to-face, printed instructional materials, web-based instructions, or audio/video conferencing for all personnel and providers. To direct and implement changes for

the upcoming contract year, operational changes resulting from MOC updates are presented to the ICT in the fourth quarter. The contents of the MOC training include, but not limited to:

- Dual-eligible benefits (Medicare and Medicaid Benefits)
- Care coordination
- Care Management roles and responsibilities
- Transitions of care program for beneficiaries who transition from settings-to settings, providers-to-providers, providers-to-facilities
- Interdisciplinary Care Team meeting participation and communication process
- How members and providers inquire and provide input
- Individualized care plan
- Health Risk Assessment process
- Use of nationally recognized protocols and clinical practice guidelines
- Electronic health information
- Communication network including provider web portal

Section 5: Consumer Protections

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

Response: Refer to the RFS Certification Check List.

Section 5.1: Consumer Choice

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

Response: Beneficiaries will choose a Primary Care Physician (PCP) who meets their healthcare needs at the time of enrollment with IEHP. Members will be allowed to choose a Specialist as their primary care provider if the Specialist accepts that role and can deliver all primary care and care coordination services needed by the member. This choice is an integral part of self-directed care. IEHP members can choose from over 700 PCPs in the network and are allowed to change on a monthly basis. Members can first choose their PCP on the Medi-Cal/Medicare Choice Form. A copy of the plan's provider directory, which includes accessibility ratings, is included in the enrollment packet to help members in their selection. If the member does not choose a PCP, IEHP will review the member's utilization data, location, and language to match the member with the

appropriate PCP in the network. Members can call IEHP Member Services to change their PCP on a monthly basis. The Member Service Representative (MSR) will help the member find the right PCP that fits their needs and one that is near member's home/community. For continuity of care, the MSR will also review the member's specialists and link them with a PCP that is in the same medical group. Members can also search for providers (including PCPs, ancillary providers, specialists, hospitals, and pharmacies) on the IEHP website by selecting search criteria such as city, services, plan, language, and/or gender. IEHP members who are enrolled in the MOC program also have the opportunity to select the participants on their ICT by notifying their Care Manager.

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

Response: Beneficiaries will be able to self-direct their care in several ways, such as by selecting the members on their Interdisciplinary Care Team, reviewing and helping develop care plans, responding to the health risk assessment (HRA) and condition-specific self-care guides developed by IEHP to provide beneficiaries a step-by-step action plan for improving health and providing valuable resources they can access.

On every level of the ICT and care coordination, members can request certain participants be included in their care team. This allows the member to self-direct their care. For example, if a member has housing issues/barriers, the member can ask his or her Care Manager to include a social service specialist in the ICT. Also, if the member feels their current ICT does not meet his or her needs, he or she can request for the Care Manager to find new or additional ICT members. Care Managers will also take a proactive approach and assess the member's needs through the member's HRA to evaluate their physical, psychosocial, cognitive, and functional needs. This ensures all participants in the ICT can make meaningful, relevant care decisions to improve the member's quality of life, while involving the member in their care discussions. At any time, members can also choose to opt-out of IEHP's Care Management, Complex Care Management or MOC Care Management programs by calling IEHP Member Services.

Through the HRA, IEHP helps members self-direct their care by giving them the right educational tools and resources. For example, when the HRA is complete an individualized care plan is created based on the member's response. The Care Manager will review the care plan as needed with the member for any updates. This way, the member is involved in his or her care and provides additional information for a more comprehensive plan. Additionally, Care Managers share health education materials with members to educate them on their

condition. For example, several self-care guides have been developed in the areas of obesity, diabetes, and asthma. Members receive these supportive guides to help them develop a concrete action plan to improve their health.

To further empower members to take control of their healthcare, the IEHP Health Navigator Program helps members with children learn to navigate the healthcare system, including how, when and where to get their medical care. The program serves as a link between the members, their providers, and IEHP, leading to better communication, coordination, and care. IEHP plans to extend this program to adults in order to collaborate with their PCPs and link adult members to community resources that will help them remain in their home/communities in lieu of institutionalized care. Health Navigators will help the dual eligible members to make appointments for preventive care visits, educate the member on how managed care works, and explain how to access their benefits and services. The Health Navigator will examine the member's health records to identify any medical needs, such as preventive care services and other needs like transportation, food, housing, and/or long-term care.

In addition, our dual choice members will retain their right in hiring, firing and supervising their personal IHSS caregivers in all 3 years of the Demonstration Project.

Section 5.2: Access

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

Response: Refer to the RFS Certification Check List.

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

Response: The dual eligible members have multiple care needs, and to ensure they receive quality care, our Demonstration program will be accessible on all levels. IEHP currently has standards and procedures in place to monitor physical, community, document/information, and doctor/provider accessibility.

To improve quality of care and ensure members have appropriate access to services and facilities, all PCPs, and specialists must meet access standards for participation in the IEHP network. IEHP monitors practitioner access to care through IEHP performed access studies, review of grievances and other methods. The IEHP Quality Management Department communicates IEHP's guidelines for accessibility, including those for provider facilities, community resources, communication materials, and doctor/provider medical visits. As new access issues are discovered, adjustments will be made accordingly. Below are examples

and explanations on how IEHP achieves high level of accessibility for our members.

- Facility site review: IEHP conducts facility site review of PCP offices when a provider joins the IEHP network and three years thereafter. The site review includes assessment of access for the disabled, languages spoken at the office, hours of availability, policies and procedures to identify and follow-up on members with missed appointments, and new members requiring notification for initial health assessments.
- DHCS site review tool/checklist: IEHP conducts additional site reviews to check for parking, exterior building, interior building, restroom, exam room, and exam table/scale accessibility.
- Community accessibility: To optimize the use of county resources and increase the availability and access to home- and community-based services, IEHP connects members to alternative resources. Through the Inland Empire Disability Collaborative (IEDC), IEHP connects with over 300 member organizations that serve the needs of seniors and people with disabilities. By informing and training staff about these resources, IEHP provides enhanced accessibility to community based services.

- Document/information accessibility: IEHP ensures members can request information in their primary language and format that suits their needs. For example, all member-informing materials are translated into IEHP's threshold language(s), determined by DHCS, and are provided in alternative formats (including Braille, large print, electronic, or audio format) upon request and in a timely fashion appropriate for the format being requested. IEHP also offers "text-only" navigation on our website and members can request a language or sign language interpreter at any medical visit.
- Doctor/provider accessibility: Accessibility standards for providers include appointment times, proximity, minimum hours on-site, telephone access, emergency services, urgent and non urgent services. To ensure proximity of providers to members, IEHP contracts with providers throughout the Inland Empire. For example, IEHP network PCPs must be within 10 miles or 30 minutes travel time from member's assigned residence. IEHP also works with BH providers to ensure members always have access to medical care. For example, all IPAs and BH providers are required to provide or ensure that members have access to medical care 24-hours a day, seven days a week. This includes

after business hours telephone access to a PCP or a triage system utilizing specific licensed personnel.

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

Response: To communicate information about the accessibility levels of providers in the IEHP network, the accessibility details for each facility is listed in the doctor search on the IEHP website and in the IEHP Provider Directory. Members can refer to either resource to decide which provider can accommodate their specific needs.

Section 5.3: Education and Outreach

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

Response: IEHP will ensure effective communication in a range of formats with beneficiaries through integrated internal systems to receive member format requests. For example, the IEHP Disability Program works with several internal departments to provide members effective communications in a range of formats and also provides communication via TTYs and video phones for members who are deaf or hard-of-hearing. First, Member Services receives requests from beneficiaries for member informing materials in alternate formats, such as Braille,

large print, electronic, or audio. The Disability Program will work with an approved vendor to produce the material in the requested alternate format in a timely manner. The Disability Program also integrates policies for providing sign language interpreters, working with the Center on Deafness Inland Empire and other organizations across Riverside and San Bernardino counties to publicize the availability of services.

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

Response: To meet the linguistic and cultural needs of beneficiaries in their own language, IEHP translates all print/written or digital member communications to IEHP's threshold languages. IEHP current threshold language is Spanish; therefore, all member informing materials are translated into Spanish using an external translation vendor and an internal Spanish Communications Writer who is bachelor-level certified, and has over 20 years experience in Spanish writing and translation. By communicating with members in their preferred language and format, IEHP is helping members understand their healthcare, resulting in more self-directed, patient-centered care.

To develop more targeted, relevant communications, IEHP also publishes a newsletter for our members with disabilities, twice a year. In 2012, IEHP will

launch another newsletter to provide dual eligibles with information on how to access benefits and services, new benefit information, preventive health care, and community resources.

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

- A detailed operational plan for beneficiary outreach and communication.
- An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.
- An explanation of our approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.

Response: Refer to the RFS Certification Check List.

Section 5.4: Stakeholder Input

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

Response: The stakeholder engagement plan and timeline during the 2012 project development and implementation will include significant input from community based organizations, county agencies, providers, and beneficiaries. IEHP and Molina Healthcare have already met with IHSS programs in both counties, and they are concerned about the funding and reimbursement

implications. Additionally, IEHP has already discussed the Demonstration Project with IEDC members. After site selection is made, IEHP will hold monthly stakeholder meetings through the Inland Empire Disabilities Collaborative (IEDC), an organization of over 300 service providers who understand the needs of dual eligibles and can help increase IEHP's capacity. We will also build additional community partnerships to provide a broader scope of resources for the incoming dual beneficiaries.

Fostering new partnerships will be extremely important and IEHP plans to collaborate with, but not limited to Molina Healthcare, D-SNP plans, medical providers, county and other local hospitals, county behavioral health departments, county social services agencies, IHSS Public Authorities, county Office on Aging, CBAS centers, and LTC facilities. We will also continue to work with our existing partners including the Independent Living Centers, Inland Regional Centers, Area Agencies on Aging, Aging and Disability Resource Connection, and many other important entities.

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

Response: To engage stakeholders throughout the three-year Demonstration, IEHP will look to its network of over 300 member organizations of the IEDC. In order to engage more stakeholders in the development, implementation, and

continued operation of an integrated care program for dual eligibles, the IEDC will continue to grow its membership. IEHP will also optimize existing partnerships and MOUs with the San Bernardino Department of Behavioral Health, the Riverside County Department of Mental Health, local Area Agencies on Aging, DPSS, CBAS, MSSP and other Medi-Cal Waivers programs to engage stakeholders.

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

Response: IEHP's method for meaningful involvement of external stakeholders in the development and ongoing operations of the program will be to optimize our current network of more than 300 member organizations that are part of the IEDC and serve seniors and people with disabilities in the Inland Empire.

The IEDC unites and mobilizes organizations to better serve seniors and people with disabilities, while promoting equal opportunity, independence, and universal access. Through collaboration, the IEDC and IEHP are able to link seniors and people with disabilities to services in their communities and avoid institutionalized care or hospital readmissions. Through monthly meetings member

organizations share resources that help their members navigate services and resources from different organizations across a widespread geographic area. The IEDC is also a forum for member organizations to provide ongoing feedback on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

Through the IEDC, IEHP bridges the gap between seniors and people with disabilities and valuable resources available throughout Riverside and San Bernardino counties. IEHP will continue to consult and involve the IEDC through monthly meetings to receive and incorporate meaningful input throughout the three year demonstration.

To engage dual eligibles, IEHP will develop a dual-specific advisory committee, providing a mechanism for structured input regarding how IEHP structure or operations impact their care delivery. Members will review changes in policy or procedures, state policies/issues, review marketing/communication materials, and provide feedback on education materials, operational issues and cultural competency.

Throughout the development of the Application and program, IEHP will collaborate with IEDC members and the counties of Riverside and San Bernardino to understand barriers, areas of opportunities for improved health, and

implementation of the Demonstration project, including integration of long-term care and support services.

Section 5.5: Enrollment Process

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

Response: IEHP agrees with DHCS on a passive enrollment process with a voluntary opt-out. This approach will give members a choice whether to join a managed care plan. The enrollment process will resemble the mandatory enrollment of seniors and people with disabilities (SPD) into managed care. IEHP envisions dual eligibles will receive information regarding the change and their options from DHCS prior to the January 2013 enrollment launch. Therefore, dual eligibles would receive a flyer and call from Health Care Options about three months before their birthday and an enrollment packet two months before their birthday. By the end of 2013, all dual beneficiaries will be enrolled in a managed care plan. However, we understand that the decision for a 6 month lock-in will be decided by CMS, and will adhere to their decision.

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

Response: Before the enrollment of seniors and people with disabilities (SPD) into managed care, IEHP served over 25,000 SPDs. Therefore, have significant experience and ability to serve the needs of this population, including care management. We already have a well-established Disability Program that offers programs and services to improve the health of members with:

- Chronic illnesses
- Behavioral health conditions
- Physical disabilities

Since the SPD mandatory enrollment in June 2011, on a monthly average, about 3,000 new SPD members have enrolled with IEHP. Today we serve over 50,000 SPDs. From this experience, we believe an influx of members of this size is very manageable in terms of building our existing programs and services, including care management. IEHP plans on taking this knowledge and experience and applying it towards the enrollment of dual eligibles.

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

Response: In order to successfully enroll dual eligibles and implement the program, IEHP is requesting DHCS to provide the following:

- utilization data

- a streamlined system for appeals and grievances
- provider data
- behavioral health data
- one eligibility file

Section 5.6: Appeals and Grievances

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

Response: Refer to the RFS Certification Check List.

Section 6: Organizational Capacity

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

Response: Our guiding principle includes our mission and core values. IEHP is a Knox-Keene licensed health plan and organized as a Joint Powers Agency. Our mission is to organize and improve the delivery of quality, accessible and wellness based healthcare services for our community. We highly respect and follow our core values which are as follows:

- Health and Quality before Cost: we believe in placing a member's health care needs above all else;
- Team Culture: we are a dedicated and cohesive team focused on member care and supporting our providers;
- Foster a Total Quality Management (TQM) Environment: we strive to continuously improve our daily operations and delivery of health care services;
- Partner with Providers: we recognize the necessity of a strong working relationship with our providers – based on mutual respect and collaboration;
- Stewardship of Public Funds: we are accountable to the public and strive for transparency and prudent fiscal management.

Our record of performance in currently delivering services to approximately 50,000 seniors and persons with disabilities (that include 10,000 dual eligible members) demonstrates that IEHP understands the needs of the community and the population. IEHP has proudly served both Riverside and San Bernardino counties for 15 years. Our membership has substantially grown in the past several years. IEHP currently serves over 540,000 members in our four programs; Medi-Cal, Healthy Families, Healthy Kids and a D-SNP plan called Medicare DualChoice. Specifically, we have grown over 40% in our Medicare DualChoice population

within the last year, indicating that our members are continuing to choose to join us. Our low disenrollment rate of about 1.7% in our D-SNP plan shows our members are satisfied with the services that they receive from IEHP.

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

Response: Refer to Attachment L.

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

Response: Seven (7) IEHP's Executive Team Members below have the relevant skills and leadership abilities to successfully carry out the Demonstration project.

Chief Executive Officer:

Dr. Bradley Gilbert was named IEHP CEO in October 2008. Since IEHP's inception in 1996, Dr. Gilbert has played a principal role in positioning IEHP as a nationally recognized leader in public health care. Prior to becoming CEO, Dr. Gilbert served as the IEHP Executive Officer, responsible for Medical Services, Marketing, Operations, and Contracting/Networks. Previous to this appointment, Dr. Gilbert served as Chief Medical Officer. He developed a Medical Services Department and qualified IEHP for Knox-Keene state licensure. Under his

leadership and direction, IEHP was the first Medi-Cal HMO in California to earn accreditation from the National Committee for Quality Assurance (NCQA). Also, IEHP was among the first health plans in the nation to receive NCQA accreditation for Disease Management. In addition, Dr. Gilbert was instrumental in building IEHP's extensive network of nearly 700 primary care physicians and 1,800 specialists. He also contributed to increasing IEHP's membership from the initial enrollment of over 60,000 to more than 540,000 members as of February 2012.

Dr. Gilbert is well-versed in the public health challenges facing residents of the Inland Empire, largely due to his work as the Director of Public Health and the Public Health Officer for Riverside and San Mateo Counties, and his experience as a primary care physician. Because of this, Dr. Gilbert provides an informed perspective on health care, emphasizing prevention and the social context of disease when organizing the delivery of care for IEHP Members. Dr. Gilbert received a bachelor's degree in Physiology/Anatomy from the University of California, Berkeley, a medical degree from University of California, San Diego, and a master's degree in Public Policy from the University of California, Berkeley. He is Board Certified in General Preventive Medicine.

Chief Operations Officer:

In May of 1995, Mr. Phil Branstetter joined IEHP to handle operations including the development, implementation, and maintenance of Medical

Information Systems as well as general plan operations, claims, and fulfillment. Prior to joining IEHP, Mr. Branstetter held a variety of positions with the Riverside County Office of Education from 1984 to 1995. Starting as their Systems Programmer, and later as Director of the Regional Data Processing Center, his responsibilities included developing, installing, and implementing new data processing systems; managing a regional data processing center providing a variety of online services; managing and directing network administrative activities; and acting as the interagency liaison to develop data and network standards. Mr. Branstetter received a bachelor's degree in Business Administration (1979) from California State University, Fullerton, and a master's degree in Business Administration (1988) from California State University, San Bernardino.

Chief Medical Officer:

When Dr. William Henning became the IEHP Chief Medical Officer in July 2007 he brought over twenty years of clinical and administrative experience with him. He oversees Medical Services, which includes Utilization, Care Management, Wellness, Quality Management, and Pharmacy. Since joining IEHP as Medical Director in September 2004, Dr. Henning has introduced a number of groundbreaking projects, such as the home evaluation model for the Medicare Special Needs Program wherein IEHP Medicare Members receive an in-home health evaluation. He has also played a key role in establishing local pain

management clinics that help members cope with chronic pain. He has been instrumental in expanding the highly successful web-based IEHP Pay for Performance (P4P) Program, a physician and medical group incentive program first launched in 1997 to improve clinical care performance. Aside from collaborating on programs for asthma and chronic disease, Dr. Henning advocates for the rights of children with disabilities and campaigns against cultural and ethnic disparities.

Prior to his work at IEHP, Dr. Henning served fifteen years as Director and practicing physician of a prominent San Diego primary care group. From 1994-1995, he served as Chief of Staff and subsequently as a member of his local hospital governing board. Dr. Henning earned a medical degree from Western University of Health Sciences in Pomona, California. He completed a one-year internship at Pacific Hospital of Long Beach before embarking on a two-year residency at Phoenix General Hospital in Arizona. He holds a bachelor's of science degree from the University of California, Irvine and completed the Dale Carnegie Leadership Program. Dr. Henning is also an active member of numerous professional organizations, including the American Osteopathic Board of Family Physicians, Osteopathic Physicians and Surgeons of California, and both the San Bernardino County Medical Society and the Riverside County Medical Associations.

Chief Finance Officer:

Mr. Chet Uma joined the IEHP team in October 2005. With over sixteen years of extensive health care management experience in managed care, indemnity insurance, and IPA industries, Mr. Uma is well prepared to guide IEHP's fiscal operations. As Chief Financial Officer, Mr. Uma directs the organization's financial planning and accounting practices, overseeing the Accounting, Capitation, and Cost Recovery Departments. Mr. Uma previously served as Senior Vice President and Chief Financial Officer at Health Plan of San Joaquin in Stockton, California. In that capacity, he planned and directed all activities related to finance, provider network development, and customer services; while providing ongoing strategic and operational leadership. He assisted the CEO in developing corporate financial policy for recommendation to the Plan's Governing Board, and functioned as Financial Advisor to the CEO and the Board. He also chaired the Plan's Strategic Planning and the New Business Development Committees.

Prior to his work at Health Plan of San Joaquin, Mr. Uma managed the accounting department at National Health Plans, reporting directly to the CEO in the capacity of Controller. Prior to this, he sat on staff at Kirby & Mangini, a CPA firm in San Francisco. Mr. Uma earned a bachelor's degree in Business Administration at California State University, Stanislaus in 1987 and received a master's in Business Administration from Golden Gate University of San

Francisco in 2002.

Chief Marketing Officer:

Ms. Susan Arcidiacono was named the IEHP Chief Marketing Officer in August 2008. With over ten years of executive marketing experience, Ms. Arcidiacono oversees marketing and media planning, marketing analytics, community outreach, and Medicare sales. Prior to joining IEHP, Ms. Arcidiacono held executive marketing positions with several major organizations, including America Online and CIGNA. Most recently she served as Marketing Director for Health Net. Firmly committed to expanding access to health care in California, Ms. Arcidiacono has successfully established Medi-Cal, Healthy Families, and Healthy Kids products in six counties. She has been instrumental in creating innovative provider strategies which helped to increase enrollment and market share of state health programs.

Ms. Arcidiacono holds a master's degree in Business Administration from the University of Phoenix. She received a bachelor's of arts degree in Communications from California State University, Los Angeles; and she is a graduate of the Management Development Executive Program at the University of Southern California. Ms. Arcidiacono is an active member of numerous organizations, including the American Marketing Association, Health Care Executives of Southern California, the Healthcare Public Relations & Marketing

Association (HPRMA), and Women in Health Administration.

Chief Network Officer:

Kurt W. Hubler was appointed Chief Network Officer of IEHP on August 1, 2011. In this role, Kurt will lead the organization's strategy for provider contracting, provider services, provider relations, provider credentialing, and contracting administration. To ensure our members have access to quality healthcare throughout the Inland Empire, Kurt works with the current IEHP provider network including, IPAs, physicians, vision providers, and hospitals. He also contracts with new healthcare providers to build the network. His 25 years of experience in contracting, credentialing, provider services, and health plan operations will prepare IEHP to enter healthcare reform with a strong network of providers to serve the diverse needs of our growing membership. Kurt's previous executive roles and achievements in the healthcare industry will contribute to IEHP's long-term growth. In his most recent role as Executive Director of Medicare at CalOptima, Kurt launched and managed all aspects of the organization's Medicare Advantage Special Needs Plan from sales, marketing, provider network management, and contracting among other responsibilities. He has a proven track-record in provider network management, contracting, internal plan operations, and negotiations at several health plans in Southern California, such as Inter Valley Health Plan where he served as the Chief Operating Officer

and CareAmerica where he served as the Administrative Director of Provider Relations.

Kurt pursued undergraduate studies at the University of Southern California, where he earned a bachelor's of science degree in Public Administration. He earned a master's degree in Public Health from the University of California, Los Angeles.

Chief Information Officer:

Michael T. Deering joined IEHP as Chief Information Officer on September 12, 2011. In this role he will oversee all technology functions for IEHP and create a technology roadmap for future growth in membership and the provider network. He will also lead the organization's software development, application support, and healthcare analytics (HAR) reporting. Mr. Deering is a technology and business-savvy visionary with broad executive leadership experience and proficiency in developing technology solutions to solve complex challenges. With more than 20 years of hands-on technology experience he has extensive knowledge in network infrastructure, server platform, and development methodologies. He has a proven track record of integrating technology strategies with business models, leading enterprise change, effectively managing risk profiles and lowering operating costs while improving efficiency ratios. He has had consistent success in recruiting, developing, motivating, and retaining high–performing technology

teams. Mr. Deering will now use his deep experience to ensure IEHP's technology strategies align with business goals and continue to drive the organization forward. Mr. Deering has extensive experience in application development, support and maintenance as well as all technical aspects of acquisition integration projects, from diligence through successful evaluation, roll-out, and completion. He has developed world-class IT staff, established overall technology strategies, defined organizational e-commerce vision, managed web-based CRM applications, and created information security strategies using best practices. He has also achieved cost savings through restructuring, renegotiations, and lean initiatives, and established solid operational foundations by engineering stable network infrastructures that gave end users instant access to all required data.

Mr. Deering comes to IEHP from Canon Communications, where as Chief Technology Officer he was responsible for all aspects of global IT infrastructure. While there he provided enterprise wide change-agent leadership for technology strategy, research and development, architecture, infrastructure designs, and evaluated applications of new technologies and standards. Prior to Canon he directed technology-based solutions and implemented strategic operational improvements as vice president of information technology at General Electric. He earned a bachelor's of science degree in computer science from State University of New York-Plattsburgh. Mr. Deering is a current member of the Society for

Information Management.

Question 6.4 Provide a resume of the Duals Demonstration Project Manager

Response: Refer to Attachment M.

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

Response: IEHP has the governance, organization and structural functions that will be in place to implement, monitor, and operate the Demonstration. As a public entity, Joint Powers Agency, IEHP is overseen by a Governing Board. By appointing public officials to review IEHP's overall policies, a layer of transparency and quality assurance is present, benefiting members and community partners. The IEHP Governing Board is comprised of representatives from Riverside and San Bernardino counties, including four County Board Supervisors (two from each county) and three appointed members of the public, who provide direction and approval for all phases of IEHP operations.

IEHP operations are divided into several functional areas which are comprised of Operations, Network Operations, Medical Services, Marketing, and Finance. Each of these departments is supervised by a Chief Officer who reports directly to the Chief Executive Officer, who then reports to the IEHP Governing

Board. The implementation team who will carry out and set the guiding principles for the Demonstration will comprise of an individual representing each of these departments. IEHP will create a cross-functional steering committee similar to what has been done to implement the mandatory enrollment of SPD members. For example, staff will ensure that we have an extensive network to serve the needs and provide continuity of care for duals eligibles.

We will build our future infrastructure to support the development and implementation of the Demonstration by expanding our existing administrative and care management structure that currently serves over 540,000 members.

Section 6.2: Operational Plan

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

Response: IEHP has developed a preliminary operational plan that includes a multi-functional steering committee. IEHP developed a similar process to implement the mandatory transition of SPDs, proving to be successful at bringing multiple departments together to identify potential issues and develop solutions. The steering committee will consist of IEHP staff members from every functional department and will participate in the planning and implementation process of the dual eligibles. IEHP will expand our provider network by adding new medical

groups and IPA that will provide medical services to the dual eligibles. We intend to provide the dual eligibles with continuity of care by having their doctor in our network and expanding care coordination and timely access to care. We will also expand our Model of Care (MOC) concept to the new dual eligible members that integrates behavioral health and LTSS services.

We plan to build upon our existing operational plans which included Behavioral Health and incorporate LTSS. We understand that long term care services are an important component in the Demonstration project. Therefore, we will continue to work with our existing long term care facilities and expand this network. Furthermore, IEHP will contract with all applicable HCBS agencies such as CBAS, MSSP, and other Medi-Cal Waivers programs.

Stakeholder engagement is an important factor for the success of the development, implementation, and evaluation of our program. We will continue to engage the IEDC during the entire period of the Demonstration.

Question 6.2.2 Provide roles and responsibilities of key partners.

Response: IEHP currently has established relationships with key partners and agencies such as counties' Behavioral Health, Department of Aging and Adult Services, Public Health, Adult Health Care Service Centers, and over 300 organizations affiliated with The Inland Empire Disabilities Collaborative (IEDC).

IEHP will play an integral role and be responsible for the coordination of services. We will closely work with other partners and agencies to deliver the care for the dual eligibles. Following is a list including, but not limited to, the key partners and their responsibilities:

Name of Organization	Roles and Responsibilities
Molina Healthcare	Collaborate with IEHP and participate in several stakeholder meetings with other partners to improve health processes and satisfaction with care.
IPA/Medical Providers/FQHCs	Deliver medical care and guide the patient to seek further specialist care as needed.
Hospitals	Deliver inpatient care.
Institutionalized Facilities	Provide nursing care and/or rehabilitation services, and other related health care services to facility residents.
IHSS Public Authorities	Administer and operate the IHSS program.

County Behavioral Health Departments	Provide specialty mental health and substance use services that are not currently provided by IEHP.
County Social Services Agencies	Serve as a vehicle of information on available resources and other agencies.
CBAS Centers	Provide services to dual eligibles that will assist them maintain independence and avoid institutionalization.
D-SNP Plans	IEHP will work in good faith to engage with other D-SNP plans to ensure continuity of care for the dual eligibles.
IEDC	Serve the dual eligibles by connecting them to community resources and provide community-based care coordination.

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

Response: Following is a timeline of major milestones and dates for successfully executing the operational plan:

Activity	Description	Approximate Timeframe
Develop a multi-functional steering committee.	Create a committee to oversee the establishment of procedures, set rules and policies, and evaluate milestones as needed.	February 2012 - ongoing
Stakeholder involvement	Work with other plans, providers, and community-based organizations (CBOs) to obtain feedback and recommendations for providing quality services to and streamlined integration of the targeted population.	February 2012 - ongoing
Network development	Extend contracts to providers, IPAs, and FQHCs to expand services available to the targeted population.	February 2012 - ongoing

Activity	Description	Approximate Timeframe
County Behavioral Health involvement	Engage with the county to provide behavioral health services that IEHP currently does not offer, such as treatment for severe mental illness or substance abuse.	February 2012 - ongoing
Contract with CBAS	Work with CBAS programs to help sustain members' ability to live in the community.	June 2012
Systems integration	Work with vendors and partners to ensure a seemless coordination of data and services to provide transparency and report outcomes.	September 2012
Contract with IHSS	Obtain a contract with the IHSS program	September 2012

Activity	Description	Approximate Timeframe
Contract with MSSP	Obtain a contract with the IHSS program	September 2012
Integration of Behavioral Health and LTSS into MOC	Build upon our existing MOC program and incorporate Behavioral Health and LTSS in order to deliver case management and care coordination for the dual eligibles.	September 2012
Provider training	Give sensitivity training to providers and their staff so they may provide quality services to the targeted population.	September 2012 - ongoing
Internal staff training	Give sensitivity training to internal staff so they may provide quality services to the dual eligibles.	September 2012 - ongoing

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

Response: Refer to the RFS Certification Check List.

Section 7: Network Adequacy

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

Response: The IEHP provider network is comprised of mixed provider model types ranging from solo private practice physicians, multi-specialty medical groups, delegated Independent Physician Associations (IPAs), FQHCs, county clinics, community clinics and other safety net provider types. The IEHP provider network offers our members ample primary care choices in various settings to suit the member's preferred care setting. In IEHP's Medicare SNP product, there are currently 440 participating primary care physicians. At our current Medicare SNP membership levels, the ratio of dual eligible Members to PCP ratio is 15:1, allowing significant capacity for future growth. Network development efforts are continuously underway at IEHP to enhance the provider network and further expand primary care and specialty capacity and access. IEHP is diligently working to secure service agreements with multiple large multi-site/multi-specialty IPAs in the Inland Empire. These IPAs have historically not participated in the managed care Medi-Cal product, but possess an extensive track record working with the

managed care Medicare Advantage population. In addition to adding new primary care and specialty physicians to our network, these IPAs bring innovative health home value to IEHP. IEHP projects the addition of these new IPAs to the network will significantly increase the number of PCPs available to our dual eligible population. Also, as referenced in Question 1.2.5, IEHP is designating project funding in support of FQHCs and FQHC lookalike clinics to build and expand primary care capacity in the Inland Empire, and encourage health home activities including enhanced care coordination. Aside from the IEHP – FQHC partnership funding project, IEHP consistently encourages FQHCs, FQHC look-a-likes, and community clinics to expedite their expansion development plans in the San Bernardino and Riverside county regions, particularly in rural outlying areas of both counties where access barriers to health care are the greatest. Several Los Angeles and Orange County FQHC's development plans include expansion into the San Bernardino and Riverside counties. IEHP fully supports all safety net expansion activities given the relatively small number of FQHCs, look-a-likes and community clinics that currently exist in San Bernardino and Riverside counties in comparison to Los Angeles and Orange counties.

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

Response: IEHP currently uses multiple reimbursement methodologies to pay primary care physicians and specialists. All contracted IPAs are reimbursed on an age-sex banded capitation rate for professional, diagnostic, and ancillary services. The IPAs then subcontract to the PCPs, usually on a capitated basis, and specialty services are subcontracted on either a capitated or fee for service (FFS) basis. IEHP also operates a directly contracted provider network. Directly contracted primary care physicians are reimbursed either on a variable flat cap rate by product line or on a variable FFS basis by product line. Also, 85% of IEHP's product membership is capitated to a PCP, while 15% is FFS for primary care physician services.

Capitation and FFS rates vary depending upon the product line (i.e. Medi-Cal rates for the Medi-Cal population, Medicare rates for the Medicare population). IEHP intends to convert directly contracted physicians currently receiving a flat cap rate to an age-sex banded capitation rate consistent with the contracted IPAs effective January 2013. In addition, IEHP has an existing Pay for Performance (P4P) program offered to our primary care physicians currently in place for the Medi-Cal, Medicare SNP, and Healthy Kids populations that will remain in place and would also apply to the dual eligible under this Demonstration. The existing P4P program focuses on HEDIS criteria and preventative care measures such as breast cancer, cervical cancer and colorectal cancer screenings,

comprehensive diabetes care, and care for older adults. IEHP consistently reviews and monitors its P4P programs to evaluate outcomes, ensure relevancy to current HEDIS standards, and compare levels of provider participation.

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

Response: IEHP views our providers as key partners, with strong provider relationships built on 15+ years of trust and respect. IEHP has consistently offered our provider partners a steady source of membership growth and fair reimbursement rates for health care services since September, 1996. IEHP's longstanding reputation in the community serves as a key factor in influencing these non-contracted providers decision to participate in our products and programs. Inland Empire providers, both contracted and non-contracted alike, have come to recognize and appreciate IEHP's organizational stability in the healthcare market particularly since the economic downturn in the commercial market negatively impacted physician practices resulting in a significant loss of commercial membership and revenue. In fact, last year IEHP experienced several commercial based IPAs that historically did not participate in managed care Medi-Cal, approaching IEHP to pursue contracts for the Medi-Cal and Medicare SNP products. IEHP would also utilize a proactive provider outreach communication campaign approach to target primary care and specialty non-Medi-Cal providers,

particularly those serving the adult and geriatric populations (e.g. Internal Medicine), presenting IEHP's products and programs, and outlining the benefits of participation including potential opportunities for significant membership growth. IEHP anticipates that the change in Medi-Cal reimbursement methodology from Medi-Cal rates to Medicare rates targeted for January 2013 will be a critical factor for many providers considering Medi-Cal participation.

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

Response: IEHP's Quality Management and Provider Services Departments work collaboratively to conduct extensive physical office auditing and pre-service training for new Primary Care and Specialty providers prior to the provider rendering services to our Members. Every three (3) years or earlier if needed, Quality Management conducts physical office site audits and accessibility assessments of all Primary Care and high volume specialty providers, regardless of IPA affiliation or directly contracted, utilizing the DHCS PARS tool (adapted from ADA). IEHP Primary Care and specialty providers are contractually responsible to meet access standards based on DMHC and NCQA standards. Primary Care and high volume specialty providers are audited on an annual basis to ensure their accessibility is consistent with appointment and wait time standards. IEHP strives to ensure our Members experience positive interaction and

communication with their primary care and specialty physicians. The patient's overall experience in the provider's office is critically important to IEHP and helps us identify opportunities for provider improvement, and when our Members communicate less than satisfactory provider encounters, our Provider Services unit conducts immediate follow up, provider re-education and re-evaluation of the identified provider offices. In addition, IEHP hosts several group provider forums throughout the year designed to keep our provider community educated and up to date on new or changing health care standards, legislative updates, and new IEHP products and programs. These types of forums are also useful in allowing the provider community to openly share operational challenges as well as their best practices and lessons learned.

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

Response: The provider recruitment approach described above is also applicable to this question. With IEHP's broad outreach to new IPAs, safety net providers and individual physicians in the community, it's likely we will cover a good share of the medical community in these two counties. Providers currently working with the Demonstration population may likely be readily agreeable to joining the IEHP provider network because of their established physician-patient

relationships. To gain providers new to managed care, it will be important for IEHP to emphasize the full scope of responsibilities applicable to the dual eligible population, as well as the provider participation requirements inherent in a managed care HMO environment.

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

Response: IEHP currently offers a broad based contracted provider network spanning across two large counties (San Bernardino and Riverside), consisting of eleven (11) IPAs and directly contracted physicians totaling over 700 Primary Care Physicians and 1450 Specialty providers serving our Medi-Cal and Medicare DualChoice populations, 25 acute care hospitals, 34 Skilled Nursing Facilities (SNFs), 350 Behavioral Health Providers (188 MFTs, 104 M.Ds, 92 PhDs, 88 LCSWs), 600 Pharmacies (378 retail chain, 158 retail independent), and a full spectrum of ancillary service vendor agreements to support the health care delivery needs of our Members. Argus is IEHP's Pharmacy Benefit Manager, which manages the pharmacy network contracting, claims adjudication and payment on behalf of IEHP.

IEHP has a robust pharmacy program where the focus is a system designed to ensure our resources are used appropriately, ensure that the treatment is

optimized, improve overall quality of care, reduce adverse events and reduce overall medical costs. The primary focus is on the Pharmacy Quality Management program where we utilize current pharmacy data to assist physicians to optimize treatment to their patients. For Medicare Members, Pharmacists and Physicians may submit prior authorization for non-formulary medications. IEHP reviews the submitted documentation, communicates with the prescribing physicians, and then determines the final status of the request. The fact that we allow Pharmacists to submit a non-formulary request is different from the commercial standard. We allow Pharmacists to submit Prescription Exception Requests (PERs) for Medi-cal Members; therefore, we extend this arrangement to Medicare Members as well. If all necessary information is received, we will make a determination within one (1) business day. We have two Pharmacy units within IEHP; one is Operations, headed by the Pharmacy Operations Manager. There are three Supervisors and 25 Pharmacy Program Specialists. Their responsibilities include: PER review, call center for Pharmacy and Physician offices, provide support to internal departments such as MSR, UM, CM, claims; Physician claims review. The second unit is the Clinical Pharmacy team, consisting of a Pharmacy Utilization Manager, Clinical Pharmacist and Pharmacy Report Specialist. Their responsibilities include: P&T review, formulary review, utilization review, and all clinical programs and reports. The Director of Pharmacy Services, Dr. Chris Chan, responsible for the overall

development of Pharmacy Services, is supported by support staff consisting an AA, one Pharmacy analyst and one pharmacy project specialist.

The IEHP Behavioral Health (BH) provider network interfaces electronically with Primary Care Physicians in that all BH providers are required to submit electronic Coordination of Care reports that, along with the members signed release of information are delivered securely to the PCP to facilitate real-time communication and coordinated treatment planning. We also contract with Substance Abuse Intensive Outpatient Programs (IOP) and have contracts with eight (8) psychiatric hospitals to provide acute, partial and IOP levels of care. We also have co-located a psychiatrist and a psychologist in an FQHC to facilitate our integrated treatment model. All BH providers are reimbursed on a FFS basis. The current BH provider network adequately meets IEHP's enrollment capacity and access needs. Interested BH providers submit surveys which we maintain in our database for possible later addition to the network.

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

Response: Refer to the RFS Certification Check List.

Question 7.8 Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long

term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Response: Refer to the RFS Certification Check List.

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

Response: Refer to the RFS Certification Check List.

Section 7.2: Technology

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

Response: In order to effectively utilize technology to provide quality care, IEHP has worked with the local medical associations and hospitals to establish the Inland Empire EHR Resource Center (IEEHRC), a Local Extension Center (LEC) that assists providers and clinics to select and implement electronic medical record (EMR) systems and meet meaningful use standards. The IEEHRC supports providers by assisting in vendor selection, workflow design, meaningful use reporting, readiness and workflow assessment, and project planning. The development of health information technology (HIT) and the use of EMR systems will enhance health care decision making and access to patient information across

several healthcare providers, proving essential when caring for dual eligibles. This technology will reduce unnecessary tests, errors, and costs while increasing quality, safety, and efficiency.

Additionally, IEHP consistently develops applicable support tools and services relevant to the needs of our providers. Through our secure provider online services, healthcare providers and office staff can access timely, comprehensive, and relevant care information. They can view the status of authorizations and claims and a wide variety of patient information, such as member health records, eligibility and lab results, preventive care alerts, medical visits, hospital visits, behavioral health visits, calls to the 24-hour Nurse Advice Line, and care plans. We plan to build upon our current provider online services, continuing to add tools and resources that will assist providers in caring for the medical, social, and long-term needs of dual eligibles. For example, a member's care plans are online for providers to review with their IEHP member. Annual visits are also posted on the member's health record as well as any chronic illness like diabetes. For example, IEHP plans to develop a health data warehouse to collect and share appropriate health information of the dual eligibles with the HCB services programs to assist in the determination of initial eligibility, on-going maintenance of eligibility and renewal of eligibility. The type of data that would be available is cognitive,

mobility and functional status, medical care/diagnoses, etc. In this way, IEHP will be able to meet the total needs of the dual eligible.

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

Response: IEHP intends to utilize care technology in the Demonstration Project for beneficiaries at very high risk of nursing home admission by identifying the IHSS recipients who have the greatest health care needs and are at most risk of entering a nursing home. IEHP will then conduct an intensive health assessment that combines the county-based IHSS assessment for determination of functional and mobility status with a broader health, social and psychological assessment. This could be done via the Health Risk Assessment (HRA) once the member joins the plan. Next, IEHP would integrate the findings in the Care Plan and share with the member, and ICT members. IEHP would also look to IHSS data and state data on the member's care history. Ideally, this information would be included in a data warehouse that IEHP would develop, for all providers who care for the members to review.

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

Response: To meet information exchange standards, IEHP is part of the Inland Empire HIE (IEHIE), a health information exchange initiative supported by 29 partner hospitals, physician groups, medical groups and IPAs. Open to all Inland Empire providers, the exchange actively seeks to connect with other existing health information exchanges and technology systems. The capacity to connect several facets of the healthcare system through a health information exchange allows IEHP to provide more coordinated, long-term care to the dual eligible. IEHP will continue to recruit physicians to join the HIE and adopt EHR systems.

The HIE connects PCPs, hospitals, and other partners in exchanging data on patients. An exchange is also integral to achieving/demonstrating meaningful use. To this date the HIE has a core group of hospitals, medical groups and IEHP that have:

- participated in design and governance policy discussions
- retained a consultant firm to develop, release, and evaluate an RFP for a partner to host the HIE services identified a collectively acceptable approach to the HIE

IEHP will continue to develop the HIE to include more partner hospitals, physicians, and other healthcare providers to fully integrate all patient medical information across all healthcare settings to ultimately improve the delivery of care and coordination of services.

Section 8: Monitoring and Evaluation

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

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

Response: IEHP currently has the capacity and capability to track and report on enrollee satisfaction, self-reported health status, access to care, condition-specific quality measures and risk-adjusted mortality rates. We have a dedicated team, the Healthcare Analytics & Reporting (HAR) Department, along with other collaborating departments, that are responsible for pulling and analyzing all data related to member care and services provided. We will also have the capacity to pull encounter data for HCBS and behavioral health services. The following are examples of the current tools used to track and report quality measures.

IEHP currently uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to track and report on member satisfaction. CAHPS is a National Committee for Quality Assurance (NCQA) required standardized assessment of consumer satisfaction regarding a member's healthcare. The survey allows health plans to identify potential opportunities for improving members' experiences in areas such as: overall satisfaction, average wait times, physician availability, and obstacles to receiving care.

To identify and track the self-reported health status of members, IEHP uses a Health Risk Assessment (HRA) tool with all DualChoice and SPD members. The HRA survey has two sections: medical and functional status and the behavioral health care (psychosocial and cognitive) status of the member. The HRA survey questionnaire includes but is not limited to the following elements:

1) Assessment of members' health status including condition-specific issues and documentation of clinical and medical history including medications.
2) Assessment of members' medical care needs, such as primary care, specialty care, durable medical equipment, transportation, health education, physical or cognitive barriers to healthcare access.

3) Assessment of members' daily living activities, including assisting with self-management skills or techniques, and life-planning activities such as advanced directive or living will.
4) Evaluation of members' caregiver resources and involvement, and available benefits.
5) Assessment of members' mental health status, including cognitive functions.
6) Assessment of members' cultural and linguistic needs, preferences or limitations.
7) Evaluation of members' visual and hearing needs, preferences or limitations.
8) Assessment of members' needs for community resource or agency referrals, such as mental health, behavioral health, In Home Supportive Services, Meals on Wheels, Inland Regional Center, Housing Authority Section 8, Senior Community Center, Alcohol or Substance Abuse Treatment Services, etc.

The completed HRA stratifies the member into one of three risk levels (high, moderate, or low) to identify the different levels of need for care management and development of care plans.

IEHP contractually requires providers to submit all utilization and encounter data to IEHP within 3 months from when the services were rendered. Providers are required to submit this data to enable IEHP to comply with regulatory requirements, to accurately capture data for various medical programs, and to help improve medical and financial performance. All providers must meet timeliness, validity, and adequacy requirements for all encounter data submissions to IEHP.

IEHP monitors access through a variety of means, such as annual studies, an appointment availability study, grievances and appeals, satisfaction studies, and utilization data monitoring. The goal is to ensure that IEHP has a sufficient number and types of providers within our service areas that can serve the cultural, ethnic, racial, and linguistic needs of our members. The access studies also assess a member's ability to receive timely access to care.

The examples of various quality measures above are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. IEHP reviews and evaluates, on not less than a quarterly basis, the information available to the plan regarding accessibility and availability. IEHP measures performance against community, national or internal baselines and benchmarks when available, and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews. The

HAR Department is responsible for study design, barrier analysis, and interpretation for all studies conducted for IEHP. HAR is also responsible for collecting and reporting HEDIS data that is required for NCQA accreditation. Sources of data include, but are not limited to, medical records, claims data, utilization management activities, encounter data, grievance data, pharmaceutical utilization data, and access assessments. Data is quantified, analyzed, and interpreted to identify trends, variances, improvements, and improvement opportunities. Findings are reported to the Quality Management Committee. Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements. Specific performance feedback regarding actions or data is communicated to providers.

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

Response: IEHP has the capability to report beneficiary outcomes by demographic characteristics, specifically by age, preferred language, disability, ethnicity, race, and gender. We have current reports that are produced by our HAR Department that illustrate outcomes by demographic characteristics. For example, every year, we conduct the Cultural and Linguistic Study. The purpose of this

study is to identify the linguistic and ethnic diversity of IEHP's provider and member populations to determine if members' cultural and linguistic needs are met. The results of the study are broken down by category and specifically report the top languages and distribution of race/ethnicity for IEHP members. Additionally, IEHP annually completes the Cultural and Linguistic Group Needs Assessment (GNA) report in accordance with regulatory guidelines. Since IEHP has processes in place to report outcomes by demographic characteristics for all of our current programs, we will also be able to provide similar reports for the dual eligibles.

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

Response: Refer to the RFS Certification Check List.

Section 9: Budget

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

Response: IEHP requests the following infrastructure support that could help facilitate integration of LTSS and behavioral health services:

1) Providing clarification on future funding sources for the IHSS program when it moves to managed care. Specifically, what is the impact from the Demonstration Project to the local county funding contribution to the IHSS program?
2) Further guidance on integration of the IHSS program for Year 2 and Year 3.
3) Further guidance on integration of the MSSP program for Year 1, 2 and 3.
4) More information and guidance about other Medi-Cal Waivers programs that DHCS intends to include in the Demonstration Project.
5) Providing utilization data about LTSS and behavioral health services, including substance abuse.
6) Providing initial funding for the development of a system to share behavioral health data between the county behavioral health program and health plan.

ATTACHMENTS

List of Attachments

Attachment A: Knox Keene License

Attachment B: Letter of financial standing with DMHC

Attachment C: Medi-Cal HEDIS Results for 2009-2011

Attachment D: Medicare HEDIS Results for 2009-2011

Attachment E1: Dual PPPC Bylaws

Attachment E2: Five Letters of Support from the community:

1. Riverside Family Physicians
2. IEDC co-chairman
3. Inland Regional Center (IRC)
4. Community Access Center
5. Member

Attachment E3: Stakeholder Engagement Document

Attachment F: Letter from Riverside County Department of Mental Health

Letter from Rolling Start, Inc. Center for Independent Living in San Bernardino County

	Letter from Community Access, Center for Independent Living in Riverside County
Attachment G:	MOU with San Bernardino county Behavioral Health Agency
	MOU with Riverside county Behavioral Health Agency
Attachment H:	Diabetes Self Guide
Attachment I:	Asthma Self Guide
Attachment J:	Letter of Agreement with American Forensic Nurses, Inc.
Attachment K:	SNP Model of Care Elements and Standards
Attachment L:	Organizational Chart
Attachment M:	Resume of the Duals Demonstration Project Manager
Attachment N:	Letter of Non-Support from County of Riverside Department of Public Social Services
Attachment O:	Letter of Concern from County of San Bernardino

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

NONTRANSFERRABLE

LICENSE

HEALTH CARE SERVICES PLAN

File No. 933-0346

Licensee: Inland Empire Health Plan
1200 E. Cooley Drive, Ste. 100
Colton, California 92324

IS HEREBY LICENSED AS A FULL SERVICE HEALTH CARE SERVICE PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975, AS AMENDED ("ACT"), AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A FULL SERVICE HEALTH CARE PLAN TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES WITHIN THE STATE OF CALIFORNIA, COUNTIES OF RIVERSIDE AND SAN BERNARDINO, SUBJECT TO THE PROVISIONS OF THE ACT AND THE RULES OF THE COMMISSIONER OF CORPORATIONS ADOPTED PURSUANT THERETO, UNTIL SUCH TIME AS THIS LICENSE IS SUPENDED OR REVOKED BY ORDER OF THE COMMISSIONER, OR IS SURRENDERED. THE PLAN'S SERVICE AREA IS DEFINED BY THE LIST OF ZIP CODES ATTACHED HERETO. THE LICENSE IS

SUBJECT TO THE UNDERTAKINGS ATTACHED HERETO. THE LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

Dated: July 22, 1996
Los Angeles, California

KEITH PAUL BISHOP
Commissioner of Corporations

By _____
ANITA J. OSTROFF

INLAND EMPIRE HEALTH PLAN
Exhibit E-1-a

SUMMARY OF INFORMATION IN APPLICATION

SUMMARY OF UNDERTAKINGS TO BE PERFORMED
BY INLAND EMPIRE HEALTH PLAN

Inland Empire Health Plan (IEHP) undertakes to provide the following Amendments to its Knox Keene Application to fulfill any remaining deficiencies under the rules promulgated by the Commissioner of Corporations thereunder.

1. Within sixty (60) days of the date of licensure, IEHP will submit an amendment to Exhibit J, namely J-6, to provide a readily understood disclosure demonstrating compliance with Section 1363.5 of the Knox Keene Act. This aforementioned Amendment shall be filed in order to provide a concise and coherent disclosure of the process used to authorize or deny health care services under the benefits provided by IEHP.

2. Within sixty (60) days of the date of licensure, IEHP will submit an Amendment to Exhibit F-1-e-i, evidencing appropriate adoption of the previously submitted amendments to Resolutions 96-45 and 96-14 of the Joint Powers Agreement. IEHP previously submitted amendments to the Joint Powers Agreement subject to verification to demonstrate compliance with the Knox Keene Act. These amendments will be executed by the Boards of Supervisors of the respective counties on July 23rd, 1996 and submitted thereafter.

3. Within thirty (30) days of its execution, a copy of the executed contract entered into between IEHP and the State of California Department of Health Services to provide health

care services to both mandatory and certain non-mandatory Medi-Cal aid-code beneficiaries in Riverside and San Bernardino Counties will be submitted as Exhibit P. This will appropriately amend the proposed agreement form previously submitted by IEHP.

4. Prior to accepting any enrollment of Medi-Cal beneficiaries, IEHP will submit an amended Exhibit HH-6-a demonstrating to the satisfaction of the Commissioner of Corporations, evidence of adequate insurance coverage or self insurance to respond to claims for damages arising out of furnishing health care services (malpractice insurance). As previously submitted the Errors and Omissions insurance Policy will be in effect six (6) days prior to September 1. IEHP will submit an executed insurance policy at this time.

5. IEHP will provide payment in full for any invoice for licensing fees from the Department of Corporations, within five (5) business days of receipt.

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-c

Geographical Areas Served

DESCRIPTION OF SERVICE AREA

SAN BERNARDINO COUNTY INCLUDED AREAS

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-1	Greater San Bernardino Area (Metro)		
1	92313	Grand Terrace		
2	92316	Bloomington	Crestmore	
3	92324	Colton		
	~~92334~~	~~Colton~~		
4	92335	Fontana		
5	92336	Fontana		
6	92337	Fontana		
7	92346	Highland	East Highland	
8	92369	Patton		
9	92376	Rialto		
10	92377	Rialto		
11	92401	San Bernardino		
12	92402	San Bernardino		
13	92403	San Bernardino		
14	92404	San Bernardino	Arrowhead Springs	Del Rosa
15	92405	San Bernardino	Muscoy	
16	92406	San Bernardino		
17	92407	San Bernardino	Devore	Verdemont
18	92408	San Bernardino		
19	92410	San Bernardino		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-c

20	92411	San Bernardino		
21	92412	San Bernardino		
22	92413	San Bernardino		
23	92414	San Bernardino	Camp Crusade	
24	92415	San Bernardino		
25	92416	San Bernardino		
26	92418	San Bernardino	City Hall	
27	92420	San Bernardino	Shearson Lehman	
28	92423	San Bernardino	GMF	
29	92424	San Bernardino	Campus Crusade	
30	92427	San Bernardino	North Park	

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-2	West San Bernardino County Area		
1	91701	Alta Loma		
2	91708	Chino		
3	91709	Chino Hills	Los Serranos	
4	91710	Chino	Sleepy Hollow	
5	91729	Rancho Cucamonga		
6	91730	Rancho Cucamonga	Cucamonga	
7	91737	Alta Loma		
8	91739	Etiwanda		
9	91743	Guasti		
10	91758	Ontario		
11	91759	Mount Baldy		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-c

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-2	West San Bernardino County Area		
12	91761	Ontario	Creekside	
13	91762	Ontario		
14	91763	Montclair		
15	91764	Ontario		
16	91766	Pomona		
17	91784	Upland		
18	91785	Upland		
19	91786	Upland		
20	91798	Ontario	San Antonio Heights	

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-3	Redlands Area		
1	92318	Bryn Mawr		
2	92350	Loma Linda University		
3	92354	Loma Linda		
4	92357	Veteran’s Hospital		
5	92359	Mentone	Mountain Home Village	
6	92373	Redlands		
7	92374	Crafton		
8	92375	Redlands		
9	92399	Yucaipa	Oak Glen	

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-c

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-3	Redlands Area		
10	92409	Norton Air Force Base	San Bernardino	

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	C-4	North West County Area (High Desert)		
1	92301	Adelanto		
2	92307	Apple Valley	Desert Knolls	
3	92308	Apple Valley		
5	92340	Hesperia		
6	92345	Hesperia		
	~~92356~~	~~Lucerne Valley~~		
	~~92368~~	~~Oro Grande~~		
7	92371	Phelan		
	~~92372~~	~~Pinon Hills~~	~~Pinon Valley~~	
8	92392	Victorville	George A.F. Base	Spring Valley
9	92393	Victorville		
10	92394	Victorville		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-d

Geographical Areas Served

DESCRIPTION OF SERVICE AREA

SAN BERNARDINO COUNTY EXCLUDED AREAS

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	D-1	Excluded Areas		
1	92242	Big River	Earp	
2	92252	Joshua Tree		
3	92256	Morongo Valley		
4	92267	Parker Dam		
5	92268	Pioneer Town	Rimrock	
6	92277	Twenty-nine Palms		
7	92278	Marine Corp Base	Twenty-nine Palms	
8	92280	Rice	Vidal Junction Vidal	
9	92284	Yucca Valley		
10	92285	Landers		
11	92286	Yucca Valley		
12	92304	Amboy		
13	92305	Angelus Oaks	Barton Flats	
14	92309	Baker	Kelso	
15	92310	Fort Irwin		
16	92311	Barstow	Lenwood	
17	92312	Barstow		
18	92314	Big Bear City		
19	92315	Big Bear Lake	Moonridge	
20	92317	Blue Jay		
21	92319	Cadiz		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-d

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	D-1	Excluded Areas		
22	92321	Cedar Glen		
23	92322	Cedarpines Park	Valley of Enchantment	
24	92323	Cima		
25	92325	Crestline		
26	92326	Crest Park		
27	92327	Daggett		
28	~~92329~~	~~Phelan~~		
29	92332	Essex	Goffs	
30	92333	Fawnskin	Minnelusa	
31	92338	Ludlow		
32	92339	Forest Falls		
33	92341	Green Valley Lake		
34	92342	Helendale	Silver Lakes	
35	92347	Hinkley		
36	92351	Kelso		
37	92352	Lake Arrowhead		
39	92358	Lytle Creek	Cajon Junction	
	Keenbrook			
40	92363	Needles		
41	92364	Nipton	Ivanpah	
42	92365	Newberry Springs		
43	92366	Mountain Pass		
	~~92371~~	~~Phelan~~		
46	92378	Rimforest		
47	92382	Running Springs	Fredalba	Arrowbear
Lake				

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-d

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	D-1	Excluded Areas		
48	92385	Sky Forest		
49	92386	Sugar Loaf		
50	92391	Twin Peaks		
51	92397	Wrightwood		
52	92398	Yermo		
	~~93555~~	~~Ridgecrest~~		
55	93558	Red Mountain		
56	93562	Trona	Argus/Westend Borosolvay	
	~~93592~~	~~Trona~~		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-a

Geographical Areas Served

DESCRIPTION OF SERVICE AREA

RIVERSIDE COUNTY EXCLUDED AREAS

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-1	Greater Riverside Area (Metro)		
1	91718	Corona		
2	91719	Corona		
3	91720	Corona		
4	91752	Mira Loma		
5	91760	Norco		
6	92501	Riverside		
7	92502	Riverside		
8	92503	Riverside	La Sierra	
9	92504	Riverside		
10	92505	Riverside		
11	92506	Riverside		
12	92507	Riverside		
13	92508	Riverside		
14	92509	Riverside	Pedley	Jurupa
15	92513	Riverside		
16	92514	Riverside		
17	92515	Riverside		
18	92516	Riverside		
19	92517	Riverside		
20	92518	Riverside	March Air Force Base	

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-a

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-1	Greater Riverside Area (Metro)		
21	92519	Riverside		
22	92521	Riverside	UCR	
23	92522	Riverside	City Light & Water	
24	92551	Moreno Valley		
25	92552	Moreno Valley		
26	92553	Moreno Valley		
27	92554	Moreno Valley		
28	92555	Moreno Valley		
29	92556	Moreno Valley		
30	92557	Moreno Valley		

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-2	Beaumont/Banning Area		
1	92220	Banning		
2	92223	Beaumont		
3	92230	Cabazon	Morongo	
4	92320	Calimesa	Cherry Valley	
5	92549	Idyllwild	Pine Cove	

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-a

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-3	San Jacinto Valley Area		
1	92543	Hemet		
2	92544	Hemet		
3	92545	Hemet	Green Acres	
4	92546	Hemet		
5	92548	Homeland		
6	92561	Mountain Center		
7	92581	San Jacinto		
8	92582	San Jacinto		
9	92583	San Jacinto		
10	92596	Winchester		
11	92599	Starcrest		

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-4	Southern Riverside County Area		
1	92530	Lake Elsinore		
2	92531	Lake Elsinore		
3	92532	Lake Elsinore		
4	92536	Aguanga		
5	92539	Anza	Cabuilla	Terwilliger
6	92562	Murrieta		
7	92563	Murrieta	Murrieta Hot Springs	
8	92564	Murrieta		
9	92567	Nuevo	Lakeview	

INLAND EMPIRE HEALTH PLAN

Exhibit H-1-a

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-4	Southern Riverside County Area		
10	92570	Perris		
11	92571	Perris		
12	92572	Perris		
13	92584	Menifee		
14	92585	Sun City	Romoland	
15	92586	Sun City		
16	92587	Sun City	Canyon Lake	
17	92589	Temecula		
18	92590	Temecula		
19	92591	Temecula		
20	92592	Temecula	Rancho CA	
21	92593	Temecula		
22	92595	Wildomar		

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-5	Central Riverside County Area (Low Desert)		
1	92201	Indio	Bermuda Dunes	
2	92202	Indio	Bermuda Dunes	
3	92203	Indio	Bermuda Dunes	
4	92210	Indian Wells		

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-a

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	A-5	Central Riverside County Area (Low Desert)		
5	92211	Palm Desert		
6	92234	Cathedral City		
7	92235	Cathedral City		
8	92236	Coachella		
9	92240	Desert Hot Springs		
10	92241	Desert Hot Springs		
11	92253	La Quinta		
12	92254	Mecca		
13	92255	Palm Desert		
14	92258	North Palm Springs	Sky Valley	
15	92260	Palm Desert		
16	92261	Palm Desert		
17	92262	Palm Springs		
18	92263	Palm Springs		
19	92264	Palm Springs		
20	92270	Rancho Mirage		
21	92274	Thermal	North Shore	Salton Sea
22	92276	Thousand Palms		
23	92282	Whitewater	San Gorgonio	

INLAND EMPIRE HEALTH PLAN
Exhibit H-1-b

Geographical Areas Served

DESCRIPTION OF SERVICE AREA

RIVERSIDE COUNTY EXCLUDED AREAS

#	Zip Code	City Name	Cross Ref.	Cross Ref.
	B-1	Excluded Areas		
1	92225	Blythe		
2	92226	Blythe		
3	92239	Desert Center		
4	92272	Ripley		
5	92280	Blythe		

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
Department of Managed Health Care
980 9th Street. Suite 500
Sacramento, CA 95814-2725
Phone: 916-445-7401
Email: reuren@dmhc.ca.gov

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Joyce McShan
Compliance Manager
Inland Empire Health Plan
303 East Vanderbilt Way, Suite 400
San Bernardino, CA 92408

Re: Letter of Standing – Inland Empire Health Plan

Dear Ms. McShan:

On January 30, 2012, you requested a letter regarding Inland Empire Health Plan's ("IEHP") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] IEHP 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, IEHP is licensed, and permitted to operate in the State of California, as a Knox-Keene health care service plan.

[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.

A review of the Enforcement Action Database shows that there is currently 1 enforcement action involving IEHP. Of those, 1 involves grievance system violations; zero regard 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 IEHP and IEHP is currently in compliance with the Department's financial solvency requirements, including Tangible Net Equity ("TNE) and financial viability.

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for IEHP was issued on December 22, 2009. There were no identified deficiencies from this Routine Medical Survey. The next Routine Medical Survey is due by August 12, 2012.

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
Kelly Gaspar, Division of Licensing
Tracy Chen, Division of Financial Oversight

Inland Empire Health Plan Medi-Cal HEDIS Results			
Measure	**2009**	**2010**	**2011**
Comprehensive Diabetes Care			
HbA1c Testing	80.2%	79.4%	79.5%
Poor HbA1c Control	46.9%	45.3%	43.8%
Eye Exams	50.2%	52.6%	42.3%
LDL-C Screening	79.5%	79.4%	79.7%
LDL-C Level <100 mg/dL	36.9%	36.0%	37.4%
Monitoring for Diabetic Nephropathy	78.7%	81.0%	80.3%
Blood Pressure Control <140/80mm Hg[3]			53.2%
Blood Pressure Control <140/90mm Hg	61.1%	71.3%	70.9%
Cardiovascular Conditions			
Controlling High Blood Pressure	65.4%	60.8%	67.7%
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	80.0%	81.0%	82.7%
LDL-C Level <100 mg/dL	36.5%	39.9%	44.2%
Pediatric Health			
Adolescent Well-Care Visits	40.1%	45.1%	43.1%
Well-Child Visits 3rd - 6th Years of Life	73.2%	74.1%	74.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI Screening		67.4%	57.6%
Counseling on Nutrition		69.0%	66.0%
Counseling on Physical Activity		61.3%	38.2%
Childhood Immunizations Combo 2	75.7%	75.5%	75.9%
Childhood Immunizations Combo 3	69.7%	70.1%	69.4%
Children & Adolescents' Access to PCPs Ages 12-24 Months	96.3%	96.6%	96.9%
Ages 25 Months – 6 Years	86.4%	87.1%	87.3%
Ages 7 – 11 Years	80.2%	82.0%	82.9%
Ages 12 – 19 Years	77.0%	77.8%	80.2%

Inland Empire Health Plan Medi-Cal HEDIS Results, continued			
Measure	**2009**	**2010**	**2011**
Respiratory Conditions			
Use of Appropriate Medications for People with Asthma[2] Ages 5-11		89.8%	89.5%
Ages 12-50		84.9%	82.6%
Combined	88.3%	86.8%	85.5%
Appropriate Testing for Children with Pharyngitis	16.3%	19.1%	21.8%
Appropriate Treatment for Children with Upper Respiratory Infection	85.7%	88.0%	88.4%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	29.9%	26.3%	23.9%
Women's Health			
Breast Cancer Screening	49.0%	50.6%	51.2%
Cervical Cancer Screening	61.9%	69.7%	71.7%
Chlamydia Screening in Women Ages 16 - 20	56.5%	56.3%	54.4%
Ages 21 - 24	61.4%	62.8%	61.4%
Timeliness of Prenatal Care	84.5%	86.7%	85.1%
Postpartum Care	57.1%	60.8%	62.9%

Inland Empire Health Plan Medicare HEDIS Results				
Measure		**2009**	**2010**	**2011**
Comprehensive Diabetes Care				
HbA1c Testing		80.89%	82.13%	83.09%
Poor HbA1c Control		39.63%	38.28%	37.42%
Eye Exams		58.28%	53.36%	58.56%
LDL-C Screening		82.98%	82.60%	84.57%
LDL-C Level <100 mg/dL		43.36%	43.16%	45.67%
Monitoring for Diabetic Nephropathy		86.48%	86.77%	84.99%
Blood Pressure Control <140/80mm Hg[3]		34.03%	34.11%	52.64%
Blood Pressure Control <140/90mm Hg		64.80%	65.66%	74.21%
Cardiovascular Conditions				
Controlling High Blood Pressure		59.71%	65.01%	70.20%
Cholesterol Management for Patients with Cardiovascular Conditions: *LDL-C Screening*		81.16%	84.82%	83.82%
	LDL-C Level <100 mg/dL	39.13%	48.21%	43.93%
Adult Health				
Adult BMI Assessment (ABA)		20.65%	31.93%	46.30%
Annual Monitoring for Patients on Persistent Medications (MPM)	*ACE Inhibitors or ARB's*	76.02%	86.27%	89.73%
	Digoxin			94.29%
	Diuretics	77.39%	86.84%	88.38%
	Anticonvulsants	68.00%	73.33%	69.88%
	TOTAL	75.71%	85.36%	86.80%
Breast Cancer Screening		48.06%	55.64%	55.42%
Care for Older Adults	*Advance Care Planning*	9.03%	15.78%	16.20%
	Medication Review	59.95%	52.90%	77.08%
	Functional Status Assessment	13.66%	12.30%	31.48%
	Pain Screening	41.20%	19.26%	12.50%
Colorectal Cancer Screening			38.46%	40.05%
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis			63.16%	69.35%
Glaucoma Screening in Older Adults			54.43%	58.12%
Medication Reconciliation Post-Discharge		42.61%	28.18%	25.93%
Pharmacotherapy Management of COPD Exacerbation	*Systemic Corticosteroid*	26.67%	16.28%	57.45%
	Bronchodilator	76.67%	83.72%	87.26%
Use of High-Risk Medications in the Elderly	*One Prescription*	33.10%	35.72%	33.96%
	At Least Two Prescriptions	10.12%	10.21%	10.93%

Inland Empire Health Plan Medicare HEDIS Results, continued				
Measure		**2009**	**2010**	**2011**
Behavioral Health				
Antidepressant Medication Management	*Effective Acute Phase*			69.70%
	Effective Continuation Phase			69.70%
Follow-Up After Hospitalization for Mental Illness	*7-Day Follow-Up*	35.00%	37.14%	25.56%
	30-Day Follow-up	15.00%	50.00%	12.22%
Initiation and Engagement of AOD Dependence Treatment	*Initiation of AOD Treatment*	43.90%	48.57%	61.81%
	Engagement of AOD Treatment	7.32%	7.14%	11.81%
Service/Access				
Adults' Access to Preventive/Ambulatory Health Services (AAP)	*20-44 Years*	82.20%	83.41%	85.92%
	45-64 Years	89.98%	89.64%	92.52%
	65+ years	89.99%	89.66%	91.18%
	TOTAL	87.23%	87.96%	90.39%
Call Answer Timelines		29.30%	79.32%	92.76%
Call Abandonment		2.89%	2.32%	0.88%
Plan All-Cause Readmissions				17.86%

INLAND EMPIRE HEALTH PLAN

PUBLIC POLICY PARTICIPATION COMMITTEE

FOR DUAL ELIGIBLE MEMBERS

BYLAWS

Effective Date:

January 1, 2013

TABLE OF CONTENTS

BYLAWS

OF THE INLAND EMPIRE HEALTH PLAN

PUBLIC POLICY PARTICIPATION COMMITTEE (PPPC)

FOR DUAL ELIGIBLE MEMBERS

In order to provide for an efficient and expeditious handling of public business, and of the business of the Inland Empire Health Plan (IEHP), the following Bylaws are promulgated for the establishment of a Public Policy Participation Committee for dual eligible members.

I. ESTABLISHMENT AND BACKGROUND OF THE PUBLIC POLICY PARTICIPATION COMMITTEE FOR DUAL MEMBERS

In coordination with the Federal Government, the California Department of Health Care Services is planning a Dual Eligible Demonstration Project to be launched in January 2013 to examine the benefits of coordinated care models. By enrolling dual eligibles into coordinated care delivery models, this three-year Demonstration (2013 to 2015) aims to test how aligning financial incentives around beneficiaries can drive streamlined, beneficiary-centered care delivery and can rebalance the current health care system away from avoidable institutionalized services and toward enhanced provision of home- and community-based services.

As part of the Dual Eligible Demonstration Project, more individuals with both Medi-Cal and Medicare will enroll in IEHP. As such, IEHP deems it necessary to establish a Public Policy Participation Committee for these dual eligible members to promote a dialogue between itself and its members and the community.

II. FUNCTION OF THE PUBLIC POLICY PARTICIPATION COMMITTEE FOR DUAL ELIGIBLE MEMBERS

a. The function of the Committee is to:

- Review changes in IEHP's policies or procedures that could impact members;
- Provide updates on state policies or issues that affect IEHP and its members;
- To allow committee members to have input on issues that have an impact on them (i.e. marketing materials, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, IEHP website, etc.);
- Periodically review the IEHP grievance process;
- To present and gather feedback on the IEHP website, covering content organization and navigation of the Member Portal;

- To allow committee members to share their experiences in getting care (medical, behavioral health, and long term support services) that will help IEHP improve how care is delivered;
- To advise on educational and operational issues affecting groups who speak a primary language other than English;
- To advise on cultural competency and general communications issues.

b. Committee Members will:

IEHP Members:

- Help IEHP understand how to meet the health needs of dual eligible members.
- Provide recommendations on:
  - Health care services
  - Educational priorities
  - Communication needs
  - Coordination and access to services

IEHP Staff:

- Provide IEHP committee members with state updates.
- Provide IEHP committee members with IEHP updates (products, programs, etc.).
- Solicit feedback from all committee members on policies.

- Preview advertising, marketing, and member materials.

III. MEETINGS

a. The Public Policy Participation Committee for dual eligible members shall meet routinely at least quarterly.

b. Special meetings may be called at any time.

c. The meetings shall begin at 12:00 p.m.

d. The business of the Public Policy Participation Committee for dual eligible members shall be taken-up for consideration and disposition in the following order, although the order may be altered by necessity:

1) Call to Order - Chairperson
2) Introductions (optional)
3) Approve the Minutes (Prior Meeting)
4) Consent Calendar
5) Reports, Discussions and Action Items
6) Adjournment

The order of business as noted above may be changed for any purpose during a meeting by the Chairperson.

e. The Communications Coordinator, or his or her designee, shall attend all meetings of the Public Policy Participation Committee for dual members, unless excused.

IV. AGENDAS

Agendas for the Public Policy Participation Committee for dual members shall be prepared by the Chief Marketing Officer, with input as needed from the Chief Executive Officer or other staff, who shall be responsible for determining when and what items are to be included.

V. MINUTES

a. In-depth minutes are recorded and transcribed for all meetings, with review by the Communications Coordinator and the Chief Marketing Officer. The minutes include the hours and place of the meeting, notice of the meeting, names of the committee members and staff present and absent are included, committee activities, reports, written communication, recommendations, findings, and all other discussions that take place. Minutes are dated and then signed by the Chief Executive Officer.

b. Written reports or other written forms of communication submitted at a committee meeting shall be included in the minutes with a record of action, if any.

c. Unless the reading of the minutes of the committee meeting is requested by a committee member, such minutes may be approved without reading if a copy thereof has been previously provided to each committee member.

VI. PROCEDURE

In the event a dispute arises concerning conduct and/or procedural matters not specifically addressed herein, then the Chairperson may resolve and otherwise rule on the matter(s).

VII. COMPOSITION

The Public Policy Participation Committee for dual members is delegated by the IEHP Governing Board to oversee the public policy activities of IEHP. The committee is comprised of IEHP members and IEHP staff. The committee will consist of thirty (30) voting dual members, 6 or who must be bilingual. The committee shall be chaired by the Chief Marketing Officer (CMO) and shall make recommendations and report findings to the Governing Board of IEHP. Potential

quality issues are referred to the Chief Medical Officer for review and action as indicated.

IEHP Members

- Thirty (30) IEHP'S dual eligible members

Chairperson

- Chief Marketing Officer

Secretary

- Communications Coordinator

Standing Committee Members

- Chief Executive Officer
- Clinical Director of Behavioral Health
- BH Care Managers & Specialists
- LTSS Director/Manager
- Director of Health Administration
- Care Managers (MOC)
- Disability Program Manager
- Medical Director
- Director of Marketing
- Director of Member Services
- Director of Community Outreach

- Health Education Manager

Committee members must be an active IEHP enrolled dual eligible member. The membership will reflect the geography of the IEHP network.

VIII. TERM

IEHP staff attends as permanent members of the committee. The full term for a dual member in the committee is two (2) years. The initial term(s) of the dual members in the committee are staggered to ensure consistent committee operation. Half of the membership is rotated each year. Members may serve additional terms. The determination of whether any member may serve additional term(s) is at the sole discretion of the Chief Executive Officer (CEO) and the Chief Marketing Officer.

IX. CODE OF CONDUCT

Purpose Statement: To provide members of the Public Policy Participation Committee (PPPC) for dual eligible members standards of behavior during meetings.

a. Personal Responsibilities

- Be on time to all meetings.
- Take an active part in committee discussions.
- Act in a safe, courteous, and respectful manner at all meetings.
- Be culturally sensitive to everyone at all times. This includes IEHP members, staff, and others individuals at the meeting.
- Be aware and sensitive to the healthcare needs of others.
- Behave in ways that allow others the chance to be heard and have their ideas considered.
- Do not reveal Personal Health Information (PHI) during meeting discussions.
- Be accountable for your opinions and feedback. Fellow members should not feel ridiculed, uncomfortable, or threatened.
- Be respectful of other's opinions, feedback, and comments.
- Comply with the Code of Conduct.

b. Policy

- The purpose of the PPPC is to provide a mechanism for structured input from IEHP dual members regarding how IEHP structure or operations impact their care delivery.
- IEHP does not tolerate illegal discrimination or harassment of any kind, on account of race, color, religion, national origin, ancestry, sex, marital status, disability, sexual orientation, gender identity or on any other category protected by federal or state law.
- Never bring weapons to any IEHP committee meeting.
- Never accept gifts of any kind from outside parties that would influence the discussion and opinions during the meeting. Any committee member who has a conflict of interest will be subject to removal from the committee.
- As a member of the PPPC for dual eligible members, there are no special privileges granted above other IEHP members, under any circumstances.
- Cannot use committee membership as a means to receive any special offer or service from IEHP providers, vendors, community organizations, partners, etc.
- Report any violations of this Code of Conduct.
- The PPPC dual eligible member term is for (2) years, one-third of the membership is rotated each year.

- Membership in the PPPC for dual eligible members is a privilege not a right; members join at his/her own will.
- Members may serve additional terms as requested by IEHP.
- Members who have completed a term, and are requested by IEHP to reapply, must wait (1) year before they can reapply for another term.
- To become a member of the committee, you must meet the qualifications, attendance standards, and follow the PPPC for dual eligible members Code of Conduct.
- Only IEHP dual eligible members can apply for the PPPC for dual members.
- Non IEHP members cannot attend meetings.
- Membership in the PPPC for dual members is not a form of employment.

c. Meeting Procedure

- Meetings shall begin at 12:00pm
- Meetings will begin with a call to order from the Chairperson followed by optional introductions and approval of the minutes (prior meeting).
- Members will introduce themselves by stating their name and enrolled program.
- Opinions and feedback may be voiced during the meeting in an orderly conduct.

- Members must raise their hand, state their name, followed by their question/comment.
- Stay on-topic when discussing an issue or asking a question, avoid discussing personal information.
- Do not discuss personal issues during the meeting.
- To resolve personal issues, members can discuss their issues with a Member Services Representative at the end of the meeting.
- Meetings are for (2) hours once every (3) months (quarterly) at IEHP.
- Special meetings may be called at anytime.

d. Attendance

- Members of the committee must make every effort to attend all meetings.
- Members are allowed (2) consecutive unexcused absences.
- Unexcused absences[1] that exceed (2) will be considered as a voluntary resignation from the PPPC for dual members.
- Legitimate excuses[2] will not be counted against the dual member.

[1] Unexcused Absence: providing no advanced notice of intent not to attend a PPPC meeting.

[2] Legitimate Excuse: a personal illness or medical emergency.

- For an absence to be considered legitimate, committee members must inform the Chairperson of their reason for not attending, prior to the meeting (this does not apply to medical emergencies).
- Any member who is removed from the PPPC for dual members may appeal to the Chief Executive Officer.
- A request for removal from the PPPC for dual members can be made to the Chief Executive Officer.

As a member of the PPPC for dual eligible members, I hereby acknowledge that I have read and understood the IEHP Code of Conduct. I agree to adhere to the standards of behavior outlined in the Code of Conduct, and to not reveal any personal health information (PHI) during the meeting. I understand that I may lose my privilege as a member of the PPPC for dual members, or be removed from the committee, should I intentionally violate the Code of Conduct.

_____ _____

PPPC Dual Member and IEHP ID *(please print)* Date

_____ _____

PPPC Dual Member *(signature)* Date

_____ _____

PPPC Chairperson *(please print)* Date

_____ _____

PPPC Chairperson *(signature)* Date

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

That I am the duly appointed Secretary of the Inland Empire Health Plan (the "Agency"), a Joint Powers Agency, a local public agency and political subdivision of the State of California; and;

That the foregoing Bylaws, which this Certificate is hereto attached, constitute the Bylaws of the Inland Empire Health Plan Public Policy Participation Committee for dual eligible members, as duly adopted by Inland Empire Health Plan.

Dated:_____

_____
Vickie Hargrove
Secretary to the Board

Riverside Family Physicians
Your Wellness is our Business

4310 Orange Street. Riverside, CA 92501
TEL 951.781.6335 FAX. 951.781.6365

February 6, 2012

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

Dear Mr. Douglas,

I am writing to express my support for Inland Empire Health Plan's efforts to participate in the California Dual Eligible Demonstration Project.

As a physician in the IEHP network, I have been pleased with the extensive medical and social services to which IEHP provides access for my patients, who have both Medicare and Medi-Cal. I'm also pleased with the tools and resources IEHP makes available to me, which enhance my ability to provide efficient care to my patients.

Especially valuable is IEHP's online technology, particularly the online access to my patients' medical records. In addition to being able to access the records anytime and anywhere, the system alerts when patients are due for preventive care services. I can also check eligibility, medical history, claims, authorization status, remittance advice, behavioral health visits and electronically submit a health education referral. My office can also submit claims online.

Also beneficial to my practice is IEHP's provider call center, which has assigned my office a personal representative. We can call this person whenever we have questions relating to IEHP services or patients who are IEHP members.

IEHP also provides continuous professional training opportunities, both for myself and for my office staff. Many of these are web-based, which allows us to maximize our time serving patients.

I believe IEHP has the technology, services and community resources in place to successfully meet the needs of providers and members under the Dual Eligible Demonstration Project, and I highly recommend them for your consideration.

Sincerely,

Dr. Tarek Z. Mahdi
President & Physician

Attachment E2: Letter of support from IEDC

Inland Empire Disabilities Collaborative
www.iedisabilitiescollaborative.org

February 10, 2012

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

Dear Toby Douglas

As the current co-chairman of the Inland Empire Disability Collaborative (IEDC), I wish to express my full support of Inland Empire Health Plan's application to the California Dual Eligible Demonstration Project.

IEDC is a network of 300 regional service providers in San Bernardino and Riverside counties who advocate with and for people with disabilities, while promoting equal opportunity, universal access and full participation of seniors and people with disabilities in all aspects of life. As a partner organization, Inland Empire Health Plan provides leadership in mobilizing and uniting organizations in the Inland Empire to better serve seniors and people with disabilities. Through this partnership Inland Empire Health Plan has taken an active role in creating a strong community-based network to meet the health care needs of its members, many of whom are seniors and people with disabilities with chronic health conditions.

Additionally, IEDC involves the community through IEHP and its other member organizations including seniors and persons with disabilities who are health plan members, in developing additional supports, improving systems of care, enhancing its communication materials and enriching other services.

In conclusion, I support Inland Empire Health Plan's efforts to serve as a pilot health plan for the California Dual Eligible Demonstration Project. I look forward to working with IEHP as an IEDC member agency to develop this demonstration project. I'm confident that the Inland Empire Health Plan and the IEDC will

leverage their existing collaborative relationship to develop enhanced services for dual eligibles in the communities we serve.

With highest regards,

Bill Nessel,
IEDC Co-chair

INLAND REGIONAL CENTER
…valuing independence, inclusion and empowerment
P.O. Box 19037, San Bernardino, CA 92423
Telephone: (909) 890-3000
Fax: (909) 890-3001

February 18, 2012

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

Dear Mr. Douglas,

It is my pleasure to write a letter in support of Inland Empire Health Plan's submittal to participate in the California Dual Eligible Demonstration Project.

IEHP maintains strong partnerships with the Regional Center and many other community-based services programs throughout the Inland Empire, to help seniors and people with disabilities maintain the highest level of independence and remain in their homes and communities as long as possible.

IEHP also has a strong network of community resources, to which it refers its members who need additional social services support. This further strengthens seniors' ability to maintain choice, independence and quality of life. IEHP employees are active in a number of these organizations, with direct knowledge of their capabilities and benefits for seniors and people with disabilities.

IEHP is also committed to working with its members to resolve care conflicts and with providers, patients and case managers to ensure patients receive proper follow up care in the appropriate setting when they’re discharged from a hospital stay. This is essential to avoiding hospital readmissions, which can be detrimental to members' health and long-term independence, as well as driving up health care costs.

In short, I urge you to give IEHP every consideration when choosing sites for the demonstration project. IEHP supports a full continuum of coordinated medical care, social supports and community resource partnerships to meet the needs of those who have dual eligibility in the Inland Empire.

Sincerely,

Carol A. Fitzgibbons
Executive Director

Community Access Center
Empowering People with Disabilities
In Riverside County since 1995
www.ilcac.org

February 13, 2012

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

Dear Toby Douglas

It is my pleasure to write a letter in support of Inland Empire Health Plan's submittal to participate in the California Dual Eligible Demonstration Project.

IEHP maintains strong partnerships with us and many other community-based services programs throughout the Inland Empire, to help seniors and people with disabilities maintain the highest level of independence and remain in their homes and communities as long as possible.

IEHP also has a strong network of community resources, to which it refers its members who need additional social services support. This further strengthens seniors' ability to maintain choice, independence and quality of life. IEHP employees are active in a number of these organizations, with direct knowledge of their capabilities and benefits for seniors and people with disabilities.

IEHP is also committed to working with its members to resolve care conflicts and with providers, patients and case managers to ensure patients receive proper follow up care in the appropriate setting when they're

discharged from a hospital stay. This is essential to avoiding hospital readmissions, which can be detrimental to members' health and long-term independence, as well as driving up health care costs.

In short, I urge you to give IEHP every consideration when choosing sites for the demonstration project. IEHP supports a full continuum of coordinated medical care, social supports and community resource partnerships to meet the needs of dual eligible in the Inland Empire.

Sincerely,

Paul Van Doren

February 10, 2012

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

Dear Toby Douglas

Before I joined IEHP, it was hard to figure out where to go for care. The whole system was very confusing for me. Since joining IEHP in 2006, things are a lot better. IEHP really knows how to take care of my needs. I value them a lot. As a DualChoice member, IEHP has helped me get all the services I need to take care of myself. I couldn't have done it without their support.

It's a relief now to get all my Medi-Cal and Medicare benefits through IEHP. It's been a lifesaver. They help me in so many ways. I even have a care team and nurse that calls to see how I'm doing. My nurse also sets up a ride for me to see my doctor if I need it.

Today, if I have any questions I call one place, IEHP Member Services. They're always very friendly. They help me get answers and better understand how to get care.

Also, as a member of the persons with disability workgroup (PDW), IEHP listens to what I say. They always make sure to involve us in everything they do. It feels good knowing they really care about what I think.

I feel IEHP has everything to meet my needs, and that they would do a great job in caring for more people like me.

Sincerely,

Belen R. Lopez

Stakeholder Involvement Activities

Throughout the Demonstration, IEHP will engage stakeholders, including partners, county agencies, and community based organizations to discuss the transition of dual eligible members into managed care and how to achieve the goals of the demonstration.

As of February 2012 IEHP has engaged with local stakeholders to discuss the Demonstration through the following meetings:

- **December 13, 2011:** Residential Facility meeting to discuss:
  - Coordination of care for IEHP members
- **January 9, 2012:** IHSS meeting involving the following individuals:
  - IEHP: Chief Executive Officer, Chief Medical Officer, Director of Health Administration, and Disability Program Manager.

  - San Bernardino County: Department of Aging and Adult Services, Human Services, and IHSS Public Authority.
  - Riverside County: IHSS Public Authority, Department of Public Social Services, and the Office on Aging.
- **January 17, 2012:** Monthly Inland Empire Disabilities Collaborative Meeting
  - Overview of the Dual Eligible Demonstration Project
  - Review impact of the Demonstration to the Inland Empire
- **February 3, 2012:** Board and Care Homes meeting to discuss:
  - Medicare Advantage
  - Board and Care Health Care Services
- **January and February 2012:** many discussions with Molina Health Care about:
  - Collaboration during the RFS application and implementation phases

- **February 2012:** many discussions with health plans that offer a D-SNP plan in the Inland Empire about:
  - Continuity of care issue
- **Ongoing activities to foster stakeholder involvement:**
  - The Director of Health Administration frequently communicates with the Department of Behavioral Health for Riverside and San Bernardino counties.
  - IEDC monthly meetings. IEDC description, structure, and membership information can be found at www.iedisabilitiescollaborative.org

Moving forward, IEHP will continue to engage local stakeholders in the development, planning, and implementation of the Demonstration.

Riverside County

Department of Mental Health

Jerry A. Wengerd, Director

Reply to: Mental Health Administration

P.O. Box 7549

Riverside, CA 92513

(951) 358-4501

January 24, 2012

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

Subject: Good Faith Letter of Agreement

Dear Mr. Douglas,

This letter documents our commitment to working with the Inland Empire Health Plan (IEHP) to develop and execute a Dual Eligible Demonstration Project in Riverside County.

We understand the purpose of this project is to demonstrate seamless access to the full continuum of medical care, social supports, and service to dual eligibles that reside in our county. Riverside County has a long history of working collaboratively with IEHP

to coordinate care and services for our mutual members. To support this collaboration, the Department of Mental Health has maintained a Memorandum of Understanding (MOU) with IEHP since 1998. Two of our county supervisors also serve on IEHP's Board of Directors.

We look forward to working with IEHP on the execution of the Dual Eligible Demonstration Project in Riverside County.

Respectfully,

Jerry Wengerd, Director

Riverside County Department of Mental Health

http://rcdmh.org

www.riverside.netwrorkofcare.org

Rolling Start, Inc.
Center for Independent Living
Serving San Bernardino, Inyo and Mono Counties
Resource Center for People with Disabilities
Main Office
570 W. 4th St., Ste. 107
San Bernardino, CA 92401
(909) 884-2129 Voice
(909) 884-7396 TTY
(909) 386-7446 Fax

Victorville Office
17330 Bear Valley Rd Ste A102
Victorville, CA 92392
(760) 843-7959 Voice
(760) 951 -8639 TTY
(760) 843-7977 Fax

February 10, 2012

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

Dear Toby Douglas:

It is my pleasure to write a letter in support of Inland Empire Health Plan's submittal to participate in the California Dual Eligible Demonstration Project.

IEHP maintains strong partnerships with us and many other community-based services programs throughout the Inland Empire, to help seniors and people with disabilities maintain the highest level of independence and remain in their homes and communities as long as possible.

IEHP also has a strong network of community resources, to which it refers its members who need additional social services support. This further strengthens seniors' ability to maintain choice, independence and quality of life. IEHP employees are active in a number of these organizations, with direct knowledge of their capabilities and benefits for seniors and people with disabilities.

IEHP is also committed to working with its members to resolve care conflicts and with providers, patients and case managers to ensure patients receive proper follow up care in the appropriate setting when they're discharged from a hospital stay. This is essential to avoiding hospital readmissions, which can be detrimental to members' health and long-term independence, as well as driving up health care costs.

In short, I urge you to give IEHP every consideration when choosing sites for the demonstration project. IEHP supports a full continuum of coordinated medical care, social supports and community resource partnerships to meet the needs of dual eligibles in the Inland Empire.

Sincerely,

Fran Bates,
Executive Director
Rolling Start, Inc.

Community Access Center
Empowering People with Disabilities
In Riverside County since 1995
www.ilcac.org

February 13, 2012

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

Dear Toby Douglas

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IEHP maintains strong partnerships with us and many other community-based services programs throughout the Inland Empire, to help seniors and people with disabilities maintain the highest level of independence and remain in their homes and communities as long as possible.

IEHP also has a strong network of community resources, to which it refers its members who need additional social services support. This further strengthens seniors' ability to maintain choice, independence and quality of life. IEHP employees are active in a number of these organizations, with direct knowledge of their capabilities and benefits for seniors and people with disabilities.

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discharged from a hospital stay. This is essential to avoiding hospital readmissions, which can be detrimental to members' health and long-term independence, as well as driving up health care costs.

In short, I urge you to give IEHP every consideration when choosing sites for the demonstration project. IEHP supports a full continuum of coordinated medical care, social supports and community resource partnerships to meet the needs of dual eligible in the Inland Empire.

Sincerely,

Paul Van Doren

Department of Behavioral Health
County of San Bernardino Human Services System
Gilbert Street San Bernardino, CA 92415-0920 (909)387-7053
Rudy G. Lopez Director of Behavioral Health

December 30, 2002

Joyce McShan, Medical Services Staff Analyst
Inland Empire Health Plan
303 E. Vanderbilt Way
San Bernardino, CA 92408

Subject: Memorandum of Understanding (MOU) with San Bernardino County (Department of Behavioral Health)

Enclosed for your records is one fully executed copy of the Memorandum of Understanding, Agreement 02-1323, between San Bernardino County (Department of Behavioral Health) and Inland Empire Health Plan.

Thank you for your services to the County of San Bernardino. If you have any questions, I may be reached by telephone at (909) 387-7170 or by fax at (909) 387-7593.

Sincerely
Patty Glas Administrative Supervisor II

Enclosure
Cc: Contract Unit

REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS OF SAND BERNADINO COUNTY, CALIFORNIA AND RECORD OF ACTION

AGREE#02-1323

December 17, 2002

From: Rudy Lopez, Director Department of Behavioral Health

Subject: MEMORADUM OF UNDERSTANDING BETWEEN THE

DEPARTMETN OF BEHAVIORAL HEALTH AND INLAND EMPIER HEALTH PLAN

RECOMMENDATION:

1. Rescind Agreement No. 01-183 with Inland Empire Health Plan (IEHP)
2. Approve Memorandum of Understating (MOU) between IEHP and San Bernardino County through its Department of Behavioral Health Mental Health Plan (SBMHP) for the purpose of coordinating the delivery of health care services to San Bernardino County Medi-Cal beneficiaries.

BACKGOUND INFORMATION: On February 4, 1997, the Board of Supervisors adopted Resolution No. 97-28 indicating "Intent to participate as the Local Mental Health Plan in Phase II of the Consolidation of Medi-Cal Mental Health Services" Phase II of the Consolidation requires the department to assume the risk for fee-for-service Medi-Cal specialty mental health services. Consolidation of hospital and outpatient series will result in a system of care that will maximize services for residents of San Bernardino County. Based upon the Resolution, the Department of Behavioral Health (DBY) began the process of developing the County's Phase II Consolidation plan to incorporate outpatient mental health services under the umbrella of Medi-Cal managed care regulations. On April 1, 1998, DBH successfully implemented the plan and began negotiation with IEHP to develop the MOU, as required by law (California Code of Regulations Title 9 Section 1810.415). On August 25, 1998 the Board of Supervisors approved the MOU between IEHP and SBMHP (Agreement 98-737, Item #026) for the purpose of

delivering coordinated health care services to Sand Bernardino County Medi-Cal beneficiaries. On March 20, 1999 the Board of Supervisors approved Amendment No. 1 to Agreement 98-737 (Item #-018). Amendment No. 1 added radiological, radioisotope and emergency room services to the MOU. On March 13, 2001 the Board of Supervisors approved Agreement 01-183 between IEHP and SBMHP (Item #023). The purpose of the Agreement was to insure that physical and specialty mental health care services delivered to Medi-Cal beneficiaries are coordinated between both plans.

cc: Behavioral Health- Carson w/agree
Inland Empire Health Plan c/o Behavioral Health – Carson w/agree
IDS w/agree
Auditor-Sandra Kelly w/agree
Risk Management
County Counsel-Larkin
CAO-Valdez
HSS Admin-Anselmi
File w/agree
(Image of Record of Action of the Board of Supervisors Agreement #02-1323 Approved, Board of Supervisors County of San Bernardino. Motion Move 1, Aye 2, Aye 3, Aye 4, Second 5, J Renee Bastian Clerk of the Board. By "signed with seal in the background" Dated December 17, 2002)

Approval of this MOU includes a section detailing the reimbursement process, claim procedures, a process whereby IEHP primary care providers (PCP) and SBMHP staff communicate in regards to treatment plans, referrals to other plans, and a system to coordinate the medical and psychiatric treatment needs of Medi-Cal beneficiaries. This MOU would also assist in providing improved, expanded services to mental health/substance abuse conditions, which were not previously provided by the current MOU.

REVIEW BY OTHERS: This item was reviewed and approved as to form by Deputy County Counsel, Charles J. Larkin on November 20, 2002. This item was also reviewed by County Administrative Office, Beatriz Valdez, Administrative Analyst on Decembers 4, 2002.

FINANCIAL IMPACT: This item has no impact on local cost funds. Medi-Cal Fee-For-Service revenue fund specialty mental health care ser ices provided by DBH under this MOU.

SUPERVISORIAL DISTRICT(S): All

PRESENTER: Rudy Lopez, Director
(909) 387-7024

(Image "For County Use Only" stating new contract number 02-1323 by County Department Behavioral Health. County Department Contract Representative Floyd Carson 909-387-7589. Project Name IEHP& SBMHP, Medi-Cal MOU)

CONTRACTOR: INLAND EMPIRE HEATLH PLAN (IEHP)

Birth Date (blank) Federal ID No. or Social Security No. (Blank)

Contractor's Representative: Richard Bruno, Chief Executive Officer

Address 303 E. Vanderbilt Way, Suite 400, San Bernardino, CA 92408-3526

Phone: 909-890-2000

Nature of Contract: (Briefly describe the general terms of the contract)

The San Bernardino County Department of Behavioral Health Mental Health Plan (SBMHP) and the Inland Empire Health Plan (IEHP) have complementary objectives to protect and promote the mental health of the general population. IEHP will be providing and arranging health care services for the community's Medi-Cal population and, thus is also concerned with the community's health, especially as it relates to the most vulnerable populations. With a common interest in the community's health, SBMHP and IEHP seek to become working partners in preventing disease, prolonging life, and promoting mental and physical health through organized efforts, This MOU delineates areas of understanding and agreement between SBMHP and IEHP.
Attach this transmittal to all contracts not prepared on the "Standard Contract" form.
(Imaged of approved as to legal form signed by a designee dated 11-20-02 other fields empty)

Joint Powers Agency
Inland Empire Health Plan

RESOLUTION NO. 02-240

APPROVAL OF THE MEMORANDUM OF UNDERSTAING WITH THE SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH FOR THE PROVISION OF MENTAL HEALTH SERVICES TO MEDI-CAL MEMBERS

WHEREAS, THE Chief Executive Officer, or his designee, has determined that it is necessary, desirable and prudent to retain the services of the San Bernardino county Department of Behavioral Health for the provision of Mental Health Services to Medi-Cal Members; and,

WHEREAS, the Inland Empire Health Plan is required by the Department of Managed Health Care to coordinate public health services with County of San Bernardino County' and,

WHEREAS, it is deemed necessary, desirable and prudent by the Chief Executive Officer, or his designee, to approve the Memorandum of Understanding with the San Bernardino county Department of Behavioral Health for the provision of Mental Health Services for Medi-Cal Members, and a copy of the document has been provided to each Board member, and the original shall be maintained by the Secretary of the Governing Board; now, therefore,

BE IT RESOLVED, DETRERMNIED AND ORDERED by the Governing Board of Inland Empire Health Plan, at its regularly meeting assembled on December 9, 2002, that the Memorandum of Understanding with the San Bernardino county Department of Behavioral Health, for the provision of Mental Health Services for Medi-Cal Members, is approved.

BE IT FURTHER RESOLVED, DETREMINED AND ORDERED that this Memorandum of Understating replaces the existing San Bernardino County Memorandum of Understanding for the provision of Mental Health Services approved on Resolution 00-218.

BE IT FURTHER RESOLVED, DETERMINED AND ORDERED that the Chief Executive Officer, or his designee, is authorized to execute any necessary documents to effectuate this Memorandum of Understanding, without requiring any further Board approval.

State of California County of San Bernardino

I, Vickie Hargrove, Secretary of the Inland Empire Health Plan, do hereby certify that the foregoing resolution was duly and regularly adopted by the Governing Board of the Inland Empire Health Plan.

Ayes: Aguiar, Buster, Ceniceros, Garcia, Hansberger, Tavaglione, Williams
Noes: 0
Abstain: 0
Absent: 0
Vacant: 0
Date: December 9, 2002
(Signed Vickie Hargrove, Secretary)

REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS OF SAN BERNARDINO COUNTY, CALIFORNIA AND RECORS OF ACTION

June 28, 2011

From: ALLAN RAWLAND, Director
Department of Behavioral Health

Subject: AMEND REVENUE AGREEMETN WITH INLAND EMPIRE HEALTH PLAN

RECOMMENDATION(S)
Approve Amendment No. 3 to Revenue Agreement No. 02-1323 with Inland Empire Health Plan to provide services to Inland Empire Health Plan members who are high users of psychiatric hospital services in an annual amount no to exceed $126, 500 for the three year period of July 1, 2011 through June 30, 2014.
(Affected Districts: All)
(Presenter: Allan Rawland, Director, 382-3133)

BOARD OF SUPERVISORS COUNTY GOALS AND OBJECTIVES
Provide for the health and Social Services Needs of County Residents.

FINANCIAL IMPACT
This item does not impact discretionary general funding (net county cost). Inland Empire Health Plan will reimburse the Department of Behavioral health (DBH) up to $110, 000 annually for the periods of July 1, 2011 through June 30, 2014, for all Telecare psychiatric hospital services plus pay a 15% administrative fee (up to $16,500) to DBH. Revenue and appropriation in the amount of $126,500 have been included in DBH's 2011-12 recommended budget and will be included in subsequent recommended budgets.

BACKGROUND INFORMATION
The Department of Behavioral Health (DBH) provides mental health and substance abuse treatment programs with the goal of promoting prevention, intervention, recovery, and resiliency for individuals and families. To meet that goal, DBH offers a broad array of services, including prevention and early intervention, intensive case management, crisis intervention, medically necessary psychiatric services, and supportive.

On December 17, 2002 (Item No. 47), the Board of Supervisors (Board) approved Agreement 02-1323 with Inland Empire Health (IEHP) as a mechanism for IEHP to refer seriously mentally ill clients to DBH for services.

On February 12, 2008 (Item No. 53), the Board approved Amendment No. 1 to Agreement 02-1323, to expand services, and include Medi-Cal eligible clients.

Page 1 of 2
Cc: Behavioral Health-Atknis w/agreement & Rawland
Contractor c/ Behavioral Health w/agreement
Auditor-Accounts Payable Manager w/agreement
County Counsel-Salazar
CAO-Ciabattini & Allen
File-w/agreement
7/25/11
(Image: Record of Action of the Board of Supervisors APPROVED (ONSENT CALENDAR) COUNTY OF SAN BERNARDINO, Board of Supervisors. Motion Aye 1, SECOND 2, AYE 3, MOVE 4, AYE 5. LAURA H. WELCH, CLERK OF THE BOARD DATED: June 28, 2011)

On February 8, 2011 (Item No. 19), the Board approved Amendment No. 2 to Agreement 02-1323 to allow IEHP to refer up to five clients who utilize psychiatric inpatient hospitals as their primary location for psychiatric services to receive services under the Members Assertive Positive Solutions (MAPS) Community Treatment Team through June 30, 2011.

DBH provides MAPS services to clients 24-houts, 7 days a week through a contracted vendor. The MAPS team provides wraparound services and supporting case management services to the client at his/her living site. Services encompass an array of case management activities to support the client's recovery and self management of mental illness.

In a related item presented on today's agenda, DBH is requesting approval to contract with Telecare Corporation to continue to provide MAPS services to county residents. DBH is recommending amending Agreement No. 02-021323 to allow IEHP to continue to refer up to five clients, who utilize psychiatric inpatient hospitals as their primary location for psychiatric services, effectively July 1, 2011 through June 30, 2014.

Approval of this item will continue to allow the provision of mental health and case management services to IEHP clients. The MAPS Team will provide services to help stabilize these clients in the community, decrease their frequency of hospitalization, and assist them in managing crises in a more adaptive manner.

REVIEW BY OTHERS
This item has been reviewed by County Counsel (Frank Salazar, Deputy County Counsel, 387-5442) on May 25 2011; and the County Administrative Office [Lori Ciabattini (388-0253) and

Monique Allen (386-8393), Administrative Analysts] on June 14, 2011.

FOR COUNTY USE ONLY (completed fields)
County Department: Behavioral Health
Contract Number: 02-1323 A-3
County Department Contract Representative: Elizabeth Atkins
Telephone 909-382-3007.
Contract Start Date: Dec. 17, 2002
Project Name: IEHP & SBMHP MOU

THIS CONTRACT is entered into in the State of California by and between the County of San Bernardino, hereinafter called the County, and

Name: Inland Empire Health Plan hereinafter called Contractor
Address : P.O. Box 19026-9026
San Bernardino, CA 92423
Telephone: (909) 890-2040

IT IS HEREBY AGREED AS FOLLOWS:
(Use this space below and additional bond sheets. Set forth service to be rendered, amount to be paid manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)

In that certain Agreement #02-1323 between the County of San Bernardino, a political subdivision of the State of California, and Inland Empire Health Plan (IEHP), which Agreement first became effective December 17, 2002, the following changes are hereby made and agreed to:

I. This amendment adds addendum II Claim Procedure for Inland Empire Health Plan Referrals for Member Assertive Positive Solutions Services (MAPS) effective July 1, 2011 through June 30, 2014.

(Box: Auditor/Controller-Recorder Use Only. Unchecked boxes "Contract Database" and "FAS." Fields, "Input Date" and "Keyed By" were left blank.

II. All other terms, conditions and covenants of this basic contract first entered into December 17, 2002 remain in full force and effect.

County of San Bernardino
Josie Gonzales, Chair Board of Supervisors
Dated: JUN 28 2011
SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
Laura H. Welco
Clerk of the Board of Supervisors of the County of San Bernardino
By: Laura H. Welco

Inland Empire Health Plan
By: Bradley P. Gilbert, MD
Title Chief Executive Officer
Dated 6-20-11
Reso 11-176
Address 303 East Vanderbilt Way
San Bernardino, CA 92408

Approved as to Legal Form: Signed by County Counsel
Dated: 6/21/11
Reviewed by Contract Compliance
Signed
Dated: 6/21/11
Presented to BOS for Signature
Signed by Department Head
Dated: 6/21/11

Riverside County Department of Mental Health Logo

Administrative Services
4095 County Circle Drive
Riverside, CA. 92503
(909) 358-4792

October 23, 2001

Gary Melton, Sr. Medical Services Manager
Inland Empire Health Plan
303 East Vanderbilt Way, Suite Four Hundred
San Bernardino, CA. 92408

RE: Signed copies of the MOU between IEHP and Riverside County

Mr. Melton:
Please find enclosed three (3) copies of the Memorandum of Understanding between IEHP and Riverside County Department of Mental Health, Approved by the Riverside County Board of Supervisors.
Please call me at (909) 358- 4521 if you have any questions.

Thank you,

Rod Jaffe,

Administrative Supervisor

Joint Powers Agency

Inland Empire Health Plan

Resolution NO. 01-79

APPROVAL OF THE MEMORANDUM OF UNDERSTANDING BETWEEN INLAND EMPURE HEALTH AND RIVERSIDE COUNTY'S DEPARTMENT OF MENTAL HEALTH FOR THE PROVISION OF MENTAL HEALTH SERVICES TO MEDI-CAL MEMBERS

WHEREAS, it is deemed necessary, desirable and prudent by the Chief Executive Officer, or his designee, to work cooperatively with Riverside County's Department of Mental Health Services for Medi-Cal Members within Riverside County, and the Medical Director of Inland Empire Health Plan has negotiated a Memorandum of Understanding for these services; and,

WHEREAS, a copy of the Memorandum of Understanding has been provided to each Board member, and the original shall be maintained by the Secretary to the Board; now, therefore,

BE IT RESOLVED, DETERMINED AND OREDERED by the Governing Board of Inland Empire Health Plan, at its regular meeting, assembled on May 14, 2001, that the Memorandum of Understanding with Riverside County's Department of Mental Health for the provision of Mental Health Services for Medi-Cal Members is approved.

BE IT FURTHER RESOLVED, DETERMINED AND ORDERED that the Chief Executive Officer, or his designee, is authorized to execute any necessary documents to effectuate this

Memorandum of Understanding, without requiring any further Board approval.

State of California) County of San Bernardino)

I, Vickie Hargrove, Secretary of the Inland Empire Health Plan, do hereby certify that the foregoing resolution was duly and regularly adopted by the Governing Board of the Inland Empire Health Plan.

Ayes:	Buster, Garcia, Hansberger, Ritter, Williams
Noes:	0
Abstain:	0
Absent:	Eaves, Mullen
Vacant:	0
Date:	May 14, 2011

Vicki Hargrove, Secretary

SUBMITTAL TO THE BOARD OF SUPERVISORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Department of Mental Health

SUBJECT: Approve the Memorandum of Understanding between Inland Empire Health Plan and the Riverside County Department of Mental Health for Medi-Cal and Medicare Dual Choice beneficiaries for FY 2011/2012;

RECOMMENDED MOTION: Move that the Board of Supervisors:

1. Approve the Memorandum of Understanding (MOU) between Inland Empire Health Plan and the Riverside County Department of Mental Health for Medi-Cal and Medicare Dual Choice beneficiaries for FY 2011/2012;
2. Authorize the Chairman of the Riverside County Board of Supervisors to sign the MOU; and
3. Authorize the Director of Riverside County Mental Health (RCDMH) to sign ministerial amendments and renewal for this MOU with IEHP for Medi-Cal and Medicare Dual Choice mental health services through June 20, 2016.

BACKGROUND: On September 2, 2008, Agenda Item 3.108, the Riverside County Board of Supervisors approved the third amendment to the MOU between Inland Empire Health (IEHP) and the RCDMH started working with IEHP to develop and updated, all inclusive MOU that appropriately reflects both parties' agreement and understanding of the services to be rendered under this agreement to both Medi-Cal and Medicare Dual Choice beneficiaries. (Continued on Page 2)

JW: KL: SL Signature

Jerry Wengerd, Director

Department of Mental Health

FINANCIAL DATE Current F.Y. Total Cost: $0

In Current Year Budget: YES

Current F.Y. Net County Cost: $0

Budget Adjustment: NO

Annual Net County Cost: $0

For Fiscal Year: 11/12

SOURCE OF FUNDS: Positions To Be Deleted Per A-30

APPROVE Requires 4/5 Vote

C.E.O. RECOMMENDATION:

County Executive Office Signature BY:Debra Courmoyer

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Tavaglione, seconded by Supervisor Stone and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

AYES: Buster, Tavaglione, Benoit and Ashley

Nays: None

Absent: None Kecia Harper-Ihem

Date: February 7, 2012 Clerk of the Board

Abstain: Stone By: Deputy

Xc: Mental Health

SUBJECT: Approve the Memorandum of Understanding between Inland Empire Health Plan (IEHP) and the Riverside County Department of Mental Health.

BACKGROUND (continued):

The California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.370, requires Medi-Cal Mental Health Plan to enter into MOU agreements with Medi-Cal Managed care Plans (physical health care) to ensure appropriate care for Medi-Cal and Medicare Dual Choice beneficiaries. These regulations stipulate that Medi-Cal and Medicare mental health services shall be provided to Medi-Cal and Medicare beneficiaries through the Mental Health Plan, which is administrative by the RCDMH.

The updated, all inclusive IEHP MOU establishes the referral protocol of the Riverside county Medi-Cal population and Medi-Cal/ Medicare eligible population enrolled in the IEHP Medi-cal and Medicare Dual Choice program. The IEHP MOU also defines the protocol for coordination the care mutually shared between IEHP and RCDMH clients. The protocol states that IEHP will refer to RCDMH IEHP members whose psychological condition would not be responsive to physical health care services. RCDMH will, in return, accept Medi-Cal referrals from IEHP for determination of medical necessity, and provide mental health specialty evaluation services. In addition, RCDMH Medi-Cal beneficiaries enrolled in IEHP will receive services with or without a referral by IEHP, Therefore, the RCDMH is requesting that the Riverside County Board of supervisors approve the MOU between IEHP and the RCDMH to provide mental services to Medi-Cal and Medicare Dual Choice beneficiaries.

PERIOD OF PERFORMANCE:

This MOU shall be effective upon execution by both parties, and shall continue in effect until June 30, 2012. The term may be extended for up to four (4) additional one (1) year periods, in succession, at the mutual consent of the parties, without requiring further action of the governing entities of wither party. The MOU may be terminated at any time pursuant to the provision herein. In the event that the term of the MOU is extended for the four (4) additional one (1) year periods, the MOU shall terminate in June 30, 2016. The MOU further stipulated that in no event shall this MOU be extended past June 30, 2016 without a new MOU, or an amendment to this MOU which specifically extends the term of the MOU.

FINANCIAL IMPACT:

The MOU between IEHP and RCDMH has a zero dollar amount ($) as specified in the agreement. However, IEHP will reimburse RCDMH at 100% of the Medicare allowable for all billable services. No County funds are required.

Attachment G: LOA- Riverside County Behavioral Health Agency

Joint Powers Agency Inland Empire Health Plan

RESOLUTION NO.11-310

APPROVAL OF THE MEMORANDUM OF UNDERSTANDING WITH THE RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH FOR MENTAL HEALTH SERVICES TO MEDI-CAL MEMBERS ANDMEDICARE DUALCHOICE MEMBERS

WHEREAS, the Chief Executive Officer, or his designee, has determined that it is necessary, desirable and prudent to retain the services of the Riverside County Department of Mental Health for the provision of Mental Health Services to Medi-Cal Members and Medicare Dual Choice Members; and,

WHEREAS, the Inland Empire Health Plan is required by the Department of Managed Health Care to coordinate public health services with the County of Riverside; and ,

WHEREAS, it is deemed necessary, desirable and prudent by the Chief Executive Officer, or his designee, to approve the Memorandum of Understanding with the Riverside county Department of Mental Health for the provision of Mental Health Services for Medi-Cal Members and Medicare Dual Choice Members, and a copy of the document has been provided to each member, and the original shall be maintained by the Secretary to the Governing Board; now, therefore,

BE IT RESOLVED, DETERMINED AND ORDERED by the Governing Board of Inland Empire Health Plan, at its regular meeting assembled on December 12, 2011, that the Memorandum of Understanding with the Riverside County Department of Mental Health, for the provision of Mental Health Services for Medi-Cal Members and Medicare Dual Choice Members, is approved.

BE IT FURTHER RESOLVED, DETERMINED AND ORDERED that this Memorandum of Understanding replaces the existing Riverside County Memorandum of Understanding for the provision of Mental Health Services approved on Resolution 08-139.

Resolution 11-310

BE IT FURTHER RESOLVED, DETERMINED AND ORDERED, that the Chief Executive Officer, or his designee, is authorized to execute any necessary documents to effectuate this Memorandum of Understanding, without requiring any further Board approval.

State of California)

County of San Bernardino)

I, Vickie Hargrove, Secretary of the Inland Empire Health Plan, do hereby certify that the foregoing resolution was duly and regularly adopted by the Governing Board of the Inland Empire Health Plan.

Ayes:	Anderson, Buster, Ovitt, Williams, Zom
Noes:	0
Abstain:	0
Absent:	Mitzelfelt, Tavaglione
Vacant:	0
Date:	December 12, 2011
Signature	Vicki Hargrove, Secretary

Inland Empire Health Plan

Type 2 Diabetes
Self-Care Guide

What is Type 2 Diabetes?

When we eat, our bodies turn food into **glucose** – a form of sugar. This sugar goes into the bloodstream and is the body's main fuel. As the levels of sugar in the blood rise, the **pancreas** (an organ behind the stomach) makes a hormone called **insulin.**

Insulin helps move the sugar into the body's cells. Once inside the cells, the sugar can be used as energy.

When you have diabetes your body has trouble getting sugar from your blood into your cells. Either your body doesn't make enough insulin to move sugar into your cells, or your cells resist the insulin and don't let the sugar in (insulin resistance).

Without the right amount of insulin working with your cells the right way

Your cells get no fuel. Even though your blood contains large amounts of sugar, your cells are starving. You may feel tired, hungry, or moody.
With no place to go, the amount of sugar in your blood builds up. Over time, this can damage your blood vessels, organs and nerves, causing many serious health problems

You Have Type 2 Diabetes–What Do You Do?

Although diabetes is a lifelong disease, it can be controlled. If you take good care of yourself and manage your diabetes, you can live a healthy life.

Managing your diabetes means:

- Keeping your blood sugar in a healthy range.
- Keeping your blood pressure, weight, and cholesterol in healthy ranges.
- Getting a yearly urine test to check kidney health.

- Having yearly dilated eye exams to protect your vision.
- Checking your feet each day to make sure you have no cuts or sores.

Sound like a lot? Don't worry…with your Doctor's help, you can set up a **Diabetes Self-Care Plan**. You'll know just what to do and when.

Controlling Your Blood Sugar

To avoid diabetes complications, you must control the levels of sugar in your blood.

Checking Your Blood Sugar

• **Checking your blood sugar at home** helps you see how your blood sugar responds to food, medicine, and exercise. Talk to your Doctor about when and how often you should test, what your blood sugar numbers should be, and what to do if your numbers are not in a healthy range. Each time you check, make sure to record your numbers and when you checked.
• **Your A1C blood test is done at the lab.** It tells you what your average blood sugar levels have been over the past 3 months. Ask your Doctor to schedule your A1C test 2 to 4 times a year, and ask your Doctor what your A1C number should be.

Why is it so important to control your blood sugar?

Poorly managed diabetes can lead to high blood sugar (**hyperglycemia**) or low blood sugar (**hypoglycemia**). In both cases, you must act right away. If you don't bring your blood sugar within a healthy range, you risk having serious problems.

High Blood Sugar

Several things can cause this:

- Eating more starchy foods than usual
- Less exercise than usual
- Being sick
- Skipping medications

• Stress

You may:
• Feel sick to your stomach or vomit
• Feel very thirsty or hungry
• Have rapid or deep breathing
• Urinate more often
• Have sweet or fruity smelling breath

Low Blood Sugar

Several things can cause this:
• Too much insulin
• Skipping meals
• Too much medication
• Too much exercise

You may feel:
• Confused or dizzy
• Nervous or shaky
• Hungry
• Sweaty or clammy

Call your Doctor if you think you have high or low blood sugar.

Control is your goal

Controlling your **blood sugar** is vital to your health. But people with diabetes often have **high blood pressure** and **high cholesterol.** You must control all 3 to stay healthy.

Protect Yourself from Complications

Over time, diabetes can damage your nerves, blood vessels and organs. Here are some common, but serious health problems and how you can prevent them.

Heart Disease and Stroke

Heart disease is the most common problem linked to diabetes. High blood sugar and high cholesterol levels can cause blood vessels to narrow and clog up. Clogged blood vessels make it hard for blood to reach all parts of your body. This can result in high blood pressure and increase your risk of heart attack and stroke.

To reduce your risk:

- Avoid high amounts of fat and cholesterol in your diet.
- Don't smoke.
- Lose weight, if needed.
- Exercise for 30 minutes on most days.

Kidney Disease

The blood vessels in the kidneys act like a filter, clearing waste from the body. High blood sugar can damage blood vessels in the kidneys. This causes **nephropathy.**

To reduce your risk:

- Keep your blood pressure in a healthy range.
- Ask your Doctor for a yearly **microalbumin screening.**

Eye Problems

People with diabetes are at risk for several eye diseases. These can lead to vision loss or blindness. One of the most serious diseases is called **diabetic retinopathy.** This happens when there is damage to the small blood vessels of the **retina,** an area in the back of your eye that sends images to your brain.

To reduce your risk:

- Visit your Eye Doctor at least once a year for a **dilated retinal exam (DRE).**

See your Eye Doctor right away if you have these signs:

- Blurry vision
- Trouble adjusting from bright to dim light
- A dark spot that blocks your vision
- Floaters and flashes

- Sudden loss of vision
- Poor night vision

Teeth and Gum Problems

High blood sugar puts you at a higher risk for dental problems, and healing may be slow when problems do occur. Dental problems include cavities, gum disease, and tooth loss.

To reduce your risk:

- Brush and floss your teeth each day.
- See your Dentist at least every 6 months.
- See your Dentist right away if you see problems like red or swollen gums, loose teeth, or if your gums bleed.

Foot and Leg Problems

Foot and leg problems can be caused by damage to nerves (**neuropathy**) or blood vessels. If your nerves are damaged, you may lose all feeling in your feet, and hurt your feet without knowing it. If your blood vessels are damaged, foot sores can get worse fast and take longer to heal.

To reduce your risk:

- Check your feet at home each day for cuts, sores and cracks. Use a mirror to check the bottom of your feet. Tell your Doctor if you see any problems.
- Never walk barefoot.
- Ask your Doctor to check your feet at each office visit.

Areas of Care	What Needs to be Done	What I Will Do
Dilated Retinal Exam (DRE)	See an Eye Doctor once a year for your DRE. Make sure results are sent to your PCP.	☐ Call my Eye Doctor to schedule my next exam. Date of eye exam: _____
Dental	See your Dentist every 6 months.	☐ Call my Dentist to schedule my next exam. Date of dental exam: _____
Blood Pressure	Check at each Doctor visit; goal is less than 130/80.	
Cholesterol	Check at least once a year.	☐ Talk to my Doctor about my diabetes self-care plan: • Tests I should have and when • How to keep my feet healthy • How to take my medicine • Healthy eating and weight loss
Blood Sugar Testing	Ask your Doctor how often and best times to check. Also ask your Doctor to schedule your A1C test.	
Urine Testing	Ask your Doctor to schedule a microalbumin test to check your kidney health.	☐Call IEHP Member Services at 1-800-440-IEHP (4347) or 1-800-718-4347 for TTY users to enroll in a **Diabetes Self-management Class.**
Foot Exams and Nerve Testing	Check your feet daily; let your Doctor know about any sores that do not heal. Get a complete foot exam by your Doctor once a year.	
Medicine	Keep your Doctor visits and take medicine the way your Doctor tells you.	

Weight Control	Talk to your Doctor about getting to and staying at a healthy weight.	
Diabetes Meal Plan	Ask your Doctor for a meal plan to follow.	
Stop Smoking	Set up a quit plan with your Doctor.	

Take an Active Role in Managing Your Diabetes

Set up your Diabetes Self-Care Plan so you know what to do.

Stay Informed About Diabetes

Web Sites

American Diabetes Association
www.diabetes.org
California Diabetes Program
www.caldiabetes.org
dLife FOR YOUR DIABETES LIFE!
www.dlife.com
WebMD
www.webmd.com

Important Phone Numbers

IEHP 24-Hour Nurse Advice Line:
1-888-244-4347 or 1-888-880-0833 for TTY users

Doctor:

_____

Phone:_____

Eye Doctor:

_____

Phone:_____

Dentist:

_____

Phone:_____

Phone Numbers and Program Information

IEHP Members can enroll in
these no-cost/low-cost programs:

Diabetes Self-Management

Healthy Heart

Blood Pressure Management

Bicycle Safety

Child Car Seat Safety

Family Asthma

Healthy Babies

Living Well with a Disability

Stop Smoking

Weight Loss

For more information on these programs, call
IEHP Member Services at 1-800-440-IEHP (4347)
or 1-800-718-4347 for TTY users.

Asthma Self-care guide

What is Asthma?

Asthma is a lifelong lung disease that affects the airways. **Airways** are tubes that carry air in and out of your lungs .When you have asthma, the inside walls of your airways are sensitive. They tend to react strongly to substances that are breathed in. These things that make your asthma worse are called **asthma triggers**.

Asthma triggers are:

Allergens – things you are allergic to:
• Pollen, mold, animal dander, dust mites, cockroach droppings, and foods
Irritants – things in the air:
• Perfume, household cleaners, paint, cooking fumes, chemicals, air pollution, changing weather, tobacco smoke
Other triggers:
• Exercise
• Viruses
• Heartburn
• Some medicines such as aspirin or ibuprofen
• Sinus infections
• Strong emotions and nervous stress

When the airways react to triggers, they get narrow and swollen. Airway muscles tighten and less air flows into your lungs. The swelling can worsen, making the airways even more narrow. Cells in the airways may increase the amount of mucus. **Mucus** is a sticky, thick liquid that can further narrow your airways. This chain reaction can result in asthma symptoms.

Asthma symptoms are:

• Wheezing – a whistling sound when you breathe
• Chest tightness – it feels like something is squeezing or pressing on your

chest
• Shortness of breath – you feel like you can't get enough air and need to breathe faster
• Coughing – this often occurs at night or early in the morning

Symptoms can happen each time the airways are irritated. When your symptoms get out of control and make you sick, you have an **asthma attack**. If this happens, get help right away!

Warning signs of an asthma attack:

• Cough, wheezing, or chest tightness
• Breathing hard and fast
• Ribs may show more than normal when you are breathing in
• Lips or fingernails may turn blue
• May not be able to walk or talk well

What Can I Do to Control My Asthma?

Poorly controlled asthma can lead to more severe lung diseases. Even though asthma does not go away, by working with your Doctor, you can have fewer symptoms. The goal of asthma treatment and self-care is to keep it under control.

Here's how:

• **Work with your Doctor to make an Asthma Action Plan.**
An **Asthma Action Plan** helps you know what to do when you are having asthma symptoms. It can also help you decide when to use your reliever medicine or when to seek emergency care.

• **Take your medicine the way your Doctor tells you.**
There are two basic types of asthma medicines:

1. **Controller** medicines help reduce the swelling in your airways to prevent asthma symptoms. Use it each day, whether or not you are having symptoms. Ask your Doctor how often you should use it.
2. **Reliever** medicines are also called **rescue** medicines. They provide quick relief of asthma symptoms by helping the muscles

around your airways relax to keep your airways open. Everyone who has asthma should have a reliever medicine. Ask your Doctor when you should use it.

• **Learn the correct way to use your inhaler and spacer.**

An **inhaler** is a plastic tube that holds asthma medicine. It is held up to the mouth and sprays a mist of asthma medicine that you breathe in. A **spacer** (or holding chamber) makes inhalers easier to use. It slows down the mist to allow more medicine to go deep into your lungs.

• **Learn how to use a peak flow meter.**

A **peak flow meter** is a hand-held device used to measure how hard you can blow air out of your lungs. You can get one from your Doctor or by attending an IEHP asthma class. By keeping track of your peak flow readings, you'll know when the airways in your lungs start to tighten hours or even days before you have any symptoms. This allows you to take the proper asthma medicine and avoid an asthma attack.

• **Know your asthma triggers.**
Write down the things that make your asthma get worse so you can avoid them.

• **Maintain a healthy weight.**
Losing weight can reduce asthma symptoms and help you breathe easier. Avoiding foods high in fat can help you lose weight and reduce heartburn, which can make asthma worse. If you need to lose weight, talk to your Doctor about a weight-loss plan.

• **Stay active!**
Asthma is not a reason to avoid exercise. You can enjoy an active lifestyle if you know how to prevent asthma symptoms when you exercise. Talk to your Doctor to find out what exercise or sport is best for you.

Tips to help control asthma when you exercise:

- Ask your Doctor if you need to use your reliever medicine before

you begin any exercise.
- Allow a warm-up and cool-down period.
- Pace yourself and rest as needed.
- During cold weather, wear a scarf over your nose and mouth.
- Limit exercise when you have a cold.

Is My Asthma Well Controlled?

You can tell how your asthma is doing by how often you:

- Have asthma symptoms (wheezing, coughing, chest tightness, shortness of breath)
- Wake up at night due to asthma symptoms
- Use your reliever inhaler (rescue medicine)
- Get emergency care due to an asthma attack

Look at the chart below. Find your age group and see if your asthma is well controlled. Talk to your Doctor right away if any of your answers fall in the "Yellow" or "Red" section.

Age 0-4 Years Old			
How often do I…	**Well Controlled**	**Not Well Controlled**	**Very Poorly Controlled**
have symptoms?	0-2 days/week	More than 2 days/week	Throughout the day
wake up at night due to symptoms?	0-1 time/month	More than 1 time/month	More than 1 time/week
use my reliever inhaler (rescue medicine)?	0-2 days/week	More than 2 days/week	A few times per day
get emergency care	0-1 time/year	2-3 times/year	More than 3

Age 0-4 Years Old			
How often do I…	**Well Controlled**	**Not Well Controlled**	**Very Poorly Controlled**
due to an asthma attack?			times/year

Age 5-11 Years Old			
How often do I…	**Well Controlled**	**Not Well Controlled**	**Very Poorly Controlled**
have symptoms?	0-2 days/week BUT not more than once on each day	More than 2 days/week OR Many times on 2 or more days/week	Throughout the day
wake up at night due to symptoms?	0-1 time/month	2 or more times/month	2 or more times/week
use my reliever inhaler (rescue medicine)?	0-2 days/week	More than 2 days/week	A few times per day
get emergency care due to an asthma attack?	0-1 time/year	2 or more times/year	2 or more times/year

Age 12 Years and Older			
How often do I…	**Well Controlled**	**Not Well Controlled**	**Very Poorly Controlled**
have symptoms?	0-2 days/week	More than 2 days/week	Throughout the day
wake up at night due to symptoms?	0-2 times/month	1-3 times/week	More than 4 times/week
use my reliever inhaler (rescue medicine)?	0-2 days/week	More than 2 days/week	A few times per day
get emergency care due to an asthma attack?	0-1 time/year	2 or more times/year	2 or more times/year

Take an Active Role in Caring for Your Asthma

Set up your Asthma Self-Care Plan so you know what to do.

The best way to keep your asthma under control is to keep your Doctor visits and work with your Doctor as a team. It is a good idea to write down questions to ask your Doctor about your asthma care before each visit.

What Needs to be Done	What I Will Do (Questions to ask my Doctor)
Have an Asthma Action Plan.	Can we work on my Asthma Action Plan?

What Needs to be Done	What I Will Do (Questions to ask my Doctor)	
Take your medicine the way your Doctor tells you.	Can you review my asthma medicine to make sure I am taking the right dose? My controller medicine: _____ My reliever medicine: _____	
Learn the correct way to use your inhaler and spacer.	Can you show me the correct way to use an asthma inhaler and spacer? Then watch me and tell me if I am using it right.	
Learn how to use a peak flow meter.	Can you show me how to use a peak flow meter and how to read the results? Then watch me and tell me if I am using it right.	
Know your asthma triggers.	I'm not sure what causes my asthma to get worse. Are there tests you can do to find my triggers?	My triggers are: _____ _____ _____ _____ _____ _____
Maintain a healthy weight and keep active!	Do I need to lose weight? What are some exercises or sports I can do? What can I do to keep my asthma under control when I	

What Needs to be Done	What I Will Do (Questions to ask my Doctor)
	exercise?
Learn more about asthma.	Call IEHP Member Services at 1-800-440-4347 or 1-800-718-4347 for TTY users to enroll in an **Asthma Class**.

Stay Informed About Asthma:

Web Sites

American Lung Association
www.lungusa.org

Global Initiative for Asthma
www.ginasthma.org

WebMD
www.webmd.com

Important Phone Numbers

IEHP 24-Hour Nurse Advice Line:
1-888-244-4347 or 1-888-880-0833 for TTY users

Phone Numbers and Program Information

IEHP Members can enroll in these no-cost/low-cost programs:

Family Asthma

Stop Smoking

Bicycle Safety

Blood Pressure Management

Child Car Seat Safety

Diabetes Self-Management

Healthy Babies

Healthy Heart

Living Well with a Disability

Weight Loss

For more information on these programs, call IEHP Member Services at 1-800-440-IEHP (4347) or 1-800-718-4347 for TTY users.

Inland Empire Health Plan

LETTER OF AGREEMENT

WHEREAS, ***Inland Empire Health Plan; IEHP Health Access, known collectively as the ("IEHP Health Plan")*** (PAYOR) and ***American Forensic Nurses, Inc*** (PROVIDER) seek to enter into an agreement for the provision of medical services to PAYOR's Members.

NOW, THEREFORE, the parties hereto agree as follows:

1. PROVIDER shall render mobile phlebotomy services as authorized by PAYOR to Member and agrees to accept the Fee Schedule listed in Attachment A. PROVIDER shall not bill, charge or attempt to collect any payments, surcharges or other remuneration, excluding applicable copayments, from Members of HMOs or other such programs as regulated by the Knox-Keene Health Care Service Plan Act of 1975 and the Department of Health Care Services through Title 22 of the California Code of Regulations, as amended.

2. Healthcare services provided by PROVIDER under this Agreement require prior authorization. All authorizations for services are only valid for the individual PROVIDER named in the authorization. Authorizations issued to a PROVIDER within a Provider Group are not considered "Group Authorization," but rather are only valid for the individual credentialed PROVIDER named in the authorization.

3. PROVIDER shall maintain a uniform medical record in accordance with community standards and in compliance with all applicable federal and state laws, rules and regulations for each Member. Upon request, PROVIDER shall allow IEHP HEALTH PLAN, the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and all other state and federal regulatory agencies to inspect medical records for Member(s) and shall provide copies of all

medical records or other medical reports, without charge.

4. PROVIDER shall prepare and maintain such records, including books, records and papers related to medical services provided to Members, and provide access to such information to IEHP HEALTH PLAN, and other applicable state and federal regulatory agencies as may be necessary to comply with federal and state laws, rules and regulations. This obligation shall survive the termination of this Letter of Agreement for minimum of ten (10) years.

5. PAYOR shall make payments to PROVIDER in accordance with Attachment A hereto, provided the member is eligible with the PAYOR at the time services are rendered.. PROVIDER shall submit claims to PAYOR for authorized covered services provided to Members within one hundred and twenty (120) days from the date of service. The claim must be submitted on a CMS 1500 or a UB-04 claim form and shall include all Member identifying information and the authorization number provided by PAYOR relating to mobile phlebotomy services provided pursuant to this Agreement. **Please mark the claim "IEHP Direct Auth".**

6. PAYOR shall compensate PROVIDER within thirty (30) working days of receipt of a complete claim from PROVIDER. Any compensation disputes must be filed within 365 calendar days of payment or denial and shall be handled in accordance with Health and Safety Code, § 1371 et. seq. (AB1455).

7. PAYOR and PROVIDER shall abide by any applicable State and Federal laws and regulations including, but not limited to, all provisions found in the Knox-Keene Health Care Service Plan Act of 1975, as amended.

8. PAYOR'S financial obligation under this agreement is subject to the Member's eligibility being effective with PAYOR at the time services are rendered.

9. The term of this Letter of Agreement shall become effective as of December 1, 2011 and shall continue in effect for an initial term of one (1) year that shall automatically renew on the anniversary date for subsequent one year periods not to exceed four (4) years after the initial term. Either Party may terminate this Agreement by giving the other Party thirty (30) working days prior written notice to terminate.

10. Completed billing forms for services must be sent to:

    Inland Empire Health Plan
    Attn: Claims Department – IEHP Direct Auth.
    PO Box 10129
    San Bernardino, CA 92423-0129

11. Payment for services rendered will be sent to:

    American Forensic Nurses, Inc
    255 N El Cielo Rd., #140-195
    Palm Springs, CA 92262

12. Any notices require to be given herein by either party to the other shall be effected by certified letter to the appropriate address as follows:

    IEHP HEALTH PLAN
    P.O. Box 19026
    San Bernardino, CA 92423
    Attn: Director of Contracts

    American Forensic Nurses, Inc
    255 N El Cielo Rd, # 140-1959
    Palm Springs, CA 92262
    Attn: Faye Battiste Otte, RN, President

13. The relationship between PAYOR and PROVIDER is an independent contractor relationship. Neither PROVIDER nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of PAYOR, and neither PAYOR nor any employee(s) and/or agents of PAYOR shall be

considered to be an employee(s) and/or agent(s) of PROVIDER. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

14. This Agreement, including all attachments, which are incorporated herein by this reference, constitutes the entire agreement by and between the parties regarding the matters contemplated by this Agreement, and supersedes any and all other agreements, promises, negotiations, either oral or written, between the parties with respect to the subject matter and period govern by this Agreement.

15. No alteration and/or amendment of any terms or conditions of this Agreement shall be binding, unless reduced to writing and signed by the parties hereto.

16. In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

17. The provisions of the Government Claims Act (Government Code section 900 et seq.) must be followed first for any disputes arising under this Agreement.

18. This Agreement shall be governed by and construed in accordance with the laws of the State of California. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the counties of San Bernardino or Riverside, State of California.

IN WITNESS WHEREOF, the parties hereto have entered into this Letter of Agreement as of **December 20, 2011**

PROVIDER: **PAYOR**

By:_____ By:_____
David Carrish

Title:_____ Title: Director of Contracts

Date:_____ Date:_____

TIN#: 330926934
NPI#:

Appendix C – SNP Model of Care Elements and Standards (Modified for the Duals Demonstration)

Note: Applicants should provide a current SNP model of care, revised to reflect the Duals Demonstration. The NCQA questions for the SNP model of care are included below.

1. Description of the Dual-specific Target Population.

IEHP's Dual-specific target population includes individuals, who have both Medicare (Part A, B and D) and Medi-Cal and live in the current Medi-Cal managed care zip codes of Riverside and San Bernardino Counties (called "the Inland Empire"). The Inland Empire has about 105,000 dual eligibles, and about 20% of this population have enrolled in D-SNP plans including IEHP Medicare DualChoice (HMO SNP). We estimate that we will serve about 50,000 – 60,000 dual eligible members in our Demonstration program after the Demonstration enrollment is complete. Since these individuals can opt-out of Medicare managed care, some will likely access their Medicare through the fee-for-service (FFS) system.

Most of our dual eligible members have multiple chronic conditions; many lack the ability to perform daily living tasks; and more than 30% of them have a behavioral health condition. Top clinical classifications include Hypertension,

Diabetes Mellitus, Respiratory Complications, Ophthalmology Disorders, etc. Dual eligibles see many healthcare providers for multiple medical conditions and take multiple medications. Generally, their medical utilization is more than 5-6 times the utilization of an adult Medi-Cal beneficiary who does not have a chronic disability. General demographics of this population are described as follows:

1) Has an average age of 55.19, and 70% are 65 and older.
2) Include 59% Female and 41% Male.
3) The top 4 ethnicities are 55% Caucasian, 20% African American, 18% Hispanic and 5% Asian.
4) Most of them live in the areas of Riverside metro, San Bernardino metro, West San Bernardino, High Desert (Hesperia/Victorville), Low Desert (Coachella Valley), and Hemet/Corona/Temecula region.

Currently, over 6,500 dual eligibles have enrolled in our D-SNP plan. Of these 97.2% have access to a provider within 10 miles and 2.8% do not have access to a provider within 10 miles. The average distance to a provider for all members is 2.5 miles to 1 provider, 3.0 miles to 2 providers, 3.5 miles to 3 providers, 4.1 miles to 4 providers and 4.8 miles to 5 providers. The top 5 cities where this population resides in are San Bernardino, Riverside, Hemet, Moreno Valley, and Fontana. The top 5 health conditions in this population are Ophthalmology Disorders,

Hypertension, Diabetes Mellitus, Respiratory Complications, and Back Complications.

2. Measurable Goals

- **Improving access to essential services such as medical, mental health, LTSS and social services:**

The goal to improve access to medical, mental health, and social services is that IEHP members will be able to access appropriate and timely care 100% of the time. Access to care is evaluated on an ongoing basis through a variety of methods, including grievances, quality of care referrals, HEDIS measures, utilization management reports and care management. IEHP has several studies and reports with identified goals related to accessibility, such as:

1) Appointment availability access study goal is 90% or greater,
2) Provider grievance rate is less than 0.20 per 1,000 members.

The network complies with the network standards set by IEHP and our regulators depending on the area of review. Areas of access are analyzed on an ongoing, monthly, quarterly, semi-annually and/or annual basis. Annually the Quality Management Department will review all of these areas to determine effectiveness of the MOC Program and will recommend goals and interventions for the following year. When a deficiency is noted around access, a corrective action

plan eliminates any barriers to the Members care. Corrective action plans can include: 1) adding Providers or Services to the network, 2) implementing quality initiatives that address reducing barriers, 3) changing process to allow for easier access, 4) providing education on access standards and processes to providers, members and their family/caregivers and members of the Interdisciplinary Care Team. IEHP evaluates all access studies/reports/processes to determine the effectiveness of our interventions. Successful interventions would result in decreased grievance and appeals, decreased access related quality of care referrals, improvement in HEDIS, CAHPS and HOS surveys, and improved health outcomes of our members.

- **Improving access to affordable care:**

To improve access to affordable care, the Healthcare Analytics & Reporting (HAR) Department will present a semi-annual GeoAccess Provider and Membership analysis of IEHP's Provider Network for our Demonstration Program to the Quality Management (QM) Committee for review in June and December of each year. The analysis includes an actual performance rate and established standards for each specialty area. If any standard is not met, a corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Provider Services Department and progress updates are presented to the QM Committee at each quarterly meeting

until the goal is achieved. Specialties selected are based on a high volume specialist analysis using historical claims and encounters activity. The specialty types selected are the top 3 specialties based on the highest volume of claims and encounters over a 3 year period. IEHP requires all contracted medical groups or IPAs to have a minimum of 3 (for established hospital links prior to 8/1/2009) or 5 (for hospital links established later than 8/1/2009) individual PCPs who can admit Members to an IEHP designated hospital, and the individual PCPs must be capable of admitting and providing care to Members of all ages and either gender.

- **Improving coordination of care through an identified point of contact:**

To improve coordination of care through an identified point of contact, IEHP ensures all members are assigned to a specific care management team or individual Nurse. Depending on the level of medical needs, the member may be assigned to the following 1) a Complex Care Manager for extensive, intense case management, 2) a General Care Manager for care coordination, or a 3) Coordinator to assist with answering basic questions such as referral status, pharmacy status, benefits, or changing Primary Care Providers. To ensure this is occurring, the Care Management and Member Services departments conduct a Model of Care (MOC) Member Satisfaction survey for all enrolled Complex CM cases, no less than annually to validate member assistance given. Three examples of measurable questions that will be trended annually are: 1) Were you happy with the amount of

phone time our nurse gave you?; 2) How useful was our Nurse's advice on your medical condition?; and 3) How useful was the assistance provided by the MOC team in making your health care easy to access? A baseline goal of 80% is set overall for each question with comparisons from year to year noted, reviewing any barriers identified and making program improvement accordingly.

- **Achieving smooth transitions of care across health care settings, providers and HCBS:**

In order to improve transitions of care across healthcare settings, providers, and HCBS, IEHP ensures a Transitions of Care (TOC) Nurse, or designee performs this function. For instance, when a Member moves from one setting to another, there is an assigned TOC Nurse to coordinates and facilitates the care. This Nurse explains the delivery system, medicine reconciliation, and the importance of keeping follow-up appointments as directed by physician(s). To ensure this is occurring, an auto task is sent to the TOC Nurse when a Member is admitted, discharged, or transitioned from any healthcare setting to another. The TOC Nurse also helps the member understand the change in their healthcare status. To ensure that all elements of the process are monitored and that goals set are monitored for compliance once a year a Measuring Care Transitions Effectiveness Study is conducted. Three examples of measurable questions that will be trended annually are: 1) Notification to Primary Care Physician (PCP) for all planned and

unplanned admissions at time of discharge; 2) Member contact initiated timely by the Case Management (CM) Team for all discharges to home; and 3) Communication with Member about the changes in the Members health status and plan of care was done timely for all admissions. A baseline goal of 90% is set with an expectation of a 10% reduction in non-compliance overall. Barriers are noted and process steps are implemented to improve performance as needed.

- **Improving access to preventive health services:**

To improve access to preventative health services, IEHP staff educates members on recommended preventative healthcare guidelines, sends Evidence of Coverage (Member Handbook) information to members, and creates alerts in the Member Service database system. Alerts are set for Member Service Representatives to remind members to obtain preventative health care services. QI shares preventive health care standards with network providers, conducts annual HEDIS oversight audits and educates physicians on the importance of getting members in for physical and preventative measures. To ensure this is occurring, the Quality Management and Healthcare Analytics and Reporting departments conduct an annual HEDIS study that monitors Member access to specific preventative care indicators. Examples of HEDIS measures for this population are: 1) Adult Body Mass Index (BMI) Assessment (ABA); and 2) Adults' Access to Preventive/Ambulatory Health Services (AAP). Goals are set at 90th percentile

with comparisons from year to year noted, reviewing any barriers identified and making program improvement as needed.

- **Improving access to HCBS:**

To meet the goal of increasing availability and access to home- and community-based alternatives, IEHP will implement the following activities, but not limited to:

1) Through comprehensive health assessments and utilization data provided by DHCS, identify dual eligible members who may be eligible for IHSS, CBAS, MSSP or PACE program but have not yet enrolled, and then coordinate with applicable program agencies to establish their eligibility.
2) Work with all HCBS programs to ensure eligibility determination process is conducted within the timeliness performance standard.
3) Develop a health data warehouse to collect and share appropriate health information of the dual eligible members with the HCBS programs to assist in the determination of initial eligibility, on-going maintenance of eligibility and renewal of eligibility.

- **Assuring appropriate utilization of services:**

To assure appropriate utilization of services, the IEHP Utilization Management (UM) Department follows nationally recognized clinical criteria,

Medicare and Medi- Cal benefit guidelines, and IEHP UM Subcommittee Approved Guidelines when making decisions on medical care. The UM Subcommittee meets quarterly to approve any new necessary guidelines. The goal is to ensure the most current clinical criteria and benefit guidelines are applied when making decisions regarding utilization 100% of the time. This monitoring is ongoing. Annually the plan audits its delegated IPAs to ensure that nationally approved criteria is used for all clinical decisions, and monthly denial letter review is conducted for appropriate application of this criteria. Monthly denial letter review results are analyzed and if the goal is not met Corrective Action Plans are issued for those delegates that do not meet the requirements.

- **Improving beneficiary health outcomes (specify Medicare Advantage Organization (MAO) selected health outcome measures).**

  To improve member health outcomes, IEHP does the following:

  1) Reduce hospitalizations and Skilled Nursing Facility (SNF) placements:

  IEHP UM Department tracks, monitors, and identifies patterns of hospital admissions, hospital readmissions, and SNF admissions. The results are reviewed and discussed in the quarterly UM Subcommittee meeting for recommendations and interventions. Review of re-admissions is done on a monthly basis and cases are forwarded to teams for further intervention:

Care Management, Complex Case Management, Disease Management, Health Education and Quality Management.

The goal is Acute Bed day/1000: 800-1200; SNF Bed day/1000: 300-600. If the goal is not met IEHP will work with the member's primary provider, contracted facilities and our inpatient nursing staff ensuring the appropriate application of clinical criteria and level of care. Our Transitions of Care Program which contacts members within 3 business days of transition to usual care setting, either by phone or home visit provides ongoing member education.

2) Improve self-management and independence:

The goal for all members is to be independent. If the health plan determines a member has difficulty achieving that the member is assigned a Nurse or Coordinator to give them with general assistance from the community. The comprehensive HRA includes an evaluation of the Members perception of self management and independence and this is evaluated no less than annually, unless required sooner. With the original HRA serving as the baseline, the HRA is evaluated annually and compared to previous HRAs. The goal is for the member to self report improvement in self management and independence in one or more Activities of Daily Living (ADL) categories (e.g., feeding yourself). If any performance

measurement does not meet the established goal for a reported period a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. It is also monitored monthly by the Care Management department and progress updates are presented to the QM Committee at quarterly meetings until the goal is achieved.

3) Improve mobility and functional status:

For all members, the goal is to be fully mobile and functional. If the health plan determines a member has trouble reaching this goal, they are assigned a Nurse or Coordinator who can provide them general assistance from the community or through a contracted vendor. The comprehensive HRA includes an evaluation of the member's mobility and functional status and is evaluated about once a year, unless required sooner. With the original HRA serving as the baseline for each Member, the HRA is evaluated annually, and compared to previous HRAs. The goal is for the Member to self report improvement in mobility and functional status in one or more

Activities of Daily Living (ADL) categories (e.g., moving in and out of bed) from the baseline HRA to the following HRA.

If any performance measurement does not meet the established goal for a reported period a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Care Management department and progress updates are presented to the QM Committee at each quarterly meeting until the goal is achieved.

4) Improve pain management:

The goal for all members is to be pain free or able to control their pain. If the health plan determines that a member needs pain management, Care Management staff, in conjunction with the PCP may refer the member to a pain management program or specialist for monitoring and treatment. The comprehensive HRA includes an evaluation of the member's perception of their pain control and is evaluated no less than annually, unless required sooner. Annually, the HRA is evaluated and compared to previous HRAs, with the original HRA serving as the baseline for each Member. The goal is

for the Member to self report improvement in pain severity (e.g., 10% reduction in perceived pain on the McCaffrey Pain Scale). If any performance measurement does not meet the established goal for a reported period a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Care Management department and progress updates are presented to the QM Committee at each quarterly meeting until the goal is achieved.

5) Improve quality of life as self-reported:

The goal for all members is for them to report a satisfactory quality of life. If the health plan determines that a member needs improvement in their quality of life, they are assigned to a Nurse or Coordinator who can provide them with effective tools to assist with life improvements. The comprehensive HRA includes an evaluation of the Member's perception of their quality of life and is evaluated no less than annually, unless required sooner. Annually, the HRA is evaluated and compared to previous HRAs, with the original HRA serving as the baseline for each Member. The goal is

for the member to self report improvement in quality of life (e.g., how the member rates their general health status). If any performance measurement does not meet the established goal for a reported period a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Care Management department and progress updates are presented to the QM Committee at each quarterly meeting until the goal is achieved.

6) Improve satisfaction with health status and health service:

Annually, IEHP conducts Member Satisfaction and also participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcome Survey (HOS) study. IEHP strives to reach a 90th percentile compared to National benchmarks. IEHP will analyze the results and present to the Quality Management Committee who will review and assist in determining the interventions that will be used to improve the satisfaction with health status and health service. If the 90th percentile is not met, improvement steps are implemented and satisfaction is re-measured, no

less than annually. If any performance measurement does not meet the established goal for a reported period, a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Care Management department and progress updates are presented to the QM Committee at each quarterly meeting until the goal is achieved. The QM Committee is the oversight body for the Model of Care Program effectiveness and therefore, is the body that reviews the annual performance measures (as reported in the Annual Effectiveness Study of the Model of Care Program). It is also the body that must approve all proposed CAPs and monitors the progress of the implementation of all CAPs. All QM Committee agendas and reports are documented and summarized annually by the Director of QM and is presented to the IEHP Board of Directors and is posted to the IEHP Member Website. The Model of Care Effectiveness evaluation is included in this annual QM report.

2b. Describe the goals as measurable outcomes and indicate how you will know when goals are met.

In our response to Question 2, listed above, we describe the goals as measurable outcomes for the MOC program. For each measurable outcome, we have specific measures to properly evaluate if the goals were met; these are listed in the description as well. Some of these measures include, but not limited to:

- CAHPS survey
- QM annual report
- CAP
- Annual HRA evaluation
- Review of utilization data

2c. Discuss actions that will be taken if goals are not met in the expected time frame.

The QM Committee is the oversight body for the Model of Care Program effectiveness and therefore, is the body that reviews the annual performance measures (as reported in the Annual Effectiveness Study of the Model of Care Program). It is also the body that must approve all proposed CAPs and is the body that monitors the progress of the implementation of all CAPs. All QM Committee agendas and reports are documented and summarized annually by the Director of

QM and is presented to the IEHP Board of Directors and is posted to the IEHP Member Website. The Model of Care Effectiveness evaluation is included in this annual QM report.

3. Staff Structure and Care Management Roles

3a. Identify the specific employed or contracted staff to perform administrative functions (at a minimum identify staff who process enrollments, verify eligibility, process claims).

IEHP has a defined staffing structure to meet the needs of the targeted population. IEHP has an infrastructure that supports the administrative functions ability to administer and coordinate benefits, plan information, data collection and analysis for beneficiaries, network providers and the public. IEHP has an infrastructure 1) that supports the clinical functions ability to coordinate care management, 2) provides clinical care, 3) manages the delivery of services and benefits, and staff education, 4) supports the ability to oversee the administrative and clinical performance by verifying licensing and competency, reviewing encounter data for appropriateness and timeliness of services, 5) reviewing pharmacy claims and utilization data for appropriateness, 6) assuring provider use of clinical practice guidelines. The IEHP Organizational Chart is provided in this manual for more information (see Attachment L, “IEHP’s Organizational Chart”).

IEHP staff is involved in the day-to-day operations of the Plan coordinating benefits, plan information, data collection and analysis for beneficiaries, network providers, and the public, including processing enrollments, verifying eligibility of enrollees, paying claims, assuring

maintenance and sharing of healthcare records, approving referrals and handling appeals and grievances. To perform administrative functions IEHP has adequate infrastructure composes of multiple departments. IEHP has employed competent, experienced, and knowledgeable staff to perform these functions:

1) **Health Administration Department** – The Health Administration Department operates under the direction of the Director of Health Administration, who is responsible for direct support to the Chief Medical Officer in managing the operations of the Medical Services Department. In this capacity, the Director of Health Administration coordinates and/or manages activities that involve multiple divisions within Medical Services and coordinates operational planning activities. Under the direction of the Chief Medical Officer, the Director of Health Administration organizes and prepares written responses to requests from regulatory agencies involving Medical Services.
2) **Healthcare Analytics and Reporting Department** – The Healthcare Analytics Department operates under the direction of the Director of

Healthcare Analytics, who must possess a Masters degree in a related field with at least five (5) or more of years' experience in research and study design, implementation and reporting. The Director of Healthcare Analytics is responsible for initiating, developing, implementing, and reporting on quality studies, demographic analysis, and other research projects. Principal accountabilities include: developing research or methodologies for quality studies; producing detailed criteria and processes for research and studies to ensure accurate and reliable results; designing data collection methodologies or other tools as necessary for research or study activities; implementing research or studies in coordination with other IEHP functional areas; ensuring appropriate collection of data or information; performing analysis, including barrier analysis of results; managing the Healthcare Analytics staff to ensure high productivity and high quality output; and working with other IEHP staff involved in research or study processes.

i. Healthcare Analytics Staff – Staff support for the Director of Healthcare Analytics consists of a Healthcare Analytics Manager, Healthcare Analytics Supervisor, Technical Analysts, Business Analyst and Administrative Assistant.

3) **Credentialing Department** – The Credentialing Department operates under the direction of the Director of Provider Services, who reports to the Chief Network Officer and is responsible for Provider Relations, including Credentialing & Recredentialing oversight for directly contracted Providers and delegated IPAs, all Credentialing & Recredentialing functions and resolving credentialing related Provider issues for directly contracted practitioners. The Director of Provider Services is responsible for developing and overseeing the IEHP Credentialing & Recredentialing Program, with input from the Chief Medical Officer.

    i. Credentialing Staff – Staff support for the Director of Provider Services consists of a Credentialing Manager and Credentialing Coordinators who are responsible for performing all C&R related activities including: primary source verifications, review of applications and other functions for all practitioners for whom IEHP is responsible for C&R, verifying Providers meet IEHP requirements for credentialed practitioners.

4) **Claims Department** - The Claims Department is led y the Director of Claims. The Director of Claims reports to the Senior Director of Operations, who reports to the Chief Operations Officer. Department

responsibilities include claims production, payment appeal resolution, quality control, claim system configuration and claim related training. Additional leadership includes a Claims Production Manager, Claims QA Manager, Claims Systems Manager, 2 Claims Production Supervisors and a Claims Appeal Supervisor. The department is structured as follows:

i. Claims Production Unit – The production team consists of the Claims manager, supervisors and processors. This unit is responsible for receiving and adjudicating all incoming facility and professional claims in accordance with Medicare processing requirements. Inventory is managed at each phase of the adjudication process. Additional functions include handling of clerical activities, ensuring a claim is coordinated under secondary Medi-Cal benefits and that claims are processed timely and accurately.

ii. Claims Quality Assurance Unit – The quality assurance team audits outgoing adjudicated claims on a prepayment basis. The team uses preconfigured control reports and performs manual claim reviews in accordance with processing guidelines. Any identified errors are logged, confirmed and adjusted by the

adjudicating processor as appropriate. A dedicated claims processing trainer is also part of this team.

iii. Claims Appeal Resolution Unit – The Claims appeal unit receives researches and responds to all claim payment appeals from contracted and non-contracted providers. Appeals are individually logged and researched independently by a specialist who was not involved in the initial claim decision. Following completion of a review a resolution letter is sent to the provider explaining the basis of the decision. Additional activities include claim adjustments, backup provider call support and reconciliation of payment refunds.

iv. Claims Configuration Unit – The Configuration unit performs front-end setup and support of the Diamond claim system benefits, fee schedules and adjudication rules. The unit is responsible for configuration and maintenance of all providers, contracted and non-contracted. The unit also produces department control reports and designs database applications used to facilitate pended claim activity, auditing, appeals and inventory management.

5) **Utilization Management Department** - The Utilization Management Department is led by the Director of UM. The Director of UM works directly with contracted IPAs, practitioners, and hospitals to ensure coordinated, continuous cost effective quality health care for Members and serves as the primary IEHP liaison to IPAs, practitioners, and hospitals for UM support. The Director of UM develops procedures for admission and concurrent reviews, referrals conducted by IEHP UM staff, and integration with the CM Program. The Director of UM monitors delegated UM activities through annual Delegation Oversight Audits; review of IPA UM Program Descriptions, processes, and semi-annual/annual UM reports; evaluation of the effectiveness of Provider discharge planning systems for continuity of care; monitoring IPA denial logs for appropriateness of decisions; and the performance of Approved and Denied Referral Audits. The Director of UM and staff assist with improving Provider UM Programs where requested.

   i. <u>UM Staff</u> – The Director of Utilization Management oversees UM staff in performing UM activities. The required qualifications for UM staff positions may consist of experience in utilization management or care management in a managed care environment. Staff positions may include: prior

authorization nurses, care managers, nurse auditors, UM Managers, Supervisors, and concurrent review nurses. UM staff includes Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Social Workers, and UM Coordinators.

6) Medicare Program – The Medicare Program operates under the Director of Medicare, who reports to the Chief Marketing Officer. The Medicare Program is responsible for outreach and sales within standards outlined by the Centers for Medicare and Medicaid Services. The Director of Medicare is responsible for developing an oversight of the Medicare Program Unit, including the Medicare Manager and the Medicare Sales Team, with input from the Chief Marketing officer.

i. Director of Medicare – the Director of Medicare will develop and lead the implementation of operational policies and strategies that support the overall program and financial stability (including HCC, star ratings, annual bid renewals, and sales) of the IEHP Medicare DualChoice (HMO SNP) product. The Director of Medicare works across the organization (with all functional departments) and external Medicare vendor(s) to ensure these strategies are implemented as scheduled and modified as needed. The Director of Medicare will also

evaluate and report the results of implemented program strategies.

7) **Medicare Operations Unit** - The Medicare Operations Unit operates under the direction of the Senior Director of Operations, who reports to the Chief Operations Officer. The Medicare Operations Unit is responsible for ensuring the processing and reconciling of Medicare enrollment and eligibility data within standards outlined by the Centers for Medicare and Medicaid Services. The Senior Director of Operations is responsible for developing an oversight of the Medicare Operations Unit, with input from the Chief Operations Officer.

   i. Medicare Operations Staff – Staff support for the Senior Director of Operations consists of a Medicare Manager, and a Medicare Operations Specialist who are responsible for coordinating and performing all tasks associated with processing and reconciling Medicare enrollment and eligibility. Core functions include: daily, weekly and monthly file processing to/from CMS; performing audits and reconciliation's to ensure the accuracy of Medicare eligibility in IEHP core systems and supporting databases. Additional responsibilities include generating correspondence, outbound

education and verification calls to all new enrollees, loss of LIS status assistance, Member demographic and out of area verification.

8) **Member Services Department** - The Member Services Department operates under the direction of the Director of Member Services, who reports to the Chief Financial Officer. The Member Services Department is responsible for Member Services functions including assistance to Members regarding benefits questions, based on the Member's product line (Medi-Cal, Healthy Families, Healthy Kids, Medicare DualChoice), eligibility questions, Plan enrollment and disenrollment questions, doctor changes, assistance in obtaining IEHP material and provider eligibility verifications. The Director of Member Services is responsible for developing and overseeing the Member Services Program, with input from the Chief Financial Officer.

   i. Member Services Staff - Staff support for the Director of Member Services consists of a 1) Call Center Analyst responsible for Call Center trend analysis and reporting, 2) Call Center Projects Manager responsible for technical and operational analysis and projects, 3) a Call Center Coordinator responsible for day-to-day operational team support, an

Administrative Assistant, who is responsible for providing administrative support for the department, a Quality and Training Manager (including Analyst Trainer and Quality Specialists), who are responsible for staff quality support and training, a Call Center Manager including Call Center Supervisors and 5) Member Services Representatives responsible for assisting members and providers through different communication methods (telephone, email, in person, and fax).

9) **Provider Services Department** - The Provider Services Department operates is led by the Director of Provider Services, who must possess a Bachelor degree in a related field with at least five (5) years experience in a managed care setting. Under the direction the Chief Network Officer, the Director of Provider Services is responsible for Credentialing and Provider Relations, including the resolution of Provider issues, education of Providers concerning IEHP Policies and Procedures, health plan programs, IEHP website training and all other functions to ensure Providers can participate in IEHP's network and provide, quality care to IEHP members. This position is also responsible for IPA oversight and monitoring in conjunction with

departments including Quality Management, Utilization Management, Care Management and Finance.

i. Provider Services Staff – Staff support for the Director of Provider Services consists of the Provider Relations Manager who oversees the Provider Services Representatives and the Provider Call Center Supervisor and Representatives. The Director of Provider Services is also supported by the Provider Services Administrative Manager and Business Analyst.

ii. Provider Services Representative – The Provider Services Representatives (PSRs) are responsible for providing in-services to the IEHP Provider network, including trainings devoted to IEHP's website, appropriate claims and referral processes, all plan programs and the Provider Policies and Procedures. The PSRs receive and review provider complaints and establish with the Provider Relations Manager and Director of Provider Services appropriate resolution. The PSRs also review the IPA Specialty Networks on a semi-annual basis as well as work on the resolution of Member access issues by educating Providers on access standards.

iii. Provider Call Center Representatives – The Provider Call Center Representatives address all Provider calls into the plan regarding concerns, questions and complaints, including claims, authorizations, vision benefits, IEHP website navigation, and all plan correspondence and updates to programs.

iv. Provider Services Administrative Manager and Business Analyst – The PS Administrative Manager and analyst who reports to the Manager are responsible for the creation, maintenance and update of the Provider Policy and Procedure manual, correspondence to the Provider network regarding to all plan updates, address of technical and reporting concerns as forwarded by the PSRs and Provider Call Center, and additions and updates to the IEHP Provider website.

10) Grievance and Appeals Department - The Grievance Department, under the direction of the Director of Quality Management, reports to the Chief Medical Officer and is responsible for investigation and resolution of grievance and service appeals received from Members, Providers, and regulatory agencies. The Grievance Department gathers supporting documentation from members, Providers and contracted entities, and resolves cases based on clinical urgency of the member's

health condition. The Grievance Manager has the primary responsibility for the timeliness and processing of the resolution for all cases. The Chief Medical Officer is the designated officer of the plan that has the primary responsibility for the maintenance of the Grievance and Appeals Resolution System.

i. Grievance Department Staff – Staff supporting the Grievance Manager include: Grievance Supervisor, Triage and Review Nurse, Administrative Assistant, Grievance Nurses and Grievance Coordinators. The Triage and Review Nurse is responsible for intake of all cases, including triaging/assigning Grievance and Appeal cases, and working directly with the Grievance team to ensure cases are processed based on clinical urgency. The Grievance Supervisor monitors of all cases for compliance with Grievance policies and procedures, and agency regulations and standards. Grievance Nurses are responsible for processing appeals of denied service requests, and conducting clinical grievance investigations. Grievance Coordinators are responsible for all non-clinical case processing functions, including Member and Provider Acknowledgement and Resolution letter generation, obtaining medical records,

supporting documentation needed to complete investigations, and monitoring case resolution status.

11) **Information Technology (IT) Department** – The IT Department, under the direction of the Director of IT, oversees security and integrity of all data systems that IEHP uses to support members, Providers and team members. IT is responsible for maintaining internal systems that provide access to beneficiary data, both from regulators and providers. The system ensures that Team Members have access to data to assist them in providing care and guidance to beneficiaries.

    i. IT Staff – Staff support for the Director of IT consists of a Decision Support Manager, Systems Support Manager, Applications Support Manager, and Applications Configuration Manager who, with their staff, are responsible for maintaining electronic systems, developing tools for both internal and external partners, assessing risks and vulnerabilities to individual health data, and maintaining appropriate administrative, physical and technical security measure.

12) **Marketing Department -** The Marketing Department is led by the Director of Marketing, who reports to the Chief Marketing Officer. The Marketing Department is responsible for conducting appropriate

product and market research to support the development of marketing and member communications plans for all products; developing and executing marketing plans; creating and distributing advertising materials (e.g., radio, billboard, print ad, etc.) and member materials (e.g., Member Newsletters, Evidence of Coverage, Provider Directory, website, etc.). Under the vision and oversight from the Chief Marketing Officer, the Marketing Director is responsible for developing and overseeing the IEHP Marketing and Member Communications programs.

i. Marketing Staff – Staff support for the Director of Marketing consists of Product and Research team (Product Manager, Technical Analysts, and Administrative Assistant) and Communications team (Communications Writers, Graphic Designers, and Marketing Coordinator). The Product and Research team is responsible for conducting necessary research about the target audience to support the Communications team to create effective advertising and member materials. In addition, the Product Team develops the Member Handbooks (Evidence of Coverage) for all products and submits appropriate marketing and Member materials to the regulators

for approval. The Communications team develops advertising collaterals (radio, billboard, print ads, etc.), member materials (Member Newsletters, Health Education brochures, website, etc.) and provider materials (Provider Newsletter, Office Staff Newsletter, etc.).

13) **Quality Management Department –** The Quality Management Department is led by the Director of QM, who must possess a valid unrestricted Registered Nurse (RN) license issued by the State of California and a valid State of California driver's license. They must also have five (5) or more years experience in a Quality Assurance Program with a Hospital or HMO. The Director of QM 1) assists in developing, coordinating, and maintaining the QM Program and its related activities; 2) oversees the quality process; and monitors for health care improvement. Activities include the ongoing assessment of Provider and practitioner compliance with IEHP requirements and standards including: medical record assessments, access and availability studies, monitoring Provider trends and report submissions, and oversight of facility inspections. The Director of QM monitors and evaluates the effectiveness of IPA QM systems. The Director of QM coordinates information for the annual QM Program Evaluation, Work

Plan and Calendar; prepares audit results for presentation to the QM Committee, associated Subcommittees, and the Governing Board; acts as liaison regarding medical issues for providers, practitioners, and members.

i. QM Program Staffing **–** The Director of QM oversees staff consisting of an adequate number of Registered Nurses with the required qualifications to complete the full spectrum of responsibilities for QM Program development and implementation, QM Nurse Manager, QM Manager(s), QM Business Analyst, QM Coordinators, and the Administrative Assistant.

IEHP staff is involved in providing care to members including advocating, informing, educating members, identifying and facilitating access to community resources, and ensuring Members receive appropriate care needs. The health plan employs clinical staff to perform care management and coordination functions that include, and are not be limited to the following:

1) Care Management Department – The Care Management Department is led by the Director of Care Management who possesses a Bachelor of Science Degree in Nursing or related health field, Masters prepared in health or related field preferred, possess a valid and nonrestricted

registered nursing license with the State of California with at least five (5) or more years' experience in managing health care operation, HMO or Medical Group preferred. The Director of CM must also possess a valid California Drivers license and valid automobile insurance. The Director of CM is responsible for direct support to the Chief Medical Officer in managing the operation of the Care Management Department. In this capacity, the Director is responsible for a comprehensive and integrated outpatient Care Management program that includes wellness and care management components, such as California Children's Services, disease management, care coordination, and care management.

i. CM Staffing – The CM staff consists of Care Managers, Care Management Coordinators, Transitions of Care Nurses and Social Workers who are required to meet certain qualifications to perform CM in a managed care environment. The CM Staff facilitate access to specialists and therapies; advocate, inform, and educate beneficiaries; identify and facilitate access to community resources and social services; triage beneficiary care needs. The CM Staff facilitate completion of the comprehensive Health Risk Assessment that assesses the

medical, psychosocial, cognitive and the functional needs of the member within 90 days of enrollment and reassesses when beneficiary conditions change or at least annually thereafter. The CM Staff 1) design individualized care plan for each beneficiary; 2) retrieve consultation and diagnostic reports from network specialists when providing care coordination; 3) oversee language interpretation services; 4) help schedule appointments and follow-up services; contact members to remind them about upcoming appointments or missed appointments; facilitate transportation services; 6) guide and monitor the member through seamless transitions (planned and unplanned) of care across healthcare settings, including setting-to-setting, provider-to-provider, and provider-to-facility; contact members to monitor their status after a transition of care from provider-to-provider, facility-to-facility, or provider-to-facility; notify the Interdisciplinary Care Team (ICT) about any transitions; assist members with access to network providers that participate in both the Medicare and Medi-Cal programs. IEHP will provide services initially under the member's Medicare coverage then assist members to access their Medi-

Cal benefits to supplement the Medicare coverage (e.g. vision, transportation and dental services).

2) **Behavioral Health Department** – The Behavioral Health Department operates under the Clinical Director of Behavioral Health, who must be a Doctoral level psychologist licensed in the State of California with at least five (5) or more years' behavioral health administrative experience. Under the direction of the Chief Medical Officer, the Clinical Director of Behavioral Health is responsible for clinical oversight and management of BH Program activities. Principal accountabilities for the BH Program include: clinical oversight and direction of the BH Program; developing and implementing clinical policy for BH activities; participation in IPA BH activities, as necessary; reviewing BH criteria to ensure that protocols and BH personnel of IEHP follow rules of conduct; monitoring and oversight of BH activities performed by IEHP. The Clinical Director of BH oversees triage and referral decisions and is available to the LCSW to make final triage determinations.

   i. <u>BH Staffing</u> – The Clinical Director of BH oversees a BH unit consisting of an adequate number of BH Care Managers with the required qualifications to perform BH care management in a

managed care environment. BH staff positions include Licensed Clinical Social Workers, Masters Level Social Workers and Bachelor Level Behavioral Health Specialists. The required qualifications for BH care management staff positions consist of experience in BH care management, UM, Social Work, or other clinical quality improvement experience sufficient to oversee and assist with BH care management issues.

3) **Pharmacy Department** - The Pharmaceutical Services Department operates under the Director of the Pharmaceutical Services, who reports to the Chief Medical Officer. The Pharmaceutical Services Department is responsible for Pharmacy Benefits and Pharmaceutical Services, including Pharmacy Network, Pharmacy benefit coverage, formulary management, drug utilization program, Pharmacy quality management program and pharmacy disease management program. The Director of Pharmaceutical Services is responsible for developing and overseeing the IEHP Pharmaceutical Services Program.

   i. Pharmaceutical Services Staff - staff support for the Director of Pharmaceutical Services consists of a Pharmacy Operations Manager, Pharmacy Program Specialist Supervisors, and Pharmacy Program Specialists who are responsible for

performing all prior authorization activities. Clinical Pharmacists also help to support the Director of Pharmaceutical Services in all clinical projects.

3b. Identify the specific employed or contracted staff to perform administrative and clinical oversight functions (at a minimum 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).

IEHP has multiple committee's that monitor MOC compliance, assures statutory and regulatory compliance, evaluates program effectiveness, monitors the ICT, oversees plan operations and develops policies, assures timely and appropriate delivery of care and pharmacotherapy services, conducts a quality improvement program, reviews and analyzes utilization data, assures providers adhere to nationally recognized clinical practice guidelines for clinical care, assures seamless transitions and timely follow-up to care, tracks and analyzes transitions of care to assure timeliness and appropriateness of services, monitors the provision of services and benefits for follow-up, surveys Members and network providers, oversees agencies and the public, conducts targeted medical chart reviews, and conducts medication reviews. The following IEHP committees are

comprised of network practitioners, specialists, and Medical Directors. Medical Directors are voting members of the QM Committee and related Subcommittees who provide their expertise in assisting, directing and overseeing MOC implementation is in compliance with the CMS and States mandates:

1) **Quality Management Committee** – The QM Committee reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The QM Committee announces the quality improvement process to participating groups and physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the Chief Medical Officer. The QM Committee meets quarterly or more frequently as needed. The QM Committee seeks methods to increase the quality of health care for the served population; institutes and directs needed actions; and ensures follow-up as appropriate. The Committee provides oversight direction for Subcommittees in related programs and activities, reviews and approves Subcommittee recommendations and findings.
2) **Peer Review Subcommittee** – The Peer Review Subcommittee is responsible for peer review activities for IEHP. It reviews Provider, member or Practitioner grievances and/or appeals; practitioner related quality issues; and other peer review matters as directed by the IEHP

Chief Medical Officer or Medical Director. The Subcommittee performs oversight of IPAs who have been delegated credentialing and re-credentialing responsibilities and evaluates the IEHP Credentialing and Re-credentialing Program with recommendations for modification as necessary. The Peer Review Subcommittee serves as the committee for clinical quality review of practitioners; evaluates and makes decisions regarding Member or practitioner grievances and clinical quality of care cases referred by the CMO.

3) **Credentialing Subcommittee –** The Credentialing Subcommittee performs credentialing functions for practitioners who either directly contract with IEHP or for those submitted for approval of participation in the IEHP network by IPAs that have not been delegated credentialing responsibilities. The Credentialing Subcommittee reviews individual practitioners who contract with IEHP and can deny or approve their participation in the IEHP network. The Credentialing Subcommittee provides thoughtful discussion and consideration of all network practitioners being credentialed or recredentialed; reviews practitioner qualifications including adverse findings; approves or denies continued participation in the network every three years for recredentialing and ensures that decisions are nondiscriminatory.

4) **Pharmacy and Therapeutics (P&T) Subcommittee** – The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; oversight of the pharmacy network including medication prescribing practices by IEHP providers; assessing usage patterns by Members; and assisting with study design, clinical guidelines and other related functions. The Subcommittee reviews and updates clinical practice guidelines that are primarily medication related. The P&T Subcommittee maintains a current, effective formulary and monitoring medication prescribing practices by IEHP practitioners, and under and over utilization of medications. The P&T Subcommittee objectively appraises, evaluates, and selects pharmaceutical products for formulary recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary inclusion and exclusion. The Subcommittee provides ongoing recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications. The Subcommittee ensures that decisions are based only on appropriateness of care and services. The P&T Subcommittee develops, reviews, recommends and directs the distribution of disease state

management or treatment guidelines for specific diseases or conditions that are primarily medication related.

5) **Utilization Management (UM) Subcommittee** – The UM Subcommittee performs oversight of UM activities conducted by IEHP and delegated IPAs to maintain high quality health, care as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. The Subcommittee reviews new technologies and new applications based on current technologies. It is also responsible for reviewing and updating preventive care and clinical practice guidelines that are not primarily medication related. The UM Subcommittee directs the continuous monitoring of all aspects of UM administered to members, with oversight by the IEHP Chief Medical Officer and the Medical Director. The UM Subcommittee reviews and approves the Utilization Management, Care Management, and Health Management Programs annually. The Subcommittee monitors for over and underutilization and ensures that UM decisions are based only on appropriateness of care and service.

6) **Grievance Committee** – The Grievance Committee is an internal oversight committee responsible for monitoring all member grievances to ensure timeliness and compliance with regulatory guidelines.

Grievance reports are presented to the IEHP Governing Board, Quality Management Committee, Peer Review Subcommittee, UM Subcommittee, P&T Subcommittee and regulatory agencies. On a quarterly and annual basis, the Grievance Committee analyzes all grievance and appeal data generated internally by IEHP, and retrieved from outside regulatory agencies. The purpose here is to identify trends, barriers, and improvement opportunities, develop interventions to address the opportunities and evaluate outcomes of actions taken.

7) **Behavioral Health Advisory Subcommittee -** The BH Advisory Subcommittee will serve as a multidisciplinary BH specialty advisory committee which will review Utilization Management (UM) and Quality Improvement (QI) activities and reports for BH services as well as review BH clinical guidelines, new BH technology and treatment innovations. The BH Advisory Subcommittee will meet quarterly and will consist of licensed clinicians from IEHP's BH network and contracted consulting clinicians including at least one psychiatrist, one psychologist, one LCSW and one MGT. The IEHP Clinical Director of Behavioral Health or the IEHP Consulting Psychiatrist will chair the Subcommittee. Members will be selected to serve on a voluntary basis for a term of at least one year.

8) **Compliance Committee** – The Compliance Committee oversees the organizational Compliance Program which includes compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent updates; the Fraud Waste and Abuse Program (FWA) to prevent, detect, investigate, manage and report incidents of suspected fraud; and, ethical considerations including the entity's Code of Conduct. The Compliance Committee was organized to comply with state and federal regulatory requirements cited by the California Department of Managed Health Care (DMHC) in the California Health and Safety Code § 1348, enacted through SB 956 in 1998; the California Department of Health Care Services (DHCS) 04-35765; the Centers for Medicaid & Medicare (CMS) in the Code of Federal Regulations, Title 42; and most recently, the compliance related requirements of the American Recovery and Reimbursement Act (ARRA) of 2009. The Committee is accountable to the Governing Board oversees all compliance activities related to the Medi-Cal, Healthy Families, Healthy Kids and Medicare Programs. The Compliance Committee aims to monitor ongoing compliance with the seven core elements of an effective program including the identification of deficiencies and the corrective action(s) required to remediate them.

4. Interdisciplinary Care Team (ICT)

The description must include at a minimum:

- **How the plan will determine the composition of the ICT**
- **How the beneficiary will participate in the ICT, as feasible**
- **How the ICT will operate and communicate**
- **How the activities of the ICT will be documented and maintained**

The MOC Interdisciplinary Care Team (ICT) was developed to provide a multi-disciplinary approach to assessing and monitoring the targeted population. The ICT will strive to address the multiple issues that affect this population (e.g. medical, behavioral health, psychosocial, cognitive and functional issues). The ICT meets monthly, but not less than 10 times a year, and will meet ad hoc when indicated. Meetings may be face-to-face or telephonic. All meetings are documented in minutes and maintained as part of the Member record through notes made into the medical management database.

- **To determine the composition of the ICT, IEHP performs the following:**

Each beneficiary is assigned an ICT composed of staff, the Primary Care Provider, ancillary providers and specialty care providers pertinent to the beneficiary's specialized needs. Reports of all new beneficiaries with hieracherial category coding (HHC) risk factors admission and discharge information are

submitted (monthly but not less than 10 times a year) to the ICT for review and recommendations. The Care Management Nurse, in consultation with the Medical Director if necessary, determines the membership of each particular Member's ICT based on individual Member needs. Cases to be presented are sent to the ICT members via secure email to ensure PHI is preserved, one (1) week prior to the meeting. The following healthcare professionals are required to attend the ICT meetings:

1) IEHP Medical Director, board certified physician
2) Social Workers (LCSW, MSW);
3) Mental/behavioral health experts (e.g. Clinical Psychiatrist);
4) Nurse Care Managers;
5) Clinical Pharmacologist

Based on the Health Risk Assessment score identified and particular member needs, the Care Manager is responsible for inviting the individuals applicable for the case discussion. Through emails, providers/agencies, telephone calls, and/or faxes the method of communication and sharing of documents are shared. The timeframe for notification is at least one (1) week prior to the meeting. When it is determined that other membership is needed based upon the individual Member needs, additional ICT members may include some or all of the following:

1) Members/Member Caregiver/IHSS caregiver/family member

2) Member Providers (e.g. PCP/board certified Specialists/Nurse Practitioner/Physician's Assistant/Mid-level provider)
3) Care Coordinators
4) Community resources specialists (e.g. Inland Regional Center, County Independent Living Centers, Meals on Wheels)
5) Restorative health specialist (physical, occupational, speech, recreation)
6) Registered Dieticians/Nutritionist
7) Disease Management Nurses
8) Health Educators (preventive health/health promotion specialist)
9) Dentist

For example, if a member is identified with speech disorder needs, the makeup of the ICT will include the member/caregiver, IEHP Medical Director, Social Worker, Mental/Behavioral Health expert, Nurse Care Manager, Clinical Pharmacologist, and a Restorative health specialist.

- **The beneficiary will participate in the ICT, as described below:**

The Care Manager will facilitate the participation of the member/beneficiary by performing the following:

1) The Care Manager will pre-screen the member for language and communication requirements in order to facilitate individual member participation at the meeting.

2) Ensure ICT meetings may be held telephonically by the member in the member's own primary language or through TTD/TTY or through use of a language line interpreter if the language is not one of the company's threshold languages.
3) Ensure conference call capabilities, if needed to include providers and members/beneficiaries.
4) Ensure the ICT develops and implements an individualized care plan with the member/beneficiary or caregiver. Prior to the care plan being presented to the ICT, the Care Manager will review the Care Plan with the member to verify if updates are needed.
5) The Care Manager will inform the member of the upcoming ICT care coordination meeting on a regular schedule, as needed.
6) The Care Manager will inform the member of an established toll free number for member/beneficiary inquires and input.

- **The ICT will operate and communicate, and it's activities will be documented and maintained, as described below:**

1) Schedule face-to-face meetings once a month (every 3rd Tuesday at 10 am) at IEHP Conference Room. The frequency of meetings may change based upon the special needs of the members.

2) Maintain a web-based meeting interface which includes community based agencies.
3) Conduct case rounds on a regular schedule (Inpatient Rounds meet weekly and ICT meets monthly, but not less than 10 times a year). These case rounds occur every Thursday, but the frequency of meetings may change based upon the special needs of members. During meetings, new cases or reports on members with changes of conditions that have previously been presented to ICT may be presented. The order of presentation starts with a progression of more complex to least complex. Examples of more complex members include members who have experienced a transition of care setting, multiple medical conditions, psychosocial complexities and/or environmental barriers.
4) Conduct conference calls among plan, providers, and beneficiaries. The frequency of these calls is based upon the special needs of the member.
5) During the meeting, the ICT will use the individualized care plan to determine participation in the plan of care. The IEHP Care Manager is responsible for keeping this document up to date. Any changes that need to be made will be communicated to the Care Manager and made accordingly.

6) The meeting is attended by the Care Management Administrative Assistant who will take minutes of the meeting.
7) Dissemination of ICT reports, notification, and communication to all stakeholders is accomplished through the use of secured e-mail, fax, phone, and written correspondence. This is done immediately after a meeting or when there is a change in the member's health status.
8) Documentations of proceedings, retention of records, and beneficiary's information are maintained via web-based electronic medical record and/or hard copies filed in a secured file.

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols.

- **Facilities pertinent to the care of the targeted special needs population (e.g., inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging, etc.);**

IEHP Provider Services and Contracts Departments ensure IEHP's network facilities have specialized clinical expertise to in delivering healthcare services to the targeted special needs population**.** This is done through a semi-annual review of the network status. IEHP will present this report to the Quality Management Committee twice a year. IEHP will request interventions from the committee to

improve the network to meet any deficient goals. These networks include the following approximates:

1) **LTSS Facilities and Providers**

   IEHP will develop a network that meets or exceeds the network adequacy and credentialing standards set by DHCS for the Demonstration Project. See our response in more details in the HCBS and LTC provider network sections below.

2) **Primary Care Providers**

   a) Assigned Members not to exceed 1:2,000

      - Quantitative Analysis - based on the current total SNP Membership of 4,362 and the total PCP count of 337, the IEHP network has a 1:13 ratio.
      - Conclusion – IEHP's current ratio far exceeds the state standard of 1:2,000. Given the IEHP ratio, IEHP PCPs have the capacity to accommodate 1,130% more members.

   b) Accepts minimum enrollment of 500 members

      - Quantitative Analysis – 10 PCPs were identified as not meeting the required minimum enrollment of 500 members.
      - Conclusion - based on a total PCP count of 337, the IEHP network is 97% compliant.

c) Family Practice to Member 1:2,000

- Quantitative Analysis – based on the current total IEHP SNP Membership of 4,362 and the total FP count of 156, the IEHP network has a 1:28.
- Conclusion - IEHP is below the IEHP standard of 1:2,000, therefore, IEHP's overall network is 100% compliant.

d) General Practice to Member 1:2,000

- Quantitative Analysis – based on the current total IEHP SNP membership of 4,362 and the total GP count of 87, the IEHP network has a 1:50.
- Conclusion - IEHP is below the IEHP standard of 1:2,000, therefore, IEHP's overall network is 100% compliant.

e) Internal Medicine to Member 1:2,000

- Quantitative Analysis – based on the current total IEHP SNP membership of 4,362 and the total IM count of 79, the IEHP network has a 1:55.
- Conclusion - IEHP is below the IEHP standard of 1:2,000, therefore IEHP's network is 100% compliant.

- **Medical specialists (e.g., cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists, etc.);**

a) General Surgeon to Member 1:15,000

- Quantitative Analysis – based on the total General Surgeon count of 52 and membership of 4,362, IEHP's network results is 1:84 ratios.
- Conclusion – IEHP is below the IEHP standard of 1:15,000, therefore IEHP's network is 100% compliant.

b) OB Providers to Members 1:4,200

- Quantitative Analysis – based on the total OB/GYN count of 130 and SNP membership female ages 14+ membership of 2,325, IEHP's network result is a 1:18 ratio.
- Conclusion – IEHP is below the IEHP standard of 1:4,200, therefore IEHP's network is 100% compliant.

c) Orthopedic Providers to Members 1:20,000

- Quantitative Analysis – based on the total Orthopedic count of 29 and membership of 4,362, IEHP's network result is 1:150 ratios.
- Conclusion – IEHP is below the IEHP standard of 1:20,000 therefore IEHP's network is 100% compliant.

d) Total Physicians to Members 1:1,200

- Quantitative Analysis – based on the total Physician count of 514 and SNP membership of 4,362, IEHP's network result is 1:8 a ratio.
- Conclusion – IEHP is below the IEHP standard of 1:1,200 therefore IEHP's network is 100% compliant.

- **Behavioral and mental health specialists (e.g., drug counselors, clinical psychologists, etc.);**

a) Mental Health to Member 1:500

- Quantitative Analysis – based on the total Mental Health provider's count of 302 and SNP membership of 4,362, IEHP's network results is a 1:14 ratio.
- Conclusion – IEHP is below the IEHP standard of 1:500, therefore IEHP's network is 100% compliant.

b) Psychiatrist Provider to Member 1:1,700

- Quantitative Analysis – based on the total Psychiatrist count of 43 and SNP membership of 4,362 IEHP's network result is a 1:101 ratio.
- Conclusion – IEHP is below the IEHP standard of 1:1,700, therefore IEHP's network is 100% compliant.

c) Marriage and Family Therapist Provider 1:2,500

- Quantitative Analysis – based on the total Marriage and Family Therapist count of 131 and SNP membership of 4,362, IEHP's network result is a 1:33 ratio.
- Conclusion - IEHP is below the IEHP standard of 1:2,500, therefore IEHP's network is 100% compliant.

d) Psychologist Provider to Member 1:16,000

- Quantitative Analysis - based on the total Psychologist count of 58 and SNP membership of 4,362, IEHP's network result is a 1:75 ratio.
- Conclusion - IEHP is below the IEHP standard of 1:16,000, therefore IEHP's network is 100% compliant.

e) Licensed Clinical Social Worker Provider to Member 1:8,000

- Quantitative Analysis – based on the total Licensed Clinical Social Worker count of 56 and SNP membership of 4,362, IEHP's network result is a 1:78 ratio.
- Conclusion - IEHP is below the IEHP standard of 1:8,000, therefore IEHP's network is 100% compliant.

- **Nursing professionals (registered nurses, nurse practitioners, nurse managers, nurse educators, etc.);**

a) Provider To Nurse Practitioner 1:4

- Quantitative Analysis – IEHP has a total of 30 Providers currently supervising 33 Nurse Practitioners, all of whom are at a ratio of 1:4 or less. IEHP monitors compliance with the required ratio whenever NPs are added to a practitioner site to ensure the 1:4 ratios.
- Conclusion –IEHP's network is 100% compliant.

b) OB To Midwives 1:3

- Quantitative Analysis - IEHP has a total of 2 OBs currently supervising 2 Midwives, all of whom are at a ratio of 1:3 or less IEHP monitors compliance with the required ratio whenever Midwives are added to a practitioner site to ensure the 1:3 ratios.
- Conclusion – IEHP's network is 100% compliant.

c) Provider To Physician Assistants 1:4

- Quantitative Analysis – IEHP has a total of 67 Providers currently supervising 99 Physician Assistants, all of whom are at a ratio of 1:4 or less. IEHP monitors compliance with the required ratio whenever PAs are added to a practitioner site to ensure the 1:4 ratios.
- Conclusion – IEHP's network is 100% compliant.

d) Provider to Total Extenders 1:4 (any combination)

- Quantitative Analysis – IEHP has a total of 89 Providers currently supervising 134 Physician Extenders, all of whom are at a ratio of 1:4 or less. IEHP monitors compliance with the required ratio whenever Physician Extenders are added to a practitioner site to ensure the 1:4 ratios.
- Conclusion –IEHP's network is 100% compliant.

- **Allied health professionals (pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc.);**

IEHP has a network of allied health professionals that meets the network standard set by CMS. For example, we have over 580 pharmacies in our network including local and large chain pharmacies, such as Walgreens, Wal-Mart, Rite Aid, and CVS. Also, we have a sufficient network of occupational specialists, speech pathologists, laboratory specialists, and radiology specialists to care for dual eligibles. For example, we have an existing contract with a vendor to provide mobile lab draws in facilities or homes when needed. Also, our ratio of physical therapists to members is 1:3,543.

- **Home-and community-based services providers (e.g. CBAS, MSSP)**

For the CBAS program, IEHP is already working with DHCS and potential CBAS centers at this point to implement the newly created CBAS program according the ADHC Court Settlement. We have met with our local CBAs on multiple occasions to facilitate the transition. The CBAS program integration into managed care will be fully implemented by July 1, 2012.

Since 2004, through the Inland Empire Disabilities Collaborative (IEDC), IEHP has collaborated with the Aging and Disability Resource Connection (ADRC) that administers the MSSP program, and also with over 300 organizations that serve seniors and persons with disabilities (SPDs). We intend to contract with the Aging and Disability Resource Connection for their social and health care management for the MSSP dual eligible members.

We will develop a network that meets or exceeds the network adequacy standards set by DHCS for the Demonstration Project.

- **Long-term care providers (e.g. skilled nursing facilities, residential care facilities)**

Currently under our D-SNP plan, we provide the skilled nursing facility (SNF) coverage for the first 100 days of SNF services. Therefore, we have existing direct contracts with Skilled Nursing Facilities and other types of long term care facilities. We have already initiated meetings with Intermediate Care Facility (ICF) and Board and Care operations to discuss delivery of care, payment issues and

other aspects related to the current transition of SPDs, and the potential future transition of dual eligibles. These discussions have already led to a focused contracting effort to find providers who can provide care at the facilities. We will develop a network that meets or exceeds the network adequacy standards set by DHCS for the Demonstration Project.

- **How the plan determines that their facilities and providers are actively licensed and competent;**

The Credentialing Department ensures prior to contracting with providers that members

receive care from those practitioners who meet IEHP's requirements for being licensed/certified, participate with Medicare and Medicaid, are properly credentialed, are reviewed for OIG exclusion, and whose malpractice or other negative history is within acceptable guidelines. They ensure that all practitioners are reviewed and accepted into IEHP's provider network through a uniform and consistent process at the time of initial contracting and at least every three years thereafter. They also protect the health and safety of all members as part of IEHP's obligation as a Public Entity through appropriate oversight of credentialing activities. The Credentialing Department ensures that IEHP, hospitals and IPAs adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing process. This includes maintaining the

confidentiality of practitioner information obtained during the credentialing process. IEHP delegates responsibility for verifying and maintaining practitioner and facility credentials within IEHP standards to IPAs who meet IEHP delegation requirements.

In accordance with IEHP requirements and NCQA standards the Credentialing Department follows all of these. The Credentialing Subcommittee is responsible for reviewing individual practitioners for denial or approval of participation in the IEHP network who are directly contracting with IEHP. The Peer Review Subcommittee is responsible for reviewing providers identified as potentially non-compliant with standards set by the health plan. The Human Resource Department is responsible for the verification of licensure for all RN, LN, Social Workers, Physicians and any other licensed personnel employed by IEHP at the time of hire and every two years thereafter. IEHP gives priority to board-certified specialists in the provider network by expediting credentialing verification. IEHP understands that the gate keeper of a member's care is their Primary Care Provider, who is responsible for identifying the needs of a beneficiary. Therefore, IEHP strives to assure that the physicians in its provider network are highly competent. Working with provider networks the health plan ensures the beneficiary has access to necessary services. IEHP notifies the member about obtaining services/referrals through the member materials distributed after

enrollment and then annually. The Provider Services and Contract Departments are responsible for assuring that the provider and facility network have specialized clinical expertise pertinent in delivering healthcare services to the targeted special needs population. These include providers that coordinate following:

1) Assess, diagnose, and treat in collaboration with the interdisciplinary care team
2) Provide 24-hour access to a clinical consultant through IEHP Nurse Advise Line
3) Conduct conference calls with the ICT, as needed
4) Assist with developing and updating individualized care plans
5) Provide in-patient acute care services
6) Provide hospital-based or urgent care facility-based emergency services
7) Provide long-term care
8) Assist with conducting disease management programs
9) Provide wound management services
10) Provide pharmacotherapy consultation and/or medication management clinics
11) Conduct home visits for clinical assessment or treatment
12) Conduct home safety assessment
13) Provide home health services

14) Provide home-based end-of-life care through hospice and/or palliative programs
15) Conduct risk prevention programs such as fall prevention or wellness promotion (e.g., diabetes classes, weight loss programs, and smoke cessation programs).

The Credentialing Subcommittee, Provider Services and Contracts Departments are responsible for assuring that IEHP's network providers:

1) Have current licensure and/or certification to perform services that meet the specialized needs of special needs individuals.
2) Are credentialed and competent to perform services that meet specialized needs of special needs individuals. The Credentialing Subcommittee represents various practicing physicians the network providers and the Subcommittee meets bimonthly.
3) Have clinical expertise pertinent to the targeted special needs population and the process includes the following:
    a) IEHP contracts with providers who have clinical expertise to meet the specialized needs of the targeted population (e.g., internal medicine, neurosurgeon, nephrologists, orthopedics, endocrinologists, cardiologists, pulmonologists, etc).

b) IEHP contracts with facilities that provide diagnostic and treatment services to meet the specialized needs of the targeted population (e.g., imaging centers, outpatient facilities, etc).

c) IEHP contracts direct how the network providers and facilities deliver services to beneficiaries.

d) IEHP UM Department tracks and analyzes service utilization.

e) To assure appropriate use of services IEHP administrative and clinical staff approves all referrals to network or out-of-network providers prior to the delivery of services and informs the interdisciplinary care team (ICT).

f) IEHP instructs and assists the beneficiary to directly contact network or out-of-network providers to schedule necessary services and notify the plan and/or ICT.

g) IEHP has established a 1-800 number for beneficiaries to notify IEHP MOC Care Management Team and/or the ICT for assistance in obtaining necessary services.

h) IEHP delegates to the Primary Care Provider and to specialists to remind the beneficiary about the upcoming appointments and follow-up appointments. In addition, if the beneficiary is enrolled in the Complex Care Management program, the Care Manager will

also remind the beneficiary of the upcoming appointment and follow up on the missed appointment.

- **Who determines the services beneficiaries will receive (e.g., who serves as the entry point, how is the beneficiary connected to the appropriate service provider, etc.);**

By using the results from the Health Risk Assessment (HRA) the Care Manager and ICT team determine the services beneficiaries will receive. IEHP ensures all members are assigned to a specific care management team or individual Nurse to serve as the entry point and connects the beneficiary to the appropriate service provider. Depending on the level of medical needs, the member may be assigned to the following: 1) a Complex Care Manager for extensive, intense case management, 2) a General Care Manager for care coordination, 3) a Coordinator to assist with answering basic questions such as referral status, pharmacy status, benefits, or changing Primary Care Providers. The Care Management and Member Services departments conduct a Model of Care (MOC) \member Satisfaction survey for all enrolled Complex CM cases, no less than annually to validate Member assistance given. Three examples of measurable questions annually are: 1) Were you happy with the amount of phone time our nurse gave you? 2) How useful was our Nurse's advice on your medical condition? and 3) How useful was the assistance provided by the MOC team in making your health care easy to

access? A baseline goal of 80% is set overall for each question with comparisons from year to year noted, reviewing any barriers identified and making program improvement accordingly.

- **How the provider network coordinates with the ICT and the beneficiary to deliver specialized services;**

The Provider network coordinates with the ICT and the beneficiary to delivery specialized services by being an active participant in the ICT. Specific activities are described below.

1) Schedule face-to-face meetings once a month
2) A web-based meeting interface which includes community based agencies
3) Conference calls with providers, and beneficiaries
4) Review care plan on IEHP secure provider
5) Review of ICT reports, notification, and communication to all stakeholders.
6) Collaborate with other ICT members, such as long term care facilities

- **How the plan assures that specialized services are delivered to the beneficiary in a timely and quality way.**

To ensure specialized quality services are delivered to the beneficiary in a timely manner, access to care is evaluated on an ongoing basis through a variety of

ways such as grievances, quality of care referrals, HEDIS measures, utilization management reports and care management. IEHP does have several studies and reports with identified goals related to accessibility and these are: Appointment availability access study goal is 90% or greater, Provider grievance rate is less than 0.20 per 1,000 members. The network must comply with the network standards set by IEHP and our regulators. Areas of access are analyzed on an ongoing, monthly, quarterly, semi-annually and/or annual basis depending on the area of review. The Quality Management department will review annually all of these areas to determine effectiveness of the MOC Program and will recommend goals and interventions for the following year. When a deficiency is noted around access, a corrective action plan is put into place to eliminate any barriers to the Members care. Corrective action plans, adding providers or services to the network, implementing quality initiatives that address reducing barriers, changing process to allow for easier access, providing education on access standards and processes to providers, members and their family/caregivers and members of the Interdisciplinary Care Team. IEHP evaluates all access studies, reports and processes to determine the effectiveness of our interventions. A successful interventions results in decreased grievance and appeals, decreased access related quality of care referrals, improvement in HEDIS, CAHPS and HOS surveys, and improved health outcomes of our Members.

- **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;**

Complex member cases are presented and sent to the ICT members via secure email to ensure PHI is preserved, one (1) week prior to the meeting. The method of communication and sharing of documents with providers/agencies is through emails, telephone calls, and/or faxes. The timeframe for notification will be at least one (1) week prior to the ICT meeting. ICT members also meet via face-to-face every month and maintain web-based meetings with community based agencies. Additionally, through monthly case rounds new information on the member is presented, such as a change in health or healthcare setting. During the meeting, the ICT will utilize the individualized care plan to determine participation in the plan of care. The IEHP Care Manager is responsible for keeping this document up to date.

- **How services are delivered across care settings and providers**

To improve transitions of care across healthcare settings, providers, and health services, IEHP ensures a Transitions of Care (TOC) Nurse, or designee performs this function. For instance, when a Member moves from one setting to another, there is an assigned TOC Nurse to coordinate and facilitate the care, educate regarding the delivery system, medicine reconciliation, and the importance

of keeping follow up appointments as directed by physician(s). To ensure this is occurring, an auto task is sent to the TOC Nurse when a Member is admitted, discharged, or transitioned from any healthcare setting to another. The TOC Nurse is responsible for education to the Member regarding the change in their healthcare status. No less than annually, a Measuring Care Transitions Effectiveness Study is conducted to ensure that all elements of the process are monitored and that goals set are monitored for compliance. Three examples of measurable questions that will be trended annually are: 1) Notification to Primary Care Physician (PCP) for all planned and unplanned admissions at time of discharge; 2) Member contact initiated timely by the Case Management (CM) Team for all discharges to home; and 3) Communication with Member about the changes in the Members health status and plan of care was done timely for all admissions. A baseline goal of 90% is set with an expectation of a 10% reduction in non-compliance overall. Barriers are noted and process steps are implemented to improve performance as needed.

- **How the plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.**

To assure appropriate utilization of services and that providers use evidence-based clinical practice guidelines and nationally recognized protocols, the IEHP Utilization Management (UM) Department utilizes nationally recognized clinical criteria, Medicare and Medi-Cal benefit guidelines, and IEHP UM Subcommittee

Approved Guidelines when making decisions on medical care. The UM Subcommittee meets quarterly to approve any new Guidelines that have been determined necessary. The goal is to ensure the most current clinical criteria and benefit guidelines are applied when making decisions regarding utilization 100% of the time. The monitoring of this is ongoing.

The plan annually audits its delegated IPAs to ensure that nationally approved criteria is used for all clinical decisions, and monthly denial letter review is conducted to ensure appropriate application of this criteria. Denial letter review results are analyzed monthly. If the goal is not met, Corrective Action Plans are issued for those delegates that do not meet the requirements.

6. Model of Care (MOC) Training for Personnel and Provider Network

- **Plan for initial and annual MOC training, including training strategies and content (at a minimum includes at least one of the following: printed instructional materials, face-to-face training, web-based instruction, audio/videoconferencing).**

IEHP provides training throughout the year on the MOC program. Training may include face-to-face training, printed instructional materials, web-based instructions, or audio/video conferencing approach for all personnel and providers. Operational changes resulting from Model of Care updates are presented to the

ICT in the fourth quarter to direct and implement changes for the upcoming contract year. The contents of the MOC training include:

1) Dual-eligible benefits (Medicare and Medicaid Benefits)
2) Care coordination
3) Care Management roles and responsibilities
4) Transitions of care program for beneficiaries who transition from settings-to-settings,
5) providers-to-providers, providers-to-facilities
6) Interdisciplinary Care Team meeting participation and communication process
7) How Members and Providers inquire and provide input
8) Individualized Care Plan
9) Health Risk Assessment Process
10) Use of nationally recognized protocols and Clinical Practice guidelines
11) Electronic Health Information
12) Communication Network including provider web portal

- **Method for assuring and documenting completion of training by the employed and contracted personnel (at a minimum include attendee lists, and at least one of the following: results of testing, web-based attendance confirmation, electronic training record).**

To ensure employed and contracted personnel complete training, the IEHP Care Management Department provides mandatory initial and annual training on the MOC to all IEHP staff, both full time and part time/temporary employees in the Care Management, Health Management, Utilization Management, Quality Management, Member Services, Enrollment Services, Provider Services, Credentialing, Claims, Pharmaceutical Services, Compliance Grievance, Health Administration, Healthcare Analytics and Reporting, Behavioral Health, Human Resources, Marketing, Finance, Information Technology, and Contract Departments.

The Care Management Department is responsible for all personnel training regarding the

Model of Care. The designated personnel ensure:

1) All IEHP employees received MOC training
2) Keep records of training including agenda and sign-in sheet
3) All MOC training is documented and includes the date of the training, staff present and an agenda
4) Forward the training records to Compliance Department to ensure compliance, evidence of completion, and for review upon CMS requests

Basic training includes health plan benefits, HIPAA compliance and cultural sensitivity. Every employee receives this training, but those that deal with Members directly receive a specialized training. Some examples of specialized training would include 1) effective interviewing skills, 2) coordinating home and community based services, 3) end of life training, 4) coordinating psychological services, 5) accessing health plan benefit, or 6) case management services. A generalized training is conducted for employees serving the members indirectly. This may be done either face-to-face, by using printed materials and/or PowerPoint presentations, or electronically by posting the printed materials on IEHP Provider web portal.

Attendance is mandatory. This is documented in the form of a sign-in sheet and kept by administrative staff in departmental records. Employees are encouraged to meet the Model of Care standards through training, one-on-one sessions, and the audit process. Make up sessions are scheduled for those unable to attend. IEHP also has a process for taking action when the required Model of Care training has not been completed by the IEHP staff or contracted individual. Follow up communication will be made to the employee and their direct supervisor, informing them that the training is mandatory. If the employee fails continually to meet this requirement, Human Resources will be informed and the employee will be placed on a Performance Improvement Plan.

- **Identified personnel responsible for oversight of the MOC training.**

The Care Management team is responsible for the oversight of the MOC training. The Care Management Team is responsible for providing additional training for the employed personnel or for specific units within IEHP as the need arises. Employees have access to the training materials and policies and procedures that support the Model of Care. Policies and procedures are reviewed and updated annually.

- **Actions to take when the required MOC training has not been completed (at a minimum includes: contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion)**

Under the leadership of the Director of Care Management, monthly staff audits are conducted by department management to ensure adherence to the policies and procedures on Model of Care. Deficiencies identified during the audit process are documented and addressed one-on-one with the staff. In-services are scheduled monthly to educate the entire staff on best practices and improved outcomes in support of the Model of Care.

IEHP has designated personnel (e.g., Provider Services and Quality Management Nurse Educator) who are responsible for overseeing training

implementation and maintaining the training records for all providers. The designated personnel ensure:

1) Training of all contracted providers, starting with high volume contracted Primary Care Providers
2) All MOC training is documented and includes the date of the training, staff present and an agenda
3) Maintenance of records of training, including agenda and sign-in sheet
4) Forward the training records to Compliance Department to ensure compliance, evidence of completion, and for review upon CMS request

7. Health Risk Assessment (HRA)

- **The HRA tool used to identify the specialized needs of its beneficiaries (at a minimum includes: medical, psychosocial, functional and cognitive needs, LTSS needs, medical and mental health history).**

The HRA tool used to identify the specialized needs of beneficiaries is outlined below:

1) <u>Initial Member Stratification</u>
    a) The Healthcare Analytics and Reporting (HAR) Department will perform initial risk stratification for all newly enrolled Medicare DualChoice (HMO SNP) Members by utilizing current HCC

scores, including participation in the Medication Therapy (MTM) program, and, if available, medical encounter, pharmacy and emergency room data, to identify Members who are at high risk, have co-morbid conditions, or have complex healthcare needs.

b) IEHP will send a Welcome Letter to all newly enrolled Medicare DualChoice (HMO SNP) Members. This letter provides eligible Members written information on how to use the Model of Care (MOC) Program, how Members become eligible to participate and how they can to opt-in or opt-out of the MOC program.

2) Health Risk Assessment

a) Upon completion of initial risk stratification, all newly enrolled Medicare DualChoice (HMO SNP) Members will be auto-routed by HAR to the MOC Team to be surveyed by utilizing a standardized HRA survey tool.

b) The MOC Team Coordinators will make at least three attempts (mail and phone) to contact the new Member to conduct the HRA survey.

i. If the MOC Team Coordinator is unable to contact the new member by phone, every effort will be made to secure a valid phone number (e.g. the PCP office, specialty care provider

office, a vendor where equipment is rented from, current pharmacy use).

ii. If the member cannot be reached by phone and/or refuses to go through the HRA survey process, the MOC Team Coordinator will ensure this information is documented in the medical management computer system the HRA may be mailed to the member to complete.

c) The HRA survey is made up of two sections, one pertaining to the medical and functional status and another pertaining to the behavioral health care (psychosocial and cognitive) status of the member. The HRA survey questionnaire includes elements, such as:

i. Assessment of members' health status including condition-specific issues and documentation of clinical and medical history including medications

ii. Assessment of members' medical care needs such as primary care, specialty care, durable medical equipment, transportation, health education, physical or cognitive barriers to healthcare access

iii. Assessment of members' activities of daily living including assisting with self management skills or techniques, and life-planning activities such as Advanced Directive or Living Will

iv. Evaluation of members' caregiver resources and involvement, and available benefits

v. Assessment of members' mental health status, including cognitive functions

vi. Assessment of members' cultural and linguistic needs, preferences or limitations

vii. Evaluation of members' visual and hearing needs, preferences or limitations

viii. Assessment of members' needs for referrals to community resources or other community based agencies such as mental health, behavioral health, In Home Supportive Services, Meals on Wheels, Inland Regional Center, Housing Authority Section 8, Senior Community Center, Alcohol or Substance Abuse Treatment Services, etc.

d) The completed HRA stratifies the member into one of three levels of care management (HIGH, MODERATE, or LOW) to identify the different levels of needs.

IEHP includes input from its stakeholders and consumers in the development of a standardized HRA survey tool by presenting the draft HRA tool to the Public Policy Participation Committee (PPPC) and Persons with Disabilities Workgroup (PDW) for discussion, recommendation and consensus.

- **When and how the initial HRA and annual reassessment are conducted for each beneficiary.**

All newly enrolled Medicare DualChoice (HMO SNP) and Seniors and Persons with Disabilities (SPD) receive a comprehensive initial Health Risk Assessment (HRA) of their medical, psychosocial, cognitive and functional needs. IEHP conducts a comprehensive initial HRA within 90 days of enrollment (for SNP) and 45 days of enrollment (for high risk SPD) and are re-assessed at least annually thereafter. Every effort is made to conduct the initial HRA within 30 days.

The HRA identifies the specialized needs of the member population. It is not designed to replace the need for a comprehensive physical exam conducted by the PCP. The HRA was developed using Interdisciplinary Care Team (ICT) oversight with input from providers, key health plan staff, and the member community. The HRA utilizes a tree logic to integrate the specialized needs of its beneficiaries. For example, when a member indicates that he or she has a specific disease, the HRA automatically triggers questions that relate to that issue. The converse of this is true

as well (e.g., questions that do not relate to the Member are not triggered during the assessment process). The HRA survey process for each beneficiary includes some or all of the following:

1) IEHP uses a standardized Health Risk Assessment (HRA) tool for all beneficiaries.
2) Clinical personnel including Nurses, social workers, clinical psychologist, pharmacists, physicians, and the IEHP Medical Director participate in the development, analyzing, and validating of the HRA tool.
3) The clinical team also consists of members from the Interdisciplinary Care Team (ICT) who assist in the development, revisions, and validation of the HRA tool utilized.
4) Conduct an initial comprehensive HRA within ninety (90) days of enrollment for every IEHP Medicare DualChoice (HMO SNP) beneficiary and within forty-five (45) days for all high risk Seniors and Persons with Disabilities (SPD) beneficiaries.
5) The HRA is performed annually after the initial assessment on all Medicare DualChoice (HMO SNP) Members to reassess and identify changes in member health status since the last assessment.

6) A re-assessment will be conducted on annually on Medicare DualChoice (HMO SNP) members. For SPD members rejoining the Plan after a disenrollment period of 30 days or more, reassessments will be performed to identify changes in health status that may have occurred during the absence from the health plan.
7) The HRA is derived from questions required by the state for SPD, NCQA, federal for SNP, and PHQ9 in its original context.
8) The HRA consists of certain questions that when answered generate referrals to either the Behavioral Health or Health Education department for further follow up.
9) The HRA tool is pre-populated with provider network claims and encounter information including medical, pharmacy, laboratory and facility data.
10) The HRA tool allows for validation of pre-populated data while collecting Member reported information. The comprehensive initial and annual HRA examines medical, psychosocial, cognitive, and functional status which includes, but is not limited to beneficiary's general health status, chronic medical conditions, living situation, family support system, decision making ability, pharmacy and hospital utilization, behavioral health problem.

11) The HRA tool uniquely stratifies the Member using the combined data elements. The subsets of members that are stratified to the highest complexity level after completion of the HRA are triaged according to complexity in Care Management.
12) IEHP uses the HRA results to develop an individualized Care Plan tailored to the member's risk for each of the special, individual needs. The Care Plan is updated as needed and will narrate, dictate and communicate the Member specific issues, goals/objectives, interventions/services needed, with measurable outcomes. The Care Plan format is designed to carry out the care coordination process.
13) The comprehensive HRA may be conducted by telephone, face-to-face, electronically or paper based. The Care Management team makes every effort to contact beneficiaries to conduct the initial HRA survey within thirty (30) days of enrollment (for SNP Members) or within forty-five (45) days of enrollment (for high-risk SPD Members).
14) IEHP periodically reviews the effectiveness of the HRA tool. The HRA scores are analyzed to determine validity of tool and scoring system on an ongoing basis.

- **The personnel who review, analyze, and stratify health care needs.**

IEHP has a process to conduct authoritative health risk assessment, analyze identified health risks, and stratify them to develop an individualized care plan that mitigates health risks through some of the following methods:

1) Clinically knowledgeable personnel analyze the HRA and stratification level to determine appropriate care management placement.
2) Comprehensive health risk analysis is conducted by a credentialed, healthcare professional. This individual can approve, add, change or remove interventions based on clinical judgment which may affect the final stratification of the member. If the HRA score is high by the stratification process, a Care Management Nurse will review the results and perform a follow-up phone call to the member/beneficiary.

- **The communication mechanism to notify the ICT, provider network, beneficiaries, etc. about the HRA and stratification results.**

IEHP notifies the ICT members, respective providers, and beneficiary about the results of the health risk analysis as applicable. The results of the HRA tool data are translated into a sixth grade reading level format. It is then distributed using HIPAA compliant specifications.

1) ICT members: electronic HRA results and summary reports
2) Responsible Providers: HRA results and care plans are posted on the secure provider portal website for their review and input.

3) Beneficiaries (SNP and high-risk SPD Members only): mailed copy of individualized care plan for review, comments, and to bring to the doctors' appointment.

All HRA data is tracked and trended to determine the need for additional specialized benefits and services. Based on the data analysis, IEHP offers additional benefits and/or services (e.g., medical transportation, vision benefits, and dental benefits) and provides extensive Complex Care Management for these special needs individuals.

IEHP uses algorithm or other software to stratify beneficiary health risk for the development of an individualized care plan. Answers to the HRA stratify the member into one of three levels of care management (low, moderate or high). There are two methods of stratifying:

1) Selected specific diagnosis/medical conditions
2) HRA tool: based on response to questions, the member is placed in high, moderate or low risk category.

8. Individualized Care Plan

- **Which personnel develop the individualized plan of care (POC) and how the beneficiary is involved in its development.**

The individualized POC is developed by the respective ICT for all MOC Members. Each beneficiary is assigned an ICT that develops the POC, with beneficiary involvement when feasible. The Care Management and ICT solicit beneficiary input relating to goals and barriers to develop the POC.

IEHP has written process to facilitate beneficiary/caregiver participation in care planning when feasible. The process includes some or all of the following:

1) DualChoice Pod Team is responsible for inviting the beneficiary and/or caregiver to attend the ICT meeting. The beneficiary and/or caregiver may attend or call into IEHP's conference room.
2) The invitation can be done by telephone or by a written correspondence with their interdisciplinary team member such as a memo, letter, or e-mail. IEHP has a written procedure for maintaining the documented POC is for each beneficiary that complies with HIPAA. The electronic POC stored in the database (maxMC) and a password is required to access it. Paper copy of the completed POCs are stored and locked in a secure file cabinet, if needed. Disposed POCs are placed in the shred bin. IEHP has access to the documented POC for the ICT, respective providers, and beneficiaries. All ICT members, respective providers and beneficiaries have access to the POCs upon completion of the HRA assessment, as condition changes, or per request. When transition of

care occurs the POC is also shared with the facility (e.g. hospital or skilled nursing facility).

- **The essential elements incorporated in the POC at a minimum includes: results of health risk assessments, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits, services beneficiaries with disabilities, services for those near the end-of-life.**

The elements put into the POC are developed from the results of initial HRA. At the time of the HRA the member is asked to identify his or her personal health goals. The results from the initial HRA are used to personalize the development of the POC (e.g., considering the beneficiary's wishes and healthcare preferences such as medical treatment versus surgery). During the on-going development and delivery of the POC, the Care Manager ensures member goals and preferences are identified and are documented in the POC.

- **The personnel who review the care plan and how frequently the POC is reviewed and revised (at a minimum: POC is developed by the 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)**

The POC is developed by the respective ICT for all MOC Members including the beneficiary whenever feasible. ICT team members update the individualized care plan as beneficiary health status changes (e.g., member was ambulatory and now bed bound and needs hospital bed).

- **How the POC is documented and where the documentation is maintained (at a minimum includes: 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)**

All documentation, including changes to the care plan is maintained in an electronic care management system. The Care Management Department ensures the care plan interventions educate, empower and facilitate the member to exercise his/her rights and responsibilities. For member-specific services and benefits, the care plan identifies those that can have measurable outcomes. The Care Manager discusses the Care Plan with the member and/or caregiver, ensuring that information and support is given so the member to make choices regarding his/her health. members are encouraged to take a copy of their care plan to their provider at each scheduled appointment to review and update goals and/or interventions as needed. The Care Managers function as the central coordinators of care across all settings and providers. They are responsible for implementing and coordinating all

case management activities relating to the special needs population; including advocating and educating members on services and benefits, triaging member's care needs, conducting and analyzing HRA, initializing and implementing the member individualized care plan, ongoing review and updating of the member individualized care plan, use of community resources, and alternative levels of care, coordinating care for beneficiaries across all care setting including provider services, assisting member with scheduling appointments and follow up services. The Care Manager also provides educational opportunities where appropriate including psychosocial interventions through resource identification, program development and other means. The ICT, Providers, and members are able to participate in the care planning process telephonically, face-to-face, through written correspondence or via the IEHP website.

- **How the POC and any care plan revisions are communicated to the beneficiary, ICT, MAO, and pertinent network providers.**

ICT members update the individualized care plan as beneficiary health status changes (e.g., Member was ambulatory and now bed bound and needs hospital bed).

The Care Management team notifies respective providers and beneficiaries when they update a care plan that result from health status changes. The respective providers are notified regarding the updated care plan via blast fax.

9. Communication Network

- **How the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies.**

IEHP has procedures to coordinate the delivery of services and benefits through communication systems connecting IEHP staff, providers and Members, public, and regulatory agencies. IEHP has written procedures to coordinate the delivery of services and benefits through communication systems connecting plan personnel such as Care Managers, Disease Managers, Behavioral Health Specialists, Health Educators, and Utilization Management; providers such as primary care providers, specialists, and any other physician associated with that Member's care; and beneficiaries which can include the following:

1) Call line for Member inquiries: IEHP has established a specific toll free number for IEHP Medicare DualChoice (HMO SNP) beneficiaries. All beneficiaries may direct their inquiries through IEHP Medicare Member Services Department at 1(877) 273-4347or 1(800) 718-4347 for TTY users, 8 a.m. to 8 p.m. (PST), 7 days a week.
2) Call line for provider network inquiries: IEHP has established a toll free number specifically inquires from providers' inquiries. Providers may

contact Provider Call Center regarding provider, utilization, claims, vision, and model of care at 1(866) 223-4347.

Additional sections below include the numerous ways IEHP connects plan, providers, beneficiaries, public and regulatory agencies.

- **The structure for a communication network (at a minimum includes at least one of the following: web-based network, audio conferencing, face-to-face meetings)**

The structure for communication includes web-based network, audio conferencing, and face-to-face meetings. See below for examples.

1) Care coordination/Interdisciplinary Care Team meetings: IEHP has a team of clinical staff available to facilitate and coordinate healthcare delivery for the beneficiaries. The Care Management staff assists beneficiaries with PCP changes, pharmacy and service referrals, durable medical equipment. Interdisciplinary Care Team (ICT) meetings take place face-to-face, with the Member/beneficiary, if indicated. Meetings are held monthly, but not less than 10 times a year and ad hoc when indicated between scheduled meetings. The Care Management Administrative Assistant, or designee, is responsible for maintaining and distributing written minutes to appropriate team

members. An internal secure web-based portal is used to maintain and access departmental meeting minutes.

2) Case rounds: The Care Management staff consults with social workers, clinical psychologist, pharmacists, health educators, and the plan Medical Director on an on-going basis. On a weekly basis, the UM Inpatient Review Team, including the Transitions of Care Nurse, UM Nurses, Social Workers, and Medical Director meet to review any new barriers to Member care. These meetings take place face to face. The Director of Utilization Management, or designee, is responsible for maintaining and distributing written documentation to appropriate team members. An internal web-based portal is used to maintain and access departmental meeting documents.
3) Grievances documentation and system for resolution: IEHP has a specific unit, Grievance and Appeals, that reviews and resolves beneficiary complaints and grievances. All pertinent documents are housed in the integrated database system.
4) Quarterly Committee Meetings (e.g., Utilization Management, Quality Management Committee, and Peer Review Subcommittee): IEHP's Quality Management Committee is supported by subcommittees that have the responsibility for communication and accountability among

the plan departments and staff. All operational departments have reporting responsibility to the Quality Management Committee for key indicator information tracked by the plan. This includes, but is not limited to, over/under utilization from the Utilization Management Subcommittee, the peer review data from the Peer Review Subcommittee, credentialing of practitioners from the Credentialing Subcommittee, pharmacological information from the Pharmacy and Therapeutics Subcommittee, clinical outcomes and a variety of other indicators from other interdepartmental subcommittees. The Quality Management Committee tracks and trends complaints through the Grievance Committee, as well as reviews and makes recommendations for interventions based on the outcomes of Member/provider satisfaction surveys. Using the report(s) generated, opportunities for possible interventions for measurable improvement(s) are identified. Committees either meet bi-monthly or quarterly. Committee minutes are taken by the Administrative Assistant of the department holding the committee meeting.

5) Conference calls: IEHP has the ability to provide communication via conference calls. This allows practitioners, beneficiary/caregiver, and

other healthcare professional representative to participate in the Interdisciplinary Care Team meetings. This occurs on an ad hoc basis.

6) Person-to-person direct interface: When a Member requires a face-to-face meeting, the majority are held in one of the IEHP conference rooms.

- **How to preserve aspects of communication as evidence of care (at a minimum includes at least one of the following: recordings, written minutes, newsletters, and interactive websites).**

IEHP preserves aspects of communication as evidence of care through recordings, written minutes, newsletters, and interactive websites). See below for examples.

1) Emails, faxes, and written correspondence: secure e-mails, faxes, web portal, and telephone systems are available for communication and correspondence.

2) Electronic network for meetings, training, information, communication: Contracted providers including practitioners and IPAs have access to IEHP provider website which contains beneficiaries' electronic health records, eligibility tape, MOC training information, etc. In addition, IEHP Marketing Department disseminates the "Evidence of Coverage" to the beneficiaries annually or as it changes and sends welcome letter

to new beneficiaries. Examples of information available on the IEHP website include but are not limited to: Beneficiary Plan and Benefits, After Hour Care, Health and Wellness Program, Clinical Practice Guidelines, Provider Policy and Procedure Manual, etc.

3) Electronic records (administrative data and/or clinical care): IEHP has computer database that stores the electronic health records such as referrals, health risk assessment survey results, care management survey results, care plan, interdisciplinary care team meeting notes, care coordination notes, etc.

4) Newsletters: IEHP produces member and Provider Newsletters at least semiannually:

   a) Provider Newsletters: IEHP sends out a Provider Newsletter called "The Heartbeat". It is generated at least semi-annually and provides information to providers regarding clinical topics geared specifically to supporting patient care and to addressing issues relevant to the success of their practice.

   b) Member Newsletters: IEHP sends out a Member Newsletter called "The IEHP Pulse". It is generated at least semi-annually and will provide free health information to members, such as preventive

services as well as information on the Disease Management and Care Management programs.

5) Evidence of Coverage (EOC): IEHP provides effective communication through the Member Handbook also known as the Evidence of Coverage (EOC). This is distributed to Members upon enrollment and annually thereafter.
6) Provider Directory: IEHP provides members with a Provider Directory in either the member's pre-enrollment kit, post-enrollment kit, or by calling IEHP directly.
7) Provider Manual: The Provider Services Department issues and maintains manuals that are distributed externally to contracting entities and, as applicable, subcontractors, in accordance with contractual and regulatory requirements. IEHP annually provides providers with a revised Provider Manual on an annual basis.
8) IEHP Website: IEHP's website www.iehp.org is a way for members and providers to obtain additional support and information from the health plan.

IEHP has written procedures and processes to coordinate communication among the interdisciplinary care team members and the beneficiary for some or all the following communication modes:

a) Regularly scheduled face-to-face team meetings: Monthly every 3rd Tuesday.

b) Regularly scheduled team conference calls: Conference calls are available for healthcare professionals who cannot come on site or are used for urgent and ad hoc meetings.

c) Team access to shared electronic health information: All IEHP clinical staff has access to the beneficiaries' electronic health information.

d) Randomly scheduled team meetings conducted when needed: occasionally an ad hoc ICT meeting is warranted.

IEHP has written procedures and processes describing how communication among stakeholders is documented and is maintained as part of the administrative and clinical care records for the following:

1) Written minutes: Formal meeting minutes are taken and kept confidential for the following but not limited to: Interdisciplinary Care Team, Quality Management Committee, UM Subcommittee, Credentialing Subcommittee, Appeals and Grievances Committee.

2) Recordings: IEHP uses tape recording during the meetings to ensure capturing accurate information. Upon completion of writing the minutes, the tape will be destroyed.

3) Newsletters, bulletins: IEHP staff communicates beneficiary health information via secured e-mails, faxes, secured website, and telephone. Newsletters or bulletins are used for the general and educational information to share with providers and beneficiaries.

4) Web-based database: IEHP uses secure database process referrals and document Care Management and uses a secured provider web portal for communicating with providers.

- **Personnel having oversight responsibility for monitoring and evaluating communication effectiveness.**

IEHP has written procedures to identify personnel having oversight responsibility for its communication network.

1) Compliance Department ensures all communications comply with HIPAA, Centers of Medicare and Medicaid (CMS), and the Department of Health Care Services.

2) Operations and Information Technology Departments ensure the database and provider web portal properly functions

3) Marketing Department ensures written materials to beneficiaries meet with the regulatory requirements.

10. Care Management for the Most Vulnerable Subpopulations

- **How the MAO identifies its most vulnerable beneficiaries.**

IEHP uses a variety of methods to identify vulnerable members and offer them additional benefits and services (such as transportation, dental and vision). At a minimum, every dual-eligible member with special needs (including frail, disabled, end-stage renal disease after enrollment, near end of life and multiple or complex conditions) will be included in the Program until the member expires or terminates with IEHP. Members may opt out of the MOC Program (e.g. refuse to participate) but will continue to be monitored for clinical/behavioral/social activity during the time they are IEHP members. Members who opt-out of the MOC Program will have a standard plan of care developed to manage any specific needs that may arise.

The MOC Care Management Program is based on an integrated system of care coordination, case management and a holistic approach to care. All case managers, social workers, and support staff work collaboratively with the Interdisciplinary Care Team (ICT). Together, they coordinate and provide quality care and improve access to health care. The Care Manager acts as the liaison between the physician, beneficiary, family, caregiver, facilities and ancillary support service providers. Through collaboration and consultation with key stakeholders (such as healthcare professionals, beneficiary, family) the Care Manager identifies beneficiary needs and health status. These needs can include

medical, psychosocial, behavioral, cognitive, culture preference, family support system and financial.

All identified beneficiaries are enrolled in the MOC Care Management Program. IEHP uses the results of comprehensive Health Risk Assessments (HRA) to identify and place Members in the appropriate level of care management (e.g., care coordination, general care management or complex care management). Furthermore, IEHP developed algorithms to identify members with 1) frequent emergency room visits, 2) multiple admissions and readmissions, 3) multiple prescription medicines, and conditions requiring disease and/or complex case management.

- **The add-on services and benefits the MAO delivers to its most vulnerable beneficiaries.**

The add-on services and benefits that IEHP delivers to its most vulnerable beneficiaries are based on the risk stratification, either through algorithms or a completed HRA. The Care Management staff is responsible for enrolling members into appropriate programs (e.g. Complex Care Management, general Care Management, or Disease/Health Management). IEHP utilizes the results of the risk stratification to develop and offer additional add-on services that target the populations with specialized needs population. Additional services can include:

1) Asthma Program

2) Diabetes Self Management Program
3) Blood Pressure Management
4) Stop Smoking Program
5) Weight Watchers Program
6) Pain Management
7) Preventative and Screening Guidelines
8) Transition of Care program
9) Family Support
10) Frailness
11) Disabilities program
12) End of life
13) Multiple illnesses and Complex Chronic Conditions

For the vulnerable population IEHP focuses on preventive benefits. The dual eligible and SPD populations not only have chronic medical conditions, but they also experience challenges with social and financial issues. These issues may block access to medical services, compliance with treatment regime, and the ability to maintain optimal health. Based on the needs of vulnerable population, IEHP offers the following benefits to the IEHP Medicare DualChoice (HMO SNP) population:

1) Transition of Care (PASS Coach)
2) Nutritional Assessment and supplements

3) Identification and referral to community based agencies/supports
4) Enhanced Transportation Services
5) Routine Vision
6) Routine Dental

The three levels of care that a Member may be placed in are Care Coordination, General Management, and Complex Case Management.

1) Care Coordination: Members are stratified LOW risk before and after the HRA survey has been conducted. Clinical staff will ensure an individualized Care Plan is maintained and updated as health status changes.
2) General Care Management: Members are stratified MODERATE risk after the HRA survey has been conducted. Clinical Nursing staff will ensure an individualized Care Plan is maintained and updated as health status changes.
3) Complex Care Management: Members are stratified HIGH before and after the HRA survey has been conducted. Clinical Nursing staff will ensure an individualized Care Plan is maintained and updated as health status changes. The Care Plan will be mailed to the member and will be maintained in an electronic format for the Primary Care Provider to review and make suggestions.

11. Performance and Health Outcome Measurement

- **How the MAO will collect, analyze, report, and evaluate the MOC (at a minimum include: specific data sources, specific performance and outcome measures).**

To collect, analyze, report, and evaluate the MOC program, IEHP will annually

perform a Quality Improvement Program that includes a targeted MOC population. Outline components of the overall Quality Improvement Program include the following activities:

1) Health information system to collect, analyze, and report accurate and complete data;
2) Chronic care improvement program (CCIP)
    a) Description of the program
    b) How CCIP relates to the targeted population
    c) How Members would benefit from participation in the CCIP
    d) Description of how Members who participate in the CCIP are monitored; and
    e) How health outcomes, quality indices, and/or improved operational systems post-intervention are evaluated

3) Quality Improvement Project (QIP)
    a) Description of the project
    b) How the QIP relates to the targeted population by clearly defining objectives, interventions, and quality indices and health outcomes written as measurable outcomes;
    c) Description of how Members would benefit from participation in the QIP
    d) Description of how Members who participate are monitored
    e) Description of how health outcomes, quality indices, and/or improved operational systems post-intervention are evaluated and achieve demonstrable improvement; and
    f) Description of how systematic and periodic follow-ups are conducted to ensure improvements is sustained
4) Measurement of the effectiveness of the MOC Program:
    a) Description of how the effectiveness of the MOC is evaluated through:
        i. Review of appropriate staffing and implementation of roles
        ii. Review of identification and stratification of health risks
        iii. Review of implementation of the individualized Care Plan and how it addresses identified health risks

iv. Review of improved coordination of care through effective communication networks and documentation of care

v. Review of improved coordination of care for vulnerable Members through implementation of the MOC

vi. Review of grievance data

vii. Review of Quality of Care referrals

viii. Analysis of UM data

b) Methodology used

c) Specific measureable performance outcomes that demonstrate improvements

d) Description of how documentation on MOC evaluations are maintained and made available; and

e) Description of how actions are determined based on the results of MOC evaluations;

5) Collection and reporting of Healthcare Effectiveness Data and Information Sets (HEDIS) measures:

a) Description of how required HEDIS measures and Structure and Process measures are collected and reported

b) Description of how the accuracy of HEDIS and Structure and Process measures are ensured

c) Description of how actions are determined based on HEDIS results and Structure and Process measurement

6) Collection and reporting of Structure and Process measures

7) Participation in Health Outcome Survey (HOS) if enrollment meets threshold:

a) Description of participation in HOS reporting

b) Description of how actions are determined based on HOS survey results

8) Participation in Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, if enrollment meets threshold:

a) Description of participation in CAHPS reporting

b) Description of how actions are determined based on CAHPS survey results

9) Monitor Member satisfaction to identify areas of improvement. IEHP review and analyze survey results, identify areas for improvement, identify barriers to improvement, and interventions.

10) Collection and reporting of Part C Reporting Elements:

a) Description of how Part C data elements are collected, analyzed, and reported

b) Description of how the accuracy of Part C data elements is ensured

c) Description of how actions are determined based on results of Part C reporting data elements

11) Collection and reporting of Part D Medication Therapy Management (MTM) data:
    a) Description of how MTM measures are collected, analyzed and reported
    b) Description of how the accuracy of MTM measures is ensured
    c) Description of how actions are determined based on MTM measurement results;
12) Care Reviews/File Reviews, including inter-rater reliability
13) Assessment of ICT meeting effectiveness
14) Network status reports to assure service delivery through a competent provider network having specialized expertise and implementing evidence-based practice guidelines
15) Provider and Member Satisfaction Surveys
16) Other reports, studies or analysis as needed.

All reports will be included in the Quality Management Program Evaluation which is presented to the Quality Management Committee annually. The Annual Quality Management Evaluation is made available to all providers on the IEHP provider website at www.iehp.org or mailed upon request. Members are able to

obtain this document upon request as well. If areas are determined to be deficient, IEHP will implement an internal quality improvement activity to address the areas of concerns such as changing policies or procedures, changing staffing patterns or personnel, changing the provider or facility network, changing systems of operation, providing targeted education to internal or external team members and educating members. The issue will be monitored and reassessed as needed.

- **Who will collect, analyze, report, and act on to evaluate the MOC (at a minimum includes: internal quality specialists, contracted consultants).**

To collect, analyze, report, and act on to evaluate the MOC, the Healthcare Analytics & Reporting (HAR) Department presents an Annual Effectiveness Study of the Model of Care (MOC) Program to the Quality Management Committee (QMC) for review, approval and for guidance for further action. The QMC is a multi-disciplinary committee that reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The data sources utilized in the Annual Effectiveness study includes: Care Management data, Utilization Management data, Inpatient and Outpatient Claims and Encounter data, Health Risk Assessment data, Call Center data, Provider Network data, Laboratory Encounter data, and Pharmaceutical Claims data.

The MOC Effectiveness Study is designed by a multi-departmental group including Directors from the following areas:

2) Director of Quality Management

3) Director of Healthcare Analytics

4) Director of Care Management

5) Clinical Director of Behavioral Health

6) Director of Provider Services

- **How the MAO will use the analyzed results of the performance measures to improve the MOC (at a minimum includes: internal committee, other structured mechanism).**

IEHP will use the analyzed results of the performance measures to improve the MOC by using the MOC Effectiveness Study, which is designed to evaluate the performance of the Model of Care program in meeting key program goals. The measurable goals of the MOC program addressed in the Annual MOC Effectiveness Study include (but are not limited to):

1) Improving transitions of care across settings and across providers

2) Improving access to preventive health services

3) Improving access to medical, mental health and social services

4) Improving Members' health outcomes

5) Improving coordination of care through a single point of care management contact

6) Ensuring effective services provided by MOC program staff through appropriate staffing levels and assigned roles
7) Improving health risk assessment and stratification process in identifying high risk members
8) Ensuring adequate provider network
9) Ensuring appropriate use of clinical practice guidelines by providers

- **Personnel having oversight responsibility for monitoring and evaluating the MOC effectiveness (at a minimum includes: quality assurance specialists, consultants with quality experience)**

The QM Committee oversees effectiveness of the Model of Care Program effectiveness. It is the body that reviews the annual performance measures (as reported in the Annual Effectiveness Study of the Model of Care Program). It also approves all proposed CAPs and monitors the progress of the implementation of all CAPs. All QM Committee agendas and reports are memorialized and summarized annually by the Director of QM in the Quality Management Annual Evaluation, which includes the Model of Care Effectiveness Evaluation.

Also, each goal has a quantifiable performance measurement developed to measure its effectiveness. Each performance measure includes established goals/benchmarks, which is used to evaluate the performance of the particular MOC program goal. From the Healthcare Analytics and Reporting department a

Technical Analyst skilled in extracting and analyzing the specified data sets is responsible for the data extraction, data compilation and report preparation. The final reported rates for each performance measurement are reviewed by the Director of Healthcare Analytics prior to being included in the final Study write-up. The evaluation of the performance of each performance measurement is completed by the Director of Healthcare Analytics. All barrier analyses are completed by the Director of Care Management.

If any performance measurement does not meet the established goal for a reported period a Corrective Action Plan (CAP) must be presented in the CAP section of the Report. The CAP is written collaboratively with the Directors from the following areas: Quality Management, Healthcare Analytics, Care Management, Behavioral Health and Provider Services. The corrective action plan is presented to the QM Committee for review and approval. The corrective action plan is monitored monthly by the Care Management department and progress updates are

presented to the QM Committee at each quarterly meeting until the goal is achieved.

The Corrective Action Plans are developed to improve the effectiveness of the overall MOC Program and may include the following type of changes:

1) Changes to policies and procedures

2) Changes to staffing patterns or personnel

3) Changes to provider or facility network

4) Changes to systems of operation

5) Communication of results internally and/or externally

- **How the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the MOC (at a minimum includes: electronic or print copies of its evaluation process).**

To evaluate the model of care, IEHP will document and preserve as evidence of the effectiveness of the MOC any performance measurement does not meet the established goal for a reported period in the form of a Corrective Action Plan (CAP). The CAP must be presented in the CAP section of the Report.

- **How the MAO will communicate improvements in the MOC to stakeholders (at a minimum includes: webpage for announcements, printed newsletters, bulletins, announcements)**

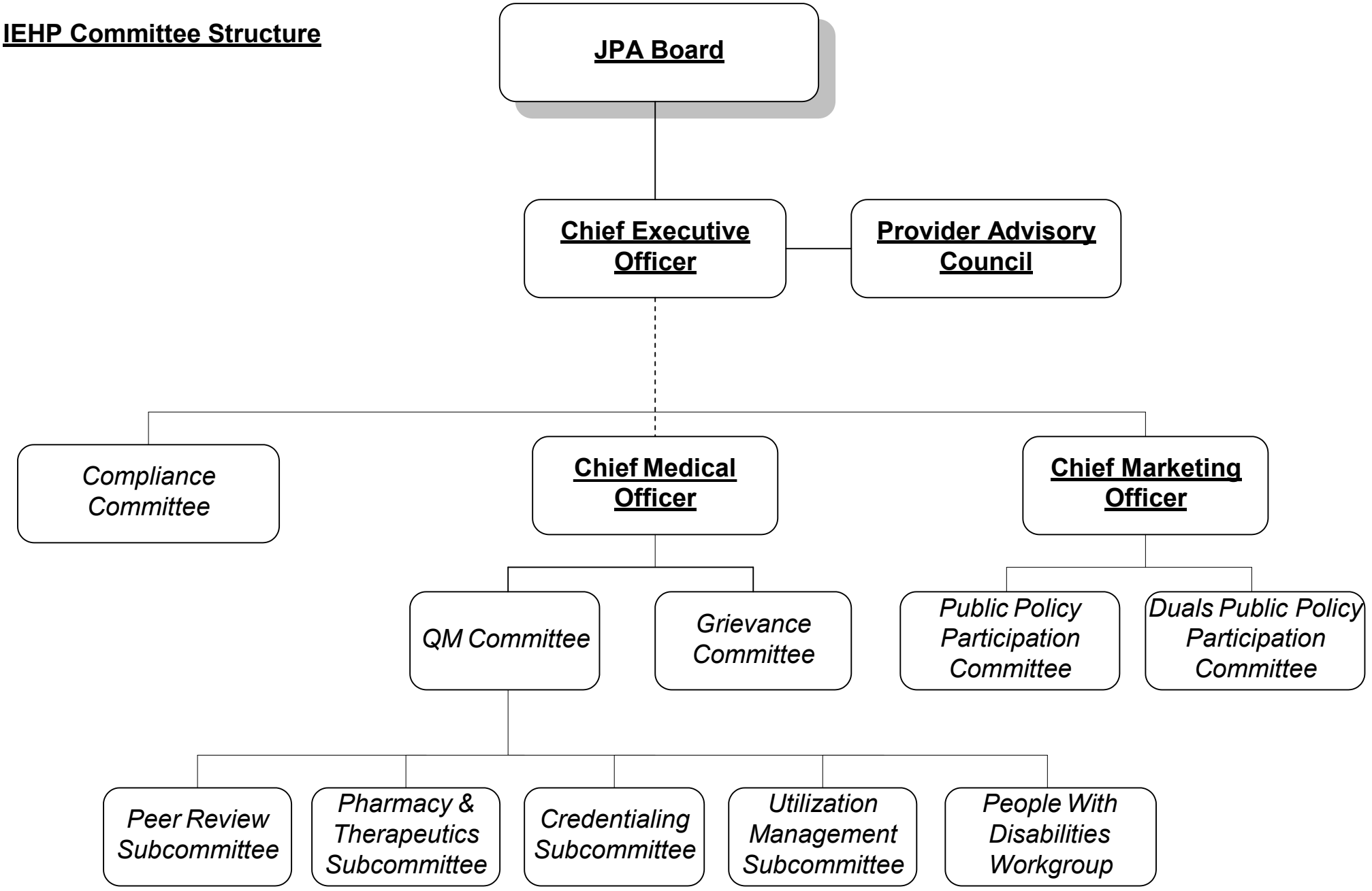
To communicate improvements in the MOC to stakeholders, The QM Annual Evaluation is presented to the IEHP Board of Directors and is posted to the IEHP website. Additionally, twice per year, IEHP issues a provider newsletter that provides information and updates on policies and programs, including improvements to the MOC program.

Through the Inland Empire Disabilities Collaborative (IEDC), IEHP shares information to over 300 member organizations who serve the dual eligible population in the Inland Empire. Through this network, IEHP communicates changes and improvements to programs, including the MOC program. It is through this forum that IEHP also gathers feedback from partners and CBOs on the MOC program.

Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

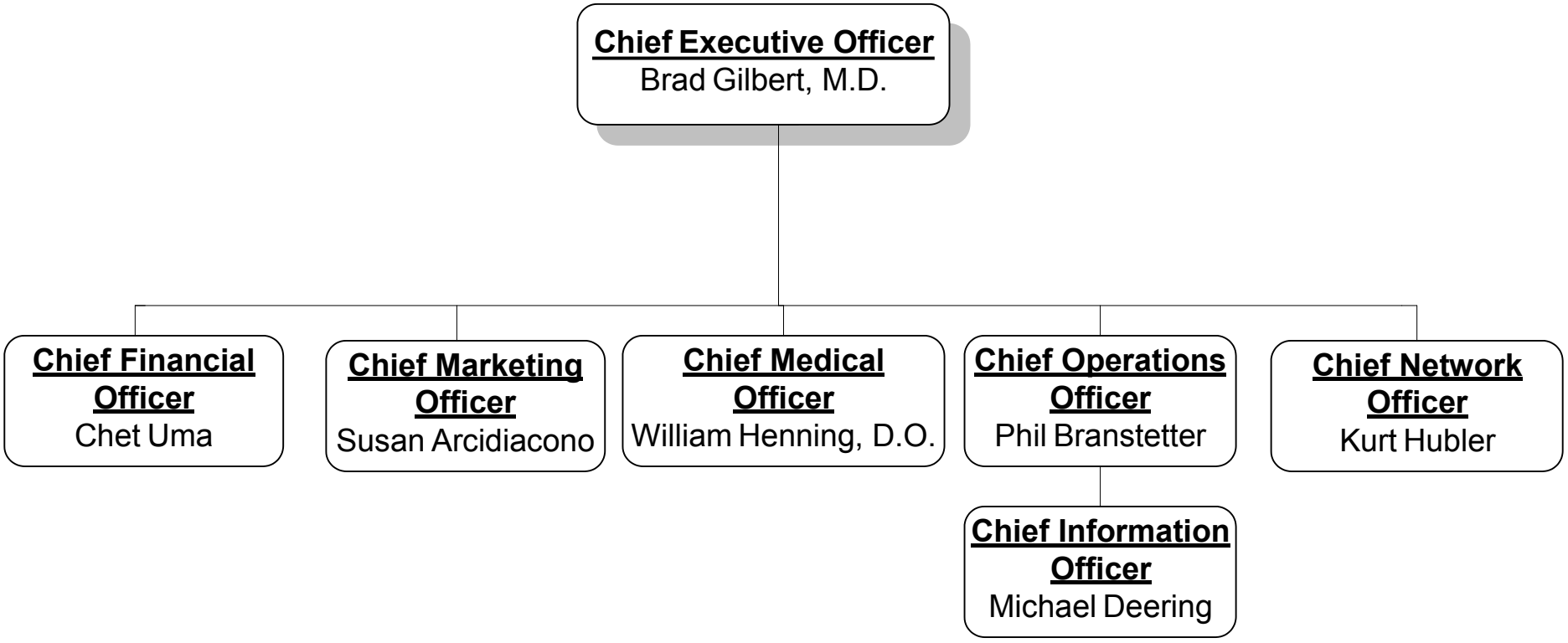
IEHP Committee Structure



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

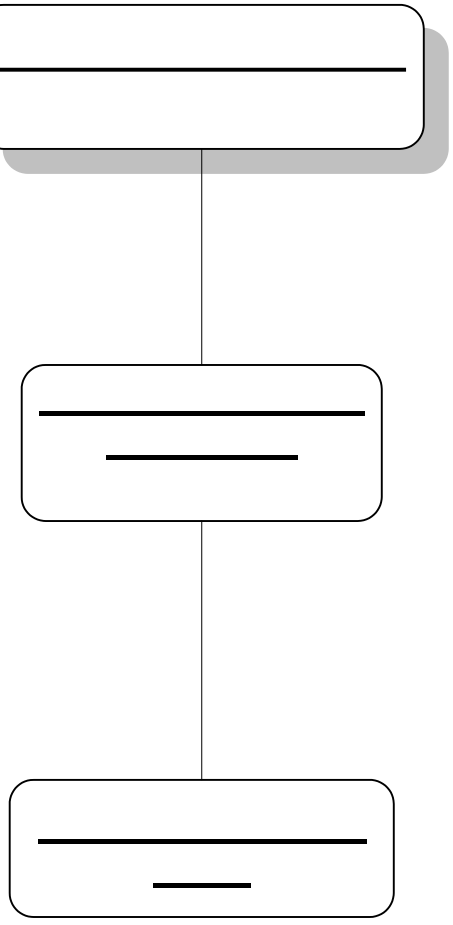
Plan Departmental Structure



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

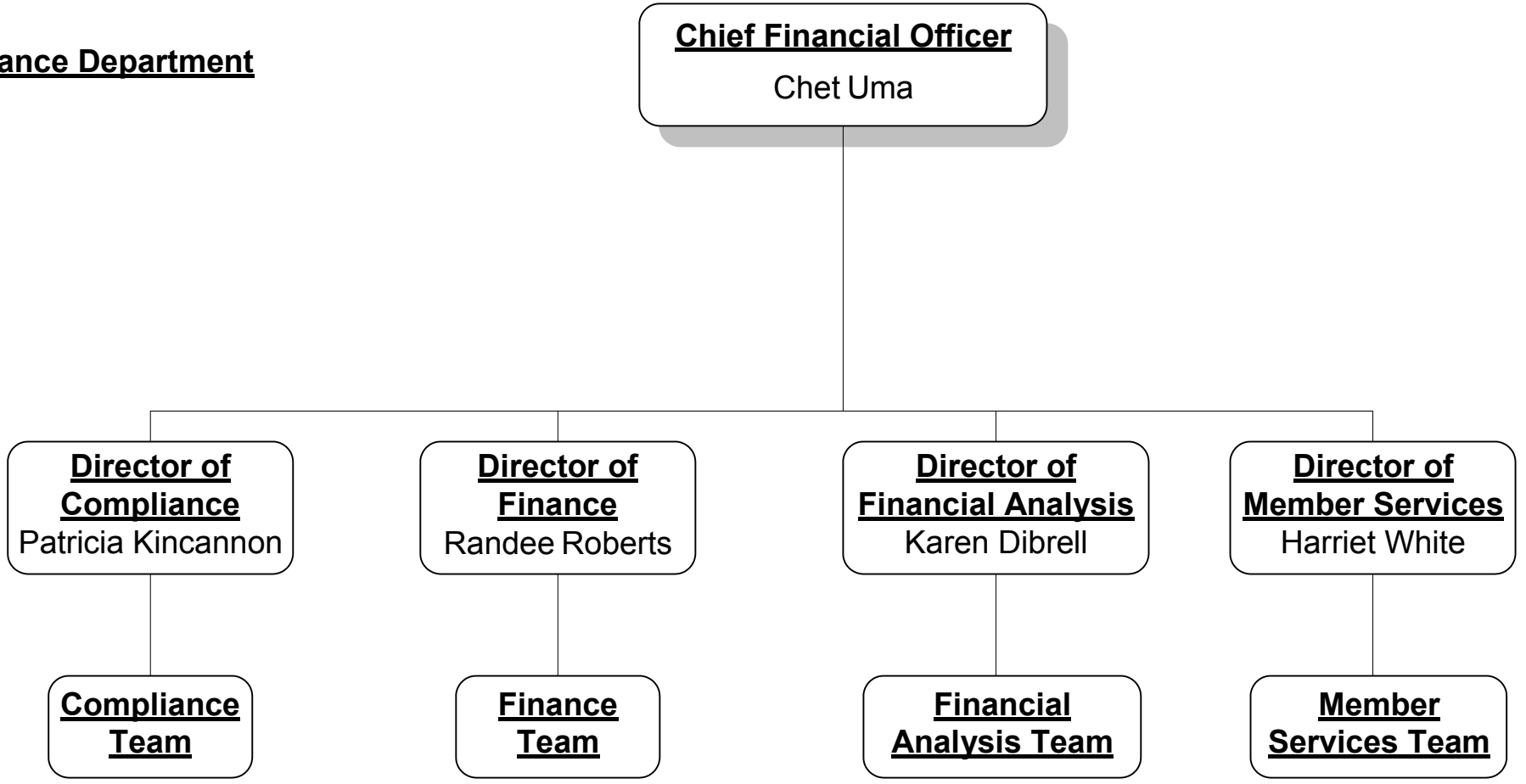
Administration Department



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

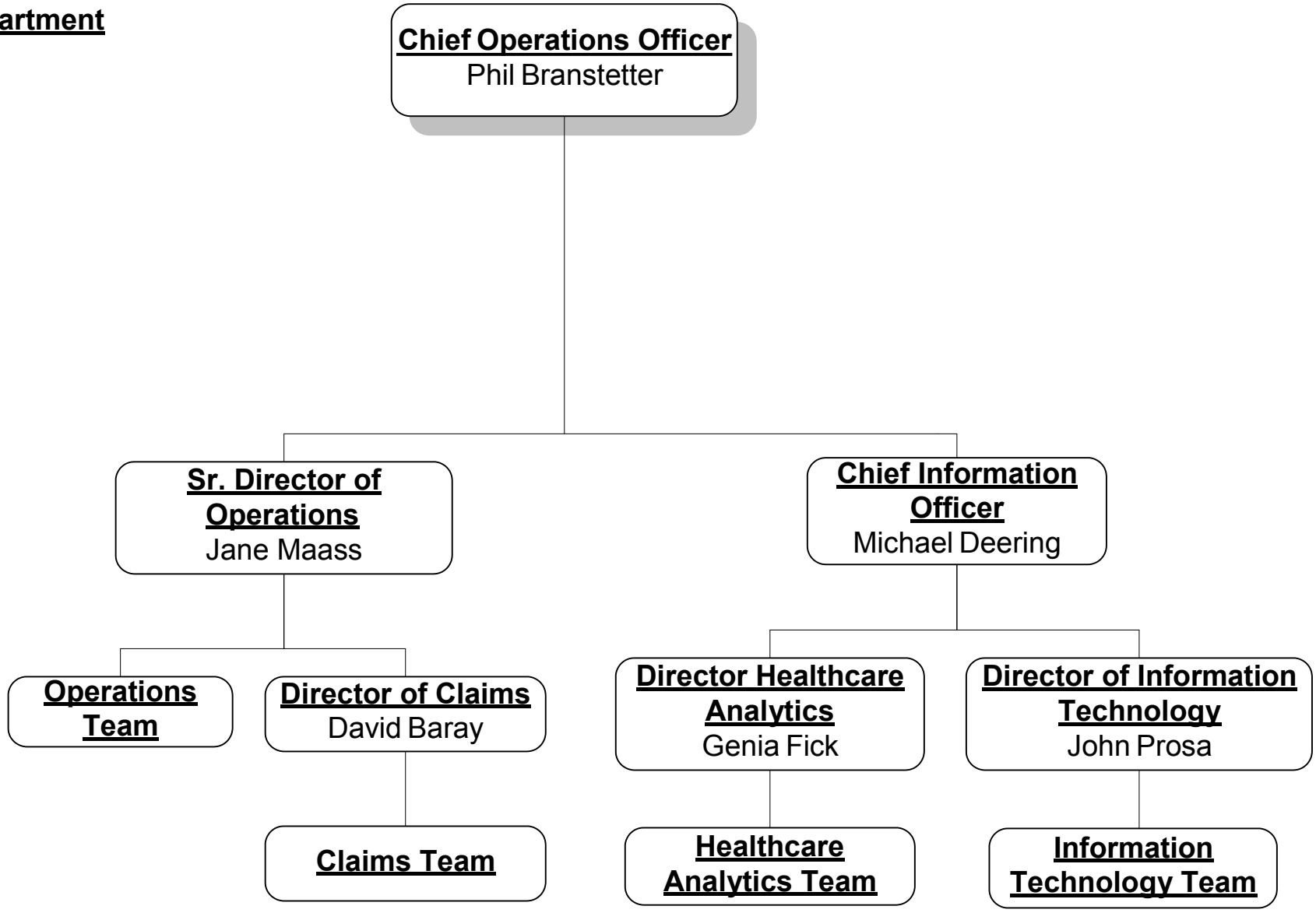
Finance Department



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

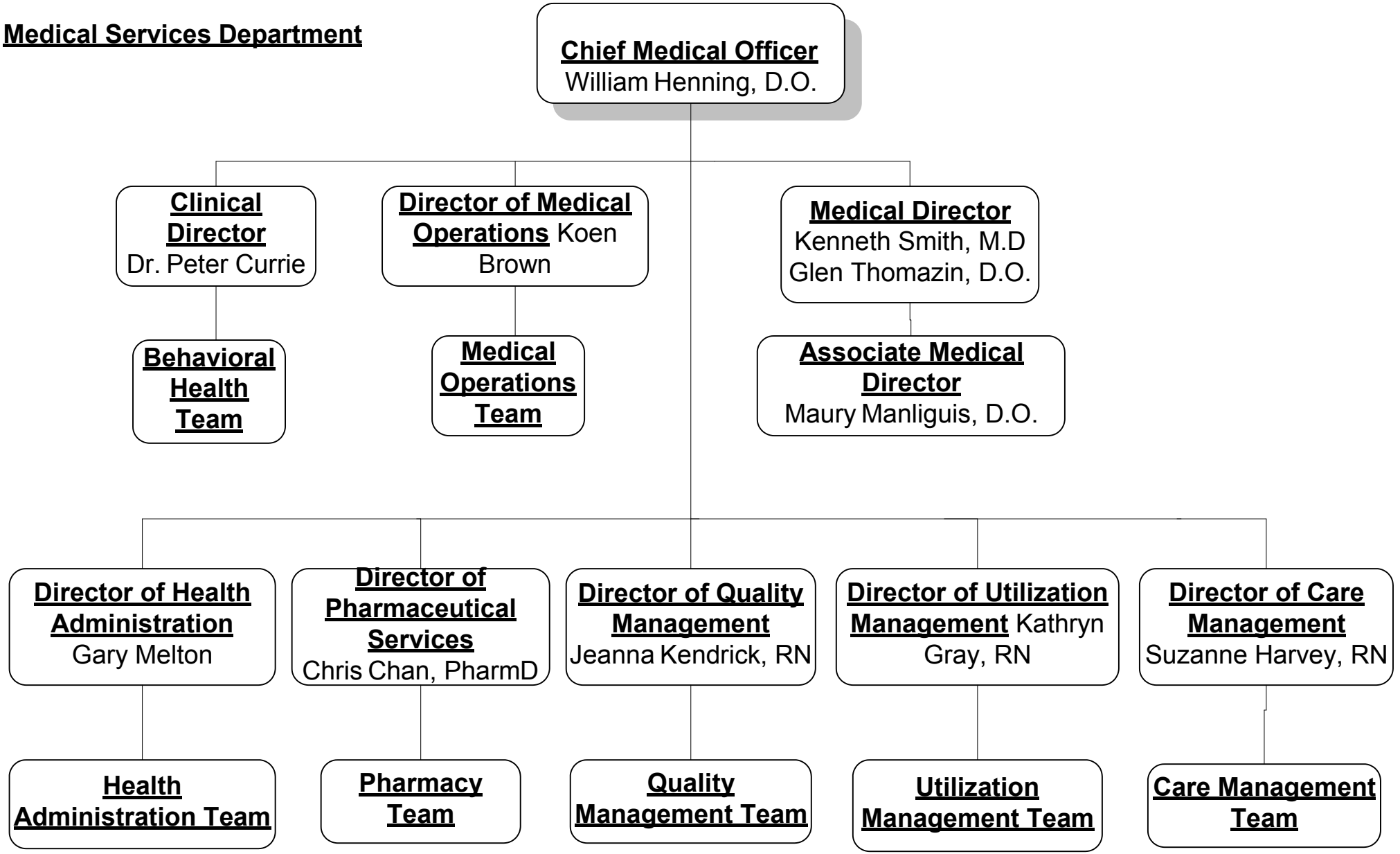
Operations Department



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

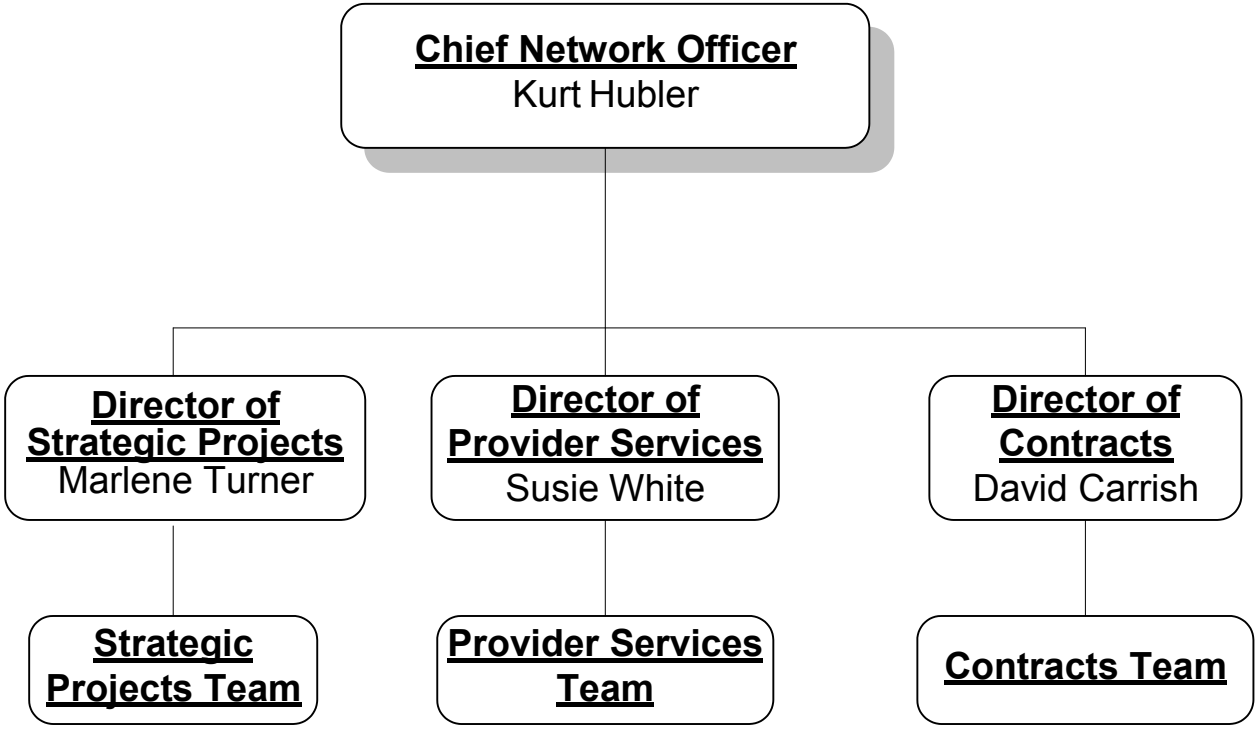
Medical Services Department



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

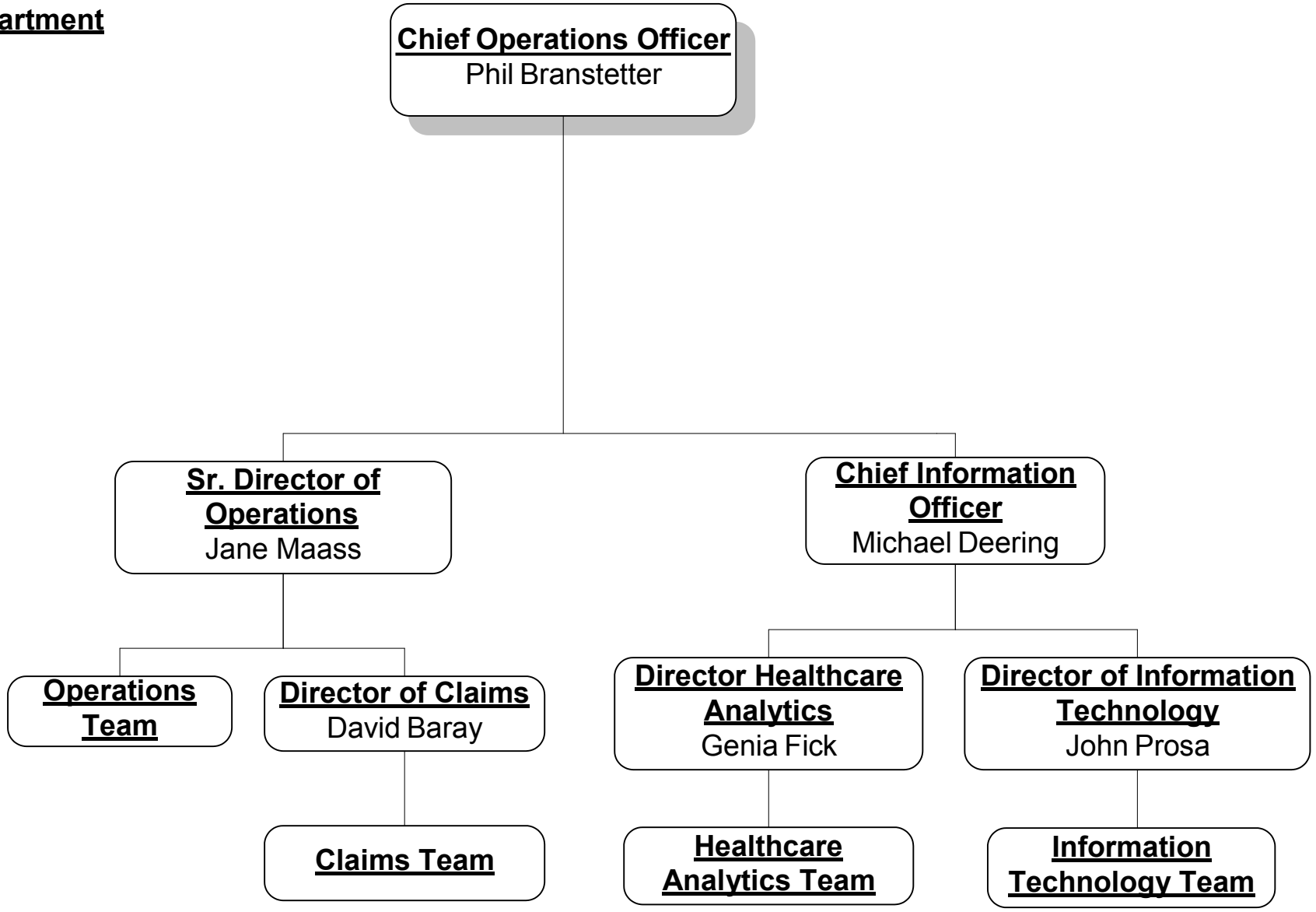
Network Operations – Contracts



Attachment L: Organizational Chart

INLAND EMPIRE HEALTH PLAN - Organization Chart and Staffing Plan

Operations Department



CURRICULUM VITAE

BRADLEY P. GILBERT, M.D., M.P.P.
(909) 936-2049

WORK EXPERIENCE:

CHIEF EXECUTIVE OFFICER
INLAND EMPIRE HEALTH PLAN **10/08-Present**

Responsible for the direction and oversight of all plan activities. Reports to the Governing Board.

Significant Accomplishments:

- NCQA Accreditation for the MCO and Disease Management
- Successfully managed IEHP through very high membership growth 2008-2012
- Appointed Chairperson of Local Health Plans of California March 2009-February 2011
- Guided IEHP through difficult economic/funding times in 2008-2010 including non-payment by State of California for multiple months each summer
- Led all planning and implementation for the mandatory enrollment of seniors and people with disabilities in the health plan.

EXECUTIVE OFFICER/CHIEF MEDICAL OFFICER
INLAND EMPIRE HEALTH PLAN **10/06-9/08**

Responsible for the administration and management of the following departments: Marketing, Medical Services, Network Operations/Contracting and Operations. Lead physician for the Health Plan, including medical policy development and implementation. Successfully launched a Medicare Advantage Special Needs Plan for improved care coordination for dual eligibles. Reports to the Chief Executive Officer.

CHIEF MEDICAL OFFICER/MEDICAL DIRECTOR
INLAND EMPIRE HEALTH PLAN 2/96-10/06

Lead physician reporting directly to the CEO, responsible for all medical aspects of a Medi-Cal and Healthy Families HMO that began operations September 1, 1996. Included initial development and on-going management of Quality Management, Care Management, Wellness Program (Disease Management and Health Education), Quality Studies, Utilization Management and Pharmacy Programs.

Significant Accomplishments:

- Developed and implemented a Medical Services Department including obtaining Knox-Keene license, Department of Health Services approval
- Developed and implemented Health Education program ranked in the top tier for California HMOs by Price-Waterhouse
- Obtained NCQA MCO Accreditation – first Medi-Cal only HMO in California
- Obtained NCQA Accreditation for Disease Management – one of the first Health Plans in the United States to receive accreditation. Re-accreditation score was 100%

DIRECTOR OF PUBLIC HEALTH/HEALTH OFFICER
RIVERSIDE COUNTY 3/93-2/96

Responsible for the administrative and clinical management of the Riverside County Department of Public Health. Responsible for eleven primary care clinics including operations, medical oversight, managed care contracting, etc. Assigned to special projects in managed care including participation in development of an Independent Physician Association, medical liaison to managed care contractors, and the Inland Empire Health Plan. Legal responsibility for

communicable disease control, certain environmental health monitoring, and public health protection for entire county.

Significant Accomplishments:

- Converted public health categorical clinics into primary care clinics
- Initiated successful managed care contracts in the clinics
- Served as President of the Statewide Health Officers group

DIRECTOR OF PUBLIC HEALTH/HEALTH OFFICER
SAN MATEO COUNTY **11/89-3/93**

Responsible for the administrative and clinical management of the Public Health Services Division of the San Mateo County Health Services Agency. Sections of the Division included: Public Health clinics, Public Health Nursing, Maternal, Child and Adolescent Health Services, Public Health Laboratory, AIDS Program, Emergency Medical Services, and Correctional Health Services.

HEALTH OFFICER
SAN MATEO COUNTY **10/88-11/89**

Responsible for the administrative and clinical management of the Public Health Clinics, Public Health Laboratory, AIDS Project, and Correctional Health Services sections of the Public Health Division. Legal responsibility for communicable disease control, certain environmental health monitoring, and public health protection for entire county. Functioned as EMS Medical Director and Maternal, Child and Adolescent Health Director.

JAIL MEDICAL DIRECTOR
SAN MATEO COUNTY **7/88-10/88**

Responsible for the administrative and clinical management of health care services for 1,200 inmates at seven facilities. Included the management of two on-site primary care clinics.

JAIL PHYSICIAN
SAN MATEO COUNTY **5/87-6/88**

Lead physician position for correctional health services, primarily clinical duties.

PRIMARY CARE PHYSICIAN
SAN MATEO COUNTY **4/86-5/87**

Part-time clinical position in the Primary Care Clinic of San Mateo County General Hospital.

URGENT CARE - EMERGENCY DEPARTMENT PHYSICIAN - KAISER PERMANENTE
REDWOOD CITY **9/85-5/87**

Part-time clinical position with a large health maintenance organization. Included pediatric, adult patients.

PHYSICIAN, SUBSTANCE ABUSE CLINIC - PROFESSIONAL TREATMENT, INC.
REDWOOD CITY **9/85-8/86**

Clinical position with a methadone treatment facility for opiate users.

PHYSICIAN, PRIVATE PRACTICE - FAMILY MEDICAL CLINIC
MINNEAPOLIS, MN 7/84-6/85

Clinical position in a busy primary care clinic. Included pediatric and adult patients.

RESIDENCY TRAINING:

7/83-6/84
University of Minnesota
Affiliated Family Practice Programs
St. Mary's and Fairview Hospitals, PGY-1 Family Practice

Based in two community hospitals, the program stresses development of ambulatory and primary care skills. Extensive Emergency Department experience was a major part of the program.

EDUCATION:

9/86-5/88
University of California at Berkeley
Graduate school of Public Policy

The first year stresses the development of general policy analysis skills using an inter-disciplinary approach. The second year is elective, courses taken included: Public Sector Accounting, Budgeting and Management.

Thesis: "AIDS in San Mateo County: A Five-Year Plan"
G.P.A. - 3.8
Degree - M.P.P. 5/88

9/79-6/83
University of California at San Diego
School of Medicine

Preceptor in Family Medicine Instructor for Introduction to Clinical Medicine Admissions Committee.

Research Thesis: "The Effect of Educational Intervention on the Smoking Rate of Junior High School students"
Degree - M.D. 6/83

9/74-3/79
University of California at Berkeley
Undergraduate Division

Dean's Honor List; Phi Beta Kappa; Education Abroad
Degree - A.B. Physiology/Anatomy 3/79

BOARD CERTIFICATION:

2/93 Preventive Medicine

ACADEMIC APPOINTMENTS:

6/98 - Present
Assistant Clinical Professor, Health Administration, Loma Linda University

APPOINTMENTS / BOARDS:

Local Health Plans of California
10/07-present- Member, Board of Directors
3/08-2/11- Chairperson

California Association of Health Plans
3/10-present- Member, Board of Directors

Inland Empire EHR Resource Center / Inland Empire Health Information Exchange
9/11-present- Chair
5/10-9/11- Member, Board of Directors

CalHIPSO – Statewide Regional Extension Center
7/10-present- Member, Board of Directors

California Association of Public Hospitals – Safety Net Institute
12/10-present- Member, Board of Directors

Riverside County Health Foundation
1/10-present- Member, Board of Directors

California Conference of Local Health Officers
11/94 - 2/96 - Member, Board of Directors
11/93 - 10/94 - President
11/92 - 10/93 - Treasurer

8/98 – 10/07
Member, Department of Health Services Medi-Cal Managed Care Division
Quality Improvement Work Group

Statewide group responsible for proposing quality studies, thresholds and indicators to the DHS for all Medi-Cal Managed Care Plans.

8/98 - 9/99 (Work Group ended)
Member, The California Managed Risk Medical Insurance Board Healthy Families Quality Improvement Work Group

Statewide group responsible for proposing the quality structure, including quality studies, activities and processes to MRMIB for all Healthy Families Health Plans.

4/97 - 1/98

Member, State of California Managed Health Care Improvement Task Force

Member, Expert Resource Group - 'Physician-Patient Relationship'

5/93 - 9/94

Chairperson, Managed Care Planning Council

Chaired the Board of Supervisor appointed committee responsible for initial development of the Local Initiative Medi-Cal Managed Care Plan.

10/93 - 10/94, 11/95 - 2/96

Chairperson, Inland Empire HIV Planning Council

Chaired the Riverside/San Bernardino EMA HIV Planning Council during the first and third years of receipt of Federal Ryan White Title I Funds.

8/93 - 6/97

Medical Staff - Riverside General Hospital

1991-93

Member, California Tobacco Education and Research Oversight Committee

Served on the Governor-appointed task force that oversaw Statewide tobacco preventive education and research efforts funded by Proposition 99.

11/88 - 3/93

Commissioner, Health Plan of San Mateo

Served on the board for the Health Plan of San Mateo, the county-wide managed care plan for most Medi-Cal clients

in the county. Included service on the Finance and Personnel Committees of the Commission. Provided the lead for a unique Comprehensive Perinatal Services Program grant program.

5/88 - 3/93
Hospital Staff - San Mateo County General Hospital

SPECIAL SKILLS:

Extensive public presentation and health education experience including: numerous public presentations regarding managed care, Health Care Reform, access to care and health care delivery, previously on environmental health, communicable disease and other health issues, "Ask the Doctor" radio show, teaching positions in medical school, AIDS education delivery to: school teachers, nurses, and the Sheriff's Department.

PUBLICATION:

'In California, Medi-Cal Managed Care is Superior to Medi-Cal Fee-for-Service' Managed Care Quarterly, Volume 6, No. 4, Autumn 1998.

REFERENCES: Available on request.

Department of Public Social Services
Administrative Office: 4060 County Circle Drive, Riverside, CA 92503
(951)258-3000 Fax: (951)258-3036
Susan Loew, Director

February 16, 2012

Dr. Bradley Gilbert, M.D., M.P.P.
Inland Empire Health Plan (IEHP)
303 E. Vanderbilt Way
San Bernardino, CA 92408

Subject: Dual Eligible Demonstration – Letter of Non-Support

Dear Dr. Gilbert,

As you know, we have had a long-standing collaborate partnership with IEHP and greatly respect your agency's efforts to support the health care needs of our residents.

In light of our history, it is truly regrettable to be providing a letter of non-support for the Dual Eligible Demonstration and I want to be clear that is not a reflection on IEHP.

While we support the idea of seamless access to the full continuum of medical care, social supports, and service to dual eligible residents of Riverside County, there are many concerns with the current pilot design, specifically, the lack of clarity around the integration of the IHSS program into a managed care model. Numerous concerns and recommendations were outlined in an 11-page letter prepared by the California State Association of Counties in collaboration with the County Welfare Directors Association and the California Association of Public Authorities. This letter was sent to the Depart of Health Care Services on January 10, 2012 and at this point the issues remain unresolved.

Specifically, a few of the concerns that were noted include:

- The lack of guidance on how the pilot will be funded and the financial risk to the County without control over how the IHSS program is integrated and eventually administered.
- The lack of clear guidelines for how IHSS would be administered after the first year, which not only calls into question the roll of counties, but also raises questions about the capacity of a pilot county to meet the diverse needs of IHSS consumers.
- The lack of detail around coordination of care and the impact on consumers, including the possible infringement on existing consumer rights and protections to select, hire, fire, schedule, and supervise their IHSS provider.
- The lack of structure from which to evaluate the effectiveness of the pilot.

Given the significant outstanding issues that exist, we do not believe that it is in the best interest of our clients, agency and our county to be part of this pilot and we are not prepared to offer our support at this time.

Sincerely,

Susan Loew
Director

COUNTY OF SAN BERNARDINO
COUNTY ADMINISTRATIVE OFFICE

GREGORY C. DEVEREAUX
Chief Executive Officer

LEGISLATIVE AFFAIRS
385 North Arrowhead Avenue
San Bernardino, CA 92415-0110
(909) 387-4821

BOARD OF SUPERVISORS

Brad Mitzelfelt, Vice-Chairman ..... First District

Janice Rutherford ..... Second District

Neil Derry.....Third District

Gary C. Ovitt ..... Fourth District

Josie Gonzales, Chair ..... Fifth District

February 16, 2012

Toby Douglas, Director
State of California—Health and Human Services Agency
Department of Health Care Services
Office of Medi-Cal Procurement MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

RE: DUALLY ELIGIBLE FOR MEDI-CAL AND MEDICARE PILOT PROGRAM - CONCERNS

The County of San Bernardino wishes to express its concerns regarding the Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare. While we identify with the objectives of improving health outcomes and reducing the cost of care for Medi-Cal and Medicare beneficiaries, we believe that the integration of long-term care for Dual Eligibles is a concept that requires additional information prior to implementing the pilot programs.

Specifically, we are concerned that the State of California has not outlined a viable financial framework for the Dual Eligibles Pilot. There is no clarity regarding the cost structure of In-Home Support Services (IHSS) under the pilot. It is also unclear as to whether counties would continue to be responsible for portions of IHSS costs, and under what legislative enactment that would occur. We believe that the lack of clarity regarding funding structures under the pilot has the potential to jeopardize counties both fiscally and legally.

The County of San Bernardino has a longstanding tradition of excellent public service and successful partnerships with private sector organizations, including Molina Health Care of California and the Inland Empire Health Plan (IEHP). As Molina and IEHP are applying for this pilot program, we have shared our concerns with them, in keeping with that positive partnership.

For these reasons, the County does not want to participate as one of the first of four counties in the pilot program. We thank you for your attention in this matter and welcome further discussion on the Dual Eligibles Pilot Program. If you have any questions, please do not hesitate to contact Linda Haugan, Assistant Executive Officer, at (909) 387-4717.

Sincerely,

JOSIE GONZALES, Chair
Board of Supervisors

cc: Bradley P. Gilbert, M.D., M.P.P, Inland Empire Health Plan Chief Executive Officer
Lisa Rubino, Molina Healthcare of California President
Kelly Brooks, California State Association of Counties
Frank Mecca, California Welfare Directors Association of California
Karen Keeslar, California Association of Public Authorities

The Mission of the government of the County of San Bernardino is to satisfy its customers by providing service that promotes the health, safety, well being and quality of life of its residents according to the County Charter, general laws, and the will of the people it serves.