CalOptima
A Public Agency
Better. Together.

February 23, 2012

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

Re: California's Dual Eligible Demonstration Request for Solutions (RFS) Submission

Dear Mr. Douglas:

The Orange County Health System dba CalOptima is pleased to submit this application to be a site for California's Dual Eligible Demonstration.

As a County Organized Health System, CalOptima has provided health care services to Orange County's Medi-Cal beneficiaries, including seniors and persons with disabilities and dual eligible beneficiaries, for more than 16 years. CalOptima's history as a successful Medi-Cal managed care plan, Medicare Advantage Special Needs Plan for Dual Eligibles, Multipurpose Senior Services Program, Aging and Disability Resource Center, and future Program of All-Inclusive Care for the Elderly site, has prepared it for the opportunity presented by the Dual Eligible Demonstration. We strongly support the State's efforts to improve the delivery of care for dual eligible beneficiaries and believe that CalOptima and Orange County present an opportunity for successful implementation of the demonstration.

We look forward to continuing our collaboration with the Department of Health Care Services, Centers for Medicare & Medicaid Services, local county agencies, and community stakeholders to develop a model that will allow our members to maintain good health and a high quality of life in their homes and communities for as long as possible.

For questions regarding CalOptima's submission, please contact Deborah Miller, Executive Director, Programs for Seniors and Persons with Disabilities via telephone at (714) 796-6185, or via email at dmiller@caloptima.org. Thank you for your consideration.

Sincerely,

Richard Chambers
Chief Executive Officer

1120 West La Veta Avenue | Orange, CA 92868 | www.caloptima.org
Main: 714. 246. 8400 | Fax: 714. 246. 8492 | TDD: 714. 246. 8523

Applicant Name: CalOptima Date 2/22/2012

California Dual Eligible Demonstration Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.	✓	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	✓	Refer to Attachment 12
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	✓	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	n/a	CalOptima has operated a D-SNP since October 2005
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.	n/a	There have been no sanctions or penalties against the plan in the last five years
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	n/a	The plan is not currently under sanction
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.	✓	Refer to Attachment 13
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	✓	Refer to Attachment 13
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	✓	CalOptima is pursuing NCQA Managed Care Accreditation. On site survey is scheduled for August 6 and 7, 2012. Refer to Attachment 14

Signature: Richard Chamberlain

Applicant Name: CalOptima Date: 2/22/2012

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	✓	
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	✓	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	✓	Refer to Attachments 15 and 16
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	✓	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	n/a	CalOptima is a public agency. Refer to Roster of Public Agencies Filing in Attachment 17
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.	n/a	CalOptima is a public agency. Refer to Roster of Public Agencies Filing in Attachment 17
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	n/a	CalOptima is a public agency. Refer to Roster of Public Agencies Filing in Attachment 17
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	✓	
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	✓	

Signature: Richard Chambers

Applicant Name: CalOptima Date: 2/22/2012

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	6 years	CalOptima has operated a D-SNP since October 2005
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	No	CalOptima has not received significant sanctions or corrective action plans
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	CalOptima's overall HEDIS scores have consistently improved over the years. Refer to attachment 18
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	No	CalOptima is pursuing NCQA Managed Care Accreditation. On site survey is scheduled for August 6 and 7, 2012. Refer to Attachment 14
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	Refer to Attachment 19
6	How long has the Plan had a Medi-Cal contract?	Since 10/1/1995	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	Depending on the financial structure, CalOptima will propose to, at a minimum, include the additional benefits currently provided through its D-SNP and described in section 1.2 Comprehensive Program Description
8	Did the Plan submit letters from County officials describing their intent to work together in good faith on the Demonstration Project? From which agencies?	Yes	Refer to Attachment 20
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	No	CalOptima plans to develop agreement in coordination with the County IHSS agency
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes	CalOptima currently has a MOU agreement with the Orange County Health Care Agency for behavioral health services. Refer to Attachment 4
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	CalOptima intends to contract with other provider groups based on criteria regarding quality, competency, access, and financial viability.

Signature: Richard Chambers

Applicant Name: CalOptima Date: 2/22/2012

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
2.2.1	Applicant will develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1, which stipulates the criteria in the RFS.	Yes	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	Yes	
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.	Yes	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	Yes	
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.	Yes	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	Yes	
6.1.1	Applicant will report monthly on the progress made toward implementation of the timeline.	Yes	
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	Yes	
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.	Yes	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	Yes	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	Yes	

Signature: Richard Chamberlain

California Department of Health Care Services
Request for Solutions for California's Dual Eligibles Demonstration Project
Orange County Health Authority

Executive Summary

CalOptima is a public agency that was created in 1993 by a dedicated coalition of local elected officials, hospitals, physicians and community advocates. The CalOptima mission is **to provide members with access to quality health care services delivered in a cost-effective and compassionate manner**. As a County Organized Health System (COHS), CalOptima is authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in Orange County and holds a contract with the California Department of Health Care Services (DHCS) to administer covered Medi-Cal services. Currently, CalOptima serves more than 424,000 Orange County residents, the majority of whom are Medi-Cal members (91%). See *Attachment 1: CalOptima Member Fast Facts, February 2012*.

CalOptima has provided health care services to seniors and persons with disabilities (SPDs) for more than 16 years. In 2005, CalOptima became licensed by the Centers for Medicare & Medicaid Services (CMS) to serve dual eligible SPDs by creating a Medicare Advantage (MA) Special Needs Plan, known as OneCare (HMO SNP). OneCare earned a 4-star designation in the Medicare Star Quality Rating System for 2012 and currently serves more than 13,000 members, or 17% of CalOptima's 75,000 dual eligible members. The remaining nearly 62,000 duals in the county receive Medicare services from different MA plans, or are a Medicare fee-for-service (FFS) member, with CalOptima coordinating the Medi-Cal wraparound benefits. Dually eligible SPDs are served in CalOptima Direct, a flexible, access-based delivery system that accommodates members who have Medicare FFS. It is notable that the county's Medi-Cal-only SPD population has been served by CalOptima's delegated delivery system of 11 health

networks for more than 16 years. Consequently, dual eligible beneficiaries and their long-time physician providers will have a diverse set of options to participate in the Demonstration.

From inception, CalOptima has been committed to reducing fragmentation in systems of care and improving care coordination across the continuum of health care services. CalOptima intends to use its significant experience caring for dual eligible beneficiaries, OneCare infrastructure, robust provider network and established community relationships as the foundation for the Demonstration. CalOptima has begun working with the Orange County Social Services Agency and the IHSS Public Authority to prepare for the integration of IHSS into the Demonstration, and with the Orange County Health Care Agency (HCA), Behavioral Health Services Division, to begin planning for the 2015 integration of behavioral health services. CalOptima has also worked collaboratively with providers and consumers for several months to prepare for the integration of Community Based Adult Services (CBAS) into managed care. In addition to working with HCA, SSA, the IHSS Public Authority and CBAS providers, CalOptima is committed to working with its providers, advisory boards, member advocates, other local stakeholders, DHCS and CMS to identify and mitigate barriers and pursue innovative solutions that:

- Preserve options, choice and the right to self-determination
- Provide enhanced, person-centered assessment, care planning and case management, as well as accessibility to services and trusted providers
- Allow for greater flexibility to purchase services that rebalance care to the community and prevent institutional care
- Support the goals of the Demonstration

- Support CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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.

As the sole Medi-Cal managed care health plan responsible for arranging and administering Medi-Cal benefits for all Orange County dual eligible beneficiaries, and having operated a MA-SNP since 2005, and a Medicare Part D plan since 2006, CalOptima has extensive experience serving the complex needs of frail and/or disabled dual eligible members in Orange County. CalOptima strategically pursued formation of Dual SNP and Part D plans to create a path to a more integrated model of care. OneCare, CalOptima's MA-SNP plan, has facilitated coordination of covered health care services across both the Medi-Cal and Medicare programs to the greatest extent allowable.

CalOptima intends to leverage the OneCare model as its platform to further unify the delivery and coordination of Medi-Cal and Medicare covered services for the dual eligible population, as well as other available long-term services and supports (LTSS), such as the Multipurpose Senior Services Program (MSSP), CBAS and IHSS. This integrated delivery system model will significantly reduce the burden, barriers and challenges involved in navigating two separately operated and funded health care programs.

CalOptima is in the unique position of having extensive and varied experience serving dual eligible beneficiaries through the following programs and activities:

- **Multipurpose Senior Services Program (MSSP)**: CalOptima has held a contract with the state since March 2001 to operate a MSSP site. MSSP provides social and

health care management services that help frail, elderly members live in the community as long as possible and prevent or delay admission to a skilled nursing facility.

- **Aging & Disability Resource Connection of Orange County (ADRC OC)**: Established by CalOptima, the Orange County Office on Aging and the Dayle McIntosh Center, the ADRC provides information on all available LTSS for seniors and persons with disabilities through a searchable online directory. It also connects individuals to the partner agencies for telephonic or in-person information, referrals and options counseling.
- **Managing the long-term care and skilled nursing facility benefit**: CalOptima assumed contractual risk and management responsibility for the Medi-Cal institutional long-term care benefit in 1998.

CalOptima has also submitted an application and leased space for a Program of All-Inclusive Care for the Elderly (PACE), with the goal of opening the first PACE center in Orange County by fall 2012. PACE will provide interested members 55 years or older, who are certified as nursing facility level of care (NFLOC), the option of participating in a fully integrated system of care that provides all needed medical and LTSS.

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

CalOptima understands that many issues impact health and a person's ability to derive the highest benefit from medical care. In delivering and coordinating services, CalOptima has adopted a holistic care approach that takes into account the medical, psychosocial and behavioral health needs of members, as well as their personal goals and preferences, cultural and linguistic needs, and motivation for change. Given the variability in members' needs and preferences,

CalOptima appreciates that a model of care must be flexible and offer a range of options that support members' ability to achieve personal health goals and improve health outcomes. For most of its more than 16-year history, CalOptima has worked to strengthen the existing continuum of services available in Orange County by strategically sponsoring new elements of the continuum, implementing and expanding successful models, and accepting contractual risk for other long-term care benefits. For example, CalOptima:

- Has operated a Member Liaison Program to help members navigate community supports since 1997
- Assumed contractual risk for skilled nursing facility (SNF) benefits beginning in 1998
- Has operated a MSSP site since 2001
- Successfully bid in 2009 to assume responsibility for an existing county-operated MSSP site that had relinquished operation back to the California Department of Aging (CDA); the two MSSP sites were subsequently consolidated
- Served as lead agency on a grant to launch the local ADRC, in partnership with the Orange County Office on Aging and the Dayle McIntosh Center, in 2008
- Became the contracted administrative service organization (ASO) for the County of Orange Specialty Mental Health Plan in 2010
- Initiated preparations for administering the CBAS benefit beginning July 1, 2012
- Secured CalOptima Board authority to establish Orange County's first PACE site, which is planned to be operational by Fall 2012

In addition, CalOptima has a long history of partnership and collaboration with various community agencies and stakeholders, and consulted these partners on development of the Demonstration proposal. CalOptima works closely with these organizations to:

- Coordinate the delivery of existing services for CalOptima members
- Develop solutions and innovations designed to address the unmet needs of the Medi-Cal and dual eligible population served in Orange County
- Determine how to best fulfill CalOptima's mission in the present and future

Participation in the Demonstration is aligned with CalOptima's mission **to provide members with access to quality health care services delivered in a cost-effective and compassionate manner**, and would give CalOptima additional resources and flexibility to pursue innovations that facilitate: holistic, member-centric care and services; a continuum of LTSS designed to meet the full range of services required by the dual eligible population; a single point of assistance for beneficiaries needing help to access services and navigate the health care system; greater inter-agency collaboration and data-sharing; and reduced duplication of resource consumption and administrative activity.

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

- **Senate Bill 208, Goal 1: Coordinate benefits and access to care, improving continuity of care and services.**

CalOptima plans to use its Dual SNP OneCare Model of Care as the foundation for the Demonstration. OneCare has an established, fully operational case management program that uses risk assessment, member-centric care planning, interdisciplinary care teams and care transitions management, which enables OneCare to integrate the full range of available LTSS for members. OneCare has begun further advancements in continuity of care, including planning and collaboration with the Orange County Social Services Agency and the Public Authority for IHSS and the Orange County Health Care Agency for behavioral health services.

- **Senate Bill 208, Goal 2: Maximize the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care.**

CalOptima will use its extensive expertise in case management to accurately assess the LTSS needs of beneficiaries, make certain that the least restrictive care alternative is provided and ensure that only services that are needed are provided. CalOptima will work with its multiple stakeholders (e.g. county agencies, providers, hospitals, nonprofit organizations, member advocates, etc.) to ensure members have access to the existing continuum of LTSS.

- **DHCS Duals Demonstration Goal 1: Preserve and enhance the ability for consumers to self-direct their care and receive high-quality care.**

CalOptima has a strong commitment to consumers' ability to direct their care. Accordingly, CalOptima, the Orange County Social Services Agency and the IHSS Public Authority have already begun meeting to discuss how to preserve the current program and make improvements as appropriate.

To the extent that the program funding allows, CalOptima will also explore inclusion of supplemental services beyond what is covered by Medicare and Medi-Cal. Benefits under consideration include vision, dental and transportation. CalOptima will issue requests for proposals as appropriate to contract for services not normally covered but necessary to help individuals avoid long-term institutionalization.

- **DHCS Duals Demonstration Goal 2: Improve health processes and satisfaction with care.**

CalOptima believes satisfaction with care is essential to the achievement of positive health outcomes. The Quality Assurance Committee (QAC) routinely monitors trends in member satisfaction by reviewing appeals and grievances, reviewing internal data, and conducting satisfaction surveys. The QAC also develops quality improvement initiatives when needed. As an established health plan delivering both Medi-Cal and Medicare benefits, CalOptima is familiar with adhering to the various regulations involving quality assurance, as evidenced by a

track record of successful regulatory site surveys. CalOptima also works with the provider networks to ensure they understand member protection requirements and strive to improve member satisfaction in every way possible.

- **DHCS Duals Demonstration Goal 3: Improve coordination of and timely access to care.**

CalOptima is highly responsive to member requests for assistance and employs multiple strategies to facilitate timely access to care. To support the Demonstration and address the anticipated increase in members needing assistance as they enroll, CalOptima will add customer service staff. Moreover, CalOptima will conduct extensive outreach to members and their caregivers to orient them regarding the Demonstration and available assistance to access care. CalOptima will reach out early and often to members in the Demonstration. In addition, CalOptima will conduct educational outreach to its provider networks to promote understanding of their responsibility to provide timely access to care.

- **DHCS Duals Demonstration Goal 4: Optimize the use of Medicare, Medi-Cal and other State/County resources.**

CalOptima's experience proves that comprehensive assessment, care planning, problem-focused interventions, and knowledge of members' needs and preferences, as well as available resources, leads to effective use of the resources and desired outcomes. For the Demonstration, CalOptima envisions several enhancements to the OneCare program in support of the above goals. These enhancements include expanded and more uniform assessment of dual eligible members; increased data sharing and collaboration with County programs, such as IHSS and behavioral health; expansion of the OneCare person-centered care coordination model; and increased access to home and community-based services that help members remain independent

and avoid institutionalization. The following sections describe the existing Model of Care and highlight the proposed enhancements in more detail.

Section 1.2: Comprehensive Program Description

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

CalOptima's proposed Demonstration model is based on OneCare, which is the second largest dual eligible SNP in California and serves more than 13,000 dual eligible members in Orange County. OneCare performs well in quality measures, having earned a 4-star rating for 2012 in the Medicare Star Quality Rating System. The Demonstration model will follow the OneCare elements described below, with adaptations made as needed, upon receipt of guidance from DHCS and CMS.

<u>OneCare Model of Care</u>

OneCare provides members with all Medicare and Medi-Cal services, along with additional benefits and services designed to meet the special needs of the membership. Provided at no cost to the member, OneCare services include but are not limited to:

- Inpatient hospital care
- Inpatient mental health care
- Services in a skilled nursing facility, up to the benefit limit
- Services by home health agencies
- Physician services, including office visits
- Chiropractic services

- Outpatient mental health services, including services for substance use and partial hospitalization
- Ambulance and non-emergency medical transportation (NEMT) services
- Outpatient rehabilitation services
- Emergency services
- Durable medical equipment and medical supplies (e.g., incontinence supplies)
- Outpatient diagnostic tests and therapeutic services, including recommended preventive screenings and vaccinations
- Comprehensive pharmacy services, including medication therapy management

OneCare also provides the following additional benefits:

- A comprehensive dental plan with zero co-payment for most covered services
- Vision care services, including a routine eye exam and prescription eyeglasses once every 12 months
- Routine podiatry services, including nail clipping for diabetic members, up to six visits a year
- 60 one-way taxi rides for health related services, in each benefit year
- Gym membership
- Worldwide emergency services

The OneCare Model of Care is member-centric to ensure the coordinated provision of seamless, individualized quality health care. CalOptima conducts a formal performance evaluation annually and establishes strategies for continuous improvement for the coming year based on evaluation results. OneCare has adopted measureable goals that are appropriate for the

membership served, consistent with regulatory requirements, and provide a means of comparing activity and performance to standards. The goals of the Model of Care are:

Goal 1: Improving Access to Essential Services

Access to essential services has three components: 1) a strong network, 2) ease of navigation to services and 3) knowledgeable, engaged members. The following sections describe these components of the OneCare model.

A Strong Network

OneCare has deep provider penetration in Orange County, facilitating access to services close to where members live or work. OneCare's 1,123 primary care providers and 2,139 specialists are geographically distributed across the entire county. This represents 60% of Orange County primary care providers and 35% of Orange County specialty providers. OneCare's network also includes 27 hospitals, 480 pharmacies and 180 ancillary providers. CalOptima's strategy of contracting with high-quality providers who are member-preferred has been especially successful in addressing our members' varied cultural preferences.

Ease of Navigation to Services

OneCare has a dedicated customer service unit with 11 representatives who can be reached through a toll-free number. Called OneCare Partners, these representatives have at least two years of experience working with seniors and persons with disabilities. OneCare Partners are often bilingual in Spanish, Vietnamese or Farsi. They provide assistance and education, helping members schedule appointments and select physicians. OneCare Partners also coordinate referrals to community services and agencies. CalOptima intends to increase the number of OneCare Partner positions, based on membership growth under the Demonstration.

Knowledgeable, Engaged Members

OneCare conducts monthly New Member Orientation sessions that educate members on use of essential services and benefits. Members receive quarterly newsletters that highlight services available within the program and community. They are also periodically invited to participate in medication therapy management visits, health fairs, health education seminars, and case management and disease management interactions.

Goal 2: Improving Access to Affordable Care

Since OneCare members have no co-payment or out-of-pocket cost for core benefits, OneCare designed a benefit set to include services that members might not otherwise be able to access due to limited finances. These services include:

- Dental: OneCare provides no-cost dental services through a contracted dental network. Coverage includes comprehensive oral exams and periodontal evaluation, prophylactic cleaning up to twice a year, periodontal scaling and root planing, dentures, extractions, and full-mouth debridement.
- Transportation: OneCare provides 60 one-way trips via taxi for any transportation needs associated with health. This can include pharmacy and gym benefit access, in addition to visits to providers and health facilities. Members are provided a toll-free number to arrange transportation on their own, or they can get assistance from OneCare Partners.
- Routine Podiatry: Upon California's elimination of the Medi-Cal benefit for routine podiatry, and in direct response to requests from the disabled community, OneCare included routine podiatry visits as a benefit. OneCare received commendation for including this benefit at a recent CalOptima Provider Advisory Committee meeting.

Goal 3: Improving Coordination of Care Through an Identified Point of Contact

All members are asked to choose a primary care provider upon enrollment. OneCare's member handbook offers detailed provider information to aid in selection, and members can also request assistance from OneCare Partners. Members who do not select a provider are automatically assigned to a provider near their home. Educating both providers and members reinforces the importance of the relationship in the coordination of care.

OneCare currently operates a pilot program promoting medical homes in the small-practice setting. Using a tool developed by the American Academy of Family Physicians, OneCare staff first assesses the potential effectiveness of the provider as gatekeeper. The assessment identifies and highlights strengths, as well as opportunities to educate physicians regarding use of evidence-based guidelines; health information technology for practice enhancement; and interdisciplinary care teams (ICT) and individualized care plans (ICP) for better-coordinated care.

Goal 4: Improving Seamless Transitions of Care Across Health Care Settings, Providers and Health Services

OneCare's transition of care process is designed to ensure that both planned and unplanned transitions are identified and managed by an ICT trained to address the member's needs and ensure smooth movement across the care continuum. OneCare has implemented evidence-based interventions, adapted from the Coleman Care Transitions Program, to ensure safe coordinated care so that members remain in the least restrictive setting that meets their health care needs and preferences.

OneCare's transition process ensures that members are screened to identify risk for complex transitions. This screening occurs during prior authorization and, for unplanned admissions, at the time of admission to a facility (either acute or skilled nursing). The screening tool incorporates questions about clinical condition, behavioral health status and social condition.

Identified high-risk members are referred to the transition ICT. Upon receipt of the referral, case managers conduct a comprehensive assessment, and the transition ICT develops or updates the care plan. The ICT also ensures that the care plan travels with the member during transition.

OneCare regularly reviews transitions to evaluate program effectiveness and identify areas for improvement. These reviews resulted in the creation of transition care coordinator positions at the two highest-volume hospitals in Orange County. The coordinators, who are stationed at the hospital, provide concurrent linkage to the transition ICT.

Goal 5: Improving Access to Preventive Health Services

OneCare employs several strategies to promote access to and delivery of preventive care services. Specific components include:

- CalOptima direct-to-member education and outreach, which is coordinated through the OneCare quality improvement committees and includes member newsletters, medication therapy management sessions and group health education sessions
- Member outreach via delegated medical groups, which includes telephonic reminders for breast cancer screenings and newsletters with prevention and health education tips
- Direct-to-provider outreach, wherein OneCare educates providers and their office staff regarding disease registries, open appointments, extended hours, walk-in friendly schedules and other best practice strategies that smooth members access
- Provider incentives, such as additional compensation for history and physical completion, and office staff rewards for conducting outreach leading to increased preventive screenings (e.g., breast and cervical cancer screening)
- Member incentives for compliance with indicated preventive care, such as returning a fecal occult blood test

- Facilitating access to preventive services in alternative settings convenient to the member, such as flu and pneumococcal vaccines at pharmacies, health fairs and other community locations
- A robust homebound program that provides preventive services in the member's home or facility of residence.

Goal 6: Assuring Appropriate Utilization of Services

OneCare ensures that members are receiving the right service, at the right level of care, by convening monthly meetings to review inpatient and ambulatory utilization data (e.g., bed days, length of stay, level of care, readmission and preventable emergency department admissions); conducting weekly case reviews to assess conformity with criteria and identification of outliers; and deploying a team to work with providers and members to reduce inappropriate emergency department use.

Moreover, OneCare's Quality Improvement Program team regularly reviews Healthcare Effectiveness Data and Information Set (HEDIS) measures and recommends initiatives with potential to improve performance on these measures. To highlight strengths and identify opportunities for improvement, OneCare staff also monitors other quality indicators, such as referral to case management, content of ICPs, use of evidence-based guidelines and ICT performance.

Goal 7: Improving Beneficiary Health Outcomes

The ultimate goal of OneCare is to improve health outcomes for all members. To measure progress toward that goal, OneCare analyzes data from multiple sources, including claims, pharmacy, utilization, member satisfaction, and appeals and grievances. This work is

directed by OneCare's quality improvement committees and documented in the OneCare Quality Work Plan. A specific Quality Work Plan will be developed for the Demonstration.

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.)

The Demonstration will offer a single set of CMS- and DHCS-approved benefits for the entire dual eligible population served. Accordingly, CalOptima plans to develop a single member handbook and other member materials that reflect an integrated benefit set. CalOptima will also educate members and their caregivers, providers, community agencies, and other stakeholders about the concept of a single benefit set, where financial risk for the benefits lies, and access and authorization rules for various benefits.

CalOptima intends to follow CMS and DHCS guidance on informing members and stakeholders regarding the changes. The single benefit set must be carefully described in a variety of formats for dual eligible members. Depending on DHCS guidance, this may include mailings with an updated explanation of coverage, benefit summary or member handbook, and a cover letter that clearly identifies the covered benefits. Materials will be easy to understand, provided in languages representative of the members served and formatted to meet the needs of people with various disabilities.

CalOptima will also provide benefit set information to the provider network in a variety of ways, such as provider bulletins, provider newsletters, blast faxes, face-to-face training sessions, website postings and computer-based training. Moreover, CalOptima will work with the provider network to ensure a clear understanding of the division of financial responsibility (DOFR). The DOFR will clarify which entity has financial risk for the various benefits. For example, the medical group may have responsibility for all services except IHSS and other LTSS, such as custodial long-term care. In the case of IHSS, CalOptima will need to clarify the

scope of the benefit and how to access the benefit, if CalOptima bears the financial risk or manages authorizations. CalOptima must also clarify the eligibility requirements for the benefits offered and whether medical necessity rules apply.

To prepare for administration of a single, integrated benefit, CalOptima will also:

1) Advise any provider networks administering delegated benefits as to the process for overseeing the administration of those benefits, including tracking utilization and addressing access to care
2) Determine if separate new provider contracts or contract amendments are necessary due to the single benefit set
3) Develop a network readiness assessment, including review of grievance and appeals process changes, to determine whether interested networks are prepared to administer the delegated benefits
4) Configure CalOptima's grievance and appeal system to track grievances and appeals specific to this benefit set
5) Configure the managed care payment system to pay for the benefits
6) Redesign the eligibility coding system to account for integration of benefits into a single set
7) Educate the network of providers on the range of beneficiary protections related to the benefits, such as uniform language for benefit determinations and grievances and appeals
8) Implement a plan to rapidly escalate member complaints about accessing the benefit if there should be confusion on the part of the provider
9) Review current staffing models and identify any additional staffing needs

10) Define billing codes for, and determine how to track utilization of, supplementary services

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

Process for Assuring Use of Evidence-Based Guidelines

The OneCare Medical Data Management Department analyses data from multiple sources on a regular basis, including the Utilization Management, Quality Management and Case Management Departments. The data are reviewed by OneCare's Quality Department to identify areas of clinical performance that can be improved through the use of clinical practice guidelines. The manager of quality improvement, with help and guidance from the OneCare Clinical Quality Improvement Committee (CQIC), which includes the chief medical officer, the OneCare medical director, practicing physicians from the network, OneCare directors of case management, quality improvement and health services, and a behavioral health practitioner, then research the literature and identify current nationally accepted, evidenced-based clinical guidelines pertinent to the area chosen for improvement. The guidelines are sent to practicing physicians with relevant specialties for review and to ensure the guidelines meet local community standards. Upon approval by the CQIC, the summary page of the guideline is posted on the CalOptima website with a link to the detailed guideline. The summary page is also faxed and mailed to all primary care providers. The approved guidelines are reviewed and updated at least every two years, or as needed when national updates occur.

As an example of the process, OneCare reviewed and adopted the following evidence-based clinical guidelines in 2010:

- American Diabetics Association guidelines for the management of type 2 diabetes

- American Psychiatric Association guidelines for major depression management in primary care
- United States Preventive Services Task Force (USPSTF) adult preventive care guidelines

In addition to reviewing and approving evidenced-based clinical guidelines, the CQIC monitors the use of the approved guidelines within CalOptima's provider network. This monitoring takes place in different forms, including medical record review, utilization review and clinical incentive review.

Examples of Evidence-Based Models Currently in Place

Several components of the CalOptima proposed model of care are derived from evidence-based models of care. OneCare is a 4-star Medicare plan that closely follows the NCQA SNP 2011 Structure & Process measures listed in the Guidelines for the Evaluation of Special Needs Plans, November 2010. For complete SNP measures, please see http://www.ncqa.org/tabid/1265/default.aspx. CalOptima is well along in the process of obtaining NCQA accreditation for the OneCare program. OneCare follows the NCQA Disease Management standards, also available on the website.

Other examples of CalOptima's evidence-based practices and initiatives underway are described below:

- CalOptima uses a transitions of care approach that incorporates elements of the Eric Coleman Care Transitions Program.
- Prochaska and DiClemente's Stages of Change Model and motivational interviewing techniques help CalOptima determine which enrollees are amenable to case management interventions and self-management training.

- A partnership is underway with the Orange County Health Care Agency and the University of California, Irvine to implement and promote the Screening, Brief Intervention and Referral to Treatment (SBIRT) model, an evidence-based method to intervene in alcohol and drug misuse that is currently underutilized within the primary care setting in the United States.
- CalOptima is reviewing how enrollees are identified for case management and studying best practices, including expanding its use of the Brief Risk Identification of Geriatric Health Tool (BRIGHT) questionnaire, which consists of 11 questions and has been found to have excellent utility in ruling out persons needing further assessment.[1] Currently, CalOptima uses this tool to screen members at risk for decompensation in health status.
- Based on a 2008 study of adults with disabilities enrolled in a Medicaid plan, which found that claims-based modeling offers advantages over Health Risk Assessments (HRA), CalOptima is also examining how to augment and improve risk-stratification practices. Both HRA and claims-based modeling provide information that yields significant predictors of the need for case management, and of emergency department use and hospitalization. Claims-based modeling, however, is easier to perform, and results are typically available earlier than through HRAs because of the difficulty of contacting members for administration of HRAs.[2]

[1] Kerse, Ngair, Boyd, Michael, Mclean, Chris, Kozial-Mclean and Robb, Gillian. The BRIGHT Tool, Age and Ageing 2008, 37:553-558

[2] Joseph P. Drozda Jr., Donald Libby, Wayne Keiserman, and Pamela Rundhaug. Case Management Decision support tools: Predictive Risk Report or Health Risk Assessment: Population Health Management. August 2008.

- CalOptima plans to study the assessment tool recently released by CMS that may be used for states that implement the Balancing Incentive Program (BIP)[3]. CalOptima's current assessment tools are electronic. Changes to the assessment need careful consideration and would likely need to coincide with current system upgrades in 2012 or later. CalOptima is also planning to consider use of any DHCS-proposed assessment tools, as well as review new electronic case management systems in 2012–13.
- CalOptima has implemented evidence-based case management procedures to help members improve the self-management of their chronic conditions. The approaches include brief, targeted assessments, evidence-based information to guide shared decision-making, use of non-judgmental approach, collaborative priority and goal setting, collaborative problem-solving, self-management support by diverse providers, and self-management interventions delivered by diverse formats.[4]

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.

On an annual basis, CalOptima reviews results for clinical preventive and outcome measures. CalOptima monitors for and identifies health care disparities by analyzing outcomes data using demographic factors. Common demographic factors used are age, gender, language and aid code category. Each outcome measure is analyzed by comparing subsets of data that are broken out by demographic category. The data subsets are compared to each other and to established goals. Difference between a data subset, the overall measure result and the goal are analyzed for barriers.

[3] CMS and Human Services Research Institute (HSRI). The Balancing Incentive Program; Implementation manual. October 2011. Chapter 4.

[4] Twelve Evidence-Based Principles for Implementing Self-Management Support in Primary Care. The Joint Commission Journal on Quality and Patient Safety. December 2010. Volume 36, Number 12.

Any measure that demonstrates deviations by a demographic factor is reviewed by the Quality Improvement (QI) Work Group Steering Committee. This committee selects focus areas for quality improvement initiatives and assigns selected areas to the appropriate QI work team for barrier analysis, intervention and evaluation.

For each QI project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must be clearly defined and outlined; have specific objectives and timelines; specify responsible departments and individuals; be evaluated for effectiveness; and be tracked by CQIC.

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

As an example, CalOptima reviewed breast care screening data stratified by age group, ethnicity, and aid category and identified disparities among groups. In follow-up, the QI work team identified the specific barriers for adherence to mammogram guidelines, by ethnicity/language spoken. The top barriers for English, Spanish and Vietnamese-speaking members tended to be the same but were ranked differently in importance. The top barrier among English-speaking members was lack of access to a car, gasoline or transportation, followed by fear of the procedure/pain; being too busy; fear of the results; and lack of doctor recommendation, in that order. Among Spanish-speaking members, fear of the procedure/pain was the top barrier, followed by lack of doctor recommendation; fear of the results; lack of

access to a car, gasoline or transportation; and no family history of breast cancer. For Vietnamese-speaking members, the top barrier was fear of the results, followed by fear of the procedure/pain; being too busy; lack of doctor recommendation; and lack of access to a car, gasoline or transportation. Examples of interventions tailored to address disparities include using culturally appropriate pictures in health education brochures; member education and outreach at culturally based community events; and outreach via Vietnamese radio.

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

Based on the information currently available, there is potential for CalOptima's Demonstration to include one or more components that qualify under the federal Health Home Plans State Plan Amendment. CalOptima's OneCare and Medi-Cal programs are currently conducting medical home pilots that include some components of the SPA. CalOptima looks forward to receiving additional information regarding the SPA program, including regulatory requirements and restrictions, and is open to dialogue with the DHCS regarding next steps.

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

In 2011, CalOptima engaged the consulting firm Health Management Associates (HMA) to conduct community stakeholder interviews related to integration opportunities and barriers, model design, and stakeholder support for the anticipated Demonstration. CalOptima also attended the DHCS-sponsored stakeholder forums leading up to the release of the RFS and has sought additional stakeholder input by conducting many advisory and informational meetings locally with various agencies and stakeholders. Below is a list of anticipated risks and mitigation strategies, based on input from numerous interviews and meetings:

Risk 1(a): Inadequate capitation that does not accurately reflect the risk assumed by the Demonstration sites for the range of unique needs of the dual eligible population

Risk 1(b): Inadequate financial incentives to rebalance care from institutional to community-based care

Mitigation Strategies: CalOptima will work very closely with DHCS to build in risk protections and will carefully monitor data from the pilot in order to justify revised rates. CalOptima, in collaboration with key stakeholders, will look for opportunities to add supplementary benefits but will be cautious given that data on utilization is limited.

Risk 2: Unsuccessful collaboration between CalOptima and IHSS, or CalOptima and OCHCA Behavioral Heath

Mitigation Strategy: All parties have agreed that there is much that can be done collaboratively to enhance and improve program services and efficiency. CalOptima and both of these county agencies have agreed to regular meetings for planning and program development, and in fact, CalOptima and OCHCA already meet monthly with respect to the behavioral health ASO.

Risk 3: Various agencies providing services refusing to collaborate with care planning and integration of services delivered

Mitigation Strategies: CalOptima is committed to increasing efforts to maintain an open dialogue with community agencies and contracting for services from these agencies when it makes sense for the member. CalOptima will seek the expertise and advice of these agencies as the Demonstration progresses.

Risk 4: Beneficiary dissatisfaction with the enrollment process, leading to high rate of disenrollment

Mitigation Strategies: CalOptima intends to follow the guidance and requirements set forth in the Memorandum of Understanding by CMS and DHCS and plans to reach out to the community early and often in preparation for implementation, with the goal of answering questions and allaying fears. CalOptima will engage various stakeholder community agencies to help potential enrollees understand the benefits of managed care plan enrollment and reach out to members as they prepare to enroll, to deliver a high-touch experience with CalOptima and ensure continuity of care.

Risk 5: Members believing the network offers inadequate choices

Mitigation Strategy: CalOptima has historically worked to offer a wide range of providers to choose from and will continue to expand the network to include primary care providers and specialists who understand the needs of the dual eligible population.

Risk 6: Hospital, physician and network dissatisfaction with the reimbursement rates

Mitigation Strategy: CalOptima has held discussions with the Orange County Medical Association, various provider networks and the Hospital Association of Southern California (HASC) to listen to their concerns and share CalOptima's position regarding rates. CalOptima's longstanding attention to minimizing administrative overhead costs supports the ability to pay providers adequately and fairly.

Risk 7: Upfront savings assumed by CMS and DHCS in early years are too aggressive, limiting alternatives to institutional care

Mitigation Strategy: CalOptima urges the CMS and DHCS to be cautious in their assumptions regarding the financial benefits that may be accrued at the federal and state levels. CalOptima will implement all of the required benefits but plans to offer services to support home and community-based living beyond the required benefits, to the extent

funding is available. These services would be purchased from various community agencies with the objective of helping beneficiaries avoid institutionalization. It is critical that this initiative be allowed sufficient time to demonstrate outcomes and to engage and attract all types of providers. CalOptima understands that contractual relationships with community-based LTSS providers, for purchase of LTSS alternatives, are important in order to realize some of the anticipated savings and will work with the existing network of LTSS for services, based on assessed needs and care planning.

Risk 8: County government's expectations about general fund relief for cost of services, such as IHSS, are not met

Mitigation Strategy: CalOptima is aware of the large county contribution to IHSS and will determine through planning and collaboration if this can be reduced, as CalOptima and IHSS move toward integration.

Risk 9: Demonstration site is inadequately staffed to handle influx of members

Mitigation Strategy: CalOptima plans to add staff in the areas of case management, customer service and enrollment, and long-term care as soon as the enrollment methodology is clear. If necessary, CalOptima will contract for services such as risk assessment, care planning and case management for low- to moderate-risk members.

Risk 10: Regulations regarding sharing of assessments between agencies prevent interdisciplinary care planning

Mitigation Strategy: CalOptima will follow CMS and DHCS guidance related to the sharing of health information needed for risk assessments, care planning and the delivery of care. CalOptima will seek and share information to the greatest extent allowable, for the purposes of the Demonstration.

Risk 11: Demonstration timeline is too compressed to allow sufficient time to ramp up operationally, including hiring and training staff needed to implement key program components and serve members

Mitigation Strategy: CalOptima will develop a comprehensive timeline with milestones listing the necessary operational changes and detailing the hiring and training plan. The milestones will be prioritized to allow for successful implementation. Some of the changes required will not be possible until the MOU and all Demonstration requirements are clearly presented to the selected Demonstration sites. A phased-in approach will be used to implement operational changes, based on priority and agreement with DHCS and CMS.

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.

CalOptima believes that a broad continuum of LTSS services is needed to meet the needs of the diverse population of dual eligibles in Orange County. Long-term care no longer refers exclusively to nursing home care. Accordingly, CalOptima has worked with its agency stakeholders to develop a continuum of services that support care in the community. CalOptima is committed to working on behalf of all members to assure that its services, and those delivered by partner organizations, are consistent with the assessed needs. To ensure seamless coordination between medical care and LTSS, CalOptima plans to undertake or expand these activities:

- **MSSP services will be available to Demonstration enrollees, based on assessed need.**

MSSP currently serves 464 Medi-Cal beneficiaries who meet California's definition of nursing facility level of care (NFLOC) eligibility and who prefer to live in their own home. Clients are assessed in their home by highly-trained case management staff consisting of nurses and social workers to determine the level of case management and services needed for the client to remain at home safely. MSSP case managers work closely with other disciplines and collaborate with IHSS and other community-based LTSS service providers to assure that the care plan is as integrated as possible and that service duplication is avoided. The MSSP staff knows the services available in the community and how to arrange services identified in the care plan.

- **As an alternative to the Demonstration, PACE will be an option for dual eligible beneficiaries who meet the eligibility criteria of NFLOC.**

  CalOptima is well along in the application process for a PACE site, with construction underway and an anticipated opening in Fall 2012. PACE manages both the medical and LTSS needs of the enrollee and is a proven model of care for the NFLOC population.

- **CalOptima will work with the CBAS agencies to conduct oversight, as defined by DHCS, and to be sure that the care plan is accurate and appropriate for the needs of the member from a medical and psychosocial perspective.** Additionally CalOptima is well known to ADHC (now CBAS) providers both within and outside the county and strengthened its collaborative ties with the centers through shared planning for the transition of CBAS to managed care in July 2012. CalOptima is prepared to contract with the approved CBAS providers in Orange County to preserve continuity of care and is well-positioned to provide enhanced case management to members who will not qualify for CBAS going forward. Furthermore, CalOptima will work with members who do not

qualify to be sure they understand the change in eligibility criteria, and to build the best plan possible to help them remain safely at home when their CBAS services terminate. CalOptima will also track members that no longer qualify for CBAS to determine if eligibility has changed, and to determine their need and eligibility for other services.

- **CalOptima will educate providers on CalOptima's responsibility for seamless coordination of services, as well as the range of LTSS services that will be the responsibility of managed care.** This education will include information on the nature and scope of the services, and when to contact CalOptima to request referral on behalf of a member. The network providers in the Demonstration will be reminded of their role in the development of the interdisciplinary care plan and encouraged to contact CalOptima when they identify the need for a change to the care plan.
- As a County Organized Health System, CalOptima has had responsibility and risk for managing long-term custodial care benefits since 1998. CalOptima has a long-term care department devoted to the management of members in custodial care; the department's case managers work with the skilled nursing facilities and providers to coordinate care for these members.
- CalOptima plans to coordinate services that are not part of the current benefit offering. For example, CalOptima envisions contracting on a fee-for-service basis with various community agencies for the following types of services:
    - Home-delivered meals on a short-term basis when a member in recovery is unable to shop and prepare meals post hospitalization
    - Short-term, community-based living options as alternatives to institutional care, pending approval by CMS

    - Home modification services to adapt current living arrangements with equipment not normally covered by Medicare, such as grab bars, shower chairs and access ramps
    - Managed care advocacy and case management for members who feel they are at a communication impasse with CalOptima and unable to get their needs met. This is a new concept being developed in response to stakeholder concerns that CalOptima is the only managed care alternative in Orange County.
    - Caregiver support services as a means of assisting unpaid caregivers in managing their long-term commitment to the member.
- To avoid disruption and promote continuity of care, CalOptima also plans to contract with select Dual Eligible Special Needs Plans in Orange County that lack a state SNP contract but have dual eligible members with established provider relationships and active care plans. CalOptima is having early conversations with other Dual SNPs and is considering the logistics and criteria for contracting with these plans as providers, similar to the way CalOptima contracts with HealthNet for Medi-Cal members.
- Additional plans include assessing the knowledge base of case managers and the provider network in regard to caring for seniors and persons with disabilities. CalOptima will develop additional training based on the assessed need, and will add case management and customer service staff with expertise in these areas as needed.

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

The contracting process is a key step in the development and maintenance of any provider network. To further develop its LTSS provider network, CalOptima envisions implementing these and other activities:

- Develop LTSS provider contract templates, with review and prior-approval by DHCS and CMS
- Develop a reimbursement schedule and payment methodology for LTSS providers. To ensure a smooth transition from fee-for-service to managed care, promote provider support and buy-in, and minimize the disruption of payment patterns for providers, CalOptima is considering preserving the fee structures and payment mechanisms already familiar to providers. Meeting with appropriate DHCS and Department of Social Services (DSS) staff at the state would help CalOptima understand the current provider reimbursement rates and methodologies.
- Develop provider education and outreach materials (e.g., frequently asked questions documents, provider fact sheets, cover letters) to support the provider contracting process
- Conduct outreach to explain the program, and negotiate and obtain signed agreements. Unlike network development efforts for medical providers, LTSS providers may not be accustomed to working with managed care plans, and therefore CalOptima intends to take a more high-touch approach (including in-person meetings) with LTSS providers as part of the contracting process. A comprehensive provider outreach, education and training program will be essential in ensuring providers understand the new integration initiatives and CalOptima's operations and processes. After contracting, CalOptima Provider Relations staff will remain in frequent communication with providers regarding the new integration initiatives through periodic trainings and through distribution of provider letters, newsletters, bulletins, emails and blast faxes. Program information and updates will also be made available on the CalOptima website and provider portal.

- Conduct ongoing monitoring and evaluation of CalOptima's contracted LTSS provider network to ensure member access to services and compliance with all applicable Medi-Cal provider network adequacy and availability standards specific to the proposed Demonstration. CalOptima intends to use feedback from member surveys, care management and utilization management staff, and provider and member grievance and appeals data to continually assess the adequacy of LTSS providers.
- Continue and build upon our existing contractual relationships with institutional providers

To facilitate further development of its LTSS provider network, CalOptima intends to request data from DHCS identifying contact information on current Medi-Cal LTSS providers (not including IHSS providers and MSSP providers), and including information on the LTSS providers by provider type, total number of members served and total Medi-Cal paid claims/spend. With this information, CalOptima's network team can prioritize providers for contracting efforts.

Question 2.1.3: Describe how you would use your 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.

In order to support a more fully integrated and efficient LTSS model, CalOptima will build on its existing case management and care coordination infrastructure by undertaking the following activities:

- **Increase the emphasis on each member's assessment of their health and functional status, strengths and desired outcomes.** This assessment will be conducted in conjunction with the member and others of the member's choosing to the extent the member wishes to do so; will include caregiver and provider input; and will be made available to all members

enrolled in care management. In response to stakeholder input received in preparation for submission of this proposal, CalOptima is also evaluating the extent to which assessments can be conducted in person, so as to better assess members' environmental, functional and social support needs.

- **Include more Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) assessment information in the tool,** especially as this relates to standardized recording of the member's need for assistance completing ADLs and IADLs. To this end, CalOptima staff are reviewing the Core Data Set for the Balancing Incentive Program (BIP), a tool that helps the assessor better identify the specific LTSS needs of the member and helps form the basis for a more specific and useful plan of care.
- **Ensure that relevant behavioral health assessment information for members is incorporated into the uniform assessment.** CalOptima is exploring development of a strengthened behavioral health needs assessment section that will include screening for several mental health conditions, substance use and current or historic use of behavioral health services.
- **Eliminate duplicative information-gathering and processes to the greatest extent possible and use one tool for Medi-Cal-only, OneCare, MSSP and PACE.** For any unique elements required by a specific program (or regulatory agency), CalOptima will develop a module that can be skipped when not relevant to the individual being assessed.
- In order to ensure that health network members receive the same comprehensive assessment and referral services as members enrolled in fee-for-service, CalOptima is considering **carving out assessment and referral for dual eligibles from the contracted health network responsibilities.** CalOptima would instead perform the assessment at the plan level

and provide case management for dual eligibles. Another option under consideration is to subcontract with a specialty care management company to provide assessment and case management for dual eligibles.

- CalOptima is exploring implementation of **telephonic HRAs and predictive modeling.** Tools under consideration include the Rand Vulnerable Elderly Survey (VES-13) or the BRIGHT questionnaire. However, since HRAs can be difficult to obtain, CalOptima will also focus efforts on enhancing the availability of relevant data for timely risk stratification.

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

CalOptima has significant experience working with a variety of LTSS providers that offer a range of services to members. With regard to home and community-based services, which assist members with daily activities and help them remain in their homes, CalOptima has garnered substantial experience through operation of, or coordination with, the following programs and activities:

Multipurpose Senior Services Program (MSSP)

CalOptima operated an MSSP site since 2001. In May 2009, CalOptima took on a second MSSP site when the existing county-operated site relinquished its operation to the CDA. CalOptima operated the two MSSP sites from June 1, 2009, through October 31, 2009. On November 1, 2009, the sites were consolidated into MSSP Site Number 41.

MSSP provides social and health care management for frail elderly clients who are certified as NFLOC, but prefer to remain at home. The program is funded through a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver with the goal of preventing or delaying premature institutional placement.

MSSP's comprehensive benefits include, but are not limited to:

- In-home assessments and ongoing monitoring
- Case management (described in more detail in a subsequent section)
- Congregate or home-delivered meals for clients who meet defined eligibility criteria
- Housing assistance, such as installation of adaptive equipment and assistive devices and temporary lodging in specific emergency situations
- Chore and personal care assistance
- Protective supervision for clients who are very frail or at risk of a medical emergency
- Adult day care as needed to meet psychosocial and therapeutic goals
- Respite for individuals who provide full-time care to the client
- Non-medical and medical transportation

CalOptima currently serves 464 seniors through MSSP. The agency has well-established staffing, policies, procedures and vendor subcontracts to ensure smooth program operation and the highest quality care.

Adult Day Health Care (ADHC)/Community Based Adult Services (CBAS)

On August 5, 2011, DHCS released its transition plan for the elimination of the ADHC benefit. Immediately following the plan's release, CalOptima scheduled the first of several transition planning meetings with more than 20 local and out-of-county ADHC providers. The meetings enabled CalOptima and the ADHCs to share information in a rapidly changing environment, identify areas of concern, develop a screening tool for discharge planning, and leverage best practices for the transition. CalOptima also visited every ADHC center in Orange County to better understand the operations and clientele of each center.

During the initial phase of the transition, CalOptima was charged with developing and implementing discharge plans for approximately 2,000 members, utilizing ADHC services. Prior

to the ADHC settlement in December 2011, CalOptima assessed 1,359 members with a screening tool developed in conjunction with the ADHCs, and began joint discharge planning at the ADHC centers for members at highest risk for long-term care placement.

Going forward, CalOptima will continue to coordinate with the newly identified CBAS providers as the benefit transitions from the Medi-Cal fee-for-service program to managed care.

Aging & Disability Resource Connection

In partnership with the Dayle McIntosh Center (the local Independent Living Center) and the Orange County Office on Aging (the local Area Office on Aging), CalOptima led a grant-funded effort to implement a local ADRC. CalOptima continues to work with these agencies to maintain and promote the ADRC. Staff regularly uses the ADRC website to locate accurate and up-to-date information about community resources and LTSS for members. The site's functionality allows staff to conduct personalized searches, using information on individual needs and preferences. Examples of search categories include disability services and products, home modification and repair, legal services, and transportation.

Care Connections Program

The Care Connections Program provides new OneCare members an initial, comprehensive in-home assessment for the purposes of care planning. CalOptima subcontracts with GeriNet, a regional network of health care professionals who specialize in geriatric medicine and the medical care of post-acute and nursing home patients, to administer this service.

Member Liaison Program

CalOptima's Member Liaison Program helps seniors, members with disabilities or chronic conditions, and members without housing, to access needed health care services.

Member Liaisons work closely with health care providers, case managers and agencies throughout Orange County to help CalOptima members navigate the health care system.

OneCare Supplementary Benefits

OneCare offers several supplementary benefits designed to support and assist members to live independently in the community. For example, members who meet medical criteria and are being discharged from the hospital without home support can receive home-delivered meals. OneCare also offers a transportation benefit that includes a set number of taxi rides for medical purposes (e.g., pharmacy, doctor visits).

Experience with Institutional Care

As a COHS, CalOptima is responsible for the administration of nursing facility benefits, which include the provision of services in sub-acute, skilled nursing care and intermediate care facilities. As such, CalOptima has a contracted network of various long-term care facilities. CalOptima employs registered nurses, who are assigned to the contracted long-term care facilities, to review the medical appropriateness of care based on Medi-Cal standards. These nurses authorize care in 3- to 6-month increments of time. Newly admitted members are reviewed upon admission and again after any hospital admission. CalOptima maintains a Long-Term Care Quality Program that provides workshops for the skilled nursing facility staff three times a year. Among the educational topics offered are information on flu vaccines, how to work with CalOptima as a partner, and reviewing quality report card scores conducted by DHCS as part of the DHCS oversight requirements.

CalOptima also has significant experience with members living in Intermediate Care Facilities (ICFs). Currently, more than 750 disabled members reside in ICFs. Members are placed at the appropriate level of care by the Regional Center of Orange County (RCOC), based

on their clinical needs. RCOC works with members and their families to ensure that the level of care meets the medical and psychosocial needs of the member. ICFs notify CalOptima of an admission and provide appropriate clinical information supplied by RCOC. CalOptima then issues an authorization, and the facility bills CalOptima at the state-established daily rate.

CalOptima also has experience working with Congregate Living Facilities (CLFs). Placement in these facilities is case-specific and is based on the clinical needs of the member. Experience with CLFs has included Well's House in Long Beach, which provides in-patient hospice care, and CareMeridian, which has several facilities in Orange Country and specializes in brain injuries. Placement at CareMeridian requires a member-specific payment contract based on the member's clinical needs.

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

CalOptima's approach for working with members in long-term care facilities has four key components:

1. Comprehensive assessment of the member, including member goals and preferences
2. Connection with the member's primary care provider (PCP)
3. Engagement with the member's family and/or others the member wants to include
4. Cultivating relationships with facilities so that members who can safely transition to the community have the opportunity and supports to do so

In 2011, CalOptima contracted with GeriNet, a provider group that specializes in the medical care of post-acute and nursing home patients, to conduct comprehensive health risk assessments of members entering a skilled nursing facility for short-term care (duals and Medi-Cal only) or long-term care (duals). This assessment includes behavioral health, physical and

social needs, as well as potential for returning home. Members receive an individualized care plan (ICP) based on their assessment results, and a transition plan when appropriate. The ICP is also shared with the OneCare interdisciplinary care team for ongoing case management and continuity.

CalOptima then communicates the assessment results and ICP to the member's primary care physician and determines whether the provider prefers to supervise implementation of the ICP recommendations directly, or delegate this to GeriNet. Many providers elect to have GeriNet perform this function since GeriNet has a daily presence in many of the facilities with which CalOptima contracts, and therefore can more closely monitor members' care and progress. GeriNet can also provide ongoing primary care; however, if the member prefers to continue receiving primary care from his or her PCP, CalOptima will arrange to have the member transported for appointments.

During the Demonstration, CalOptima anticipates working closely with the Dayle McIntosh Center and Orange County Community Services to assist members, particularly non-elderly disabled persons, who are willing and able to leave institutional care, make a safe transition to the community with adequate support. This plan is described in more detail in section 2.3.4.

Section 2.2: IHSS

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.**
- **A plan for coordinating emergency systems for personal attendant coverage.**

As the largest source of Medi-Cal-funded, in-home care in Orange County, serving about 20,000 CalOptima members per month, IHSS is an essential part of an integrated program. IHSS also has a complex administrative structure and serves a diverse group of consumers, including individuals who will not be eligible for, or choose not to participate in, the Demonstration. Program enhancements must be approached with care in order to ensure adequate protections for IHSS consumers and preservation of their rights (such as the rights to hire, fire, schedule and supervise the IHSS provider). However, caution must be taken to ensure that enhancements to the program designed for the dual eligible do not negatively impact individuals who are not part of the Demonstration. For successful planning and implementation, the agencies must collaborate closely on key program decisions, and have agreed to do so. Accordingly, this section of the RFS was co-written and approved by the three participating agencies.

CalOptima, the Orange County Social Services Agency (SSA), and the IHSS Public Authority (PA) have begun discussions about the challenges and opportunities presented by the Demonstration and have outlined initial ideas for how to work together. Meetings with UDW, the Homecare Providers Union, are planned for the immediate future. It is mutually understood by the three agencies that Year 1 will be an intensive planning period during which the agencies will work together to:

1. Educate each other regarding each other's services as mandated by law, the scope of administrative responsibilities, and funding streams
2. Engage consumers in learning about their needs and preferences

3. Ensure that input is received from both seniors and persons with disabilities, especially older beneficiaries
4. Identify opportunities to realize care and service improvements for IHSS consumers, including innovative use of supplementary benefits not covered under Medi-Cal and/or Medicare that are integral to helping persons remain in their home and communities (e.g., housing modifications, adaptive equipment, and designated flex hours that beneficiaries can use to meet needs IHSS currently does not cover)
5. Identify training and other support needs of the IHSS consumer, such as hiring managing and terminating caregivers; social and community participation needs (e.g., participation in faith communities, social events and activities)
6. Identify training and other support needs of personal care providers, such as appropriate communication styles, work ethics, mandated reporting of abuse, specific nutritional needs and safe lifting
7. Identify training needs of physicians, such as relate to assessment and accurate certification of need
8. Determine how best to obtain State support to facilitate interagency data exchange for more effective care coordination
9. Plan for years 2 and 3

As an outcome of Year 1 efforts, the agencies will work collaboratively, and with consumer representation, to develop a three-year tactical plan for further integration of IHSS with the covered services under the Demonstration. The three-year plan will take into consideration the time needed to transition and realign operations, any financial implications, and the consumer impact of all decisions. Other areas not specifically discussed in the RFS, such as

fraud prevention and detection, will be incorporated into the plan. The three-year plan will also include strategies to address the increased demand for services anticipated with the expansion of Medi-Cal beginning in 2014, and will be informed by direct input from consumers, caregivers, family members, and care and case managers, as well as pertinent published studies.

While precise terms have not been discussed, CalOptima plans to contract with SSA for referral processing, intake coordination, assessments and authorization of IHSS services. To ensure comprehensive and person-centered care coordination, CalOptima's care coordination teams will work closely with contracted IHSS staff, when approved by the consumer, IHSS social workers and consumers themselves. Similarly, IHSS will be encouraged to contact CalOptima's care coordination teams for information regarding the medical needs of its members or to request assistance in contacting the member's primary care provider or specialist. Moreover, CalOptima, SSA and the PA will jointly explore mechanisms to share data in order to develop comprehensive care plans, avoid duplication of services, and enhance overall coordination of care and service delivery. The agencies will also identify trigger points to notify each other when there is a change to an individual's health status. CMIPS, a data system currently utilized by SSA, will be evaluated to determine if it can serve as a platform for shared information, especially the enhanced version currently under development (CMIPS II). The primary purposes of understanding each other's data needs, and developing ways to share data, are to increase efficiencies in the delivery of services provided and meet the full needs of members.

Another key planning consideration is the enhancement of the PA's role. The PA performs important administrative functions for the IHSS program, including recruiting and educating individual providers, maintaining a provider registry, and processing required

paperwork for all Orange County providers entering the IHSS Program, including forms related to criminal background checks that determine if there have been crimes committed that would exclude them from being a provider. Due to budget reductions over the past four years amounting to almost 56% of its FY 2008–09 funding, the PA is currently only able to conduct 20% of the training provided in previous years. Consequently, many training needs go unmet. If chosen as a Demonstration site, CalOptima and the PA will explore making additional resources available to the PA to enhance its role as trainer. The PA in Orange County has developed a comprehensive training program for both the provider and consumer. A list of existing training modules is presented in *Attachment 2:OC IHSS PA Provider & Consumer Training Modules*. Unfortunately, due to funding cuts, the PA has been unable to implement the training programs. Additionally, because training is not an authorized IHSS service, providers are often required to seek additional training on their own. If allowed in the Demonstration, CalOptima and the PA will explore incentives to encourage providers to become better trained.

During the Demonstration, the agencies will also develop a plan for coordinating emergency systems for personal attendant coverage. The PA and SSA previously designed an emergency system that was not implemented due to lack of funding, and currently rely on Adult Protective Services in emergency situations. The agencies agree that an emergency system is needed and will be developed for members, should additional funding become available through the Demonstration. Ideally, the emergency system should provide a safety net for members 24 hours a day, 7 days a week.

In order to move forward, CalOptima, SSA and the PA have agreed to meet regularly to discuss, plan, and implement the requirements under the Demonstration. There is great synergy and momentum for this effort, and agency representatives look forward to developing shared

solutions that avoid undue financial burdens and maximize the positive impact of the IHSS program to consumers and their caregivers.

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.

Please refer to attached California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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

CalOptima assesses members and connects them to community social programs primarily through the four programs described below:

1. Multipurpose Senior Services Program (MSSP)

MSSP's home-based care management provides client assessment, care planning, service arrangement and client monitoring through periodic home visits and, at minimum, monthly telephone contacts. An interdisciplinary team of health and social work professionals provides each client with a complete health and psychosocial assessment at program entry to determine the services needed. The team then works with the client and client's representatives to develop an individualized care plan for continuity of care.

To arrange for services, MSSP care management staff first explores informal support that may be available through clients' family and friends. Staff then reviews existing publiclyfunded services and make assisted referrals. If needed services are not available through friends, family and other programs, the care management team can authorize the purchase of waiver-specified services from a dedicated set of program funds.

2. Member Liaison Program

Member Liaisons help CalOptima members schedule medical appointments, access non-emergency medical transportation, deal with medication issues, and obtain durable medical equipment, including wheelchairs, wheelchair repairs, crutches and other supplies.

3. OneCare Partners

In addition to assisting members to access specialty care, find needed medication and schedule non-emergency medical transportation, OneCare Partners often assist members to access home and community-based services. OneCare maintains strong links with senior centers and community organizations that provide services for older adults or persons with disabilities.

4. 2-1-1 Orange County Directory

CalOptima has special subscriber access to 2-1-1 Orange County's comprehensive and up-to-date information and referral system. Case managers and customer service staff use this directory frequently and routinely to link CalOptima members with community services and supports.

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

CalOptima has a long history of working with the Orange County Office on Aging (OOA), which is the local Area Agency on Aging, and the Dayle McIntosh Center (DMC), the county's only Independent Living Center (ILC). CalOptima will continue to build on the strong partnership with OOA and DMC throughout the Demonstration, and will seek their input and guidance on the program model, operations, benefits and services.

The OOA carries out the mandates of the Older Americans Act and the Older Californians Act by serving as the lead advocate, systems planner and facilitator relative to all

aging issues on behalf of older adults in Orange County. This is accomplished by developing area plans for services and funding, administering service contracts, providing staff support to the Senior Citizens Advisory Council, supporting the continuum of community-based long-term care services, publicizing and disseminating information on available resources, identifying service barriers and gaps, and providing direct services through health education and a toll-free Information and Assistance (I&A) call center.

DMC is the largest ILC in California and is a consumer-controlled organization, which means that at least 51% of the Board of Directors and Center staff are persons with disabilities. DMC provides five core services: advocacy, peer support, Information & Assistance/Referral, independent living skills training, and transitioning services. DMC is also the local contact agency for MDS 3.0§Q, the local California Community Transitions Lead Organization, and a Money Follows the Person Demonstration Grant recipient.

In 2009, CalOptima, in partnership with OOA and DMC, established the Aging & Disability Resource Connection of Orange County (ADRC OC) through a grant from the California Health and Human Services Agency. The ADRC OC is one of seven centers in California. The ADRC OC provides education, information and resource referrals for community support services, options counseling for long-term care needs, and assistance with hospital-to-home transitions. The success of the ADRC OC is a result of strong leadership, experience and collaboration among CalOptima, OOA, DMC and the ADRC OC Advisory Committee, which included more than 20 health and social service providers and consumer advocates.

In addition to the ADRC OC, CalOptima, OOA and DMC work together on community outreach activities, such as the annual Senior and Caregiver Health Expos, Disability Rights Workshops, and Senior Citizens Advisory Council Health and Nutrition Subcommittee.

CalOptima will meet regularly with the Director of Orange County Community Services which oversees OOA, Executive Director of OOA and Executive Director of DMC to explore other strategic opportunities to promote the goals of the Demonstration.

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.

CalOptima recognizes the pivotal role that accessible and appropriate housing plays in the ability for older adults and persons with disabilities to remain independent. For many low-income older adults and persons with disabilities, finding affordable housing in Orange County can be challenging. Orange County is one of the most expensive places to live in the country. A market-rate studio or one-bedroom apartment in Orange County costs between $1,175 and $1,327 per month, which exceeds the typical amount low-income seniors and persons with disabilities receive through publicly funded cash assistance and disability support programs. Low-income older adults and persons with disabilities on fixed incomes and limited or no significant assets may need to get a Housing Choice Voucher from one of the county's four Housing Authorities to assist with paying for rent.

In 2010, CalOptima assisted the Orange County Housing Authority (OCHA), the largest of the four Housing Authorities, to secure community letters of support for its application for Section 8 Housing Choice Vouchers for non-elderly persons with disabilities. OCHA was one of only five Housing Authorities in California selected to receive the housing vouchers. OCHA, in partnership with the Dayle McIntosh Center (DMC), can provide rental assistance for 50 non-elderly persons with disabilities to leave institutional care facilities and relocate to affordable and safe rental housing. CalOptima considers this program a potential model that may be expanded

and/or replicated. As one way to connect members to housing resources, CalOptima will work with OCHA and DMC to explore opportunities to increase referrals to this program.

In 2011, CalOptima commissioned a report to examine housing options for low-income older adults and persons with disabilities, as a first step to identify potential avenues for policy initiatives that allow more flexibility and/or options for assisting members with housing needs. CalOptima will share the report findings with its community partners in Fall 2012 and seek their input on next steps. In the meantime, CalOptima will continue to:

- Refer members to local housing experts, referral centers, and community organizations such as Orange County Community Services, Kennedy Commission, Orange County Office on Aging I&A call center, Orange County 2-1-1, ADRC OC, Illumination Foundation, and Regional Center of Orange County;
- Participate in the Homeless Provider Forum and Disability Access and Solutions for Housing (DASH) Collaborative to network with community based organizations that provide housing assistance and/or work on policy issues that impact housing;
- Learn more about and get involved, as appropriate, with Orange County's Ten Year Plan to End Homelessness, which aims to increase permanent housing options for the county's most vulnerable residents; and
- Explore options to provide temporary housing as an "in lieu of service" when appropriate in the Demonstration, as an alternative to institutionalization.

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.**

CalOptima plans to implement, and then build upon, key components of the current OneCare Model of Care (MOC) for the members of the Demonstration in order to provide seamless and coordinated access to the full array of mental health and substance use benefits. Demonstration members will receive screening for behavioral health and substance use at several junctures. At implementation, all new members to the Demonstration will receive a health risk assessment (HRA), which includes questions on past hospitalizations, medications, perception of health status and two questions to screen for depression (see *Attachment 3: OneCare Model of Care, p. 99*). The HRA will be used for risk stratification of members and proactive identification of members needing case management services.

In addition to the HRA, all new members will receive a separate behavioral health assessment that will screen for behavioral health diagnoses and substance use. Monthly, a list of new members will be sent to CalOptima's community-based behavioral health vendor. A behavioral health specialist will conduct a brief telephone survey, and those who screen positive will be offered a home or office-based visit to conduct a more comprehensive assessment to confirm the diagnosis. The assessment results will be sent to the member's primary care provider, and referrals will be provided as appropriate to the member's needs. For those members who screen negative, the assessment is conducted annually. CalOptima intends to work closely with stakeholders to identify validated screening tools for mental health and substance use conditions to include as a component of the comprehensive uniform assessment that will be developed for the Demonstration.

There are several other instances where members will be screened for behavioral health and substance use conditions. When receiving their annual physical, members will receive depression (PHQ-9) and substance use (CAGE) screenings. For members who enter the diabetes or heart health disease management programs, the PHQ-9 is part of the initial assessment.

CalOptima's Demonstration will be member-centric in design to ensure the coordinated provision of seamless access to individualized quality health care. Members will receive behavioral health services based on their needs, not the financial stream they may or may not fit into. Members whose behavioral health service needs are beyond the scope of a PCP's practice, but can be well-managed in a community-based private practice setting, will be referred to a contracted network of community-based behavioral health providers, with the current OneCare behavioral health network as the foundation.

CalOptima will contract with the County of Orange, Health Care Agency Behavioral Health Services (OCHCA/BHS) and their network of contracted provider organizations to provide services to members of the Demonstration with a serious and persistent mental illness (SPMI) who are not enrolled with a community-based provider at the start of the Demonstration, or who require additional expertise and services that have not been historically provided by community-based behavioral health providers. This will build on CalOptima's current process for OneCare members, approximately 130 of whom are receiving care through the OCHCA/BHS system. At present, the OCHCA/BHS system for persons with SPMI serves approximately 1,600 dual-eligible beneficiaries (2.2% of the dual eligible population in Orange County).

The warmest handoff that will be available at the inception of the program is the ability for primary care providers to call directly to the behavioral health vendor while the member is still at the office and hand the phone to the member to talk directly with the behavioral health

intake person to make an appointment, either in office or at a member's home. This process is currently in place for OneCare members.

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).

CalOptima will establish a Behavioral Health Clinical Director position to be held by a psychiatrist or psychologist who will provide clinical expertise for quality assurance, quality improvement, and strategic program development. The position will work in tandem with CalOptima's Director of Behavioral Health Integration, who will provide operational, performance improvement, and program implementation expertise. CalOptima established the Director of Behavioral Health Integration position in Fall 2010 as the agency intensified its efforts to pursue behavioral health integration across all product lines. The position has been CalOptima's key representative in collaborative projects undertaken to improve care coordination for members with both physical and behavioral health needs.

Until the Behavioral Health Clinical Director position is filled, CalOptima has several options for using clinical consultants, including the offer of consultation from the OCHCA/BHS Medical Director as part of the HCA's commitment to the partnership in developing and implementing the Demonstration.

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

The Demonstration will use Interdisciplinary Care Teams (ICT) to provide multidisciplinary, team-based care coordination following the OneCare model *(*see *Attachment 3: OneCare Model of Care, p.40*). There are three (3) levels of ICTs that reflect the health risk status of members. A behavioral health specialist is a standing participant on the ICT for moderate to high-risk members, along with the member, if feasible, and the medical director,

PCP, specialist, case management team (including case manager from behavioral health program, if applicable), and social worker. Additional disciplines, such as the clinical pharmacist, dietician and/or long-term care manager may be included in the ICT, based on the member's specific needs. Behavioral health specialists participate on the ICT as needed for low-risk members.

Members are identified and referred by providers, physician medical groups, or the OneCare clinical team. There is a specific OneCare mental health ICT referral form for members with behavioral health co-morbid conditions. An ICP with the member's prioritized goals is developed at the ICT. The ICP is disseminated to the member, caregiver or authorized representative, PCP, and all other participants of the ICT. In addition, the ICP is documented in the PMG's and OneCare's HIPAA-compliant, electronic case management documentation system.

Also worth mentioning is CalOptima's partnership with OCHCA in an exciting project to pilot bi-directional co-location integration in Orange County. The Integrated Community Services (ICS) project is an MHSA-funded three-and-a-half-year project launched in October 2011. ICS provides behavioral health services at three primary care clinics, and provides primary care at three behavioral health clinics. The behavioral health team consists of a psychiatrist, behavioral health specialist, and a medical care coordinator, who is a trained consumer employee. A primary care team affiliated with the community clinic organization, and consisting of a physician, a nurse, and a medical care coordinator, is available at three OCHCA behavioral health sites (all of which provide both mental health and substance use services). CalOptima members who participate in the pilot can select the behavioral health site as their health home since the clinic is a designated primary care provider.

The ICS program is currently available to Medi-Cal only members. As CalOptima continues to develop its behavioral health integration model for the Demonstration, the ICS will be a key model the agency will look to replicate within the Demonstration service delivery system.

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.

With a long history of consumer and family-member involvement, Orange County understands and respects the perspective of "nothing about us without us." The County has a well-established Mental Health Services Act (MHSA) steering committee with 65 members, including consumers and family members. The steering committee has four standing subcommittees and convenes ad hoc workgroups if more focused work is required on a specific topic. CalOptima has been an active participant of the steering committee since its inception. CalOptima and the OCHCA will jointly present to the MHSA steering committee at its March 2012 meeting to request the formation of a Duals Demonstration Workgroup to provide oversight of the planning and implementation of behavioral health integration in the Demonstration. There is a representative of the OCHCA's Alcohol and Drug Abuse Services (ADAS) division on the MHSA Steering Committee, and there will be representatives from ADAS participating in the Duals Demonstration Workgroup, as well.

CalOptima will also be working with the OCHCA to provide an initial presentation and ongoing updates to the Orange County Mental Health Board (MHB). Many MHB board members are also involved with the MHSA Steering Committee, and so will have multiple opportunities to be involved in the integration planning for the Demonstration.

These stakeholder engagement opportunities pertain specifically to behavioral health integration for the Demonstration and are in addition to CalOptima's multiple avenues for

members, advocates, and providers to provide input on the overall Demonstration planning and implementation (described further in Section 5.4: Stakeholder Input).

3.1 County Partnerships

Question 3.1.1: Describe in detail how your model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders. In preparing the response, keep in mind that your system of care may evolve over time, relying more heavily on the County in Year 1 of the Demonstration. (See Appendix G for technical assistance on coordinating and integrating mental health and substance use services for the seriously affected.)

The Orange County Health Care Agency provides services to approximately 1,600 dual eligible beneficiaries with a severe and persistent mental illness (SPMI) each year, through their system of county-operated and contracted clinics and programs. In the Demonstration, the OCHCA/BHS and their network of contracted provider organizations will provide services for CalOptima members with an SPMI. Approximately 130 of these individuals are OneCare members currently, and CalOptima has intensified its partnership with the OCHCA over the last year to improve care coordination for these members. The Demonstration will provide the vehicle to more fully integrate the behavioral health benefit.

CalOptima and the OCHCA have committed to establishing a working group to meet regularly to design a model that supports integrated benefits for individuals with severe mental illness and chronic substance use disorders. A key component the working group will focus on is the design of a fuller continuum of substance use services. Substance use conditions can cause or exacerbate other chronic health conditions and add to the overall cost of health care, but the current range of covered benefits in both the Medicare and Medi-Cal programs is inadequate. Orange County's integration design proposal will include expansion of the continuum of substance use services available to Demonstration members. A full range of services will lead to

better health outcomes for members, present no greater overall costs for the Demonstration, and possibly provide an opportunity to accrue savings.

Question 3.1.2: 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.**

Orange County Specialty Mental Health Plan and ASO

CalOptima and OCHCA have coordinated care for members needing specialty mental health services since 1996. CalOptima's first Memorandum of Understanding (MOU) with the OCHCA for mental health was completed in 1998; an updated MOU was implemented in 2001 (see *Attachment 4: Most Current MOU between CalOptima & OCHCA Behavioral Health Services)*. In developing the Orange County Specialty Mental Health Plan (OCMHP), Orange County chose to use an administrative services organization (ASO) model for the provision of outpatient specialty mental health services, and contracted with a behavioral health organization. CalOptima, HCA, and the behavioral health organization held "tri-agency" meetings on a regularly-scheduled basis to continually collaborate on improving coordination of care for members. The group developed a behavioral health-primary care communication tool that was implemented in 2003 (see *Attachment 5*: *Behavioral Health/Primary Physician Patient Care Communication Form*).

Since July 1, 2010, CalOptima has held the ASO contract for the OCMHP; the agencies meet at least monthly and have developed a case management referral process and specific form

to assist in coordinating care for members with co-occurring mental and physical health needs (see *Attachment 6: Beacon Fax Cover*).

In April 2011, CalOptima established a Behavioral Health Quality Improvement Subcommittee as part of its quality improvement structure. Three representatives of the OCHCA/BHS participate on the committee, representing mental health, substance use services, and quality management components of OCHCA/BHS.

Moreover, the OCHCA and CalOptima have worked, and continue to work, in partnership on several quality improvement and integration projects, as described below:

Integrated Community Services

This MHSA-funded project provides integrated physical and mental health services at both behavioral health and physical health sites for persons with co-occurring mental and physical health conditions, and often with co-occurring alcohol/substance use problems. There are co-located behavioral health teams at three primary care clinic sites, and primary care teams co-located at three behavioral health sites. The primary care sites are designated CalOptima primary care providers; CalOptima members who have selected these sites for their primary care will have access to the co-located behavioral health teams. An especially innovative component is that members can also choose to have their primary care provided at the behavioral health site, since the primary care team members are employees of the community clinic organization. CalOptima has been a partner on the planning team and now sits on the Innovations Advisory Committee to provide input on program evaluation. The agencies look forward to the expansion of this model to other sites and the inclusion of Demonstration participants.

CalMEND Pilot Collaborative for Integration (CPCI) and Care Integration Collaborative (CIC)

A team from Orange County participated in the CalMEND Pilot Collaborative for Integration (CPCI), which was launched in 2010 in an effort to improve the health of individuals with SPMI and co-occurring chronic medical disorders, through more effective partnerships between mental health and primary care providers. Sponsored by the State of California Departments of Health Care Services and Mental Health through State Mental Health Services Act funds, the structure of the Pilot Collaborative was based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) Collaborative model. The Orange County team included representatives from the OCHCA/BHS, CalOptima and Asian Health Center, a Federally Qualified Health Center Look-Alike clinic that is a primary care site for CalOptima members.

The team worked together intensively for fifteen months with the goal of establishing a delivery system that facilitates the integration of services for primary care, mental health and substance use conditions for individuals with SPMI and chronic medical diagnoses currently treated in the Orange County health care systems. The Integrated Community Services project sites were the focus of this collaborative. A key outcome of the collaborative was the approval by the County of Orange of a template Release of Information (ROI) that was pre-populated and very easy for staff and client to complete and sign. This has facilitated the goal of all clients having active ROIs in their chart to ease information exchange among clients' providers.

Due to the success of the collaboration, the Orange County team applied and was accepted to participate in the next CalMEND collaborative – the Care Integration Collaborative (CIC). This second collaborative began in February 2012 and will continue for one year. In this collaborative, county partnership teams will test and make changes to achieve better health status for individuals living with serious mental illness and/or substance use disorders as well as

cardiovascular disease, diabetes and/or metabolic syndrome. The county partners will accomplish these improvements by working together to provide care coordination for affected individuals. We will again use the ICS project as our base, but focus on persons with co-occurring behavioral health and physical health conditions.

Screening, Brief Intervention, Referral and Treatment (SBIRT) pilot in FQHC

Early in 2011, Alcohol and Drug Abuse Services (ADAS), a division within Orange County's OCHCA/BHS began reaching out to community partners in hopes that a partnership could be forged with providers to implement SBIRT at one or more busy primary care practices. CalOptima facilitated ADAS and the University of California Irvine (UCI) Family Health Center meeting to collaboratively explore co-location of SBIRT services at the UCI Family Health Center in Santa Ana. As a high-volume safety net provider, the Center is an ideal setting for the SBIRT model, and ADAS has committed to training and funding two SBIRT screening personnel to work within the health center. Recognizing the potential for leveraging each others' resources, the group formed a steering committee composed of UCI, OCHCA, and CalOptima representatives and has continued to meet monthly to articulate a program model and consider logistics of program implementation. Early on, there was consensus among group members that screening should be expanded to include other co-occurring risk conditions, such as mental illness and intimate partner violence.

With leveraged project management support from CalOptima, the committee continues to meet and work through implementation logistics, such as how best to integrate SBIRT staff into the primary care team and how to screen patients most effectively. Choices of key metrics and outcomes to follow are being reviewed as well. With continuing support from the collaborative

partners, it is anticipated services could begin as early as spring 2012. This pilot is another model that could be replicated through the Demonstration.

MEDNET

The Medicaid Mental Health Network for Evidence Based Care (MEDNET) is an Agency for Healthcare Research and Quality (AHRQ)-funded comparative effectiveness grant, submitted by CERT (Center for Education and Research on Mental Health Therapeutics) at Rutgers University. The grant began in 2011 and was funded for a 3-year period. In addition to Rutgers, other partners include New York State Psychiatric Institute/Columbia University, Academy Health, and the Mayo Clinic, all of which will provide analysis and technical support. Six state Medicaid programs committed to participate in the project--California, Maine, Missouri, Oklahoma, Texas and Washington. In April, 2011, CalOptima was asked by the California Department of Mental Health (DMH) to be the unique site representing California in the collaborative. The Orange County Health Care Agency is a key partner in the project.

The goal of the MEDNET project is to improve the health of Medicaid beneficiaries who are prescribed atypical antipsychotics. Seven clinical target areas were identified for measurement and intervention based on clinical effectiveness evidence. Orange County chose to focus on antipsychotic polypharmacy, and management of metabolic risk for members prescribed antipsychotics. Since anti-psychotic medications can be potentially prescribed by CalOptima providers, ASO-network providers, or County and County-contracted providers, the project provides a unique opportunity to bring together providers from both physical and behavioral health care to work together on key quality initiatives.

To date, the partners have established a Quality Collaborative and several work groups, and have completed a consensus guideline for the use of atypical antipsychotics in adults (see

Attachment 7: CalOptima Atypical Antipsychotic Guidelines). Over the next few months, the partners will work on a process for distribution of the guideline, and monitoring adherence to the guideline. In addition, the collaborative is completing consumer information material with the assistance of consumers.

Though currently MEDNET is focused on Medi-Cal members, most of the providers also prescribe to the dual eligible population; therefore, the education and feedback given to these providers will also impact care for patients who are duals. CalOptima's participation in the Demonstration will present an opportunity to expand the provider monitoring and feedback components to providers who care for Demonstration members.

Planning for full behavioral health integration in the Demonstration

The Orange County Health Care Agency (OCHCA) and CalOptima have committed to convene a working committee that will discuss and determine the design and timing for full behavioral health integration in the Demonstration. The working committee will invite other key stakeholders, including consumers and family members, to participate in the committee to ensure that all perspectives are considered in the development of the plan. The behavioral health implementation plan will only be submitted with concurrence from the OCHCA.

Integration is not an event but a process. CalOptima and its partners have already taken several steps, documented above, that provide a strong foundation for continued collaboration to develop Orange County's plan for full behavioral health integration in the Demonstration by 2015. It will take dedicated staff and champion leaders to move it forward, and Orange County is fortunate to have such leaders who are determined to work to integrate the Orange County health care systems.

Section 4: Person-Centered Care Coordination

Question 4.1: Describe how care coordination would provide a person-centered approach for the wide range of intellectual and cognitive abilities among dual eligibles, including those with dementia and Alzheimer's disease.

One of the primary rules of working with people in a case management capacity is to "start where the member is." CalOptima staff first administers a health screening, and the information is used to determine a patient-specific assessment process. The Health Risk Assessment (HRA) and subsequent additional assessments yield comprehensive information about the member's health status, including mental state and intellectual capacity. The case manager will honor the member's right to participate to the fullest extent in the event of intellectual and cognitive disability. If the member is able to communicate well enough to verbalize goals and preferences, those will be taken into consideration.

CalOptima's HRA contains a section related to member preferences for participation in the development of the care plan and in ongoing care coordination. The assessment focuses on the member's goals for health care, preferences, cultural variations, life goals and ability to participate. The member's goals and preferences are then reflected in the care plan to the extent that the enrollee can express them. An existing advance directive can be instructive for the member's representative whilst participating in the development of a care plan, with regard to honoring a person's wishes when they can no longer speak for themselves.

The ICT plays an important role in supporting and engaging the member as a participant in his/her own health care to the greatest extent possible. ICT meetings are conducted in a member-friendly format, with language interpretation provided if needed, and sensitivity to cultural perspectives. The member's understanding of the discussion is verified as the ICT meeting progresses. ICT meetings are designed to reinforce members' understanding of their right to participate in the ICT and in all health care choices; teach members how to navigate the

health care system; provide at least a basic understanding of key clinical conditions and planned interventions; and discuss and document members' expectations of and goals for the care to be provided.

Question 4.2: Attach the model of care coordination for dual eligibles as outlined in Appendix C.

OneCare's ICTs are aligned with the delegated delivery system. The participants in the ICT include the member, if feasible, the medical director, PCP, specialist, case management team, behavioral health specialist and social worker. The process is designed to ensure that members' needs are identified and managed by an appropriately composed team. Additional disciplines, such as the clinical pharmacist, dietitian and/or long-term care manager may be included in the ICT, based on the member's specific needs. The individual care plan (ICP) developed by the team is stored in the PCP medical record, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and all contractual, statutory and regulatory requirements. There are three levels of ICTs, specific to the health risk status of members. Risk level is determined through risk stratification methodology, using data sources that include acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy data.

1. **Basic ICT — PCP Level:** For low-risk OneCare members, as determined through stratification methodology. The team includes the member, caregiver or authorized representative, PCP, PCP support staff, and specialist(s). Roles and responsibilities of this team include:
    - Basic case management, including advanced care planning
    - Medication reconciliation
    - Identification of member at risk of planned and unplanned transitions

- Referral and coordination with specialists
- Development and implementation of ICP
- Communication with members or their representatives, vendors and medical group
- Reviews and update the ICP at least annually and with changes to the member's health status
- Referral to the Primary or Complex ICT as needed

2. **Primary ICT — Physician Medical Group (PMG) level:** For moderate to high-risk OneCare members. The team typically includes the member, caregiver or authorized representative, PMG medical director, PCP and/or specialist, ambulatory case manager, hospitalist, hospital case manager and/or discharge planners, PMG utilization management staff, behavioral health specialist, and social worker. Meetings are held as frequently as necessary to coordinate care and stabilize the member's medical condition. Roles and Responsibilities of this team include:
    - Identification and management of planned transitions
    - Case management of high-risk members
    - Coordination of ICPs for high-risk members
    - Facilitating member, PCP and specialists, and vendor communication
    - Identification and referral of members to OneCare Clinical Complex ICT
3. **Complex ICT — OneCare Clinical Level:** For members who have experienced a recent clinical event or diagnosis that requires extensive use of resources and requires assistance to navigate the delivery system. These members are identified and referred by providers, the PMG, and/or the OneCare Clinical Team. At this level, the ICT comprises the

member, caregiver or authorized representative, OneCare/PMG medical director, OneCare clinical/PMG case manager, PCP and/or specialist, social worker and behavioral health specialist. The team's roles and responsibilities are to:

- Consult with the PCP and PMG teams
- Ensure member engagement and participation in the ICT process
- Coordinate and manage members with complex transition needs and develop the ICP
- Provide support for implementation of the ICP by the PMG
- Track and trend the activities of the ICT
- Analyze data from different sources to evaluate the management of transitions and the activities of the ICT to identify areas for improvement
- Oversee all transition activities at all levels of the delivery system
- Meet as often as needed until the member's condition is stabilized

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 providers who are not experience in care teams and care coordination.

CalOptima network providers participate in care coordination activities at multiple levels. At the most basic level, all primary care providers in the OneCare network are trained on the Model of Care and recognize their responsibility to participate on the ICT. The Physician Medical Groups have significant infrastructure for case management, service coordination and referral. CalOptima staff supports the providers' participation in coordination of service through telephonic meetings, expedited referrals, specialty coordination, incentive programs and medical home pilots.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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.

Communication with members regarding PCP selection takes place in various formats including telephonic, face-to-face, written and via website. OneCare maintains the California Medi-Cal regulation that all written materials is at the 6th grade level and is available in the predominant spoken languages of the plan. Face-to-face communication takes place in both group and individual settings. Examples are the New Member Orientation and Medication Therapy Management sessions.

The ICP is communicated verbally and in written format to the member. The ICP and revisions to the ICP, including any changes to the composition of the care team, are developed in collaboration with the member.

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.

As discussed previously, CalOptima intends to work closely with SSA and the IHSS PA to preserve the IHSS program and make improvements, as appropriate. Please refer to Section 2.2 for additional information on planning efforts currently underway.

CalOptima's care coordination approach is another means by which members are encouraged and supported to self-direct their care. For example, CalOptima's HRA contains a section related to beneficiary preferences for participation in the development of the care plan,

and in ongoing care coordination. The assessment focuses on the member's goals for health care, preferences, cultural variations, life goals and ability to participate. The member's goals and preferences are then reflected in the care plan. Additionally, the care plan may contain specific actions for which the member is willing to take responsibility, such as following up with a smoking cessation program if smoking cessation is a personal goal.

Participation in care plan development, following through on actions that support stated goals, seeking guidance from the assigned case manager and/or the physician, and participation in the ICT are the primary means by with a member can participate in care. Although beneficiaries are asked how they would like to participate in care coordination at the time of the initial assessment, they have the opportunity to change the amount and frequency of involvement at any time. Members' right to decline to participate in the process, or to request that case management not be conducted on their behalf, is honored. Case managers will present the pros and cons of participation, if the member is willing to hear the information on the benefits and burdens of participating, or about treatment options.

CalOptima uses the Prochaska and DiClemente Readiness for Change Tool to gauge the member's motivation to participate and change health-related behaviors. Care plan interventions that involve member behavior change are tailored to match the member's stage of readiness for change. For example, if the member's readiness is low, education is offered about empowerment and the importance of participating in self-management.

An important goal of the ICT is to support and fully engage the member as a participant in his/her own health care. ICT meetings are conducted in a member-friendly format, with language interpretation provided if needed, and sensitivity to cultural perspectives. The member's understanding of the discussion is verified as the ICT meeting progresses. ICT

meetings are designed to reinforce members' understanding of their right to participate in the ICT and in all health care choices; teach members how to navigate the health care system; provide at least a basic understanding of key clinical conditions and planned interventions; and discuss and document members' expectations of and goals for the care to be provided.

Candidates for disease and chronic condition management programs are identified through risk stratification and predictive modeling. CalOptima reaches out to these members to offer education and create awareness of how self-management can improve clinical outcomes and help them achieve their personal and health care goals. Case managers serve as advocates for members' health care goals and preferences, and encourage members to create advance directives to ensure that their wishes and goals are honored in the future, especially in cases of dementia, Alzheimer's disease or other progressive, debilitating condition. In the case of members who are unable to speak for themselves, case managers verify that an authorized health care representative is speaking for the member. Whenever an advance directive is in place for a member, the family is encouraged to use this as a guide for decision-making on behalf of the member.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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

The OneCare provider network comprises providers with extensive experience in caring for Medicare and Medicaid populations. The majority of these providers participate in

CalOptima's Medi-Cal program and are experienced with the needs of the dual eligible population. They also have expertise in care of the frail elderly, complex medical conditions such as end stage renal disease, behavioral and substance use, and SPDs.

The OneCare specialty provider network has 2,139 specialty providers, which includes a broad spectrum of specialists to meet the needs of frail or disabled members and members with multiple chronic conditions. These specialists include but are not limited to specialists such as cardiologists, oncologists, nephrologists, general surgeons, geriatricians, gynecologists, ophthalmologists, orthopedic surgeons, psychiatrists, neurologists and pain management specialists. OneCare guarantees that the needed services will be provided, regardless of contracted status, in cases where a physician determines that a member requires care from a specialist or sub-specialist provider who is not available within the network.

OneCare monitors geographic adequacy of the provider network using GeoAccess software. The accessibility analysis report helps to identify possible coverage gaps. The most recent GeoAccess survey results show that greater than 98% of our members are within five miles of a PCP, and no more than 30 minutes from most specialists.

In terms of ancillary providers, OneCare is contracted with 21 home health agencies, 16 DME vendors, 6 custom rehabilitation wheelchair companies, medical supplies companies, and non-emergency medical transportation vendors. OneCare provides 60 one-way taxi rides to the members to facilitate access to medically related services.

OneCare also contracts with facilities that are pertinent to the special needs of its population. These facilities include acute inpatient facilities, including behavioral health, dialysis centers, post-acute hospital facilities, including skilled nursing facilities and long-term care, specialty outpatient clinics, rehabilitation facilities, radiology and imagining facilities, and

laboratory facilities. The majority of facilities are located within Orange County and within 15–30 minutes of the member's home. For some tertiary specialty facilities, OneCare contracts with regional centers of excellence to provide specialized services. Examples include rehabilitative services through a contract with Rancho Los Amigos National Rehabilitation Center and transplant services through the University of Southern California.

Facilities and other ancillary providers are credentialed by the Healthcare Delivery Organizations (HDO) process. These providers include, but are not limited to: acute inpatient, outpatient, skilled nursing, laboratories, dialysis, radiology and home health.

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

CalOptima is currently updating our provider directories and the CalOptima provider search tool on the CalOptima website to indicate which physician offices are physically accessible to persons with disabilities. This information is being obtained through Facility Site Review audits as part of CalOptima's effort to obtain NCQA accreditation.

Moreover, OneCare has an integrated system of communication with members and network of physicians, and other health care service providers. The system uses different communication methods to reach stakeholders with varying communication capabilities. These methods include regular and ad hoc face-to-face meetings; web-based, telephonic conferences; and written communications. The latter includes a quarterly newsletter, which is mailed to all OneCare members and produced in English, Spanish and Vietnamese. The newsletters are used to communicate a variety of topics, such as benefits and how to use them. OneCare adheres to the California Medi-Cal regulation that all written materials be at the 6th grade level, and available in the predominant spoken languages of the plan. Face-to-face communication takes place in both group and individual settings. Examples are the New Member Orientation and

Medication Therapy Management sessions (group-based) and ICT meetings (individual members).

5.3 Education and Outreach

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

To accommodate members' communication needs, CalOptima contracts with Pacific Interpreters to provide 24-hour access to telephonic interpreting services and Interpreters Unlimited to provide face-to-face interpreter services for scheduled appointments. These vendors can interpret more than 180 languages and are available to all CalOptima staff, whether they are working in the office or out in the field. For members with speech or hearing impairments, CalOptima provides sign-language interpreter services through the Dayle McIntosh Center of Orange County. Moreover, CalOptima uses the California Relay Services and the Telecommunication Device for the Deaf (TDD) to assist our staff in communicating with hearing or sensory-impaired members. CalOptima also provides written materials in the health plan's threshold languages: English, Vietnamese, Spanish and Farsi. For members with vision impairments or other language needs, materials can be provided in alternative formats upon the member's request (Braille, large print, audio and oral translation).

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

As a health care provider in the diverse community of Orange County, CalOptima strongly believes in the importance of providing culturally and linguistically appropriate services. We understand the importance of members being able to communicate with us in their native language about their health care needs. Therefore, CalOptima has designed a program that integrates culturally and linguistically appropriate services at all levels of operations.

With its strong roots in the community, CalOptima is in a unique position to recruit from local residents who have the knowledge and experience of working among the diverse population that makes up Orange County. CalOptima has worked diligently to put in place a process to recruit knowledgeable bilingual staff. As part of this process, CalOptima developed a screening tool for assessing the language skills of bilingual applicants for open positions. This process also utilizes qualified bilingual staff as screeners to assess the bilingual abilities of applicants. By doing so, CalOptima has been able to recruit and retain highly qualified bilingual staff members who care about the community they work for and live in. CalOptima currently has staff with linguistic expertise in the following languages:

- Armenian
- Chinese – Cantonese
- Chinese – Mandarin
- Farsi
- French
- German
- Korean
- Spanish – multiple dialects
- Tagalog
- Thai
- Vietnamese

Another way that CalOptima works to reduce cultural and linguistic barriers to care is to identify and map the languages spoken by providers in its network. CalOptima uses language data obtained through the provider registration process to generate language summary reports by contracted health network. These reports show the ratio of member language preference to provider language capability, information that allows CalOptima to map and generate language accessibility reports by geographic area for each contracted health networks. Currently, the linguistic capabilities of CalOptima's provider network encompass 67 languages/dialects.

To ensure the quality of translated materials, CalOptima's process for translating and reviewing written member materials includes a selection of qualified translators who are familiar, not only with medical terminology, but also managed care terminology; a consistent method for assessing, translating and reviewing written member materials; and field testing of the translated material with appropriate audiences, if needed. CalOptima developed a bilingual glossary that is used in all translation work so that terms are consistent among providers, contracted health networks, CalOptima staff and translation consultants.

Finally, CalOptima has developed working relationships with community and faith-based organizations to refer members to culturally and linguistically appropriate community services, such as psychosocial services. CalOptima staff regularly conducts informational presentations at these organizations to educate members about CalOptima programs and services.

To ensure that a wide range of members is reached, CalOptima has targeted outreach to different ethnic groups, and actively participates in community coalitions. For example, CalOptima regularly conducts outreach programs with local Vietnamese radio stations regarding health education topics and access information. CalOptima also attends and participates in the annual Tet celebration in Little Saigon, which celebrates the Lunar New Year in the Vietnamese community. In the Latino community, CalOptima provides outreach through Hispanic newspapers, which are widely read by Spanish-speaking members.

CalOptima's Member Advisory Committee (MAC) actively recruits and maintains a roster of members from various multicultural groups to ensure broad member representation. In addition, CalOptima's Provider Advisory Committee (PAC) was established to provide advice and recommendations to the Board of Directors. Appointment of PAC members is determined by the ethnic and cultural diversity and special needs of the CalOptima member population.

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

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

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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.

CalOptima has strong ties with the community and relies on a broad spectrum of stakeholders for input and guidance. CalOptima recognizes that the success of the Demonstration will depend heavily on enhanced and effective collaboration with its multiple stakeholders (county agencies, providers, hospitals, nonprofit organizations, member advocates, policy makers, etc.). Accordingly, CalOptima was ardent in its efforts to get stakeholder input throughout the development of the Demonstration application. There were many different ways in which input was sought and provided, including email notices to more than 100 stakeholders requesting feedback, formal meetings, and stakeholder interviews.

<u>Formal Meetings</u>

More than 25 meetings have been held since January 2012 to inform stakeholders about the Demonstration and to listen to ideas, input, and concerns about the impact of the Pilot in Orange County. CalOptima met with leaders at the County of Orange, including:

- The Honorable Janet Nguyen, Board of Supervisors, First District and member of the CalOptima Board of Directors

- Tom Mauk, County Executive Officer
- Bob Miller, Executive Director, Public Authority
- Mark Refowitz, Director, Health Care Agency Behavioral Health Services and his senior staff
- Dr. Michael Riley, Director, Social Services Agency and his senior staff
- Karen Roper, Director, OC Community Services
- Bob Wilson, Assistant Director, Health Care Agency and his senior staff

CalOptima worked collaboratively with, and incorporated feedback from county agency partners into the Demonstration proposal, and outlined a plan for ongoing work. This includes, and is not limited to, identification and refinement of program models and processes. Program models and options for collaborative integration will continue to be identified and refined throughout implementation of the Demonstration.

As part of the ongoing work, if the final Demonstration requirements confirm that supplemental benefits include meals, transportation, housing and other services not previously available to dual eligible members, CalOptima will work with its county agency partners and other stakeholders to identify potential funding sources to pay for each proposed component of service, give input on how these services are provided to members and share best practices and lessons learned from this collaboration. Furthermore, CalOptima will continue to work with its county agency partners and other stakeholders to enhance care coordination to meet the broader needs of its dual eligible members.

In addition to the valuable input from the County of Orange, CalOptima received important feedback from its provider community at multiple meetings, including the CalOptima Health Network meetings, CalOptima Managed Care meetings organized by the Hospital

Association of Southern California, Orange County Medical Association Board meetings and CalOptima Provider Advisory Committee meetings.

CalOptima also received input from policymakers, consumers and community representatives at the following meetings:

- Area Board XI Task Force — made up of consumers and service providers
- CalOptima's Legislative Luncheon — attended by more than 60 individuals representing local elected officials and advocacy organizations
- CalOptima's Member Advisory Committee
- Community Alliances Forum — attended by more than 300 consumers and individuals representing health and social service agencies
- Orange County Aging Services Collaborative — made up of more than 33 organizations serving older adults
- Orange County Adult Day Services Coalition — made up of 13 CBAS and adult day care providers
- Partnership for Community and Home Options for Independence and Consumer Education (CHOICE) — made up of county agencies, nonprofit health and social service providers, consumer advocate groups and CalOptima

Stakeholder Interviews

As previously mentioned, CalOptima contracted with Health Management Associates to conduct interviews with CalOptima Board members, Orange County government leaders, CalOptima providers, member advocates and representatives from community-based organizations that serve older adults and/or persons with disabilities. A total of 17 interviews were conducted, and some of the feedback has been incorporated into the Demonstration

proposal. CalOptima will continue to carefully consider the recommendations from the stakeholder interviews as it moves forward with the Demonstration.

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

Stakeholder input has always been an integral part of CalOptima's decision-making process; as a result, there are well-established conduits to ensure a fully inclusive engagement plan for the Demonstration. This plan will focus on leveraging existing relationships and expanding outreach activities to solicit meaningful input.

One of the primary stakeholder groups that will have an expanded role in the Demonstration is the Partnership for CHOICE. Established in 2005, the Partnership for CHOICE has served as an advisory group to CalOptima for long-term care integration activities and is made up of representatives from county agencies, nonprofit health and social service providers and consumer advocate groups (see *Attachment 8: Partnership for Choice*). It was the Partnership for CHOICE that encouraged CalOptima to pursue a grant opportunity to establish the ADRC OC. Once CalOptima received the grant, the Partnership for CHOICE helped establish a subcommittee to develop the program. The Partnership for CHOICE also has played a vital role in CalOptima's efforts to launch the first PACE site in Orange County. The PACE Development Advisory Group was established in 2011 and is a subcommittee of the Partnership for CHOICE. CalOptima anticipates establishing a Demonstration advisory group as a subcommittee for the Partnership for CHOICE that will provide feedback on program operations.

Another key stakeholder group is the County of Orange. CalOptima has a long history of collaboration with county agency partners and will continue to meet with them regularly to discuss program operations throughout the Demonstration period. In addition, CalOptima will

continue to update the Orange County Board of Supervisors and Chief Executive on the progress of the Demonstration.

CalOptima will work with the PAC to keep providers informed and engaged. CalOptima will host special events and attend meetings to solicit feedback from a broad network of providers, including but not limited to:

- CalOptima's Health Networks
- CalOptima Managed Care Committee
- Orange County Medical Association Board
- Orange County Coalition of Community Health Centers
- CalOptima Long-Term Care Quality Committee
- Orange County Adult Day Services Coalition
- California Association of Health Facilities, Orange County Chapter
- Hospital Association of Southern California

Table 2 below outlines CalOptima's broad framework of activities for stakeholder engagement.

Table 2: Stakeholder Engagement Framework	
Activities	**Time Frame/Frequency**
Host Partnership for CHOICE meetings	Quarterly
Establish Duals Demonstration Committee	Before January 2013
Update Orange County Board of Supervisors and County Executive	Quarterly
Develop behavioral health plan with Health Care Agency	Meet weekly
Implement IHSS plan with Social Services Agency/Public Authority	Meet monthly beginning Feb 2012
Work with community-based organization to promote support services	Meet bimonthly
Host special events or attend meetings to update providers	Monthly
Host special events or attend meetings to update consumers	Monthly
Update local elected officials	Quarterly

Update CalOptima's Provider and Member Advisory Committees	Quarterly
Meet with UDW The Homecare Providers Union	To be determined

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 the integration entities, at a minimum, should develop a process for gathering and incorporating ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

CalOptima understands the importance of meaningful stakeholder involvement throughout the Demonstration. Accordingly, CalOptima is building on current efforts to establish a formal process for gathering and incorporating ongoing feedback from a broad spectrum of stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections. Additionally, CalOptima will hold regular meetings with external stakeholders and organize community forums to solicit feedback. CalOptima will be accountable to stakeholders for incorporating ongoing feedback and will provide regular updates on how issues raised have been or will be addressed.

The existing Partnership for CHOICE, described in the previous section, will be expanded to include more stakeholder groups. CalOptima proposes to continue hosting quarterly meetings for the Partnership for CHOICE to update the community on the progress of the Demonstration, solicit feedback, and provide the opportunity for discussion among community partners about next steps. CalOptima will establish a subcommittee of the Partnership for CHOICE to focus specifically on the Demonstration. This subcommittee will provide an important venue for interested stakeholders to work closely with CalOptima staff to develop and implement the Demonstration and establish a clear channel for gathering feedback from stakeholders.

CalOptima also recognizes the fundamental role of county agencies, e.g., the Health Care Agency, Social Services Agency, Office on Aging and OC Community Services, in the development and successful implementation of the Demonstration. CalOptima has longstanding relationships with these agencies and has worked closely with their staff over the years to improve care for Medi-Cal beneficiaries. Given the complexity and aggressive timeline of the Demonstration, CalOptima will work with these county partners to establish regular weekly and/or bi-monthly meetings, or use existing forums, to develop needed operational components, identify areas of concern, solicit feedback, and discuss next steps.

CalOptima will also continue to work with the PAC and provider networks to engage the provider community, recognizing that the Demonstration will have a significant impact on both providers and beneficiaries. To ensure that the provider community is up-to-date and has the opportunity provide feedback throughout the development process, CalOptima proposes to host or participate in monthly meetings for providers, opening a regular channel of communication and enabling CalOptima to reach a broad range of providers.

CalOptima also proposes to host or participate in monthly meetings for consumers, providing them the opportunity to work directly with members of CalOptima's team to address questions or concerns that they may have.

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.

CalOptima envisions a phased enrollment approach wherein the initial phase would entail enrollment of all OneCare members, members participating in MSSP and/or CBAS, and members with a birthday that month. Enrollment for all other eligible members would occur in the month of their birth. As an example, a person born in January would receive mailing about

the benefits and rules starting in October, allowing for continuity of care counseling prior to the January 1, 2012, enrollment.

Members with health concerns or high-risk health or continuity of care issues will be encouraged to contact CalOptima for a pre-enrollment screening to begin planning for continuity of care 90 days prior to enrollment. CalOptima will use its data to identify members with potential continuity of care issues, and will also reach out via mailings and phone calls, starting in October 2012 and continuing throughout the first year of enrollment.

A special team of **continuity of care specialists/counselors** will conduct brief screenings, obtain needed information about medications, planned surgeries, etc. and develop a tentative preliminary care plan. Continuity of care counselors can also work with anyone who plans to opt out after initial enrollment, and who needs continuity of care assistance. Enrollees with more complex issues would receive more intensive ongoing case management after enrollment, to be delivered by the medical group or CalOptima case management staff.

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

CalOptima has provided health care services to SPDs since February 1996, more than 16 years. Dual eligible SPDs have been capably served in CalOptima Direct, a flexible access-based delivery system that accommodates members who have Medicare FFS. In addition, CalOptima has served SPDs enrolled in Medicare Advantage Plans for a number of years; more than 13,000 of these individuals are served through OneCare, CalOptima's premier, 4-star plan.

It also should be noted that CalOptima's Medi-Cal-only SPD population has been served by a delegated delivery system of 11 health networks for more than 16 years. Dual eligible beneficiaries and their long-time physician providers enjoy a diverse set of options to participate in the Demonstration project.

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.

CalOptima appreciates the opportunity to request additional information from DHCS regarding operational logistics of the Demonstration. In order to implement the Demonstration, CalOptima will need to know, at minimum:

Enrollment Process

- Specifics regarding passive enrollment, voluntary enrollment, proposed lock-in and members' options prior to, and after, the start of the Demonstration
- The communication process with members regarding enrollment
- Whether plans will be required to follow CMS' current SNP enrollment process, or if eligibility determinations will be made by DHCS
- How eligibility data will be transmitted to Demonstration sites and their subcontracted D-SNPs

Credentialing and Oversight

- Oversight requirements
- Credentialing requirements
- Additional requirements not in the current DHCS Medi-Cal managed care contract or the CMS D-SNP contract

Provider Network

- Demonstration sites' obligations to contract with local D-SNPs
- Ability for Demonstration sites to establish participation criteria based on quality, financial solvency and network capacity
- Degree of flexibility regarding delivery model and methods of payment

- Any limitations on contracting with a medical group, IPA, hospital or other provider with existing D-SNP contractual relationships
- Ability for Demonstration site to maintain its existing D-SNP as a subcontractor
- Ability to expand the Demonstration's provider network through contracts with, or establishment of, additional PACE facilities

Long-term Services and Supports

- IHSS administration and provider payment processes
- Contact information for current Medi-Cal LTSS providers (not including IHSS providers and MSSP providers), including information on the LTSS providers by provider type, total number of members served and total Medi-Cal paid claims/spend.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

Section 6: Organizational Capacity

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

CalOptima's guiding principles are reflected in its mission, which is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. CalOptima has a demonstrable record of serving as an efficient steward of public funds and consistently operating with administrative costs of around approximately 5%. Our commitment to quality is reflected in consistently high HEDIS scores, as well as a recent

national quality award for our Medicare Pharmacy program. CalOptima's OneCare Part D plan achieved a 4.5 star rating for 2012, within the top 3% of SNP plans nationally for Part D. In 2011, OneCare's Part D plan was one of three plans in the U.S. to receive the Pharmacy Quality Alliance (PQA) Quality Award. This award recognizes the achievement of a 5-star rating on the PQA measures of medication safety that are included in the Medicare Star Quality Rating System. The awardees were also required to achieve at least a 4-star plan rating overall. The winners were honored at the Awards Recognition Program held June 2011 in Washington, D.C.

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

Please see *Attachment 8: CalOptima Organizational Chart*.

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

CalOptima has established a department dedicated to programs for SPDs. Currently, this department is responsible for launching the first PACE site in Orange County, implementation of the new CBAS benefit, management of the Demonstration, which this RFS addresses, and other programs affecting SPDs. Key staff members directly working on this project, include but are not limited to:

Deborah Miller, MSW, Executive Director, Programs for Seniors and Persons with Disabilities: Ms. Miller has more than 11 years experience in Medicare health plan operations at the senior executive level. She has expertise in developing and implementing dual, institutional, and chronic special needs plans, oversight of case management programs for NFLOC members, managing home and community-based service programs, and coordinating alternate services for long-term institutionalized care.

Candice Gomez, MSHCA, Director, Long Term Care Integration: Ms. Gomez has been an employee of CalOptima for nearly 12 years. Through her tenure, she has implemented or participated on projects related to encounter data submission, system implementation, network expansion, and the launch of new programs, including OneCare and the Behavioral Health ASO. More recently, she was directly responsible for the administration of CalOptima's Healthy Families Program.

Dianna Daly, MSPH, Director, Behavioral Health Integration: Ms. Daly has worked with CalOptima for more than 14 years and has developed and implemented many quality and operational programs for the organization. In her current role, she is directly responsible for the administration of the Behavioral Health ASO contract with the County of Orange and developing innovated ways to better integrate physical and behavioral health care services.

Sandra Rose, MPH, Director, Community Relations: Ms. Rose and her staff are directly responsible for developing and fostering relationships with community-based organizations and the County of Orange. Interacting with the community on a daily basis, the Community Relations Department is instrumental in coordinating, facilitating and obtaining stakeholder feedback regarding CalOptima and our programs, and advising senior management on community affairs.

Ilia Rolón, MPH, Manager, Long Term Care Integration: Ms. Rolón has more than 15 years of experience with program development, evaluation, and facilitation of strategic planning processes in partnership with community and county agencies. Prior to assuming the role of Manager, Long Term Care Integration, Ms. Rolón was a Senior Program Manager at CalOptima, assigned to major initiatives, such as launching the managed fee-for-service CalOptima Care Network.

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

Please see *Attachment 9: Resume of Duals Demonstration Project Manager.*

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

CalOptima is a public agency and governed by an 11-member Board of Directors that is appointed by the Orange County Board of Supervisors. The Board of Directors is made up of member advocates and representatives from the medical community, business, and local government. They represent the diverse backgrounds, interests, and demographics of Orange County residents, and help ensure CalOptima remains highly accountable and responsive to the health care needs of members.

Key CalOptima initiatives receive approval by the Board of Directors prior to implementation. CalOptima has an established internal governance structure through which programs for SPDs are implemented, monitored and operated. There are three levels within this reporting structure, which will also guide the Demonstration: SPD Governance Committee, Steering Committee and Implementation Team. The SPD Governance Committee consists of the senior executive team and the SPD program staff, and provides strategic direction and operational guidance. All executive staff participates on the Steering Committee, along with select operational directors. The Steering Committee provides direction to the Implementation Team and its workgroups. Information and communication is channeled through the Steering Committee.

Section 6.1: Operational Plan

Question 6.1.1: 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.

Please see *Attachment 10: Preliminary Operational Plan.*

Question 6.1.2: Provide roles and responsibilities of key partners.

CalOptima has identified and continues to identify key partners though its stakeholder engagement process. Roles and responsibilities will be defined collaboratively with key partners as benefit and program structure for the Demonstration becomes more defined.

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

Please see *Attachment 10: Preliminary Operational Plan.*

Question 6.1.4: Certify that the Applicant will report monthly on the progress made toward implementation of the timeline. These reports will be posted monthly.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist (Item 6.1.1).

Section 7: Network Adequacy

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

CalOptima currently utilizes the access and availability of services standards defined by the Department of Managed Health Care to demonstrate provider network adequacy. CalOptima's current provider network has a unique delivery model in that approximately 75% of members are with private or community providers who participate in large IPAs or medical groups. This allows CalOptima to provide dual eligible members access to clinical services that are often not available in the traditional Medi-Cal environment. By leveraging strong medical group and IPA provider relationships, CalOptima will be able to increase access to specialists and other clinical services.

Additionally, for purposes of the Demonstration, CalOptima will conduct analysis of the providers currently participating in other MA SNP plans in the county, and where data is

available, in Medicare FFS. CalOptima recognizes that for the Demonstration, ancillary, institutional and community-based providers will also need to be considered in its analysis. However, in preparation for the January 2013 launch date, CalOptima's first priority is to ensure continual access to the member's primary care and specialty provider whenever possible.

CalOptima intends, through a transparent process and with approval from the Board of Directors, to subcontract with other MA SNP plans available in Orange County that have demonstrated commitment to achieving the goals of Triple Aim: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. CalOptima will establish participation criteria that may include, but not be limited to:

- Length of participation as a MA SNP plan
- Star rating
- Size of enrollment and experience with dual eligible beneficiaries
- Care coordination and case management capacity
- Financial solvency including the abilities to meet a minimum 85% medical loss ratio, sustain risk, and meet the financial solvency deposit requirements
- Fiscal soundness, strong liquidity, Tangible Net Equity (TNE) above the minimum requirements, and consistent financial operating performance as demonstrated through filings with the DMHC
- Experience with Medi-Cal beneficiaries, especially with Seniors SPDs, and the administration of Medi-Cal benefits
- Ability to coordinate or directly provide social and community-based services
- Geographic coverage
- NCQA accreditation or demonstrated progress toward NCQA accreditation

- Data reporting capabilities
- Ability to increase the number of participating providers in CalOptima's current delivery system

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

CalOptima pays diverse network providers through an array of different methodologies based on capitation, per diems, and Medicare and Medi-Cal FFS rates. Payment strategies include FFS payment to providers such as physicians and ancillary providers; per diem and Diagnostic Related Groupings (DRG) payment to hospitals; global capitation to providers such as PCPs, specialists, laboratory and vision providers; and delegated risk capitation to medical groups, independent physician associations (IPAs) and some health maintenance organizations (HMOs), such as Kaiser. Medi-Cal capitation payments to participating medical groups, IPAs and HMOs are adjusted and stratified by aid code, age and gender. As relates to full risk capitated contracts, CalOptima has established a division of financial responsibility matrix that delegates responsibility for covered services based on the contracted entity's ability to arrange for and coordinate the delivery of the respective delegated services. CalOptima has also entered into shared risk arrangements with delegated medical groups and IPAs wherein the plan capitates the medical group or IPA for the professional services, but assumes risk for the inpatient benefit and shares a percent of any surplus.

The current OneCare payment methodology to participating medical groups includes compensation for professional services, including care coordination, based on a percentage of revenue for professional services. Similar to the Medi-Cal delegated arrangements, CalOptima has entered into shared risk arrangements with OneCare medical groups. CalOptima believes that basing professional capitation on a percentage of revenue aligns incentives for providers to

perform and properly document services for Hierarchical Condition Category (HCC) risk adjustment and quality incentives.

For the past 10 years, CalOptima has also incorporated a pay-for-performance program, which delivers millions each year back to the provider community.

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

CalOptima has developed multiple options in which providers can participate. Currently, Medi-Cal providers have the option to participate through a delegated network or to contract directly with CalOptima in a FFS model. As the Demonstration progresses, CalOptima will looks at mechanisms which will allow the continuation of these options. Additionally, CalOptima will proactively outreach to non-participating providers and inform them of the enhanced benefit options through the Demonstration. Unlike the recent statewide transition of SPD beneficiaries into managed care plans, SPD members have been enrolled with CalOptima since 1996. CalOptima plans to leverage that experience when encouraging new provider participation.

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

SPDs have been enrolled with CalOptima since early 1996. Approximately 75,000 dual eligible beneficiaries are enrolled with CalOptima today, more than 13,000 of whom participate in OneCare. For the Demonstration, CalOptima will work with providers to ensure accessibility for beneficiaries with various disabilities.

In addition, CalOptima is already preparing for the new SPD requirements that will go into effect for COHS plans in November 2012 by developing a new facility site review process and updating provider education modules. CalOptima will provide ongoing educational opportunities in various modes (e.g., written materials, group and individual sessions).

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.

Applying lessons learned from previous OneCare passive enrollment experience, CalOptima has developed a diverse network that provides different options in which providers can participate. Additionally, CalOptima values the importance of strong communication relationships and data sharing between the plan and providers. Currently, there are providers who do not participate in CalOptima's provider network but serve dual eligible members. As a result, CalOptima continues to include the non-participating providers in outreach and educational opportunities through:

- One-on-one meetings with CalOptima's Provider Relations staff
- Invitations to provider workshops coordinated or sponsored by CalOptima
- Access to CalOptima's robust provider section on www.caloptima.org, which contains current provider manuals, policies and procedures, a provider portal, and health education tools in English, Spanish, Vietnamese, and Farsi
- Inclusion on the distribution of quarterly Quality Improvement newsletters, monthly provider bulletins, periodic fax blasts and email communications regarding pertinent and urgent updates or changes
- Access to quarterly educational seminars and continuing educational events sponsored by CalOptima's Cultural and Linguistics department

CalOptima will also seek additional support from the PAC. Fourteen voluntary members representing a provider constituency that provides services to CalOptima members serve on PAC. The concepts put forth in the RFS have been discussed with the PAC over the years, and the PAC has expressed support for CalOptima's participation in the Demonstration.

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

In order to support the goal of an integrated delivery system, CalOptima plans to leverage existing subcontract arrangements. CalOptima currently holds direct and delegated subcontracts with medical groups, ancillary provider groups, hospitals, and other support services. Through OneCare, CalOptima has experience in contracting for supplemental Medicare benefits. CalOptima also currently contracts with a pharmacy benefits manager (PBM) that administers pharmacy benefits for all lines of businesses. As more information is released regarding the Demonstration sites' ability to provide supplemental benefits that better support members' needs, CalOptima will evaluate how best to integrate these services into the model.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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.

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

Section 7.1 Technology

Question 7.1.1: Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the "meaningful use" health information technology (HIT) standards.

CalOptima has been actively involved with HIT initiatives at the county, state and federal level for the past four years and contributes to both policy and technology decisions at the state and county level. CalOptima is one of only two health plans in the country to be awarded a $5.7 million ARRA Hi-Tech Regional Extension Center Grant that facilitates implementation or upgrading of Electronic Health Records (EHR) systems for 1,000 Priority Primary Care Providers (PPCP) within Orange County. CalOptima provides onsite technical assistance to PPCPs including EHR selection, implementation and achievement of meaningful use as well as facilitating the drawdown of Medicare and Medi-Cal incentive funds for achieving meaningful use. CalOptima utilizes software that extracts meaningful use and other quality data directly from seven of the most commonly installed EHR applications within Orange County. The review and aggregation of this clinical information is essential to patient care.

CalOptima also participates in statewide HIT committees that promote Statewide Health Information Exchange (HIE), ePrescribing, Lab Data standards and Immunization Registry data exchange. Moreover, CalOptima participates in the local HIE, Orange County Regional Health Information Organization (OCPRHIO). OCPRHIO facilitates the exchange of data between EHRs and other HIEs.

Question 7.1.2: 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.)

CalOptima utilizes HIT to remotely monitor and send reminders to patients. As an example, CalOptima is the recipient of a mHealth grant that uses scales to remotely monitor the

weight of patients with Congestive Heart Failure. Through the OneCare Medication Therapy Management (MTM) program, CalOptima has also piloted an electronic "pillbox" from MedMinder, which allows remote monitoring of medication compliance. CalOptima plans to continue the use of similar technology to meet the needs of the duals patient, and is involved in several hospital and county-based telehealth initiatives, including the use of telemedicine within the PACE center CalOptima will open later this year.

CalOptima receives electronic admission, census, and discharge data from all the hospitals within Orange County and two of the major ER facilities. These data are used to notify providers of admissions, and for case management purpose. CalOptima also has the ability to transfer information using portals, directly into EHRs and other approaches that would be effective for patients as well as their care providers. Lastly, CalOptima uses a vendor-supported Care Management system, wherein patients are stratified and individual care plans and assessments are used to oversee patient care.

Question 7.1.3: Describe how technologies will be utilized to meet information exchange and device protocol interoperability standards (if applicable).

CalOptima is an active participant in setting policies and standards for data exchange within Orange County and the State of California and offers software tools to aggregate and format data to facilitate interoperability between organizational systems and HIEs. Moreover, CalOptima closely monitors progress at a federal and state level as standards are being defined, tested and implemented. CalOptima has participated in various HIT demonstration projects that test the usability and feasibility of such technology.

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 (Part D requirements for reporting PDE will continue to be applied)**
- **Condition-specific quality measures, and**
- **Risk-adjusted mortality rates.**

OneCare uses previous performance to identify and select the measurement outcome targets for the coming year. CalOptima has ongoing work groups that monitor the performance of each measurement and identify opportunities for modifying the plan to ensure the goals are met. Goal areas for 2012 include improving access to essential services, improving access to affordable care, improving coordination of care, improving seamless transitions of care, improving access to preventative health services, assuring appropriate utilization of services and improving beneficiary health outcome. Benchmarks are based on the previous year's performance, and the measurement timeframe is one year. Performance is reported up to governance through our committee structure.

With failure to meet a goal, a thorough review is done and a corrective action plan (CAP) is developed by the appropriate quality workgroup. The correction action process is as follows:

- Corrective Action Plan(s) to Improve Care/Service: When an evaluation identifies an opportunity for improvement, the delegated and/or functional area will determine the appropriate action(s) to be taken to correct the problem. These may include the following:
    - Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements
    - Discussion of the data or problem with the involved practitioner, either in the respective committee or by a medical director
    - Further observation of performance via the appropriate clinical monitor (This process shall determine if follow-up action has resolved the original problem.)

- Discussion of the results of clinical monitoring
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e. when the current data are insufficient to fully define the problem
- Changes in policies and procedures, as needed

CalOptima will produce monthly PDE records as well as meet all required reporting requirements.

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)

CalOptima has robust data systems that capture sufficient information to comprehensively report outcomes for beneficiaries by demographic characteristics. CalOptima's Department of Financial Analysis routinely produces demographics and outcomes reports from its data warehouse and is currently engaged in developing a refined data warehouse infrastructure that will facilitate single source of truth, rapid deployment data reporting, and improved data consistency and integrity. This enhanced infrastructure will be in place by January 2013.

As a recent example of CalOptima's data reporting competence and efficiency, in the third quarter of 2011, CalOptima submitted 1,565,219 records to DHCS (claims and encounters) with a 99.998% accuracy rate.

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

Please refer to the California Dual Eligible Demonstration Request for Solutions Proposal Checklist.

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).

The CalOptima Regional Extension Center facilitates the implementation of EHRs and meaningful use for primary care providers. CalOptima is collaborating with the state to consider extending these services to specialist and other types of providers not covered under grant funding. Behavioral health providers, in particular, would benefit from Demonstration funding to enhance their technical abilities to exchange patient care information, resulting in greater coordination of care.

CalOptima also hosts a robust provider portal that allows for sharing of patient data in a secured manner online. The agency has a multiyear plan to enhance the adoption and capabilities of this portal, and infrastructure funding support from the Demonstration would expedite this plan.

CalOptima has a long history of investing in the provider practices in the community using grants to fund equipment to support the needs of LTSS patient, such as specialized exam tables and patient home monitoring tools. Due to the challenges of the California state budget and potential cuts to reimbursement, CalOptima has adopted a more conservative approach to these types of initiatives. Demonstration funding could be used to complete a landscape assessment of the needs within the county and provide funding where applicable

Lastly, CalOptima has created a process to receive hospital data on a daily basis from the 23 hospitals within the county. This process has been in place for more than five years, predating many of the data standards adopted within the past few years. CalOptima would invest Demonstration dollars to work with the hospital community to convert to the use of Continuity of Care Document (CCD) format so that this data can be imported directly into provider EHRs in

the community. This would greatly enhance the awareness of hospital admissions, resulting in the ability to provide enhanced care management and discharge planning.

Attachment 1: CalOptima Member Fast Facts, February 2012

Member Fast Facts: February 2012

Member Demographics

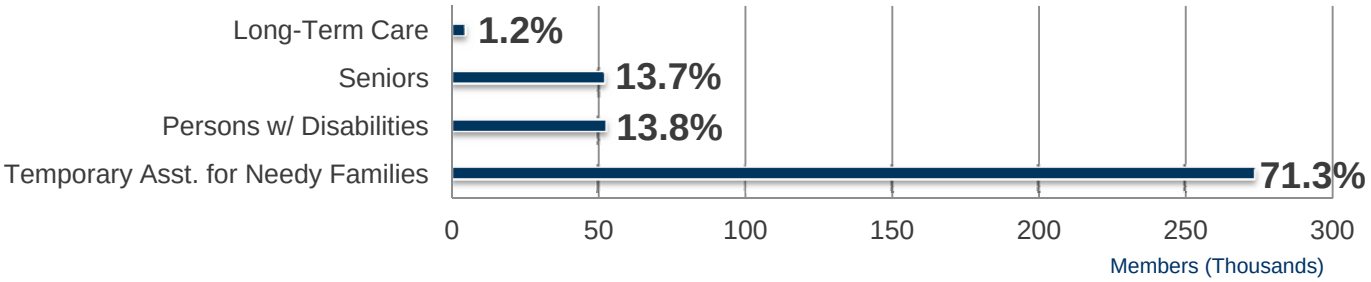
Total CalOptima Membership

424,210

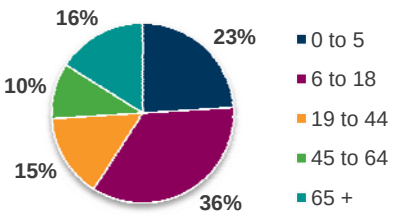
Source: CalOptima Board of Directors Book (February 2012)

Program	Members	% Total Membership
Medi-Cal	387,389	91%
Healthy Families Program	36,821	9%
OneCare (HMO SNP)*	13,218	-
Multipurpose Senior Services Program*	464	-
* Membership already accounted for in total Medi-Cal membership		

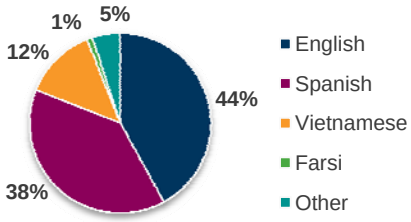
Medi-Cal Members by Aid Category



Member Age (All Programs)



Languages Spoken (All Programs)



By the Numbers

CalOptima insures **32%** of children in Orange County

CalOptima insures **14%** of all Orange County residents

FY 2011–12 Budget Information

Program	Annual Revenue	% Total Revenue
Medi-Cal	$1,178,580,473	84.52%
Healthy Families Program	$37,806,966	2.71%
OneCare	$171,169,369	12.28%
MSSP/ASO	$6,809,620	.49%

Total Annual Revenue

$1.4 billion

Current Reserves = $149.9 million (as of December 31, 2011)

CalOptima has the third lowest administrative cost ratio (4.36%) among all health plans in California.[1]

Member Fast Facts: February 2012

Comparisons by the Numbers

Medi-Cal

- CalOptima is the largest county organized health system in California[2]
- CalOptima is the fifth largest Medi-Cal managed care plan in California based on total enrollment[2]
- CalOptima serves more Medicaid beneficiaries than 18 state Medicaid programs[2,3]
- CalOptima serves nearly 75,000 dual eligible beneficiaries (Medi-Cal and Medicare)[4]
- CalOptima dual eligible enrollment is larger than 19 state managed care programs[4]

Healthy Families Program

- CalOptima has been the Community Provider Plan for the Healthy Families Program (HFP) in Orange County since the inception of the program in 1998
- CalOptima serves more beneficiaries than 22 state Children's Health Insurance Programs[5]
- CalOptima is the fifth largest HFP in California based on total enrollment[6]
- CalOptima is the largest HFP in Orange County, with approximately 45% market share[6]
- CalOptima was recognized as one of eight HFP plans with the highest HEDIS performance score out of 24 plans[7]
- CalOptima is one of three HFP plans with the highest HEDIS performance score for three consecutive years[7]

OneCare (HMO SNP)

- OneCare is the 16th largest dual eligible Special Needs Plan (SNP) in the United States[8]
- OneCare is the second largest dual eligible SNP in California[9]
- OneCare serves more beneficiaries than the Medicare Advantage SNP enrollment in 28 states[9]
- OneCare is a 4-star plan overall for 2012 in the Medicare Star Quality Rating System[10]

Notes and Sources

1. Department of Managed Health Care, full-service plans 2010 annual data. Scripps Health Plan Services is first with 4.17%. Kaiser Foundation Health Plan is second with 4.30%.
2. CMS Medicaid Managed Care Enrollment Report, Program Summary as of July 2010.
3. Includes the District of Columbia; Kaiser Family Foundation, *State Health Facts*, Monthly Medicaid Enrollment, June 2009.
4. CalOptima Board of Directors Meeting Materials, February 2012.
5. Includes the District of Columbia; Kaiser Family Foundation, *State Health Facts*, Monthly CHIP Enrollment, December 2009, and Healthy Families Program Current Enrollment Distribution by County and Health Plan, December 2009.
6. Healthy Families Program total enrollment is 37,717. Healthy Families Program Current Enrollment Distribution by County and Health Plan, October 2011.
7. Healthcare Effectiveness Data and Information Set (HEDIS) reports, 2010.
8. Kaiser Family Foundation, *Data Spotlight,* Special Needs Plans: Availability and Enrollment, September 2011.
9. Includes the District of Columbia; OneCare total enrollment is 13,052 (Kaiser Foundation Health Plan enrollment is 64,319 and HealthNet is 12,930); CMS SNP Comprehensive Report, December 2011.
10. Medicare.gov, October 2011. Plan performance summary ratings are assessed each year and may change from year to year.

Attachment 2: OC IHSS PA Provider & Consumer Training Modules

OC IHSS PUBLIC AUTHORITY
Provider Training Modules

Facilitated in English, and can also be translated to Vietnamese and Spanish by staff and with the purchase of language specific videos

1. Being a Companion Homemaker: Roles and Responsibilities (with a 30 minute video)
2. Being a Companion Homemaker: Safety and Housekeeping (with a 22 minute video)
3. Communication: How to Communication with Someone Who has Alzheimer's Disease or Related Dementia (with a 30 minute video) (English and Spanish videos available)
4. Communication: Caring for Someone with Mid to Late Stage Alzheimer's Disease (with a 43 minute video)
5. Communication: How to Communicate with Someone Who Has Aphasia (Aphasia is a language disorder that impairs one's ability to speak and comprehend what is said by others) (with a 24 minute video)
6. Communication: Developing Cultural Competence (with a 40 minute video)
7. Communication: How to Communicate with Someone Who Has Hearing Loss (with a 28 minute video)
8. Caregiver Wellness (with 32 minute video)
9. Combative Residents: Mirror Their Reality (with a 23 minute video)
10. Essential Bedrest Skills: Caring for someone confined to a bed (with a 35 minute video)
11. Fall Prevention (with a 24 minute video) (Spanish and English videos available)
12. Home Health Safety Orientation (with a 20 minute video)
13. Home Healthcare Violence: Be Smart, Be Safe (with a 22 minute video)
14. How to Help Someone Who Uses a Wheelchair Without Hurting Yourself (English and Spanish videos available)
15. Infection Control (with a 26 minute video)
16. It's Your Back: Don't Break It (with a 20 minute video) (English and Spanish videos available)
17. Nutrition (with a 43 minute video)
18. Personal Care (with a 36 minute video) (English and Spanish videos available)
19. Emergency Preparedness
20. IHSS Timesheet Management Workshop (English and Spanish)
21. IHSS Provider Enrollment Orientation (English, Spanish, Vietnamese)
22. How to Work with Difficult Clients

OC IHSS PUBLIC AUTHORITY

Consumer Training Modules

1. Emergency Preparedness
2. How to Hire and Keep an IHSS Provider
3. Fall Prevention (with a 24 minute video)
4. Community Resources
5. Transportation Resources
6. How to Interview a Provider
7. Communicating your needs effectively

Attachment 3: OneCare Model of Care

2012 Model of Care
Orange County Health Authority

MA Contract Name:	OneCare
MA Contract Number:	H5433
Type of Dual-eligible SNP:	Zero cost-sharing, Medicaid subset

Background

CalOptima was created in the mid-1990s by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a County Organized Health System authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County. CalOptima has a contract with the California Department of Health Services (DHS) to arrange and pay for covered services to Medi-Cal recipients.

In 2005, CalOptima became licensed to provide a Medicare Advantage Special Needs Plan (MA-SNP) through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This allowed CalOptima to offer Medicare and Medicaid benefits to dual-eligible individuals under one program called OneCare. CalOptima is based in the community it serves and has extensive experience in serving the complex needs of the frail/disabled, dual-eligible members in Orange County. CalOptima's mission is to provide members with access to quality healthcare services delivered in a cost-effective and compassionate manner.

Model of Care Elements

1. Description of the SNP - Specific Target Population

OneCare is a Medicare Advantage Prescription Drug plan. OneCare operates exclusively as a "Zero Cost Share, Medicaid Subset Dual Special Needs Plan." OneCare only enrolls beneficiaries who Medicaid qualifies as a zero cost sharing Medicaid subset. To identify dual-eligible members, OneCare imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of SSDI, ESRD, or ALS.) Nearly one third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California and administered at the county social services agency level. The standards for qualifying for State Medicaid include a review of income, assets, and in some cases, medical condition.

As of March 2011, OneCare had 11,481 members of which 55% were female and 45% were male. Member demographic data by language spoken and race are listed below. The threshold languages spoken by the majority of OneCare members are English, Spanish, and Vietnamese. OneCare member represent over twenty ethnic groups with the majority of members being of White, Asian/Pacific Islander, Alaskan native, American Indian, Black, and Hispanic, respectively.

Table 1: Age

Age Group	Percentage
19-44 years	12.15%
45-64 years	20.22%
65+ years	67.63%
Total	100.00%

Table 2: OneCare Languages Spoken

Language Spoken	Percentage
English	51.59%
Spanish	25.78%
Vietnamese	11.06%
Farsi	0.79%
Korean	0.28%

Table 3: OneCare Race

Race	Percentage
White	45.43%
Asian/Pacific Islander	21.80%
Alaskan Native/American Indian	22.30%
Black	4.30%
Hispanic	2.58%

OneCare members fall into the following Medicaid aid code categories with 53% assigned an Aged aid code and 40% assigned a Blind and Disabled aid code category.

Table 4: Medicaid Aid Code Categories

Aid Code Category	Percent
Aged	53.10%
Blind and Disabled	39.64%
Other Aid code	7.26%
OneCare Total	**100.00%**

The top chronic conditions that OneCare members have are listed below. These conditions represent a broad range of endocrine, cardiac, renal, vascular, and behavioral health systems.

Table 5: Chronic Conditions by HCC

Chronic Condition by HCC	Count	Percent
Diabetes without Complication	3,217	22.13%
Major Depressive, Bipolar, and Paranoid Disorders	2,275	15.65%
Renal Failure	1,521	10.46%
Chronic Obstructive Pulmonary Disease	1,516	10.43%
Congestive Heart Failure	1,227	8.44%
Vascular Disease	1,135	7.81%
Polyneuropathy	1,014	6.97%
Diabetes with Renal or Peripheral Circulatory Manifestation	1,005	6.91%
Diabetes with Neurologic or Other Specified Manifestation	830	5.71%
Specified Heart Arrhythmias	800	5.50%
Total	14,540	100.00%

2. Measurable Goals

2a. The OneCare Model of Care is member centric in design to ensure the coordinated provision of seamless access to individualized quality health care. The Model of Care meets the unique needs of our special member populations. Strategic activities and goals are incorporated throughout the organization by the linkage of quality initiatives, the alignment of departmental objectives and the assignment of organizational owners dedicated to successful implementation. Annually, a formal performance evaluation is conducted and strategies for continuous improvement for the coming year are established. OneCare has adopted measureable goals that are appropriate for the membership served, consistent with regulatory requirements, and provide a means of comparing activity and performance to standards. The goals of the Model of Care are the following:

- Improving Access to Essential Services: Access to essential services is composed of three components; strong network, ease of navigation between the member and services, and knowledgeable, engaged members.

  - Strong Network

    OneCare has a strong patient-choice primary care base. OneCare has a unique delivery model in that 98% of the providers are community providers who participate in large IPAs or medical groups. This allows OneCare to provide access to clinical services that are often not available in the traditional Medicaid environment. This also allows members the ability to maintain past relationships with providers. OneCare is able to leverage the provider relationships to increase access to specialists and services. For example, access to pain management services in an area of the county that has only four pain management specialists was improved through OneCare medical group contracting. These pain specialists did not accept fee-for-service Medicaid. However, our contracted PMG OneCare was able to negotiate for these specialists to provide services to OneCare members. OneCare has deep

provider penetration in the county. Its provider base has 1,123 primary care physicians and 2, 139 specialists that are geographically distributed across the entire county. This represents 60 % of the Orange County primary care providers and 35 % of the Orange County specialist providers. This allows access to services geographically close to where members live and work. The OneCare provider contracting strategy of contracting with high quality providers who are member preferred has been especially successful in addressing our members' cultural preferences.

Behavior health access has been increased by OneCare contracting with an experienced behavioral health IPA with multiple offices throughout the county. They provide telephonic and in-home assessments and therapy. They work closely with the contracted primary care physicians. They also have a rich outreach service that has various levels of engagement and is based on the members' readiness for engagement. For example, recently a member refused both telephone and in-home therapy but was willing to talk with a behavior health specialist one day a week at the local McDonalds.

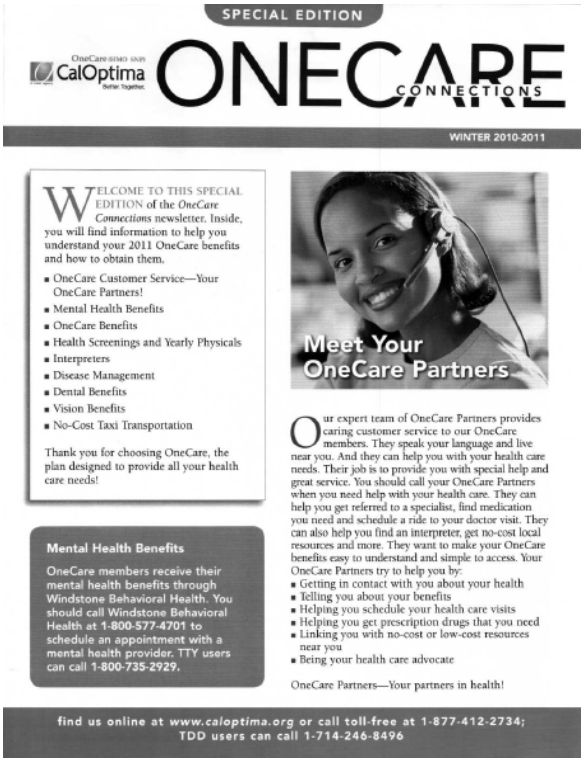
OneCare improves access to social services. This is provided through traditional case management which includes social workers and behavioral health specialists. Also, strong links with community organizations like Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, Orange County Goodwill and Orange County Community Centers. Especially exciting are the direct links to the **Multipurpose Senior Service Program (MSSP)** and the Orange County Aging and Disability Resource Center (ADRC). These resources provide direct links that serve as a means of connecting members with needed social services. OneCare also participates in the Orange County Committee for Choice. This committee is a quarterly forum of community organizations aimed at providing services for the aged and disabled. Recently, OneCare sponsored a well attended meeting of over 150 community service coordinators participants and discussed referrals for community programs with presentations by the Orange County Department of Behavioral Health, Orange County Department of Education and the Orange County Regional Center. In summary, the size and stability of our provider network has significantly increased coverage and access for the dual membership.

- Ease of Navigation

  OneCare has dedicated customer services staff for its members. The unit is made up of 11 representatives. The OneCare Partners have at least 2 years of experience working with seniors and disabled members. They are often bi-lingual. Their role is to provide assistance and education, to assist members in appointment scheduling and physician selection. They coordinate referrals to community services and agencies. The members can contact the OneCare Partners through a toll-free 800 number and physicians can do direct referrals. For example, a member called confused about the use of the OneCare taxi benefit. The OneCare Partner explained the benefit, the process, and scheduled the first appointment for the member. Another example is a senior couple who contacted a OneCare Partner to obtain aid in transportation to physician visits when the husband, who was the driver, could no longer drive. The OneCare Partner assisted in scheduling the taxi rides and coordination with the

physician's office with scheduling the visits. She also arranged for pharmacy visits to obtain the prescribed medications. To facilitate access to behavioral health, OneCare has several means of providing access to those services. Members and caregivers can call a toll-free 800 number and talk to a behavioral health specialist. They can also call the OneCare Partners who can assist them in making the connection. Physicians can initiate an automatic direct referral for members to see a behavioral health specialist or to obtain a behavioral health consultation. In addition, behavioral health services can be provided in many settings including home, clinic, or an individual physician's office. A recent example is a member who is home bound was determined by his physician to need behavioral health services. The physician did a direct referral to behavioral health. Behavioral health specialist completed a telephonic assessment and has been providing in-home therapy for the last four months.

- Knowledgeable, Engaged Member
  OneCare conducts new member orientation which includes education on use of essential services and benefits. Members are sent periodic member newsletters that highlight services available within the program and community. There are multiple forums where OneCare members are educated not only on the clinical services but also on the essential services available in OneCare and through the community at large. These forums include person to person Medication Therapy Management visits and case management and disease management interactions. Group settings include educational forums, health fairs, and community engagements. A recent instance where this occurred was a presentation done at the Area Board XI Committee for Persons with Developmental Disabilities. Example: Sample of the OneCare Connections newsletter.



SPECIAL EDITION

CalOptima

ONECARE CONNECTIONS

WINTER 2010-2011

WELCOME TO THIS SPECIAL EDITION of the *OneCare Connections* newsletter. Inside, you will find information to help you understand your 2011 OneCare benefits and how to obtain them.

- OneCare Customer Service—Your OneCare Partners!
- Mental Health Benefits
- OneCare Benefits
- Health Screenings and Yearly Physicals
- Interpreters
- Disease Management
- Dental Benefits
- Vision Benefits
- No-Cost Taxi Transportation

Thank you for choosing OneCare, the plan designed to provide all your health care needs!

Mental Health Benefits

OneCare members receive their mental health benefits through Windstone Behavioral Health. You should call Windstone Behavioral Health at 1-800-577-4701 to schedule an appointment with a mental health provider. TTY users can call 1-800-735-2929.

Our expert team of OneCare Partners provides caring customer service to our OneCare members. They speak your language and live near you. And they can help you with your health care needs. Their job is to provide you with special help and great service. You should call your OneCare Partners when you need help with your health care. They can help you get referred to a specialist, find medication you need and schedule a ride to your doctor visit. They can also help you find an interpreter, get no-cost local resources and more. They want to make your OneCare benefits easy to understand and simple to access. Your OneCare Partners try to help you by:

- Getting in contact with you about your health
- Telling you about your benefits
- Helping you schedule your health care visits
- Helping you get prescription drugs that you need
- Linking you with no-cost or low-cost resources near you
- Being your health care advocate

OneCare Partners—Your partners in health!

find us online at *www.caloptima.org* or call toll-free at 1-877-412-2734; TDD users can call 1-714-246-8496

- Improving Access to Affordable Care: Since OneCare members have no co-pay or out of pocket cost for the core essential benefits, OneCare has focused on those areas with the highest potential cost to members in its benefit design.

  Dental: OneCare provides no-cost dental services through a contracted dental network. Services include comprehensive oral exams and periodontal evaluation, prophylaxis cleaning up to twice a year, periodontal scaling and root planing, dentures, extractions and full-mouth debridement. Recently, OneCare enrolled a 78 year old member who had not had a routine exam for over 10 years. Upon examination, the member was shown to require several extractions, cleaning and dentures.
  Transportation: OneCare provides sixty (60) one-way trips via taxi for any needs associated with care. This can include pharmacy and gym benefit access besides the provider and health facilities trips. Members are provided an 800 toll-free number and they can arrange transportation as needed by themselves or with the assistance of a OneCare Customer Service partner. An aged couple, both OneCare members utilized the transportation benefit recently. The husband (the driver for the couple) had an illness where he did not feel comfortable driving. His wife used the OneCare benefit to go to the pharmacy to get prescriptions.
  Routine Podiatry: California eliminated the Medicaid benefit for routine podiatry. OneCare included this benefit in direct response to requests from the disabled community. At a recent Provider Advisory Committee meeting, OneCare received commendation for the inclusion of this benefit to the program from the community.

  Example: Detailed information regarding the benefit set was included in the Winter 2010-2011 and Spring 2011 Newsletter/ articles attached below.

OneCare 2011 Benefits

Benefits	Covered	Your Cost
Premium and deductible	Yes	0
Transportation (60 one-way taxi trips)	Yes	0
Doctor and hospital services	Yes	0
Inpatient mental health up to 190 days	Yes	0
Skilled nursing facility	Yes	0
Home health care	Yes	0
Hospice	Yes	0
Podiatry services	Yes	0
Outpatient mental health	Yes	0
Outpatient substance abuse	Yes	0
Emergency care	Yes	0
Out-of-area care (USA only)	Yes	0
Durable medical equipment and prosthetic devices	Yes	0
Medical supplies (includes incontinence products)	Yes	0
Vision care ($150 frames and lenses / $150 contact lenses)	Yes	0
Diabetic supplies (monitors, test strips, lancets)	Yes	0
Dental (including cleanings, crowns [some restrictions apply], dentures, root canals)	Yes	0
Fitness benefits (including gym membership)	Yes	0
Out-of-country emergency care	Yes, up to $5,000	0 up to $5,000

- Improving Coordination of Care Through an Identified Point of Contact:
  All members are asked to choose a primary care provider upon enrollment. Assistance can be provided by the OneCare Customer Service department. The member handbook provides detailed physician information to also aid in physician choice. If a member does not choose, they are auto-assigned to a physician near their home. Members are educated on their right to switch physician on a monthly basis. Also, members receive education around optimization of the relationship with the primary care provider. The primary care provider is the point of contact. Education to both providers and members reinforces the importance of the relationship in the coordination of care. The primary care provider has clear delineation of the point of contact role both in the contract and the OneCare Provider Manual. OneCare recognized that primary care providers need the support of the primary care ICT and ultimately to function in a medical home environment. Example: OneCare initiative to determine medical home readiness. OneCare currently has a pilot that promotes medical home in a small physician practice setting. OneCare has adopted the screening tool developed by the American Academy of Family Physicians in order to assess the effectiveness of the physician in the role of the gatekeeper. The assessment allows OneCare to not only identify strengths but opportunities to educate and assist the providers. The focus is to assist providers regarding use of evidence based guidelines, effective practice enhancement through use of information and health technology, and the use of ICT and ICP processes to better coordinate the care of our members.

Patient-Centered Medical Home Checklist

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Build your medical home with a strong foundation in family medicine. Apply this checklist to your practice.

QUALITY MEASURES

Are you using these clinical information systems:

- ❒ Registries
- ❒ Referral tracking
- ❒ Lab result tracking
- ❒ Medication interaction alerts
- ❒ Allergy alerts

Your practice is a culture of improvement if you and your staff:

- ❒ Establish core performance measures
- ❒ Collect data for better clinical management
- ❒ Analyze the data for quality improvement
- ❒ Map processes to identify efficiencies
- ❒ Discuss best practices

Does your practice use these checklists and reminders?

- ❒ Evidence-based reminders
- ❒ Preventive medicine reminders
- ❒ Decision support

Do your care plans reflect:

- ❒ An updated problem list?
- ❒ A current medication list?
- ❒ Patient-oriented goals and expectations?

PATIENT EXPERIENCE

Which of the following are you using to improve your patients' access to care?

- ❒ Same day appointments
- ❒ Email
- ❒ Web portal for Rx, appointments, or information
- ❒ Referral to online resources
- ❒ Non-visit based care and support

Does your practice support patient self-management through:

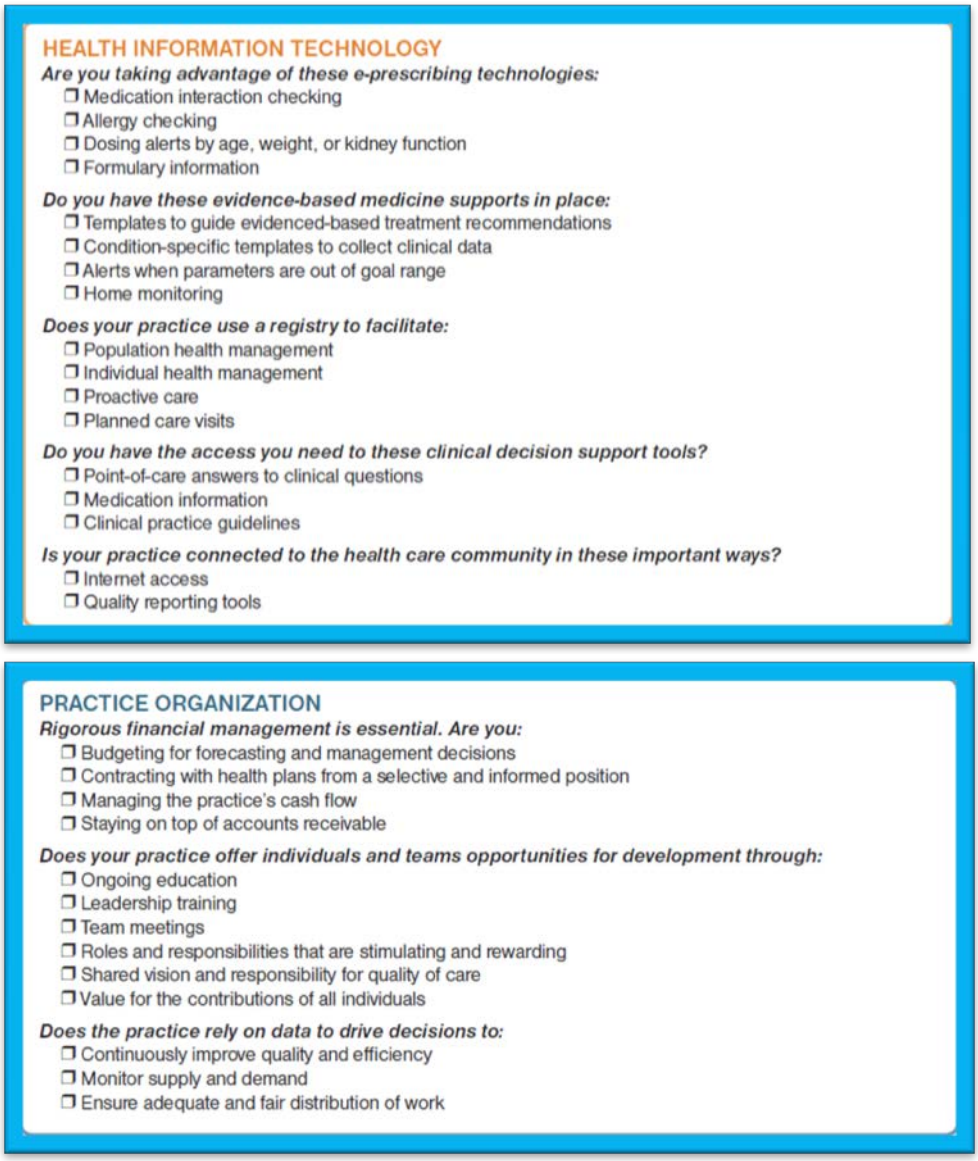
- ❒ Motivational interviewing
- ❒ Shared goal-setting
- ❒ Home monitoring (when appropriate)
- ❒ Group visits and support groups
- ❒ Family and caregiver engagement

Clear communication requires:

- ❒ Patient language preference
- ❒ Cultural sensitivity
- ❒ Active listening
- ❒ Plain language, no jargon
- ❒ Patient satisfaction surveys

Do you and your patients share in the decision-making process by:

- ❒ Discussing treatment options in an unbiased way
- ❒ Considering the patient's priorities
- ❒ Creating and revisiting follow-up plans



HEALTH INFORMATION TECHNOLOGY

Are you taking advantage of these e-prescribing technologies:

- ❒ Medication interaction checking
- ❒ Allergy checking
- ❒ Dosing alerts by age, weight, or kidney function
- ❒ Formulary information

Do you have these evidence-based medicine supports in place:

- ❒ Templates to guide evidenced-based treatment recommendations
- ❒ Condition-specific templates to collect clinical data
- ❒ Alerts when parameters are out of goal range
- ❒ Home monitoring

Does your practice use a registry to facilitate:

- ❒ Population health management
- ❒ Individual health management
- ❒ Proactive care
- ❒ Planned care visits

Do you have the access you need to these clinical decision support tools?

- ❒ Point-of-care answers to clinical questions
- ❒ Medication information
- ❒ Clinical practice guidelines

Is your practice connected to the health care community in these important ways?

- ❒ Internet access
- ❒ Quality reporting tools

PRACTICE ORGANIZATION

Rigorous financial management is essential. Are you:

- ❒ Budgeting for forecasting and management decisions
- ❒ Contracting with health plans from a selective and informed position
- ❒ Managing the practice's cash flow
- ❒ Staying on top of accounts receivable

Does your practice offer individuals and teams opportunities for development through:

- ❒ Ongoing education
- ❒ Leadership training
- ❒ Team meetings
- ❒ Roles and responsibilities that are stimulating and rewarding
- ❒ Shared vision and responsibility for quality of care
- ❒ Value for the contributions of all individuals

Does the practice rely on data to drive decisions to:

- ❒ Continuously improve quality and efficiency
- ❒ Monitor supply and demand
- ❒ Ensure adequate and fair distribution of work

- Improving Seamless Transitions Of Care Across Healthcare Settings, Providers, and Health Services:

  The OneCare transition of care process is designed to ensure that unplanned and planned transitions are identified and managed by a transition Interdisciplinary Care Team (ICT) whose members are trained to manage the specific member's needs and ensure smooth movement across the continuum. OneCare has implemented specific evidence based interventions to ensure safe coordinated care so that the member remains at the least restrictive setting that meets their healthcare needs. OneCare has a transition process where members are screened to identify members at high risk for complex transition. This screen is done at prior authorization and for unplanned admissions at the time of admission to a facility either acute of skilled nursing. The screening tool incorporates questions about clinical condition, behavior health status and social condition. Identified high risk members are referred to the transition ICT. Upon receipt of the referral, case

management does a comprehensive assessment and the transition ICT develops or updated the ICP. It also ensures that the ICP travels with the member during the transition. OneCare analyzes the transitions to evaluate the effectiveness of the program and identify areas for improvement. For example, OneCare created a transition care coordinator position for our two highest volume hospitals. The coordinator is stationed at the hospital and able to provide concurrent linkage to the transition ICT. OneCare feels that this proactive approach will improve seamless member friendly coordination of care across health care settings.

Example:

Referral source identified member as high-risk member due to frequent readmissions to an inpatient psychiatric facility.

Complex IDT assigned a designated case manager to facilitate the process.

Interventions: The case manager met with the member at the community based mental health program. A full comprehensive assessment was completed. The assessment revealed two mental health provider teams treating the member. The providers on the team were unaware of the duplication of services

Review of medical records and member interview revealed the following barriers to care:

- Lack of coordination of care related to multiple providers and involvement of a community based mental health program
- Frequent re-admissions related to co-morbid psychiatric diagnosis and non-adherence to medication regimen

Case manager discussed scheduling an IDT with both mental health providers, PCP and the case management team. The member was encouraged to participate in the IDT meeting. The member declined to participate in the IDT meeting. The member agreed to share her goals with the case manager for input at the IDT. The case manager and the member developed an initial ICP which included the member's goals for current care and barriers to remaining in the outpatient setting.

Summary: An IDT meeting was held. The attendees at the team meeting consisted of the OneCare Medical Director, case managers, social workers, a behavioral health specialist, and a representative from the community based mental health program. The two (2) mental health providers collaborated and developed a communication process that will prevent duplication and increase the quality of the member's care.

The member's goals and barriers were presented by the case manager who conducted the face to face interview. An ICP that included the member's goals and barriers was developed at the IDT meeting. The ICP was shared with member, PCP, behavioral health specialists, and case management team. The outcome resulted in decreased readmissions and increased coordination of care for the member.

- Improving Access to Preventive Health Services:
  OneCare has outreach programs aimed at ensuring members receive preventive care. The OneCare program is on three levels: The health plan level where direct to member education and outreach takes place. These activities are coordinated under the Quality Improvement Committees. At the delegated medical group level, additional outreach occurs through focused practice strategies. Finally, at the direct to provider level, OneCare assists providers with registries, provider office education and best practice strategies. In addition OneCare incentivizes both member and physician to get the required services. Examples include: 1) History and physical incentive program where physicians receive additional dollars for history and physical completion; 2) Physician

office incentive program in which office staff receives rewards for outreaching and getting members into the office for preventive screenings such as breast cancer screening and cervical cancer screening; 3) Small member incentives for the return of the fecal occult blood test (FOBT). OneCare encourages physicians to participate in office strategies such as open appointments, extended hours and walk-in friendly schedules.

The following summary of the Pay for Performance Incentive Program is provided to demonstrate current provider incentive programs:

Health Network/Medical Group
Performance Measurement System
FY2010

PROGRAM SPECIFIC MEASUREMENT SETS

Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

The proposed performance measurement sets are listed below:

Medicare Performance Measures:

OneCare Measures:

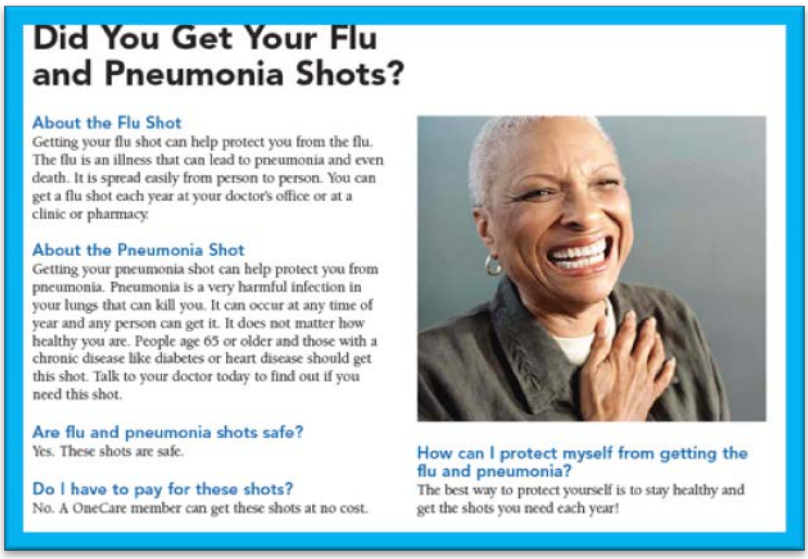
Measure by Domain	Percentage of Allocation CY2010	Data Source	Anticipated Payment Date	Benchmark
Quality of Care	100%			
1. Breast Cancer Screening	20%	HEDIS 2011	October 2011	NCQA Medicare Percentiles 2009
2. Comprehensive Diabetes Care (30%) • HbA1c Screening for Patients with Diabetes • LDL Screening for Patients with Diabetes • Nephropathy Monitoring for Patients with Diabetes	 10% 10% 10%	HEDIS 2011	October 2011	NCQA Medicare Percentiles 2009
3. Colorectal Screening	20%	HEDIS 2011	October 2011	NCQA Medicare Percentiles 2009

4. Antidepressant Medication Management (30%) • Optimal Practitioner Contacts for Medication Management • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	10% 10% 10%	HEDIS 2011	October 2011	NCQA Medicare Percentiles 2009

Health Networks will be awarded for performance based on comparison to NCQA Medicare percentiles per the methodology depicted below:

Benchmark	Percentile	Percent of Allocation Recouped	Allocation for Demonstrating Significant Improvement	Potential Net Allocation Earned
NCQA Medicare	At or above 75th	100%		100%
NCQA Medicare	At or above the 50th and below the 75th	50%	If Networks demonstrate a 10% reduction in the performance gap, can earn 25%	75%
NCQA Medicare	Below 50th	0%	If Networks demonstrate a 10% reduction in the performance gap, can earn 25%*	25%*
* If a Health Network falls below the 50th percentile in an existing HEDIS measure for 2 measurement cycles, then that Health Network would not be eligible to earn 25% of the withhold amount; even if significant improvement is achieved in the second measurement year.				
* If a Health Network falls below the 50th percentile in new HEDIS measure for 3 measurement cycles, then that Health Network would not be eligible to earn 25% of the withhold amount; even if significant improvement is achieved in the third measurement year.				

Additionally, OneCare provides access to preventive services in alternative settings that are convenient to the member. Flu and pneumococcal vaccines can be attained at pharmacies, health fairs, and other locations in the community.



OneCare has a robust home bound program which provides the provision of preventive services in the member's home. For members residing in Long Term Care Facilities OneCare provides preventive services at the location.

- Assuring Appropriate Utilization of Services:
  Utilization of service is making certain that members are receiving the right service at the right level of care. OneCare does this by monitoring key indicators that support the stated goals. OneCare does this through monitoring inpatient utilization data that includes bed day, length of stay, level of care and readmission. This is done through electronic feeds and the concurrent review process. There are weekly case reviews to assess conformity with criteria and identification of outliers. Examples: Utilization Management Committee monthly review of UM data. Ambulatory utilization review that includes ER utilization reviews as well as HEDIS utilization. The ER utilization is focused on identification of utilization that is preventable by improved ambulatory management. OneCare has a team called FOCUS who has initiatives that work with physicians and members to reduce inappropriate emergency department use. Examples: QIP team that regularly review HEDIS and makes recommendations. Quality review: OneCare monitors the appropriate quality indicators such as referral to case management, content of the ICP, use of evidence based guidelines and ICT functions.

- Improving Beneficiary Health Outcomes:
  Ultimately, the goal of the OneCare program is to improve health outcomes for all members. OneCare analyzes data from multiple sources including claims, pharmacy, utilization, member satisfaction and grievance and appeals to identify areas of opportunity for improvement. The work is done under the direction of the Quality Improvement Committee and documented in the OneCare Quality Work Plan. The 2010

plan activities were prioritized based on areas with the greatest opportunity for improvement, condition prevalence and past performance compared to the goal. The areas of opportunity are diabetes, heart disease/failure and depression.
The implementation of the work plan interventions are conducted by the workgroup. Monitoring and measurements are reported to the Quality Improvement Committee (QIC).

See sample below of the work plan interventions.

QI Activity	Strategic Priorities	Work Plan Goal/s	Work Plan Planned Activities	Responsible Person Title/Dept.	Methodology/Target Date for Completion
	identify opportunities for improvement & to act as outcome measures for QI programs		Identify opportunities for improvement based on SNP Structure and Process		
HEDIS Performance Improvement	Achieve goals and improve the process and performance of HEDIS 2011 measures	Improve HEDIS performance for each line of business	Implement intervention to improve Care of Older Adults and achievement of a 5% reduction in the performance gap for Comprehensive Diabetes Care	Linda Lee, MPH Director Medical Data Management	Report to QIC Quarterly
Disease Management	Disease Management Program is a targeted program for the management, coordination & interventions for a highly vulnerable patient population.	Implement a multi-disciplinary, continuum-based approached to healthcare delivery that proactively identifies population with or at risk for established medical conditions	Diabetes Congestive Heart Failure Depression	Mary Curry, RN Disease Management Manager Marie Jeannis, RN Director, Case Management	Report to QIC quarterly
QI Workgroups	Successfully implement ongoing QI programs that help improve the quality of	*"The Quality Improvement Workgroup is a result oriented, multi-disciplinary collaboration*	Organizational-wide representation from departments to improve, collaborate & recommend interventions on specific QI projects.	Linda Lee, MPH Director Medical Data Management	Report to QIC Quarterly

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Goals for HEDIS 2011

HEDIS 2011 Measure Reporting Set and Goals – OneCare

Measure	HEDIS 2010 Rate	HEDIS 2011 Goal
Adult BMI Assessment (ABA)	42.13%	46.30%
Breast Cancer Screening (BCS)	53.86%	67.80%
Colorectal Cancer Screening (COL)	51.51%	54.20%
Glaucoma Screening in Older Adults (GSO)	56.03%	62.20%
Care for Older Adults (COA)		
1. Advance Care Planning	9.56%	12.10%
2. Medication Review	70.86%	72.40%
3. Functional Status Assessment	7.46%	24.80%
4. Pain Screening	10.72%	72.00%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	13.49%	27.70%
Pharmacotherapy Management of COPD Exacerbation (PCE)		
1. Systemic Corticosteroid	65.08%	69.50%
2. Bronchodilator	80.95%	82.10%
Cholesterol Management for Patients with Cardiovascular Conditions (CMC)		
1. LDL-C Screening	86.60%	89.40%
2. LDL-C Control (<100 mg/dL)	57.89%	59.20%
Controlling High Blood Pressure (CBP)	61.61%	66.40%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	73.08%	81.00%
Comprehensive Diabetes Care (CDC)		
1. HbA1c Testing	88.97%	89.50%
2. HbA1c Poor Control (>9.0%) *(Rate NOT inverted)*	23.22%	16.80%
3. HbA1c Control (<8.0%)	65.52%	66.90%
4. Eye Exams	70.80%	72.30%
5. LDL-C Screening	88.28%	90.70%
6. LDL-C Control (<100 mg/dL)	54.25%	58.00%
7. Nephropathy Monitoring	91.95%	93.60%
8. Blood Pressure Control (<130/80 mm Hg)	36.78%	43.10%
9. Blood Pressure Control (<140/90 mm Hg)	62.30%	68.00%
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	51.69%	73.10%
Osteoporosis Management in Women Who Had a Fracture (OMW)	17.44%	19.10%
Antidepressant Medication Management (AMM)		
1. Effective Acute Phase Treatment	54.17%	62.50%
2. Effective Continuation Phase Treatment	36.11%	37.20%
Follow-Up After Hospitalization for Mental Illness (FUH)		
1. 30-Day Follow-Up	42.86%	58.30%
2. 7-Day Follow-Up	22.69%	37.20%
Annual Monitoring for Patients on Persistent Medications (MPM)		
1. ACE Inhibitors or ARBs	86.63%	89.60%
2. Digoxin	89.92%	92.60%
3. Diuretics	88.09%	90.20%
4. Anticonvulsants	75.93%	68.20%
5. Total	86.44%	89.40%
Medication Reconciliation Post-Discharge (MRP)	72.79%	72.79%
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) *(Rate NOT inverted)*		
1. Falls + Tricyclic Antidepressants or Antipsychotics	17.99%	15.80%
2. Dementia + Tricyclic Antidepressants or Anticholinergic Agents	29.53%	27.10%
3. Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	19.23%	10.50%
4. Total	24.21%	21.60%

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

2b. Goals as measureable outcome for improvement over the next year:
OneCare uses previous performance to identify and select the measurement outcome targets for the coming year. We have ongoing Work Groups that monitor the performance of each measurement and identify opportunities for modifying the plan to ensure the goals are met. Benchmarks are based on the previous year's performance. The timeframe for measurement is one year. Performance is reported up to governance through our committee structure.

- Improving Access to Essential Services by Three Indicators:
  - A 63 percentage point improvement in the urgent specialty visit within 2 days of referral approval for Behavioral Health. Review the monthly behavioral health services utilization report at the UM Committee.
  - A Decrease to less than 5% in the customer service cases related to access. In 2010 the rate was 6%. Customer service member issue tracking log to be reported to the QI Committee.
  - A 9 percentage point improvement in adult preventive/ambulatory health service access. In 2010, the rate was 85.41 %. The goal in 2011 is 94.3%. Tracked through the QI Work Group.

- Improving Access to Affordable Care:
  - 10% increase in utilization of dental benefit. In 2010, 35% (3,884) of OneCare members used the dental benefit. Utilization report obtained from dental provider on quarterly basis.
  - Decrease to less than 1% member complaints related to dental benefit services. In 2010, the complaint rate was 2%. Customer service activity tracked and reported on a quarterly basis to the QI Committee.
  - 10% increase in utilization of OneCare taxi benefit. In 2010, 22% (2,361) of OneCare members utilized the taxi benefit. . Taxi utilization by member and type of trip reported to QI Committee on a quarterly basis.
  - Decrease to less than 1% member complaints related to taxi benefit services. In 2010, the rate was 3%. Customer service activity tracked and reported on a quarterly basis to the QI Committee.

- Improving Coordination of Care:
  - 98% of members switching primary care providers are reassigned within 48 hours. Member reassignment reported to QI Committee on a quarterly basis.
  - 90% primary care provider/member retention rate. In 2010, the rate was 85%. Provider/member retention rate reported on a quarterly basis to QI Committee.
  - 10% improvement in the CAHPS 4.0 composite How Well Doctors Communicate. Conduct a mid-year focused composite survey. Report results to the QI Work Team. Results to be reported upon completion of CAHPS survey.

- Improving Seamless Transitions of Care:
  - 10% increased rate of referrals to complex transition team. Members monitored by ICT tracked and reported on a monthly basis.

- 10% increase in screening done by concurrent review nurse. Referrals to ICT by concurrent review staff reported on a monthly basis.
- 90% rate of screening completed within 48 hours of admission. In conjunction with measure above activity, is monitored on a monthly basis.
- 10% decrease in readmission rate. In 2010, the readmission rate was 11%. Readmission rate monitored by Utilization Committee on a quarterly basis.

- Improving Access to Preventative Health Services
  - 14 percentage point improvement in breast cancer screening. In 2010, the rate was 53.86%. The goal for 2011 is 67.8%. Tracking on a monthly basis and coordinated through QI Work Group.
  - 3 percentage point improvement in colorectal screening. In 2010, the rate was 50.51%. The goal for 2011 is 54.2%. Tracking on a monthly basis and coordinated through QI Work Group.
  - 10% improvement in osteoporosis testing in older women as measured in HOS. Cohort 12 baseline is 54%. Tracking on a monthly basis and coordinated through QI Work Group.

- Assuring Appropriate Utilization of Services
  - 10% decrease in inpatient bed days/1000. In 2010, the inpatient bed days/1000 was 1,200 bed days/1000. Aggregate bed days monitored monthly and reported to the Utilization Committee on a quarterly basis.
  - 10% decrease in readmission rate. In 2010, the readmission rate was 11%. Aggregate readmission rate monitored monthly and reported to the Utilization Committee on a quarterly basis.
  - 10% decrease in emergency room utilization. In 2010, the emergency room utilization rate was 650 visits/1000 members per year. Aggregate ER utilization monitored monthly and reported to the Utilization Committee on a quarterly basis..

- Improving Beneficiary Health Outcome:
  The quantitative measures of improvement, utilized for OneCare, include the following:
  - Diabetes
    - 7 percentage point improvement in blood pressure control. The 2010 rate was 36.78%. The 2011 goal is 43.1%. Tracking on a monthly basis and coordinated through QI Work Group.
  - Depression
    - 8 percentage point improvement in effective acute phase treatment for depression. The 2010 rate was 54.17%. The 2011 goal is 62.5%. Tracking on a monthly basis and coordinated through QI Work Group.
    - 16 percentage point improvement in follow up within 30 days after hospitalization. The 2010 rate was 42.86%. The 2011 goal is 58.3%. Tracking on a monthly basis and coordinated through QI Work Group.

c. Discuss actions MAO will take if goals are not met in the expected time frame

2c. With failure to meet goal, a thorough review is done and a corrective action plan (CAP) is developed. The CAP is developed by the appropriate quality workgroup. The designated workgroup for OneCare is the Care for Older Adults workgroup. The workgroup is comprised of

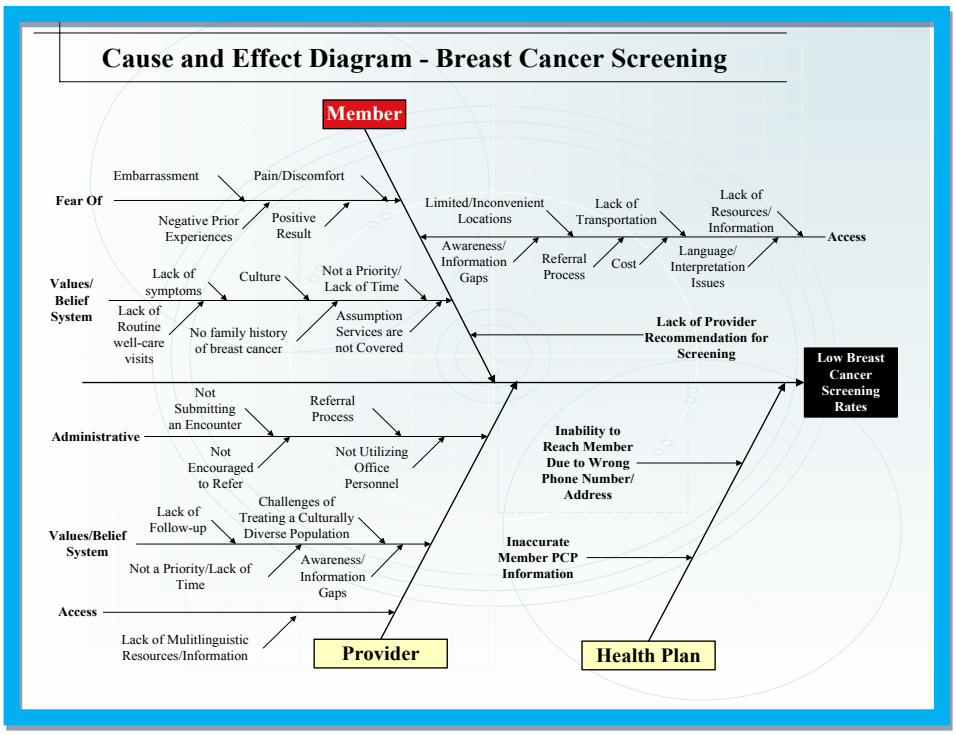
quality staff, delegated entity medical directors, health education staff, medical data management staff and case management staff. They follow the corrective action process which is as follows: Corrective Action Plan(s) to Improve Care/Service: When an evaluation identifies an opportunity for improvement, the delegated and/or functional area will determine the appropriate action(s) to be taken to correct the problem. These may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow up action has resolved the original problem.)
- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e. when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: The monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.

The following case study documents the actions taken by the Women's Health QI Team as the result of not meeting the stated goal for HEDIS® 2010 rate for Breast Cancer Screening:

OneCare's HEDIS® 2010 rate for Breast Cancer Screening was 53.86%. The performance target was selected as 68.0% based on Medicare HMO National Percentiles for HEDIS® 2008. 68.0% represents the 50th percentile and the health plan viewed this as an attainable goal within the one-year re-measurement period. The 75th percentile of 75.1% was considered but did not appear to be attainable. Therefore, the 50th percentile was chosen for the benchmark.

A detailed analysis was undertaken by the Women's Health QI Team to identify causes for failure to meet goal.



A corrective action plan was developed to address the necessary barriers that were identified.

Lack of provider recommendation was cited by members as one of the main reasons screening was not obtained. The Healthy Women Campaign was initiated in 2007 to target those providers with the majority of women needing screening and encourage them to focus on incorporating more screening recommendation and education into their practice. In September 2009, follow-up visits were conducted by the Provider Office Education Manager to the fifty Healthy Women Campaign offices. Graphs were presented demonstrating improvement or lack of improvement in their screening rates since implementing the recommended tools/processes to increase screenings during the prior year. Additional assistance was provided if needed to the offices. Since office staff was very involved in this project, when outcomes were provided they felt ownership of the rates and were either proud of the achievement or very motivated to come up with ways to further improvement. Overall, this intervention was positively received by the offices and provision of the Healthy Women Campaign tools was standardized as an ongoing intervention for OneCare.

The team deemed it important to convey to the providers that their opinions are valued and that OneCare is willing to support them and incorporate their recommendations when feasible. Screening reminders conducted by OneCare was cited by physicians as a beneficial intervention as it motivated patients to come into the office and discuss the reminder with the doctor. In response to this feedback, reminder calls were made to 1,152 OneCare members needing breast cancer screening. The intent of this outreach was to address the barriers members had stated of forgetting screening, it not being a priority and lack of transportation. During the calls, members were reminded of the OneCare transportation benefit and transferred to a OneCare Partner if they needed help arranging transportation or making an appointment.

One major barrier encountered with this intervention was the inability to convey the message to all members due to the following: wrong phone number, member moved, no answer, busy signal, or phone disconnected. Overall, of the 1,152 members called, 40% were reached and reminded of the importance of breast cancer screening. The Women's Health QI Team evaluated this intervention and determined that more information may be conveyed to the member via mail as opposed to a phone call. Therefore, in December 2009, an article on health screenings was placed in the member newsletter and mailed to all OneCare members. In March 2010, a targeted reminder letter was mailed to those needing breast cancer screening along with educational material on mammograms and information on the transportation benefit. The letter was written to address the same barriers as intended with the phone calls along with: the assumption services are not covered, not having a family history of breast cancer and lacking symptoms. The following

month, an article on breast cancer screening was featured in the OneCare member newsletter and it was decided to standardize this as a yearly intervention.

To further increase the number of women obtaining screening, OneCare conducted outreach to members, providers and office staff in May 2010. Letters were sent to all OneCare members emphasizing the importance of mammograms. Providers and office staff were sent a list of their members identified as needing screening. The aim of this project is to support provider and office staff efforts in outreaching to the members and ensuring they obtain mammograms as appropriate.

The preliminary 2011 HEDIS results are demonstrating improvement. The 2010 rate was 53.86% increased in 2011 to 61.88%.

Intervention Description	Implement Date	Duration OR Indicate if Ongoing	Target Group for Intervention	Staff/Partners in Implementation	Barriers Addressed by the Intervention	Percent/number of plan members who received the intervention
Reminder mailing to 1,217 OneCare members needing BCS	3/10	One-time	OneCare Members	Women's Health QI Work Team	Awareness/ Information Gaps, Lack of Transportation, Assumption Services are not Covered, No Family History of Breast Cancer, Lack of Symptoms, Not a Priority	1,217 members
"Breast Cancer Screening" article placed in Spring OneCare member newsletter	4/10	Yearly	OneCare Members	Women's Health QI Work Team, OneCare Staff	Awareness/ Information Gaps, Lack of Transportation	100% of OneCare members
BCS Provider and Office Staff Project for ensuring members obtain	5/10	5/10-7/10	OneCare Providers and Office Staff	Women's Health QI Work Team, Provider Office	Awareness/ Information Gaps; Not Fully Utilizing Office	N/A

Intervention Description	Implement Date	Duration OR Indicate if Ongoing	Target Group for Intervention	Staff/Partners in Implementation	Barriers Addressed by the Intervention	Percent/number of plan members who received the intervention
screening; lists of members needing screening sent to 596 offices.				Education Manager, Provider Relations Staff	Personnel, Inaccurate Member PCP Information, Not a Priority, Lack of Provider Recommendation	
BCS Member Outreach Project; mailing sent to 10,512 OneCare members	5/10	5/10-12/10	OneCare Members	Women's Health QI Work Team	Awareness/ Information Gaps, Not a Priority	10,512 members
"Health Screenings" article placed in summer OneCare member newsletter; focus on the importance of BCS	7/10	One-time	OneCare Members	Women's Health QI Work Team, OneCare Staff	Awareness/ Information Gaps, Not a Priority	100% of OneCare members

The follow are examples of the action plans for the Appropriate Medication Management Team and the Adult Preventive Care Team:

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QI Project Update
Updated On: 04.14.11

Appropriate Medication Management Team
Team Lead: Carol Matthews/Kris Gericke

Date Implemented	Ongoing	Target Population	Intervention	Status Update	Other
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)					
Planned June 2011		OC	Provide listing to physicians of members diagnosed with RA not receiving a DMARD	Conducting barrier analysis.	
Osteoporosis Management of Women who had a Fracture (OMW)					
Q1 2011		OC	Run CORE report of members that have had a hip fx; if not on medication fax PCP a letter with recommendation to begin treatment with medication.	Reviewing hospital data to identify members that have had a hip fracture to fax letter to PCP regarding medications or tests.	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)					
Planned Sept. 2011		MC and HFP	AWARE Campaign	Ongoing meetings; AWARE to send timeline; focus to remain the same as last year.	
Annual Monitoring for Patients on Persistent Medications (MPM)					
Planned Sept. 2011		OC	Lab mailing	Educate Physicians by providing list of members that received a medication without required lab test.	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
April 2011		OC	Run report of members that were hospitalized with a MI and fax PCP letter regarding beta blocker treatment.	13 OC members were identified as having a MI that were not on a beta blocker.	
Medication Reconciliation Post-Discharge (MRP)					
TBD		OC		New measure for team; reviewing specifications to develop target interventions.	
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)					
Ongoing	√	OC	Formulary Restrictions		
Use of Appropriate Medications for People with Asthma (ASM)					
Ongoing	√	HFP	Step Therapy		
Use of High-Risk Medications in the Elderly (DAE)					
Ongoing	√	OC	Formulary Restrictions; Educate top 10 pharmacies identified by CMS regarding DAE		
Pharmacotherapy Management of COPD Exacerbation (PCE)					
TBD		OC		Conducting barrier analysis.	

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QI Project Update
Updated On: 04.19.11

Adult Preventive Care Team
Team Lead: Sarah Saia

Date Implemented	Ongoing	Target Population	Intervention	Status Update	Other
Adult's Access to Preventive/Ambulatory Health Services (AAP) - OC					
TBD		OC members	**March Outreach to call all members** Contract with March Outreach Solutions to outreach to our members in order to increase preventive screenings/well-care visits	Received quote - Currently on hold.	
Adult BMI Assessment (ABA) - OC					
Care for Older Adults (COA) - SNP					
Planned June 2011		OC providers	**Provider letter Mailing** Details the components of COA, including some helpful standardized tools that can be used in carrying out the necessary assessments.	Draft in PA review	
Colorectal Cancer Screening (COL) - OC					
Planned June 2011		OC members	**HY mailing** Colorectal Cancer Brochure about the importance of screening	Brochure designed/finalized; preparing for mailing	
Planned July 2011		OC members	**BCS/COL Member Incentive** OneCare member incentive (two movie tickets) per screening obtained; mailing to include BCS, COL Healthy You brochures	Printing brochures. Drafting materials.	
6/30/10	√	OC members	**FOBT Kit Distribution with Office Incentive**	Provider Office Education Manager distributing FOBT kits to provider offices.	
Glaucoma Screening in Older Adults (GSO) - OC					
TBD		OC members	Idea: **Glaucoma and Retinopathy On-Site Screening** Mail out information on on-site screening along with VSP eye disease cards, and "Common Eye Problems" brochure; use Ansafone to schedule screening, include sheet reminding members of eye care benefits	Brochure designed/finalized; intervention pending approval	

3. Staff Structure and Care Management Roles

OneCare has staff that performs necessary functions to coordinate Medicare and Medicaid benefits, provide access to Plan information, and collect, analyze, and report data for our special populations, network providers and the community.

a. Identify the specific employed or contracted staff to perform administrative functions (e.g. process enrollments, verify eligibility, process claims, etc.)

- **OneCare Partner – Enrollment Coordinator**
  - **Experience & Education Requirements:**
    - 2 years experience working with the needs of persons with disabilities in a sales capacity
    - HMO, Medi-Cal/Medicaid and health services experience preferred
    - Bachelor's degree preferred
    - Bilingual in English/Spanish or English/Vietnamese required
    - Knowledge of Medicare eligibility and benefits preferred
    - Driver's license and vehicle, or other approved means of transportation, and an acceptable driving record may be required for some assignments
  - **Roles and Responsibilities:**
    - Provide assistance and education for enrollment purposes to potential members regarding OneCare program
    - Prepare and conduct presentations to potential members and community agencies
    - Outreach to potential members and provide them with information about OneCare at cultural events/ fairs
    - Facilitates enrollment and marketing activities with Members and Medical Groups
    - Conducts new member orientation regarding OneCare services
    - Conducts educational sessions for providers and community-based organizations

- **OneCare Partner – Customer Service**
  - **Experience & Education Requirements:**
    - 2+ years experience working with the needs of seniors or persons with disabilities (SPD) in a customer/member service capacity
    - HMO, MediCal/Medicaid and health services experience preferred
    - Bachelor's degree recommended
    - CA Driver's License and reliable transportation is required for some assignments
    - Bilingual in English/Spanish or English/Vietnamese, or English/Farsi is required
    - Knowledge of Medicare eligibility and benefits preferred
    - Issues that face members with special needs, such as seniors and persons with disabilities
    - Principles and practices of health care service delivery and managed care, Medi-Cal/ CalOptima eligibility and benefits
    - Principles and techniques to serve the SPD population in diverse social and ethnic groups

- **Roles and Responsibilities:**
  - Outreach calls welcoming members into the program, and 45-day follow-up calls
  - Facilitate health risk assessment completion
  - Assists member to schedule appointments
  - Assists member to locate a doctor or specialist within their area
  - Advocate, inform and educate beneficiaries on available benefits
  - Assists with transportation needs
  - Arranges an interpreter services
  - Coordinates referrals to community services and agencies

- **Claims Examiner**
  - **Experience & Education Requirements:**
    - High School graduate or equivalent
    - 1 year of experience processing on-line claims in a managed care and/or PPO/indemnity environment, billing environment or equivalent experience in a claims processing unit
    - Experience processing Medicare or Medi-Cal claims preferred
    - Knowledge of revenue Codes, CPT-4/HCPCS, ICD-9 codes
    - Knowledge of industry pricing methodologies, such as RBRVS, Medicare/Medi-Cal Fee Schedule, etc
    - Knowledge of medical terminology, benefit interpretation and administration
    - Knowledge of Medicare/Medi-Cal guidelines and regulations
  - **Roles and Responsibilities:**
    - Claims processing based upon contractual and/or OneCare agreements, involving the use of established payment methodologies, Division of Financial Responsibility, applicable regulatory legislation, claims processing guidelines and company policies and procedures
    - Analyze, process, research, adjust and adjudicate claims, in a timely manner, with the use of accurate procedure/revenue and ICD-9 codes, under the correct provider and member benefits
    - Prepare written requests to providers; follow up and handle completion of claim for returned correspondence

- **Grievance and Appeals Resolution Specialist**
  - **Experience & Education Requirements:**
    - Active California registered nurse license required
    - 5 years of health care experience, preferably in a managed care environment in related area of responsibility, i.e. utilization management, quality management, grievances and appeals
    - Strong interpersonal, verbal and written communication skills
    - Strong problem solving skills, implementing initiatives or projects, and collaborating with other professional and non-clinical staff
    - Knowledge of Medicare and Medi-Cal health care program regulations

  - **Roles and Responsibilities:**

        - Coordinate the overall process of complaint resolution, responding to all verbal and written complaints from members and/or providers relating to member eligibility and benefits, contract administration, claims processing, utilization management decisions, pharmacy and vision decisions
        - Initiate contact with members and families, health care providers, organizations and regulators as required
        - Collaborates with internal departments such as Customer Service, Provider Operations, Pharmacy, TPA Vision Administrator, Medical Management and other resources to identify additional information to resolve complaints

- **Grievance and Appeals Nurse Specialist**
    - **Experience & Education Requirements:**
        - 1-2 years of experience in claims processing or appeals and grievances highly desirable
        - Customer service experience preferred
        - Experience in healthcare practice standards, for both government and commercial plans
        - An Associate's degree or higher in Humanities, Social Science, Health Care or Business is preferred
        - Bilingual skills in either English/Spanish or English/Vietnamese highly desirable
    - **Roles and Responsibilities**
        - Managing OneCare's clinical grievance and appeal review which includes expedited and standard appeals
        - Provides oversight of resolution specialists
        - Prepares clinical reviews and provides monitoring of cases involving medical decisions and quality or care or service
        - Meets timeframes for performance with balancing the need to produce high quality work and resolving complex and sensitive member issues
        - Ensures integrity of departmental database by thorough, timely and accurate entry of cases assigned (CMS Hotline)
        - Assists with analyzing and reporting of cases through the Grievance and Appeals Resolution Services (GARS) Subcommittee
        - Provides coverage for the department in the Director's absence and/or when requested to do so by the Director

- **Manager, Performance Measurement**
    - **Experience & Education Requirements:**
        - Master's degree in Public Health, Health Care, Health Administration or a related field
        - Extensive experience with HEDIS, NCQA, CMS, DHS, and other quality performance standards
        - Significant experience within Managed Care and Quality Management

    - **Roles and Responsibilities**

        - Collect clear, accurate and appropriate data used to analyze problems and measure improvement
        - Risk identification and stratification of members using all available data sources
        - Coordinate and communicate organizational information
        - Conduct satisfaction surveys for members and providers
        - Measure access and availability to ensure provider adequacy of provider network

- **Manager, Medicare Data Management**
    - **Experience & Education Requirements:**
        - Bachelor's degree in Computer Science or related field is required
        - 2-4 years experience in a Medicare managed care environment
        - Knowledgeable of Medicare Advantage enrollment and reconciliation requirements
        - Knowledgeable of CMS reporting and regulatory processes
        - Knowledgeable of data analysis and formulating the IntegriGuard reconciliation process
    - **Roles and Responsibilities:**
        - Responsible for interaction with internal resources within the Customer Service, OneCare, Accounting and Finance departments and support discussions regarding membership at operational meetings; as well as, external CMS and CMS contracting resources
        - Support management and analysis of accretion file submission, Transaction Reply Report (TRR) analysis and follow up assignment, MMR analysis and reconciliation and management of the issue resolution
        - Participating in CMS workgroup/conference calls as well as analysis of and action in response to HPMS communications related to enrollment
        - Participates in CMS workgroup/conference calls as well as analysis of and action in response to HPMS communications related to enrollment
        - Project Lead for Ingenix Insite HCC program
        - Responsible for monthly data pulls based on HCC findings

- **Data Analyst**
    - **Experience & Education Requirements:**
        - Bachelor's degree in Health Care Administration, Business Administration, Mathematics or a related field is preferred
        - 2-3 years as a Data Analyst that would provide the knowledge and abilities listed

    - **Roles and Responsibilities:**
        - Supports the data reporting requirements of the Finance Encounters Team
        - Monitors and analyzes all files throughout the encounter process, and works closely with Health Networks to resolve data issues
        - Responsible for the continued development of improved data acquisition and assurance of data integrity

        - Responsible for exception reporting to ensure routine, timely, and accurate data submissions to the Department of Health Services (DHS) and Centers for Medicare & Medicaid Services (CMS)

- **Data Analyst Sr.**
    - **Experience & Education Requirements:**
        - Bachelor's degree in Health Care Administration, Business Administration, Mathematics or a related field is preferred
        - 5 -7 years as a Data Analyst that would provide the knowledge and abilities listed
    - **Roles and Responsibilities:**
        - Analysis of encounter and claims data
        - Designs and creates encounters reports from FED, FACETS, or the Data Warehouse. Responsible for assurance of data integrity
        - Maintains databases to support improvement, data acquisition, and reporting methods
        - Trains other analysts on their functions
        - Develop internal systems and exception reporting to ensure accurate data submissions to Department of Health Services (DHS) and Centers for Medicare & Medicaid Services (CMS)

- **Manager, Community Relations**
    - **Experience & Education Requirements:**
        - Bachelor's degree required, Master's degree preferred
        - At least 5 years experience working in a healthcare agency or community based organization
        - Excellent verbal and interpersonal skills are mandatory, with a proven ability in relationship building
        - General knowledge of managed healthcare system
        - HMO, Medi-Cal, Medicare and health services experience preferred
        - Bilingual skills preferred in Vietnamese or Spanish
        - Principles and practices of health care services delivery and managed care
        - Principles of community engagement
        - Principles and techniques to establish positive communication
        - Effective project management, facilitation and presentation skills
        - Community health program design, development, implementation and evaluation a plus
        - Cultural and linguistic sensitivities
    - **Roles & Responsibilities:**
        - Assist in developing and implementing a community relations plan in connection with CalOptima's strategic goals
        - Build/maintain positive stakeholder relationships and cultivate support for public policy issues that impact CalOptima
        - Ensure key messages are clearly communicated to external stakeholders with the goal of enhancing and preserving CalOptima's image and reputation
        - Advise senior management on community affairs
        - Develop and maintain a clearinghouse of volunteer opportunities to increase CalOptima's visibility in the community

        - Serve as primary manager for CalOptima's signature community events and outreach activities
        - Enhance and oversee the process for sponsoring community events, endorsements and use of CalOptima's name and/or logo
        - Participate on assigned committees and task forces in order to develop and maintain community partnerships designed to enhance health care access and/or services, increase membership growth and/or retention

- **Health Educator, Sr.**
    - **Education & Experience:**
        - Bachelor's degree in Health Education or related field.
        - 5 years health education experience.
        - Desirable characteristics:
            - A Certified Health Education Specialist (CHES)
            - A Master's degree in Public Health or other clinical specialty
            - A Certified Diabetes Educator
            - Fluency in Vietnamese or Spanish is preferred
    - **Roles & Responsibilities:**
        - Oversee Health Education programs with health networks, practitioners, and contracted vendors
        - Oversee the creation of materials including brochures, newsletter articles, and training curricula
        - Oversee and maintain Health Education literature supply and database
        - Act as a resource person for CalOptima practitioners, Health Plans and the community
        - Oversight of state and federal requirements as they pertain to Health Education
        - Evaluate the effectiveness of Health Education services offered using Department of Health Care Services, Group Needs Assessment (GNA) and other state and federal regulations as applied. Generate documentation/reports and action plans when necessary
        - Review literature and other educational media for advancements and research in the health care field apply them to CalOptima Health Education system
        - Assess member and community needs and determine priorities for Health Education and member self-care management
        - Oversight of Health Education referrals
        - Provide education in-services for health care staff of CalOptima

- **Provider Enrollment Data Coordinator**
    - **Education & Experience**:
        - High school diploma or equivalent
        - 1 year of data entry experience
        - Provider licensure nomenclature
        - Medi-Cal and Medicare provider guidelines

- **Roles & Responsibilities:**
  - Enter data from various documents or data sources
  - Enter data from provider registration forms and files
  - General computer research
  - Review data and determine appropriateness for adding the information into CalOptima provider database
  - Maintain provider data files
  - Perform special data-entry procedures, including sorts and mergers, and compile reports
  - Filing provider registration files

- **Contracts Manager**
  - **Experience & Education:**
    - Minimum of 5-7 years of middle management health care experience, including health plan or large provider delivery system in provider contracting or network management role.
    - Experience in California; Southern California preferred.
    - Bachelor's Degree in Business Administration, Public Policy, Health Care Administration or a related field of study required.
    - Advanced degree preferred such as a Master's degree in Business Administration, Public Administration, or Health Plan Administration or related field of study.
    - Managed care contracting for Commercial, Medi-Cal and Medicare Advantage including language requirements and payment methodologies.
    - Various reimbursement methodologies including capitation and fee for service provider payment methodologies for physician, hospital and ancillary providers.
    - Health care industry and provider community including Medi-Cal, Medicare, Healthy Families benefits and services, and commercial marketplaces specific to Southern California preferred.
    - Managed care contracting requirements for physician, hospital, ancillary and plan.
    - Health plan, large medical group/IPA and hospital operations in a capitated and/or delegated claims, medical management, and credentialing model.
    - Regulatory and business related contracting issues between providers and plans.
  - **Roles and Responsibilities:**
    - Negotiation and on-going management of Medi-Cal, Medicare, and Healthy Families related provider contracts with physician groups, hospitals and ancillary providers in conjunction with Director of Network Management, as assigned
    - Effectively communicate both internally and externally CalOptima's mission to help facilitate our contracting efforts and on-going relationship building with Orange County's provider community, as needed
    - Monitor the health care marketplace and internal utilization trends to assess new opportunities for cost savings, alternate delivery models and financial risk sharing through contractual arrangements in conjunction with Executives

- Develop internal processes to monitor effectiveness of existing contracts and contracted networks. Recommend strategies to enhance existing networks as identified

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

- **Case Manager**
  - **Experience & Education Requirements:**
    - LVN, RN, with an AS, BS or higher degree and current CA professional license in good standing
    - Minimum 5 years clinical experience, managed care experience preferred
    - Certified Case Manager (CCM) certificate preferred
    - Knowledge of Medicare and Medicaid services, regulations, and populations served
    - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
    - Medical Terminology.
    - CPT and ICD-9 coding.
  - **Roles and Responsibilities:**
    - Reviews utilization data for pro-active identification of members appropriate for care management
    - Initiate appropriate follow-up and conducts a comprehensive assessment
    - Responsible for organization determination for utilization management
    - Facilitation and management of member transition of care needs
    - Development of an individual care plan in collaboration with member, member's family or representative and providers
    - Develop a self management plan incorporating assessment, member engagement and education
    - Coordination of services utilizing community resources and support when appropriate
    - Acts as an advocate to assists in the coordination of the client's identified psycho social needs
    - Facilitate interdisciplinary care team meetings (ICT)
    - Provide consultation to the delegated medical groups
    - Provide oversight to the delegated medical groups

- **Disease Management Coordinator**
  - **Experience & Education Requirements:**
    - CA Registered Nurse with a Bachelor's Degree in nursing or related clinical discipline
    - 2-3 years in case management, health education experience, and preferably in a managed care environment
    - Experience in working with seniors and persons with disabilities

        - Certified Health Education Specialist (CHES) desired
        - Master's degree in Public Health or other clinical specialty preferred
        - Certified Diabetes Educator desired
        - Bilingual in English and Spanish preferred
        - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
    - **Roles and Responsibilities**
        - Outreach and conduct assessments
        - Develop individualized self management plan
        - Ensure compliance with established treatment plan through condition and adherence monitoring
        - Support and encourage member communication with their primary physician
        - Coordination and referrals to community resources

- **Medical Assistants**
    - **Experience & Education Requirements:**
        - High school graduate or equivalent
        - 2 years of related experience that would provide the knowledge and abilities listed
        - Bilingual skills in either English/Spanish or English/Vietnamese highly desirable
        - Knowledge of personal computers, keyboarding, appropriate software to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment
        - Medical Terminology.
        - CPT and ICD-9 coding.
        - Medi-Cal and Medicare benefits and regulations
    - **Roles and Responsibilities:**
        - Provides case management support services
        - Provides disease management support services
        - Serves as a liaison between members, physicians, providers and CalOptima staff, performing initial intake of information
        - Assists with authorization functions and obtaining informing information
        - Data entry of authorizations for delegated entities
        - Serves as interpreter when required

- **Medical Director, OneCare**
    - **Experience & Education Requirements:**
        - Current, valid, unrestricted California Physician & Surgeon's License with Board certification in area of specialty
        - Considerable experience in medical management, quality management, and utilization management in a managed care setting
    - **Roles and Responsibilities:**
        - Oversight responsibility for the delivery of medical services for OneCare members
        - Quality Improvement projects and new programs
        - Provider education regarding Clinical Practice Guidelines
        - Consultant and conduit for the delegated entities

        - Manages medical aspects of contracts for services, oversees authorization for service and quality assurance for OneCare
        - Reviews complex cases and participates in the ICT process
        - Ensure policies and procedures are compliant with regulatory and accreditation requirements
        - Review of all appeals and second level provider grievances

- **Director, Case Management**
    - **Experience & Education Requirements:**
        - Extensive experience that would provide the knowledge and abilities listed above, including at least 3 years as a manager
        - HMO, Medi-Cal/Medicare and insurance experience or equivalent government client or public service experience preferred
        - California Licensed Registered Nurse.
        - Certified Case Manager (CCM) Preferred
        - Bachelor's degree in Nursing
        - Relevant Master's degree desirable
        - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
    - **Roles and Responsibilities:**
        - Coordinate the Case Management and Disease Management program including the overall planning, promotion, implementation and evaluation of services to assure compliance regulatory and accreditation requirements
        - Responsible for planning, implementing and directing utilization management, case management, and disease management services
        - Assist in the development and implementation of quality improvement activities
        - Develop staffing and budget plan and monitor resource allocation for the department

- **Manager, Case Management**
    - **Experience & Education Requirements:**
        - Registered Nurse with a valid CA license
        - Certified Case Manager (CCM) Preferred
        - At least 5 years of managed care experience
        - Clinical experience with seniors and persons with disabilities preferred
        - Associates or Bachelors Degree in Nursing
        - Supervisory experience required (of clinical and non-clinical staff)
        - Senior management experience preferred
        - Knowledge of Medicare and MediCal regulations and standards of practice
        - Appropriate strategies to serve diverse social and ethnic groups
    - **Roles and Responsibilities:**
        - Responsible for the daily operations and activities of the OneCare clinical team
        - Responsible for the oversight of the OneCare Special SNP (Special Needs Plan) processes to ensure compliance with regulatory and accreditation requirements

        - Works with the Director/Medical Director to develop, implement and evaluate the department's OneCare policies, procedures, processes and program structure
        - Manages the daily activities and performance of the OneCare team, included but not limited to; Care Transition, care coordination/case management and coordination of benefits/services
        - Works closely with delegated groups to assure the effectiveness and efficiency of the program
        - Evaluates need and provides educational training to staff and delegated entities

- **OneCare Pharmacist**
    - **Experience & Education Requirements:**
        - At least 3 years experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees
        - Current knowledge and expertise in clinical pharmacology and disease states required
        - Basic working knowledge of the Medi-Cal or Medicare programs preferred
        - A current, valid, unrestricted California State Pharmacy License and Pharm.D. required
        - ASHP-accredited residency in Pharmacy Practice or equivalent background/experience required
        - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
    - **Roles and Responsibilities:**
        - Review the member's medication profile for potential therapeutic issues
        - Reviews members' medication profiles and makes recommendations to health care providers based on evidence based medicine and national guidelines for disease management
        - Review medication profiles for potential adverse medication interactions in the elderly and contact the primary physician to recommend alternative to the medication regimen
        - Identify and refer members to the medication therapy management (MTM) program
        - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups

- **Social Worker**
    - **Experience & Education Requirements:**
        - Bachelor's degree in Behavioral Sciences or completion of other relevant professional course of study
        - Master's in Social Work or other behavioral practice desirable.
        - At least 5 years' experience that would have developed the knowledge and abilities listed
        - California driver's license and vehicle or other approved means of transportation may be required for some assignments.

        - Ability to meet with members/families and perform a psycho/social assessment
        - Experience in working with members in a multi discipline care team setting
        - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
    - **Roles and Responsibilities:**
        - Resource for OneCare members, delegated plan case managers, and community partners to address medical, behavior, and psychosocial concerns
        - In conjunction with other team members, develops and makes recommendations for a comprehensive individualized care plans
        - Assists the Physician Medical Groups (PMGs) in managing members identified at risk for transition
        - Collaborates and communicates with the member, family, significant other(s), physicians, PMG designee and other health care providers to support and accomplish goals identified on the Individualized Care Plan (ICP) in all care settings
        - Serves as a liaison and resource for internal partners including: CalOptima Customer Service, OneCare Partners, Health Services and Case Management and external partners including agencies such as Orange County Social Services, IHSS, ADHCs and the Office on Aging

- **Behavioral Health Specialists**
    - **Roles and Responsibilities (Credentialed Contracted Vendor):**
        - Behavioral health services are provided through OneCare's Behavioral Health service vendor. Under the behavioral health program, all OneCare members are screened for behavioral health diagnosis and substance use. Those who screen positive are offered an office or home comprehensive assessment to confirm the diagnosis in conjunction with their PCP. Appropriately, trained and credentialed providers within the contracted vendor network manage members with a confirmed behavioral diagnosis. Members with confirmed substance use are referred to the appropriate drug dependency rehabilitation resources.

- **Primary Care Provider**
    - **Roles and Responsibilities (Credentialed Contracted Providers):**
        - Responsible for providing care for the majority of the member's health care needs
        - Ensures preventive care screening for assigned members
        - Provides basic case management for the member including identification and timely management of medical care, and referral to needed specialty services
        - Ensures coordination of care along the continuum
        - Active participation in the development and implementation of the ICP

- **Hospitalist**
    - **Roles and Responsibilities (Credentialed Contracted Providers):**
        - Manage the member's inpatient medical needs while member is in an acute facility
        - Primary point of contact for members and their PCP's during inpatient stays
        - Participate in interdisciplinary team meetings to facilitate the movement of member to the least restrictive setting

- **SNFist**
    - **Roles and Responsibilities (Credentialed Contracted Providers):**
        - Manage the member's inpatient medical needs while member is in a skilled nursing facility
        - Primary point of contact for members and their PCP's during inpatient stays
        - Participate in interdisciplinary team meetings to facilitate the movement of member to the least restrictive setting

- **Specialist/Specialty Care Providers**
    - **Roles and Responsibilities (Credentialed Contracted Providers):**
        - OneCare provider network includes a broad spectrum of specialists to meet the needs of frail/disabled members and members with multiple chronic illnesses:
            - Cardiologist
            - Oncologist
            - Nephrologists
            - Gynecologist
            - Ophthalmologist
            - Orthopedic Surgeon
            - Neurologist
            - Pain Management

- **Mid Level Practitioners**
    - **Roles and Responsibilities (Credentialed Contracted Providers):**
        - OneCare physicians utilize mid-level practitioners such as nurse practitioners and physician assistants in their health care delivery model. The physician is responsible for ensuring that the mid-level practitioners function within their scope of practice.

- **Pharmacy Benefit Manager**
    - **Roles and Responsibilities (Credentialed Contracted Vendor):**
        - CalOptima contracts with a Pharmacy Benefit Manager (PBM) to provide claims processing, pharmacy network management, prior authorization processing, and drug utilization management services

- **American Logistics (Credential Contracted Vendor)**
    - No cost taxi benefit: OneCare provides a taxi benefit in the form of sixty (60) one-way trips to members within the service area. Members may use this benefit to access services including, but not limited to, transportation to doctors visits, pharmacies, and to dialysis centers. The benefit is limited to

trips for medical services. Members are provided an 800 toll free phone number to arrange transportation as needed and are also supported by the OneCare Partners for their scheduling needs.

- **Liberty Dental (Credential Contracted Vendor)**
  - OneCare provides a no-cost dental benefit for its membership through a contracted dental network of dentists and other dental health providers. The network is diverse in its ability to provide culturally sensitive services to the unique OneCare membership. The providers have expertise in providing services to the frail and disabled population. Members may self refer by calling a toll free number that is available twenty four (24) hours a day. Services include comprehensive oral exams and periodontal evaluation, prophylaxis cleaning up to twice a year, periodontal scaling and root planning, dentures, extractions, and full mouth debridement as needed to enable medical evaluation.

- **Silver & Fit (Credential Contracted Vendor)**
  - OneCare provides a no cost gym benefit to all its members. The benefit allows members to go to any Silver & Fit fitness club or center of their choice. Members may also receive a home fitness kit for exercise at home. There is a toll free customer service number to answer members' questions and concerns about the program. The program is consistent with the recent National Institute of Health report which indicated even moderate physical activity can improve the health of seniors who are frail or who have diseases that accompany aging.

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

Human Resource Representative

- **Experience & Education:**
  - Bachelor's degree in Human Resources, Business, Communications or related field.
  - Human Resources experience a plus with excellent written and verbal communications skills.
  - Knowledge of policies & procedures, general responsibilities, requirements and regulations pertaining to the Human Resources Department.
  - Knowledge of existing laws and regulations dealing with employment law.
- **Roles & Responsibilities:**
  - Support recruitment team on OpenHire by: posting all job openings, keeping job descriptions/postings up-to-date, removing jobs after they're filled, and adding or deactivating hiring managers as needed
  - Process new hire/termination paperwork
  - Maintain I-9 files; background checks and drug screen paperwork according to the legal requirements

- Manage licensure tracking for all positions requiring a professional license and Driver's License/Auto Insurance for positions that travel in the field

Credentialing Coordinator

- **Experience & Education:**
  - Associate's degree or equivalent experience.
  - Certification as Certified Provider Credentialing Specialist (CPCS) preferred.
  - 3+ years experience with credentialing in a hospital or ambulatory setting, such as health plan, medical group, IPA.
  - Significant knowledge of Federal and State regulatory requirements and accreditation standards: NCQA, JCAHO, DHCS, DMHC, CMS, and other relevant or accreditation certifying agencies.
- **Roles & Responsibilities:**
  - Ensures that the required timely documentation is appropriate and complete for verification processing of practitioners, providers, midlevel, allied health professionals, and other health care delivery organizations for the credentialing and re-credentialing process
  - Processes all credential applications, initiates re-credential, and/or applications in established file folders
  - Initiates primary source verifications and other follow-up as required into the applicant's background, education and experience through the use of online systems, written correspondence, telephone inquiries, and printed reference guides and reports
  - Collaborates with the Provider Operations department on the status of candidates to ensure timely credentialing prior to being contracted with CalOptima
  - Develops and maintains a computerized database for the use in the credentialing and re-credentialing processes
  - Prepares required reports , monitors and maintains reports published by MBOC, CMS, DHS, OIG and NPDB, and other applicable sources to identify adverse findings

Manager, Quality Improvement

- **Experience & Education:**
  - Registered Nurse plus relevant Bachelor's degree in a health care field.
  - Master's degree and CPHQ certification preferred.
  - Significant experience within a Managed Care Plan and Quality Management in a clinical setting.
  - Drivers' license and vehicle or other approved means of transportation may be required for some assignments.
  - Legislative, regulatory and quality requirements for health care service delivery to beneficiaries of the following programs: Medi-Cal, Healthy Families (HF), Medical Services for Indigents (MSI), and Medicare.
  - Clinical issues related to the successful achievement of quality improvement initiatives.

        - Principles and techniques of project management to ensure that numerous goals, objectives and detailed actions are properly identified and their status monitored.
        - Principles and practices of managed health care, health care systems, and medical administration.
    - **Roles & Responsibilities:**
        - Responsible for all quality management and peer review functions such as quality of care monitoring, credentialing, facility site review, and delegation oversight
        - Direct the credentialing processes linked with physician profiling
        - Measurement and reporting use of Clinical Practice Guidelines
        - Educate the CalOptima staff and external customers on quality initiatives
        - Participates in, workgroups that address both clinical and non-clinical internal activities for which CalOptima must demonstrate improvement to meet its contractual requirements

- **Medical Director, OneCare**
    - **Experience & Education Requirements:**
        - Current, valid, unrestricted California Physician & Surgeon's License with Board certification in area of specialty
        - Considerable experience in medical management, quality management, and utilization management in a managed care setting
    - **Roles and Responsibilities:**
        - Oversight responsibility for the delivery of medical services for OneCare members
        - Quality Improvement projects and new programs
        - Provider education regarding Clinical Practice Guidelines
        - Consultant and conduit for the delegated entities
        - Manages medical aspects of contracts for services, oversees authorization for service and quality assurance for OneCare
        - Reviews complex cases and participates in the ICT process
        - Ensure policies and procedures are compliant with regulatory and accreditation requirements
        - Review of all appeals and second level provider grievances

- **Manager, Case Management**
    - **Experience & Education Requirements:**
        - Registered Nurse with a valid CA license
        - Certified Case Manager (CCM) Preferred
        - At least 5 years of managed care experience
        - Clinical experience with seniors and persons with disabilities preferred
        - Associates or Bachelors Degree in Nursing
        - Supervisory experience required (of clinical and non-clinical staff)
        - Senior management experience preferred
        - Knowledge of Medicare and MediCal regulations and standards of practice
        - Appropriate strategies to serve diverse social and ethnic groups

- **Roles and Responsibilities:**
  - Responsible for the daily operations and activities of the OneCare clinical team
  - Responsible for the oversight of the OneCare SNP (Special Needs Plan) processes to ensure compliance with regulatory and accreditation requirements
  - Works with the Director/Medical Director to develop, implement and evaluate the department's OneCare policies, procedures, processes and program structure
  - Manages the daily activities and performance of the OneCare team, included but not limited to; Care Transition, care coordination/case management and coordination of benefits/services
  - Works closely with delegated groups to assure the effectiveness and efficiency of the program
  - Evaluates need and provides educational training to staff and delegated entities

- **OneCare Pharmacist**
  - Experience & Education Requirements**:**
    - At least 3 years experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees
    - Current knowledge and expertise in clinical pharmacology and disease states required
    - Basic working knowledge of the Medi-Cal or Medicare programs preferred
    - A current, valid, unrestricted California State Pharmacy License and Pharm.D. required
    - ASHP-accredited residency in Pharmacy Practice or equivalent background/experience required
    - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups
  - **Roles and Responsibilities:**
    - Review the member's medication profile for potential therapeutic issues
    - Reviews members' medication profiles and makes recommendations to health care providers based on evidence based medicine and national guidelines for disease management
    - Review medication profiles for potential adverse medication interactions in the elderly and contact the primary physician to recommend alternative to the medication regimen
    - Identify and refer members to the Medication Therapy Management (MTM) program
    - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups

- Medicare Data Manager
  - **Experience & Education Requirements:**
    - Bachelor's degree in Computer Science or related field is required.
    - 2-4 years experience in a Medicare managed care environment.
  - **Roles and Responsibilities:**
    - Responsible for interaction with *internal* resources within the Customer Service, OneCare, Accounting and Finance departments and support discussions regarding membership at operational meetings; as well as, external CMS and CMS contracting resources.
    - Processes will support management and analysis of accretion file submission, Transaction Reply Report (TRR) analysis and follow up assignment, MMR analysis and reconciliation and management of the issue resolution.
    - Participating in CMS workgroup/conference calls as well as analysis of and action in response to HPMS communications related to enrollment.
    - Design and develop analytic and operational reports to support organizational awareness of membership trends, financial variances, and resolution status.

4. Interdisciplinary Care Team (ICT)

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

OneCare has Interdisciplinary Care Teams (ICT) that are aligned with the delegated delivery system. There are three (3) levels of ICTs that reflect the health risk status of members. The participants of the ICT include the member, if feasible, Medical Director, PCP, Specialist, Case Management Team, Behavioral Health Specialist, and Social Worker. The teams are designed to ensure that members' needs are identified and managed by an appropriately composed team. Additional disciplines such as the Clinical Pharmacist, Dietician and/or Long Term Care Manager may be included in the ICT based on the member's specific needs. The ICP is stored in the PCP medical record in accordance with HIPAA and all contractual, statutory and regulatory requirements. The summary of the ICT minutes and the ICP are stored in the health plan medical management system.

1. Basic ICT for Low Risk Members - Basic Team at PCP level

- OneCare members who identified as low risk per stratification methodology that utilizes data sources such as; acute hospital/emergency department utilization, severe and chronic conditions and pharmacy data

- **ICT Composition:** Member, Caregiver, or Authorized Representative, PCP, PCP support staff and Specialist(s)
  - Roles and responsibilities of this team:
    - Basic case management including advanced care planning
    - Medication reconciliation
    - Identification of member at risk of planned and unplanned transitions
    - Referral and coordination with specialists

- Development and implementation of ICP
- Communication with members or their representatives, vendors and medical group
- Reviews and update the ICP at least annually and with changes to the member's health status
- Referral to the Primary or Complex ICT as needed

2. **Primary ICT for Moderate to High Risk Members - ICT at the Physician Medical Group (PMG) level**

- OneCare members who are identified as moderate to high risk per stratification methodology that utilizes data sources such as; acute hospital/emergency department utilization, severe and chronic conditions and pharmacy data

- **ICT Composition (As appropriate to identified needs)** – Member, Caregiver, or Authorized Representative, PMG Medical Director, PCP and/or Specialist, Ambulatory Case Manager (CM), Hospitalist, Hospital CM and/or Discharge Planners , PMG Utilization Management staff, Behavioral Health Specialist, and Social Worker

  - Roles and Responsibilities of this Team
    - Identification and management of planned transitions,
    - Case management of high risk members
    - Coordination of ICPs for high risk members
    - Facilitating member, PCP and specialists and vendor communication
    - Identification and referral of members to OneCare Clinical Complex ICT
    - Meets as frequently as necessary to coordinate care and stabilize member's medical condition

3. **Complex ICT for High-Risk Members – OneCare Clinical Level**

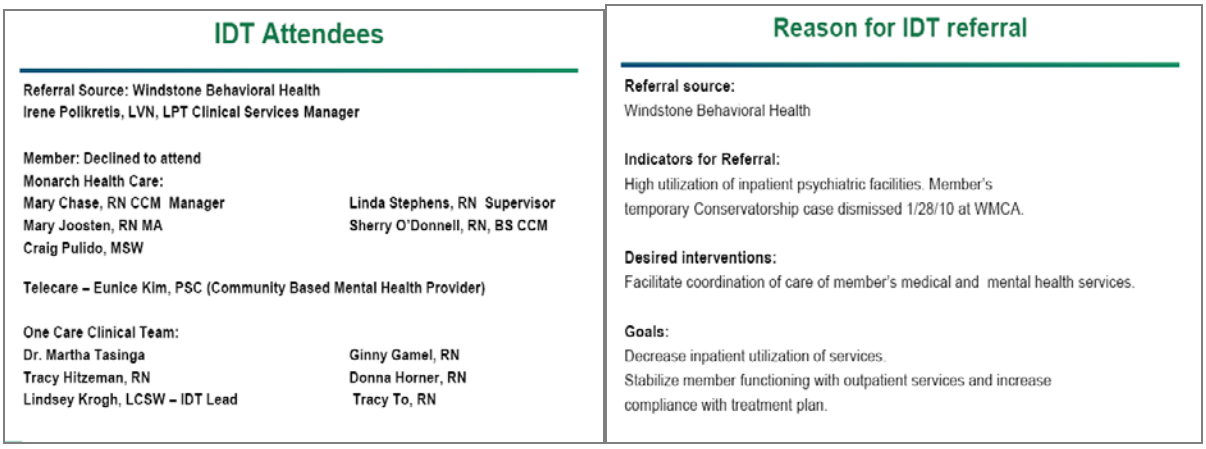
- Members who have experienced a recent clinical event or diagnosis that requires extensive use of resources and requires assistance to navigate the delivery system. These members are identified and referred by providers, PMG and OneCare Clinical Team. The referral sources may utilize the following ICT Referral Form to facilitate the identification of the members needs:
  - OneCare Ambulatory ICT Referral Form – Members who are in the community
  - OneCare Inpatient ICT Referral – Members who are confined in a facility
  - OneCare Mental Health ICT Referral – Members with behavioral health co-morbid conditions

- **ICT Composition (As appropriate for identified needs):** Member, Caregiver, or Authorized Representative, OneCare/PMG Medical Director, OneCare Clinical/PMG Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist

- Roles and responsibilities,
  - Consultative for the PCP and PMG teams
  - Ensures member engagement and participation in the ICT process
  - Coordinating the management of members with complex transition needs and development of ICP
  - Providing support for implementation of the ICP by the PMG
  - Tracks and trends the activities of the ICTs
  - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ICTs to identify areas for improvement
  - Oversight of the activities of all transition activities at all levels of the delivery system
  - Meets as often as needed until member's condition is stabilized

EXAMPLES:

1. **Sample of ICT record**



IDT Attendees

Referral Source: Windstone Behavioral Health
Irene Polikretis, LVN, LPT Clinical Services Manager

Member: Declined to attend
Monarch Health Care:
Mary Chase, RN CCM Manager — Linda Stephens, RN Supervisor
Mary Joosten, RN MA — Sherry O'Donnell, RN, BS CCM
Craig Pulido, MSW

Telecare – Eunice Kim, PSC (Community Based Mental Health Provider)

One Care Clinical Team:
Dr. Martha Tasinga — Ginny Gamel, RN
Tracy Hitzeman, RN — Donna Horner, RN
Lindsey Krogh, LCSW – IDT Lead — Tracy To, RN

Reason for IDT referral

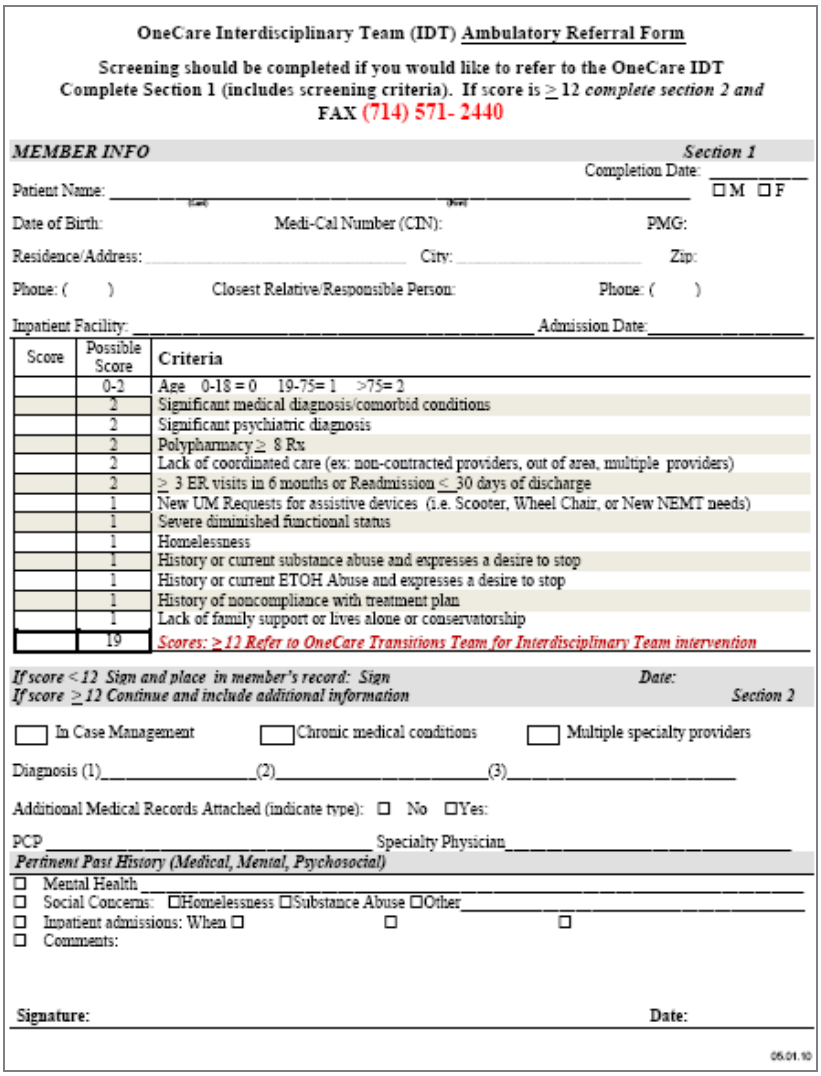
Referral source:
Windstone Behavioral Health

Indicators for Referral:
High utilization of inpatient psychiatric facilities. Member's temporary Conservatorship case dismissed 1/28/10 at WMCA.

Desired interventions:
Facilitate coordination of care of member's medical and mental health services.

Goals:
Decrease inpatient utilization of services.
Stabilize member functioning with outpatient services and increase compliance with treatment plan.

2. **Sample Ambulatory ICT Referral Form**



OneCare Interdisciplinary Team (IDT) Ambulatory Referral Form

Screening should be completed if you would like to refer to the OneCare IDT
Complete Section 1 (includes screening criteria). If score is ≥ 12 *complete section 2 and*
FAX (714) 571- 2440

MEMBER INFO ***Section 1***

Completion Date: _____

Patient Name: _____ ☐M ☐F
(Last) (First)

Date of Birth: Medi-Cal Number (CIN): PMG:

Residence/Address: City: Zip:

Phone: ( ) Closest Relative/Responsible Person: Phone: ( )

Inpatient Facility: _____ Admission Date: _____

Score	Possible Score	Criteria
	0-2	Age 0-18 = 0 19-75= 1 >75= 2
	2	Significant medical diagnosis/comorbid conditions
	2	Significant psychiatric diagnosis
	2	Polypharmacy ≥ 8 Rx
	2	Lack of coordinated care (ex: non-contracted providers, out of area, multiple providers)
	2	≥ 3 ER visits in 6 months or Readmission ≤ 30 days of discharge
	1	New UM Requests for assistive devices (i.e. Scooter, Wheel Chair, or New NEMT needs)
	1	Severe diminished functional status
	1	Homelessness
	1	History or current substance abuse and expresses a desire to stop
	1	History or current ETOH Abuse and expresses a desire to stop
	1	History of noncompliance with treatment plan
	1	Lack of family support or lives alone or conservatorship
	19	*Scores: ≥ 12 Refer to OneCare Transitions Team for Interdisciplinary Team intervention*

If score < 12 Sign and place in member's record: Sign ***Date:***
If score ≥ 12 Continue and include additional information ***Section 2***

☐ In Case Management ☐ Chronic medical conditions ☐ Multiple specialty providers

Diagnosis (1)_____(2)_____(3)_____

Additional Medical Records Attached (indicate type): ☐ No ☐Yes:

PCP _____ Specialty Physician_____

Pertinent Past History (Medical, Mental, Psychosocial)

☐ Mental Health _____
☐ Social Concerns: ☐Homelessness ☐Substance Abuse ☐Other_____
☐ Inpatient admissions: When ☐ ☐ ☐
☐ Comments:

Signature: **Date:**

05.01.10

3. Notification to PCP of ICT requirement

Administrative Offices:
1920 E. 17th Street, Suite 200
Santa Ana, CA 92705
(800) 708-3230 or (714) 796-5900

PROSPECT MEDICAL
Quality Service – Quality Care

(DATE)

DOCTOR
ADDRESS
CITY CA ZIP

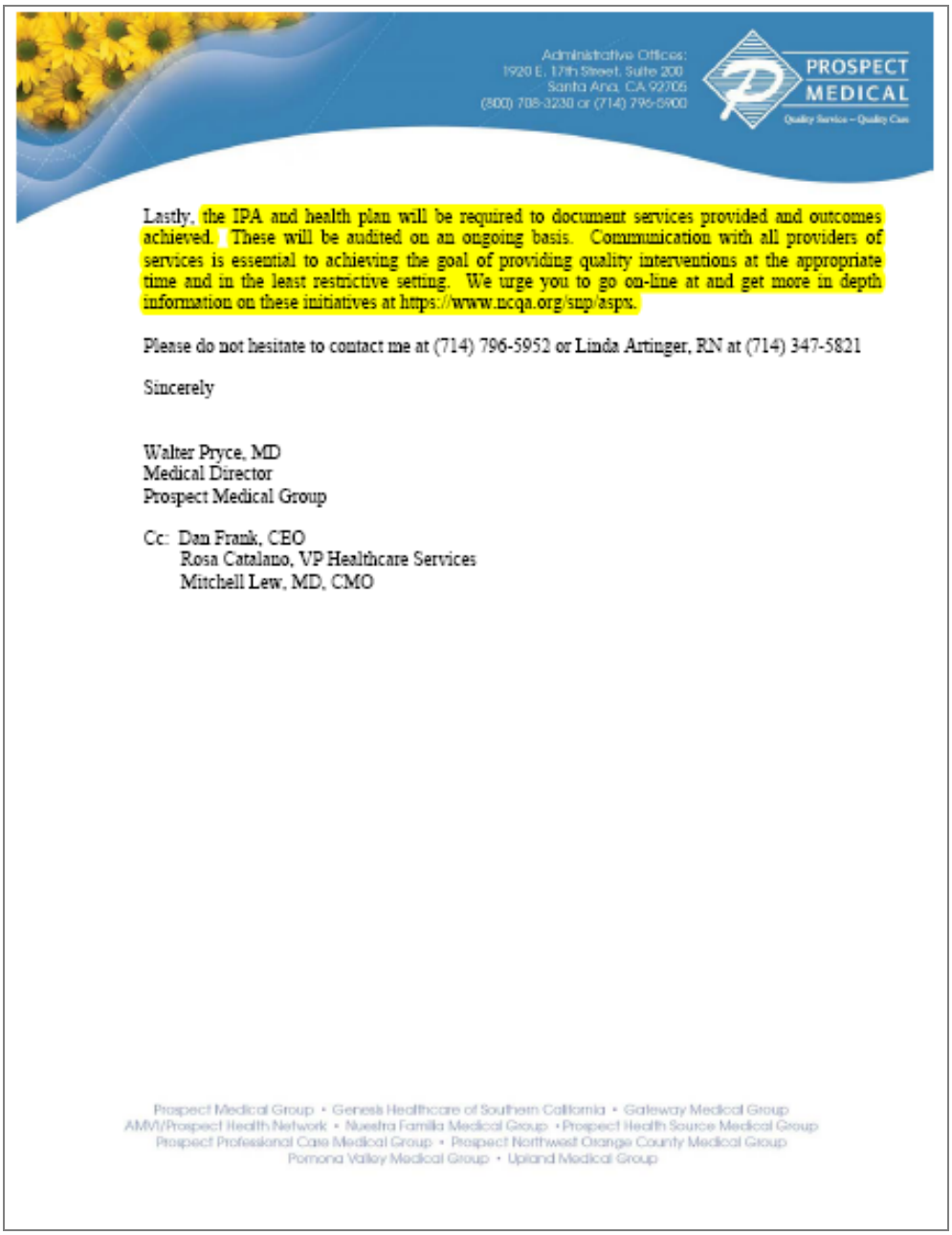
Dear Doctor,

This letter is being sent to you to outline new government requirements for health plans and provider organizations in the care of special needs program (SNP) members (dual eligible, Medicare / Medi-Cal, or Medi-Medi's) outlined by the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA). Each of the health plans is addressing the requirements in a different way. The fundamental goals common to all of the plans is to assign each member to an interdisciplinary care team (IDT) which will be headed up by the PCP; other members of the team could include a licensed nurse, behavioral health and social services experts; a pharmacist could participate as could a health educator, e.g. Patient care will be coordinated and documented by the team and will be evaluated by the plan and /or IPA.

There will be several steps in the process for each member:

1) the patient will be assigned to a case manager,
2) a health risk assessment (HRA) will be administered by a case manager to the patient and/or caregiver,
3) a case manager will do an initial assessment of the patient's health status,
4) an initial care plan will be developed and the appropriate composition of the inter-disciplinary care team (ICT) will be determined,
5) the ICT will review the patient's clinical and psychosocial history and participate in the patient's individual care plan (ICP) development and care coordination,
6) care plans (ICP's) will need to be updated annually at a minimum and when the SNP patients status changes, and
7) ICT activities will be documented in the patient care record and shared with all members of the team.

Another area that is being addressed is that of the management of patient care through transitions(when a Medi-medi patient transitions from one care setting to another, for example, from a board and care into an acute hospital for a surgery), the inpatient case manager will perform a similar series of steps and develop a care plan appropriate for the new requirements that the patient has; this will be updated as needed and shared with the members of the transition team; the purpose will be to coordinate the patient's care through the transition, document said, and communicate the data to team members. It should be noted that the hospitalist will replace the PCP on the inpatient team. A skilled nursing facility (SNF) team will be developed later this year and it will perform the same process in the SNF.



Administrative Offices:
1920 E. 17th Street, Suite 200
Santa Ana, CA 92705
(800) 708-3233 or (714) 796-5900

PROSPECT MEDICAL
Quality Service – Quality Care

Lastly, the IPA and health plan will be required to document services provided and outcomes achieved. These will be audited on an ongoing basis. Communication with all providers of services is essential to achieving the goal of providing quality interventions at the appropriate time and in the least restrictive setting. We urge you to go on-line at and get more in depth information on these initiatives at https://www.ncqa.org/sup/aspx.

Please do not hesitate to contact me at (714) 796-5952 or Linda Artinger, RN at (714) 347-5821

Sincerely

Walter Pryce, MD
Medical Director
Prospect Medical Group

Cc: Dan Frank, CEO
Rosa Catalano, VP Healthcare Services
Mitchell Lew, MD, CMO

Prospect Medical Group • Genesis Healthcare of Southern California • Gateway Medical Group
AMVI/Prospect Health Network • Nuestra Familia Medical Group • Prospect Health Source Medical Group
Prospect Professional Care Medical Group • Prospect Northwest Orange County Medical Group
Pomona Valley Medical Group • Upland Medical Group

b. Describe how the MAO will facilitate the participation of the beneficiary whenever

feasible

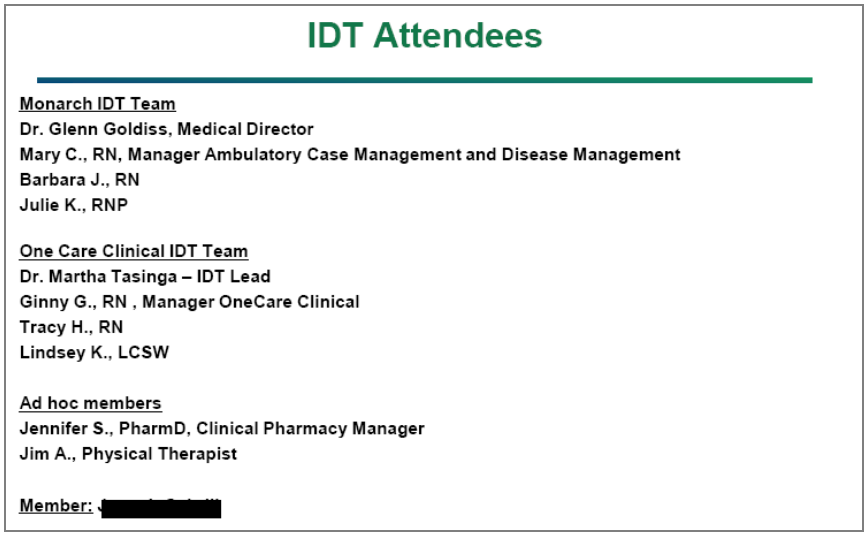
1. **Basic ICT**
   The PCP engages the member, caregiver or authorized representative through direct communication and coordinates ICT meeting at a time that is convenient for all participants. The PCP facilitates the member's engagement in the ICT by discussing their current acute, chronic and preventive health needs, specialty care, coordination with ancillary providers and establishing a basic ICP.

2. **Primary ICT**
   The Case Manager outreaches, via telephone or face-to-face meetings to educate the member, caregiver, or authorized representative on the ICT process. The Case Manager encourages the member to participate and obtains consent for ICT. Member is informed that the ICT is a collaborative process that includes their PCP, case manager and other disciplines, as indicated. Member is also informed that the ICT process is an opportunity discuss their health care and develop a feasible ICP with their care team. Members who decline to participate in the ICT continue to receive case management services and are informed that they can request an ICT in the future.

3. **Complex ICT**
   The Case Manager outreaches, via telephone or face-to-face meetings to educate the member, caregiver, or authorized representative on the ICT process. The Case Manager encourages the member to participate and obtains consent for ICT. Member is informed that the ICT is a collaborative process that includes their PCP, case manager and other disciplines, as indicated. Member is also informed that the ICT process is an opportunity discuss their health care and develop a feasible ICP with their care team. Members who decline to participate in the ICT continue to receive case management services and are informed that they can request an ICT in the future.

EXAMPLES:

1. **Example of ICT that Member attended**



IDT Attendees

Monarch IDT Team
Dr. Glenn Goldiss, Medical Director
Mary C., RN, Manager Ambulatory Case Management and Disease Management
Barbara J., RN
Julie K., RNP

One Care Clinical IDT Team
Dr. Martha Tasinga – IDT Lead
Ginny G., RN , Manager OneCare Clinical
Tracy H., RN
Lindsey K., LCSW

Ad hoc members
Jennifer S., PharmD, Clinical Pharmacy Manager
Jim A., Physical Therapist

Member: [redacted]

2. **Documentation of member's interaction during ICT – member's expressed goals**

IDT Referral Source & Member Goals

Referral source: OneCare Clinical

Indicators for Referral:

- Coordination of care for provision of needed services

Member's goals as expressed during IDT:

- Linkage with a primary care physician
- Appropriate specialist referrals for treatment of current medical conditions
- Home Therapy services
  - Home Health RN
  - Home Health PT
- Medications
- Appropriate durable medical equipment
- Appropriate in home community based services

3. Sample Case Study:

Referral source identified member as high-risk member due to frequent readmissions to an inpatient psychiatric facility.

Complex IDT assigned a designated case manager to facilitate the process.

Interventions: The case manager met with the member at the community based mental health program. A full comprehensive assessment was completed. The assessment revealed two mental health provider teams treating the member. The providers on the team were unaware of the duplication of services

Review of medical records and member interview revealed the following barriers to care:

- Lack of coordination of care related to multiple providers and involvement of a community based mental health program
- Frequent re-admissions related to co-morbid psychiatric diagnosis and non-adherence to medication regimen

Case manager discussed scheduling an IDT with both mental health providers, PCP and the case management team. The member was encouraged to participate in the IDT meeting. The member declined to participate in the IDT meeting. The member agreed to share her goals with the case manager for input at the IDT. The case manager and the member developed an initial ICP which included the member's goals for current care and barriers to remaining in the outpatient setting.

Summary: An IDT meeting was held. The attendees at the team meeting consisted of the OneCare Medical Director, case managers, social workers, a behavioral health specialist, and a representative from the community based mental health program. The two (2) mental health providers collaborated and developed a communication process that will prevent duplication and increase the quality of the member's care.

The member's goals and barriers were presented by the case manager who conducted the face to face interview. An ICP that included the member's goals and barriers was developed at the IDT meeting. The ICP was shared with member, PCP, behavioral health specialists, and case management team. The outcome resulted in decreased readmissions and increased coordination of care for the member.

c. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings,

dissemination of ICT reports to all stakeholders, etc.)

1. **Basic ICT**
   The Basic ICT is initiated at the first encounter with the PCP. The PCP develops the basic ICP at the ICT. The ICP is reviewed and updated annually and as health status changes by the ICT. Changes or revisions of the ICP are shared with the member, caregiver or authorized representative, ICT and treating providers. The ICP is stored in the PCP medical record in accordance with HIPAA and all contractual, statutory and regulatory requirements.

2. **Primary ICT**
   The Primary ICT meetings can be via telephone or face-to-face. The frequency of meetings is individualized to suit the member's need. An initial ICT may have a follow up ICT to evaluate progress towards meeting goals or resolution of barriers. The PMG Case Manager facilitates the meeting. All participants engage in an interactive case discussion. The member, caregiver or authorized representative is encouraged to actively engage in the discussion.

   An ICP with the member's prioritized goals is developed at the ICT. The ICT is documented in the PMG's HIPAA compliant case management computerized documentation system that maintains physical safeguards to restrict access, encryption, user identification and password. The ICP is disseminated to the member, caregiver or authorized representative, PCP and all other participants of the ICT.

3. **Complex ICT**
   The Complex ICT meetings can be via telephone or face-to-face. The frequency of the meetings is individualized to suit the member's need. An initial ICT may have a follow up ICT to evaluate progress towards meeting goals or resolution of barriers. The OneCare Clinical Case Manager facilitates the meeting. All participants engage in an interactive case discussion. The member, caregiver or authorized representative is encouraged to actively engage the in the discussion.

   An ICP with the member's prioritized goals is developed at the ICT. The ICT is documented in the PMG's and OneCare's HIPAA compliant case management computerized documentation system that maintains physical safeguards to restrict access, encryption, user identification and password. The ICP is disseminated to the member, caregiver or authorized representative, PCP and all other participants of the ICT.

EXAMPLES:

1. Example of PCP Care plan

INDIVIDUAL CARE PLAN **Date:____**

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____ CIN #:

BP:	P:	WT: HT: BMI:	Chief complaint:
R:	T:	Allergies:	Problem - From last visit:

Risk Stratification Score: _____ **HRA Reviewed:** ☐ Yes ☐ No **Language Preference: _____**

Diagnosis	Plan/Intervention/Follow-up
#1 #2	Goals

Preventive Services	Plan/Intervention/Follow-up
Flu Vaccine: ☐ Yes ☐ No Date:	Goals
Pneumonia Vaccine: ☐ Yes ☐ No Date:	
Mammogram: ☐ Yes ☐ No Date:	
PAP: ☐ Yes ☐ No Date:	
Prostate Screening ☐ Yes ☐ No Date:	
Colorectal Screening: ☐ Yes ☐ No Date:	

Social	Plan/Intervention/Follow-up
Marital Status: ☐ Married ☐ Divorced ☐ Single	Goals
Transportation: ☐ Yes ☐ No	
Caregivers: ☐ Yes ☐ No	
Living Arrangements: ☐ Yes ☐ No	
Recreational Activities: ☐ Yes ☐ No	
Comments:	

Nutrition	Plan/Intervention/Follow-up
BMI	Goals
Hemoglobin	
Serum Albumin	
Recent Weight Change: ☐ Yes ☐ No	
Dentures: ☐ Yes ☐ No	
Comments:	

Functional Assessment (assistance needed)				Plan/Intervention/Follow-up
	Independent	Assisted	Dependent	Goals
Ability to Take Medication:				
Feeding:				
Grooming:				
Toileting:				
Continence:				
Ambulation:				
Risk for Falls:				
Pain Scale: (1-10)				
Comments:				

INDIVIDUAL CARE PLAN Date:_____

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____ CIN #:

Psychological Assessment	Plan/Intervention/Follow-up
Recent Major Stress: ☐ Yes ☐ No	Goals
Feeling Down: ☐ Yes ☐ No	
Sleep Disturbance: ☐ Yes ☐ No	
History of Depression: ☐ Yes ☐ No	
Advance Directive on File: ☐ Yes ☐ No	

Cognitive Functioning	Plan/Intervention/Follow-up
Orientated: ☐ Yes ☐ No	Goals
Immediate Recall: ☐ Good ☐ Poor	
Delay Recall: ☐ Good ☐ Poor	
Confused: ☐ Mostly ☐ At times ☐ Not at all	
Memory Deficit: ☐ Yes ☐ No	
Inappropriate Behavior: ☐ Yes ☐ No	
Comments:	

Case Management/Coordination	Plan/Intervention/Follow-up
Risk of admission to hospital: ☐ Yes ☐ No	Goals
Risk of placement to SNF: ☐ Yes ☐ No	
Referral to CM: ☐ Yes ☐ No	
Referral to DM: ☐ Yes ☐ No	
Comments:	

Topics Discussed

- ☐ Advanced Directives
- ☐ Health Care Prefences
- ☐ Cholesterol
- ☐ Dental
- ☐ Diabetes
- ☐ Diet/Nutrition
- ☐ Exercise
- ☐ Family Planning
- ☐ Hypertension
- ☐ Immunizations
- ☐ Asthma
- ☐ Other
- ☐ Flu IZ
- ☐ Pneumonia IZ
- ☐ Injury Prevention
- ☐ Mammogram
- ☐ Medications
- ☐ Menopause
- ☐ Obesity
- ☐ PAP
- ☐ Prenatal Care
- ☐ Post Partum Visit
- ☐ Self Breast Exam
- ☐ Sexually Transmitted Infections
- ☐ Substance Abuse
- ☐ Tobacco Cessation
- ☐ Testicular Self Exam
- ☐ Tuberculosis
- ☐ Breast Cancer Screening
- ☐ Cervical Cancer Screening
- ☐ Colorectal Cancer Screening
- ☐ Prostate Cancer Screening

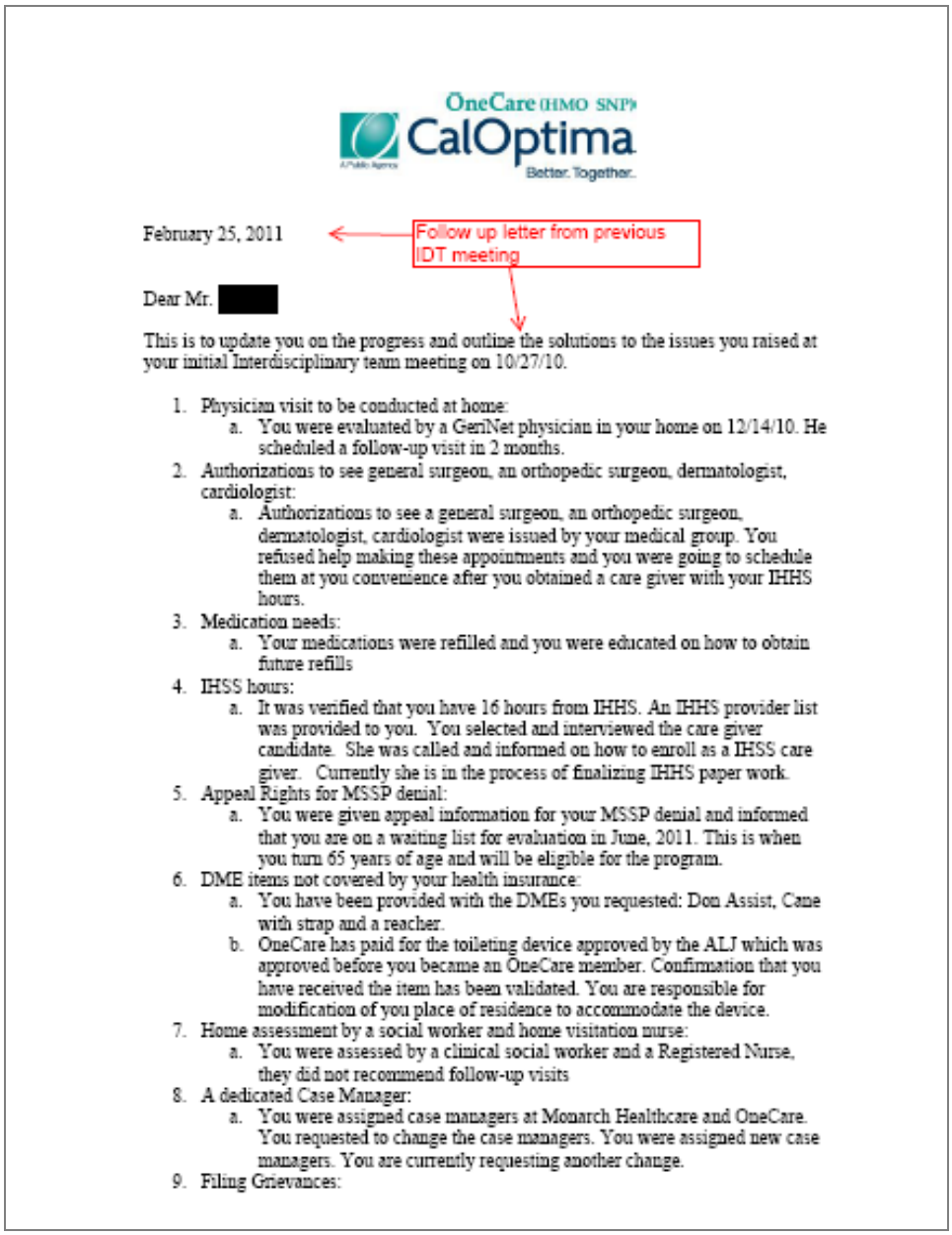
Physician's Name/Contact #: _____

Member's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

Copy to Chart and Member

2. Example of communication to member after ICT



OneCare (HMO SNP)
CalOptima
Better. Together.

February 25, 2011

Follow up letter from previous IDT meeting

Dear Mr. [redacted]

This is to update you on the progress and outline the solutions to the issues you raised at your initial Interdisciplinary team meeting on 10/27/10.

1. Physician visit to be conducted at home:
   a. You were evaluated by a GeriNet physician in your home on 12/14/10. He scheduled a follow-up visit in 2 months.
2. Authorizations to see general surgeon, an orthopedic surgeon, dermatologist, cardiologist:
   a. Authorizations to see a general surgeon, an orthopedic surgeon, dermatologist, cardiologist were issued by your medical group. You refused help making these appointments and you were going to schedule them at you convenience after you obtained a care giver with your IHHS hours.
3. Medication needs:
   a. Your medications were refilled and you were educated on how to obtain future refills
4. IHSS hours:
   a. It was verified that you have 16 hours from IHHS. An IHHS provider list was provided to you. You selected and interviewed the care giver candidate. She was called and informed on how to enroll as a IHSS care giver. Currently she is in the process of finalizing IHHS paper work.
5. Appeal Rights for MSSP denial:
   a. You were given appeal information for your MSSP denial and informed that you are on a waiting list for evaluation in June, 2011. This is when you turn 65 years of age and will be eligible for the program.
6. DME items not covered by your health insurance:
   a. You have been provided with the DMEs you requested: Don Assist, Cane with strap and a reacher.
   b. OneCare has paid for the toileting device approved by the ALJ which was approved before you became an OneCare member. Confirmation that you have received the item has been validated. You are responsible for modification of you place of residence to accommodate the device.
7. Home assessment by a social worker and home visitation nurse:
   a. You were assessed by a clinical social worker and a Registered Nurse, they did not recommend follow-up visits
8. A dedicated Case Manager:
   a. You were assigned case managers at Monarch Healthcare and OneCare. You requested to change the case managers. You were assigned new case managers. You are currently requesting another change.
9. Filing Grievances:

a. You were given information on how to file a grievance with CalOptima OneCare

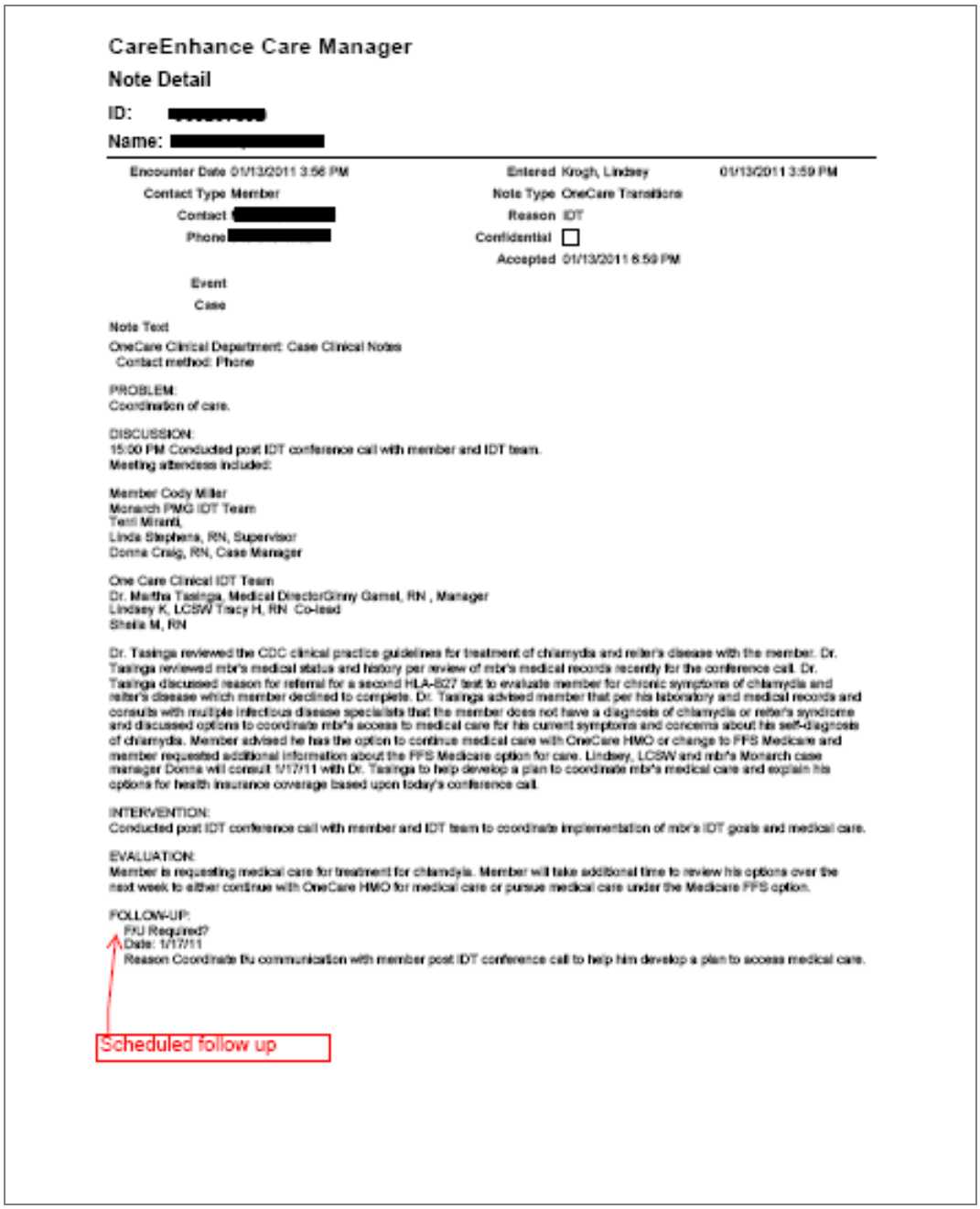
10. Home Ultrasound treatments:
    a. Request for Ultrasound treatment has been approved, however, no vendors are available to provide this modality of treatment at home. We have offered to provide you transportation to a facility for your treatment.
11. Filing complaints:
    a. You requested information on how to file a complaint about the treatment you received from House Call Doctors. The case was referred to our Peer review committee.
12. Direct Access to you plans Medical Director:
    a. You wanted direct access to the Medical Director of Monarch. We informed you that he cannot be your first contact into the organization and you can always call the Monarch case manager assigned to your case.
13. Direct Access to Dr. Tasinga, OneCare Medical Director:
    a. You have my direct line and we have had multiple conversations which you have been sent summaries.
14. A dedicated Social Worker and Case Manager:
    a. You hung up on me during the last call 1/4/11 when I tried to explore your expectations of an assigned Case Manager or Social worker.

We are in the process or scheduling a follow-up Interdisciplinary team meeting. Please review these points so that we can be able to give feedback at the meeting.

Sincerely,

Martha Tasinga, MD
Medical Director, OneCare
(714) 246-8794

3. Example of system documentation and scheduled follow up



CareEnhance Care Manager

Note Detail

ID: [redacted]

Name: [redacted]

Encounter Date 01/13/2011 3:56 PM
Contact Type Member
Contact [redacted]
Phone [redacted]

Entered Krogh, Lindsey 01/13/2011 3:59 PM
Note Type OneCare Transitions
Reason IDT
Confidential ☐
Accepted 01/13/2011 8:59 PM

Event
Case

Note Text

OneCare Clinical Department: Case Clinical Notes
Contact method: Phone

PROBLEM:
Coordination of care.

DISCUSSION:
15:00 PM Conducted post IDT conference call with member and IDT team.
Meeting attendees included:

Member Cody Miller
Monarch PMG IDT Team
Terri Miranti,
Linda Stephens, RN, Supervisor
Donna Craig, RN, Case Manager

One Care Clinical IDT Team
Dr. Martha Tasinga, Medical DirectorGinny Gamet, RN , Manager
Lindsey K, LCSW Tracy H, RN Co-lead
Sheila M, RN

Dr. Tasinga reviewed the CDC clinical practice guidelines for treatment of chlamydia and reiter's disease with the member. Dr. Tasinga reviewed mbr's medical status and history per review of mbr's medical records recently for the conference call. Dr. Tasinga discussed reason for referral for a second HLA-B27 test to evaluate member for chronic symptoms of chlamydia and reiter's disease which member declined to complete. Dr. Tasinga advised member that per his laboratory and medical records and consults with multiple infectious disease specialists that the member does not have a diagnosis of chlamydia or reiter's syndrome and discussed options to coordinate mbr's access to medical care for his current symptoms and concerns about his self-diagnosis of chlamyda. Member advised he has the option to continue medical care with OneCare HMO or change to FFS Medicare and member requested additional information about the FFS Medicare option for care. Lindsey, LCSW and mbr's Monarch case manager Donna will consult 1/17/11 with Dr. Tasinga to help develop a plan to coordinate mbr's medical care and explain his options for health insurance coverage based upon today's conference call.

INTERVENTION:
Conducted post IDT conference call with member and IDT team to coordinate implementation of mbr's IDT goals and medical care.

EVALUATION:
Member is requesting medical care for treatment for chlamdyia. Member will take additional time to review his options over the next week to either continue with OneCare HMO for medical care or pursue medical care under the Medicare FFS option.

FOLLOW-UP:
FU Required?
Date: 1/17/11
Reason Coordinate fu communication with member post IDT conference call to help him develop a plan to access medical care.

Scheduled follow up

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines

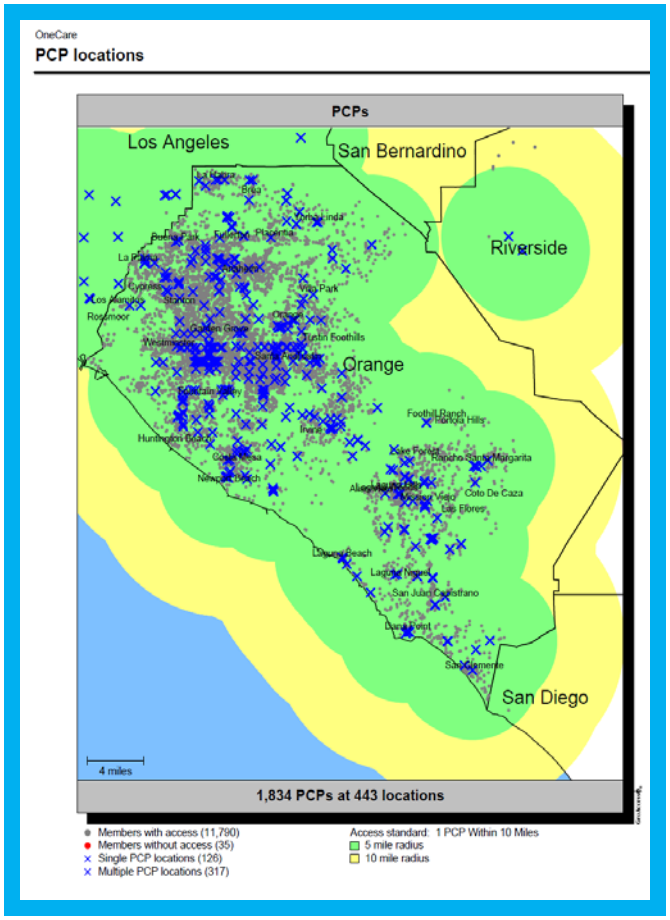
and Protocols

a. Describe the specialized expertise in the MAO's provider network that corresponds to the target population including facilities and providers (e.g. medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.)

The OneCare provider network is comprised of providers with extensive experience in caring for Medicare and Medicaid populations. The majority of providers participates in CalOptima's Medicaid program and is experienced with the needs of a dual-eligible population. They also have expertise in care of the frail elderly, complex medical conditions such as ESRD, behavioral and substance use, and seniors and persons with disabilities. All the provider groups have had extensive prior experience in the care of these special populations through CalOptima's County Organized Health System (COHS) or SCAN a Social HMO.

Geographically OneCare monitors network adequacy of its provider network using GeoAccess software. The accessibility analysis report helps to identify possible coverage gaps. The most recent GeoAccess survey results show that greater than 98% of our members are within 5 miles of a PCP and no more than 30 minutes from most specialists.

April 2011 GeoAccess:



The OneCare network includes different types of providers and facilities.

1. Primary Care Providers:
The provider network includes 1,123 primary care physicians. They have experience in managed care and management of members with multiple conditions. The Primary Care Provider acts as the gatekeeper and leads the member's basic Interdisciplinary Care Team (ICT). The primary care provider works collaboratively with the member and specialists to ensure timely access to quality care.

OneCare Contracted Primary Care Network		
Specialty	**Count**	**Pct**
General Practice	96	8.4%
Family Medicine	438	38.2%
Obstetrics & Gynecology	7	0.6%
Pediatrics	206	18.0%
Internal Medicine	400	34.9%
Total	**1,147**	**100.0%**

The role and responsibilities of the PCP include but are not limited to:

- Identification of services and any specialty care needs that the member may have and coordination of appropriate referrals.
- Provide appropriate care for the health care problems presented by a member, including preventive, acute and chronic health care services within his/her scope of training; and referring to other practitioners for other services. The PCP leads the basic Interdisciplinary Care Team.
- The PCP acts as the members advocate, annually performs a comprehensive health assessment of the member's medical, psychosocial, cognitive and functional needs, identifies gaps in care, and works collaboratively with the member, family and specialists and case management to develop and ensure implementation of the Individual Care Plan (ICP).
- The PCP is responsible for coordinating the provision of medically necessary services, through appropriate specialty and case management referral, follow-up, and monitoring.
- The PCP works collaboratively with the physician group and health plan to identify other community resources that meet the members needs.

2. Specialty Care Providers:
The OneCare specialty provider network has 2,139 specialty providers which includes a broad spectrum of specialists to meet the needs of frail/disabled members and members with multiple chronic conditions. These specialists include but are not limited to specialists such as Cardiologists, Oncologists, Nephrologists, General Surgeons, Geriatricians, Gynecologist, Ophthalmologist, Orthopedic Surgeon, Psychiatry, Neurologist and Pain Management Specialist.

OneCare guarantees that the needed services will be provided regardless of contracted status, in cases where a physician determines that a member requires care from a specialist or sub-specialist provider that is not available within the network. Our

Geoaccess survey results supports that our members are within 5 miles of their PCP and no more than 30 minutes from most specialists.

OneCare Contracted Specialist Network		
Most commonly used Specialties		**Total Specialists**
General Surgery		133
Pain Medicine		45
Cardiovascular Disease		126
Neurology		74
Psychiatry		32
Geriatric Medicine		44
Nephrology		61
Medical Oncology		43

The role and responsibilities of the specialists include but are not limited to:

- Identification of services and specialty care needs that the member may have and coordination of appropriate referrals.
- Provide specialty care for the health care problems relative to the specific needs of the member within his/her scope of training; and referring to other practitioners for other services. The specialist serves on the ICT as appropriate for the member.
- The specialist acts as the members advocate, and works collaboratively with the primary care provider, the member and family, and other specialists to develop and ensure implementation of the Individual Care Plan (ICP).
- The specialist documents and provides timely communication with the primary care provider and the member.

3. Nursing Staff:
OneCare and its contracted physician medical groups employ nurses to interact and provide services to the OneCare membership that is consistent with the education, experience and level of licensure. The nurses include Licensed Vocational Nurses (LVN) and Registered Nurses (RN). The active licensure status of the nurses is monitored. OneCare performs Inter-rater reliability of the nurses to evaluate and ensure consistency of decisions. The nurses perform functions which include but are not limited to:

- Complex case management
- Disease management
- Quality management activities
- Concurrent review and in-patient case management
- Management of appeals and grievances
- Credentialing
- Facility site review
- Management of referrals,
- Care coordination with vendors
- Oversight of delegate medical management functions

4. Allied Health Providers:
   OneCare delivery system has allied health providers who work side by side with physicians in different specialties. These include Nurse Practitioners, Physician Assistants, Pharmacy Technicians, Optometrists, Audiologists, Speech Therapists, and Physical Therapists. The allied health providers perform functions that are consistent with their education, experience and scope of licensure in compliance with State and Federal regulations. These providers are either employed or contracted with OneCare.

   The role and responsibilities of the allied health providers include but are not limited to:

   - Provide the specialized care for the health care problems relative to the specific needs of the member within his/her scope of training. The professional may serve on the ICT as appropriate for the member.
   - The specialist acts as the members advocate, and works collaboratively with the primary care provider, the member and family, and other specialists to develop and ensure implementation of the Individual Care Plan (ICP).
   - The professional documents and provides timely communication with the primary care provider and the member.

5. Mental/Behavioral Health Providers:
   Behavioral health services are provided through OneCare's Behavioral Health service contracted vendor. The vendor has a network of Psychiatrists/physicians, Psychologists, licensed psychiatric assistants, licensed therapists, and licensed clinical social workers throughout Southern California. The services provided include the Senior Behavioral Health & Wellness Program to proactively detect behavioral health diagnoses which have previously gone unrecognized. Also a Crisis Assessment Team ("CAT") which is a 24/7 triage management service for hospital emergency rooms designed to manage and triage all behavioral health patients that present themselves in hospital emergency rooms. Psychiatric Consultation Liaison Service ("PCLS") for primary care physicians is also available. This service is designed to provide M.D. psychiatric consults to inpatient medical patient's pre and post procedure. Finally, case management services are available at both a senior case management level and an inpatient intensive case management service. Example of the behavior health services, all OneCare members are screened for behavioral health diagnosis. Those who screen positive are offered an office or home comprehensive assessment to confirm the diagnosis in conjunction with their PCP. Members with a confirmed diagnosis are managed by appropriately trained and credentialed providers within the contracted vendor network. All members have direct access to behavioral health services through a self referral process, caregivers and provider referrals. Members can also be referred from multiple sources within the deliver care system, such as disease management, case management, pharmacy and the utilization management (UM) process. The vendor manages members admitted to psychiatric hospitals and provides a post hospitalization case management program. The vendor assists the members by connecting them to community base support programs to ensure compliance with medications and follow up appointments. The behavioral health vendor actively participates in the IDT and the development and update of the ICP.

6. Pharmacy Network:

The CalOptima Pharmacy Program provides our members with convenient and quality pharmaceutical services. We have a network of over 450 pharmacies located throughout Orange County, giving our members the convenience of using a local pharmacy. The majority of OneCare members live within a mile of a CalOptima network pharmacy. Our member-focused pharmacy program is diverse, with many of the network's pharmacies offering services in several languages. The pharmacy network also includes specialty pharmacies that provide specialty services such as home infusions, oncology and enteral nutritional services. CalOptima contracts with a Pharmacy Benefit Manager (PBM) to provide claims processing, pharmacy network management, prior authorization processing, and drug utilization management services.

7. Ancillary Providers:

The OneCare network has ancillary providers who provide ancillary services and products to the members. One care is contracted with 21 home health agencies, 16 DME vendors, 6 custom rehabilitation wheelchair companies, medical supplies companies such as incontinence supplies, and non-emergency medical transportation vendors. One care provides 60 one-way taxi rides to the members to facilitate access to medically related services.

The role and responsibilities of the ancillary providers include but are not limited to:

- Provide timely delivery of services.
- Provide services that are of the highest possible quality.
- Responsible for providing services in a member centric manner that promotes member satisfaction.
- Document and report utilization of services.

OneCare contracts with facilities that are pertinent to the special needs of its population. These facilities include acute inpatient facilities including behavioral health, dialysis centers, post-acute hospital facilities including skilled nursing facilities and long term care, specialty outpatient clinics, rehabilitation facilities, radiology and imagining facilities, and laboratory facilities. The majority of facilities are located within Orange County and within 15-30 minutes of the member's home. For some tertiary specialty facilities, OneCare contracts with regional centers of excellence to provide specialized services. Examples include rehabilitative services through a contract with Rancho Los Amigos National Rehabilitation Center and transplant services through the University of Southern California.

8. Acute Facilities:

The OneCare facility network is comprised of 23 contracted hospitals. These hospitals represent 77% of all acute hospitals in the service area. All the hospitals are Joint Commission or Healthcare Facility Accreditation Program (HFAP) and Medicare certified in good standing. This network of hospitals provide a full range of in-patient and out-patient services from general medical, surgical to complex and specialized in-patient services. They provide a full range of diagnostic and interventional services. They also provide specialty out-patient clinics such as Coumadin, Complex Wound Management, and Infusion Therapy.

Examples of specialized services provided include:

- Burn center at Western Medical Center of Santa Ana
- Transplantation services at University of California Irvine (UCI) Medical Center and Western Medical Center, Santa Ana
- Specialty Ophthalmology including retinal and glaucoma services at University of California Irvine (UCI) Medical Center

9. Dialysis Centers:

OneCare network includes 26 dialysis centers for the management of the ESRD members. The centers are a mixture of for-profit stand alone and hospital based units. All are licensed by the State of California and oversight by the Department of Health Services. Specialty services provided include dialysis unit, nurse case management and on-site nutritionist services. The geographic distribution of the centers ensures that members receive their treatment within close proximity of their residence eliminating the need for lengthy transportation. The centers work closely with the nephrology providers and with the ESRD Interdisciplinary Care Team (ICT). OneCare has recently contracted with a provider who has the capability of providing in-home peritoneal dialysis. OneCare is working closely with the Nephrologists to identify members who would be appropriate for this service.

10. Post Acute Hospital Facilities:

There are different levels of Post hospital care facilities that are a part of the OneCare network. OneCare has 6 Long Term Acute Care (LTAC) facilities in the network. They provide care to patients who may need ventilator or tracheotomy care, dialysis and extensive medical services. OneCare has 8 sub-acute facilities in the network. Services provided are extensive medical services that meet the sub-acute level of care medical necessity criteria. OneCare has 48 SNFs in the network. These facilities provide a range of services from immediate post acute hospital admission care, to long-term custodial services. OneCare does contract with several facilities that provide behavioral health services. These services range from locked units to custodial care.

11. Specialty Out-patient Clinics:

The OneCare network has free-standing outpatient specialty clinics such as wound care centers for the management of complex wounds, Coumadin clinics for monitoring and management of patients on anticoagulants, cancer centers for comprehensive management of patients with cancer and providing support and education to both the patients and their care givers. OneCare is also contracted with 19 outpatient surgery centers in the service area. Services rendered in outpatient surgery centers include complex surgical procedures, pain management, and diagnostic and interventional procedures.

12. Rehabilitation facilities:

OneCare contracts with both free-standing rehabilitation centers and with those that are part of acute hospitals. OneCare is contracted with regional specialty hospitals for rehabilitation. A center of excellence is Rancho Los Amigos National Rehabilitation Center. Rancho Los Amigos National Rehabilitation Center has over 50 years of experience providing quality care for persons with physical disabilities. It is one of the largest comprehensive rehabilitation centers in the United States. It is licensed for 395 beds, providing patient care services through a patient's recovery, rehabilitation and

reintegration. The medical staff is composed of physicians and dentists representing the major medical, surgical and dental specialties required for the care of the catastrophically disabled. It has been a pioneer in the interdisciplinary team approach to patient care. Patients are treated by highly specialized teams dedicated to specific disability categories such as spinal cord injury, brain injury, etc.

13. Radiology/Imaging Facilities:
    OneCare contracts with both free-standing and hospital based radiology and imaging centers. Most of the free-standing facilities are located in professional office buildings or within walking distance from the PCP office. They provide a full range of diagnostic and therapeutic services. An example is RADNET; a free- standing radiology center that provides full range of diagnostic imaging studies with multiple locations throughout Orange County. These services include MRI, PET Scans, CT, Angiography, and Infusion therapy.

14. Laboratory:
    OneCare contracts with multiple clinical laboratories throughout the service area. The main contracted laboratories are Quest, Consolidated Laboratory and LabCorp West. They provide a wide range of laboratory services including routine blood testing and specialized testing such as genetic analysis. These laboratories have many draw stations in the service area and also provide pick-up service from physician offices.

b. Describe how the MAO determined that its network facilities and providers were actively licensed and competent

One Care's comprehensive credentialing process is managed by the Quality Improvement Department. The process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the OneCare contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.'s, D.O.'s, allied health and midlevel practitioners, which include, but are not limited to; behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and non-delegated entities. Providers are re-credentialed at a minimum of every three years. The Credentialing and Peer Review Committee (CPRC) provides guidance and peer input into the OneCare practitioner and provider selection process; and determines corrective actions as necessary to ensure that all practitioners and providers that serve OneCare members meet generally accepted standards for their profession or industry. The CPRC conducts reviews and evaluates the qualifications of each applicant for becoming or remaining in the network. The review and findings of the CPRC are reported to the Quality Improvement Committee (QIC) with recommendations for approval/denial of credentialing. All approved providers are presented to the CalOptima Board Quality Assurance Committee (QAC) on a quarterly basis.

The comprehensive credentialing and re-credentialing program assures that the providers and facilities are actively licensed and competent.

Provider credentialing and re-credentialing program includes the following requirements:

1. Practitioners complete and submit a credentialing application (CalOptima/OneCare has adopted the universal CPPA application for both initial and re-credentialing – this is the industry standard application), which includes a signed and dated attestation statement regarding the correctness and completeness of the information submitted; and a Release of Information signature page. All required application addenda (i.e. addenda A-D, which evaluate for history of loss of licenses or privileges, or other disciplinary activity, lack of current illegal drug use, history of felony convictions, current health status or reasons for any inability to perform the essential functions of the position, etc).

2. Credentialing/re-credentialing application must be processed within 180 days of submission.

3. At the time of credentialing, OneCare verifies the following information from primary sources:
    - Current unrestricted California valid license
    - Valid DEA Certificate, as applicable
    - Board Certification, if applicable
    - History of professional liability claims that resulted in a judgment or settlement paid by or on the behalf of the provider
    - Work history
    - Education and training
    - Hospital privileges or documentation to demonstrate practitioner coverage by Hospitalist program
    - National Practitioners Data Bank (NPDB) information
    - Healthcare Integrity and Protection Databank (HIPDB)
    - Review and verification of the List of Excluded Individuals and Entities, which is maintained by Office of the Inspector General (OIG)

Example: Provider GC discussed contracting with OneCare Provider Contracting department. During the discussion, the need to be credentialed was explained and a credentialing application was initiated. Dr. GC completed and submitted the requested application and all supporting documentation to the OneCare Credentialing Department. Upon receipt of the application, primary source verification was completed. The complete file was compiled and presented at the next CPRC. The committee reviewed the application and supporting documentation and was approved. Once approved by CPRC, the provider was notified by letter. The contracting department was notified of approval and the contract was executed.

Facilities and other ancillary providers are credentialed by the Healthcare Delivery Organizations (HDO) process. These providers include, but are not limited to: acute inpatient, out-patient, skilled nursing, laboratories, dialysis, radiology and home health. The HDO credentialing and re-credentialing program includes the following requirements:

- Provider completes and submit a credentialing application (CalOptima/OneCare has adopted the universal CPPA application for both initial and re-credentialing – this is the industry standard application), which includes a signed and dated attestation statement regarding the correctness and completeness of the information submitted; and a Release of Information signature page. All required application addenda (i.e. addenda A-D, which evaluate for history of loss of licenses or privileges, or other disciplinary activity, lack of current illegal drug use, history of felony convictions, current health status or reasons for any inability to perform the essential functions of the position, etc).
- Credentialing/re-credentialing application must be processed within 180 days of submission
- A current Medicare certificate and a copy of the Medicare exemptions
- Active Medi-Cal enrollment status or licensure
- Licensure to operate in the State and compliant with any applicable State or Federal requirements
- Approved by an appropriate accrediting body
- Current liability (malpractice) insurance of at least the minimum amounts required by the Contract for Health Care Services

Example: Re-credentialing of a skilled nursing facility. The facility re-credentialing became due 3 years after the initial credentialing. A re-credentialing application was sent to the facility 90 days before the expiration of credentialing. Facility completed and returned the application within 30 days of notification. Upon receipt of the completed application, credentialing staff queries for sanctions, review the quality monitoring log which includes satisfaction, issuance of bans on admissions and current status with regulatory agencies and completes primary source verification. The complete file was compiled and presented at the next CPRC. The committee reviews the application and supporting documentation and facility was approved. Once approved by CPRC, the provider was notified by letter.

Monitoring of the competency of the delivery system:

OneCare monitors on-going board certification through it "Certification Renewal Database". OneCare developed in house a data base that tracks the initial board certification date and the expiration of the certification if applicable. The database displays an alert on pending board expirations 6 months ahead of the date. OneCare notifies the provider of the impending expiration, the importance of maintaining certification and request documentation of completion of the required board. If the documentation isn't received or the provider notifies OneCare of his intent to not renew than the case is presented to CPRC. CPRC decision is dependent on the specific board status of the provider and the specialty. Example is a cardiologist who declined to take cardiology boards but who maintained his internal medicine board status in good standing and was approved to remain in the network.

OneCare has a sentinel event monitoring process which is part of the CalOptima patient safety. A sentinel event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." Sentinel event monitoring includes patient safety monitoring across the entire continuum of OneCare contracted providers and other health care delivery organizations. The presence of a sentinel event is an indication of possible quality issues. Sentinel event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.
QI Department also tracks monitors, and trends, service, and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to C&PRC at time of re-credentialing. Quality of care case referral to the QI Department come from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

OneCare has also adopted policies and procedures for ongoing monitoring of sanctions between re-credentialing periods, which include, but are not limited to:

- State or Federal sanctions,
- restrictions on licensure or limitations on scope of practice,
- potential quality concerns, and
- Member complaints between re-credentialing periods
- Medicare and Medicaid sanctions such as:
    - License actions
    - Member complaints
    - Adverse events
    - Medicare Opt outs

The following procedure is implemented for management of negative activity identified in the monitoring process:

- Case file is assigned to a Credentialing Specialist
- Credentialing Specialist collects and verifies the completeness of the information
- Entire case file is brought back to CPRC for review
    - Board certified peer-matched specialists review the case
- Based on the findings the following actions may be implemented:
    - Limited or immediate termination dependant on the seriousness of the findings. Also reporting to the relevant licensure and regulatory entities
    - Case closure if non-substantiated findings
    - Issuance of a Corrective Action Plan (CAP) with a specified timeframe
        - Pending completion of the CAP, may be placed on reduced review cycle
        - Monitor CAP at scheduled Credentials and Peer Review meetings

        - Final determination at the end of the CAP period with appropriate notification
- Providers are informed of appeal rights if negative actions are taken
- Documentation is protected under Section 1157 and becomes part of the credentials record to be used in future credentialing activity

- Findings from the following quality improvement activities are also included in on-going monitoring:
    - State or Federal sanctions
    - Restrictions on licensure or limitations on scope of practice
    - Medicare and Medicaid sanctions
    - Potential quality concerns
    - Member complaints between re-credentialing periods

    Examples of cases identified through monitoring activities and actions taken:

    1. A physician was identified through member complaints about the cleanliness of the office. An OneCare certified Facility Site Review (FSR) Nurse made an unannounced visit to the office. The findings from the site review were presented to the CPRC and a CAP request was sent to the provider. The provider responded with a plan. The plan was reviewed and approved by CPRC. The CAP was tracked and monitored to ensure implementation. Upon completion of the CAP, a final review was taken to CPRC and the information was filed in the physician credentialing file and is reviewed during re-credentialing.
    2. The Department of Health Care Services (DHCS) notified OneCare that a skilled nursing facility was banned from new admissions. Upon review by DHCS, the facility was closed and OneCare worked closely with the department to move members to alternative facilities. Upon re-opening, the facility submitted a re-credentialing application and was given a limited credentialing status with review every 6 months.
    3. Review of the monthly "hot sheet" from the State of California Medical Board, a physician was found to no longer have Medi-Cal registration thus unable to see Medi-Cal members. Physician was notified that he no longer met the credentialing criteria and was asked to submit an explanation of Medi-Cal ineligibility. Physician responded with the necessary documentation which was reviewed at CPRC. The review did not support continued participation as an OneCare provider and the physician was terminated with the network. The physician filed an appeal with additional information, which was reviewed by CPRC and the termination was repealed.

Example: Monitoring reports

Primary Issue Summary

Cases Opened Between 1/1/2011 and 3/31/2011

Primary Issue	# of issue	Primary issue	# of issue
Access to care	6	Authorization denied or delayed	1
Claim of discrimination	1	Coordination of care	2
Delay of service	10	Diagnosis: delay, failure, missed	3
Failure to communicate	4	Failure to order appropriate medications	4
Failure to refer	4	Improper management of med regimen	12
Inadequate work-up/ evaluation	9	✓Inadequate or inappropriate communication	4
Lengthy wait time in facility	2	Inappropriate patient/provider/office behavior (ex: rudeness)	12
Medication reaction	1	Miscommunication	4
Mismanaged care	7	Non-Compliant patient	8
Not medically indicated	1	Treatment: delay, failure, inappropriate, or complication	5
Unable to see chosen provider	1	Unexpected death at any age	2
Unplanned admission	1	Total	104

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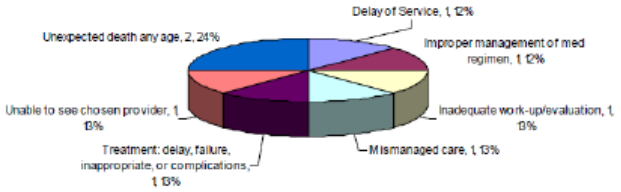
PQI Primary Issues – HDOs

Issues Identified from: 1/1/2011 to: 3/31/2011

Number of Issues (combined)



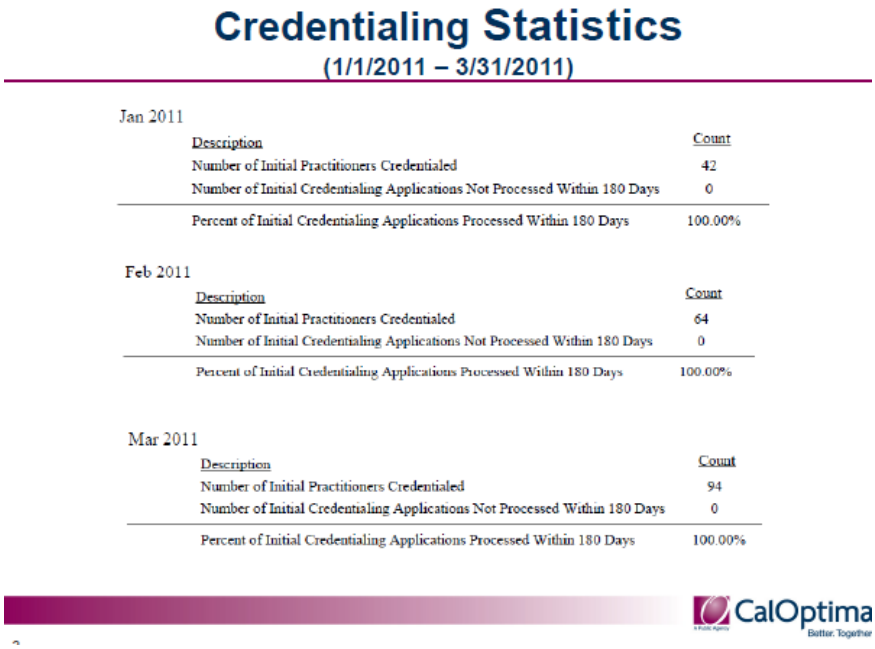
W9330979956 *Liberty Dental Plan of California*

Primary Issue	Count	
Unable to see chosen provider	1	
Treatment: delay, failure, inappropriate, or complications	1	
Mismanaged care	1	
Inadequate work-up/evaluation	1	
Delay of Service	1	
Total:	5	62.50%

HSCX00164 *UCI MEDICAL CENTER*

Primary Issue	Count	
Unexpected death any age	2	
Improper management of med regimen	1	
Total:	3	37.50%

Grand Total: 8



Credentialing Statistics

(1/1/2011 – 3/31/2011)

Jan 2011

Description	Count
Number of Initial Practitioners Credentialed	42
Number of Initial Credentialing Applications Not Processed Within 180 Days	0
Percent of Initial Credentialing Applications Processed Within 180 Days	100.00%

Feb 2011

Description	Count
Number of Initial Practitioners Credentialed	64
Number of Initial Credentialing Applications Not Processed Within 180 Days	0
Percent of Initial Credentialing Applications Processed Within 180 Days	100.00%

Mar 2011

Description	Count
Number of Initial Practitioners Credentialed	94
Number of Initial Credentialing Applications Not Processed Within 180 Days	0
Percent of Initial Credentialing Applications Processed Within 180 Days	100.00%

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Above are examples of monitoring tracking credentialing reports

c. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.)

In OneCare, the PCP acts as the gatekeeper and is the center of ICT responsible for coordinating services. Per CalOptima OneCare policy MA.5010 PCP Roles and Responsibilities the PCP is required to have:

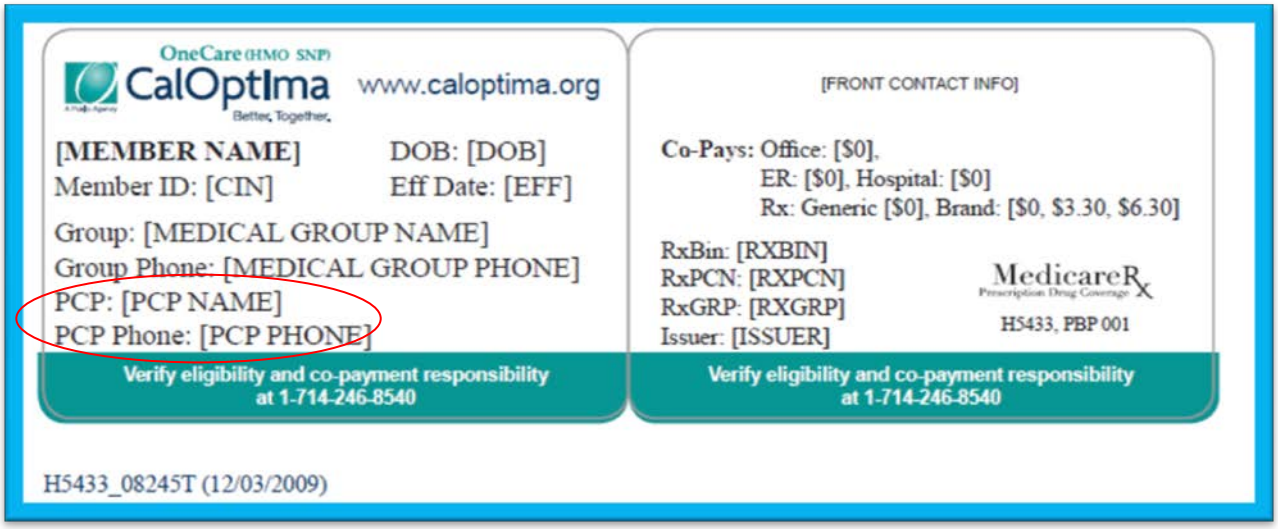
- Support staff to assist in the provision of these services
- Training to provide the scope of services required by assigned members
- Ability to verify member eligibility with OneCare
- Capacity to assure access to care twenty-four (24) hour per day, seven (7) days per week, including accommodations for urgent matters and identify back-up coverage in case of an absence
- Capacities to maintain office wait times to less than 45 minutes
- Ability to maintain a medical record and make it available for review upon request by the physician group, OneCare or other regulators
- Ability to submit encounter data using current CPT and current ICD codes reported on the health insurance claim form for billing statement supported by the documentation in the medical record

In addition, the role and responsibilities of the PCP as gatekeeper are noted in the PCP contract and described in detail in the Provider Manual. These roles and responsibilities include but are not limited to:

- Identification of services and any specialty care needs that the member may have and coordination of appropriate referrals.
- Provide appropriate care for the health care problems presented by a member, including preventive, acute and chronic health care services within his/her scope of training; and referring to other practitioners for other services. The PCP leads the basic Interdisciplinary Care Team.
- The PCP acts as the members advocate, annually performs a comprehensive health assessment of the member's medical, psychosocial, cognitive and functional needs, identifies gaps in care, and works collaboratively with the member, family and specialists and case management to develop and ensure implementation of the Individual Care Plan (ICP).
- The PCP is responsible for coordinating the provision of medically necessary services, through appropriate specialty and case management referral, follow-up, and monitoring.
- The PCP works collaboratively with the physician group and health plan to identify other community resources that meet the members needs.
- The PCP maintains a medical record for the member and ensures that the member and other care providers have a copy of the ICP. PCP updates the ICP with the member at least annually and when the member's health status changes.
- The PCP is the keeper of the patient's medical record. He/she initiates the ICP and maintains medical record in compliance with CMS medical record documentation requirements.
- The PCP communicates the ICP with providers involved in the member's care at the point of notification of a planned or unplanned transition of care.

The PCP gatekeeper role is reinforced with members from the time of enrollment. OneCare members select PCP from the OneCare Provider Directory upon enrollment. The name and phone number of the PCP is printed on the member's identification card. The OneCare welcome packet also has information on the PCP and PCP appointment scheduling information.

Example of a member ID card with the PCP assignment:



Example of communication about the role of the PCP on OneCare website for members:

OneCare provides members with all Medicare and Medicaid services, OneCare also provides extra benefits and services designed to meet the special needs of the membership. OneCare provides all Medicare and Medicaid services at no cost to the member including but not limited to:

- Inpatient hospital care,
- Inpatient mental health care,
- Skilled nursing facilities up to limit of benefit,
- Services by home health agencies,
- Physician services including doctor's office visits,
- Chiropractic services,
- Outpatient mental health services including services for substance abuse and partial hospitalization,
- Ambulance and Non-Emergency Medical Transportation (NEMT) services,
- Outpatient rehabilitation services,
- Emergency services
- Durable medical equipment and medical supplies such as incontinence supplies,
- Outpatient diagnostic tests and therapeutic services including recommended preventive screenings and vaccinations.
- Comprehensive pharmacy services

OneCare provides the following additional benefits:

- Comprehensive dental plan with zero co-payment for most covered services
- Vision care services which include routine eye exam and prescription eyeglasses once every 12 months,
- Routine podiatry services including nail clipping for non diabetics up to 6 visits a year.
- 60 one-way taxi trips in each calendar year
- Gym membership
- Worldwide emergency services

2011 Winter member newsletter:

OneCare 2011 Benefits

Benefits	Covered	Your Cost
Premium and deductible	Yes	0
Transportation (60 one-way taxi trips)	Yes	0
Doctor and hospital services	Yes	0
Inpatient mental health up to 190 days	Yes	0
Skilled nursing facility	Yes	0
Home health care	Yes	0
Hospice	Yes	0
Podiatry services	Yes	0
Outpatient mental health	Yes	0
Outpatient substance abuse	Yes	0
Emergency care	Yes	0
Out-of-area care (USA only)	Yes	0
Durable medical equipment and prosthetic devices	Yes	0
Medical supplies (includes incontinence products)	Yes	0
Vision care ($150 frames and lenses / $150 contact lenses)	Yes	0
Diabetic supplies (monitors, test strips, lancets)	Yes	0
Dental (including cleanings, crowns [some restrictions apply], dentures, root canals)	Yes	0
Fitness benefits (including gym membership)	Yes	0
Out-of-country emergency care	Yes, up to $5,000	0 up to $5,000

Members access services in various ways. OneCare strives to make access as simple, easy and member driven as possible. The access process is driven predominately by the urgency of the services, complexity of the service, benefit coverage and the nature of the network. Members are educated on accessing services from enrollment. Part of the New Member Orientation is education on accessing medical services.

OneCare (HMO SNP)
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You're Invited to a New Member Orientation!

To learn more about OneCare, you can sign up to attend one of our New Member Orientation meetings. At this meeting you will learn:

- How to get medical services
- How to obtain an authorization for your medication (if required)
- How to use resources available in your community
- About your rights and responsibilities as a member

American Sign Language interpreters and other language interpreters are available upon request. ***Please fill out the form below and return it in the postage-paid envelope to sign up for the meeting.***

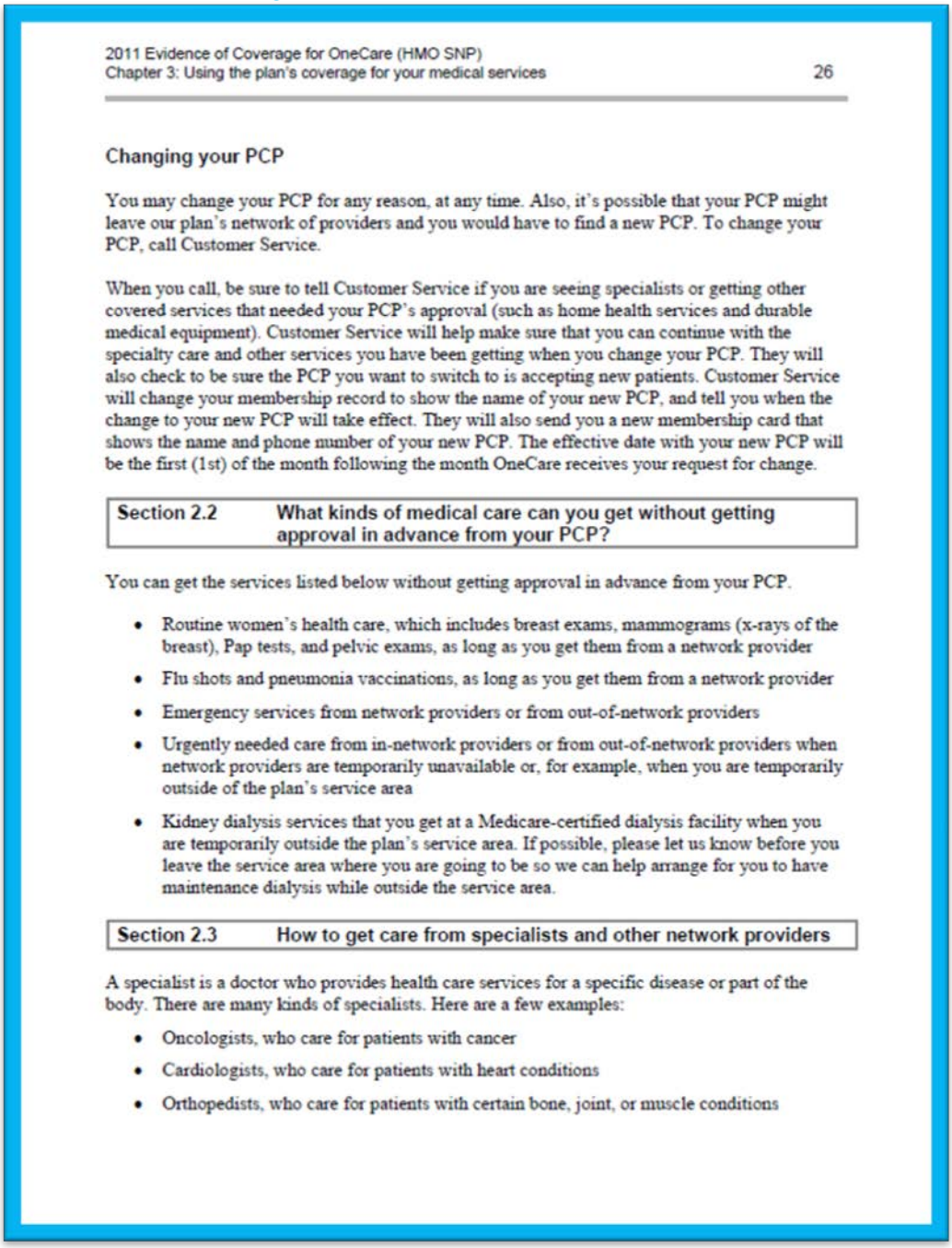
All meetings below will be held at:

CalOptima
1120 West La Veta, Orange, CA 92868.
Please see map on the reverse side. You can park at CalOptima at no cost.

The types of access are:

- Emergency services and urgent services. There are no prior authorization requirements for these services. Emergency services do not require prior authorization at any time. Urgent services do not require prior authorization in the event a network provider is unavailable or the member is out of area. Dialysis services out of area also do not require prior authorization.
- Member self referrals are driven by regulatory requirements and member convenience. They often encompass preventative services such as behavioral health, well woman care and emergency services. They do not require prior authorization. Members are educated and encouraged by the PCP, health educational materials and case management and disease management to use these services.

2011 Evidence of Coverage:



2011 Evidence of Coverage for OneCare (HMO SNP)
Chapter 3: Using the plan's coverage for your medical services 26

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. To change your PCP, call Customer Service.

When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP. The effective date with your new PCP will be the first (1st) of the month following the month OneCare receives your request for change.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or, for example, when you are temporarily outside of the plan's service area
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

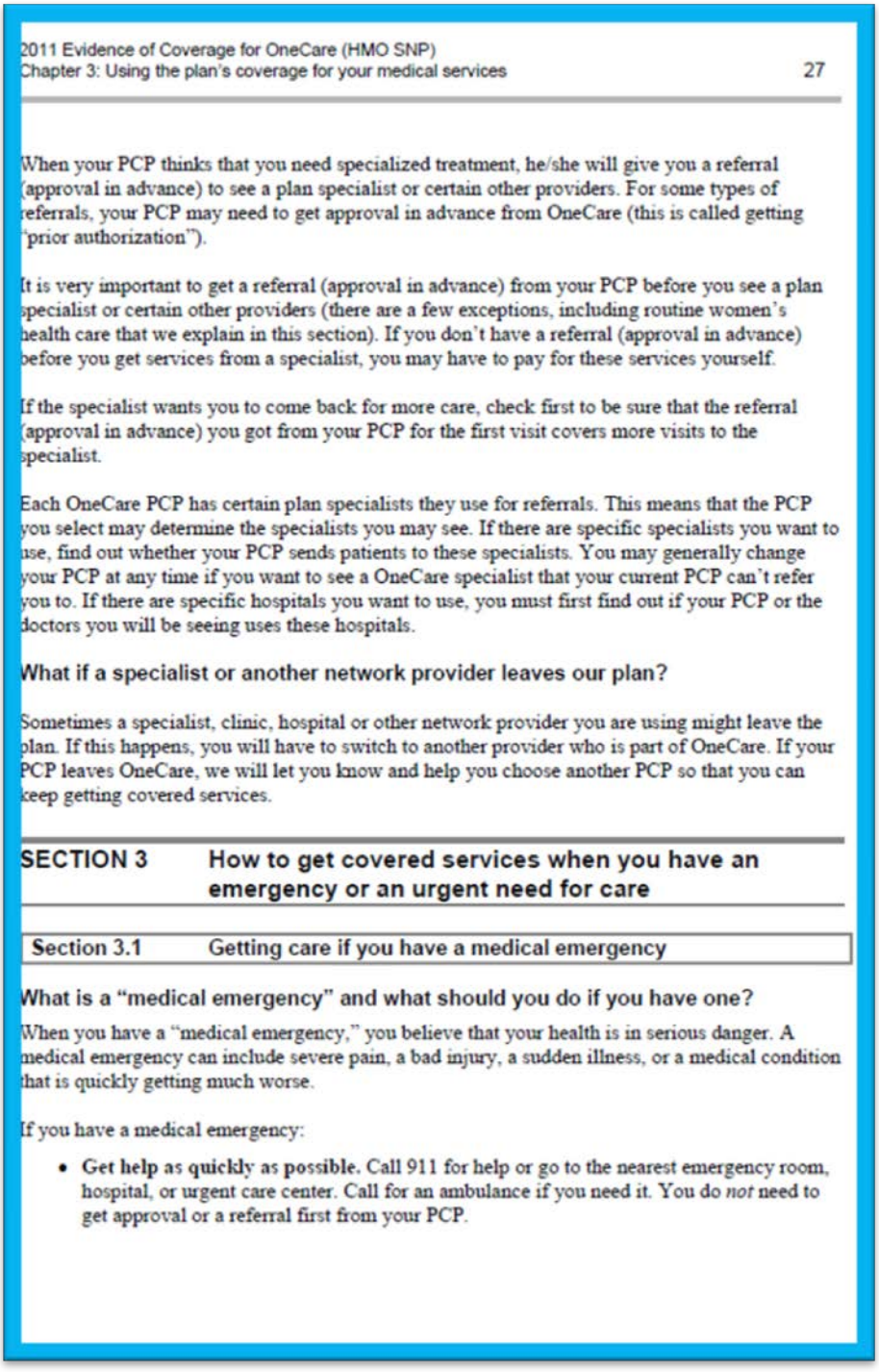
Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer
- Cardiologists, who care for patients with heart conditions
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions

- Direct referrals are initiated by the PCP to facilitate timely referral to network providers. These services do not require a prior authorization. These services may include, but are not limited to, routine diagnostic, laboratory services, PCP to specialist referrals and specialist to specialist referrals. The direct referrals are driven by continuous assessment of the network through the UM process.

- Prior authorization is required for those services when a medical review is necessary. The PCP or specialist will request the services on the member's behalf. The member is educated on the services requiring prior authorization in the Evidence of Coverage and the New Member Orientation and by the health care providers.



2011 Evidence of Coverage for OneCare (HMO SNP)
Chapter 3: Using the plan's coverage for your medical services 27

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from OneCare (this is called getting "prior authorization").

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain in this section). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

Each OneCare PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. You may generally change your PCP at any time if you want to see a OneCare specialist that your current PCP can't refer you to. If there are specific hospitals you want to use, you must first find out if your PCP or the doctors you will be seeing uses these hospitals.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of OneCare. If your PCP leaves OneCare, we will let you know and help you choose another PCP so that you can keep getting covered services.

SECTION 3 How to get covered services when you have an emergency or an urgent need for care

Section 3.1 Getting care if you have a medical emergency

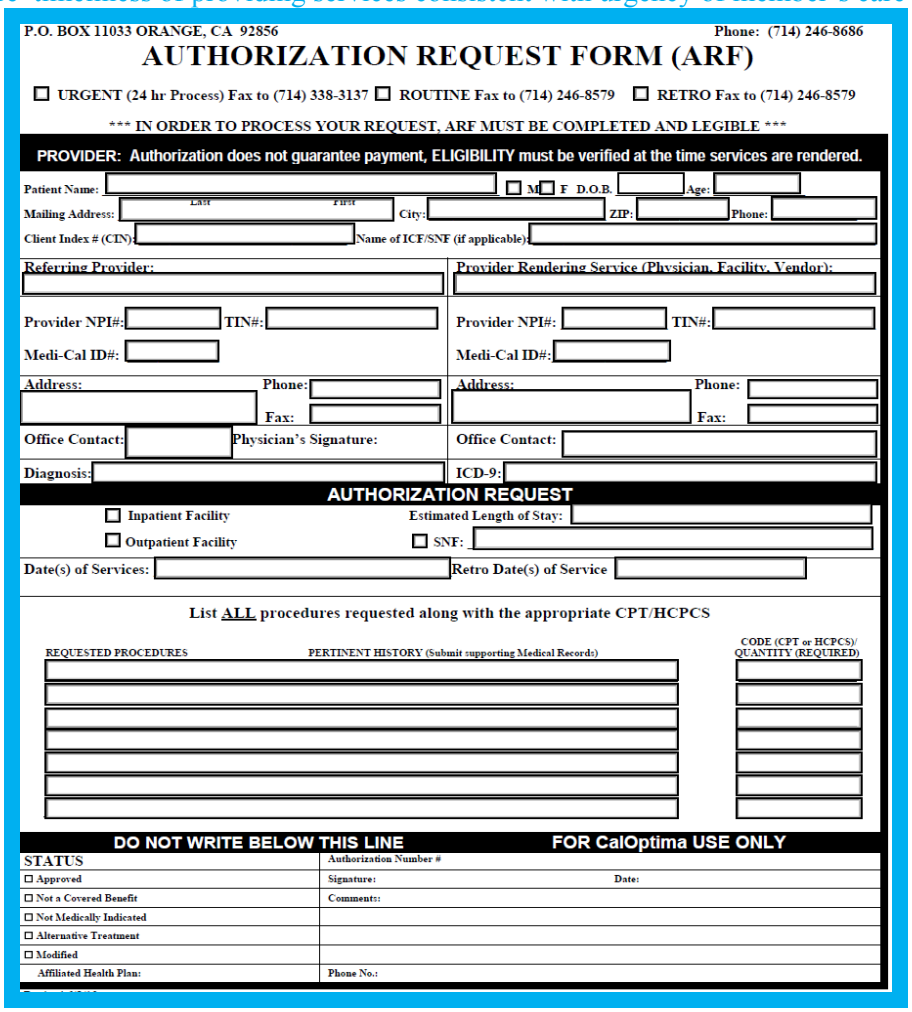
What is a "medical emergency" and what should you do if you have one?

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

Referral form used by PCP to request services from specialist with indication of urgent or routine to ensure timeliness of providing services consistent with urgency of member's care needs.



P.O. BOX 11033 ORANGE, CA 92856 Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ URGENT (24 hr Process) Fax to (714) 338-3137 ☐ ROUTINE Fax to (714) 246-8579 ☐ RETRO Fax to (714) 246-8579

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

Patient Name: Last First ☐ M ☐ F D.O.B. Age:

Mailing Address: City: ZIP: Phone:

Client Index # (CIN): Name of ICF/SNF (if applicable):

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: TIN#:	Provider NPI#: TIN#:
Medi-Cal ID#:	Medi-Cal ID#:
Address: Phone: Fax:	Address: Phone: Fax:
Office Contact: Physician's Signature:	Office Contact:
Diagnosis:	ICD-9:

AUTHORIZATION REQUEST

☐ Inpatient Facility Estimated Length of Stay:

☐ Outpatient Facility ☐ SNF:

Date(s) of Services: Retro Date(s) of Service

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)/ QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE FOR CalOptima USE ONLY

STATUS	Authorization Number #
☐ Approved	Signature: Date:
☐ Not a Covered Benefit	Comment::
☐ Not Medically Indicated	
☐ Alternative Treatment	
☐ Modified	
Affiliated Health Plan:	Phone No.:

d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.)

OneCare has Interdisciplinary Care Teams (ICT) that are aligned with the delegated delivery system. There are three (3) levels of ICTs that reflect the health risk status of members. All OneCare members are stratified using a plan developed stratification tool which utilizes information from data sources such as: acute hospital/emergency department utilization, severe and chronic conditions and pharmacy. The members are stratified into high, moderate and low risk levels.

The low risk members are managed by the basic ICT at the PCP level. Moderate members are managed by the primary ICT at the Medical Group level. High risk members are managed by the Complex ICT at the Plan level.

The members of the ICT include the member, if feasible, Medical Director, PCP, Specialist, Case Management Team, Behavioral Health Specialist, and Social Worker. The teams are designed to ensure that members' needs are identified and managed by an appropriately composed team. Additional disciplines such as the Clinical Pharmacist, Dietician and/or Long Term Care Manager may be included in the ICT based on the member's specific needs.

1. **Basic ICT for Low Risk Members - Basic Team at PCP level**
    - **Team Composition:** Member, Caregiver, or Authorized Representative, PCP, PCP support staff (Nurse, etc) and Specialist(s)
        - Roles and responsibilities of this team:
            - Basic case management including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of ICP
            - Communication with members or their representatives, vendors and medical group
            - Reviews and updates the ICP at list annually and when there is a change in the members health status
            - Referral to the primary ICT as needed

2. **Primary ICT for Moderate to High Risk Members - ICT at the Physician Medical Group (PMG) level**

    - **ICT Composition (appropriate to identified needs)** – Member, Caregiver, or Authorized Representative, PMG Medical Director, PCP and/or Specialist, Ambulatory Case Manager (CM), Hospitalist, Hospital CM and/or Discharge

Planners , PMG Utilization Management staff, Behavioral Health Specialist, and Social Worker

- Roles and Responsibilities of this Team
  - Identification and management of planned transitions
  - Case management of high risk members
  - Coordination ICPs for high risk members
  - Facilitating member, PCP and specialists and vendor communication
  - Identification and referral of members to OneCare Complex ICT
  - Meets as frequent as is necessary to coordinate and care and stabilize members medical condition
  -

3. **Complex ICT for High-Risk Members – OneCare Clinical Level**

- **Team Composition (As appropriate for identified needs):** Member, Caregiver, or Authorized Representative, OneCare/PMG Medical Director, OneCare Clinical/PMG Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist
  - Roles and responsibilities
    - Consultative for the PCP and PMG teams
    - Ensures member engagement and participation in the IDT process
    - Coordinating the management of members with complex transition needs and development of ICP
    - Providing support for implementation of the ICP by the PMG
    - Tracks and trends the activities of the IDTs
    - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
    - Oversight of the activities of all transition activities at all levels of the delivery system
    - Meets as often as needed until members condition is stabilized.

The nurse/case managers are responsible for follow-up on interventions recommended by the ICT. The member is in case management and has frequent communication with the Case Manager who ensures all recommended interventions are completed. The information from each ICT becomes part of the member's medical record at the PCP's office. The Primary and Complex ICT information is also stored in the Plan and physician group medical management systems. Copies of the ICP from these ICT levels are sent to the PCP and other providers of care. Information is stored at the Plan and a physician group medical management system is also available to the PCP at the point of care. All the information is stored in compliance with State, Federal and HIPAA requirements.

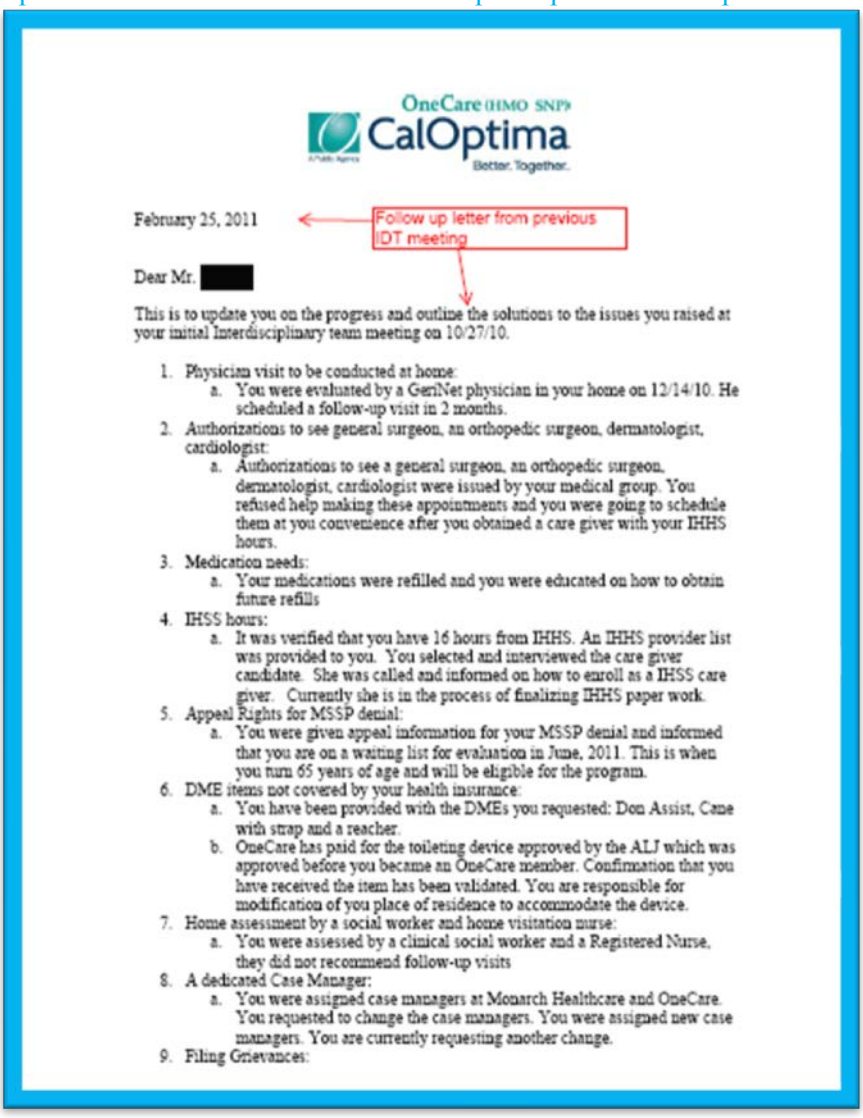
OneCare has an integrated system of communication with its members, network physicians and other healthcare services providers. This system uses different methods of communication to meet the varying communication capabilities of our members, providers and other stakeholders. These methods include but are not limited to phone, face-to-face, fax, web-based and written. When indicated, the information is translated to the member's primary language. These methods

are all used to communicate information between ICTs, members, plan and physician group, PCP and other providers of health care services.

1. Example of communication to PCP and member. This member had participated in a level 2 primary ICT. The example below shows that she received the resultant care plan from the ICT. A copy was also sent to the PCP. Also noted that the ICT had been completed with the member via telephone.

12/10/2010 10:32 AM	Task Comment	Received care plan from Lindsey Krogh, SW at OneCare. Mailed copy to mbr & also to Dr. Crawford, pcp.	Donna Craig RN
12/3/2010 1:13 PM	Telephone	IDT completed with mbr in attendence via telephone. OneCare will request evidenced based guidelines for Chlamydia & give to Dr. Crawford, pcp. They will provide the team as well as the mbr with a care plan.	Donna Craig RN

2. Example of communication to member who participated in a complex ICT:



OneCare (HMO SNP)
CalOptima
Better. Together.

February 25, 2011 ← Follow up letter from previous IDT meeting

Dear Mr. [redacted]

This is to update you on the progress and outline the solutions to the issues you raised at your initial Interdisciplinary team meeting on 10/27/10.

1. Physician visit to be conducted at home:
   a. You were evaluated by a GeriNet physician in your home on 12/14/10. He scheduled a follow-up visit in 2 months.
2. Authorizations to see general surgeon, an orthopedic surgeon, dermatologist, cardiologist:
   a. Authorizations to see a general surgeon, an orthopedic surgeon, dermatologist, cardiologist were issued by your medical group. You refused help making these appointments and you were going to schedule them at you convenience after you obtained a care giver with your IHHS hours.
3. Medication needs:
   a. Your medications were refilled and you were educated on how to obtain future refills
4. IHSS hours:
   a. It was verified that you have 16 hours from IHHS. An IHHS provider list was provided to you. You selected and interviewed the care giver candidate. She was called and informed on how to enroll as a IHSS care giver. Currently she is in the process of finalizing IHHS paper work.
5. Appeal Rights for MSSP denial:
   a. You were given appeal information for your MSSP denial and informed that you are on a waiting list for evaluation in June, 2011. This is when you turn 65 years of age and will be eligible for the program.
6. DME items not covered by your health insurance:
   a. You have been provided with the DMEs you requested: Don Assist, Cane with strap and a reacher.
   b. OneCare has paid for the toileting device approved by the ALJ which was approved before you became an OneCare member. Confirmation that you have received the item has been validated. You are responsible for modification of you place of residence to accommodate the device.
7. Home assessment by a social worker and home visitation nurse:
   a. You were assessed by a clinical social worker and a Registered Nurse, they did not recommend follow-up visits
8. A dedicated Case Manager:
   a. You were assigned case managers at Monarch Healthcare and OneCare. You requested to change the case managers. You were assigned new case managers. You are currently requesting another change.
9. Filing Grievances:

e. Describe how the MAO assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to MAO Medical Director for review, etc.)

The OneCare Medical Data Management Department analyses data from multiple sources including UM, QM, and Case Management on a regular basis. This data is reviewed by OneCare Quality department to identify area of clinical performance that can be improved by the use of clinical practice guidelines. The data analysis is presented to the Clinical Quality Improvement Subcommittee (CQIC).

The Quality Committee refers the request for clinical practice guidelines to its Clinical Quality Improvement Subcommittee (CQIC). The Manager of Quality Improvement researches the literature and identifies current nationally accepted evidenced based clinical guidelines pertinent to the area chosen for improvement. The guidelines are sent to practicing physicians, in the specialty of the guideline, for review and recommendation of changes to ensure the guideline meets local community standards. Upon approval by the CQIC, the summary page of the guideline is posted on the CalOptima website with a link to the detailed guideline. The summary page is also blast faxed to all physicians and hard copies are mailed to all Primary Care Providers. The approved guidelines are reviewed and update at least every 2 years or as needed when national updates occur.

For example, in 2010, OneCare reviewed and adopted the following evidenced based clinical guidelines:

- In 2010, OneCare reviewed and adopted the American Diabetics Association Guideline for the Management of Type II Diabetes.
- In 2010, OneCare reviewed, adopted and implemented the American Psychiatric Association guideline for major depression management in primary care.
- United States Preventive Services Task Force (USPSTF) 2010, OneCare reviewed and adopted the USPSTF adult preventive care guidelines

The CQIC is responsible for reviewing, and approving evidenced based clinical guidelines. The CQIC also has the responsibility for monitoring the use of the approved guidelines within the network. The CQIC is a subcommittee of Quality Improvement Committee (QIC) which reports to the Quality Assurance Committee (QAC) of the CalOptima Board of Directors. Membership of the CQIC include but is not limited to the Chief Medical Officer, Medical Director of OneCare, practicing physicians from the network, OneCare Directors of CM, QI and Health services and a Behavioral Health Practitioner.

OneCare monitoring of the use of clinical guidelines takes place in different forms including medical record review, utilization review and clinical incentive review.

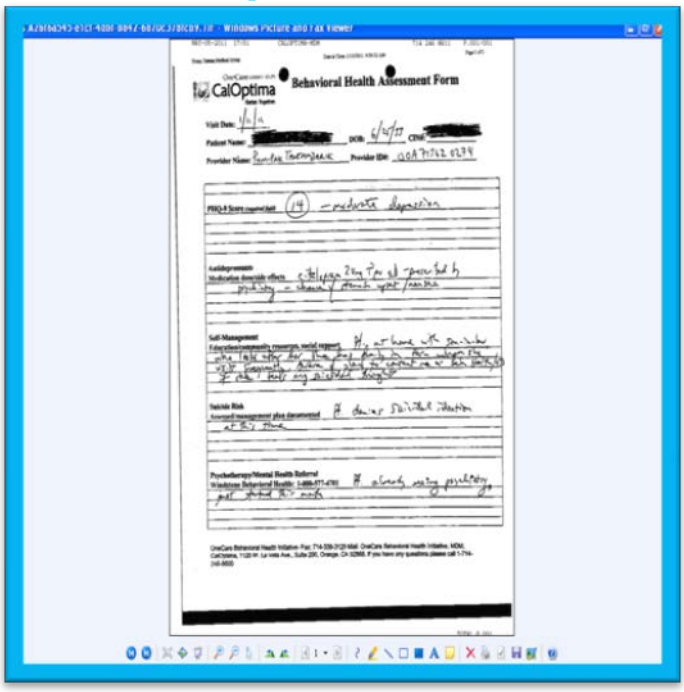
Examples of Result showing effectiveness of use of 2010 guidelines:

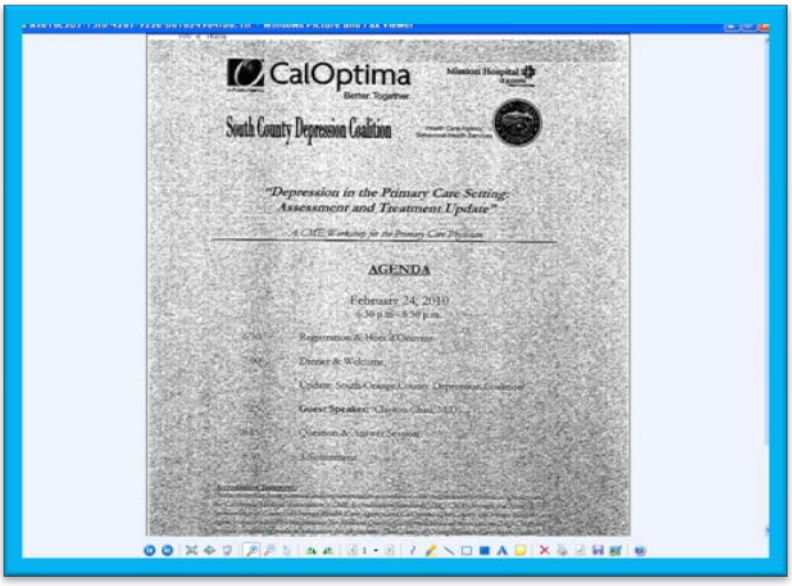
1. Review and analysis of 2009 data identified diabetes as the primary diagnosis for all utilization area in OneCare. In 2010 OneCare reviewed and adopted the American Diabetics Association Guideline for the Management of type II Diabetes. As part of the implementation of use of the guideline, OneCare hosted training programs on management of type 2 diabetes. One was a network wide CME for providers and CEU program for nurses titled: Recent advances in the treatment of type 2 diabetes. Appropriate management of diabetes was part of the 2010 provider incentive program. HEDIS 2011showed significant improvement on the diabetes measures over 2010

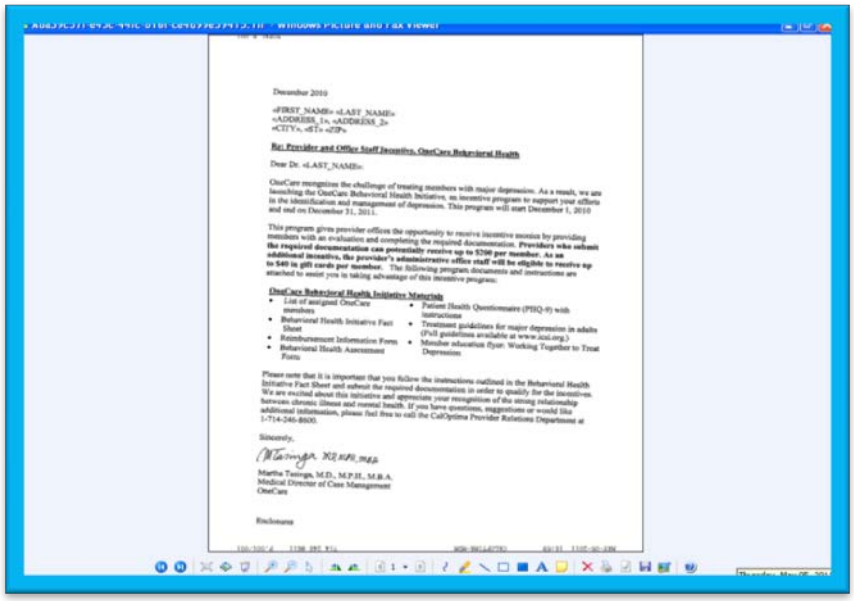
2. Pharmacy review of the prescribing patterns for the use of clinical guidelines on the use of disease modifying anti-rheumatoid medications showed opportunity for improvement. Letters containing the clinical pathway were sent to the physicians and an on-going report that tracked compliance was instituted. Recent registries show improvement and the preliminary HEDIS results shows increased use of the appropriate medication.

3. OneCare behavioral health screening program shows that 5.6% of OneCare members have a confirmed diagnosis of major depression through OneCare behavioral health screening program. Analysis of utilization data shows that 85% of these patients are being managed by the PCP. Analyses of pharmacy data showed that majority of the patients were receiving sub-optimal doses of antidepressants. This management by the PCPs was also not compliant with evidenced based recommendation for management of acute and chronic phase of major depression not getting adequate dosing and the acute phase and chronic phase management part of the guideline was not consistent with established guidelines for managing depression in primary care. OneCare reviewed, adopted and implemented the American Psychiatric Association guideline for major depression management in primary care. As part of the implementation, OneCare hosted network wide CME program on depression for network physicians. OneCare also hosted an education program with CEUs for nurses titled “Depression Fundamentals”. OneCare has developed and implemented an incentive program on Depression Management. To receive pay-out from the incentives, the physician has to submit for review completed Behavioral Health Assessment Form.

Behavioral Health Depression Tools:







Dear Dr. «LAST_NAME»,

OneCare recognizes the challenge of treating members with major depression. As a result, we are launching the OneCare Behavioral Health Initiative, an incentive program to support your efforts in the identification and management of depression. This program will start December 1, 2010 and end on December 31, 2011.

This program gives provider offices the opportunity to receive incentive monies by providing members with an evaluation and completing the required documentation. **Providers who submit the required documentation can potentially receive up to $200 per member. As an additional incentive, the provider's administrative office staff will be eligible to receive up to $40 in gift cards per member.** The following program documents and instructions are attached to assist you in taking advantage of this incentive program:

OneCare Behavioral Health Initiative Materials

- List of assigned OneCare members
- Behavioral Health Initiative Fact Sheet
- Reimbursement Information Form
- Behavioral Health Assessment Form
- Patient Health Questionnaire (PHQ-9) with instructions
- Treatment guidelines for major depression in adults (Full guidelines available at www.icsi.org.)
- Member education flyer: Working Together to Treat Depression

Please note that it is important that you follow the instructions outlined in the Behavioral Health Initiative Fact Sheet and submit the required documentation in order to qualify for the incentives. We are excited about this initiative and appreciate your recognition of the strong relationship between chronic illness and mental health. If you have questions, suggestions or would like additional information, please feel free to call the CalOptima Provider Relations Department at 1-714-246-8800.

Sincerely,

Martha Twinga, M.D., M.P.H., M.B.A.
Medical Director of Case Management
OneCare

Enclosures

6. Model of Care Training for Personnel and Provider Network

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

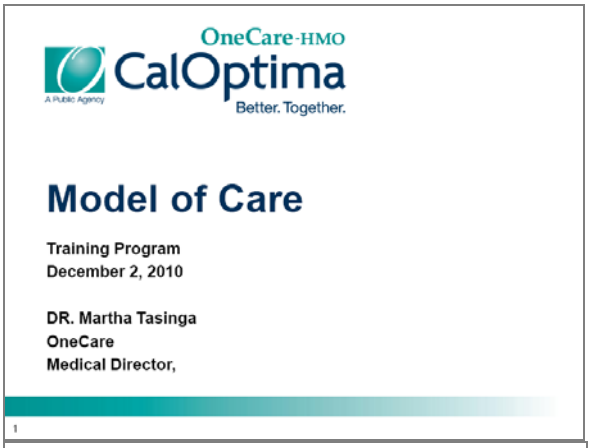
OneCare ensures that a physician group has the capacity and operational processes in place prior to delegation of any services. OneCare provides extensive training to the physician group's staff prior to the effective date of the delegation agreement. OneCare employees are provided the MOC training as part of their comprehensive orientation. The training includes the components and goals of the OneCare Model of Care, the roles and responsibilities of the OneCare staff, the OneCare specialized programs, the essential role of the OneCare network and the evaluation of the Model of Care. Model of Care training is provided to all new employees, and annually to all employed and contracted staff, and providers. Training is also provided to the services and administrative staffs of the delivery system when there are procedural, benefits or regulatory changes that affect the activities of the Model of Care. The methods used for training include, but are not limited to, face-to-face, interactive, web based platforms and paper format.
OneCare notifies employed and contracted staff, and providers of annual MOC training through newsletters and emails. The MOC training is also conducted annually at Joint Operations Meetings held with the physician medical groups.

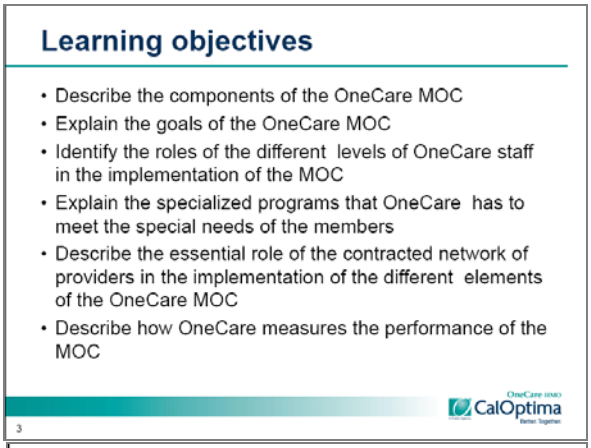
- Training Frequency
  - Initial
    - Total participants = 143
  - Annual
    - Total participants = 276 (in 2011 year-to-date)

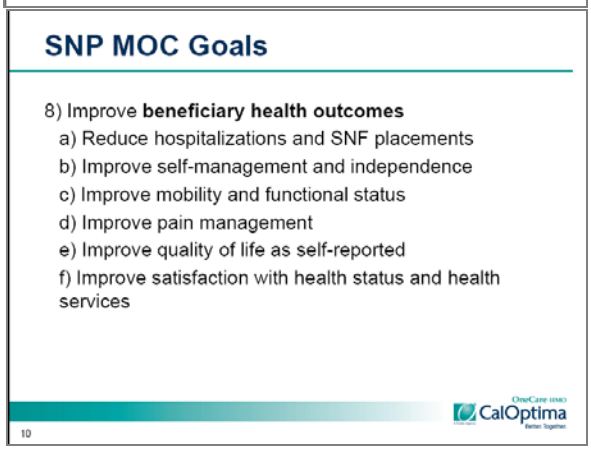
        - In response to changes or updates to policies and procedures that affect the MOC and changes in national and regionally utilized criteria, guidelines and protocols
- Target audience is the administrative, clinical and oversight staff which includes:
    - OneCare employees
    - PMGs
    - Contracted providers
- Training Strategy
    - Face to Face Presentations
        - Interactive forums
        - Printed materials provided
        - Training session evaluation
    - Web based
        - Self paced and interactive
        - Printed materials available
        - Post test required to assess knowledge
- Content
    - Model of Care Training Agenda
        - OneCare's SNP Population
        - Measurable Goals
        - Staff Structure and Case Management Roles
        - OneCare Interdisciplinary Care Team (IDT)
        - Provider Network Having Special Expertise and Use of Clinical Guidelines
        - Training on the Model of Care
        - Health Risk Assessment (HRA)
        - Individualized Care Plan (ICP)
        - Communication Network
        - Performance & Health Outcome Measurements

EXAMPLES:

1. Sample of slides from MOC training held on 12/2/10:

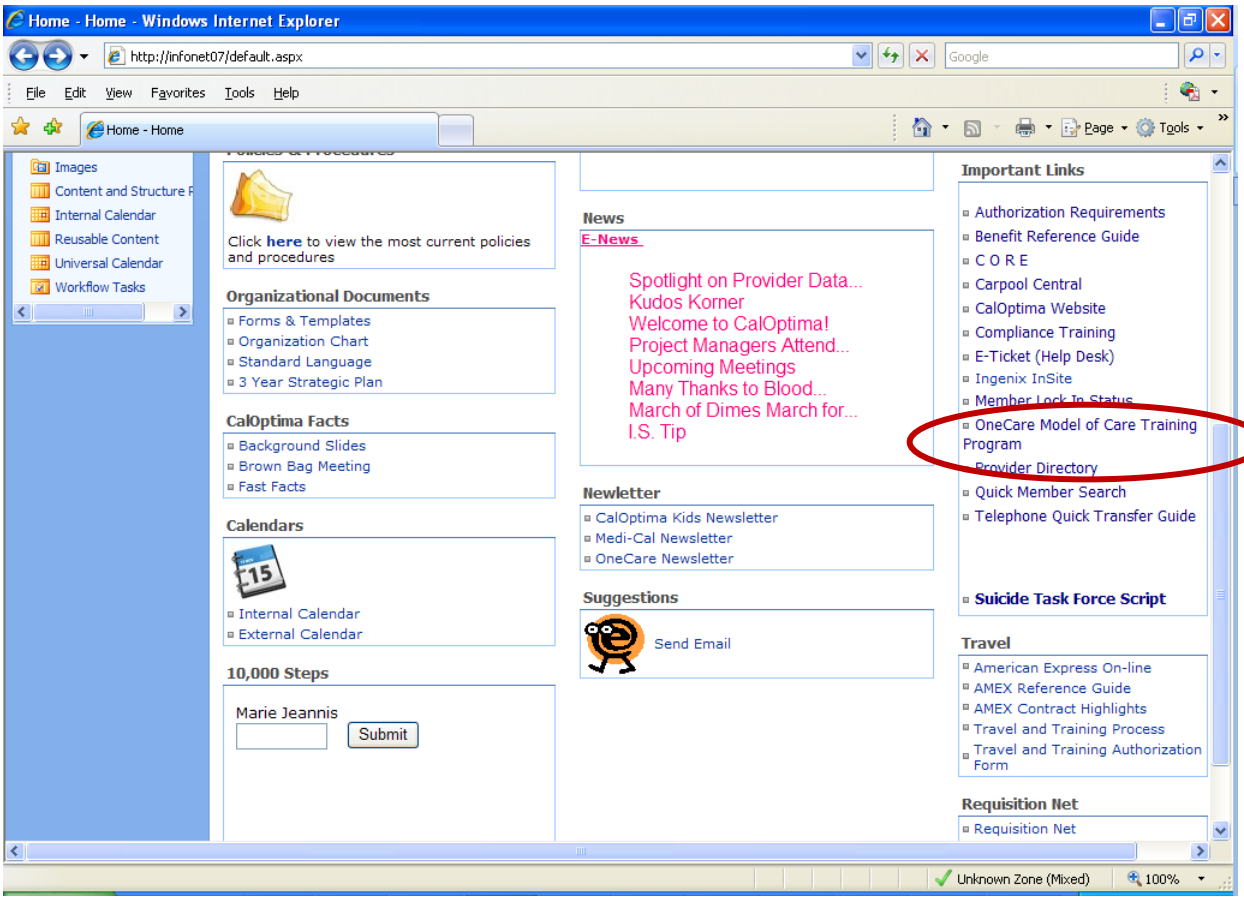






2. Provider web-based link to OneCare MOC training

3. Internal Staff web-based link to OneCare MOC training



4. Email notification of annual MOC training (strategy to engage staff)

From: Nate, Byron
Sent: Tuesday, April 05, 2011 4:44 PM
To: Gamel, Ginny
Subject: FW: OneCare MOC Training - Sent to all appropriate CalOptima staff

OneCare-HMO CalOptima Better. Together.

Greetings from OneCare!

On behalf of OneCare, we are asking your cooperation to complete the CMS Model of Care Training. The Center for Medicare and Medicaid (CMS) requires all Medicare Advantage Special Needs Plans (MA-SNP) to complete a Model of Care (MOC) training.

What is the Model of Care (MOC)?

It is the architecture for care management policy, procedures, and operational systems.

Who needs to take the training?

CMS requires all employed personnel and providers of the SNP to be trained on the MOC. This includes anyone who interacts with OneCare members or Providers.

When is the deadline to training?

This training is mandatory and must be completed by March 31, 2011.

You can access the training through the infonet at http://infonet07/default.aspx under the "Important Links" section. At the end of the training, it will prompt you to click on the MOC Assessment. Please complete the assessment then you're done!

Please contact Dr. Tasinga X8794 or Freddy Reynoso X3253 if you have any questions.
Your cooperation in this matter is greatly appreciated.

Byron Naté, MPH
Senior Health Educator
CalOptima
1120 W. La Veta Ave.
Orange, CA 92868
tel: (714) 347-3203
fax: (714) 338-3128
bnate@caloptima.org

Please consider the environment before printing this e-mail

4. JOM Agenda with MOC Training

OneCare-HMO
CalOptima
Better. Together.

Bristol Park Medical Group

March 10, 2011
Joint Operation Meeting

	TOPIC:	Presenter:	Pg. #
I.	**PMG Issues**		
II.	**Follow-up Action Items**		
III.	**Program Updates** 1. Enrollment a. Eligibility Trend Report ***(handout)*** b. Disenrollment Summary Report ***(handout)*** c. Retrospective Treand Analysis ***(handout)*** d. 2011 OneCare Benefits 2. Processing Physicians Incentives	**Ted Holloway** Manager, OneCare Sales & Marketing **Kurt Hubler** Executive Director, OneCare	1 2 A
IV.	**OneCare Star Ratings Update** 1. CAHP Scores ***(handout)***	**Kurt Hubler** Executive Director, OneCare	3-20
V.	**Medical Management** 1. Model of Care Training 2. SNP Structure & Process Update 3. Bed Day Report ***(handout)*** 4. Individual Care Plan (ICP) Update 5. Inter-Disciplinary Transitions Team (IDT) Update 6. Risk Stratification 7. Organizational Determinations/Reconsiderations Report ***(handout)*** 8. Windstone Outreach Program ***(handout)*** 9. Dental Anesthesia	**Martha Tasinga, M.D.** OneCare Medical Director	21 22-27 28-32
VI.	**HEDIS** 1. HEDIS Activities Report Update ***(handout)*** 2. Depression Medication Update	**Martha Tasinga, M.D.** OneCare Medical Director	33-40
VII.	**HCC Report** 1. Ingenix Timeline Update 2. 2011 HCC Scores ***(handout)*** 3. Encounters Submission MG Profile ***(handout)*** a. Professional Files Submitted 4. Coding Source Medical Record Review Audits	**Kurt Hubler** Executive Director, OneCare	41-43 44-45 46

5. Model of Care Training Log – Number of participants was 32. Example shows scores of the post-training test:

Model Of Care Assessment Results:

#	Email Address	Full Name	Date	Time	Score
1.	asaucedo@caloptima.org	BECERRA, ANGIE	2/3/2011	0:03:20	100%
2.	lbupp@caloptima.org	BUPP, LISA	2/10/2011	0:02:13	90%
3.	rcabral@caloptima.org	CABRAL, RICK	1/12/2011	0:02:18	100%
4.	semerzian@caloptima.org	EMERZIAN, SHIRLEY	2/14/2011	0:12:53	100%
5.	pfay@caloptima.org	FAY, PAUL	2/3/2011	0:09:16	100%
6.	mflores@caloptima.org	FLORES, MARIAH	2/10/2011	0:13:39	100%
7.	ggamel@caloptima.org	GAMEL, GINNY	1/7/2011	0:02:42	100%
8.	ogarcia@caloptima.org	GARCIA , OLGA	2/10/2011	0:12:41	90%
9.	tgracia@caloptima.org	GRACIA, TONY	2/11/2011	0:02:19	100%
10.	thitzeman@caloptima.org	HITZEMAN, TRACY	1/24/2011	0:02:52	90%
11.	tholloway@caloptima.org	HOLLOWAY, TED	2/3/2011	0:15:31	100%
12.	klhunt@caloptima.org	HUNT, KAREN	2/1/2011	0:14:47	90%
13.	mjeannis@caloptima.org	JEANNIS, MARIE	4/5/2011	0:03:04	100%
14.	sjones@caloptima.org	JONES, SUE	2/9/2011	0:06:08	70%
15.	lkrogh@caloptima.org	KROGH, LINDSEY	1/24/2011	0:00:56	100%
16.	cloria@caloptima.org	LORIA, CINDY	1/13/2011	0:15:21	90%
17.	jluna@caloptima.org	LUNA, JAMES	2/7/2011	0:08:41	100%
18.	amagana@caloptima.org	MAGANA, ALICIA	Incomplete	Inc.	Inc.
19.	smarton@caloptima.org	MARTON, SHEILA	1/11/2011	0:04:14	100%
20.	smoyer@caloptima.org	MOYER, SALLY	2/3/2011	0:18:42	80%
21.	lnguyen@Caloptima.org	NGUYEN, LUCIE	2/15/2011	0:03:11	100%
22.	tnguyen@CalOptima.org	NGUYEN, TAMMY	2/10/2011	0:04:29	100%
23.	dpickell@caloptima.org	PICKELL, DALILA	1/24/2011	0:21:01	100%
24.	apruitt@caloptima.org	PRUITT, ANNIE	2/18/2011	0:10:09	90%
25.	crevel@caloptima.org	REVEL, MARI CARMEN	2/16/2011	0:10:18	90%
26.	ssaia@caloptima.org	SAIA, SARAH	1/19/2011	0:05:53	100%
27.	tto@caloptima.org	TO, TRACY	1/11/2011	0:08:28	90%
28.	stoledo@caloptima.org	TOLEDO, SANDRA	2/15/2011	0:07:39	100%
29.	vtran@caloptima.org	TRAN, VINH	1/12/2011	0:02:13	100%
30.	avalentine@caloptima.org	VALENTINE, ALEXES	2/11/2011	0:01:30	100%
31.	hvuong@caloptima.org	VUONG, HELEN	2/10/2011	0:03:15	100%
32.	mvuong@caloptima.org	VUONG, MINH (ALVIN)	2/18/2011	0:26:26	100%

6. Sign in sheet for an Initial MOC Training. Total participants - 29

OneCare Model of Training
Thursday, December 2, 2010
Sign-In Sheet

	Signature	Print Name	Organization
1	[illegible]	Kimberly Blue	Talbert / HCP
2	[illegible]	Cynthia Holt	Health Care Partners
3	[illegible]	Gary Emmons	GNP
4	[illegible]	Pamela Gross	GNP
5	[illegible]	Arunt Merz	Monarch
6	[illegible]	Teri miranti	Monarch
7	[illegible]	Linda Stephens	Monarch
8	[illegible]	Lois R Johnson	Monarch
9	[illegible]	Jeremias Azuela	AltaMed
10	[illegible]	Genevieve Angel	AltaMed
11	[illegible]	christine Hugh	AMVI / Prospect
12	[illegible]	Kurt Hubler	OneCare
13	[illegible]	Shellianne Redding	Bristol Park
14	[illegible]	Karen Lynn Joyce	Bristol Park
15	[illegible]	Char Jones	Bristol Park

OneCare Model of Training
Thursday, December 2, 2010
Sign-In Sheet

	Signature	Print Name	Organization
16	[illegible]	Dawn Geesink	BPMG
17	[illegible]	Ginny Gamel	OneCare California
18	[illegible]	Peter [illegible]	CalOptima
19	[illegible]	Jim Banks	CalOptima
20	[illegible]	NANCY MACKEY	CAL O
21	[illegible]	WALTER PRYCE, M.D.	PROSPECT
22	[illegible]	Halima Rascus	AltaMed
23	[illegible]	Amy Wong	Alta Med
24	[illegible]	Betsy Chang Ha	AltaMed
25	[illegible]	Gloria Jenkins	AltaMED
26	[illegible]	Dorenne Renteria	AltaMed
27	[illegible]	Margo Beers	AltaMed
28	[illegible]	Shirley Emerzian	Cal Optima
29	[illegible]	THUY NGUYEN	FCMG
30			

7. Web base Annual MOC Training - Sample participant log. Total participants for 2011 annual training (to date) is 276

Monarch HealthCare Model of Care Training Results

First Name	Last Name	Email Address	Functional Role	Health Network	Final Score	Pass/ Fail	Date Finished	Times Taken
MARY	CHASE	mchase@mhealth.cm	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/9/2011 18:03	1
ROMELAINE	PABLO-ASUNCION	Rpablo-Asuncion@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
DARYL	LOVE	dlove@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
DONNA	CRAIG	dcraig@mhealth.com	RN / LVN	MONARCH HEALTH CARE	100	Pass	3/10/2011 12:01	1
ELIANE	SANTOS	esantos@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:03	1
ANITA	SEAMSTER	aseamster@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:03	1
STAR	ALISON	sallison@mhealth.com	RN / LVN	MONARCH HEALTH CARE	100	Pass	3/10/2011 12:10	1
PATTI	HOUGHTON	phoughton@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:10	1
LETICIA	JUAREZ	lrjuarez@mhealth.com	Non-Clincal Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
ERIC	MCDANIEL	emcdaniel@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
PAMELA	BELTRAN	pbeltran@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
CARITA	SATOLA	csatola@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
BETHANY	COFFEY	bcoffey@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:15	1
XOCHILT DESIREE	RAMIREZ	dramirez@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:17	1
YOLANDA	GARCIA	ygarcia@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:17	1
LYNN	GAST	lgast@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:20	1
PATRICIA	ROMERO	tromero@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:39	1

8. Example of Post Test evaluation results

Model of Care (MOC) Assessment

MCKESSON
Empowering Healthcare

Review Results

Assessment ID: MODEL-OF-CARE-ASSMNT

Email Address:	mjeannis@caloptima.org
Full Name:	JEANNIS, MARIE
Health Network Name:	(IF APPLICABLE)
Functional Role:	RN / LVN
Date Started:	04/05/2013 3:19:04 PM
Date Completed:	04/05/2013 3:22:08 PM

Question Group		
Num	Question	
Model of Care Questions.		Earned 10 of 10 points (100%).
☑ 1.	The Center for Medicare and Medicaid (CMS) requires all Medicare Advantage Special needs Plans (MA-SNP) to have a Model of care (MOC) Correct Answer: True	
☑ 2.	Which of the following is not a OneCare Model of Care measurable goals: Correct Answer: b. Increase the number of emergency room visits	
☑ 3.	OneCare service delivery roles include: Correct Answer: d. All of the above.	
☑ 4.	OneCare conducts initial (30 days) and bi-annual health risk assessments for EACH beneficiary. Correct Answer: False	
☑ 5.	Which of the following is not part of the individualized care plan: Correct Answer: c. Scope of Work	
☑ 6.	What is the role of the interdisciplinary care team? Correct Answer: d. All of the above	
☑ 7.	Which of the following is not an OneCare specialized programs? Correct Answer: b. Childhood obesity program	
☑ 8.	The following processes and resources are in place to facilitate communication: Correct Answer: d. All of the above	
☑ 9.	OneCare supports the physician management of chronic conditions by dissemination of best practices, evidence-based guidelines and provider tool kits to promote education and adherence. Correct Answer: True	
☑ 10.	OneCare uses results of data collected and analyzed to: Correct Answer: d. All of the above	

Final Score: 100%

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

OneCare monitors and tracks compliance with completion of MOC training. Minutes and sign in sheets are collected and stored to document face-to-face participation. They are made available to regulatory agencies as needed. OneCare uses commercially developed software to track and document participation and understanding for web based participation.

EXAMPLES:

1. Sample of MOC Assessment Results (MOC test results and confirmation of web-based attendance) – delegated and contracted staff

Monarch HealthCare Model of Care Training Results

First Name	Last Name	Email Address	Functional Role	Health Network	Final Score	Pass/ Fail	Date Finished	Times Taken
MARY	CHASE	mchase@mhealth.cm	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/9/2011 18:03	1
ROMELAINE	PABLO-ASUNCION	Rpablo-Asuncion@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
DARYL	LOVE	dlove@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
DONNA	CRAIG	dcraig@mhealth.com	RN / LVN	MONARCH HEALTH CARE	100	Pass	3/10/2011 12:01	1
ELIANE	SANTOS	esantos@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:03	1
ANITA	SEAMSTER	aseamster@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:03	1
STAR	ALISON	sallison@mhealth.com	RN / LVN	MONARCH HEALTH CARE	100	Pass	3/10/2011 12:10	1
PATTI	HOUGHTON	phoughton@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:10	1
LETICIA	JUAREZ	lrjuarez@mhealth.com	Non-Clincal Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
ERIC	MCDANIEL	emcdaniel@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
PAMELA	BELTRAN	pbeltran@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
CARITA	SATOLA	csatola@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
BETHANY	COFFEY	bcoffey@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:15	1
XOCHILT DESIREE	RAMIREZ	dramirez@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:17	1
YOLANDA	GARCIA	ygarcia@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:17	1
LYNN	GAST	lgast@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:20	1
PATRICIA	ROMERO	tromero@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:39	1

2. Sample of MOC Assessment Results (MOC test results and confirmation of web-based attendance) – internal staff

Model Of Care Assessment Results:

#	Email Address	Full Name	Date	Time	Score
1.	asaucedo@caloptima.org	BECERRA, ANGIE	2/3/2011	0:03:20	100%
2.	lbupp@caloptima.org	BUPP, LISA	2/10/2011	0:02:13	90%
3.	rcabral@caloptima.org	CABRAL, RICK	1/12/2011	0:02:18	100%
4.	semerzian@caloptima.org	EMERZIAN, SHIRLEY	2/14/2011	0:12:53	100%
5.	pfay@caloptima.org	FAY, PAUL	2/3/2011	0:09:16	100%
6.	mflores@caloptima.org	FLORES, MARIAH	2/10/2011	0:13:39	100%
7.	ggamel@caloptima.org	GAMEL, GINNY	1/7/2011	0:02:42	100%
8.	ogarcia@caloptima.org	GARCIA , OLGA	2/10/2011	0:12:41	90%
9.	tgracia@caloptima.org	GRACIA, TONY	2/11/2011	0:02:19	100%
10.	thitzeman@caloptima.org	HITZEMAN, TRACY	1/24/2011	0:02:52	90%
11.	tholloway@caloptima.org	HOLLOWAY, TED	2/3/2011	0:15:31	100%
12.	klhunt@caloptima.org	HUNT, KAREN	2/1/2011	0:14:47	90%
13.	mjeannis@caloptima.org	JEANNIS, MARIE	4/5/2011	0:03:04	100%
14.	sjones@caloptima.org	JONES, SUE	2/9/2011	0:06:08	70%
15.	lkrogh@caloptima.org	KROGH, LINDSEY	1/24/2011	0:00:56	100%
16.	cloria@caloptima.org	LORIA, CINDY	1/13/2011	0:15:21	90%
17.	jluna@caloptima.org	LUNA, JAMES	2/7/2011	0:08:41	100%

3. Sample page from sign in sheet at face-to-face MOC training

OneCare Model of Training
Thursday, December 2, 2010
Sign-In Sheet

	Signature	Print Name	Organization
1		Kimberly Blue	Talbert / HCP
2		Cynthia Holt	Healthcare Partners
3		Gary Emmons	GNP
4		Panda Gross	GNP
5		Brent Merz	Monarch
6		Teri miranti	Monarch
7		Linda Stephens	Monarch
8		Lois R Johnson	MONARCH
9		JEREMIAS AZUELA	ALTAMED
10	Genevieve Angel	Genevieve Angel	ALTAMED
11		Christine Huynh	AMVI / Prospect
12		Kurt Hubler	Ogelare
13		Shellianne Redding	Bristol Park
14		Karen Lynn Joyce	Bristol Park
15		Char Jones	Bristol Park

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

The Medical Director of OneCare, Director of Case Management and Manager of Case Management are responsible for the provision of MOC training. The Medical Director of OneCare and the Quality Improvement Manager are responsible for monitoring the completion of the MOC training. Reports of completion are generated on a quarterly basis and forwarded to the Quality Improvement Manager. The Medical Director reviews the report with the Quality Improvement Manager and identifies areas of deficiency which are reported to the Compliance Department for action and follow up. OneCare identifies the individuals responsible for the training and oversight of the MOC through the hiring and interview process. During the interview process education, skills and previous experience in the development, implementation and oversight of models of care for special populations are assessed and given priority. MOC training is a core responsibility in the job description for these individuals.

- **Medical Director, OneCare**
  - **Experience & Education Requirements:**
    - Current, valid, unrestricted California Physician & Surgeon's License with Board certification in area of specialty
    - Considerable experience in medical management, quality management, and utilization management in a managed care setting
  - **Roles and Responsibilities:**
    - Oversight responsibility for the delivery of medical services for OneCare members including the Model of Care
    - Quality Improvement projects and new programs
    - Provider education regarding Clinical Practice Guidelines
    - Consultant and conduit for the delegated entities
    - Manages medical aspects of contracts for services, oversees authorization for service and quality assurance for OneCare
    - Reviews complex cases and participates in the ICT process
    - Ensure policies and procedures are compliant with regulatory and accreditation requirements
    - Review of all appeals and second level provider grievances

- **Director, Case Management**
  - **Experience & Education Requirements:**
    - Extensive experience that would provide the knowledge and abilities listed above, including at least 3 years as a manager
    - HMO, Medi-Cal/Medicare and insurance experience or equivalent government client or public service experience preferred
    - California Licensed Registered Nurse.
    - Certified Case Manager (CCM) Preferred
    - Bachelor's degree in Nursing
    - Relevant Master's degree desirable
    - Knowledge of appropriate techniques to serve the SPD population and diverse social and ethnic groups

- **Roles and Responsibilities:**
    - Coordinate the Case Management and Disease Management program including the overall planning, promotion, implementation and evaluation of services to assure compliance regulatory and accreditation requirements
    - Responsible for planning, implementing and directing utilization management, case management, and disease management services
    - Assist in the development and implementation of quality improvement activities
    - Develop staffing and budget plan and monitor resource allocation for the department

- **Manager, Case Management**
    - **Experience & Education Requirements:**
        - Registered Nurse with a valid CA license
        - Certified Case Manager (CCM) Preferred
        - At least 5 years of managed care experience
        - Clinical experience with seniors and persons with disabilities preferred
        - Associates or Bachelors Degree in Nursing
        - Supervisory experience required (of clinical and non-clinical staff)
        - Senior management experience preferred
        - Knowledge of Medicare and Medi-Cal regulations and standards of practice
        - Appropriate strategies to serve diverse social and ethnic groups
    - **Roles and Responsibilities:**
        - Responsible for the daily operations and activities of the OneCare clinical team
        - Responsible for the oversight of the OneCare Special SNP (Special Needs Plan) processes to ensure compliance with regulatory and accreditation requirements
        - Works with the Director/Medical Director to develop, implement and evaluate the department's OneCare policies, procedures, processes and program structure
        - Manages the daily activities and performance of the OneCare team, included but not limited to; Care Transition, care coordination/case management and coordination of benefits/services
        - Works closely with delegated groups to assure the effectiveness and efficiency of the program
        - Evaluates need and provides educational training to staff and delegated entities

Manager, Quality Improvement

- **Experience & Education:**
    - Registered Nurse plus relevant Bachelor's degree in a health care field.
    - Master's degree and CPHQ certification preferred.
    - Significant experience within a Managed Care Plan and Quality Management in a clinical setting.

- Drivers' license and vehicle or other approved means of transportation may be required for some assignments.
- Legislative, regulatory and quality requirements for health care service delivery to beneficiaries of the following programs: Medi-Cal, Healthy Families (HF), Medical Services for Indigents (MSI), and Medicare.
- Clinical issues related to the successful achievement of quality improvement initiatives.
- Principles and techniques of project management to ensure that numerous goals, objectives and detailed actions are properly identified and their status monitored.
- Principles and practices of managed health care, health care systems, and medical administration.

- **Roles & Responsibilities:**
  - Responsible for all quality management and peer review functions such as quality of care monitoring, credentialing, facility site review, and delegation oversight
  - Direct the credentialing processes linked with physician profiling
  - Measurement and reporting use of Clinical Practice Guidelines
  - Educate the CalOptima staff and external customers on quality initiatives
  - Participates in, workgroups that address both clinical and non-clinical internal activities for which CalOptima must demonstrate improvement to meet its contractual requirements

EXAMPLES:

1. Sample report of completion and test results – internal staff

Model Of Care Assessment Results:

#	Email Address	Full Name	Date	Time	Score
1.	asaucedo@caloptima.org	BECERRA, ANGIE	2/3/2011	0:03:20	100%
2.	lbupp@caloptima.org	BUPP, LISA	2/10/2011	0:02:13	90%
3.	rcabral@caloptima.org	CABRAL, RICK	1/12/2011	0:02:18	100%
4.	semerzian@caloptima.org	EMERZIAN, SHIRLEY	2/14/2011	0:12:53	100%
5.	pfay@caloptima.org	FAY, PAUL	2/3/2011	0:09:16	100%
6.	mflores@caloptima.org	FLORES, MARIAH	2/10/2011	0:13:39	100%
7.	ggamel@caloptima.org	GAMEL, GINNY	1/7/2011	0:02:42	100%
8.	ogarcia@caloptima.org	GARCIA , OLGA	2/10/2011	0:12:41	90%
9.	tgracia@caloptima.org	GRACIA, TONY	2/11/2011	0:02:19	100%
10.	thitzeman@caloptima.org	HITZEMAN, TRACY	1/24/2011	0:02:52	90%
11.	tholloway@caloptima.org	HOLLOWAY, TED	2/3/2011	0:15:31	100%
12.	klhunt@caloptima.org	HUNT, KAREN	2/1/2011	0:14:47	90%
13.	mjeannis@caloptima.org	JEANNIS, MARIE	4/5/2011	0:03:04	100%
14.	sjones@caloptima.org	JONES, SUE	2/9/2011	0:06:08	70%
15.	lkrogh@caloptima.org	KROGH, LINDSEY	1/24/2011	0:00:56	100%
16.	cloria@caloptima.org	LORIA, CINDY	1/13/2011	0:15:21	90%
17.	jluna@caloptima.org	LUNA, JAMES	2/7/2011	0:08:41	100%
18.	amagana@caloptima.org	MAGANA, ALICIA	Incomplete	Inc.	Inc.
19.	smarton@caloptima.org	MARTON, SHEILA	1/11/2011	0:04:14	100%
20.	smoyer@caloptima.org	MOYER, SALLY	2/3/2011	0:18:42	80%
21.	lunguyen@Caloptima.org	NGUYEN, LUCIE	2/15/2011	0:03:11	100%
22.	tnguyen@CalOptima.org	NGUYEN, TAMMY	2/10/2011	0:04:29	100%
23.	dpickell@caloptima.org	PICKELL, DALILA	1/24/2011	0:21:01	100%
24.	apruitt@caloptima.org	PRUITT, ANNIE	2/18/2011	0:10:09	90%
25.	crevel@caloptima.org	REVEL, MARI CARMEN	2/16/2011	0:10:18	90%
26.	ssaia@caloptima.org	SAIA, SARAH	1/19/2011	0:05:53	100%
27.	tto@caloptima.org	TO, TRACY	1/11/2011	0:08:28	90%
28.	stoledo@caloptima.org	TOLEDO, SANDRA	2/15/2011	0:07:39	100%
29.	vtran@caloptima.org	TRAN, VINH	1/12/2011	0:02:13	100%
30.	avalentine@caloptima.org	VALENTINE, ALEXES	2/11/2011	0:01:30	100%
31.	hvuong@caloptima.org	VUONG, HELEN	2/10/2011	0:03:15	100%
32.	mvuong@caloptima.org	VUONG, MINH (ALVIN)	2/18/2011	0:26:26	100%

2. Sample of report of completion and test results – delegated and contracted staff

Monarch HealthCare Model of Care Training Results

First Name	Last Name	Email Address	Functional Role	Health Network	Final Score	Pass/ Fail	Date Finished	Times Taken
MARY	CHASE	mchase@mhealth.cm	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/9/2011 18:03	1
ROMELAINE	PABLO-ASUNCION	Rpablo-Asuncion@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
DARYL	LOVE	dlove@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:01	1
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LETICIA	JUAREZ	lrjuarez@mhealth.com	Non-Clincal Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
ERIC	MCDANIEL	emcdaniel@mhealth.com	Clinical Support	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:13	1
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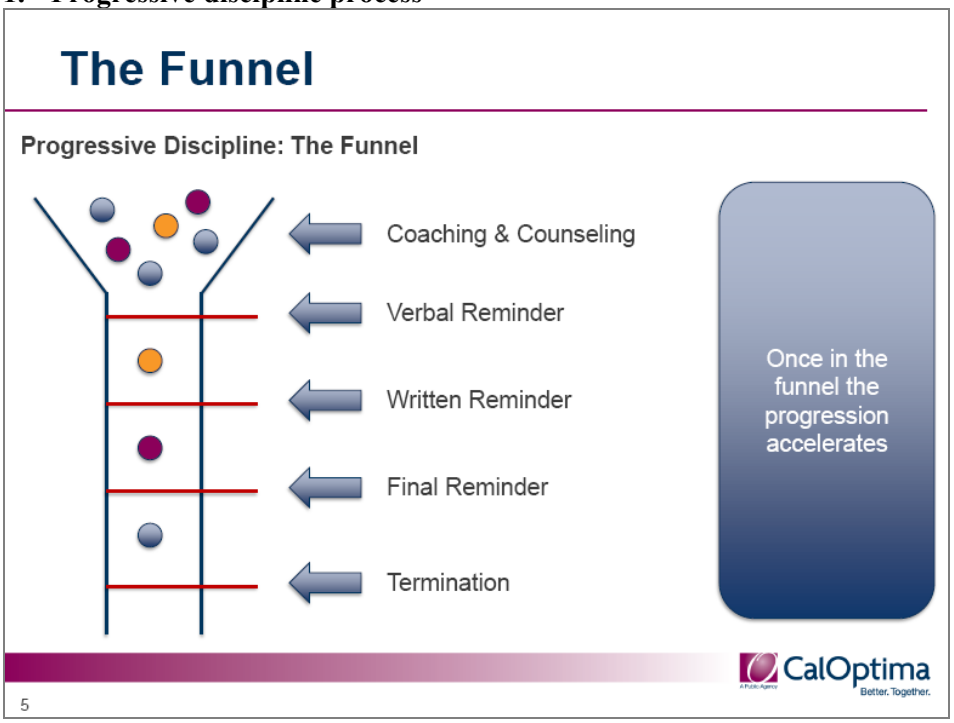
LYNN	GAST	lgast@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:20	1
PATRICIA	ROMERO	tromero@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:39	1

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

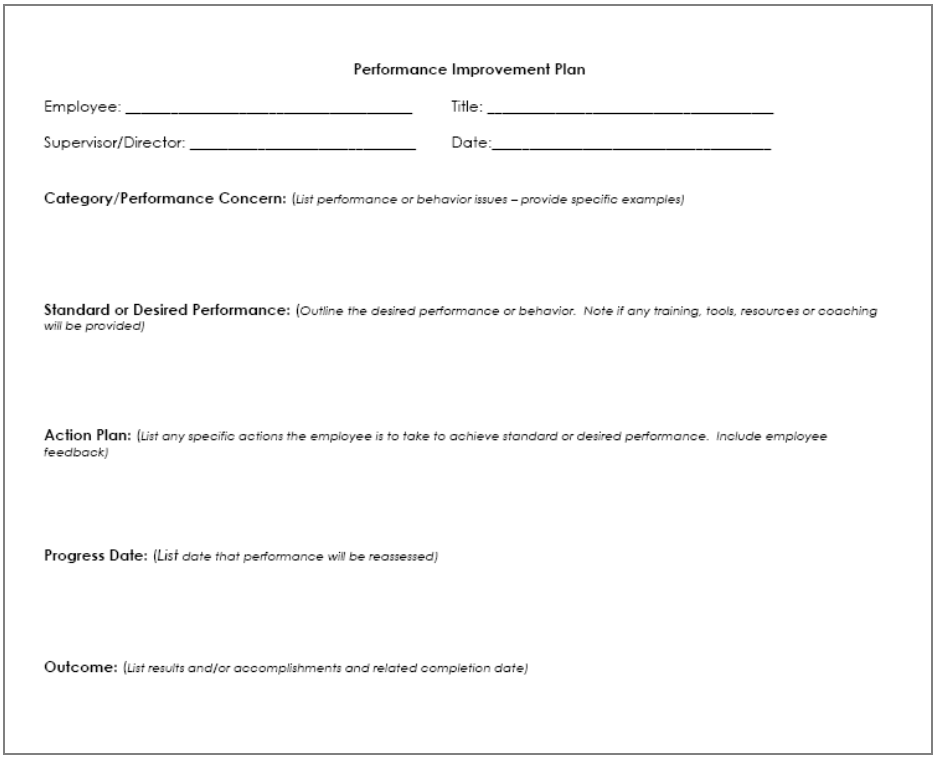
The Model of Care training is mandatory for all employed staff. Internal staff non-compliance is managed according to CalOptima's progressive discipline process. The purpose of CalOptima's progressive discipline process is to correct unacceptable performance and prepare for termination, if performance does not improve. The progressive discipline process addresses the identified disciplinary issue in a timely manner and implements a Performance Improvement Plan to rectify the behavior. Internal staff who fail to complete their MOC train are requested, as part of the Performance Improvement Plan, to complete the MOC within one week. Employees who do not complete the training are reminded by their supervisor to do so within a specific time frame. If they still do not complete the training they are given a verbal warning which is the first step in the above disciplinary process. If non-compliance continues they are suspended from OneCare employment until the training is completed. Example, one of the OneCare Quality employees did not complete training after several reminders. However, when threatened with suspension, the employee complied immediately and completed the training with a score of 100%.

EXAMPLES:

1. **Progressive discipline process**



2. **Performance Improvement Plan documentation template used for progressive discipline**



Performance Improvement Plan

Employee: _____ Title: _____

Supervisor/Director: _____ Date:_____

Category/Performance Concern: *(List performance or behavior issues – provide specific examples)*

Standard or Desired Performance: *(Outline the desired performance or behavior. Note if any training, tools, resources or coaching will be provided)*

Action Plan: *(List any specific actions the employee is to take to achieve standard or desired performance. Include employee feedback)*

Progress Date: *(List date that performance will be reassessed)*

Outcome: *(List results and/or accomplishments and related completion date)*

The training is also mandatory for the contracted network staff and providers. Contracted network staff and provider compliance is monitored. Identified areas of deficiency are reported to the Compliance Department for action and follow up. The Compliance Department shall notify the contracted network staff or provider of the deficiency and request immediate resolution. Continued non-compliance will be referred to the Compliance Committee for decision regarding potential sanction or de-delegation activities. The training is completed via web-based application and the monitoring is done electronically. OneCare Compliance oversees the completion and collection of the attestations of completion. In the event of non-compliance, the provider is notified via written notification. If continued non-compliance, the provider will be suspended from network participation in OneCare.

Monarch HealthCare Model of Care Training Results

First Name	Last Name	Email Address	Functional Role	Health Network	Final Score	Pass / Fail	Date Finished	Times Taken
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PAMELA	BELTRAN	pbeltran@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
CARITA	SATOLA	csatola@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:14	1
BETHANY	COFFEY	bcoffey@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:15	1
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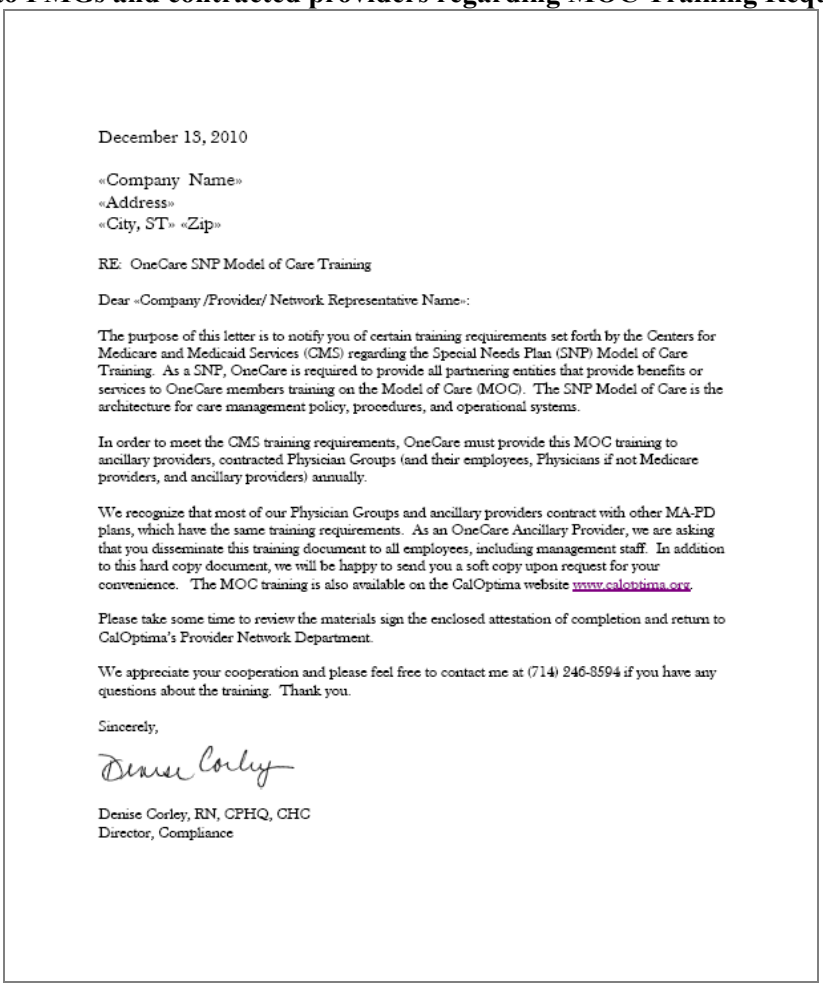
PATRICIA	ROMERO	tromero@mhealth.com	RN / LVN	MONARCH HEALTHCARE	100	Pass	3/10/2011 12:39	1

3. Notice to PMGs and contracted providers regarding MOC Training Requirements



December 15, 2010

«Company Name»
«Address»
«City, ST» «Zip»

RE: OneCare SNP Model of Care Training

Dear «Company /Provider/ Network Representative Name»:

The purpose of this letter is to notify you of certain training requirements set forth by the Centers for Medicare and Medicaid Services (CMS) regarding the Special Needs Plan (SNP) Model of Care Training. As a SNP, OneCare is required to provide all partnering entities that provide benefits or services to OneCare members training on the Model of Care (MOC). The SNP Model of Care is the architecture for care management policy, procedures, and operational systems.

In order to meet the CMS training requirements, OneCare must provide this MOC training to ancillary providers, contracted Physician Groups (and their employees, Physicians if not Medicare providers, and ancillary providers) annually.

We recognize that most of our Physician Groups and ancillary providers contract with other MA-PD plans, which have the same training requirements. As an OneCare Ancillary Provider, we are asking that you disseminate this training document to all employees, including management staff. In addition to this hard copy document, we will be happy to send you a soft copy upon request for your convenience. The MOC training is also available on the CalOptima website www.caloptima.org.

Please take some time to review the materials sign the enclosed attestation of completion and return to CalOptima's Provider Network Department.

We appreciate your cooperation and please feel free to contact me at (714) 246-8594 if you have any questions about the training. Thank you.

Sincerely,

Denise Corley

Denise Corley, RN, CPHQ, CHC
Director, Compliance

7. Health Risk Assessment

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

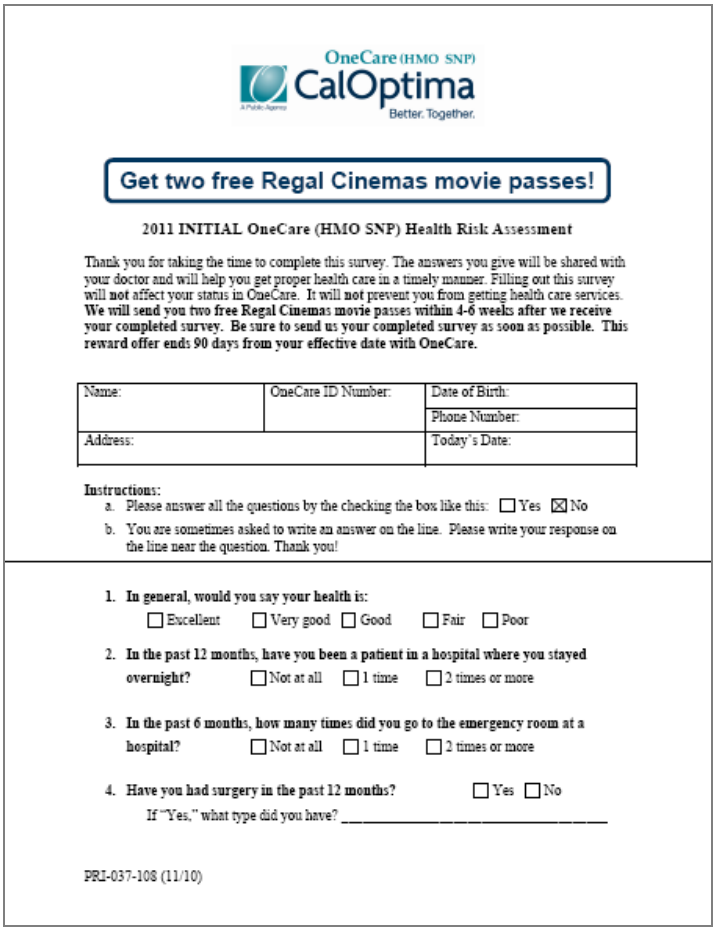
OneCare utilizes a plan-developed health risk assessment tool to conduct an initial and annual assessment of OneCare members. The HRA questions are designed to assess the health and social risks of each member by assessing responses to:

- Perception of health status
- Hospital and ER utilization
- Number of medications
- ESRD on Dialysis
- Chronic and severe medical conditions
- DME and/or medical supplies in the home
- Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Depression screening using components of the Patient Health Questionnaire (PHQ 9)
- Other History such as: pain level, history of falls and mobility limitations

The HRA questions are scored and used to stratify the members into high, moderate and low risk levels based on a risk algorithm. The HRA and risk stratification level are posted to a secure File Transfer Protocol (FTP) site daily for the care providers and PMGs.

EXAMPLES:

1. **OneCare HRA Form**



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2011 INITIAL OneCare (HMO SNP) Health Risk Assessment

Thank you for taking the time to complete this survey. The answers you give will be shared with your doctor and will help you get proper health care in a timely manner. Filling out this survey will **not** affect your status in OneCare. It will **not** prevent you from getting health care services. **We will send you two free Regal Cinemas movie passes within 4-6 weeks after we receive your completed survey. Be sure to send us your completed survey as soon as possible. This reward offer ends 90 days from your effective date with OneCare.**

Name:	OneCare ID Number:	Date of Birth:
		Phone Number:
Address:		Today's Date:

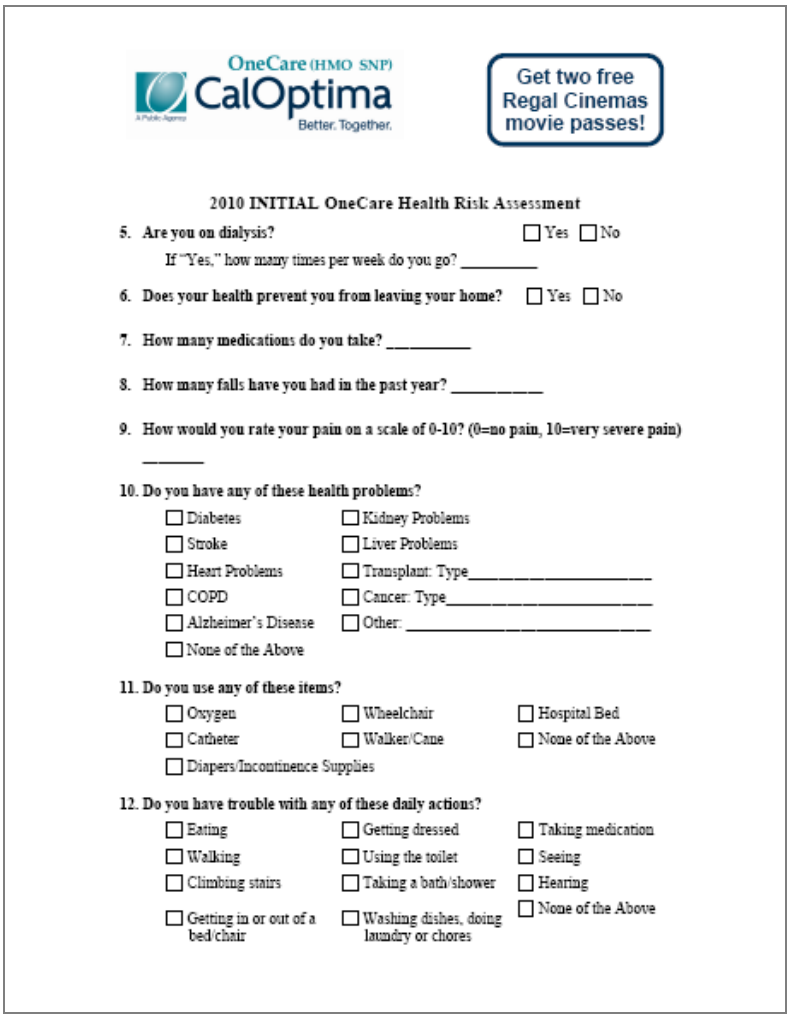
Instructions:

a. Please answer all the questions by the checking the box like this: ☐ Yes ☒ No

b. You are sometimes asked to write an answer on the line. Please write your response on the line near the question. Thank you!

1. **In general, would you say your health is:**
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
2. **In the past 12 months, have you been a patient in a hospital where you stayed overnight?** ☐ Not at all ☐ 1 time ☐ 2 times or more
3. **In the past 6 months, how many times did you go to the emergency room at a hospital?** ☐ Not at all ☐ 1 time ☐ 2 times or more
4. **Have you had surgery in the past 12 months?** ☐ Yes ☐ No
   If "Yes," what type did you have? _____

PRJ-037-108 (11/10)



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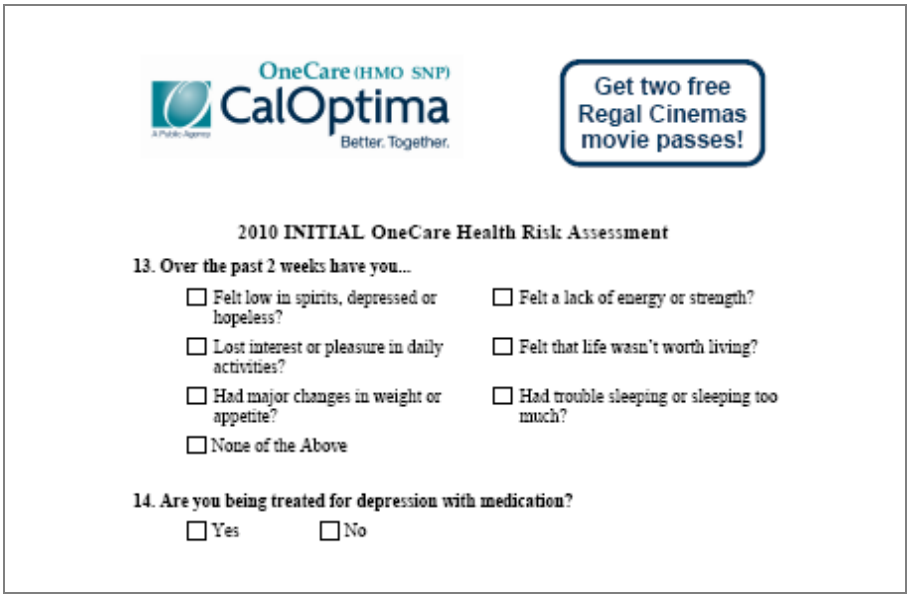
5. **Are you on dialysis?** ☐ Yes ☐ No
   If "Yes," how many times per week do you go? _____
6. **Does your health prevent you from leaving your home?** ☐ Yes ☐ No
7. **How many medications do you take?** _____
8. **How many falls have you had in the past year?** _____
9. **How would you rate your pain on a scale of 0-10? (0=no pain, 10=very severe pain)**
   _____
10. **Do you have any of these health problems?**
    - ☐ Diabetes
    - ☐ Stroke
    - ☐ Heart Problems
    - ☐ COPD
    - ☐ Alzheimer's Disease
    - ☐ None of the Above
    - ☐ Kidney Problems
    - ☐ Liver Problems
    - ☐ Transplant: Type_____
    - ☐ Cancer: Type_____
    - ☐ Other: _____
11. **Do you use any of these items?**
    - ☐ Oxygen
    - ☐ Catheter
    - ☐ Diapers/Incontinence Supplies
    - ☐ Wheelchair
    - ☐ Walker/Cane
    - ☐ Hospital Bed
    - ☐ None of the Above
12. **Do you have trouble with any of these daily actions?**
    - ☐ Eating
    - ☐ Walking
    - ☐ Climbing stairs
    - ☐ Getting in or out of a bed/chair
    - ☐ Getting dressed
    - ☐ Using the toilet
    - ☐ Taking a bath/shower
    - ☐ Washing dishes, doing laundry or chores
    - ☐ Taking medication
    - ☐ Seeing
    - ☐ Hearing
    - ☐ None of the Above



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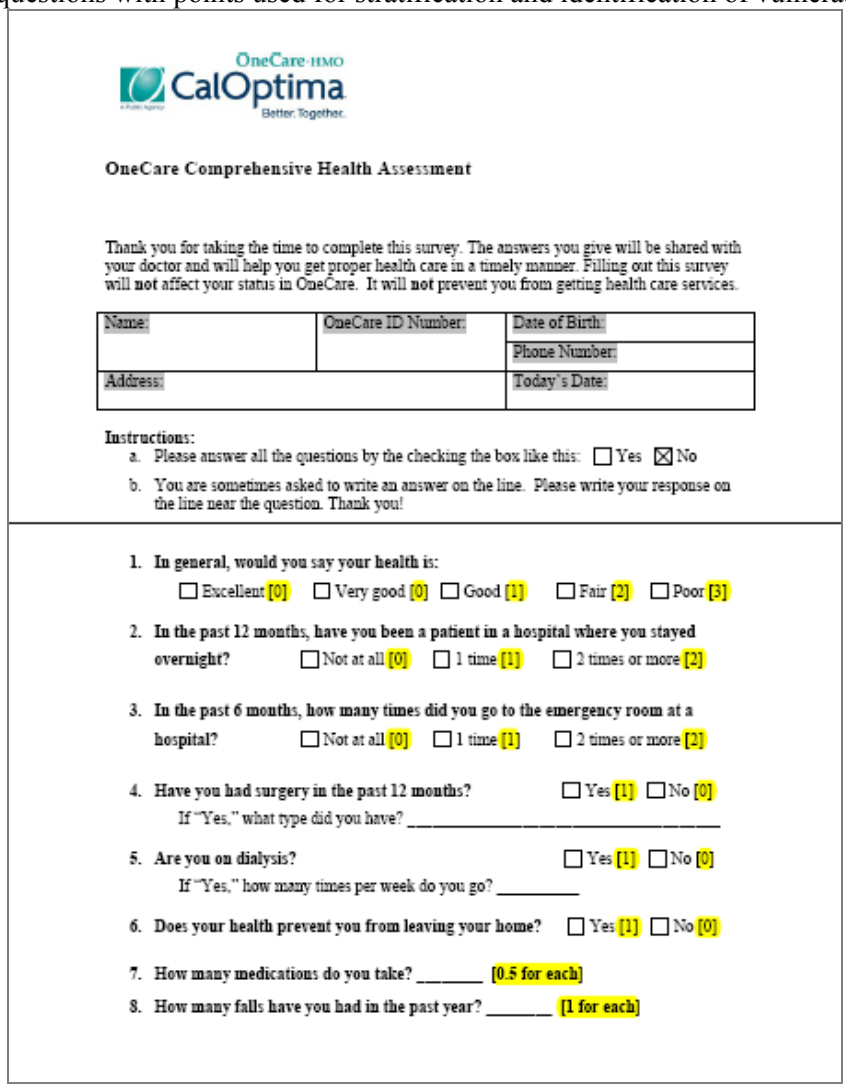
13. **Over the past 2 weeks have you...**
    - ☐ Felt low in spirits, depressed or hopeless?
    - ☐ Lost interest or pleasure in daily activities?
    - ☐ Had major changes in weight or appetite?
    - ☐ None of the Above
    - ☐ Felt a lack of energy or strength?
    - ☐ Felt that life wasn't worth living?
    - ☐ Had trouble sleeping or sleeping too much?
14. **Are you being treated for depression with medication?**
    ☐ Yes ☐ No

2. HRA questions with points used for stratification and identification of vulnerable members



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OneCare Comprehensive Health Assessment

Thank you for taking the time to complete this survey. The answers you give will be shared with your doctor and will help you get proper health care in a timely manner. Filling out this survey will **not** affect your status in OneCare. It will **not** prevent you from getting health care services.

Name:	OneCare ID Number:	Date of Birth:
		Phone Number:
Address:		Today's Date:

Instructions:

a. Please answer all the questions by the checking the box like this: ☐ Yes ☒ No

b. You are sometimes asked to write an answer on the line. Please write your response on the line near the question. Thank you!

1. **In general, would you say your health is:**
   ☐ Excellent [0] ☐ Very good [0] ☐ Good [1] ☐ Fair [2] ☐ Poor [3]

2. **In the past 12 months, have you been a patient in a hospital where you stayed overnight?** ☐ Not at all [0] ☐ 1 time [1] ☐ 2 times or more [2]

3. **In the past 6 months, how many times did you go to the emergency room at a hospital?** ☐ Not at all [0] ☐ 1 time [1] ☐ 2 times or more [2]

4. **Have you had surgery in the past 12 months?** ☐ Yes [1] ☐ No [0]
   If "Yes," what type did you have? _____

5. **Are you on dialysis?** ☐ Yes [1] ☐ No [0]
   If "Yes," how many times per week do you go? _____

6. **Does your health prevent you from leaving your home?** ☐ Yes [1] ☐ No [0]

7. **How many medications do you take? _____ [0.5 for each]**

8. **How many falls have you had in the past year? _____ [1 for each]**

9. **How would you rate your pain on a scale of 0-10? (0=no pain, 10=very severe pain)**

☐ 0 [0] ☐ 1-3 [1] ☐ 4-6 [2] ☐ 7-10 [3]

10. **Do you have any of these health problems? [1 for each]**

☐ Diabetes
☐ Kidney Problems
☐ Stroke
☐ Liver Problems
☐ Heart Problems
☐ Transplant: Type_____
☐ COPD
☐ Cancer: Type_____
☐ Alzheimer's Disease
☐ Other: _____
☐ None of the above

11. **Do you use any of these items? [0.5 for each]**

☐ Oxygen
☐ Wheelchair
☐ Hospital Bed
☐ Catheter
☐ Walker/Cane
☐ None of the above
☐ Diapers/Incontinence Supplies

12. **Do you have trouble with any of these daily actions? [0.5 for each]**

☐ Eating
☐ Getting dressed
☐ Taking medication
☐ Walking
☐ Using the toilet
☐ Seeing
☐ Climbing stairs
☐ Taking a bath/shower
☐ Hearing
☐ Getting in or out of a bed/chair
☐ Washing dishes, doing laundry or chores
☐ None of the above

13. **Over the past 2 weeks have you... [0.5 for each]**

☐ felt low in spirits, depressed or hopeless?
☐ felt a lack of energy or strength?
☐ lost interest or pleasure in daily activities?
☐ felt that life wasn't worth living?
☐ had major changes in weight or appetite?
☐ had trouble sleeping or sleeping too much?
☐ None of the above

14. **Are you being treated for depression with medication?**

☐ Yes [1] ☐ No [0]

H5433 _ 08240 (11/22/2009)

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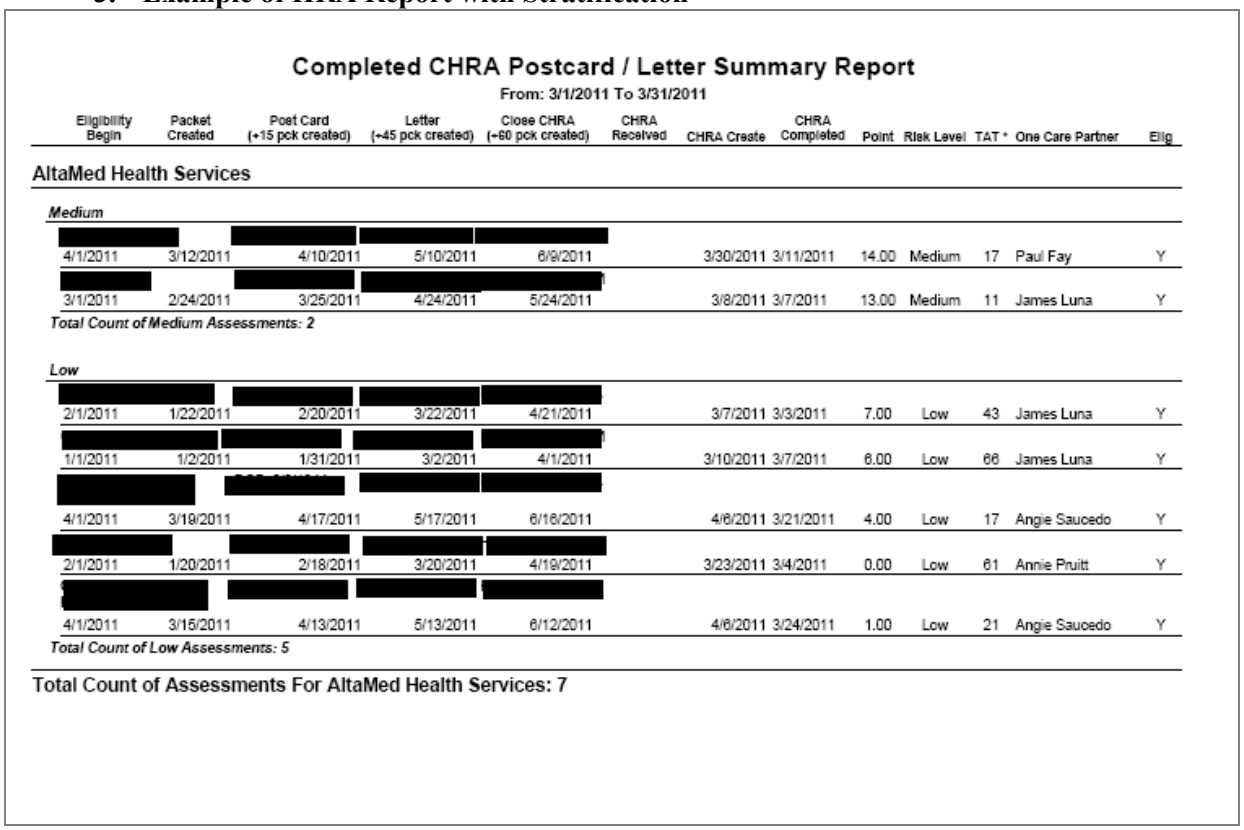
2010 CHRA Scoring

Question	Points Options	Total Possible
1	0, 1, 2, 3	3
2	0, 1, 2	2
3	0, 1, 2	2
4	0, 1	1
5	0, 1	1
6	0, 1	1
7	0.5 for each (no limit)	???
8	1 for each (no limit)	???
9	0=0, 1-3=1 , 4-6=2, 7-10=3	3
10	1 for each	11
11	0.5 for each	7.5
12	0.5 for each	5.5
13	0.5 for each	3
14	0, 1	1
	Overall Total:	41 +

2010 Risk Thresholds

Risk Level	Scoring
Low	0-10
Medium	11-20
High	21+

3. Example of HRA Report with Stratification



Completed CHRA Postcard / Letter Summary Report

From: 3/1/2011 To 3/31/2011

Eligibility Begin	Packet Created	Post Card (+15 pck created)	Letter (+45 pck created)	Close CHRA (+60 pck created)	CHRA Received	CHRA Create	CHRA Completed	Point	Risk Level	TAT *	One Care Partner	Elig
AltaMed Health Services												
Medium												
[redacted] 4/1/2011	3/12/2011	4/10/2011	5/10/2011	6/9/2011		3/30/2011	3/11/2011	14.00	Medium	17	Paul Fay	Y
[redacted] 3/1/2011	2/24/2011	3/25/2011	4/24/2011	5/24/2011		3/8/2011	3/7/2011	13.00	Medium	11	James Luna	Y
Total Count of Medium Assessments: 2												
Low												
[redacted] 2/1/2011	1/22/2011	2/20/2011	3/22/2011	4/21/2011		3/7/2011	3/3/2011	7.00	Low	43	James Luna	Y
[redacted] 1/1/2011	1/2/2011	1/31/2011	3/2/2011	4/1/2011		3/10/2011	3/7/2011	6.00	Low	66	James Luna	Y
[redacted] 4/1/2011	3/19/2011	4/17/2011	5/17/2011	6/16/2011		4/6/2011	3/21/2011	4.00	Low	17	Angie Saucedo	Y
[redacted] 2/1/2011	1/20/2011	2/18/2011	3/20/2011	4/19/2011		3/23/2011	3/4/2011	0.00	Low	61	Annie Pruitt	Y
[redacted] 4/1/2011	3/15/2011	4/13/2011	5/13/2011	6/12/2011		4/6/2011	3/24/2011	1.00	Low	21	Angie Saucedo	Y
Total Count of Low Assessments: 5												
Total Count of Assessments For AltaMed Health Services: 7												

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

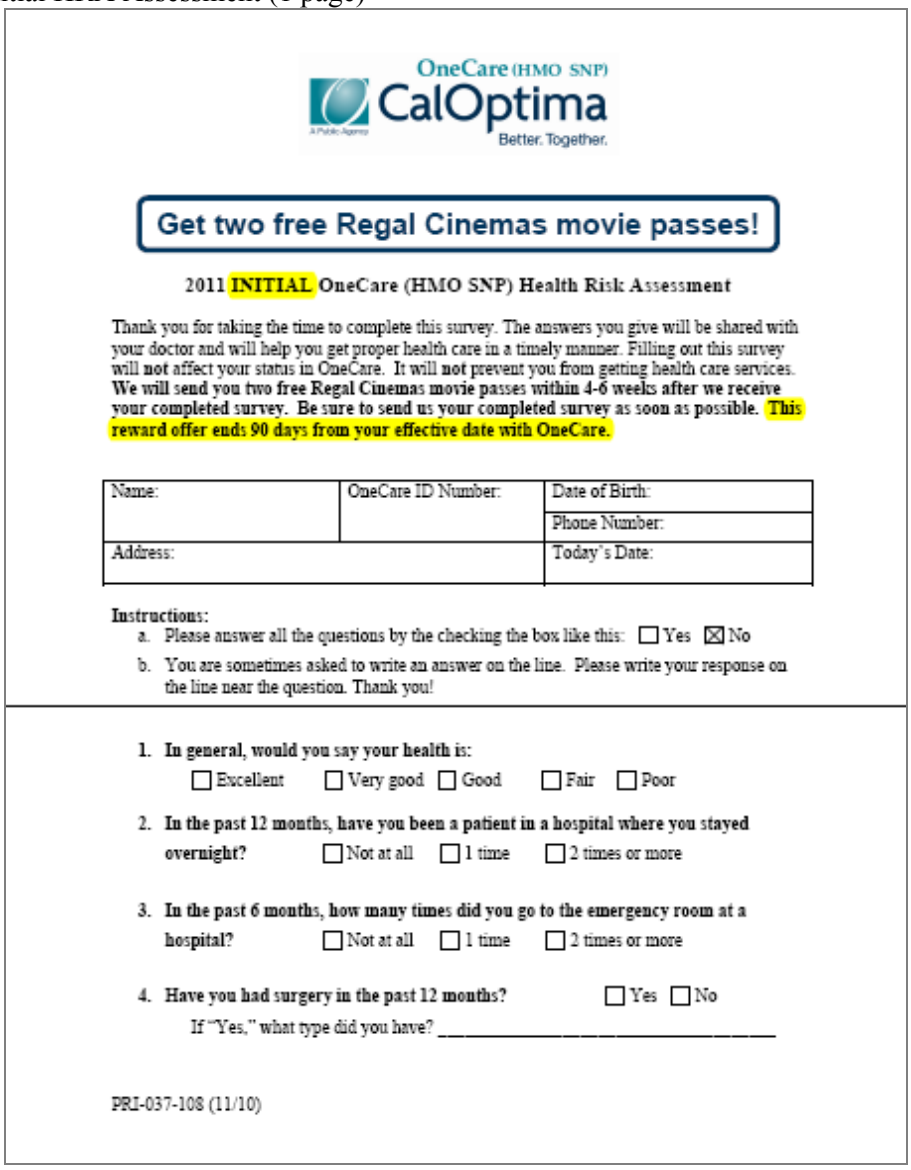
All new members receive an initial HRA in their welcome packet along with instructions for completing the HRA questionnaire. Members are encouraged to complete and return by mail as soon as possible. New members are provided with a movie ticket incentive for completing the HRA. Members may complete the HRA either in-person, telephonically with assistance or at the primary care office.

Every effort is made to complete the initial HRA within 90 days of enrollment. If a member fails to complete and return the HRA within thirty (30) days after the initial mailing, OneCare mails a postcard reminding the member to complete the HRA. If the completed HRA is not received within sixty (60) days of the initial mailing, OneCare mails a reminder letter along with along with a second copy of the HRA.

Annually, the HRA is mailed to all OneCare members. At least three (3) outreach attempts are made to the member within a 90-day period. If there is a change in the member's medical health status, a new HRA is completed that reflects the changes and updates the member's individual care plan.

EXAMPLES:

1. Initial HRA Assessment (1 page)



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2011 INITIAL OneCare (HMO SNP) Health Risk Assessment

Thank you for taking the time to complete this survey. The answers you give will be shared with your doctor and will help you get proper health care in a timely manner. Filling out this survey will **not** affect your status in OneCare. It will **not** prevent you from getting health care services. **We will send you two free Regal Cinemas movie passes within 4-6 weeks after we receive your completed survey. Be sure to send us your completed survey as soon as possible. This reward offer ends 90 days from your effective date with OneCare.**

Name:	OneCare ID Number:	Date of Birth:
		Phone Number:
Address:		Today's Date:

Instructions:

a. Please answer all the questions by the checking the box like this: ☐ Yes ☒ No

b. You are sometimes asked to write an answer on the line. Please write your response on the line near the question. Thank you!

1. **In general, would you say your health is:**
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

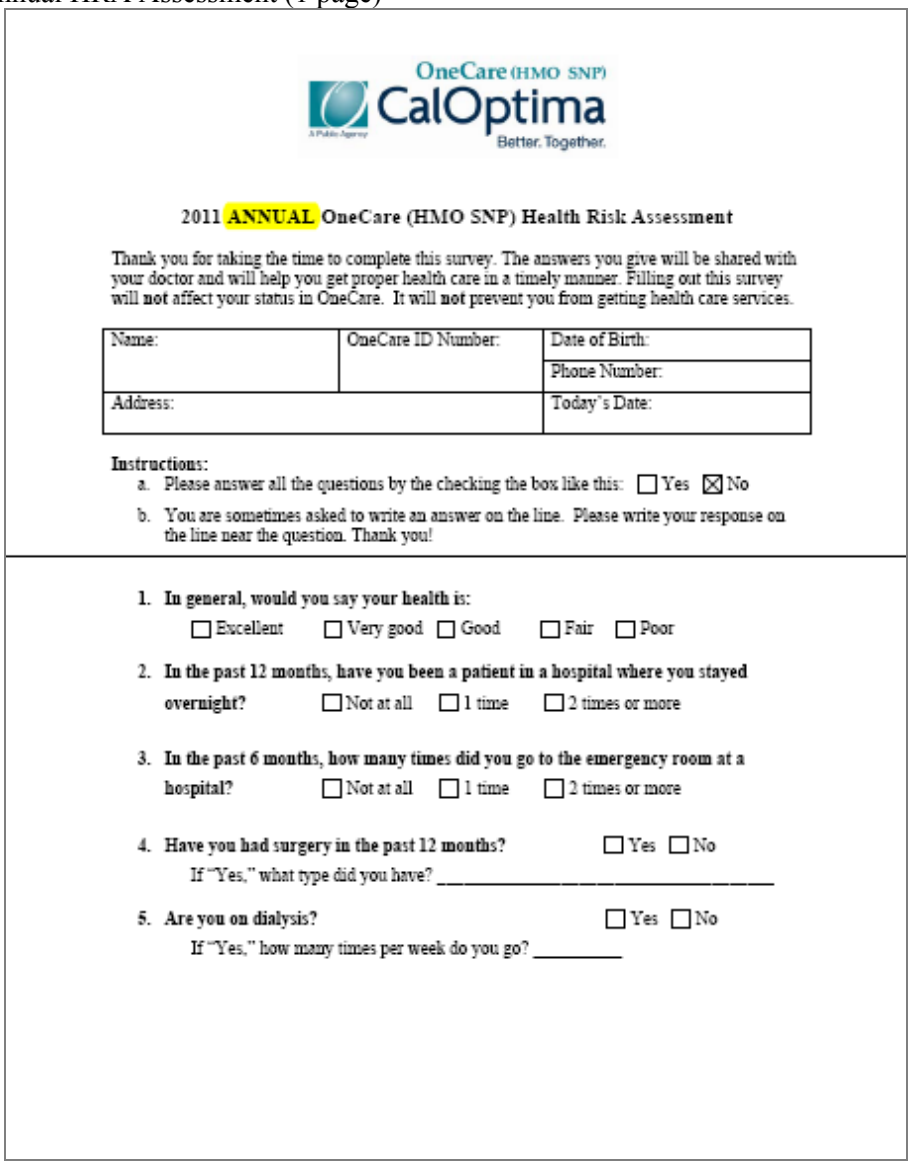
2. **In the past 12 months, have you been a patient in a hospital where you stayed overnight?** ☐ Not at all ☐ 1 time ☐ 2 times or more

3. **In the past 6 months, how many times did you go to the emergency room at a hospital?** ☐ Not at all ☐ 1 time ☐ 2 times or more

4. **Have you had surgery in the past 12 months?** ☐ Yes ☐ No
   If "Yes," what type did you have? _____

PRI-037-108 (11/10)

2. Annual HRA Assessment (1 page)



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2011 ANNUAL OneCare (HMO SNP) Health Risk Assessment

Thank you for taking the time to complete this survey. The answers you give will be shared with your doctor and will help you get proper health care in a timely manner. Filling out this survey will **not** affect your status in OneCare. It will **not** prevent you from getting health care services.

Name:	OneCare ID Number:	Date of Birth:
		Phone Number:
Address:		Today's Date:

Instructions:

a. Please answer all the questions by the checking the box like this: ☐ Yes ☒ No

b. You are sometimes asked to write an answer on the line. Please write your response on the line near the question. Thank you!

1. **In general, would you say your health is:**
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

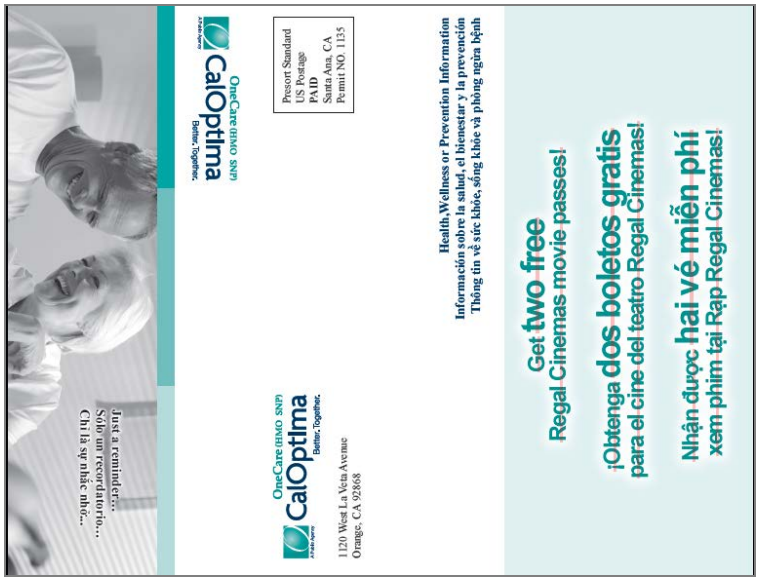
2. **In the past 12 months, have you been a patient in a hospital where you stayed overnight?** ☐ Not at all ☐ 1 time ☐ 2 times or more

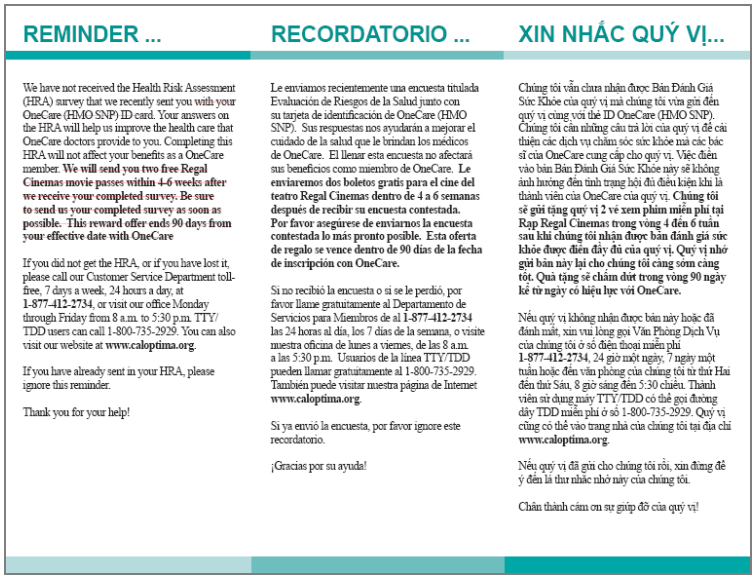
3. **In the past 6 months, how many times did you go to the emergency room at a hospital?** ☐ Not at all ☐ 1 time ☐ 2 times or more

4. **Have you had surgery in the past 12 months?** ☐ Yes ☐ No
   If "Yes," what type did you have? _____

5. **Are you on dialysis?** ☐ Yes ☐ No
   If "Yes," how many times per week do you go? _____

3. HRA Reminder Postcard





REMINDER ...

We have not received the Health Risk Assessment (HRA) survey that we recently sent you with your OneCare (HMO SNP) ID card. Your answers on the HRA will help us improve the health care that OneCare doctors provide to you. Completing this HRA will not affect your benefits as a OneCare member. **We will send you two free Regal Cinemas movie passes within 4-6 weeks after we receive your completed survey. Be sure to send us your completed survey as soon as possible. This reward offer ends 90 days from your effective date with OneCare**

If you did not get the HRA, or if you have lost it, please call our Customer Service Department toll-free, 7 days a week, 24 hours a day, at **1-877-412-2734**, or visit our office Monday through Friday from 8 a.m. to 5:30 p.m. TTY/TDD users can call 1-800-735-2929. You can also visit our website at **www.caloptima.org**.

If you have already sent in your HRA, please ignore this reminder.

Thank you for your help!

RECORDATORIO ...

Le enviamos recientemente una encuesta titulada Evaluación de Riesgos de la Salud junto con su tarjeta de identificación de OneCare (HMO SNP). Sus respuestas nos ayudarán a mejorar el cuidado de la salud que le brindan los médicos de OneCare. El llenar esta encuesta no afectará sus beneficios como miembro de OneCare. **Le enviaremos dos boletos gratis para el cine del teatro Regal Cinemas dentro de 4 a 6 semanas después de recibir su encuesta contestada. Por favor asegúrese de enviarnos la encuesta contestada lo más pronto posible. Esta oferta de regalo se vence dentro de 90 días de la fecha de inscripción con OneCare.**

Si no recibió la encuesta o si se le perdió, por favor llame gratuitamente al Departamento de Servicios para Miembros de al **1-877-412-2734** las 24 horas al día, los 7 días de la semana, o visite nuestra oficina de lunes a viernes, de las 8 a.m. a las 5:30 p.m. Usuarios de la línea TTY/TDD pueden llamar gratuitamente al 1-800-735-2929. También puede visitar nuestra página de Internet **www.caloptima.org**.

Si ya envió la encuesta, por favor ignore este recordatorio.

¡Gracias por su ayuda!

XIN NHẮC QUÝ VỊ...

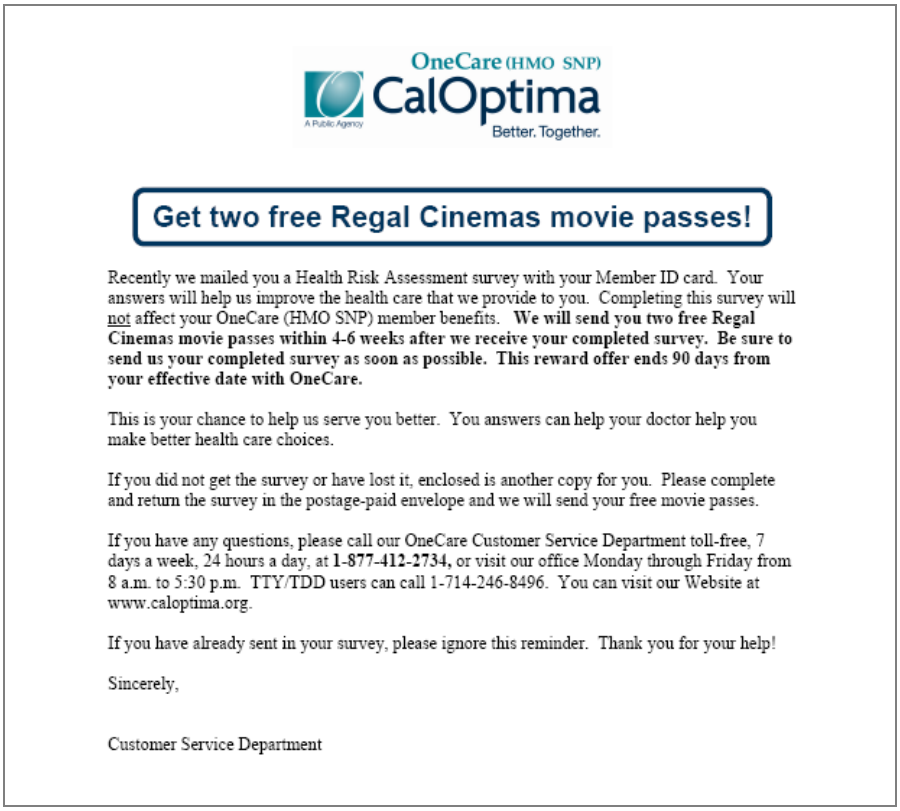
Chúng tôi vẫn chưa nhận được Bản Đánh Giá Sức Khỏe của quý vị mà chúng tôi vừa gửi đến quý vị cùng với thẻ ID OneCare (HMO SNP). Chúng tôi cần những câu trả lời của quý vị để cải thiện các dịch vụ chăm sóc sức khỏe mà các bác sĩ của OneCare cung cấp cho quý vị. Việc điền vào bản Bản Đánh Giá Sức Khỏe này sẽ không ảnh hưởng đến tình trạng hội đủ điều kiện khi là thành viên của OneCare của quý vị. **Chúng tôi sẽ gửi tặng quý vị 2 vé xem phim miễn phí tại Rạp Regal Cinemas trong vòng 4 đến 6 tuần sau khi chúng tôi nhận được bản đánh giá sức khỏe được điền đầy đủ của quý vị. Quý vị nhớ gửi bản này lại cho chúng tôi càng sớm càng tốt. Quà tặng sẽ chấm dứt trong vòng 90 ngày kể từ ngày có hiệu lực với OneCare.**

Nếu quý vị không nhận được bản này hoặc đã đánh mất, xin vui lòng gọi Văn Phòng Dịch Vụ của chúng tôi ở số điện thoại miễn phí **1-877-412-2734**, 24 giờ một ngày, 7 ngày một tuần hoặc đến văn phòng của chúng tôi từ thứ Hai đến thứ Sáu, 8 giờ sáng đến 5:30 chiều. Thành viên sử dụng máy TTY/TDD có thể gọi đường dây TDD miễn phí ở số 1-800-735-2929. Quý vị cũng có thể vào trang nhà của chúng tôi tại địa chỉ **www.caloptima.org**.

Nếu quý vị đã gửi cho chúng tôi rồi, xin đừng để ý đến là thư nhắc nhở này của chúng tôi.

Chân thành cảm ơn sự giúp đỡ của quý vị!

4. HRA Reminder Letter (Initial HRA)



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Recently we mailed you a Health Risk Assessment survey with your Member ID card. Your answers will help us improve the health care that we provide to you. Completing this survey will not affect your OneCare (HMO SNP) member benefits. **We will send you two free Regal Cinemas movie passes within 4-6 weeks after we receive your completed survey. Be sure to send us your completed survey as soon as possible. This reward offer ends 90 days from your effective date with OneCare.**

This is your chance to help us serve you better. You answers can help your doctor help you make better health care choices.

If you did not get the survey or have lost it, enclosed is another copy for you. Please complete and return the survey in the postage-paid envelope and we will send your free movie passes.

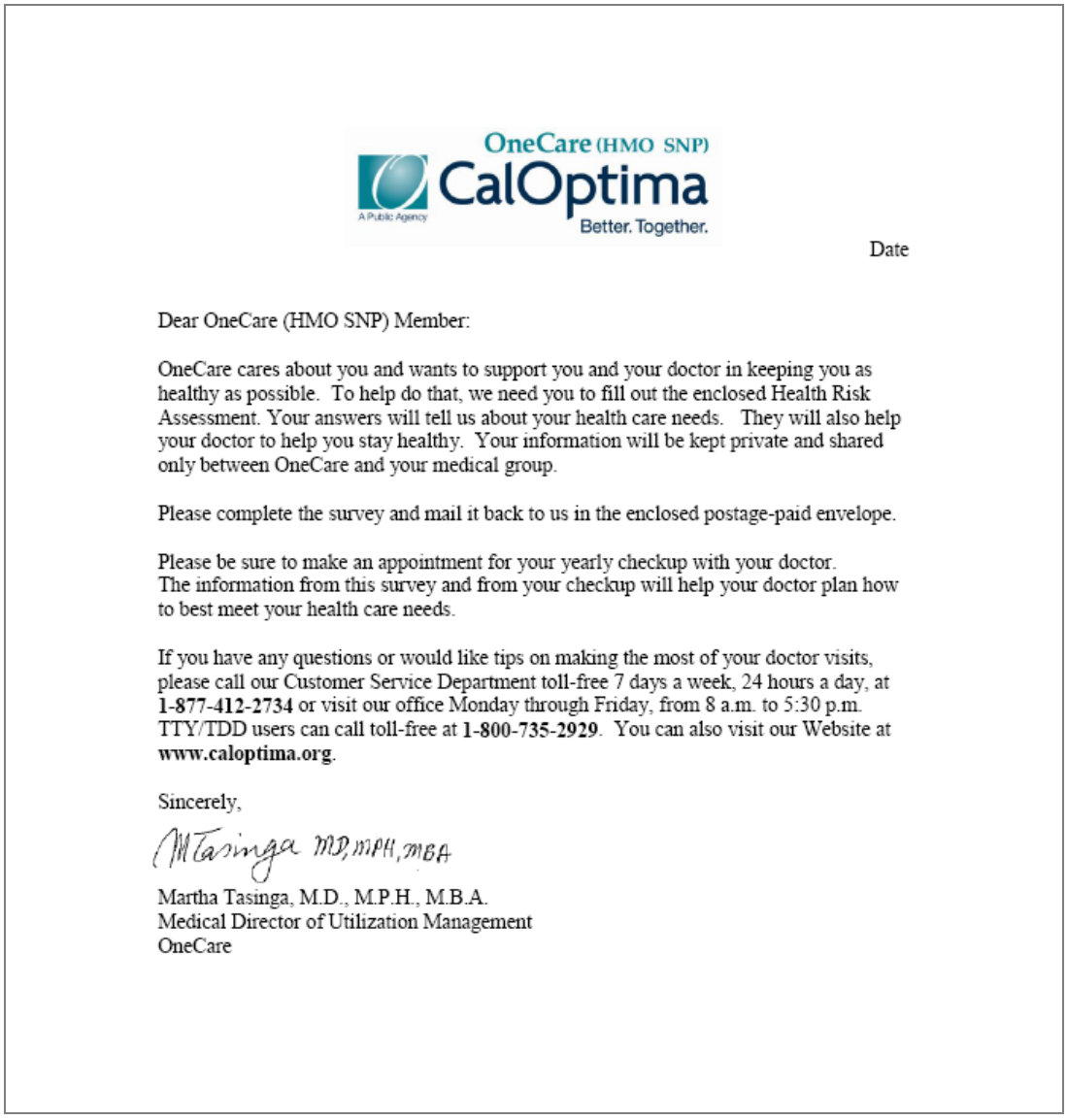
If you have any questions, please call our OneCare Customer Service Department toll-free, 7 days a week, 24 hours a day, at **1-877-412-2734,** or visit our office Monday through Friday from 8 a.m. to 5:30 p.m. TTY/TDD users can call 1-714-246-8496. You can visit our Website at www.caloptima.org.

If you have already sent in your survey, please ignore this reminder. Thank you for your help!

Sincerely,

Customer Service Department

5. HRA Cover Letter



OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

Date

Dear OneCare (HMO SNP) Member:

OneCare cares about you and wants to support you and your doctor in keeping you as healthy as possible. To help do that, we need you to fill out the enclosed Health Risk Assessment. Your answers will tell us about your health care needs. They will also help your doctor to help you stay healthy. Your information will be kept private and shared only between OneCare and your medical group.

Please complete the survey and mail it back to us in the enclosed postage-paid envelope.

Please be sure to make an appointment for your yearly checkup with your doctor. The information from this survey and from your checkup will help your doctor plan how to best meet your health care needs.

If you have any questions or would like tips on making the most of your doctor visits, please call our Customer Service Department toll-free 7 days a week, 24 hours a day, at **1-877-412-2734** or visit our office Monday through Friday, from 8 a.m. to 5:30 p.m. TTY/TDD users can call toll-free at **1-800-735-2929**. You can also visit our Website at **www.caloptima.org**.

Sincerely,

MTasinga MD, MPH, MBA

Martha Tasinga, M.D., M.P.H., M.B.A.
Medical Director of Utilization Management
OneCare

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

Upon receipt of the completed HRA, the responses are entered into the medical management system. The data is automatically scored by the system and the stratification report is produced. The report is reviewed daily and analyzed by the OneCare Clinical Team, which includes the Medical Director, Director of Case Management, OneCare Clinical Manager, Director of Medical Data Management, OneCare Director of Pharmacy, Social Worker, Manager of Performance Measurement and the Case Manager.

The team members have extensive case management, managed care, quality, Medicare and Medicaid experience. The team is knowledgeable on OneCare's benefits and available resources. They also have the following expertise:

- Medical Director: Board Certified Physician with a current, valid, unrestricted California license has a Master's in Public Health. The Medical Director has over 25 years experience in case management.
- Director of Case Management: Registered Nurse, Bachelor Degree in Nursing with a valid California license and Certification in Case Management (CCM). The Director has over 17 years experience in case management.
- OneCare Clinical Manager: Registered Nurse, Bachelor Degree in Nursing with a valid California license and CCM. The Manager has over 10 years experience in case management.
- Case Manager: Registered Nurse with a valid California license and CCM and over five years experience in case management.
- OneCare Director of Pharmacy: Registered Pharmacist, Doctor of Pharmacy Degree (Pharm.D.) with a valid California license. The Director has over 20 years experience in Pharmacy management.
- Social Worker: Licensed Clinical Social Worker, Masters in Social Work with valid California license. The Social Worker has over 12 years experience in case management.
- Manager of Performance Measurement: PhD in Health Economics and Statistics with a Masters in Economics. The Manager of Performance Measurement has 14 years experience in statistical and data analysis.
- Director of Medical Data Management: Master's Public Health- Community Health Sciences. The Director of Medical Data Management has over 15 years experience in quality improvement, HEDIS, QI projects, CAHPS, HOS, health education and health informatics.

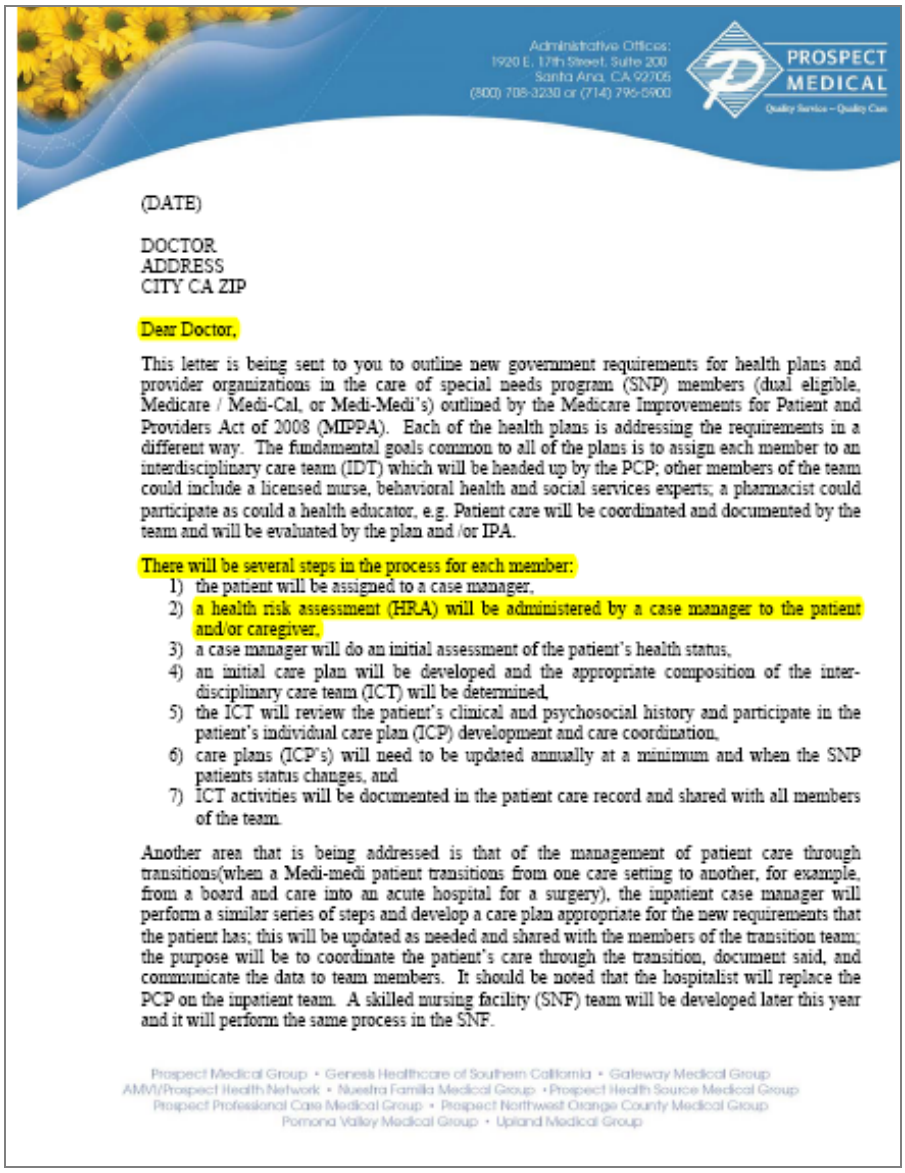
The Clinical Team follows the stratification protocol and to ensure appropriate referrals. Members who answered positively to the behavioral health questions are referred daily to the contracted Behavioral Health Specialist. Members who indicated the presence of DME or supplies in the home are referred to case management for coordination of services. Members meeting the screening criteria for case management or chronic condition management are referred to the appropriate program.

The HRA and risk stratification level are also posted to a secure File Transfer Protocol (FTP) site daily for the care providers and PMGs. The PMG is expected to validate the high-risk data and schedule an appoint for the member to be seen by the PCP within thirty (30) calendar days. The PCP is expected to review the HRA results with the member during his initial or annual assessment.

On an annual basis, OneCare population health risk data is used to evaluate and modify the HRA tool, track and trend population characteristics and develop specialized programs. It is also used in the determination of additional benefit offerings of the Plan.

EXAMPLES:

1. Example of Communication validation Case Manager and Physician reviews HRA



Administrative Offices:
1920 E. 17th Street, Suite 200
Santa Ana, CA 92705
(800) 708-3230 or (714) 796-6900

PROSPECT MEDICAL
Quality Service – Quality Care

(DATE)

DOCTOR
ADDRESS
CITY CA ZIP

Dear Doctor,

This letter is being sent to you to outline new government requirements for health plans and provider organizations in the care of special needs program (SNP) members (dual eligible, Medicare / Medi-Cal, or Medi-Medi's) outlined by the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA). Each of the health plans is addressing the requirements in a different way. The fundamental goals common to all of the plans is to assign each member to an interdisciplinary care team (IDT) which will be headed up by the PCP; other members of the team could include a licensed nurse, behavioral health and social services experts; a pharmacist could participate as could a health educator, e.g. Patient care will be coordinated and documented by the team and will be evaluated by the plan and /or IPA.

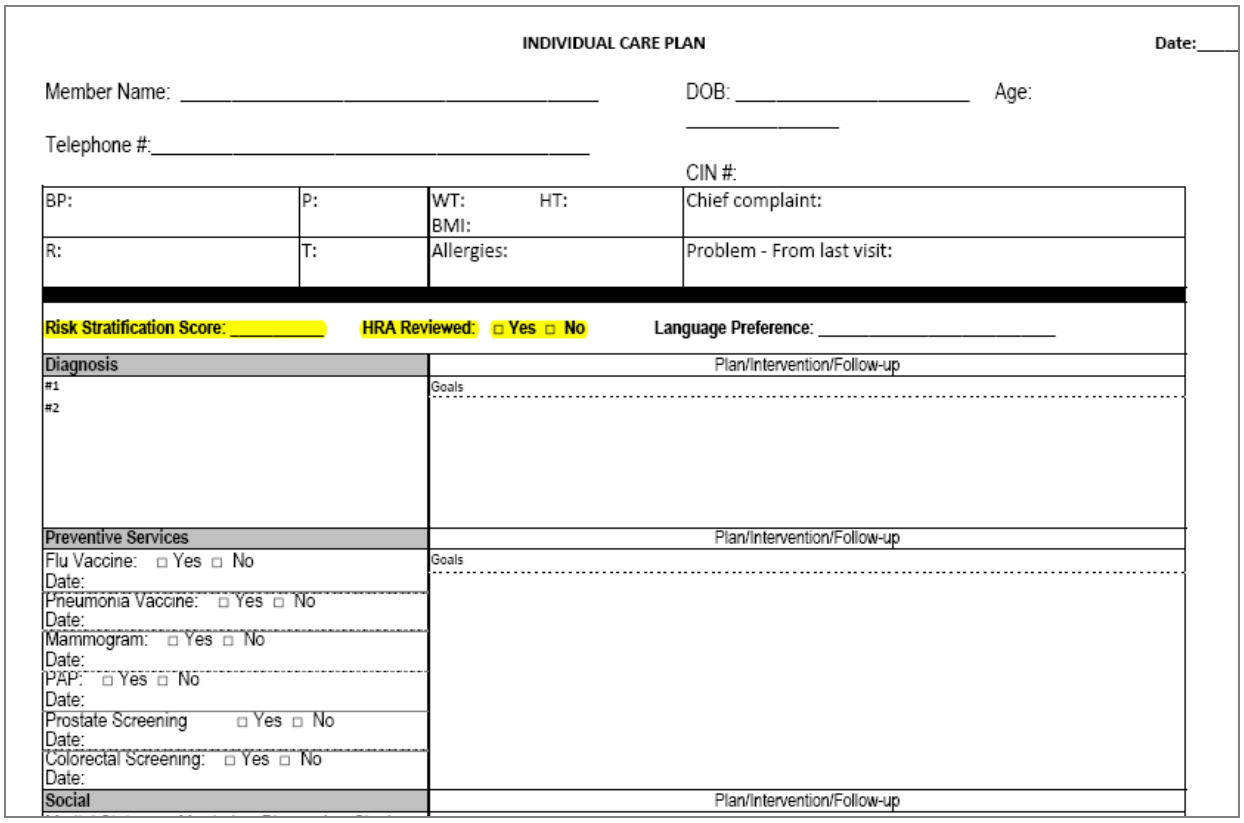
There will be several steps in the process for each member:

1) the patient will be assigned to a case manager,
2) a health risk assessment (HRA) will be administered by a case manager to the patient and/or caregiver,
3) a case manager will do an initial assessment of the patient's health status,
4) an initial care plan will be developed and the appropriate composition of the inter-disciplinary care team (ICT) will be determined,
5) the ICT will review the patient's clinical and psychosocial history and participate in the patient's individual care plan (ICP) development and care coordination,
6) care plans (ICP's) will need to be updated annually at a minimum and when the SNP patients status changes, and
7) ICT activities will be documented in the patient care record and shared with all members of the team.

Another area that is being addressed is that of the management of patient care through transitions(when a Medi-medi patient transitions from one care setting to another, for example, from a board and care into an acute hospital for a surgery), the inpatient case manager will perform a similar series of steps and develop a care plan appropriate for the new requirements that the patient has; this will be updated as needed and shared with the members of the transition team; the purpose will be to coordinate the patient's care through the transition, document said, and communicate the data to team members. It should be noted that the hospitalist will replace the PCP on the inpatient team. A skilled nursing facility (SNF) team will be developed later this year and it will perform the same process in the SNF.

Prospect Medical Group • Genesis Healthcare of Southern California • Gateway Medical Group
AMVI/Prospect Health Network • Nuestra Familia Medical Group • Prospect Health Source Medical Group
Prospect Professional Care Medical Group • Prospect Northwest Orange County Medical Group
Pomona Valley Medical Group • Upland Medical Group

2. Example of Physician Basic ICP with section to document review of HRA and stratification



INDIVIDUAL CARE PLAN Date:____

Member Name: _____ DOB: _____ Age: _____

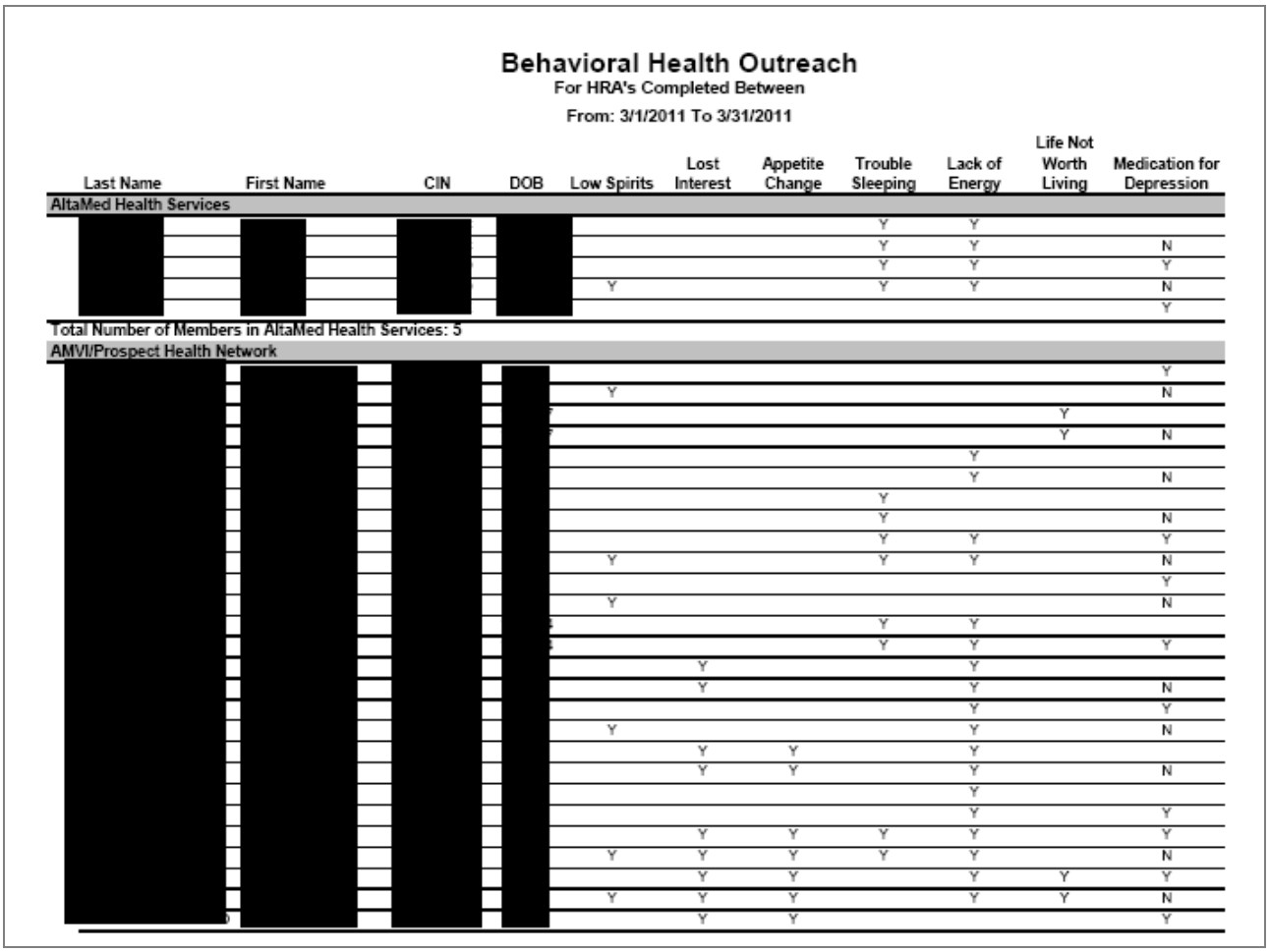
Telephone #:_____ CIN #:

BP:	P:	WT: HT: BMI:	Chief complaint:
R:	T:	Allergies:	Problem - From last visit:

Risk Stratification Score: _____ **HRA Reviewed:** □ **Yes** □ **No** **Language Preference:** _____

Diagnosis	Plan/Intervention/Follow-up
#1 #2	Goals
Preventive Services	Plan/Intervention/Follow-up
Flu Vaccine: □ Yes □ No Date: Pneumonia Vaccine: □ Yes □ No Date: Mammogram: □ Yes □ No Date: PAP: □ Yes □ No Date: Prostate Screening □ Yes □ No Date: Colorectal Screening: □ Yes □ No Date:	Goals
Social	Plan/Intervention/Follow-up

3. Example of Report for stratification of behavioral health screening questions on the HRA



Behavioral Health Outreach

For HRA's Completed Between

From: 3/1/2011 To 3/31/2011

Last Name	First Name	CIN	DOB	Low Spirits	Lost Interest	Appetite Change	Trouble Sleeping	Lack of Energy	Life Not Worth Living	Medication for Depression
AltaMed Health Services										
[redacted]							Y	Y		
							Y	Y		N
							Y	Y		Y
				Y			Y	Y		N
										Y
Total Number of Members in AltaMed Health Services: 5										
AMVI/Prospect Health Network										
[redacted]										Y
				Y						N
									Y	
									Y	N
								Y		
								Y		N
							Y			
							Y			N
							Y	Y		Y
				Y			Y	Y		N
										Y
				Y						N
							Y	Y		
							Y	Y		Y
					Y			Y		
					Y			Y		N
								Y		Y
				Y				Y		N
					Y	Y		Y		
					Y	Y		Y		N
								Y		
								Y		Y
					Y	Y	Y	Y		Y
				Y	Y	Y	Y	Y		N
					Y	Y		Y	Y	Y
				Y	Y	Y		Y	Y	N
					Y	Y				Y

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

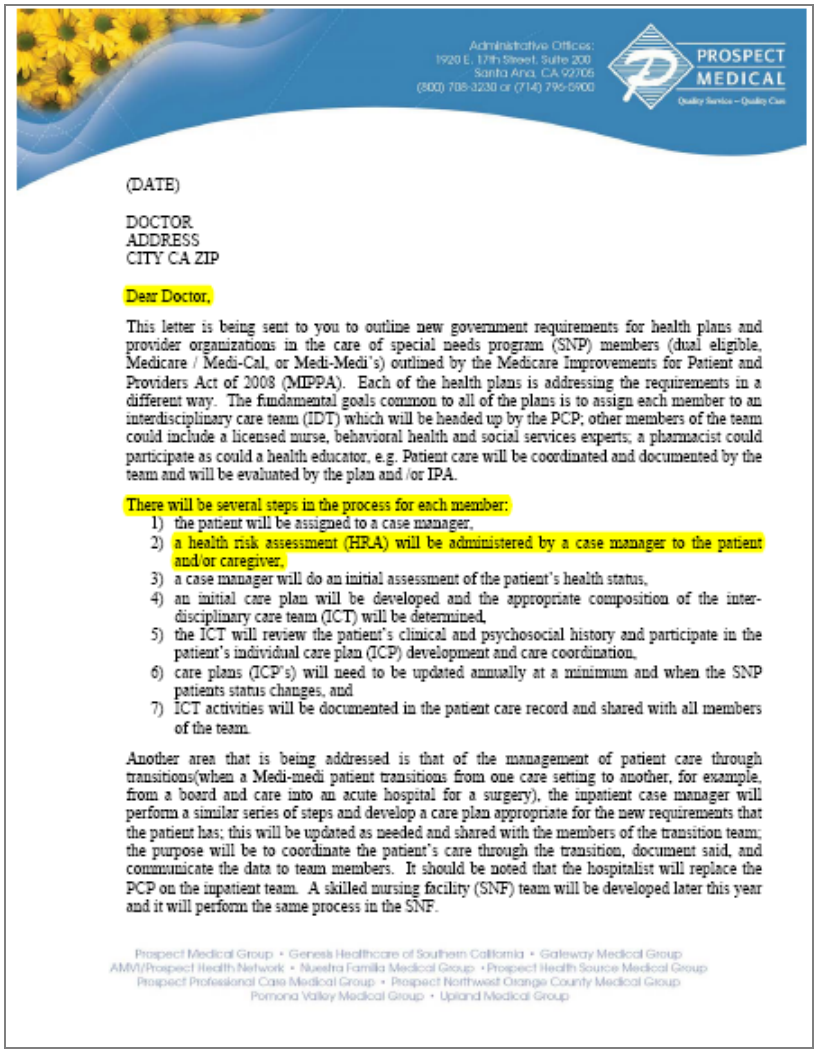
All new members receive an initial HRA in their welcome packet along with instructions for completing the HRA questionnaire. Members are also informed that their provider will receive the results of the HRA and use it in the development of their treatment plan. OneCare communicates result of the HRA to the PMGs, PCP and behavioral health specialist. The results of the completed HRA, along with the scores are posted on a secure File Transfer Protocol (FTP) site daily for the physician medical groups. The physician medical groups make results available to the PCPs. PCP access is limited to their assigned patients. The PMGs review the HRA information and identify members who require Primary or Complex ICT. The PCP will review and discuss the HRA with the member during the initial and annual visits. The PCP obtains the member's signature to acknowledge the review and discussion of the HRA and ICP. The HRA information is discussed with the member and incorporated in the development of the ICP, which is shared with the participants of the Primary and Complex ICT. On a daily basis, the behavioral health specialist receives the Behavioral Health Outreach Report via encrypted email. The report identifies members who answered positively to the HRA mental health questions. Members who answered positively to the HRA behavioral health questions (members on Behavioral Health Outreach Report) are reviewed for Primary or Complex ICT. Those who screen positive are

offered a home or office comprehensive assessment to confirm the diagnosis and the information is incorporated into the ICP.

The HRA and risk stratification level are posted to a secure File Transfer Protocol (FTP) site and is accessible to the care providers and PMGs. The Behavioral Health Outreached report is encrypted and emailed to the vendor for follow up. OneCare Clinical staff has access to the HRA and stratification results in the HIPAA compliant case management documentation system.

EXAMPLES:

1. Example of communication to provider regarding HRA indicating HRA as part of ICP process



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Santa Ana, CA 92705
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PROSPECT MEDICAL

(DATE)

DOCTOR
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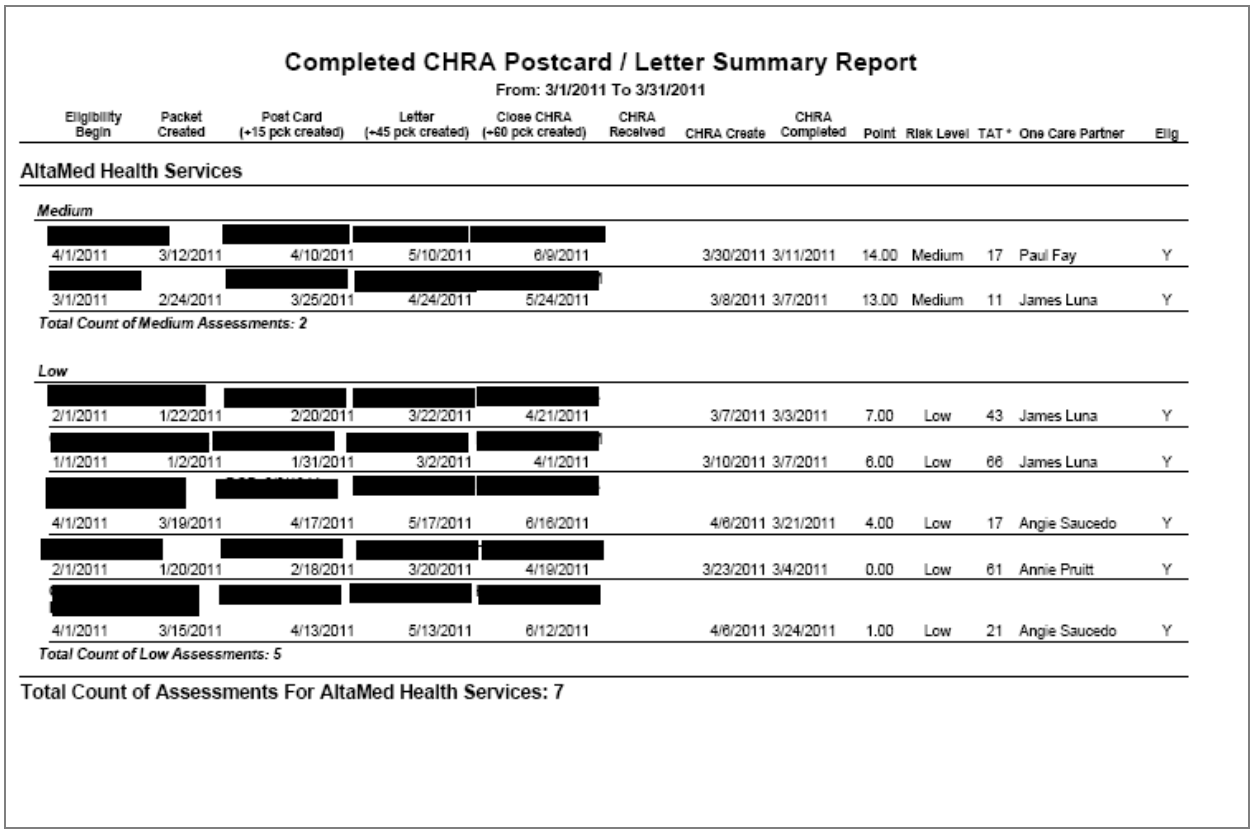
Prospect Medical Group • Genesis Healthcare of Southern California • Gateway Medical Group
AMVI/Prospect Health Network • Nuestra Familia Medical Group • Prospect Health Source Medical Group
Prospect Professional Care Medical Group • Prospect Northwest Orange County Medical Group
Pomona Valley Medical Group • Upland Medical Group

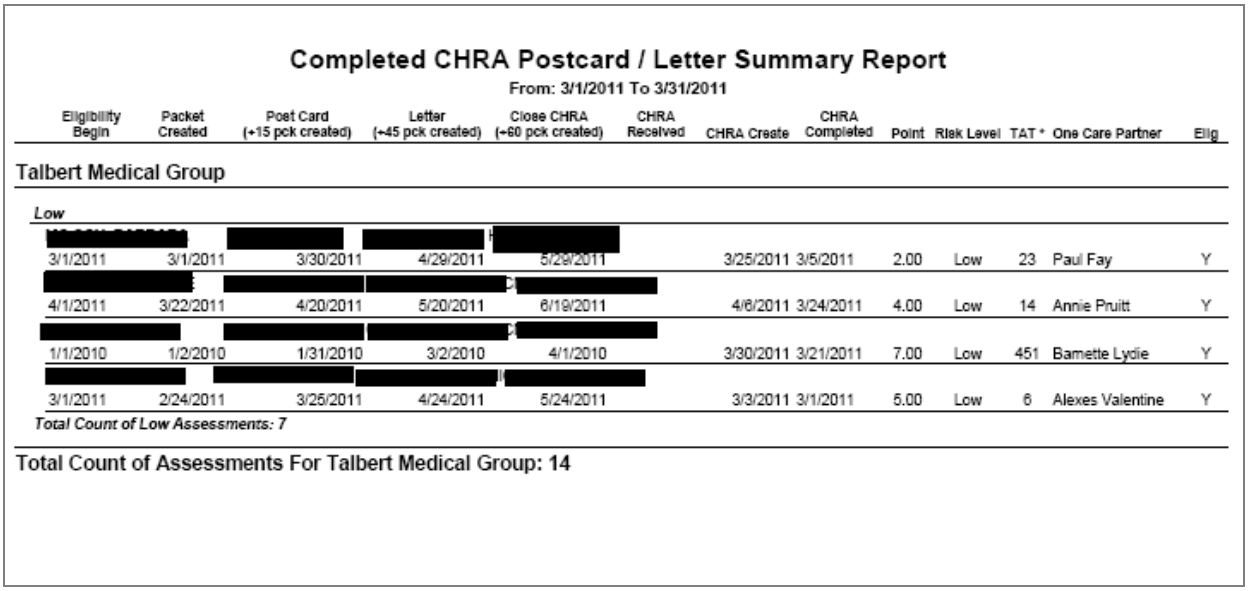
2. Example of HRA Stratification Report that is posted on the FTP site for the PMGs and providers



Completed CHRA Postcard / Letter Summary Report

From: 3/1/2011 To 3/31/2011

Eligibility Begin	Packet Created	Post Card (+15 pck created)	Letter (+45 pck created)	Close CHRA (+60 pck created)	CHRA Received	CHRA Create	CHRA Completed	Point	Risk Level	TAT *	One Care Partner	Elig
AltaMed Health Services												
Medium												
[redacted] 4/1/2011	3/12/2011	4/10/2011	5/10/2011	6/9/2011		3/30/2011	3/11/2011	14.00	Medium	17	Paul Fay	Y
[redacted] 3/1/2011	2/24/2011	3/25/2011	4/24/2011	5/24/2011		3/8/2011	3/7/2011	13.00	Medium	11	James Luna	Y
Total Count of Medium Assessments: 2												
Low												
[redacted] 2/1/2011	1/22/2011	2/20/2011	3/22/2011	4/21/2011		3/7/2011	3/3/2011	7.00	Low	43	James Luna	Y
[redacted] 1/1/2011	1/2/2011	1/31/2011	3/2/2011	4/1/2011		3/10/2011	3/7/2011	6.00	Low	66	James Luna	Y
[redacted] 4/1/2011	3/19/2011	4/17/2011	5/17/2011	6/16/2011		4/6/2011	3/21/2011	4.00	Low	17	Angie Saucedo	Y
[redacted] 2/1/2011	1/20/2011	2/18/2011	3/20/2011	4/19/2011		3/23/2011	3/4/2011	0.00	Low	61	Annie Pruitt	Y
[redacted] 4/1/2011	3/15/2011	4/13/2011	5/13/2011	6/12/2011		4/6/2011	3/24/2011	1.00	Low	21	Angie Saucedo	Y
Total Count of Low Assessments: 5												
Total Count of Assessments For AltaMed Health Services: 7												

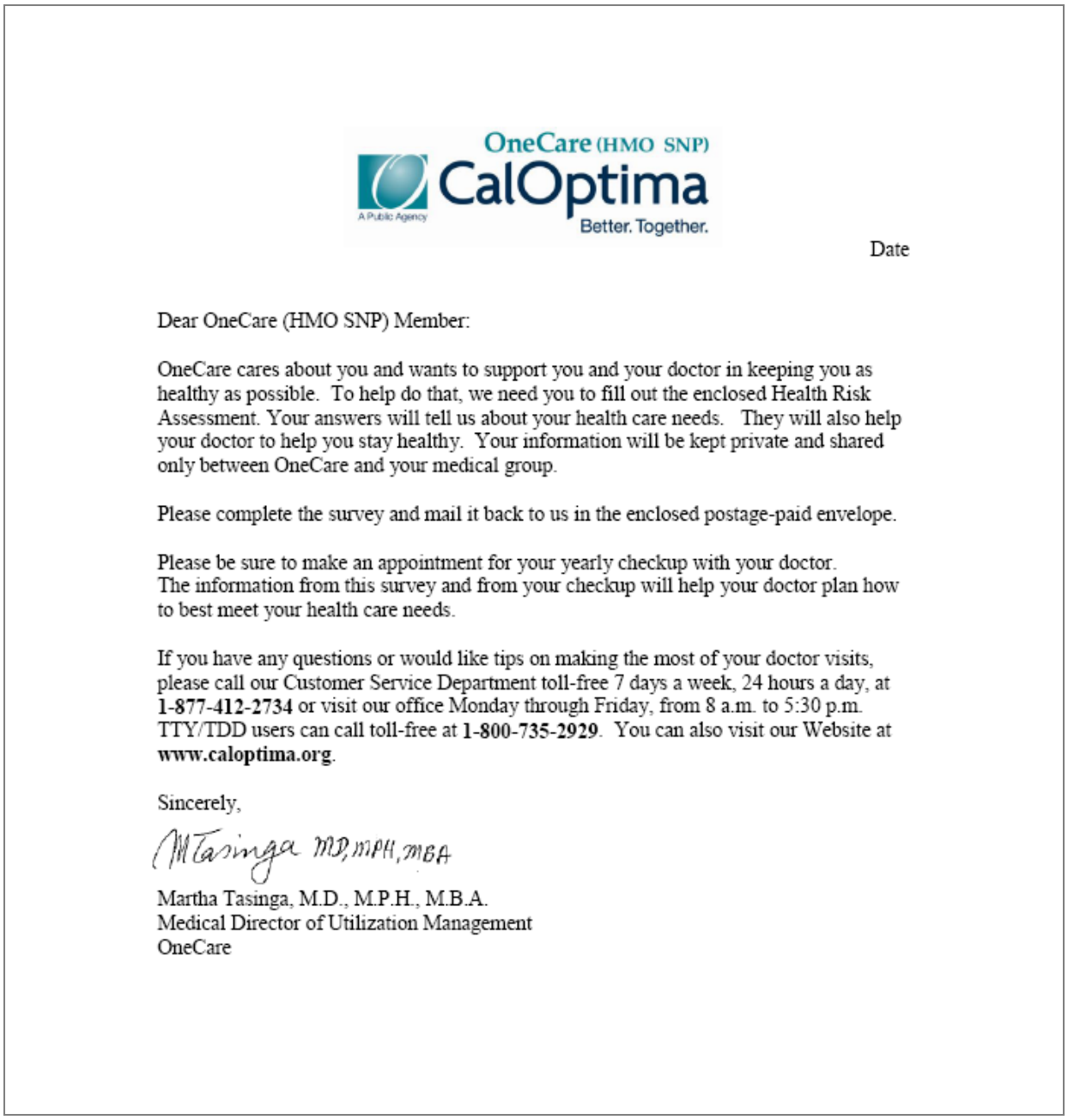


Completed CHRA Postcard / Letter Summary Report

From: 3/1/2011 To 3/31/2011

Eligibility Begin	Packet Created	Post Card (+15 pck created)	Letter (+45 pck created)	Close CHRA (+60 pck created)	CHRA Received	CHRA Create	CHRA Completed	Point	Risk Level	TAT *	One Care Partner	Elig
Talbert Medical Group												
Low												
[redacted] 3/1/2011	3/1/2011	3/30/2011	4/29/2011	5/29/2011		3/25/2011	3/5/2011	2.00	Low	23	Paul Fay	Y
[redacted] 4/1/2011	3/22/2011	4/20/2011	5/20/2011	6/19/2011		4/6/2011	3/24/2011	4.00	Low	14	Annie Pruitt	Y
[redacted] 1/1/2010	1/2/2010	1/31/2010	3/2/2010	4/1/2010		3/30/2011	3/21/2011	7.00	Low	451	Bamette Lydie	Y
[redacted] 3/1/2011	2/24/2011	3/25/2011	4/24/2011	5/24/2011		3/3/2011	3/1/2011	5.00	Low	6	Alexes Valentine	Y
Total Count of Low Assessments: 7												
Total Count of Assessments For Talbert Medical Group: 14												

3. Sample of HRA Member Cover letter – informs member that the HRA answers will be shared with their physician



OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

Date

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Please complete the survey and mail it back to us in the enclosed postage-paid envelope.

Please be sure to make an appointment for your yearly checkup with your doctor. The information from this survey and from your checkup will help your doctor plan how to best meet your health care needs.

If you have any questions or would like tips on making the most of your doctor visits, please call our Customer Service Department toll-free 7 days a week, 24 hours a day, at **1-877-412-2734** or visit our office Monday through Friday, from 8 a.m. to 5:30 p.m. TTY/TDD users can call toll-free at **1-800-735-2929**. You can also visit our Website at **www.caloptima.org**.

Sincerely,

MTasinga MD, MPH, MBA

Martha Tasinga, M.D., M.P.H., M.B.A.
Medical Director of Utilization Management
OneCare

4. Sample PCP Basic ICP which documents review of HRA, is signed by the member and the member is given a copy

Top of Page 1

INDIVIDUAL CARE PLAN Date:_____

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____ CIN #:

BP:	P:	WT: HT: BMI:	Chief complaint:
R:	T:	Allergies:	Problem - From last visit:

Risk Stratification Score: _____ **HRA Reviewed: □ Yes □ No** **Language Preference: _____**

Diagnosis	Plan/Intervention/Follow-up
#1 #2	Goals

Preventive Services	Plan/Intervention/Follow-up
Flu Vaccine: □ Yes □ No Date:	Goals
Pneumonia Vaccine: □ Yes □ No Date:	
Mammogram: □ Yes □ No Date:	
PAP: □ Yes □ No Date:	
Prostate Screening □ Yes □ No Date:	
Colorectal Screening: □ Yes □ No Date:	

Bottom of page 2 with signatures

Topics Discussed

- □ Advanced Directives
- □ Health Care Prefences
- □ Cholesterol
- □ Dental
- □ Diabetes
- □ Diet/Nutrition
- □ Exercise
- □ Family Planning
- □ Hypertension
- □ Immunizations
- □ Asthma
- □ Other
- □ Flu IZ
- □ Pneumonia IZ
- □ Injury Prevention
- □ Mammogram
- □ Medications
- □ Menopause
- □ Obesity
- □ PAP
- □ Prenatal Care
- □ Post Partum Visit
- □ Self Breast Exam
- □ Sexually Transmitted Infections
- □ Substance Abuse
- □ Tobacco Cessation
- □ Testicular Self Exam
- □ Tuberculosis
- □ Breast Cancer Screening
- □ Cervical Cancer Screening
- □ Colorectal Cancer Screening
- □ Prostate Cancer Screening

Physician's Name/Contact # : _____

Member's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

Copy to Chart and Member

Update Revison 06/28/10

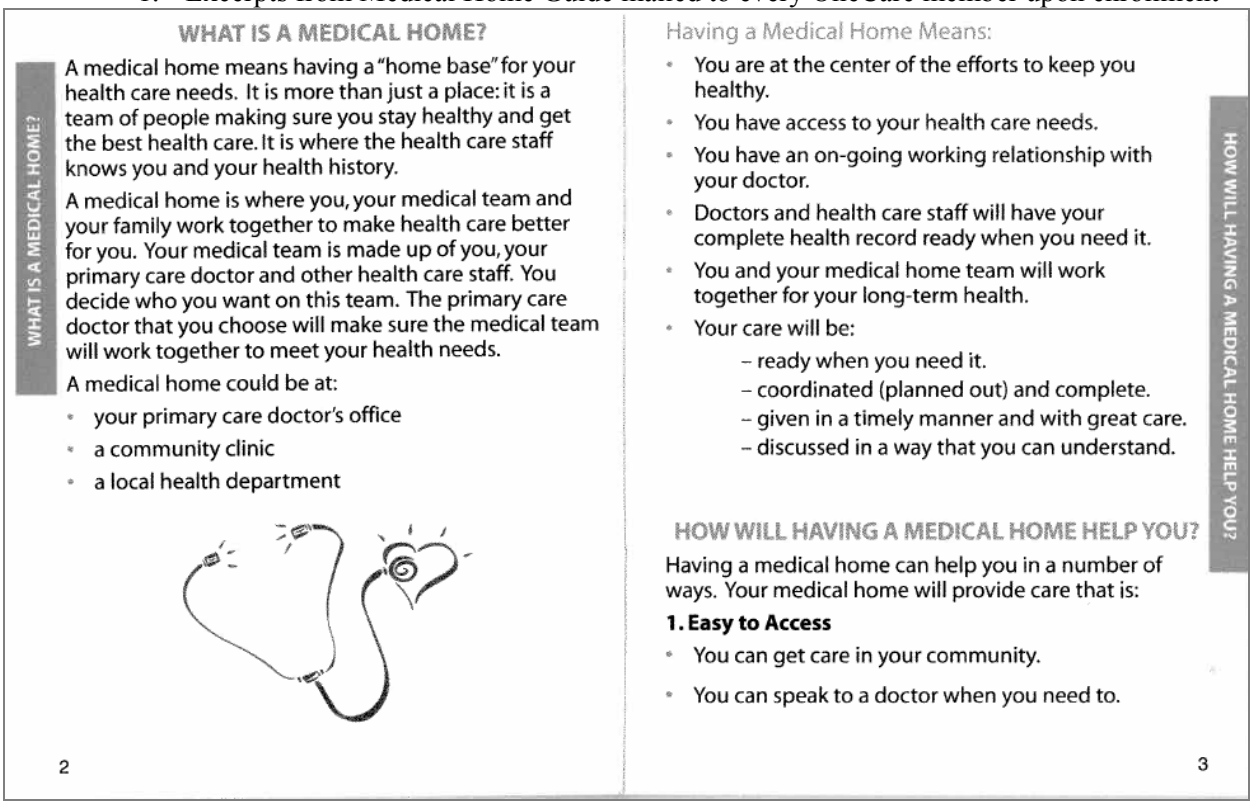
8. Individualized Care Plan

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

OneCare Members are encouraged to participate actively in the development of their ICP within his or her individual physical and psychosocial capabilities. A PCP or case manager develops the ICP in collaboration with the member, caregiver, or authorized representative. The member, caregiver, and/or authorized representative actively participate in development of the ICP by the means most convenient such as face-to-face, written and telephonic. The ICP incorporates the member, caregiver, or authorized representative prioritized goals, preferences and takes into consideration the desired level of participation.
OneCare members are provided with a Medical Home Guide after enrollment. The Medical Home Guide describes how the member can participate in the development of their plan of care (ICP). The Medical Home Guide is available in English, Spanish and Vietnamese. OneCare Case Managers communicate with the member, caregiver, or authorized representative, in their preferred language, in the development and updating of the ICP. All members identified as meeting case management criteria receive introductory letters describing the case management ICP process. The ICP is made available to all caregivers and the member or authorized representative via mail and/or secured email.

EXAMPLES:

1. Excerpts from Medical Home Guide mailed to every OneCare member upon enrollment



WHAT IS A MEDICAL HOME?

A medical home means having a "home base" for your health care needs. It is more than just a place: it is a team of people making sure you stay healthy and get the best health care. It is where the health care staff knows you and your health history.

A medical home is where you, your medical team and your family work together to make health care better for you. Your medical team is made up of you, your primary care doctor and other health care staff. You decide who you want on this team. The primary care doctor that you choose will make sure the medical team will work together to meet your health needs.

A medical home could be at:

- your primary care doctor's office
- a community clinic
- a local health department

2

Having a Medical Home Means:

- You are at the center of the efforts to keep you healthy.
- You have access to your health care needs.
- You have an on-going working relationship with your doctor.
- Doctors and health care staff will have your complete health record ready when you need it.
- You and your medical home team will work together for your long-term health.
- Your care will be:
  - ready when you need it.
  - coordinated (planned out) and complete.
  - given in a timely manner and with great care.
  - discussed in a way that you can understand.

HOW WILL HAVING A MEDICAL HOME HELP YOU?

Having a medical home can help you in a number of ways. Your medical home will provide care that is:

1. Easy to Access

- You can get care in your community.
- You can speak to a doctor when you need to.

3

2. Family Centered

- Your medical home or doctor is someone who knows about your health history and provides constant care for you.
- You and your doctor have a strong trust in each other and work together to manage your health care needs.
- Your family is known as the main caregiver and the center of strength and support for your health care needs.

3. Continuous

- You have the same doctor that you have been working with to take care of your health care needs.
- Your doctor will assist you in getting care and discharge planning when you are in the hospital.

4. Comprehensive

- You have a doctor or medical home team who is there to help you with your care.
- Your doctor can help you stay well by making sure you get preventive health care such as routine check-ups, health screenings, and needed vaccines.
- Your doctor can help you catch problems early to help reduce the number of visits to the emergency room and hospital.
- Your doctor will help you learn skills to stay healthy and to manage any chronic or acute health problems you may have.
- Your doctor can explain your test results to you.

5. Coordinated (planned out)

- A plan of care will be created and shared with other doctors who are involved with your health care.
- Your doctor will provide referrals to specialists.

6. Compassionate

- Doctors will show concern and care for your health and make the effort to support family members.

7. Culturally Competent (respects your cultural background)

- Your beliefs and values will be respected as part of your care.
- Interpreters will be available to help you or your family members understand what happens at a doctor's visit.
- Written materials will be given in the appropriate language.

Reference: http://www.aap.org/healthtopics/medicalhome.cfm

HOW TO GET A MEDICAL HOME?

HOW TO GET A MEDICAL HOME?

Finding a medical home takes time. There are a number of places where you can seek health care. Your doctor may work in a clinic, hospital, or medical office building. In a community health clinic, the doctor may change from day to day. That's okay. That can still be better than long waits in the emergency room.

If your medical home is a clinic, make sure you stay with the same clinic to get your health care. Do not go from clinic to clinic or the emergency room for basic health care needs. That way, you can keep your health records in one place. When your health records are in one place, your medical home team or doctor can better provide and manage your health care.

WHAT WILL YOUR DOCTOR DO?

Your doctor helps you stay well by making sure you get:

- routine check-ups, screenings, and tests to keep you healthy.
- care for both acute and chronic diseases.
- referrals to a specialist and help coordinating care.
- care after a hospital stay and follow up with your health care needs.

6

Your doctor will help you create an individual care plan, (ICP) if you need one. An ICP is a plan that your doctor uses to ensure that all of your health care needs are taken care of. Individual means that the plan is about your health care needs. An ICP is like a road map of your health. It has information on your health history and how to take care of you in any future events. You can work with your doctor to create a plan that is right for you. Make sure to update the plan yearly so that your providers can make sure all of your needs are taken care of.

Your doctor will give advice on what to do when you are sick or hurt. Your doctor can tell how to take care of yourself at home for minor injuries. He or she can tell you if you need to come into the doctor's office or go to the emergency room.

WHAT WILL YOU DO?

WHAT WILL YOU DO?

You play an active role in your plan to stay healthy. You are the key to taking care of your own health. Be a full partner in your health care. This means working with your doctor and talking about any health concerns you may have upfront. When you get to know and trust your doctor, taking care of your health becomes easier.

7

2. Example of Case Management Introduction Letter discussing ICP

AltaMed
Health Services

Date

Dear < Member Name>

We are very pleased that you have selected us for your medical care. As a member of AltaMed, you have been assigned to our Case Management Department to help you maintain optimal wellness under the care of your primary care physician (INSERT PCP NAME).

Members are considered eligible for the Special Needs Program when it identified that they have complex conditions or multiple conditions.

The first step is to set up a telephone call to talk about your health and safety needs, and to help you obtain services that will help you stay healthy.

Our Case Management Coordinator will call you within the next two (2) weeks of receiving this letter to see how you are doing and determine what needs you may have. We will go over certain questions to gather information about your health status. I have included a copy of the questions we will cover. You do not need to complete this form as I will do it for you. However, it might be helpful to look at it and see what we will be talking about.

The Special Needs Program (SNP) is a case management program to coordinate care and services. Our goal is to help you regain your best level of wellness or to improve your functional capability by using the available insurance coverage and resources. When we begin, you and your case manager, will work together to develop goals and follow-up. Your case manager will be in contact with you by telephone to work with you for your case management services.

Your case manager will provide you with information regarding the SNP Program.

Please remember, it is your choice to receive services and participate in the Program or you can decide not to receive services or participate in the Program. This is called the Opt-in/Opt Out process. You may call us to discuss your decision at any time by calling your case manager at <INSERT CASE MGR. TELEPHONE NUMBER HERE>

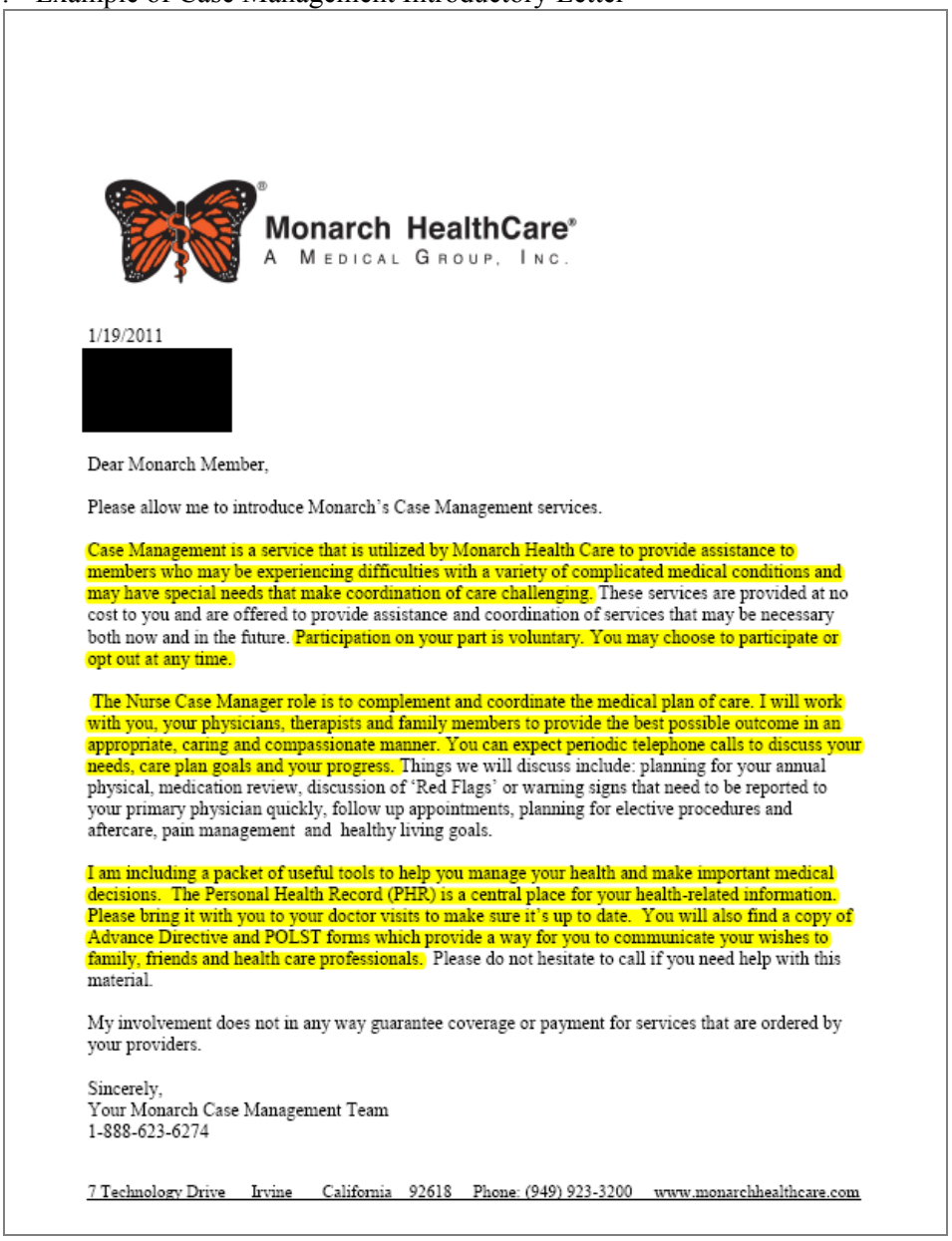
If you have questions, please feel free to call <INSERT CASE MANAGEMENT DEPARTMENT PHONE #>. If you are hearing impaired, please call (800) 735-2929, (800) 794-1099, or (888) 757-6034; I am available Monday through Friday, 8 a.m. to 5 p.m. and look forward to talking with you

Sincerely,

AltaMed Health Services Corporation Case Management Department

500 Citadel Drive Suite 490 Los Angeles, California 90040

3. Example of Case Management Introductory Letter



Monarch HealthCare®
A Medical Group, Inc.

1/19/2011

[redacted]

Dear Monarch Member,

Please allow me to introduce Monarch's Case Management services.

Case Management is a service that is utilized by Monarch Health Care to provide assistance to members who may be experiencing difficulties with a variety of complicated medical conditions and may have special needs that make coordination of care challenging. These services are provided at no cost to you and are offered to provide assistance and coordination of services that may be necessary both now and in the future. Participation on your part is voluntary. You may choose to participate or opt out at any time.

The Nurse Case Manager role is to complement and coordinate the medical plan of care. I will work with you, your physicians, therapists and family members to provide the best possible outcome in an appropriate, caring and compassionate manner. You can expect periodic telephone calls to discuss your needs, care plan goals and your progress. Things we will discuss include: planning for your annual physical, medication review, discussion of 'Red Flags' or warning signs that need to be reported to your primary physician quickly, follow up appointments, planning for elective procedures and aftercare, pain management and healthy living goals.

I am including a packet of useful tools to help you manage your health and make important medical decisions. The Personal Health Record (PHR) is a central place for your health-related information. Please bring it with you to your doctor visits to make sure it's up to date. You will also find a copy of Advance Directive and POLST forms which provide a way for you to communicate your wishes to family, friends and health care professionals. Please do not hesitate to call if you need help with this material.

My involvement does not in any way guarantee coverage or payment for services that are ordered by your providers.

Sincerely,
Your Monarch Case Management Team
1-888-623-6274

7 Technology Drive Irvine California 92618 Phone: (949) 923-3200 www.monarchhealthcare.com

b. Describe the essential elements incorporated in the plan of care (e.g., results of health

risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc)

OneCare members have an initial assessment completed by their PCP or case manager, which may include but is not limited to:

- Review of Health Risk Assessment result
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Mental health, cognitive function and cultural linguistic assessment
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Reviews current status and treatment plan
- Identifies barriers to quality, cost-effective care and treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Assessment and coordination of palliative/ hospice services and alternate care setting

Based on the initial assessment an ICP is developed with the following components:

- Prioritized goals that take into account:
  - Member or caregiver's goals or preferences
  - Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with plan
- Self management plan
- Scheduled time frame for re-evaluation
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family participation

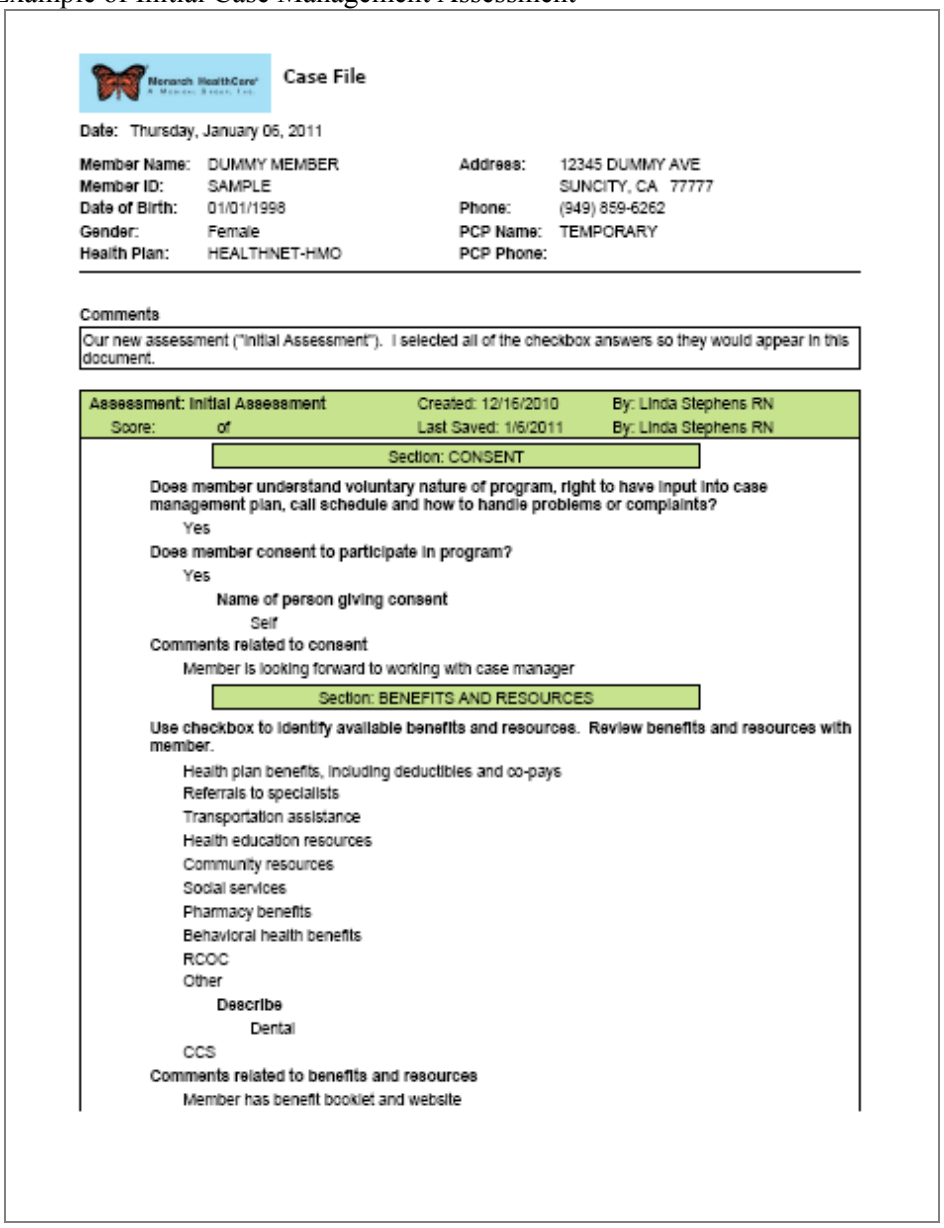
Coordination of Benefits and Services

- Assessment and referral for add on benefits such as: no cost taxi transportation, dental benefit, podiatry and no cost gym benefit
- Assessment and referral to community resources
- Coordinates services provided in and out of plan
- Coordinates treatment plan utilizing an interdisciplinary approach
- Communicates the treatment plan to all entities as necessary to ensure continuity of care (PCP, specialists, health care delivery organizations, member, family, etc.)
- Communicates regularly with individuals and support systems
- Promotes efficient and coordinated care
- Facilitation of member referrals to resources, as appropriate

- Follow up process to determine whether member acts on referrals
- Coordination of carve-out services

EXAMPLES:

1. Example of Initial Case Management Assessment



Case File

Date: Thursday, January 06, 2011

Member Name:	DUMMY MEMBER	**Address:**	12345 DUMMY AVE
Member ID:	SAMPLE		SUNCITY, CA 77777
Date of Birth:	01/01/1998	**Phone:**	(949) 859-6262
Gender:	Female	**PCP Name:**	TEMPORARY
Health Plan:	HEALTHNET-HMO	**PCP Phone:**	

Comments

Our new assessment ("Initial Assessment"). I selected all of the checkbox answers so they would appear in this document.

Assessment: Initial Assessment	Created: 12/16/2010	By: Linda Stephens RN
Score: of	Last Saved: 1/6/2011	By: Linda Stephens RN

Section: CONSENT

Does member understand voluntary nature of program, right to have input into case management plan, call schedule and how to handle problems or complaints?

Yes

Does member consent to participate in program?

Yes

Name of person giving consent

Self

Comments related to consent

Member is looking forward to working with case manager

Section: BENEFITS AND RESOURCES

Use checkbox to identify available benefits and resources. Review benefits and resources with member.

Health plan benefits, including deductibles and co-pays
Referrals to specialists
Transportation assistance
Health education resources
Community resources
Social services
Pharmacy benefits
Behavioral health benefits
RCOC
Other

Describe

Dental

CCS

Comments related to benefits and resources

Member has benefit booklet and website

Case File

Member Name: DUMMY MEMBER
Member ID: SAMPLE

Section: CAREGIVER RESOURCES AND LIFE PLANNING

What best describes caregiver status?

Member has a caregiver with adequate back-up

Use checkbox to describe role of caregiver

Member provides self-care

Caregiver provides hands-on support

Caregiver helps the member make medical decisions

Other

Describe

Primary caregiver is room mate

Who is the primary support person in member's life?

Room mate, BFF

Use checkbox to describe status of member's life planning

Advance Directive has been completed and represents member's wishes

POLST has been completed and represents member's wishes

Member would like information about Advance Directives and POLST

Member is not interested in Advance Directives and POLST

Member has identified healthcare power of attorney

Name and contact information

Room mate, BFF

Comments related to caregiver resources and life planning

Room mate has written material and web resources to access health-related information and community resources

Section: CULTURAL, SPIRITUAL, VALUES, BELIEFS AND DECISION-MAKING

Use checkbox to describe how culture, spirituality, values and beliefs enter into member's healthcare decision-making

Culture, spirituality, beliefs and values play an active role in decision-making

Culture, spirituality, beliefs and values do not enter into decision-making

Culture, spirituality, beliefs and values play an active role in member's sense of well-being

Culture, spirituality, beliefs and values do not impact member's sense of well-being

Member's provider is sensitive to his/her culture, spirituality, values and beliefs

Member would like provider to be more sensitive to his/her culture, spirituality, values and beliefs

Member has adequate information and support to make healthcare decisions

Member is lacking information and support to make healthcare decisions

Member's preferred language

English

Case File

Member Name: DUMMY MEMBER
Member ID: SAMPLE

Comments related to culture, spirituality, values, beliefs and decision-making

Member is active in church and has strong belief system which offers comfort

Section: CLINICAL HISTORY, HEALTH STATUS AND PREVENTION

Overview of clinical history and current health status, including condition-specific issues

Diabetes diagnosed in 2008, diet-controlled.

Date of last primary care provider visit

1/5/2011

What is member's height, weight and BMI?

23.49 BMI 5'7" 150 lbs

What is member's nutritional status?

Adequate nutrition

What is member's pain status?

Pain does not interfere with daily activities
Pain interferes somewhat with daily activities
Pain significantly interferes with daily activities
Satisfied with pain management plan
Would like improvement in pain management plan

What recommended interventions is adult member not receiving?

Hypertension screening
Lipid profile
Aspirin prophylaxis for patients at risk for coronary artery disease
Screening for osteoporosis (DXA scan) and calcium supplementation
Tobacco use screening and intervention
Drug or substance abuse screening and counseling
Tetanus immunization
Influenza immunization
Pneumococcus immunization
Hepatitis immunization
Zoster (shingles) immunization
Glaucoma screening
Dental care
Colorectal screening
Breast cancer screening
Cervical cancer screening
Member has received all recommended interventions
N/A (Member is a child)

Does member have diabetes?

Yes

Use checkbox to identify the recommended interventions that member has not completed

A1C
LDL

Microalbumen
Retinal eye exam
Foot examination
Dental care

What recommended interventions is child not receiving?

Vision care
Infant sleep positioning and sudden infant death syndrome counseling
Blood lead testing
Car seat/booster seat/seat belt when riding in motor vehicle
Dental screening
Obesity screening
Tobacco use screening; prevention and intervention in adolescents
Drug or substance abuse screening and counseling
Chlamydia screening for sexually active teenagers
Diphtheria, pertussis, and tetanus immunizations
Influenza immunization
Polio vaccination
Measles, mumps, and rubella immunizations
Varicella immunization
Human papillomavirus immunization
Other

Describe

Safe internet usage

Member has received all recommended interventions
N/A (Member is an adult)

What is member's smoking status?

Smokes and is contemplating quitting

Does member have quit date?

Yes

Planned quit date

1/6/2011

Does member have current or past substance abuse issues?

Yes

Describe

History of alcohol abuse

Describe

1 pint/day x 10 years/ Quit 1 year ago

History of drug abuse

Describe

Heroin/quit 1 year ago

Current alcohol abuse

Describe

1 pint/day. Not interested in making a change

Current drug abuse

Describe

heroin. Not interested in making a change

Comments related to clinical history, health status and prevention

Free text comments.

Section: MENTAL HEALTH, COGNITIVE FUNCTION AND HEALTH LITERACY

Use checkbox to describe problems understanding health-related instructions

- No problems understanding health-related instructions
- Problems understanding health provider's directions
- Problems understanding medication instructions
- Poor understanding of diagnoses
- Poor understanding of preventive care
- Poor support system

Use checkbox to describe memory problems

- Adequate short-term memory
- Adequate long-term memory
- Inadequate short-term memory
- Inadequate long-term memory
- Recent memory changes

Use checkbox to describe problems with depression

- No depression
- History of depression but no recent symptoms
- Symptoms of depression, interested in treatment
- Symptoms of depression, resistant to treatment
- Member is satisfied with current depression treatment plan
- Member is not satisfied with current depression treatment plan

Is member receiving care from a behavioral health provider?

Yes

Name

Dr Feelgood

Describe behavioral health problems that interfere with functioning or access to health care.

Free text comments

Comments related to mental health, cognitive function and health literacy

Free text comments

Section: ACTIVITIES OF DAILY LIVING AND SAFETY

Use checkbox to describe problems with activities

- No problems with activities of daily living
- Problems with dressing
- Problems with bathing
- Problems with eating
- Problems with communication
- Problems with meal preparation

Problems with housekeeping
Problems with transportation
Problems managing finances
Problems with toileting

Use checkbox to describe problems with safety

History of falls
Problems with dizziness
Potential for medication side effects that increase fall risk
Potential for clinical problems that increase fall risk
Member is reluctant to use walking aids such as a cane or walker
Member's home is cluttered
Member's home lacks smoke detectors and fire extinguishers
Member's home has stairs that are difficult to climb
Member has poor safety awareness
Member does not have caregivers, friends or neighbors that can be easily reached if needed
Member does not have an emergency plan
Member has unsafe smoking practices
Member does not know how to safely handle medications
Member's home is not child-proofed if children are present
Member has weapons that are not safely stored
No safety problems have been identified

Use checkbox to describe member's visual and hearing needs, preferences or limitations

Adequate vision
Adequate hearing
Moderate vision impairment: requires mechanism to enlarge the visual field
Severe vision impairment: requires mechanism to translate contents to speech or braille
Moderate hearing impairment: requires mechanism to increase the volume
Severe hearing impairment: needs to have auditory information presented in visual form

Comments related to ADL's

Free text comments

Section: SELF-CARE MANAGEMENT

Use checkbox to identify medication concerns

Member is concerned about effects and side effects
Member is not sure if he/she needs medication that has been prescribed
Member is worried about the cost of medication
Member does not have a system to organize medication administration
Member does not understand medication instructions

Use check box to identify problems with self-care management

Member does not have a written action plan describing how to take medications

Case File

Member Name: DUMMY MEMBER
Member ID: SAMPLE

Member does not have a written action plan describing how to recognize symptoms
Member does not have a written action plan describing how to respond to symptoms
Member does not have a written action plan describing how to manage during an emergency
Member has inadequate caregiver support
Member does not have problems with self-care management

Comments related to self-care management

Comments

2. PCP Basic ICP and Assessment

INDIVIDUAL CARE PLAN **Date:_____**

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____

CIN #:

BP:	P:	WT: HT: BMI:	Chief complaint:
R:	T:	Allergies:	Problem - From last visit:

Risk Stratification Score: _____ **HRA Reviewed: □ Yes □ No** **Language Preference: _____**

Diagnosis	Plan/Intervention/Follow-up
#1 #2	Goals

Preventive Services	Plan/Intervention/Follow-up
Flu Vaccine: □ Yes □ No Date:	Goals
Pneumonia Vaccine: □ Yes □ No Date:	
Mammogram: □ Yes □ No Date:	
PAP: □ Yes □ No Date:	
Prostate Screening □ Yes □ No Date:	
Colorectal Screening: □ Yes □ No Date:	

Social	Plan/Intervention/Follow-up
Marital Status: □ Married □ Divorced □ Single	Goals
Transportation: □ Yes □ No	
Caregivers: □ Yes □ No	
Living Arrangements: □ Yes □ No	
Recreational Activities: □ Yes □ No	
Comments:	

Nutrition	Plan/Intervention/Follow-up
BMI	Goals
Hemoglobin	
Serum Albumin	
Recent Weight Change: □ Yes □ No	
Dentures: □ Yes □ No	
Comments:	

Functional Assessment (assistance needed)				Plan/Intervention/Follow-up
	Independent	Assisted	Dependent	Goals
Ability to Take Medication:				
Feeding:				
Grooming:				
Toileting:				
Continence:				
Ambulation:				
Risk for Falls:				
Pain Scale: (1-10)				
Comments:				

INDIVIDUAL CARE PLAN **Date:**_____

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____ CIN #:

Psychological Assessment	Plan/Intervention/Follow-up
Recent Major Stress: □ Yes □ No	Goals
Feeling Down: □ Yes □ No	
Sleep Disturbance: □ Yes □ No	
History of Depression: □ Yes □ No	
Advance Directive on File: □ Yes □ No	

Cognitive Functioning	Plan/Intervention/Follow-up
Orientated: □ Yes □ No	Goals
Immediate Recall: □ Good □ Poor	
Delay Recall: □ Good □ Poor	
Confused: □ Mostly □ At times □ Not at all	
Memory Deficit: □ Yes □ No	
Inappropriate Behavior: □ Yes □ No	
Comments:	

Case Management/Coordination	Plan/Intervention/Follow-up
Risk of admission to hospital: □ Yes □ No	Goals
Risk of placement to SNF: □ Yes □ No	
Referral to CM: □ Yes □ No	
Referral to DM: □ Yes □ No	
Comments:	

Topics Discussed

- □ Advanced Directives
- □ Health Care Prefences
- □ Cholesterol
- □ Dental
- □ Diabetes
- □ Diet/Nutrition
- □ Exercise
- □ Family Planning
- □ Hypertension
- □ Immunizations
- □ Asthma
- □ Other
- □ Flu IZ
- □ Pneumonia IZ
- □ Injury Prevention
- □ Mammogram
- □ Medications
- □ Menopause
- □ Obesity
- □ PAP
- □ Prenatal Care
- □ Post Partum Visit
- □ Self Breast Exam
- □ Sexually Transmitted Infections
- □ Substance Abuse
- □ Tobacco Cessation
- □ Testicular Self Exam
- □ Tuberculosis
- □ Breast Cancer Screening
- □ Cervical Cancer Screening
- □ Colorectal Cancer Screening
- □ Prostate Cancer Screening

Physician's Name/Contact # : _____

Member's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

Copy to Chart and Member

Update Revison 06/28/10

3. Example of Member ICP with essential elements (review of HRA, goals, specific/add on services and outcome measures

Care Plan			
Goal	Created	Created By	Completed
Referral source aware of case disposition (Triage)	10/1/2010	D. Craig RN	10/1/2010
Goal Comments	Created	Created By	
referral from Barbara Joseph, Quality Management	10/1/2010	Donna Craig RN	
Interventions	Created	Created By	Completed
Inform referral source of case disposition (Coordinator)	10/1/2010	D. Craig RN	10/1/2010
Comments:	Created	Created By	
notified Barbara Joseph, Quality Management, that mbr has agreed to case management	10/1/2010	Donna Craig RN	
Barriers	Created	Created By	
No Barriers Identified	10/1/2010	D. Craig RN	
Comments:	Created	Created By	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	Created	Created By	
Met	10/1/2010	D. Craig RN	
Goal	Created	Created By	Completed
Member, family and caregiver are knowledgeable about resources	10/1/2010	D. Craig RN	12/2/2010
Goal Comments	Created	Created By	
STG 12/1/2010; mbr will be aware of community resources for the homeless	10/1/2010	Donna Craig RN	
Interventions	Created	Created By	Completed
Refer to Social Worker (1)	10/1/2010	D. Craig RN	12/2/2010
Comments:	Created	Created By	
CM will refer to social worker for discussion regarding community resources	10/1/2010	Donna Craig RN	
mbr is aware of community resources; he refused to meet with the Senior Touch team (SW & NP)	12/2/2010	Donna Craig RN	
Barriers	Created	Created By	
Availability	10/1/2010	D. Craig RN	
Comments:	Created	Created By	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	

Behavioral	10/1/2010	D. Craig RN	
Comments:	Created	Created By	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Psychosocial	10/1/2010	D. Craig RN	
Comments:	Created	Created By	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	Created	Created By	
Met	12/2/2010	D. Craig RN	
Not Met	10/1/2010	D. Craig RN	
Goal	Created	Created By	Completed
Additional Interventions	10/1/2010	D. Craig RN	12/2/2010
Interventions	Created	Created By	Completed
Send initial assessment and care plan summary to PCP	10/21/2010	D. Craig RN	11/3/2010
Request medical records (Coordinator)	10/1/2010	D. Craig RN	10/20/2010
Comments:	Created	Created By	
10/19/10 4th request.	10/19/2010	Mahogany McKelton	
2nd request for medical records	10/13/2010	Mahogany McKelton	
coordinator to request records from pcp	10/1/2010	Donna Craig RN	
Medical records requested from pcp.	10/7/2010	Mahogany McKelton	
Requested info faxed.	10/20/2010	Mahogany McKelton	
Barriers	Created	Created By	
Other	10/1/2010	D. Craig RN	
Comments:	Created	Created By	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	Created	Created By	
Met	12/2/2010	D. Craig RN	
Partially Met	10/21/2010	D. Craig RN	
Not Met	10/1/2010	D. Craig RN	
Goal	Created	Created By	Completed
Member practices optimal self-care behaviors	10/1/2010	M. McKelton	
Goal Comments	Created	Created By	
LTG moved forward to 3/8/12; mbr will be adherent with the treatment plan, including psychiatric care	3/8/2011	Donna Craig RN	
mbr schedules appointments with his pcp & specialists; however, he is not adherent with medical advice & prescriptions	11/29/2010	Donna Craig RN	
LTG 3/1/11; mbr will see his pcp & specialists routinely & take his medications as prescribed in order to maintain optimal health AEB no ER visits or unplanned hospitalizations	10/1/2010	Donna Craig RN	
Interventions	Created	Created By	Completed
Coach self-care management	10/1/2010	M. McKelton	
Comments:	Created	Created By	
CM continues to coach mbr to comply with the treatmet plan, but mbr is non compliant with medications for BP & schizophrenia; he schedules appts with his pcp & specialists, but does not follow medical advice	12/2/2010	Donna Craig RN	

CM will continue to encourage compliance with the treatment in order to prevent long term complications	3/8/2011	Donna Craig RN	
CM will encourage mbr to develop a trusting relationship with one pcp so that his care will not be fragmented	10/1/2010	Donna Craig RN	
Barriers	**Created**	**Created By**	
Behavioral	10/1/2010	D. Craig RN	
Comments:	**Created**	**Created By**	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Psychosocial	10/1/2010	D. Craig RN	
Comments:	**Created**	**Created By**	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	**Created**	**Created By**	
Partially Met	12/2/2010	D. Craig RN	
Not Met	10/1/2010	M. McKelton	
Goal	Created	Created By	Completed
Health Risk Assessment: Review	10/1/2010	M. McKelton	3/4/2011
Goal Comments	**Created**	**Created By**	
start report received & reviewed	3/4/2011	Donna Craig RN	
LTG 10/1/11	10/1/2010	Donna Craig RN	
Interventions	**Created**	**Created By**	**Completed**
Health Risk Assessment: review and update care plan	10/1/2010	M. McKelton	
Barriers	**Created**	**Created By**	
No Barriers Identified	10/1/2010	D. Craig RN	
Comments:	**Created**	**Created By**	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	**Created**	**Created By**	
Not Met	10/1/2010	M. McKelton	
Goal	Created	Created By	Completed
Interdisciplinary Care Team	10/1/2010	M. McKelton	10/3/2010
Goal Comments	**Created**	**Created By**	
IDT held on 10/1/10 with Caloptima; it was recommneded by the team that mbr be referred to a urologist & also to Windstone Behavioral Health; it was also recommended that the Senior Touch Team be present at mbr's pcp appt on 10/4/10 @ 3:00 with his new pcp, Dr. Udnani	10/3/2010	Donna Craig RN	
STG 10/1/10	10/1/2010	Donna Craig RN	
Interventions	**Created**	**Created By**	**Completed**
Interdisciplinary Care Team: review and update care plan as indicated	10/1/2010	M. McKelton	10/3/2010
Comments:	**Created**	**Created By**	
IDT's held with OneCare on 12/3/10 & 1/27/11	3/4/2011	Donna Craig RN	
mbr's appts scheduled: 1. Dr. Schuhrke, M.D. (uro) on 10/7/10 @ 8:45 am 2. Windstone behavioral Health, Dr.Agshar on 10/14/10 @ 9:00 am	10/3/2010	Donna Craig RN	

	Barriers	Created	Created By	
	No Barriers Identified	10/1/2010	D. Craig RN	
	Comments:	Created	Created By	
	mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
	Outcomes	Created	Created By	
	Met	10/3/2010	D. Craig RN	
	Not Met	10/1/2010	M. McKelton	
Goal		Created	Created By	Completed
No ER visits or unplanned hospitalizations		10/1/2010	D. Craig RN	
	Goal Comments	Created	Created By	
	LTG moved forward to 3/8/12; mbr continues to utilize the ER	3/8/2011	Donna Craig RN	
	mbr has been to the ER multiple times	11/29/2010	Donna Craig RN	
	LTG 3/1/11; mbr will not use the ER as a clinic	10/1/2010	Donna Craig RN	
	Interventions	Created	Created By	Completed
	Coach utilizing pcp, urgent care vs ER	10/1/2010	D. Craig RN	
	Comments:	Created	Created By	
	CM will coach mbr regarding going to pcp or urgent care; CM will educate mbr regrding when it is appropriate to go to the ER	10/1/2010	Donna Craig RN	
	CM will continue to coach using urgent care or pcp rather than the ER for non emergent issues	3/8/2011	Donna Craig RN	
	Barriers	Created	Created By	
	Behavioral	10/1/2010	D. Craig RN	
	Comments:	Created	Created By	
	mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
	Psychosocial	10/1/2010	D. Craig RN	
	Comments:	Created	Created By	
	mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
	Outcomes	Created	Created By	
	Partially Met	4/1/2011	D. Craig RN	
	Comments:	Created	Created By	
	mbr has been coached re use of urgent care vs ER	4/1/2011	Donna Craig RN	
	Not Met	10/1/2010	D. Craig RN	
Goal		Created	Created By	Completed
Psychosocial conditions managed effectively		10/1/2010	D. Craig RN	4/8/2011
	Goal Comments	Created	Created By	
	goal closed as mbr is not interested	4/8/2011	Donna Craig RN	
	LTG moved forward to 3/8/12	3/8/2011	Donna Craig RN	

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

1. The ICP developed in the Basic IDT, which includes the member, PCP and/ or Specialist, is reviewed and revised annually and as the member's health status changes. The Basic ICP is reviewed updated by the PCP in collaboration with member and participants of the ICT.:

   - At each PCP visit and member contact
   - Review when additional information is obtained from member, caregiver, or authorized representative, Case Manager, Specialist(s) and the annual HRA

- Review when health status changes such as; hospital or SNF admissions, ER visits, readmission within 30 days, change to medication regimen, new diagnosis or exacerbation of current condition or change in requirements for DME or medical supplies
- Review when psychosocial barriers are identified such as; change in support system, unsafe home environment or potential for change in care setting, change in adherence to medication or treatment plan or change in mental status

2. The ICP developed in the Primary and Complex IDTs, which includes at a minimum the member and /or authorized representative, PCP and Specialist, Medical Director, Case Manager, Social Worker and Behavioral Health Specialist. The ICP is this reviewed and updated by the Case Manager in collaboration with the member, PCP, and participants of the ICT:

    - At each contact with the member
    - With additional information from:
        - Member, caregiver, or authorized representative
        - PCP and/or specialist
        - Annual HRA
    - With changes to the member's health status
        - Hospital or SNF admissions
        - ER Visit
        - Readmission within 30 days
    - When barriers are identified and modifications are required
        - Alteration in mental or functional status
        - With a change of care setting
        - Unsafe home environment or potential for change in care setting
        - Lack of support system
        - Change in adherence

    a. When goals are met or case closure

3. Modifications to the ICP include but is not limited to:

    a. Increased frequency of monitoring
    b. Medication reconciliation and monitoring of adherence
    c. Implementation of a transition of care plan
    d. Home safety assessment
    e. Assessment for additional services and benefits
    f. Community resource referrals
    g. Assessment and coordination of palliative/ hospice services and alternate care setting

EXAMPLES:

Example of PCP Basic ICP

INDIVIDUAL CARE PLAN Date:_____

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____ CIN #:

BP:	P:	WT: HT: BMI:	Chief complaint:
R:	T:	Allergies:	Problem - From last visit:

Risk Stratification Score: _____ **HRA Reviewed:** ☐ Yes ☐ No **Language Preference:** _____

Diagnosis	Plan/Intervention/Follow-up
#1 #2	Goals

Preventive Services	Plan/Intervention/Follow-up
Flu Vaccine: ☐ Yes ☐ No Date: Pneumonia Vaccine: ☐ Yes ☐ No Date: Mammogram: ☐ Yes ☐ No Date: PAP: ☐ Yes ☐ No Date: Prostate Screening ☐ Yes ☐ No Date: Colorectal Screening: ☐ Yes ☐ No Date:	Goals

Social	Plan/Intervention/Follow-up
Marital Status: ☐ Married ☐ Divorced ☐ Single Transportation: ☐ Yes ☐ No Caregivers: ☐ Yes ☐ No Living Arrangements: ☐ Yes ☐ No Recreational Activities: ☐ Yes ☐ No Comments:	Goals

Nutrition	Plan/Intervention/Follow-up
BMI Hemoglobin Serum Albumin Recent Weight Change: ☐ Yes ☐ No Dentures: ☐ Yes ☐ No Comments:	Goals

Functional Assessment (assistance needed)	Independent	Assisted	Dependent	Plan/Intervention/Follow-up
Ability to Take Medication:				Goals
Feeding:				
Grooming:				
Toileting:				
Continence:				
Ambulation:				
Risk for Falls:				
Pain Scale: (1-10)				
Comments:				

INDIVIDUAL CARE PLAN

Date:_____

Member Name: _____ DOB: _____ Age: _____

Telephone #:_____

CIN #:

Psychological Assessment	Plan/Intervention/Follow-up
Recent Major Stress: □ Yes □ No	Goals
Feeling Down: □ Yes □ No	
Sleep Disturbance: □ Yes □ No	
History of Depression: □ Yes □ No	
Advance Directive on File: □ Yes □ No	

Cognitive Functioning	Plan/Intervention/Follow-up
Orientated: □ Yes □ No	Goals
Immediate Recall: □ Good □ Poor	
Delay Recall: □ Good □ Poor	
Confused: □ Mostly □ At times □ Not at all	
Memory Deficit: □ Yes □ No	
Inappropriate Behavior: □ Yes □ No	
Comments:	

Case Management/Coordination	Plan/Intervention/Follow-up
Risk of admission to hospital: □ Yes □ No	Goals
Risk of placement to SNF: □ Yes □ No	
Referral to CM: □ Yes □ No	
Referral to DM: □ Yes □ No	
Comments:	

Topics Discussed

- □ Advanced Directives
- □ Health Care Prefences
- □ Cholesterol
- □ Dental
- □ Diabetes
- □ Diet/Nutrition
- □ Exercise
- □ Family Planning
- □ Hypertension
- □ Immunizations
- □ Asthma
- □ Other
- □ Flu IZ
- □ Pneumonia IZ
- □ Injury Prevention
- □ Mammogram
- □ Medications
- □ Menopause
- □ Obesity
- □ PAP
- □ Prenatal Care
- □ Post Partum Visit
- □ Self Breast Exam
- □ Sexually Transmitted Infections
- □ Substance Abuse
- □ Tobacco Cessation
- □ Testicular Self Exam
- □ Tuberculosis
- □ Breast Cancer Screening
- □ Cervical Cancer Screening
- □ Colorectal Cancer Screening
- □ Prostate Cancer Screening

Physician's Name/Contact # : _____

Member's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

Copy to Chart and Member

Update Revison 06/28/10

1. Documentation of ICP reviewed and updated by case manger per IDT recommendations

Goal	Created	Created By	Completed
Interdisciplinary Care Team	10/1/2010	M. McKelton	10/3/2010
Goal Comments	**Created**	**Created By**	
IDT held on 10/1/10 with Caloptima; it was recommneded by the team that mbr be referred to a urologist & also to Windstone Behavioral Health; it was also recommended that the Senior Touch Team be present at mbr's pcp appt on 10/4/10 @ 3:00 with his new pcp, Dr. Udnani	10/3/2010	Donna Craig RN	
STG 10/1/10	10/1/2010	Donna Craig RN	
Interventions	**Created**	**Created By**	**Completed**
Interdisciplinary Care Team: review and update care plan as indicated	10/1/2010	M. McKelton	10/3/2010
Comments:	**Created**	**Created By**	
IDT's held with OneCare on 12/3/10 & 1/27/11	3/4/2011	Donna Craig RN	
mbr's appts scheduled: 1. Dr. Schuhrke, M.D. (uro) on 10/7/10 @ 8:45 am 2. Windstone behavioral Health, Dr.Agshar on 10/14/10 @ 9:00 am	10/3/2010	Donna Craig RN	

2. Example of ICP communication with PCP

Goal	Created	Created By	Completed
Member schedules and completes follow-up visits with Primary Care Provider / Specialist and is empowered to be an active participant in these interactions.	10/3/2010	D. Craig RN	4/1/2011
Goal Comments	**Created**	**Created By**	
mbr has been compliant regardind pcp & specialist f/u appts	12/2/2010	Donna Craig RN	
Interventions	**Created**	**Created By**	**Completed**
Coach when/if practitioner should be called	12/2/2010	D. Craig RN	4/1/2011
Send initial assessment and care plan summary to PCP	12/2/2010	D. Craig RN	12/2/2010
Comments:	**Created**	**Created By**	
information faxed to Dr. Crawford	12/2/2010	Donna Craig RN	
Barriers	**Created**	**Created By**	
Psychosocial	10/3/2010	D. Craig RN	
Comments:	**Created**	**Created By**	
mbr changes pcp frequently, so it may be difficult to obtain current records	10/1/2010	Donna Craig RN	
Outcomes	**Created**	**Created By**	
Met	4/1/2011	D. Craig RN	
Partially Met	12/2/2010	D. Craig RN	
Not Met	10/3/2010	D. Craig RN	

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

The Basic ICP is part of the member's permanent medical record. The member acknowledges and signs the Basic ICP by the PCP. The PCP provides the member and the other participants of the IDT with a copy of the ICP. The ICP is stored in the PCP member's medical record, at the PCP's office, in accordance with HIPAA and all contractual, statutory and regulatory requirements.

The Primary ICP is documented in the PMG's HIPAA compliant case management computerized documentation system. Copies of the ICP are mailed to the member, provider, and sent via secured emailed to OneCare Clinical Team, and all other participants of the IDT. The ICP is stored in the PCP member's medical record, at the PCP's office, in accordance with HIPAA and all contractual, statutory and regulatory requirements.

The Complex ICP is documented in OneCare's HIPAA compliant case management computerized documentation system. Copies of the ICP are mailed to the member, provider, and sent via secured emailed to the PMG, and all other participants of the IDT. The ICP is stored in the PCP member's medical record, at the PCP's office, in accordance with HIPAA and all contractual, statutory and regulatory requirements.

The PCP and other providers must designate an individual to be responsible for the medical records maintenance and storage in accordance with CalOptima OneCare Policy MA.9021 Medical Records Maintenance.

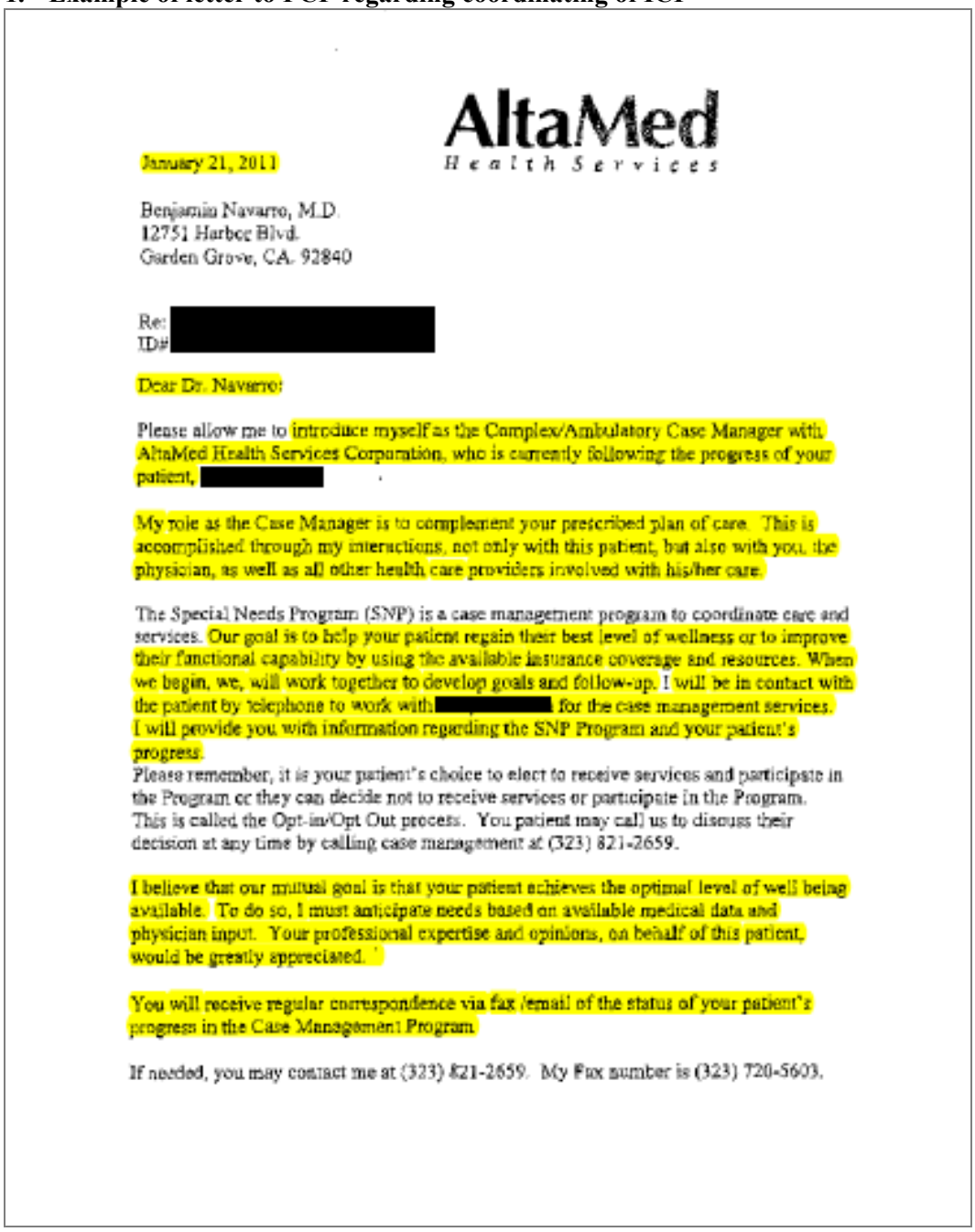
- Active records should be labeled and stored in a secured area that protects the record from loss, tampering, alteration, destruction and access by unauthorized individuals
- Inactive records shall be maintained and stored for five years in either electronic or hard copy format
- The providers ensure that the member has access to their medical record which includes the ICP
- The providers ensure that all staff complies with confidentiality requirements

OneCare, PMGs and ICT participants who stores the ICP in their information system must ensure compliance with Electronic Protected Health Information (EPHI) in accordance with CalOptima policy IS.1101 EPHI Physical Controls and IS.1302 Contingency and Data Backup Plan

- Physical access controls are implemented to prevent unauthorized access, tampering, theft, damage and breach
- Physical access to PHI is aligned with personnel role and function in accordance with minimum necessary
- Physical controls ensure that only authorized users have access to information systems that process or store EPHI
- Establish data backup plan that includes scheduled backups and offsite storage

EXAMPLES:

1. **Example of letter to PCP regarding coordinating of ICP**



AltaMed
Health Services

January 21, 2011

Benjamin Navarro, M.D.
12751 Harbor Blvd.
Garden Grove, CA. 92840

Re: [redacted]
ID# [redacted]

Dear Dr. Navarro:

Please allow me to introduce myself as the Complex/Ambulatory Case Manager with AltaMed Health Services Corporation, who is currently following the progress of your patient, [redacted].

My role as the Case Manager is to complement your prescribed plan of care. This is accomplished through my interactions, not only with this patient, but also with you, the physician, as well as all other health care providers involved with his/her care.

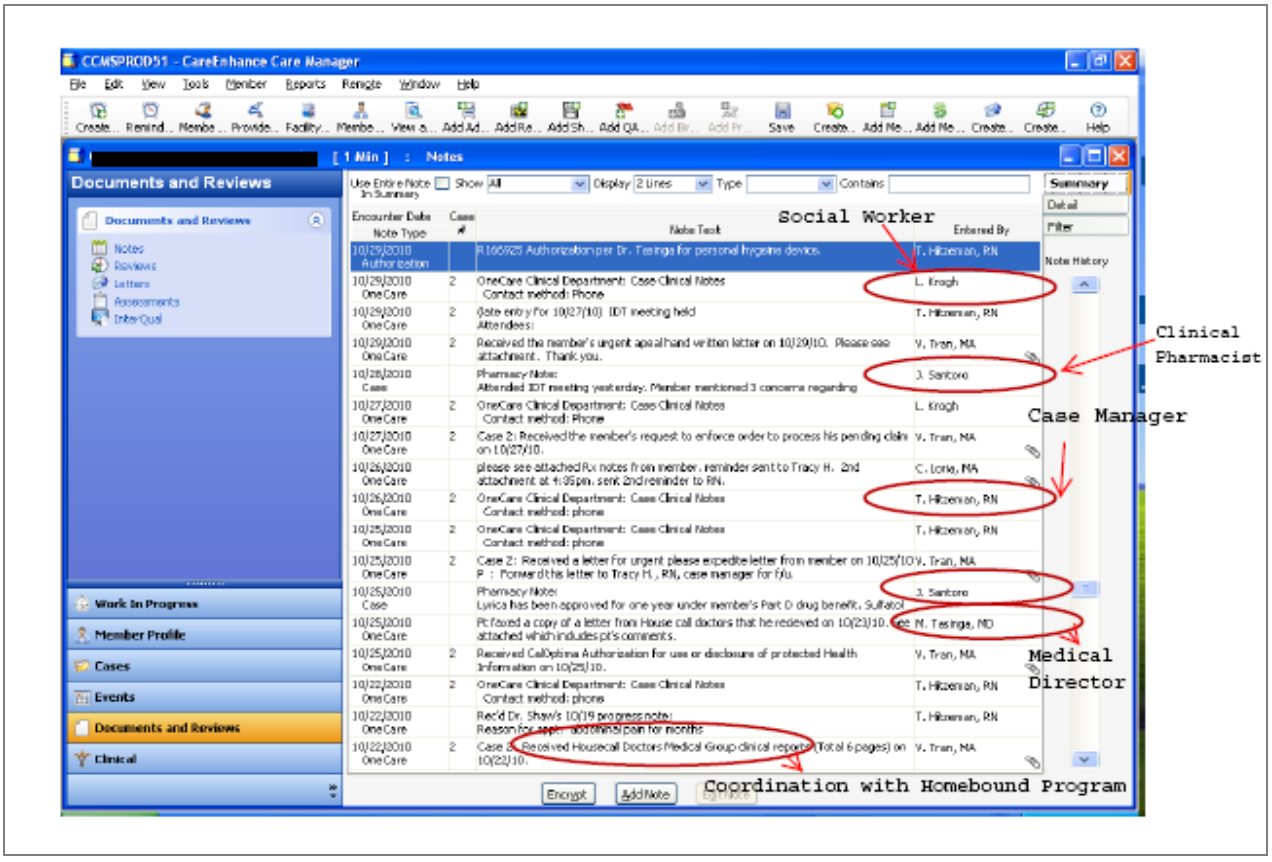
The Special Needs Program (SNP) is a case management program to coordinate care and services. Our goal is to help your patient regain their best level of wellness or to improve their functional capability by using the available insurance coverage and resources. When we begin, we, will work together to develop goals and follow-up. I will be in contact with the patient by telephone to work with [redacted] for the case management services. I will provide you with information regarding the SNP Program and your patient's progress.
Please remember, it is your patient's choice to elect to receive services and participate in the Program or they can decide not to receive services or participate in the Program. This is called the Opt-in/Opt Out process. You patient may call us to discuss their decision at any time by calling case management at (323) 821-2659.

I believe that our mutual goal is that your patient achieves the optimal level of well being available. To do so, I must anticipate needs based on available medical data and physician input. Your professional expertise and opinions, on behalf of this patient, would be greatly appreciated.

You will receive regular correspondence via fax /email of the status of your patient's progress in the Case Management Program.

If needed, you may contact me at (323) 821-2659. My Fax number is (323) 720-5603.

2. **Screen print of case management documentation system demonstrating accessibility of the ICP to members IDT**



3. Example of Member ICP documenting communication to member

Monarch HealthCare
A Medical Group, Inc.

Case File

Member Name: [redacted]
Member ID: [redacted]

Case Notes

Date/Time	Contact Type	Note	Completed By
1/27/2011 2:15 PM	Telephone	Called Dr. Castro's office; they will fax the notes today.	Donna Craig RN
1/18/2011 3:32 PM	Task Comment	Faxed request for cnslt notes from Rheumo Dr Castro,@ 949-364-1647 as requested from L Krogh LCSW @ Onecare, per D Craig RN CCM.	Patti Houghton
1/14/2011 11:48 AM	Task Comment	IDT conference call held 1/13/11 with mbr in attendance via phone. Caloptima attendees were: Dr. Tasinga, Ginny, Lindsey, Sheila & Tracy H. Monarch attendees were Linda Stephens, Teri Miranti & Donna Craig. Mbr continues to believe he has Chlamydia, but refuses to have a repeat HLA-B27 to r/o Reiter's syndrome done, or virology testing ordered by Dr. Khempa. Will discuss with mbr.	Donna Craig RN
1/4/2011 2:08 PM	Task Comment	Received e-mail from mbr. His new pcp is Dr. Maya Kaura & his initial appt is 1/5/11 at 11:30 am.	Donna Craig RN
12/17/2010 3:46 PM	Telephone	Received vm from Lindsey Krogh at Caloptima stating a discussion re mbr is planned for the second week in January. Lindsey requestd CM request the notes from Dr. Crawford, pcp (called Dr. Crawford's office & requested notes), the ER visits for December, & all labs from 1/1/2006 (mbr became eligible with Monarch on this date). E-mailed Quest & requested labs from 1/1/2006.	Donna Craig RN
12/17/2010 12:01 PM	Telephone	Received e-mails & also phone calls from mbr (on 12/15 & 12/16) stating he wants a new pcp. He said Dr. Crawford would not treat him for Chlamydia & that he needs antibitotics. E-mailed mbr to ask him to reconsider getting the HLA-B27 test done. Per. Dr. Crawford, mbr refused to have the test done. This test is part of the care plan received from Caloptima following the last IDT (12/3/10).	Donna Craig RN
12/10/2010 10:32 AM	Task Comment	Received care plan from Lindsey Krogh, SW at OneCare. Mailed copy to mbr & also to Dr. Crawford, pcp.	Donna Craig RN
12/3/2010 1:13 PM	Telephone	IDT completed with mbr in attendence via telephone. OneCare will request evidenced based guidelines for Chlamydia & give to Dr. Crawford, pcp. They will provide the team as well as the mbr with a care plan.	Donna Craig RN

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

1. The Individualized care plan (ICP) is communicated verbally and in written format to the member. The ICP and revisions to the ICP are developed in collaboration with the member. The priority of goals takes into consideration the member's preference and desired level of involvement. The care plan is communicated in a variety of ways, including but not limited to, faxing, mailing, or electronic medical record transfer to the other participants of the IDT.

    - ICP Developed from the Basic ICT (PCP Level)
        - Initial ICP
            - Initiated at the first PCP visit with the member
            - The member's signature is obtained as an acknowledgment of participation in the development of the plan
            - The member is provided with a copy of the written ICP
            - The ICP becomes part of the medical record
        - Updates and revisions to the ICP
            - Occurs with a change in health status
            - Additional ICT participants may be identified
            - Member's signature is obtained as an acknowledgment of participation in the updating of the plan
            - Member is provided with a copy of the updated ICP
            - The updated ICP becomes part of the medical record
            - Participants of the ICT are provided a copy of the ICP either by secure email, fax or mail

    - ICP Developed from the Primary ICT (PMG Level) and Complex ICT (OneCare Clinical Level)
        - Initial ICP
            - Developed in collaboration with member, PCP and ICT participants
            - Completed ICP is provided to the member
            - A copy of the is provided to the PCP and becomes part of the medical record
            - ICP is faxed or electronically sent via secure email to the participants of the ICT
        - Updates and revisions to the ICP
            - Occurs with a change in health status
            - Additional ICT participants may be identified
            - Updated ICP is provided to the member
            - A copy of the is provided to the PCP and becomes part of the medical record
            - ICP is faxed or electronically sent via secure email to the participants of the ICT

2. Each OneCare member who experiences a transition is assigned a consistent case manager to support and educate the member through the transition. The case manager also ensures that the ICP travels with the member during the transition.

    - For planned and unplanned transitions from the Member's usual setting of care to the hospital, and from the hospital to the next setting, the PMG will facilitate the transfer

and communication of the member's ICP between the sending setting and the receiving setting within one (1) business day of notification that a transition has occurred.

- Transfer of the ICP may occur in a variety of ways, including but not limited to, faxing, mailing, or electronic medical record transfer to the next setting or PCP, or face-to-face giving of the hard copy to the Member.

EXAMPLES:

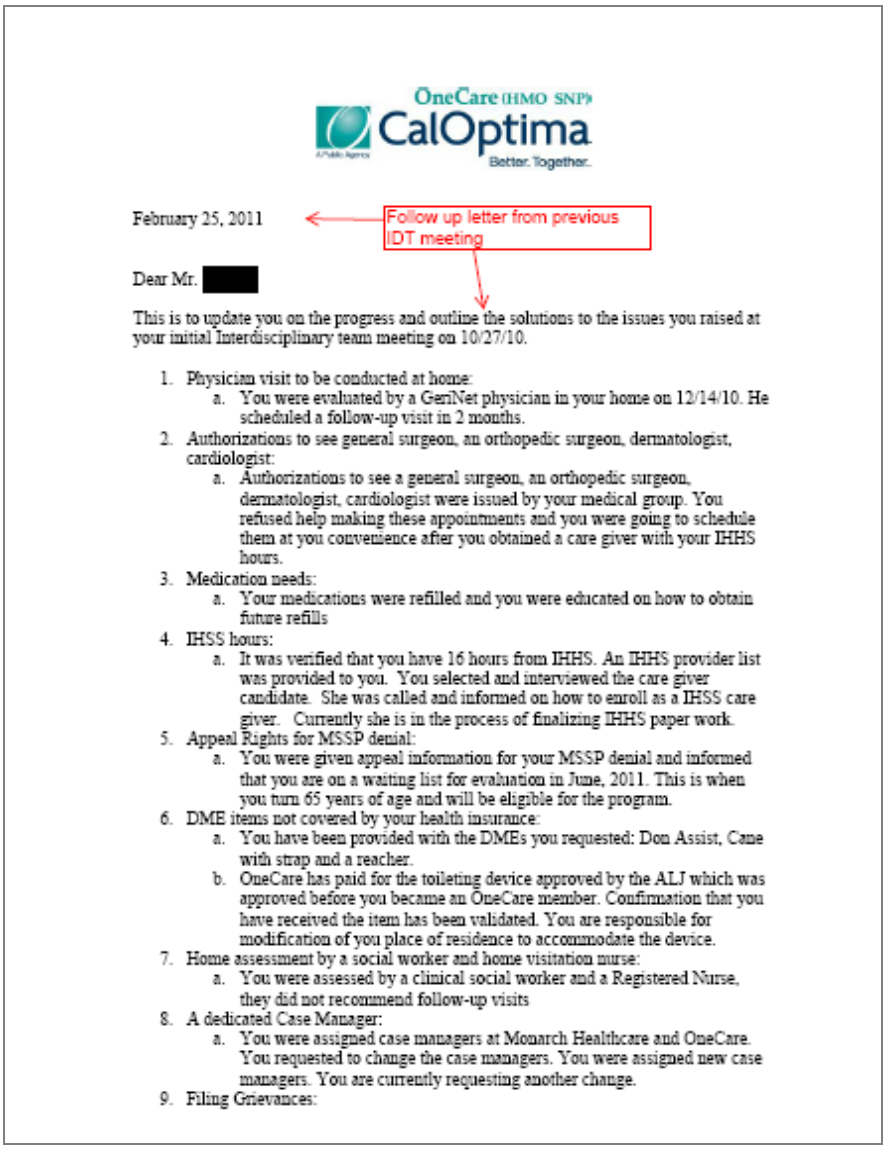
3. Example of ICP revised and communicated to PCP

Goal	Created	Created By	Completed
Interdisciplinary Care Team	10/1/2010	M. McKelton	10/3/2010
Goal Comments	Created	Created By	
IDT held on 10/1/10 with Caloptima; it was recommneded by the team that mbr be referred to a urologist & also to Windstone Behavioral Health; it was also recommended that the Senior Touch Team be present at mbr's pcp appt on 10/4/10 @ 3:00 with his new pcp, Dr. Udnani	10/3/2010	Donna Craig RN	
STG 10/1/10	10/1/2010	Donna Craig RN	
Interventions	Created	Created By	Completed
Interdisciplinary Care Team: review and update care plan as indicated	10/1/2010	M. McKelton	10/3/2010
Comments:	Created	Created By	
IDT's held with OneCare on 12/3/10 & 1/27/11	3/4/2011	Donna Craig RN	
mbr's appts scheduled: 1. Dr. Schuhrke, M.D. (uro) on 10/7/10 @ 8:45 am 2. Windstone behavioral Health, Dr.Agshar on 10/14/10 @ 9:00 am	10/3/2010	Donna Craig RN	

4. Example of ICP revised at Complex ICT by OneCare, communicated to the PMG, PCP and member

12/10/2010 10:32 AM	Task Comment	Received care plan from Lindsey Krogh, SW at OneCare. Mailed copy to mbr & also to Dr. Crawford, pcp.	Donna Craig RN
12/3/2010 1:13 PM	Telephone	IDT completed with mbr in attendence via telephone. OneCare will request evidenced based guidelines for Chlamydia & give to Dr. Crawford, pcp. They will provide the team as well as the mbr with a care plan.	Donna Craig RN

5. Example of revised ICP communication to member post ICT



OneCare (HMO SNP)
CalOptima
Better. Together.

February 25, 2011

Follow up letter from previous IDT meeting

Dear Mr. [redacted]

This is to update you on the progress and outline the solutions to the issues you raised at your initial Interdisciplinary team meeting on 10/27/10.

1. Physician visit to be conducted at home:
   a. You were evaluated by a GeriNet physician in your home on 12/14/10. He scheduled a follow-up visit in 2 months.
2. Authorizations to see general surgeon, an orthopedic surgeon, dermatologist, cardiologist:
   a. Authorizations to see a general surgeon, an orthopedic surgeon, dermatologist, cardiologist were issued by your medical group. You refused help making these appointments and you were going to schedule them at you convenience after you obtained a care giver with your IHHS hours.
3. Medication needs:
   a. Your medications were refilled and you were educated on how to obtain future refills
4. IHSS hours:
   a. It was verified that you have 16 hours from IHHS. An IHHS provider list was provided to you. You selected and interviewed the care giver candidate. She was called and informed on how to enroll as a IHSS care giver. Currently she is in the process of finalizing IHHS paper work.
5. Appeal Rights for MSSP denial:
   a. You were given appeal information for your MSSP denial and informed that you are on a waiting list for evaluation in June, 2011. This is when you turn 65 years of age and will be eligible for the program.
6. DME items not covered by your health insurance:
   a. You have been provided with the DMEs you requested: Don Assist, Cane with strap and a reacher.
   b. OneCare has paid for the toileting device approved by the ALJ which was approved before you became an OneCare member. Confirmation that you have received the item has been validated. You are responsible for modification of you place of residence to accommodate the device.
7. Home assessment by a social worker and home visitation nurse:
   a. You were assessed by a clinical social worker and a Registered Nurse, they did not recommend follow-up visits
8. A dedicated Case Manager:
   a. You were assigned case managers at Monarch Healthcare and OneCare. You requested to change the case managers. You were assigned new case managers. You are currently requesting another change.
9. Filing Grievances:

4. Case Study demonstrating ICP communicated from OneCare to the beneficiary, PCP and ICT

IDT 1

Referral Source: Case management referral was received from the OneCare Customer Service department. The member called requesting assistance with coordination of care needs.

Complex IDT assigned a designated case manager to coordinate the member's care.

Interventions: Case manager contacted the member and completed a comprehensive assessment, which revealed the following:

- Multiple medical conditions which included HTN, recurrent UTIs, and STIs
- Has a history of mental health condition with recent decompensation
- Member is currently homeless and refuses to access shelters.
- Member has requested multiple provider changes and has had difficulty in establishing a medical home.
- Member reports inability to obtain treatment for his recurrent genitourinary infections due to his providers expressing inability to confirm diagnosis.
- Member uses a local library's computer system for email communication and public telephones for landline communication.

Case manager discussed the benefits and goals of an IDT to the member. The member agreed to participate in an IDT. The IDT was arranged at time that was convenient for the member to access local library and secure a private room. The library also provided the member with a dedicated phone line to participate in the IDT via telephone conference.

IDT Summary: The IDT attendees included the member, OneCare Medical Director, PCP, case managers, social workers, a behavioral health specialist, and a clinical pharmacist. Case was presented and member was provided an opportunity to express his concerns, self-management goals and barriers to care. The member also expressed his desire for specialty referral to infectious disease specialist.

ICP Development: The member's ICP was developed based on the goals set forth in the IDT. Member was provided a comprehensive ICP via secure email following the IDT. The ICP was faxed to the PCP, and sent via secured email to the IDT participants.

Scheduled Follow Up: Additional phone calls to coordinate services were scheduled at convenient times for the member to access a phone line at the library. Secure email communication was established as preferred method of communication and will be used to follow up on the progression of the goals ICP.

9. Communication Network

a. Describe the MAO's structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.)

OneCare has an integrated system of communication with its members and its network of physicians and other healthcare service providers. The system uses different methods of communication, in order to reach stakeholder with varying communication capabilities. These methods include regular and ad hoc face-to-face meetings, web-based, telephonic conferences, and written communications include. Examples include written member communication. OneCare produces a quarterly newsletter which is mailed to all OneCare members and is produced in our three spoken languages: English, Spanish and Vietnamese. The newsletters are used to communicate a variety of topics. Topics can include benefits and how to use them to specific intervention such as flu vaccine. We also use this forum to educate the members on Health Education topics such as healthy eating and adherence to physician treatment plans. The OneCare newsletter is also used to share member stories that might be of interest to other OneCare members. In the March 2011 edition, we printed an article on a OneCare member who lost 110 pounds in hopes that his story would be an inspiration to others. A list of community resources and telephone numbers is included as an effort to put our members in touch with services that may assist them in improving their quality of life. The OneCare Customer Service Manager is responsible for compiling the content in conjunction with the contributing departments of Health Education, OneCare Clinical, Disease Management, Compliance, Cultural and Linguistic Service and any other ad hoc contributors. The OneCare Executive Director reviews all publications and helps set the tone and theme for a particular edition.

Face to Face Provider Meeting are held quarterly and are used for information sharing and identification of systems issues that have potential of affecting care provided to the members. The OneCare Medical director and the OneCare executive director are responsible for these meetings. They are held quarterly. The minutes are sent to all attendees and stored with the sign-in sheet at OneCare. Areas covered include clinical performance, operations and finances. Attendees include Health Plan employees as well as medical group managers.

Example

OneCare HMO
CalOptima
A Public Agency
Better. Together.

Monarch HealthCare
March 5, 2010

	TOPIC:	Presenter:	Pg. #
I.	**PMG Issues**		
II.	**Follow-up Action Items**		
III.	**Information Updates**		
	1. **Marketing - 2010 Updates**	**Ted Holloway**	
	2. **Enrollment**		
	a. Eligibility Trend Report **(handout)**	**Ted Holloway**	1
	b. Disenrollment Summary Report **(handout)**		2
	3. **Compliance**		
	a. Timeliness Report **(handout)**	**Kurt Hubler**	3-4
	b. 2009 Audit Summary **(handout)**	**Novella Quesada**	5
	c. Denial Letters	**Novella Quesada**	
IV.	**HCC Report**		
	1. **Encounter Submission MG Profile (handout)**		6
	2. **RAF Scores (handouts)**	**Kurt Hubler**	
	a. OneCare Medical Group Risk Adjustment Scores		7
	b. Monarch Report by Provider (January 2010)		8-18
	3. **Missing LTC Professional Encounter Institutional Report** (handout)		19-20
V.	**Medical Management**		
	1. **Updates**		
	a. 2010 OneCare H&P Incentive	**Linda Lee**	
	b. HEDIS - Health Plan Star Ratings **(handout)**		21-25
	c. SNP Structure and Process Audit **(handout)**		26-42
	d. Pharmacy Part D Results **(handout)**	**Dr. Martha Tasinga**	43-50
	2. **2010 Requirement Follow-up**		
	a. Stratification **(handout)**	**Dr. Martha Tasinga**	51
	b. OneCare Benefit Referral Guide **(handout)**	**Linda Young/Ginny Gamel**	52-54
	c. Primary Care ICP **(handout)**		55-56
	d. Interdisciplinary Care Teams & Transition Process **(handout)**		57-60

Sign In Sheet

Information : 9:00 AM to 11 AM

CALOPTIMA
A Public Healthcare Agency

JOM - Monarch (OneCare) **March 05, 2010**

Name	*Affiliation*	*Sign-In*
Bartlett, Jackie	Monarch HealthCare	
Beltran, Robert	Monarch HealthCare	
Cameron, Susan	Monarch HealthCare	
Chicoine, Ray	Monarch HealthCare	
Do, Mimi	CalOptima	
Epstein, Steve	CalOptima	
Fristensky, Kathryn	Monarch HealthCare	
Gamel, Ginny	CalOptima	
~~Gomez, Candice~~	~~CalOptima~~ Remove when OneCare only	
Haccou, Michelle	Monarch HealthCare	
Holloway, Ted	CalOptima	
Hubler, Kurt	CalOptima	
Lee, Linda	CalOptima	
McKinney, Melissa	Monarch Healthcare	
Mellentine, David	Monarch HealthCare	
Meyer, Nancy	CalOptima	
Miranti, Teri	Monarch HealthCare	
Patricio, Deborah	Monarch Family HealthCare	

b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies

OneCare Communication Strategy is a multi-departmental effort. The communication department is responsible for coordinating with the customer service department, provider services and OneCare Clinical Department. The communication department oversees all communication in order to ensure accuracy, consistence and presentation.

Communication to members takes place in various formats including face to face, written and via web. Communication to members is predominately written and/or telephonic which are the preferred modes of our members. OneCare maintains the California Medi-Cal regulation that all written materials is at the 6th grade level and is available in the predominant spoken languages of the plan. The face to face communication takes place in both group and individual settings. Examples are the New Member Orientation (group setting) and Medication Therapy Management sessions and ICT (individual setting).

OneCare (HMO SNP)

CalOptima

A Public Agency

Better. Together.

You're Invited to a New Member Orientation!

To learn more about OneCare, you can sign up to attend one of our New Member Orientation meetings. At this meeting you will learn:

- How to get medical services
- How to obtain an authorization for your medication (if required)
- How to use resources available in your community
- About your rights and responsibilities as a member

American Sign Language interpreters and other language interpreters are available upon request. ***Please fill out the form below and return it in the postage-paid envelope to sign up for the meeting.***

All meetings below will be held at:

CalOptima
1120 West La Veta, Orange, CA 92868.
Please see map on the reverse side. You can park at CalOptima at no cost.

If you have questions, please call OneCare's Customer Service Department toll-free at **1-877-412-2734**. TDD users should call **1-714-246-8496**.

OneCare has quarterly newsletters that communicate information to members about the health plan, providers, and benefits. The newsletter also offers additional education opportunities about clinical conditions and coordination of care.

10 TIPS FOR HEALTHY EATING

FROM OUR MEMBERS – A SUCCESS STORY

WE WANT TO HEAR FROM YOU!

IMPORTANT PHONE NUMBERS – RESOURCES TO HELP YOU

ONECARE RESOURCES

CalOptima

ONECARE CONNECTIONS

OneCare Increases Benefits in 2011!

2011 Evidence of Coverage

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. To change your PCP, call Customer Service.

When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP. The effective date with your new PCP will be the first (1st) of the month following the month OneCare receives your request for change.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or, for example, when you are temporarily outside of the plan's service area
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

Section 2.3 How to get care from specialists and other network providers

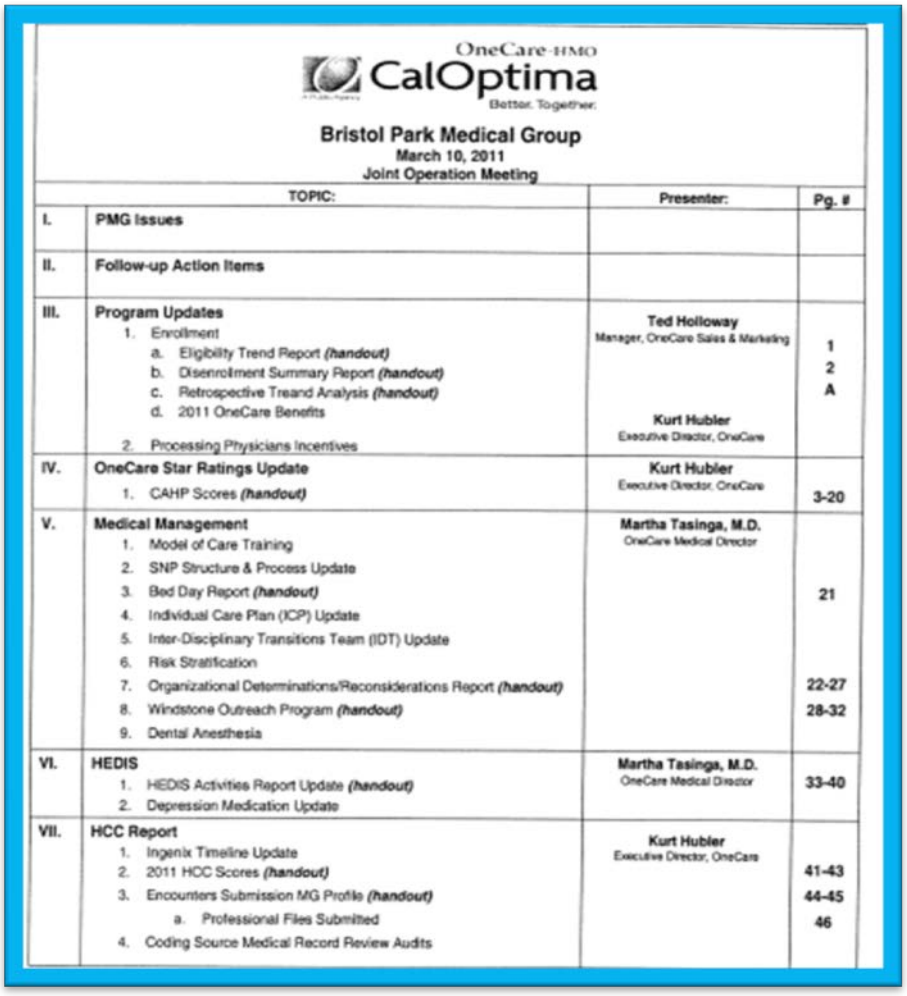
A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer
- Cardiologists, who care for patients with heart conditions
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions

OneCare also has a robust website where members can obtain information at their convenience.

Similarly, OneCare communicates to providers and stakeholders using similar venues. Communication to providers, the public and other stakeholders is more varied ranging from face to face to web and internet. Again, OneCare makes every effort to make it simple and convenient for the provider.

Face to face communication with providers take place at regularly scheduled joint operations meetings, CME forums, and office visits. Example: OneCare Monthly Physician Medical Group Meetings are face to face which is helpful as the subjects can be controversial. However, the sharing of data is done through OneCare provider portal.

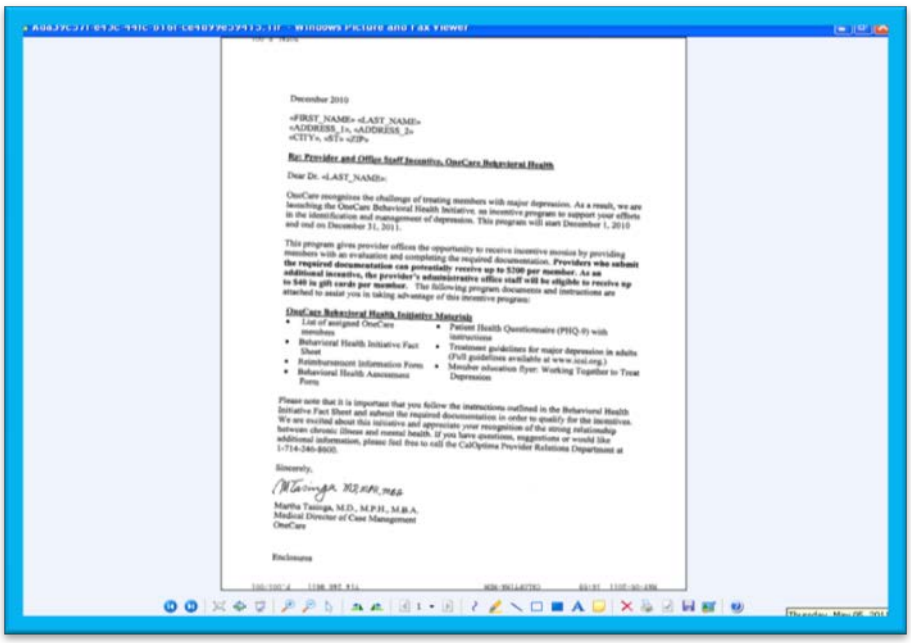


OneCare HMO
CalOptima
Better. Together.

Bristol Park Medical Group
March 10, 2011
Joint Operation Meeting

	TOPIC:	Presenter:	Pg. #
I.	**PMG Issues**		
II.	**Follow-up Action Items**		
III.	**Program Updates** 1. Enrollment a. Eligibility Trend Report ***(handout)*** b. Disenrollment Summary Report ***(handout)*** c. Retrospective Treand Analysis ***(handout)*** d. 2011 OneCare Benefits 2. Processing Physicians Incentives	**Ted Holloway** Manager, OneCare Sales & Marketing **Kurt Hubler** Executive Director, OneCare	1 2 A
IV.	**OneCare Star Ratings Update** 1. CAHP Scores ***(handout)***	**Kurt Hubler** Executive Director, OneCare	3-20
V.	**Medical Management** 1. Model of Care Training 2. SNP Structure & Process Update 3. Bed Day Report ***(handout)*** 4. Individual Care Plan (ICP) Update 5. Inter-Disciplinary Transitions Team (IDT) Update 6. Risk Stratification 7. Organizational Determinations/Reconsiderations Report ***(handout)*** 8. Windstone Outreach Program ***(handout)*** 9. Dental Anesthesia	**Martha Tasinga, M.D.** OneCare Medical Director	21 22-27 28-32
VI.	**HEDIS** 1. HEDIS Activities Report Update ***(handout)*** 2. Depression Medication Update	**Martha Tasinga, M.D.** OneCare Medical Director	33-40
VII.	**HCC Report** 1. Ingenix Timeline Update 2. 2011 HCC Scores ***(handout)*** 3. Encounters Submission MG Profile ***(handout)*** a. Professional Files Submitted 4. Coding Source Medical Record Review Audits	**Kurt Hubler** Executive Director, OneCare	41-43 44-45 46

Written communication



December 2010

«FIRST_NAME» «LAST_NAME»
«ADDRESS_1», «ADDRESS_2»
«CITY», «ST» «ZIP»

Re: Provider and Office Staff Incentive, OneCare Behavioral Health

Dear Dr. «LAST_NAME»:

OneCare recognizes the challenge of treating members with major depression. As a result, we are launching the OneCare Behavioral Health Initiative, an incentive program to support your efforts in the identification and management of depression. This program will start December 1, 2010 and end on December 31, 2011.

This program gives provider offices the opportunity to receive incentive monies by providing members with an evaluation and completing the required documentation. **Providers who submit the required documentation can potentially receive up to $200 per member. As an additional incentive, the provider's administrative office staff will be eligible to receive up to $40 in gift cards per member.** The following program documents and instructions are attached to assist you in taking advantage of this incentive program:

OneCare Behavioral Health Initiative Materials

- List of assigned OneCare members
- Behavioral Health Initiative Fact Sheet
- Reimbursement Information Form
- Behavioral Health Assessment Form
- Patient Health Questionnaire (PHQ-9) with instructions
- Treatment guidelines for major depression in adults (Full guidelines available at www.icsi.org.)
- Member education flyer: Working Together to Treat Depression

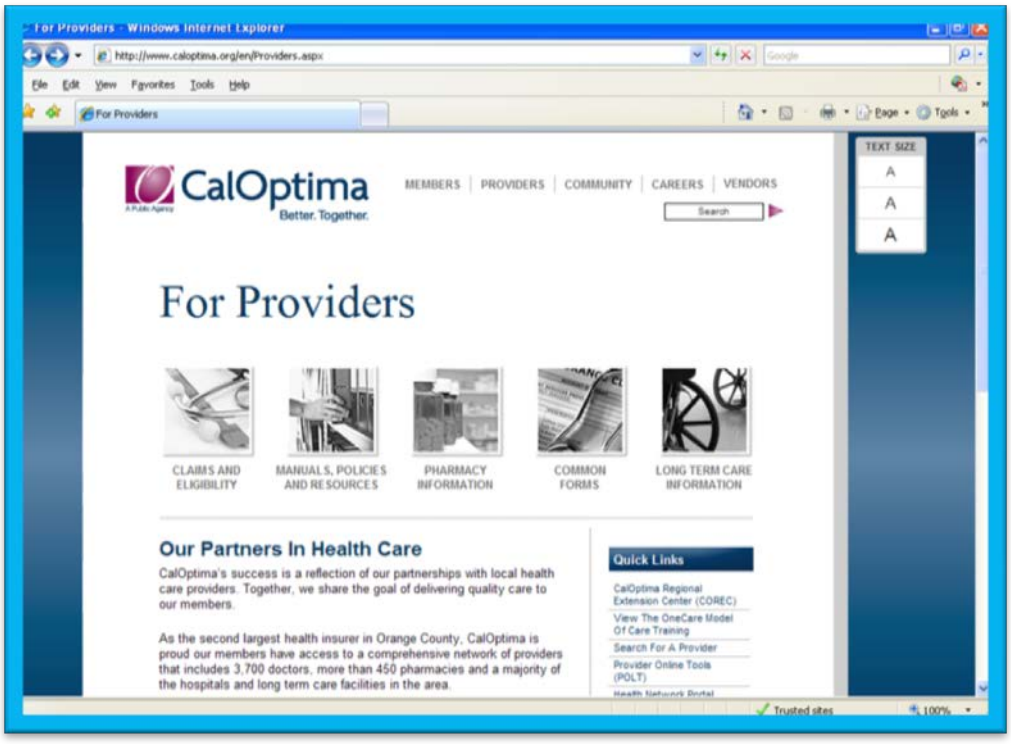
Please note that it is important that you follow the instructions outlined in the Behavioral Health Initiative Fact Sheet and submit the required documentation in order to qualify for the incentives. We are excited about this initiative and appreciate your recognition of the strong relationship between chronic illness and mental health. If you have questions, suggestions or would like additional information, please feel free to call the CalOptima Provider Relations Department at 1-714-246-8800.

Sincerely,

Martha Tasinga, M.D., M.P.H., M.B.A.
Medical Director of Case Management
OneCare

Enclosures

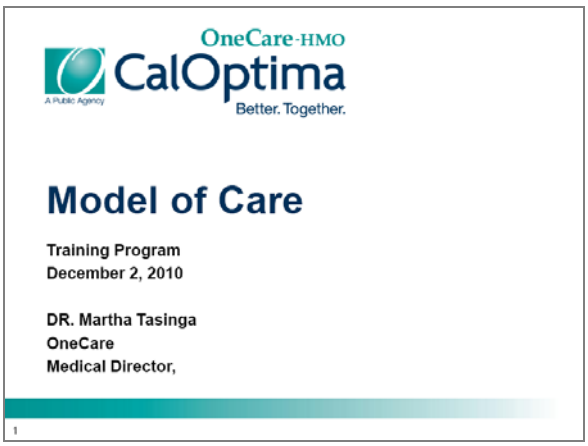
Also, web based and FTP site communication is strong among providers.

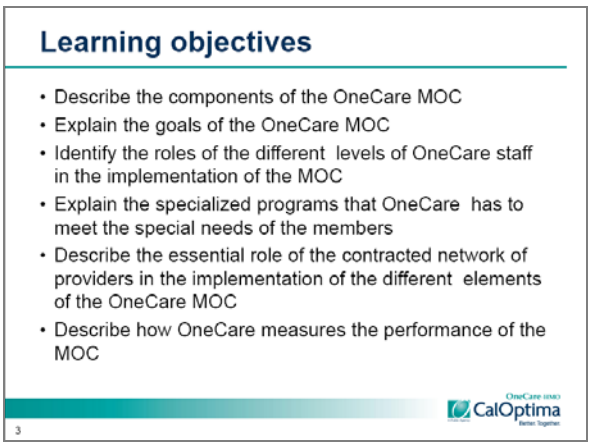


Regulatory agencies communication is through our Regulatory Affairs Department. The communication is electronic, written and telephonic. We have designated organization point of contact to guarantee ease and consistence of communication.

Public communication is extremely important to OneCare since it is a part of a Public Agency which is governed by the Brown Act. All written communication is a matter of public record. OneCare Public Affairs department manages all communication.

Web-based Model of Care Training:
This training is done both for internal employees as well as external stakeholders.





c. Describe how the MAO preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.)

- All clinically related communication with the member and member's providers of care are stored in the OneCare medical management system (CCMS) under the member's identification number and is retrievable upon request incompliance with HIPPA and other regulatory requirements for protecting member's personal health record. The information is only available for staff clinical staffs who need the information manage member's health care needs. Electronic copies of all communication between ONECARE, providers and regulatory agencies and other stake holders are store in ONECARE Core systems(FACETS) and is made available upon request. All electronic communication is stored in CALOPTIMA systems and retrievable s needed. All other communication between employees not stored but is required to be compliant with HIPPA and regulatory requirements for protection of personal health Information. The CALOPTIMA employee hand book describes consequences of not complying with these requirements up to and including termination.

d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness

The OneCare Communication department coordinates all communication irrespective of the medium. Staffing in the communication department includes the following:

- Executive Director of Public Affairs
  - Experience and Education
    - Bachelor's Degree in Communications/Public Relations or related field
    - Minimum of 5 years communications/public relations experience
    - Health care experience is highly desirable
    - 2 years of supervisory experience is required
  - Roles and Responsibilities
    - Directs the Public Affairs Department, including the supervision of professional and administrative personnel
    - Coordinates, develops and measures the contribution and impact of communication on behalf of the organization. These include marketing

and general communication activities as well as those that may involve CalOptima's government affairs and regulatory department in concert with leadership of those departments
- Works with all CalOptima departments in response to inquiries, problem solving, and promoting CalOptima's mission and message
- Directs internal and external CalOptima communications, as managed by department staff and other CalOptima departments. These include the coordination of all publications, management speeches or other formal public remarks, templates for standard CalOptima correspondence, and other communications of a highly sensitive nature
- Responsible for conducting and coordinating day-to-day contact with the media, coordination and management of press inquiries and relationships, and the execution and measurement/evaluation of media initiatives designed to promote CalOptima's image
- Advises all departments on public relations protocols and policies; assists them with the conception and execution of external public and special events.

- Director, Communications
  - Experience and Education
    - 7-10 years experience in managing communications, public relations, community relations, crisis communication, or media relations for a health plan or public agency.
    - Bachelor's degree in Political Science, Health or related field. Master's preferred.
    - Strong demonstrated record of developing cooperating relationships
  - Roles and Responsibilities
    - Ensure the timely creation and distribution of CalOptima's publications including, but not limited to, the annual Report to the Community, newsletters, and fact sheets
    - Write, coordinate, and edit content for CalOptima's publications
    - Ensure regular updates to publications
    - Support executive leadership communications by providing talking points, executive messages and announcements, and presentations
    - Assist with public and media relations
    - Foster and maintain relationships with media representatives
    - Write, edit, and publish news releases
    - Create press kits
    - Coordinate responses to media inquiries and support interactions with the media
    - Ensure maximum use of CalOptima's website as a communications tool
    - Write, coordinate, and edit content for CalOptima's website
    - Manage process to review and update website content on a regular basis
    - Work with other members of the Public Affairs Department to continuously improve the CalOptima website for its audiences
    - Assist with marketing initiatives to ensure consistent and strategic messaging and use of the CalOptima brand
    - Support planning, message development, and brand alignment for all communication vehicles

        - Maintain a library of all CalOptima communications
        - Supporting other activities and assignments in the Public Affairs Department
        - Special projects and other duties as assigned

- Manager, Communications
    - Experience and Education
        - Experience in managing communications, public relations, community relations, crisis communication, or media relations for a health plan or public agency
        - Bachelor's degree in Political Science, Health or related field. Master's preferred
        - Strong demonstrated record of developing cooperating relationships
        - HMO, Medi-Cal, Medicare and health services experience preferred
    - Roles and Responsibilites
        - Assist in developing and implementing CalOptima's communications plans
        - Supervise department staff
        - Write and edit copy for a broad range of communications tools and publications including, but not limited to: newsletters, annual reports, press releases, and the CalOptima website
        - Ensure timely completion of Communications projects and deliverables
        - Implement and maintain a process to update regular communications tools and publications
        - Provide support to the Director in developing key messages for the organization and Executives
        - Build and maintain exceptional quality standards for products
        - Provide excellent customer service to both internal and external clients
        - Support other activities and assignments in the Public Affairs department
        - Special projects and other duties as assigned

- Graphic Designer
    - Experience and Education
        - 3-5 years of professional print design, web design, content management and production experience
        - Strong project management skills
        - Bachelor's degree in a related field, or equivalent
    - Roles and Responsibilities
        - Develop concepts for and design branded collateral materials, including brochures, ads, postcards, newsletters, flyers, invitations, and other items as needed
        - Develop creative design briefs for projects by meeting with internal clients, gathering information and data to clarify design issues
        - Maintain brand standards to ensure a consistent look and feel throughout the Website, Intranet, and Printed materials
        - Provide technical support to assist in the ongoing development and maintenance of the Website and Intranet
        - Manage content on the Website and Intranet using content management software

- Assist content authors in creating the web presence they are looking for
- Assist with developing, proofreading and copyediting print and web content
- Monitor the Website to ensure an accurate and consistent presence on the internet
- Archive web-based information for future needs and reference

Effective use of the communication network is measured in several ways. OneCare conducts annual audits aimed at members and stakeholder and query regarding effectiveness. OneCare also will conduct ad hoc focus groups. For public events, post event evaluations are collected, analyzed and used for future events.

10. Care Management for the Most Vulnerable Subpopulations

a. Describe how the MAO identifies its most vulnerable beneficiaries

OneCare identifies the most vulnerable members of its population by running a proprietary clinical risk algorithm on the entire OneCare population each month. The risk algorithm categorizes each OneCare member as high, moderate, or low risk. These risk levels are used to determine the appropriate level of intervention to meet the specific needs of each risk group and to improve health outcomes**.** Risk stratification serves several purposes:

- Identification of most vulnerable members
- Classify members by risk level
- Tailor interventions to improve outcomes to members individual risk

The algorithm analyzes the following data sources:

a. Claims or encounter data;
b. Hospital discharge data;
c. Pharmacy data;
d. Laboratory results, as available; and
e. Data from the UM process

The algorithm utilizes the above data sources and considers the following in establishing a Member-specific risk score:

a. Inpatient admissions;
b. Emergency department utilization;
c. Severe diagnosis;
d. Co-morbid diagnosis;
e. Cancer diagnosis;
f. Number of prescriptions;
g. Behavioral health diagnosis;
h. Residence in a Long Term Care (LTC) facility; and
i. Member age.

Each of the above indicators is assigned risk points based on the criteria below. The sum of each member's risk points gives each member a risk score. Next, the distribution of the risk scores for the entire population of members is evaluated on a normal curve to determine whether the member's risk score falls below the mean; between the mean and one standard deviation above

the mean; between one and two standard deviations above the mean; or over two standard deviations above the mean.

Table 6: Risk Indicators and Points

Field Name	Comments	Risk Points
Age	Age of member	0 = less than 65 years, 1 = 65-80 years, 2 = greater than 80
HPS	Hospitalization last 12 months any reason	0 = 0 hosp, 1 = 1-4 inpatient stays, 2 = more than 4
ERV	ER visits last 12 months any reason	0 = 0 visits, 1 = 1-5 visits, 2 = more than 5
SDX	Severe diagnosis w/i last 2 years	0 = 0 diagnoses, 1 = 1-3 diagnoses, 2 = more than 3. Severe diagnoses are listed in the *Notes below.
CDX	Co-morbid diagnosis w/i last 2 years	0 = 0 diagnoses, 1 = 1-3 diagnoses, 2 = more than 3. Co-morbid diagnoses are listed in the *Notes below.
RXS	Rx # of unique prescriptions last 12 months	0 = 0-3 prescriptions, 1 = 4-6 prescriptions, 2 = more than 6
BH	Behavioral health diagnosis w/i last 2 years	0 = 0 diagnoses, 1 = 1 or more diagnoses. Behavioral health diagnoses are listed in the *Notes below.
RAF	Individual CMS Score	
HPS_Sev	Hospitalization last 12 months with severe or co-morbid diagnoses	1 point for each primary diagnosis (max 5 points)
ERV_Sev	ER visits last 12 months with severe or co-morbid diagnoses	1 point for each primary diagnosis (max 6 points)
CA_DX	Cancer diagnosis w/i last 2 years	0 = 0 diagnoses; 1 = severity level 1; 2 = severity level 2; 3 = severity level 3; 4 = severity level 4. Severity levels are explained in the *Notes below.
LTC_AC	Member has LTC Aid Code 23, 63, 13, 53 (Y or N)	
LTC_Comp	LTC Composite: Member is LTC institutionalized or has Aid Code 23, 63, 13, 53 (Y or N)	
LTC_Risk	LTC Risk Score (5 if in LTC Composite; 0 otherwise	
Total	Total Risk Points for member	
RiskScore	Risk Score Level based on member's Total Risk Points. Levels range from 1-4, with 1 being the lowest and 4 the highest.	

***Notes**

1. **Severe Diagnoses:** HIV/AIDS, Hemophilia, Transplant status, MS, Hepatitis C, ESRD.
2. **Co-Morbid Diagnoses:** Asthma/COPD, Hyperlipidemia, Hypertension, Congestive heart failure, Diabetes, Obesity.
3. **Behavioral Health Diagnoses:** Major depressive disorder, Bipolar disorder, Paranoid disorder.

4. **Cancer Dx Severity Levels by ICD-9 Codes:** 1 = (ICD-9 235-238, 239, 209.4-209.6); 2 = (ICD-9 230-234); 3 = (ICD-9 140-195, 199, 200-208, 209.0-209.3); and 4 = (ICD-9 196-198).

This statistical analysis results in the following Risk Level classification: Low Risk Members are those with risk scores of 0 to 5.22; Moderate Risk Members are those with risk scores of 5.23 to 8.109; and High Risk Members are those with risk scores of 8.11 and above. The risk score is then normalized on a scale of 1 to 5, as described below.

- A Member who resides in an LTC facility is automatically ranked at a risk level of 5, the highest level, and placed into case management.

- A Member who is ranked at a risk level of 4 is assessed for placement into case management utilizing a complex case management assessment tool based on the standards of the National Committee for Quality Assurance (NCQA) Special Needs Plan Structure & Process Measures 1 (SNP 1).

- A Member who is ranked at a risk level of 3 is assessed, using the Rand Vulnerable Elderly Survey (VES-13), and placed into case management as appropriate.

- A Member who is at risk levels 1 or 2 is referred to the Member's PCP for primary care intervention and case management as needed.

In order to monitor members, the risk algorithm is run each month on all members. Newly enrolled members are assigned an initial risk score. If a member's risk score changes, they are flagged for case management follow-up. Members that are identified with chronic conditions are referred to the CCIP programs. Members with gaps in preventive care are referred to their PCP for follow-up.

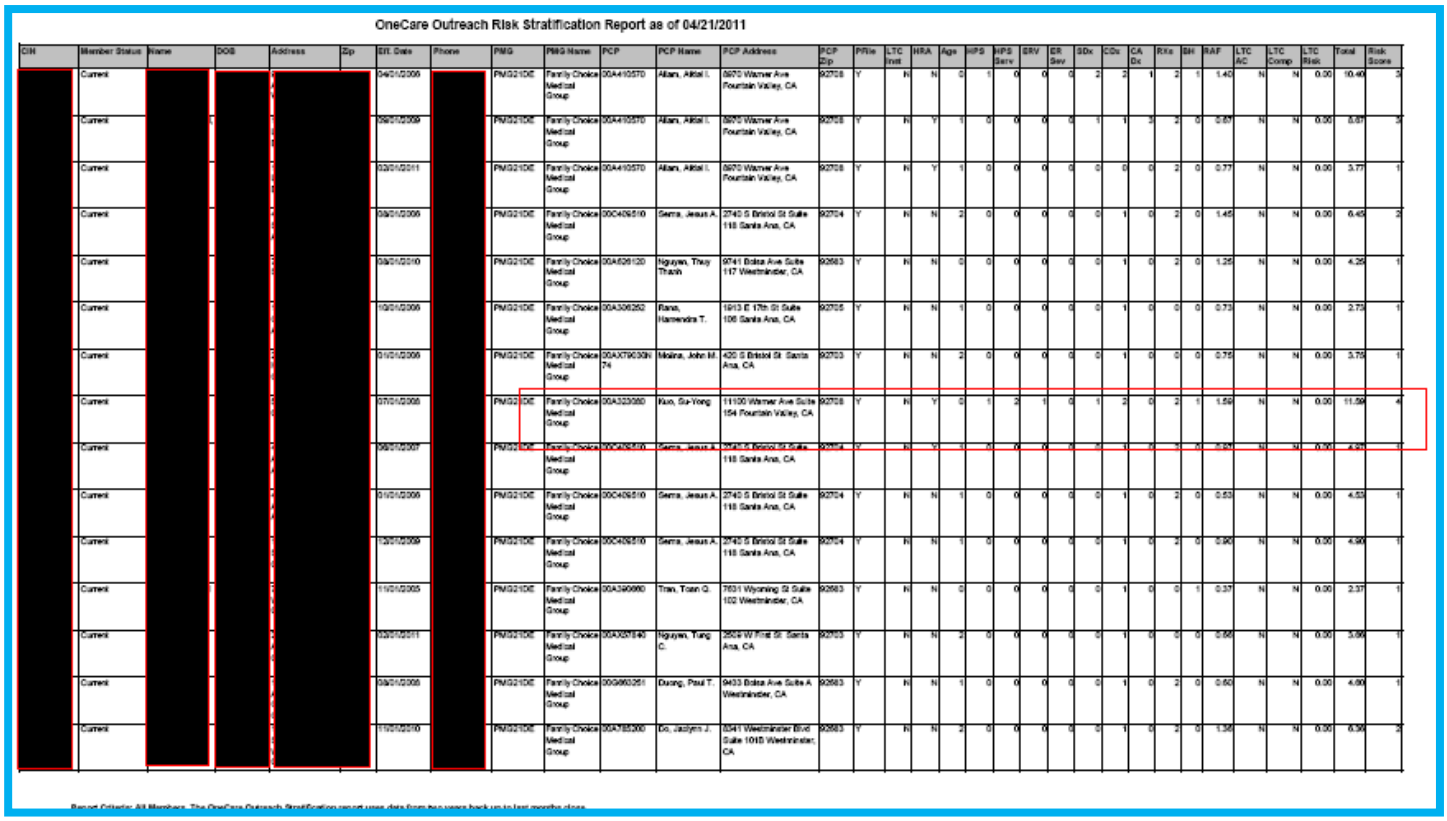
Vulnerable members referred to case management are assessed for the need for add-on services and benefits.

- The Transitional Interdisciplinary Care Team (ICT) provides additional clinical coordination. The Transitional ICT is designed to ensure that planned and unplanned transitions are managed for the vulnerable population. Members with multiple hospitalizations, readmissions, and frequent emergency room utilization are referred to the Transitional ICT.
- The End Stage Renal Disease (ESRD) ICT provides specialized clinical care coordination for members on dialysis. The ESRD ICT is designed to ensure coordination of their services and facilitation of the potential transplant evaluation process.
- The Community Resource Coordination occurs for members who require additional services or support systems to maintain them in the least restrictive care setting.
- The Behavioral Health Program provides comprehensive assessment by behavior health specialists. Case management is provided through the program to ensure coordination of behavior health and physical health services for members who have severe and persistent mental illness.

EXAMPLES:

The stratification information is used to identify the most vulnerable members and the services that need augmentation to meet their special needs. These services include increased frequency of interventions from our Transition Interdisciplinary Care Team, ESRD Interdisciplinary Care Team and Community Resource Coordination and Behavioral Health Resource Teams.

OneCare Risk Stratification Tool



OneCare Outreach Risk Stratification Report as of 04/21/2011

CIN	Member Status	Name	DOB	Address	Zip	Eff. Date	Phone	PMG	PMG Name	PCP	PCP Name	PCP Address	PCP Zip	PPIn	LTC Inst	HRA	Age	HPS	HPS Serv	ERV	ER Sev	SDx	CDx	CA Dx	RXs	BH	RAF	LTC AC	LTC Comp	LTC Risk	Total	Risk Score
[redacted]	Current	[redacted]	[redacted]	[redacted]		04/01/2006	[redacted]	PMG21DE	Family Choice Medical Group	00A410570	Allam, Akbal I.	9870 Warner Ave Fountain Valley, CA	92708	Y		N	N	0	1	0	0	0	2	2	1	2	1	1.40	N	N	0.00	10.40	3
	Current					09/01/2009		PMG21DE	Family Choice Medical Group	00A410570	Allam, Akbal I.	9870 Warner Ave Fountain Valley, CA	92708	Y		N	Y	1	0	0	0	0	1	1	3	2	0	0.87	N	N	0.00	8.87	3
	Current					03/01/2011		PMG21DE	Family Choice Medical Group	00A410570	Allam, Akbal I.	9870 Warner Ave Fountain Valley, CA	92708	Y		N	Y	1	0	0	0	0	0	0	2	0	0.77	N	N	0.00	3.77	1
	Current					03/01/2006		PMG21DE	Family Choice Medical Group	00C426510	Serra, Jesus A.	2740 S Bristol St Suite 118 Santa Ana, CA	92704	Y		N	N	2	0	0	0	0	0	1	0	2	0	1.45	N	N	0.00	6.45	2
	Current					03/01/2010		PMG21DE	Family Choice Medical Group	00A626120	Nguyen, Thuy Thanh	9741 Bolsa Ave Suite 117 Westminster, CA	92683	Y		N	N	0	0	0	0	0	0	1	0	2	0	1.25	N	N	0.00	4.25	1
	Current					10/01/2006		PMG21DE	Family Choice Medical Group	00A306252	Rana, Hamendra T.	1913 E 17th St Suite 106 Santa Ana, CA	92705	Y		N	N	1	0	0	0	0	0	1	0	0	0	0.73	N	N	0.00	2.73	1
	Current					01/01/2006		PMG21DE	Family Choice Medical Group	00AX79030N 74	Molina, John M.	420 S Bristol St Santa Ana, CA	92703	Y		N	N	2	0	0	0	0	0	1	0	0	0	0.75	N	N	0.00	3.75	1
	Current					07/01/2006		PMG21DE	Family Choice Medical Group	00A323080	Kwo, Su-Yong	11100 Warner Ave Suite 154 Fountain Valley, CA	92708	Y		N	Y	0	1	2	1	0	1	2	0	2	1	1.59	N	N	0.00	11.59	4
	Current					06/01/2007		PMG21DE	Family Choice Medical Group	00C426510	Serra, Jesus A.	2740 S Bristol St Suite 118 Santa Ana, CA	92704	Y		N	Y	1	0	0	0	0	0	1	0	2	0	0.93	N	N	0.00	4.93	1
	Current					01/01/2006		PMG21DE	Family Choice Medical Group	00C426510	Serra, Jesus A.	2740 S Bristol St Suite 118 Santa Ana, CA	92704	Y		N	N	1	0	0	0	0	0	1	0	2	0	0.53	N	N	0.00	4.53	1
	Current					12/01/2009		PMG21DE	Family Choice Medical Group	00C426510	Serra, Jesus A.	2740 S Bristol St Suite 118 Santa Ana, CA	92704	Y		N	N	1	0	0	0	0	0	1	0	2	0	0.90	N	N	0.00	4.90	1
	Current					11/01/2005		PMG21DE	Family Choice Medical Group	00A390660	Tran, Toan Q.	7631 Wyoming St Suite 102 Westminster, CA	92683	Y		N	N	0	0	0	0	0	0	1	0	0	1	0.37	N	N	0.00	2.37	1
	Current					02/01/2011		PMG21DE	Family Choice Medical Group	00AX20140	Nguyen, Tung C.	2509 W First St Santa Ana, CA	92703	Y		N	N	2	0	0	0	0	0	1	0	0	0	0.66	N	N	0.00	3.66	1
	Current					03/01/2006		PMG21DE	Family Choice Medical Group	00G960251	Duong, Paul T.	9433 Bolsa Ave Suite A Westminster, CA	92683	Y		N	N	1	0	0	0	0	0	1	0	2	0	0.60	N	N	0.00	4.60	1
	Current					11/01/2010		PMG21DE	Family Choice Medical Group	00A785200	Do, Jaclyn J.	8341 Westminster Blvd Suite 101B Westminster, CA	92683	Y		N	N	2	0	0	0	0	0	1	0	2	0	1.36	N	N	0.00	6.36	2

Report Criteria: All Members. The OneCare Outreach RiskStratification report uses data from two years back up to last months close.

Case Study Example #1: OneCare member identified as a vulnerable beneficiary on the risk stratification due to a diagnosis of breast cancer with co-morbid conditions of HTN and diabetes, greater than six prescriptions, and five hospitalizations within a six-month period. The member was ranked at a risk level four and referred for case management. The member was placed in complex case management. The member expressed to her Case Manager that she was unable to pay her rent. The Case Manager provided the member with Community Resource Coordination. The case manager was able to link the member to American Cancer Society "Support and Treatment." The member received assistance with needed services including housing and transportation. The requested service was not a benefit but crucial for the physical and mental well being of the member. The services provided to the member allowed her to remain in her home for her final days. The Community Resource Coordination for vulnerable members facilitates linkage to support services and programs.

Example of OneCare Ambulatory IDT For use to refer vulnerable member to the Transition IDT

OneCare Interdisciplinary Team (IDT) Ambulatory Referral Form

Screening should be completed if you would like to refer to the OneCare IDT
Complete Section 1 (includes screening criteria). If score is ≥ 12 *complete section 2 and*
FAX (714) 571- 2440

MEMBER INFO ***Section 1***

Completion Date: _____

Patient Name: _____ ☐M ☐F

Date of Birth: _____ Medi-Cal Number (CIN): _____ PMG: _____

Residence/Address: _____ City: _____ Zip: _____

Phone: ( ) Closest Relative/Responsible Person: Phone: ( )

Inpatient Facility: _____ Admission Date: _____

Score	Possible Score	Criteria
	0-2	Age 0-18 = 0 19-75= 1 >75= 2
	2	Significant medical diagnosis/comorbid conditions
	2	Significant psychiatric diagnosis
	2	Polypharmacy ≥ 8 Rx
	2	Lack of coordinated care (ex: non-contracted providers, out of area, multiple providers)
	2	≥ 3 ER visits in 6 months or Readmission ≤ 30 days of discharge
	1	New UM Requests for assistive devices (i.e. Scooter, Wheel Chair, or New NEMT needs)
	1	Severe diminished functional status
	1	Homelessness
	1	History or current substance abuse and expresses a desire to stop
	1	History or current ETOH Abuse and expresses a desire to stop
	1	History of noncompliance with treatment plan
	1	Lack of family support or lives alone or conservatorship
	19	*Scores: ≥ 12 Refer to OneCare Transitions Team for Interdisciplinary Team intervention*

If score < 12 Sign and place in member's record: Sign ***Date:***
If score ≥ 12 Continue and include additional information ***Section 2***

☐ In Case Management ☐ Chronic medical conditions ☐ Multiple specialty providers

Diagnosis (1)_____(2)_____(3)_____

Additional Medical Records Attached (indicate type): ☐ No ☐Yes: _____

PCP _____ Specialty Physician_____

Pertinent Past History (Medical, Mental, Psychosocial)

☐ Mental Health _____
☐ Social Concerns: ☐Homelessness ☐Substance Abuse ☐Other_____
☐ Inpatient admissions: When ☐ ☐ ☐
☐ Comments:

Signature: **Date:**

05.01.10

1. Example of Case Management Log documenting cases identified as high risk (vulnerable members) and behavioral health

MEMORIALCARE MEDICAL FOUNDATION - BRISTOL PARK MEDICAL GROUP
QUARTERLY ONECARE CASE MANAGEMENT REPORTING.
Period: 1st Qtr 2011 (Date Opened: 01/01/2011- 03/31/2011).
Protocol types: Primary and Secondary Protocols.
Run date: 04-11-2011; 3:15 PM. Data source: Plandata_Stage and Prod_mcmf_Plandata.

Member Name	Health Plan ID	DOB	Referral Source	Program	Date Opened	Date Closed	ICD9 Primary	Desc 1	ICD9 Secondary	Desc 2
[redacted]			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/3/2011		714.9	UNS INFLAMMATORY POLYARTHROPATHY	472	CHRONIC RHINITIS
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/3/2011		250.61	DIABETES NEURO MANIF TYPE I	401.1	BENIGN ESSENTIAL HYPERTENSION
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/4/2011		401.1	BENIGN ESSENTIAL HYPERTENSION	496	CHRONIC AIRWAY OBSTRUCTION OTHER
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/6/2011		402.1	BENIGN HYPERTEN HEART DIS UNSPEC	414	CORONARY ATHRSCLER UNS VESSEL
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/7/2011		401.1	BENIGN ESSENTIAL HYPERTENSION	242.9	THYROTOXICOSIS WO GOITER/OT WO CRIS
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/7/2011		250	DIABETES UNCOMPL TYPE II	753.12	POLYCYSTIC KIDNEY UNS TYPE
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/7/2011		401.1	BENIGN ESSENTIAL HYPERTENSION	733.9	DISORDER BONE/CARTILAGE
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/7/2011		285.9	ANEMIA UNSPECIFIED	496	CHRONIC AIRWAY OBSTRUCTION OTHER
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/14/2011		401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	v45.02	IMPLANTABLE CARDIAC DEFIB IN SITU
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/20/2011		53.9	HERPES ZOSTER WO COMPLICATION	786.59	OTHER CHEST PAIN
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	1/24/2011		496	CHRONIC AIRWAY OBSTRUCTION OTHER	305.1	TOBACCO USE DISORDER
			Predictive Analysis Repo	CARE MANAGEMENT - COMPLEX	3/10/2011		585.6	END STAGE RENAL DISEASE	250.4	DIABETES RENAL MANIF TYPE II
			Care Transitions	CARE MANAGEMENT - COMPLEX	3/11/2011	4/5/2011	585.6	END STAGE RENAL DISEASE		
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	3/14/2011		250.71	DIABETES CIRCULAT DIS TYPE I	v13.02	HISTORY URINARY TRACT INFECTION
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	3/16/2011		753.12	POLYCYSTIC KIDNEY UNS TYPE	715.96	OSTEOARTHROSIS UNSP LOWER LEG
			Health Plan referral	CARE MANAGEMENT - HIGH RISK	3/18/2011		401.1	BENIGN ESSENTIAL HYPERTENSION	729.1	UNS MYALGIA/MYOSITIS
			Health Plan referral	Behavioral Health	3/25/2011					
			New Member	CARE MANAGEMENT - HIGH RISK	3/30/2011		250	DIABETES UNCOMPL TYPE II	401.1	BENIGN ESSENTIAL HYPERTENSION
			New Member	CARE MANAGEMENT - HIGH RISK	3/31/2011		250	DIABETES UNCOMPL TYPE II	493.9	ASTHMA UNSPECIFIED

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

Transition Interdisciplinary Care Team
The OneCare transition of care process is designed to ensure that unplanned and planned transitions are identified and managed by a transition Interdisciplinary Care Team (ICT) whose members are trained to manage the specific member's needs and ensure smooth movement across the continuum. OneCare has implemented specific evidence based interventions to ensure safe coordinated care so that the member remains at the least restrictive setting that meets their healthcare needs. OneCare has a transition process where members are screened to identify members at high risk for complex transition. This screen is done at prior authorization and for unplanned admissions at the time of admission to a facility either acute of skilled nursing. The screening tool incorporates questions about clinical condition, behavior health status and social condition. Identified high risk members are referred to the transition ICT. Upon receipt of the referral, case management does a comprehensive assessment and the transition ICT develops or updated the ICP. It also ensures that the ICP travels with the member during the transition.

ESRD Interdisciplinary Care Team (ICT)
ESRD ICT is a dedicated team with the responsibility of coordinating services for ESRD members. The core team composition is a physician (often a nephrologist), primary care provider, case manager, social worker, behavioral health specialist and member. Additional team members may include a nutritionist, pharmacist and other professionals as needed. The team provides assessments, care plan development and case management through the continuum. The team supports development of a medical home for ESRD.

A SNP 1 complex case management assessment is completed and a preliminary ICP is developed in collaboration with the member, PCP and participants of the ESRD ICT. Urgent service needs are incorporated into the ICP and addressed immediately. The assessment information is used to determine the member specific composition of the ESRD ICT. Every effort is made to encourage

member and/or family participation at the ICT. The member can participate in person face to face, by phone or by any other electronic communication method of their choice. Interpretation services are available during ICT meetings for non English speaking members. The ESRD ICT case manager gathers any pertinent medical/psychosocial information and prepares for the initial ICT. Each member of the ICT brings their expertise to the collaborative process for the coordination of care.

The team develops and oversees the implementation of the Individual Care Plan (ICP). The ICT reviews and updates each member's ICP when the member's health status changes. The ICT is also responsible for the communication and ensuring that the ICP travels with the member from care setting to care setting. The communication of the ICP is done in compliance with HIPAA and other regulatory requirements. The team ensured that ICP is available to the member and care providers.

The ESRD ICT works collaboratively with the dialysis center, primary care provider, member, family and the different doctors managing the member's chronic conditions to coordinate care, facilitate potential transplant evaluation process, ensure access to extra benefits, and community resources. It fosters a more intimate relationship with members and family. It leverages the experience of the team in order to more quickly facilitate resolution of common issues.

Community Resource Coordination for Vulnerable Members

Community Resource Coordination: OneCare improves access to community services. This is provided through traditional case management, which includes social workers and behavioral health specialists. As part of Community Resource Coordination for vulnerable members, the case manager will complete an additional assessment (Community Resource Referral) to identify add on services and benefits and services the member needs. The assessment identifies add on services and benefits such as shelter, Meals on Wheels, Multipurpose Senior Services Program (MSSP), In Home Operations (IHO), In Home Support Services (IHSS), Adult Day Health Care Services, transportation, home health, vision, dental and community resources for cancer / transplant/ kidney / hemophilia. The case manager facilitates the referral to the appropriate community resource or service and follows up to ensure that the services are in place. Also, through strong links with community organizations like Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, Orange County Goodwill and Orange County Community Centers, the cases manager has identified key contact personnel and telephone numbers. There are direct links to the Multipurpose Senior Service Program (MSSP) and the Orange County Aging and Disability Resource Center (ADRC). These resources provide a means of connecting members with needed social services. The goal of Community Resource Coordination is to ensure the vulnerable members have the supportive services required to minimize unplanned transitions and keep them at the least restrictive setting.

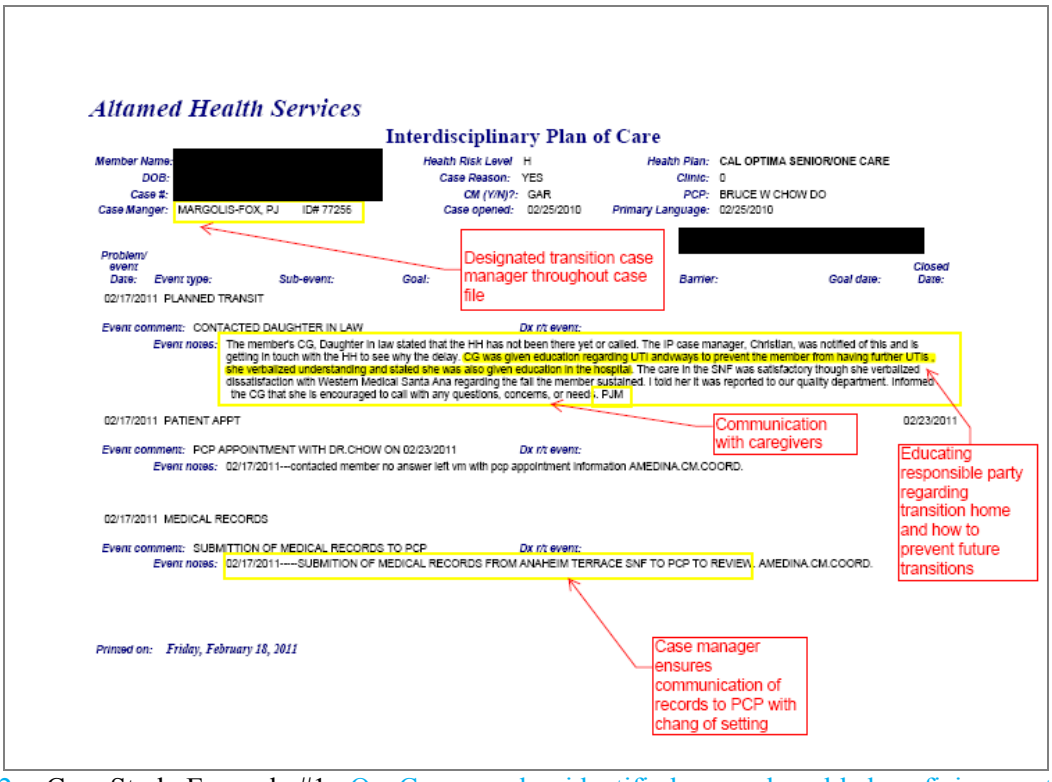
Behavioral Health Program

Case management facilitates coordination of behavioral health services for vulnerable members identified as having a mental health diagnosis. Through traditional case management, the nurses, social workers and PCP link the member with the appropriate behavioral health specialists. Behavioral health services are provided through OneCare's contracted vendor. The services

provided include the Senior Behavioral Health & Wellness Program to proactively detect behavioral health diagnoses which have previously gone unrecognized. Also a Crisis Assessment Team ("CAT") which is a 24/7 triage management service for hospital emergency rooms designed to manage and triage all behavioral health patients that present themselves in hospital emergency rooms. The case manager assesses the vulnerable member for behavioral health diagnosis, substance use and the presence of behavioral health services. Members who are not receiving behavioral health services are referred to the contracted vendor. Members with confirmed substance use are referred to the appropriate drug dependency rehabilitation resources. OneCare's vendor contacts the member and offers a choice of an office or home comprehensive assessment to confirm the diagnosis. If a mental diagnosis is confirmed, a team of mental health providers including Psychiatrists, Psychologists and Therapists manages the member. If the mental health diagnosis is not confirmed, the member is referred back to the OneCare case manager for evaluation of additional case management needs. The case manager on the mental health team share assessment results with the referring case manager and the PCP to ensure coordination of add on services and benefits. The goal of the Behavioral Health Program is to proactively address the mental health needs of the vulnerable members.

EXAMPLES:

1. Example of documentation for increased transition of care services for identified vulnerable member

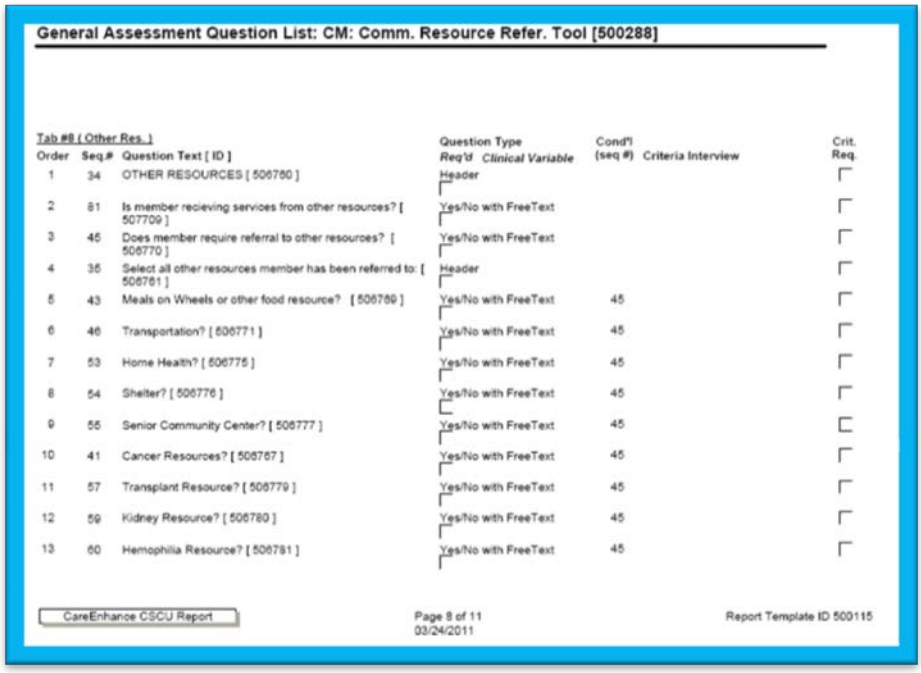


2. Case Study Example #1: OneCare member identified as a vulnerable beneficiary on the risk stratification due to a diagnosis of breast cancer with co-morbid of HTN and diabetes, greater than six prescriptions, and five hospitalizations within a six-month period. The member was ranked at a risk level four and referred for case management. The member was placed in complex case management. The OneCare member diagnosed with breast cancer expressed to her case manager that she had was unable to pay her rent. The case manager provided the member with Community Resource Coordination. The case manager was able to link the

member to American Cancer Society "Support and Treatment." The member received assistance with needed services including housing and transportation. The requested service was not a benefit but crucial for the physical and mental well being of the member. The services provided to the member allowed her to remain in her home for her final days. The Community Resource Coordination for vulnerable members facilitates linkage to support services and programs.

3. Case Study Example # 2: OneCare member identified as a vulnerable beneficiary on the risk stratification due to diagnosis of COPD, HTN, CHF, diabetes and hyperlipidemia, history of skin cancer, 13 prescriptions, a behavioral health diagnosis, and more than one hospitalization within the last year. The member was ranked at a risk level four and was placed into complex case management. The member is homebound and gets SOB when ambulating short distances of ten feet. The OneCare member required a toileting device, which required modifications to his place of residence in order to accommodate the device. The member was unable to afford the cost of the modifications to his residence. The case manager provided the member with Community Resource Coordination. The member was linked to the Dayle MacIntosh Independent Living Center. The center located a volunteer plumber who modified the patient's residence and installed the device at no cost to the member. Coordinating this service facilitated the member remaining in his home independently. This met our goal of maintaining the member in the least restrictive setting.

4. Excerpt from Community Resource Referral Assessment completed to identify add on services and benefits



General Assessment Question List: CM: Comm. Resource Refer. Tool [500288]

Tab #8 (Other Res.)

Order	Seq.#	Question Text [ID]	Question Type Req'd *Clinical Variable*	Cond'l (seq #)	Criteria Interview	Crit. Req.
1	34	OTHER RESOURCES [506760]	Header			☐
2	61	Is member recieving services from other resources? [507709]	Yes/No with FreeText			☐
3	45	Does member require referral to other resources? [506770]	Yes/No with FreeText			☐
4	35	Select all other resources member has been referred to: [506761]	Header			☐
5	43	Meals on Wheels or other food resource? [506769]	Yes/No with FreeText	45		☐
6	46	Transportation? [506771]	Yes/No with FreeText	45		☐
7	53	Home Health? [506775]	Yes/No with FreeText	45		☐
8	54	Shelter? [506776]	Yes/No with FreeText	45		☐
9	55	Senior Community Center? [506777]	Yes/No with FreeText	45		☐
10	41	Cancer Resources? [506767]	Yes/No with FreeText	45		☐
11	57	Transplant Resource? [506779]	Yes/No with FreeText	45		☐
12	59	Kidney Resource? [506780]	Yes/No with FreeText	45		☐
13	60	Hemophilia Resource? [506781]	Yes/No with FreeText	45		☐

CareEnhance CSCU Report

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11. Performance and Health Outcome Measurement

a. Describe how the MAO will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.)

Model of Care performance and outcome measures are collected and tracked from OneCare's health information system also known as the ~~or~~ clinical data warehouse. OneCare's clinical data warehouse contains the following data fields and sources:

Table: Clinical Data Warehouse Health Data Fields

Data Element	Data Source	Frequency of Update
Health Risk Assessment Data	HRA survey tool	Daily
Diagnosis codes	Encounters	Daily
Inpatient admissions	Encounters	Daily
Emergency department visits	Encounters	Daily
Pharmacy	PBM transactions	Daily
Case management events	CM transactions	Daily
Authorization data	Authorization transactions	Daily
Member complaints and appeals	Events	Daily

The clinical data warehouse is the data source for the following categories of measures:

- Utilization
- Case management
- Care coordination
- Transitions of care
- Beneficiary health outcomes
- Access and availability
- Sample frame data for member and provider surveys
- Complaints and appeals

Specific Model of Care measures that are collected through the data warehouse include:

- Access to Essential Services
  - Member complaints due to access to care: 6%

- Access to Affordable Care
  - Dental benefit utilization: 35% of members that utilized the dental benefit
  - Member complaints due to dental benefit services: 2% of member complaints related to dental benefit services.
  - Utilization of taxi benefit: 22% of members utilized OneCare taxi benefit
  - Member complaints due to taxi benefit: 3% of member complaints related to taxi benefit services

- Coordination of Care
  - PCP change: 98% of members switching primary care providers are reassigned within 48 hours.
  - Member retention rate: 85% of members who remain with their chosen primary care provider

- Transition
  - Rate of referral to transition team
  - Rate of member screening assessments performed by concurrent review nurse
  - Rate of screening completed within 48 hours of admission

- Utilization
  - Bed days/1000: 1200
  - Readmission rate: 11%
  - Emergency room utilization rate: 650 visits/1000 members per year

An example of the process that OneCare undergoes to prioritize, take action, and initiate quality improvement activities based on health information data is described below using complaints data as an example:

1. Complaints and Appeals

   Identifying the appropriate population
   The CalOptima Customer Service department handles incoming member call and routed any member appeals or grievances to Grievance and Appeals Resolution Services for processing. The cases were entered in the Facets Appeals Module where they were assigned a category, type, and subtype based on the specific issue and an acknowledgement letter is sent to the member. The cases were assigned to a resolution specialist and forwarded to Director or designee for review.

   Sampling Method
   There was no sampling involved. The entire population of member complaints was included in the analysis. Member complaint data is extracted from the clinical data warehouse for the period of January through December 2010.

   Data Collection
   Complaints and appeals data was collected from January through December 2010 for a total of 375 complaints and 104 appeals. The categories for the major complaints are Billing/Financial, Quality at the office site, Quality Care, Attitude/Quality Service, and Access. The categories for the major appeals are Coverage Disputes and Medical Necessity. The overall percentage of each category for complaints and appeals are presented in *Figures* 7 and *8*, respectively. Member complaints and appeals are analyzed monthly, quarterly, semi-annually and annually. They are reported quarterly to the Grievance and Appeals Subcommittee of the Quality Improvement Committee (QIC) where trends and recommendations for follow up are noted in the minutes that are reported and forwarded to QIC.
   For complaints and appeals data, we analyzed the attitude/quality service and billing/financial categories due to the majority of complaints being related to these areas. To develop these into measures for improvement, we prioritized the measures based on the greatest amount of complaints within each category. Within the attitude/quality service category, the large majority of complaints were against practitioners/office staff

and the transportation service for members to get to their appointments. Therefore these areas were given priority and were developed into measures for improvement.

Table 8: 2010 OneCare Complaints by Category

Complaints Category	Percent of Total Complaints	Avg. Rates per 1000/year
Access	6%	0.53
Attitude/Quality Service	54%	4.62
Billing/Financial	26%	2.31
Quality Care	14%	1.16
Quality - Office site	0%	0.02

Table 9: 2010 OneCare Appeals by Category

Appeals Category	Percent of Total Appeals	Avg. Rates per 1000/year
Coverage Disputes	54%	1.29
Medical Necessity	46%	1.11

Practitioner Unprofessionalism/Rudeness and Bad Bedside Manner

Data:

Complaint Trend Report: The largest amount of complaints by members was regarding Attitude/Quality Service (53%). Medical and dental practitioners made up nearly half of the complaints within this category.

Quantitative Analysis:

Complaint Trend Report: Approximately half of the Attitude/Quality of Service complaints was related to practitioners within medical and dental facilities. Similar complaints were made against practitioners across other services such as vision, behavioral health, lab and physical therapy. The majority of complaints involved communication problems between these providers and the members. Due to half of the Quality of Service complaints being associated with the practitioners of OneCare services, there is an evident need for improvement in this area.

Qualitative Analysis:

In trying to consider what may be driving this result, we looked at the top areas of dissatisfaction identified from member complaints and appeals. Following are some of the findings:

Complaints and Appeals Logs: Most of the complaints against practitioners from various service areas were due to unprofessionalism and rudeness, in addition to an overall "bad bedside manner" during treatment. Many of the complaints against dental practitioners were in regards to disagreeing with the treatment plan, cost of services, and dental product problems. Some complaints against all service areas were related to being denied from certain treatments because of authorization issues, and a small amount of complaints were for the lack of cleanliness in the facility, not calling the members back, and long wait time in the office.

Opportunity for Improvement:

Due to the complaints against practitioners' unprofessionalism/rudeness and bad bedside manners being a large portion of the complaints within the Quality of Service category, there is an opportunity for improvement for this measure. There is a great need to address practitioners with the types of complaints members often have with their services and identify ways to improve a member's experience at their appointments. There is also a need for member education about the differences in treatment plans between medical and dental and what the OneCare benefits are for each of these areas.

Intervention:

Provide outreach to medical and dental facilities on a quarterly basis to address any member issues and how to solve them. By opening up the lines of communication between OneCare and the office staff, any outstanding member complaints or problems can get resolved early on. Provide the office staff with reference sheets for common member complaints and how to best resolve them. In addition, mail out detailed brochures to members that specify the difference in medical and dental benefits, the types of questions to ask their practitioners about their treatment plan at their next appointment, and tips for how to develop a strong communicative relationship with their practitioner. The brochure should also make members aware of possible "up-selling" of services in either the medical and dental office, which gives members the choice to pay out of pocket for upgraded or extra services that are not covered by their plan.

Billing Issues

Data:

Complaint Trend Report: The second largest amount of complaints by members was regarding Billing/Financial issues (26%).

Appeals Report: Over half (54%) of the appeals data was related to coverage disputes.

Quantitative Analysis:

Complaint Trend Report: Approximately one-third of the billing issues was related to the member being misinformed about the billing process and coverage, one-third were charged for the service but were told by office staff that they would be reimbursed by their plan, and another one-third of the issues were due to the lack of member understanding of what benefits were covered, especially for dental benefits.

Appeals Report: With over half of the appeals due to coverage disputes, there is an evident need for billing clarification for members for what is covered under the OneCare plan.

Qualitative Analysis:

In trying to consider what may be driving this result, we looked at the top areas of dissatisfaction identified from member complaints and appeals. Following are some of the findings:

Complaints and Appeals Logs: Nearly half of the overall billing issues were associated with medical bills, while slightly less than half were related to dental bills. A small amount billing complaints were associated with lab and vision benefits.

Opportunity for Improvement:

Identify the need for member and office staff education regarding what is covered for both medical and dental benefits, the terms of coverage, how to best communicate the billing process between both parties.

Intervention:

Provide office staff with FAQ sheet "Common Member Billing Questions" that addresses common member billing issues and how to answer them. This sheet should also explain the OneCare billing process for staff to understand what they can bill members. Provide this same FAQ sheet that focuses on the types of questions they may have, when to ask them, and what is covered under their medical and dental benefits. There needs to be a clear explanation to members that if they accept certain treatments or medications that are not covered by OneCare, they will be responsible for the out of pocket portion. The FAQ sheet should have contact number for both office staff and members to call for an immediate billing question so as to not give out the wrong information, which can often lead to such billing disputes later in the process.

HEDIS

Some Model of Care measures are also HEDIS measures. Data collection for HEDIS measures is handled as part of the annual HEDIS data collection and reporting process, which also includes a HEDIS Compliance Audit. A high-level project plan and timeline are listed below:

HEDIS Project Summary

Planning • Complete evaluation of HEDIS2010 project • Review new NCQA measures for HEDIS 2011 • Review changes to HEDIS 2011 specifications • Develop 2011 work plan • Update all contracts with vendors
Development • Define requirements per measure • IT and business unit testing • Business and HEDIS team sign-off • HEDIS auditor approval
Medical Record Pursuit and Review • On-site training • Medical Record Pursuit • Medical Record Acquisition • Medical Record Review & Abstraction • Data Entry • Over-read & Oversight

HEDIS Audit Activity • Complete Road Map • Preparation for On-site Audit • Audit and Audit Follow-up, for Medi-Cal: HSAG, for OneCare/Healthy Families: Thomson Reuters • Completion and submission of DST to NCQA, DHCS, and MRMIB (Quality Matrix)

HEDIS Timeline

Milestone	Timeframe
Health Network HEDIS Training #1	January 10, 2011
Health Network HEDIS Training #2	February 17, 2011
Distribute Medical Record Lists to Copy Service	February 1, 2011 – May 15, 2011
Pursuit by OneCare	February 17, 2011 – May 20, 2011
OneCare Chart Review Ends	June 10, 2011
Road MapTool due to Auditor	February 10, 2011
Audit On-Site Review	1) Medi-Cal: TBD 2) OC/HF: TBD
Submission of Final HEDIS Results to DHS/NCQA	June 15, 2011
Submission of Final HEDIS Results to MRMIB	June 30, 2011
TARGET COMPLETION DATE	June 15, 2011
PROPOSED TIMEFRAME	12 Months

HEDIS measures are used for assessing access to preventive health services and certain aspects of beneficiary health outcomes.
Once data is collected, it is analyzed by the respective business department. For example, model of care measures related to coordination of care is analyzed by the case management department. Operational data is analyzed on a monthly basis and reported to QIC quarterly. Outcomes measures are reported quarterly or annually. For example, beneficiary health outcomes related to CCIP programs are reported to QIC quarterly whereas HEDIS is reported annually.
Results are compared to established benchmarks. Any measure that does not achieve benchmarks is subject to a root cause analysis, identification of opportunities for improvement, and development of a quality improvement activity.

Examples of HEDIS measures that are used to evaluate the Model of Care are:

1. Preventative Health
   - 53.86% rate of breast cancer screening
   - 54.02% rate of colorectal screening

2. Beneficiary Health Outcome
   a. Diabetes
      - Blood pressure control: 36.78%
   b. Depression
      - Effective acute phase treatment for depression: 54.17%
      - Follow up within 30 days after hospitalization: 42.86%

HEDIS Improvement Activities

Upon completion of required reporting and throughout the year, the HEDIS team works to improve HEDIS rates by analysis of HEDIS process and outcomes; submitting software issues and enhancements; providing HEDIS data to assist in state collaborative projects, incentives and QI work teams; and identifying opportunities for improvement in data completeness and accuracy.

OneCare implements QI initiatives that continuously improve the quality of care and service. QI initiatives target specific needs for preventive care and chronic care management that reflect the demographics and health status of OneCare members and meet contractual guidelines.

The Medical Data Management Department coordinates a QI initiative for HEDIS and SNP data collection and reporting for the OneCare program data in conjunction with supporting OneCare departments and the Physician Medical Group.

A summary of model of care improvement initiatives based on HEDIS results for Colorectal Cancer Screening follows:

Colorectal Cancer Screening: Increase member tests and screenings	Providers will receive: # members on the list who received the needed screening or test FOBT Kit Distribution with Office Incentive	The member will receive: • A letter telling them to contact their doctor. • Fact sheet on recommended preventive health care. • Fact sheet on flu, swine flu, and pneumococcal shots. • Transportation coupon. • Colorectal Cancer Brochure about the importance of screening BCS/COL Member Incentive • OneCare member incentive (two movie tickets) per screening obtained; mailing to include BCS, COL Healthy You brochures

CAHPS

Another data collection method that is used to evaluate the Model of Care is the CAHPS survey. OneCare participates in the CAHPS survey process annually. The CAHPS survey methodology is summarized below.

Identifying the appropriate population

The Centers for Medicare and Medicaid Services (CMS) administered the CAHPS® 4.0 survey to its contract-level organizations. CalOptima has contract number H5433 with CMS. Eligible participants for the survey had to be at least 18 years of age and currently enrolled in the plan for six months or longer.

Sampling method

The survey sample was randomly selected from CMS records of all the adult individuals who had been in the plan for at least six months. Samples for the

Medicare CAHPS® 4.0 survey were selected to yield a minimum of 390 completed surveys. The oversampling was accounted for in contract-level estimation through weighting. For OneCare the total number of respondents was 324.

Data collection
The CAHPS® 4.0 survey was conducted between February 23 and June 20, 2010 and measured members' experiences with OneCare over the previous six months. The data collection protocol included mailing of pre-notification letters, up to two mailings of paper surveys, and telephone surveys with those sample members who did not respond to the mail survey. The mail and telephone surveys were available in both English- and Spanish-language versions. Two percent of beneficiaries in the study followed experimental survey protocols designed to help improve response rates, better understand beneficiary ratings, and reduce the cost of the project.

Case-mix adjusted data were used to compare data from each contract to the national mean. The State mean is also available for comparison; however, significance testing is only available in relation to the national mean for survey responses. Survey respondents used a 0 to 10 scale to give their "overall ratings" for various measures of their health plan and drug coverage benefits. Specific "composite" questions for the member's health plan and prescription drug coverage were rated on a 1 to 4 scale.

Overall Ratings	Score	Benchmark
Health Plan	8.25	8.40
Care Received	8.39	8.48
Personal Doctor	8.96	9.01
Specialists	8.56	8.85
Prescription Drug Coverage	8.07 ↓	8.35

↓ = Results were significantly lower than the 2010 national average for MA contracts

Composites Category	Score	Benchmark
Getting Needed Care	3.50	3.57
Getting Care Quickly	3.16	3.24
Doctors Who Communicate Well	3.65	3.69
Customer Service	3.57	3.64
Getting Needed Prescription Drugs	3.54 ↓	3.71
Getting Information from the Plan about Prescription Drug Coverage and Cost	3.32	3.42

↓ = Results were significantly lower than the 2010 national average for MA contracts

As a Medicare Advantage (MA) Special Needs Plan (SNP), OneCare monitors member satisfaction of its services and identifies areas for improvement. OneCare assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal of OneCare is to improve member satisfaction by better meeting the member's healthcare needs.

The Medical Data Management department analyzes survey results and discusses results, barriers, and opportunities for improvement. Analysis is presented at the Quality Improvement Committee. Analysis of findings includes a first level quantitative data analysis that incorporates aggregate results and trends over time. OneCare utilizes root cause analysis or barrier analysis to identify the reasons for the results. Staff also conducts qualitative analysis to further inform the analytical process and identify root causes. Results are compared against a standard, goal, or benchmark.

The Quality Improvement Committee identifies target areas for improvement and assists staff in determining interventions and actions. OneCare prioritizes areas for improvement by:

a. The QIC shall formulate interventions, as appropriate, based on the results of the analysis of the surveys, and shall consider the results and analysis of Complaints, Grievances, and Appeals data, information from any outreach calls, and any other data relevant to Members' health outcomes and satisfaction with care.

b. The QIC shall formulate a Quality Improvement Project Plan, if appropriate, indicating the interventions to implement, identify the responsible person or department, and set timeframe.

Various data sources including member satisfaction and complaints and appeals data were reviewed to assess the current needs for improvement for OneCare. Based on all of the different data analyzed, we have prioritized the following opportunities for improvement:

1. Identify the need for better communication and delivery of provider and vendor services, specifically from medical, dental and transportation providers. This includes:

    a. Better accountability of the taxi vendor, including communication between OneCare and the expectations of their contracted services. There is also a need for improved member awareness of how to use the taxi services and what the services entail.

    b. Address practitioners with the types of complaints members often have with their services and identify ways to improve a member's experience at their appointments. There is also a need for member education about the differences in treatment plans between medical and dental and what the OneCare benefits are for each of these areas.

2. Identify the need for quicker response to member care by increasing access to appointments and improving member education of the referral/authorization process.

3. Identify the need for improving members' understanding of specialty providers and benefits and who to contact for authorization/referral inquiries. This includes:

    a. Identify the need for member education of specialist providers and benefits that are covered through OneCare and who to contact for authorization/referral

inquiries. In addition, there is a need to identify specialists that are not providing enough access and availability to members' questions and appointment needs.

4. Identify the need for member and office staff education regarding what is covered for both medical and dental benefits, the terms of coverage, and how to best communicate the billing process between both parties.

5. Identify the need for member education about DME benefits through OneCare and how to maintain DME to ensure it stays in good condition.

6. Identify the need for improved member outreach and education on prescription drug benefits and coverage.

7. Identify the need for a Monarch practitioner training in patient satisfaction, in addition to improving Monarch members' understanding of their benefits through OneCare.

To address the opportunities for improvement as listed above, the following actions and interventions will be implemented:

- Provide a bi-annual training for the customer service department to discuss the details of the OneCare pharmacy benefits, policy changes, and address any issues or questions that members have about their prescription drug plan. In addition, a detailed prescription drug coverage reference sheet should be given to each customer service employee for use during member calls.

- Provide and exchange customer service information with the taxi vendor, such as quarterly reports of member issues/complaints and drivers' issues, on a quarterly basis to provide greater transparency and communication of member issues. In addition, mail FAQ sheets to members that highlights how to schedule a taxi ride, what information to provide the taxi vendor, and what to do if they are late or not at the right location.

- Promote improved access to appointments through physician office process changes such as: quick call back response for members' phone inquiries, short wait time in the waiting room, and greater availability of appointments for OneCare members. In addition, provide a FAQ sheet to members and provider offices for where members can call to check on authorization of referrals for treatment.

- Provide members with frequently asked questions (FAQ) brochures about specialty services by mail and in PCP offices. These brochures would discuss the specialty benefits that are covered under OneCare, how to go about getting a referral to a specialist, and who to call for following up on a referral that was made by a PCP. To address specialists with grievances against them and their staff's access and availability of appointments, carry out quarterly outreach to these providers to address member concerns and monitor performance. Provide a provider brochure "How to help patients with authorization questions" that will be a reference sheet for office staff to address members' referral inquiries.

- Provide a practitioner and office staff training for Monarch providers about how to improve member satisfaction in the office. The training must cover bedside manner issues, cultural competency, and administrative issues.

- Provide member brochures at practitioners' offices and in the mail upon receiving a DME that details the types of equipment covered and who to contact for referral/authorization inquiries. In addition, specific instruction sheets that detail how to maintain and extend the life of the various types of DME should be mailed to members on a quarterly basis.

- Provide a quarterly member newsletter highlighting the current prescription drug benefits under OneCare and FAQs about getting referrals, medical necessity of drugs, and co-pay issues. The newsletter should also include information about medication management and who to contact for referral inquiries.

HOS

A fourth data collection method is the HOS survey. A summary of the HOS survey process follows:

OneCare participates in the required annual HOS reporting process. In 2011, OneCare is fielding the HOS survey for Cohort 14 Baseline and Cohort 12 Follow-Up. OneCare uses a NCQA-certified survey vendor to conduct the HOS surveys.
Upon receipt of the HOS report from our contracted HOS vendor, OneCare conducts an analysis, creates a summary report, and identifies opportunities for improvement.
An example of the reporting and analysis process using the most recent HOS results (2009 Cohort 12 Baseline) is provided below:

OneCare MA-HOS 2009 Cohort 12 Baseline
Survey Methodology

- Simple Random Sample of Members
- Protocol:
    - HEDIS® 2009 Medicare Health Outcomes Survey
    - 5-wave mail with telephone follow-up
    - English and Spanish
- Timeline
    - Field Survey April to June 2009
- Survey data checked for completeness

Sample Disposition

- 1,200 Questionnaires mailed
- 1,089 eligible seniors members sampled (age 65+)
    - 111 members removed due to age < 65, incorrect address or language barriers
- Response rate overall: 51.8%
  Total completed surveys: 564

Table 19: HOS Cohort 12 Baseline Respondent Demographics

	OneCare	All Plans
Age	(N=417)	(N=250,733)
65-69	19.9%	21.1%
70-74	26.4%	28.9%
75-79	24.2%	22.6%
80-84	17.7%	15.7%
85+	11.8%	11.6%
Gender	(N=417)	(N=250,733)
Male	37.6%	42.3%
Female	62.4%	57.7%
Race	(N=417)	(N=250,733)
White	49.2%	82.1%
Black	1.9%	10.9%
Other/Unknown	48.9%	7.0%
Marital Status	(N=389)	(N=240,859)
Married	36.2%	55.6%
Widowed	34.4%	28.2%
Divorced or Separated	23.9%	12.6%
Never Married	5.4%	3.6%

Figure 1: Physical and Mental Score Summary

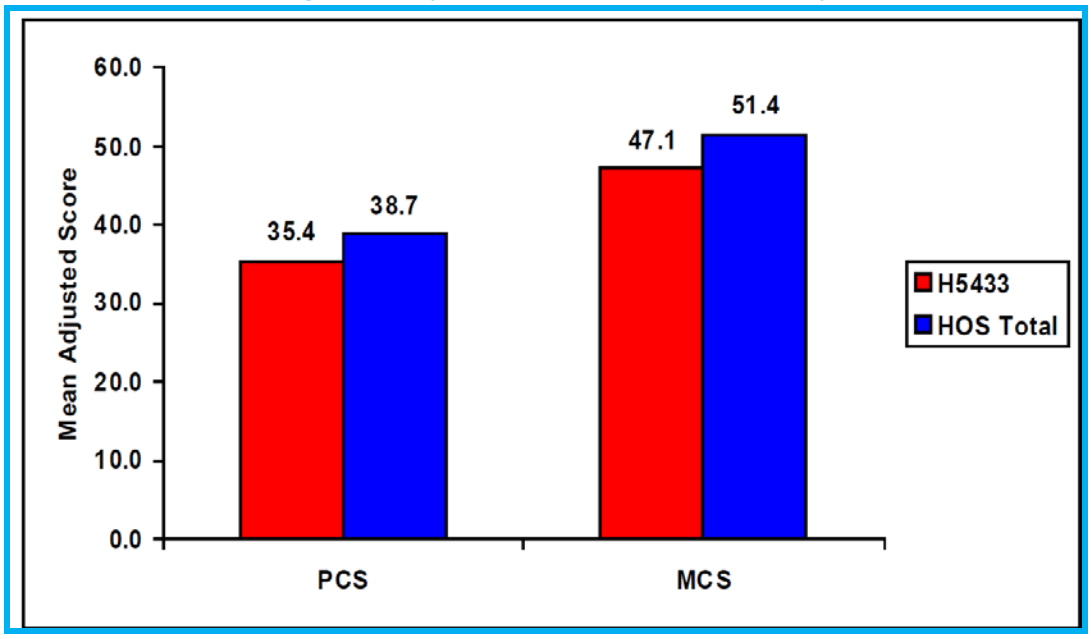


Table 20: HEDIS® Measures

HEDIS Measure	Numerator	Denominator	Percent
MUI			
Discussing Urinary Incontinence	81	120	67.5%
Receiving Urinary Incontinence Treatment	47	118	39.8%
PAO			
Discussing Physical Activity	205	360	56.9%
Advising Physical Activity	196	362	54.1%
FRM			
Discussing Fall Risk	108	263	41.1%
Managing Fall Risk	134	182	73.6%
OTO			
Osteoporosis Testing in Older Women	123	228	54.0%

Table 21: Chronic Medical Conditions

Medical Condition	OneCare		All Plans	
	N	Percent	N	Percent
Hypertension	259	65.2%	162,805	67.2%
Arthritis - Hip or Knee	201	51.0%	104,729	43.5%
Arthritis - Hand or Wrist	172	44.3%	92,949	38.7%
Diabetes	121	30.7%	62,928	26.0%
Other Heart Conditions	75	19.1%	55,710	23.3%
Sciatica	108	27.6%	55,206	23.1%
Osteoporosis	132	34.3%	52,627	22.0%
Coronary Artery Disease	55	14.3%	37,696	15.8%
Pulmonary Disease	52	13.1%	37,725	15.7%
Any Cancer (except skin cancer)	38	9.6%	38,320	15.8%
Myocardial Infarction	39	10.0%	27,760	11.6%
Congestive Heart Failure	49	12.7%	23,713	9.9%
Stroke	53	13.4%	22,890	9.5%
Gastrointestinal Disease	34	8.8%	12,733	5.3%

HOS results are analyzed and compared to the all plan rate. Any areas below the all plan rate are considered for quality improvement activities. Based on the HOS Cohort 12 Baseline, OneCare decided to focus on early identification of depression based on lower rates of the MCS score and high prevalence of depression in the OneCare population (second highest HCC category, see table 5).

Beginning in December 2010, OneCare launched a depression screening initiative as described below:

OneCare Behavioral Health Initiative
December 2010 - December 2011

Goals:

1. Provide behavioral health screening for all OneCare members, 18 years or older, to identify major depressive disorder (MDD).

2. Ensure cost-effectiveness through directed therapy, when appropriate, for members with a new or pre-existing diagnosis of major depression
3. Promote member adherence to antidepressant medication during acute and maintenance phases of treatment
4. Improve quality of care for members with depression

Member Eligibility: Members must be 18 years or older and eligible with OneCare on the date of service.

Provider and Office Staff Intervention:

Provider Action	Send to CalOptima	Provider Incentive	Provider Administrative Office Staff Incentive
Conduct an initial office visit for all assigned OneCare members with administration of the PHQ-9	• Reimbursement Information Form (submit one time) • Completed Behavioral Health Assessment Form for each member (If PHQ-9 score is not indicative of MDD, completion of the entire form is not necessary).	$50 per member	$10 gift card per member
For Members with a Newly Identified or Existing Diagnosis of Major Depressive Disorder			
Conduct a 12-week follow-up office visit with completion of the PHQ-9 again to monitor treatment effectiveness.	• Behavioral Health Assessment Form for each member indicating a 12- week visit and second PHQ-9 score	$50 per member	$10 gift card per member
Conduct a 6-month follow-up office visit with completion of the PHQ-9 again to monitor treatment effectiveness.	• Behavioral Health Assessment Form for each member indicating a 6-month visit and third PHQ-9 score	$50 per member	$10 gift card per member
Member remains on antidepressant medication for 6 consecutive months from week of initial office visit.	N/A (will be evidenced by pharmacy data)	$50 per member	$10 gift card per member

b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.)

OneCare maintains a variety of staff with a broad scope of expertise and qualifications to perform functions related to evaluation of the model of care. Responsible staff includes the following:

The following staff is responsible for all aspects of data collection and analysis. Staff performs functions such as creation of databases and queries to pull data, conducting statistical analysis, and summarizing large data sets into metrics. Data is collected as described in section 11.a. above.

- Manager, Performance Measurement
  - Experience:
    - PhD in health economics and statistics
    - Over 30 years working in various roles in the health care industry
    - Significant experience conducting statistical analysis and clinical outcome analysis in health care settings: hospital and health plan
  - Roles and Responsibilities
    - Collect clear, accurate and appropriate data used to analyze problems and measure improvement
    - Risk identification and stratification of members using all available data sources
    - Coordinate and communicate organizational information
    - Oversee satisfaction surveys for members and providers
    - Measure access and availability to ensure provider adequacy of provider network
    - The manager participates in the following data collection activities for the model of care: risk stratification, identification and stratification of members for CCIP, health risk assessment analysis, and HOS and CAHPS result analysis. Data is collected using the clinical data warehouse. Analysis is conducted using SAS.

- Manager, Medicare Data Management
  - Experience:
    - Bachelor's degree
    - Over 25 years in a variety of health care settings including: internal corporate consultant, hospitals, clinics, large medical groups, and managed care plans

  - **Roles and Responsibilities:**
    - Responsible for interaction with internal resources within the Customer Service, OneCare, Accounting and Finance departments and support discussions regarding membership at operational meetings; as well as, external CMS and CMS contracting resources.
    - Support management and analysis of accretion file submission, transaction reply report (TRR) analysis and follow up assignment, MMR analysis and reconciliation and management of the issue resolution
    - Participating in CMS workgroup/conference calls as well as analysis of and action in response to HPMS communications related to enrollment
    - Participates in CMS workgroup/conference calls as well as analysis of and action in response to HPMS communications related to enrollment
    - Project Lead for Ingenix Insite HCC program
    - Responsible for monthly data pulls based on HCC findings

        - The manager participates in the following data collection activities for the model of care: risk stratification, HCC analysis, and health risk assessment analysis

- Data Analyst Sr.
    - Experience:
        - Bachelor's degree in urban studies and planning
        - Certified in Microsoft Office applications including Access
        - Over 10 years of experiencing in data analysis in a health care setting
    - Roles and Responsibilities:
        - Responsible for creating data tables for annual HEDIS reporting using certified software application
        - Designs and creates reports to track data completeness and accuracy
        - Creates databases using SQL, VBA, etc to collect and report metrics in support of clinical outcome measures
        - Trains other analysts on their functions
        - Develop internal systems and exception reporting to ensure accurate data submissions to Department of Health Services (DHs) and Centers for Medicare & Medicaid Services (CMS)
        - The analyst participates in the following data collection activities in support of the model of care: HEDIS, CCIP outcome measures, utilization measures, HOS and CAHPS survey sample creation

HEDIS Program Manager:

- **Experience & Education Requirements:**
    - Registered nurse with over 35 years of clinical and data mining experience in a variety of health care settings including hospital, specialty clinic and manage care
    - Extensive experience with HEDIS, NCQA, CMS, DHS, and other quality performance standards
    - Significant experience with HEDIS project oversight
- **Roles and Responsibilities:**
    - Provide oversight for HEDIS data collection and reporting for all programs
    - Identify and implement opportunities to improve data accuracy and completeness
    - Train Health Networks on HEDIS reporting processes
    - Provide subject matter expertise for data warehouse and analytics
    - Oversee analytical staff
    - Monitor clinical data systems to ensure data integrity
    - The manager participates in the following data collection activities in support of the model of care: HEDIS, CCIP outcome measures, utilization measures, HOS and CAHPS survey sample creation

Performance Measurement Specialist:

- **Experience & Education Requirements:**
    - Master's degree in Public Health
    - 4 years of experience conducting quality improvement data analysis in managed care, community clinic settings, and hospital settings
- **Roles and Responsibilities:**
    - Provide administrative and analytical responsibilities for quality measurement activities within the QI Department

- Assist in data collection and project coordination of the HEDIS program
- Prepare reports and presentations relating to performance measurements, such as HEDIS, satisfaction survey results, and clinical outcomes
- The program specialist participates in the following data collection activities in support of the model of care: HEDIS and HOS and CAHPS survey sample creation

MMS Program Coordinator:

- **Experience & Education Requirements:**
  - Bachelor's degree in Health Care Administration, Business Administration, Public Health or a related field is preferred.
  - 2-3 years as a Data Analyst that would provide the knowledge and abilities listed
  - Work experience in within Managed Care and Quality Management
- **Roles and Responsibilities:**
  - Create and conduct end-user training on the medical management system
  - Partner with business units to analyze and improve business work flows
  - Provide business expertise for clinical data system improvement and upgrades

The following staff is responsible for root cause analysis, creation of quality improvement activities, and quality improvement projects.

The process to analyze and select target areas for quality improvement activities is as follows:

On an annual basis, OneCare reviews results for clinical preventive and outcome measures. Results are compared to selected benchmarks and established goals. Any measure that falls below annual goals is reviewed by the Quality Improvement Work Group Steering Committee. This committee selects focus areas for quality improvement initiatives and assigns selected areas to the appropriate Quality Improvement Work Team for barrier analysis, intervention, and evaluation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by internal Clinical Quality Improvement Committee (CQIC)

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there is no other CMS reporting requirement related to that project. OneCare may internally choose to continue the project or to go on to another topic.

Senior QI Project Manager:

- **Experience & Education Requirements:**
  - Master's degree in Public Health, Health Care, Health Administration or a related field
  - Extensive experience with HEDIS, NCQA, CMS, DHS, and other quality performance standards
  - Significant experience in project management within Managed Care and Quality Management
- **Roles and Responsibilities:**
  - Provide project management skills in support of special projects, survey implementation, and implementation of clinical data systems
  - Conduct research and analysis to improve clinical business processes
  - Implement request for proposals and vendor oversight for department projects
  - The manager participates in the following data collection activities in support of the model of care: HEDIS and CCIP outcome measures

SNP Coordinator

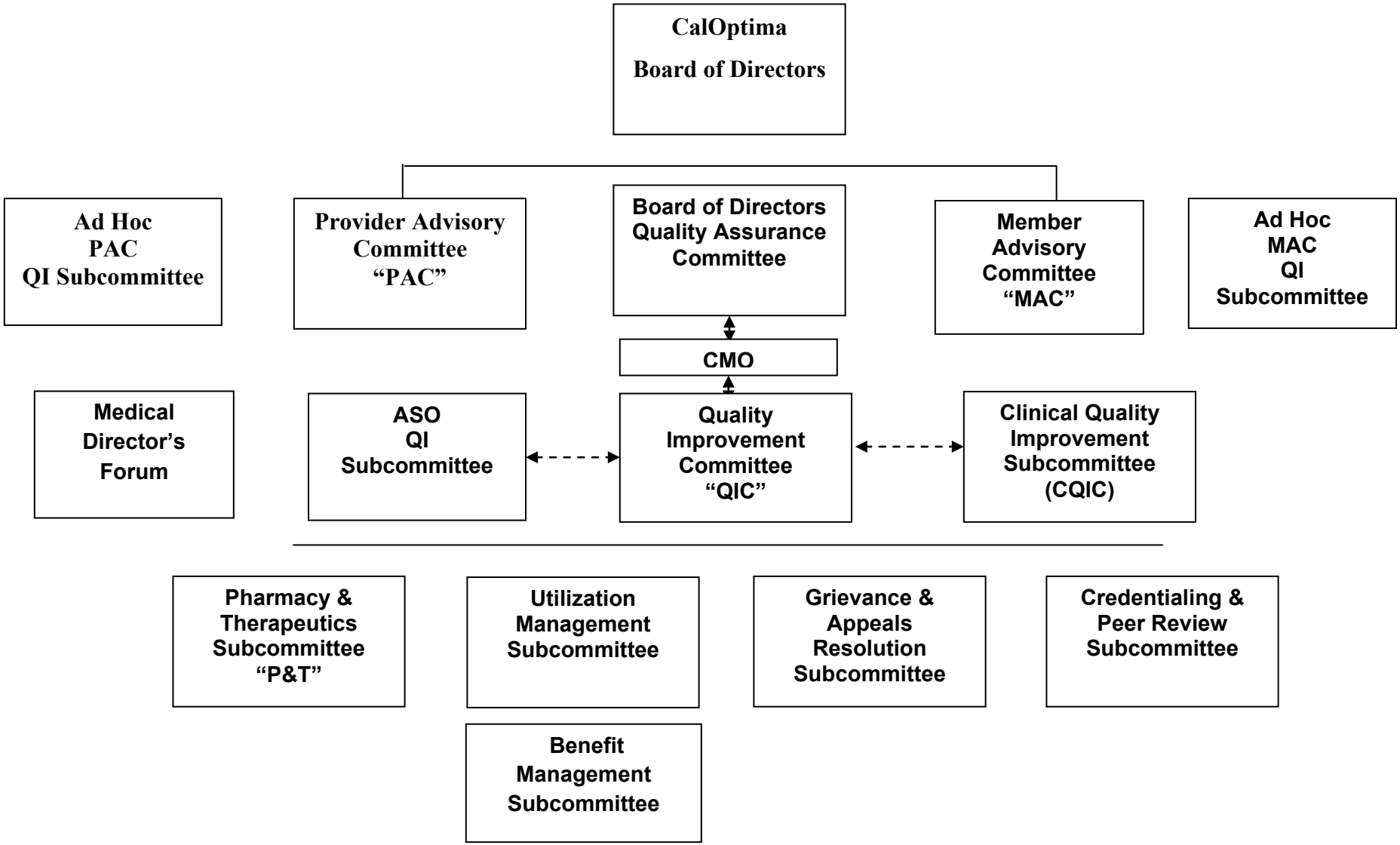
- **Experience & Education Requirements:**
  - Bachelor's degree in Health Care Administration, Business Administration, Public Health or a related field is preferred.
  - 2-3 years as a Data Analyst that would provide the knowledge and abilities listed
  - Work experience in within Managed Care and Quality Management
- **Roles and Responsibilities:**
  - Provide project management for workflow and documentation activities to achieve and maintain SNP compliance
  - Coordinate collection of reports, policies, and data to ensure compliance with SNP Structure and Process survey

- Participate on internal work team to improve SNP functions
- The coordinator participates in the following data collection activities in support of the model of care: CAHPS data analysis, transition of care measurement, and case management data analysis

OneCare does not use contracted consultants to measure or evaluate its MOC.

c. Describe how the MAO will use the analyzed results of the performance measures to improve the model of care (e.g,, internal committee, other structured mechanism, etc.)

Data to support evaluation of the model of care is presented to internal committees with oversight responsibility for providing strategic direction to the model of care and all clinical operations. The primary committee with this responsibility is the Quality Improvement Committee.
OneCare's committee structure also includes working committees that are subordinate to the QIC. These committees report to the QIC and are responsible for specific functions.


CalOptima
Board of Directors
Ad Hoc
PAC
QI Subcommittee
Provider Advisory
Committee
"PAC"
Board of Directors
Quality Assurance
Committee
Member
Advisory
Committee
"MAC"
Ad Hoc
MAC
QI
Subcommittee
CMO
Medical
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ASO
QI
Subcommittee
Quality
Improvement
Committee
"QIC"
Clinical Quality
Improvement
Subcommittee
(CQIC)
Pharmacy &
Therapeutics
Subcommittee
"P&T"
Utilization
Management
Subcommittee
Grievance &
Appeals
Resolution
Subcommittee
Credentialing &
Peer Review
Subcommittee
Benefit
Management
Subcommittee

In 2010, OneCare identified unplanned transitions as an opportunity to improve the effectiveness of the model of care. A summary of that analysis and actions is described below:

2011 OneCare Care Reducing Transitions Analysis

I. Introduction:

At least annually, OneCare monitors its overall process for minimizing unplanned transitions by analyzing admission rates for the entire population and determining actions to take to reduce potentially avoidable or unplanned admissions. Analysis includes patterns of both planned and unplanned admissions, readmissions, emergency department (ED) visits and repeat ED visits, and admissions to both participating and non-participating facilities.

II. Methodology and Data Analysis:

Utilization Patterns: The data used to analyze utilization data in order to identify opportunities to minimizing unplanned admissions came from inpatient encounter and claims data, emergency department visits from encounters and claims data, and inpatient census reports for the period January 1, 2010 through December 31, 2010. There were a total of **2,150 admissions** representing:

Quantitative Analysis – Hospital Admissions:

2010 Data:

17.38 admits per thousand member months
208.58 admits per thousand members per year

9,279 Days
75.02 Days per thousand member months
900.20 Days per thousand members per year
4.32 average length of stay

There were **228 readmissions** representing 11% of total admissions. There were **35 admissions to non-participating facilities** representing 1.6% of total admissions.

2010 Benchmarks:

330 Admits per thousand members per year
1206 Bed days per thousand members per year
4.8 Average length of stay
45 Readmissions per thousand members per year

(Benchmarks are based on historical trend of OneCare utilization data from 2010)

Each of the metrics was below the established benchmark.

Qualitative Analysis – Hospital Admissions:

A more detailed review of the data showed that the majority of readmissions were due to diagnoses of: long-term complications of diabetes, bacterial pneumonia, congestive heart failure, urinary tract infections, and chronic obstructive pulmonary disease. Of these re-admissions, a relatively large volume of admissions into the hospital occurred from long

term care facilities. The most common diagnoses for readmissions from LTC facilities were bacterial pneumonia, UTI, and CHF.

These readmissions directly into the hospital and through LTC facilities may have been avoidable with member interventions. Member self management, knowledge of signs and symptoms to be aware of, and self-monitoring may have resulted in earlier outpatient management.

Quantitative Analysis – ED Visits:

In the period of January 1, 2010 through December 31, 2010 there were a total of **3,697 emergency department visits** representing:

2010 Data:
29.89 ED visits per thousand member months
358.66 ED visits per thousand members per year
There were **248 repeat ED** visits representing 6.7% of total ED visits.
2010 Benchmark:
262.7 ED visits per thousand members per year
(Benchmark is based on HEDIS 2008 means and percentiles for Ambulatory Care- ED Visits measure)
The OneCare ED visit rate of 358.66 ED visits was well above the benchmark of 262.7 visits.

Qualitative Analysis – ED Visits:
The high rate of ED visits relative to the benchmark necessitated further analysis. A review of hours of the day for which ED visits were high revealed that members used the ED during day time hours of 12pm to 2pm and 5 to 7pm. These hours represent times when primary care offices are closed but may be amenable to use of urgent care.

Reasons for use of the ED included diagnoses that are potentially avoidable. To monitor potentially avoidable ED usage, OneCare uses the following diagnosis codes:

	Dx Code Range	Avoidable ICD-9 Diagnosis Codes
	Code	Label
1	110.5	Dermatophytosis of the body (Herpes circinatus, Tinea imbricata)
2	112:112.3	Candidiasis
	112.5:112.9	Disseminated
4	133: 133.9	Acariasis
8	372: 372.39	Disorders of Conjunctiva
10	382:382.9	Suppurative
12	460	Acute nasopharyngitis (common cold)
13	462	Acute Pharyngitis
14	465: 465.9	Acute upper respiratory infections of multiple or unspecified sites
18	466:466.0	Acute bronchitis
19	472: 472.2	Chronic pharyngitis & nasopharyngitis
23	473:473.9	Chronic sinusitis
30	474: 474.9	Chronic disease of tonsils & adenoids
34	595: 595.9	Cystitis

	Dx Code Range	Avoidable ICD-9 Diagnosis Codes
	Code	Label
42	599.0	Urinary tract infection, site not specified
43	616:616.1	Inflammatory disease of cervix, vagina, & vulva
46	628.8	Infertility, female-Of other specified origin
47	698.8	Other specified pruritic conditions (hiemalis, senillis, Winter itch)
48	698.9	Unspecified pruritic disorder (itch NOS, Puritis NOS)
49	705.1	Prickly heat
50	724.2	Lumbago
51	724.5	Backache, unspecified
52	724.7	Disorders of coccyx
53	724.8	Other symptoms referrable to back
54	784.0	Headache (excluded: 350.2; 346.0-346.9; & 307.1) atypical face pain, migraine, & tension headache
55	V67:V67.9	Follow up examination
56	V68:V68.9	Encounters for administrative purposes
57	V70:V70.9	General medical examination
58	V72:V72.9	Special investigations & examinations

III. Analysis of Opportunities for Improvement

Review of the data show an opportunity for improvement to reduce unplanned admissions by reducing ED visits. In our review of unplanned transitions, the data revealed that the vast majority of unplanned transitions to the hospital were due to an ED visit. While these ED visits did result in an inpatient admission, a review of the admitting diagnoses show that these admissions may be avoidable as they are ambulatory care sensitive conditions. Therefore, an opportunity to minimize potentially avoidable admissions exists.

IV. Interventions

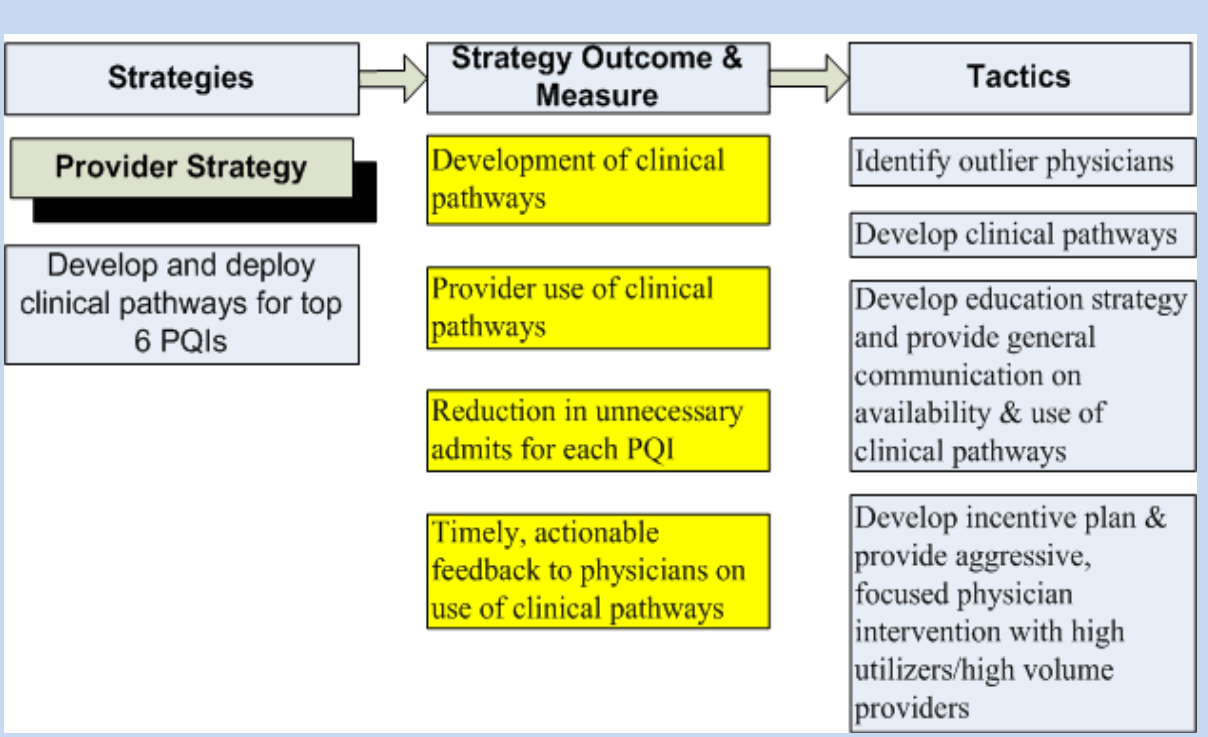
OneCare has identified unplanned transitions as an opportunity for improvement. Data shows that appropriate ambulatory care may prevent avoidable inpatient admissions (Ambulatory Care Sensitive Conditions, AHRQ Guide to PQI). OneCare has determined that an appropriate intervention is to monitor potentially avoidable admissions using the AHRQ measures for prevention quality indicators (PQIs). Specifically, the PQIs that will be monitored for OneCare are:

1. Diabetes short-term complications
2. Chronic obstructive pulmonary disease
3. Congestive heart failure
4. Bacterial pneumonia
5. Urinary tract infection

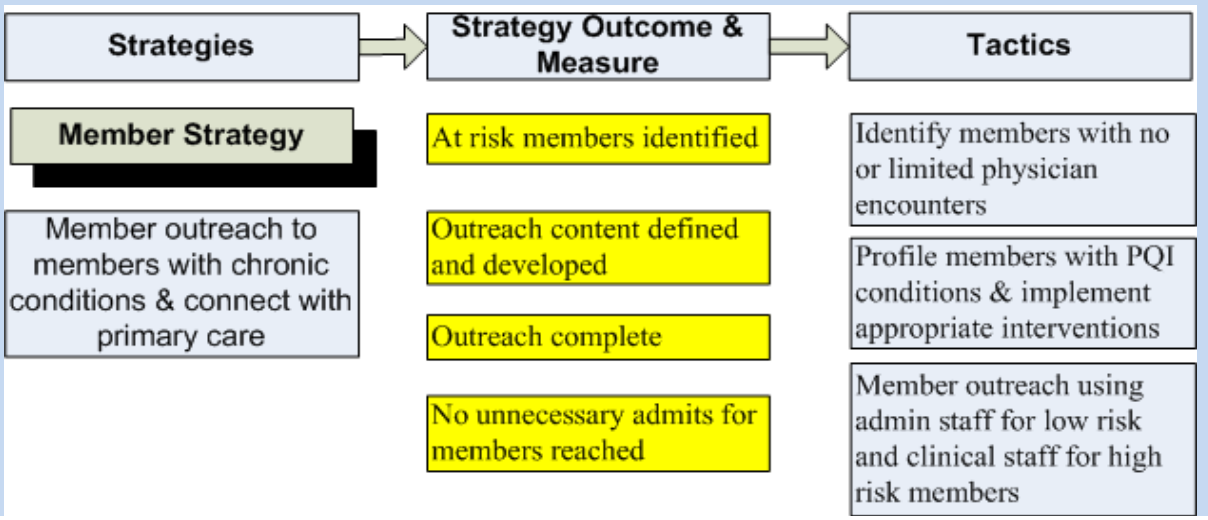
These indicators will be monitored on a monthly basis to identify members at risk for unplanned or avoidable transitions. Members that are flagged as having one of these diagnoses will be referred for care management that may include, as appropriate, member self-care management and case management.

Planned Interventions are listed below:

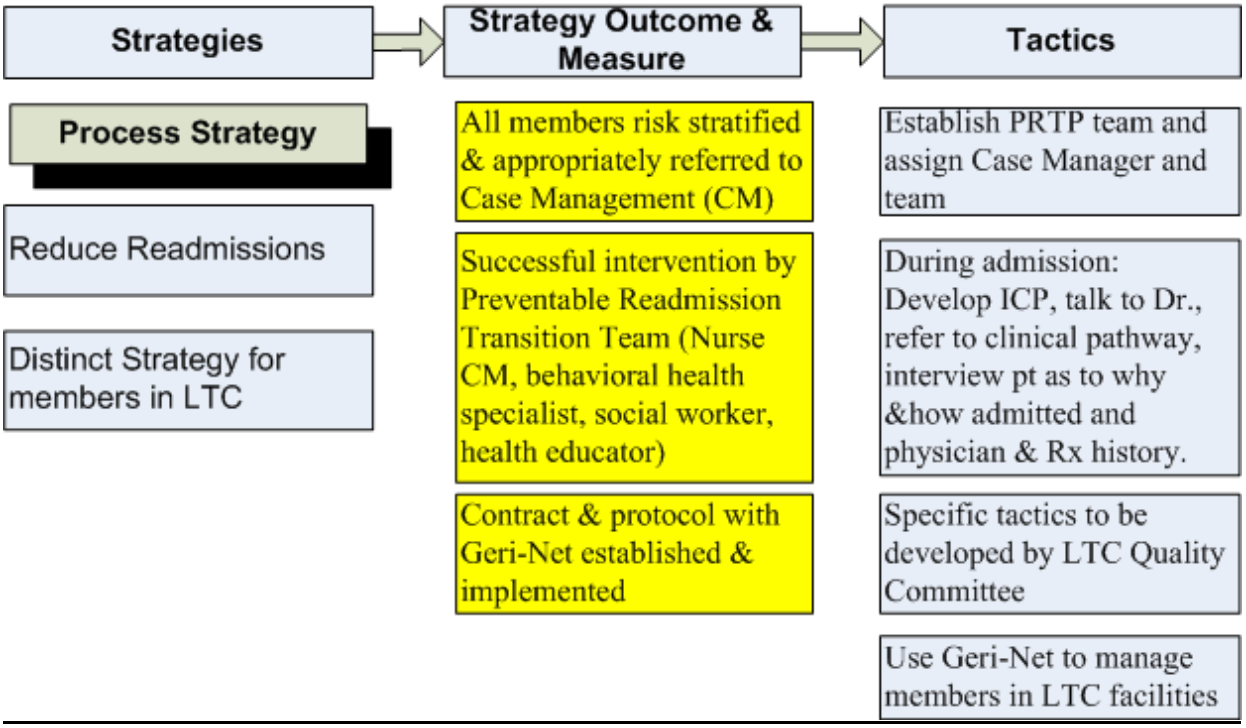
Provider Focused Interventions



Member Focused Interventions



Process Improvement Strategies



A second opportunity to improve the effectiveness of the model of care is in the care transition process as described below:

2011 OneCare Care Transition Process Analysis

V. Introduction:

As a Medicare Advantage Special Needs Plan, OneCare maintains a care transition program that is focused on the identification of members at risk for transitions and facilitating the movement of members between care settings, including hospitals, SNFs, the member's home, outpatient primary care and specialist offices and clinics, assisted living facilities, home health care, rehabilitation facilities, and other long term care facilities. Specific evidenced-based interventions are implemented to prevent readmissions and ensure safe and coordinated care across the care continuum. The goal of the OneCare transition program is to ensure that the member is in the least restrictive setting that meets the member's healthcare needs.

The implementation of care transition processes is delegated to the Physician Medical Group (PMG) and is the responsibility of the assigned primary care physician (PCP).

VI. Methodology:

The data used to analyze the OneCare Care Transition process was compiled from monthly inpatient and skilled nursing facility census reports. The transitions data represents planned and unplanned transitions for OneCare Special Needs Plan (SNP) Members during July 1, 2010 through December 31, 2010. The

average membership during the period was 10,960. There were a total of **2550** cases identified as experiencing a planned or unplanned transition which represents **23%** of OneCare average SNP population**.**

- **Total Planned and Unplanned Transitions: 2550** (includes planned transitions from usual setting of care to Hospital and from Hospital to the next setting as well as unplanned transitions to the hospital that had a planned transition to the next setting). Of the 2550 transitions, **1579** were planned and **971** were unplanned.

Transitions to the following settings:

1. **Hospital**
   a. Home to Hospital = 1146
   b. SNF to Hospital = 34

2. **SNF (Skilled Nursing Facility)**
   a. Hospital to SNF= 318
   b. Home to SNF = 16

3. **Home**
   a. Hospital to Home = 962
   b. SNF to Home = 127

For this transitions analysis, the general process measures used a **simple random** sampling of 40 cases from July 1, 2010 through December 31, 2010. The analysis was conducted using transition case logs. Of the 40 cases, 31 were unplanned and 9 were planned transitions. The 40 cases represented the following transitions:

Home to hospital = 19
Hospital to home = 13
SNF to home = 5
SNF to hospital = 1
Hospital to SNF = 1
Hospital to hospital = 1

III. Analysis of Managing Transitions (Element A, Factor 4):

Identification of planned transitions (Element A, Factor 1):

The identification for planned transitions occurred through review of the following reports:
1. Authorization and Referral reports
2. Case Management Notes-identification of change in health status
3. Hospital/SNF Discharge planning and reports from concurrent review

Support of the members with a planned transition begins at the notification process. Identification of the members with a planned transition is done at the time the authorization is generated. Notifying the concurrent review nurse assigned to the facility on the date of admission allows for a proactive approach in transition/discharge planning to the next healthcare setting. Initiating the discharge plan along with the first CCR will ensure timely interventions for transition planning. Monitoring the process to ensure both processes are addressed at the time of the first concurrent review will increase a proactive action for all planned transitions. This will allow for identification of gaps in the process and enable OneCare to target the specific areas that are causing a less than optimum transition plan implementation process.

Data:
9 of the 40 cases in the review were identified as planned transitions to the hospital. 13 of the 40 cases were planned transitions from the hospital to home. A total of 21 cases of the 40 were planned transitions, representing 55%.
Analysis:
22.5% of the cases represented a planned transition to the hospital. To validate that these 9 planned transitions were identified prior to the transition, data from the precertification process was reviewed. These data included prior authorization case notes and medical records to approve requests for prior authorizations. In each of these 9 cases, the planned transition was identified prior to the transition to the hospital.

To validate the 13 cases of transitions from the hospital to home, discharge planning case notes and medical records were reviewed. In each of the 13 cases, the planned transitions were appropriately identified.

Opportunity for Improvement:

No opportunity for improvement was identified.

Intervention:

None at this time to identify cases for planned transitions.

Sharing the Sending Setting's Care Plan with the Receiving Setting within One Business Day (Element A, Factor 2):

The PMGs send the care plan from the sending setting to the receiving setting in one of two ways: for PMGs with an electronic medical management system, the care plan is sent via the system and the sending setting is alerted of the care plan within one business day. For PMGs that do not have an electronic system, the care plan is faxed to the receiving setting within one business day.

Data:
29 of the 40 cases (73%) in the review demonstrated that the care plan was sent to the receiving setting within one business day. To validate this measure the following data was reviewed: case management notes as evidenced by screen shots from electronic medical records and hard copies of medical records, facility transition forms, and case management care plans.
Analysis:
Of the eleven cases that did not meet the standard, four were due to admissions over the weekend. The care plan was given on the next business day. The remaining seven cases were due to one medical group that underwent a software system upgrade. The OneCare benchmark for this measure is 90%. The benchmark was not achieved.

Opportunity for Improvement:

Since the benchmark was not achieved, there is an opportunity to improve the care plan transmittal process.

Intervention:

Review of transition data identified one physician medical group as the driver in low performance for this measure. During the timeframe of analysis, this particular group underwent a care management software system upgrade. The system upgrade resulted in the group's inability to provide timely communication of the care transition process because the group uses an electronic medical record system that generates the care plan and transmits the care plan from setting to setting. As a result of poor performance, this group was placed on corrective action and is being monitored post-upgrade.

Notifying the Patient's Usual Practitioner of the Transition within Two Business Days (Element A, Factor 3):

The PMGs notify the patient's usual practitioner of the transition in one of two ways: for PMGs with an electronic medical management system, the care plan is sent via the system to the practitioner and the practitioner receives an electronic fax alert within two business days. For PMGs that do not have an electronic system, the practitioner is notified via fax within two business days.

Data:
33 of the 40 cases (83%) in the review demonstrated notification of the patient's usual practitioner of the transition within two business days. To validate this measure the following data was reviewed: case management notes as evidenced by screen shots from electronic medical records and hard copies of authorization approvals sent to the usual practitioner.

Analysis:
Each of the seven cases that did not meet the standard was due to the physician group that underwent a software system upgrade. The OneCare benchmark for this measure is 90%. The benchmark was not achieved.

Opportunity for Improvement:
Since the benchmark was not achieved, there is an opportunity to improve the process to notify the usual practitioner regarding the transition.

Intervention:
Review of transition data identified one physician medical group as the driver in low performance for this measure. During the timeframe of analysis, this particular group underwent a care management system upgrade. The system upgrade resulted in the group's inability to provide timely communication of the care transition process because the group uses an electronic medical record system that generates the care plan and transmits the care plan from setting to setting. As a result of poor performance, this group was placed on corrective action and is being monitored post-upgrade.

IV. Analysis of Supporting Members Through Transitions (Element B, Factor 4):

Communicating with the Member/Responsible Party about the Care Transition Process within Two Business Days (Element B, Factor 1):

The concurrent review nurse or case management nurse at the PMG communicates with the member or responsible party regarding the care transition process within two business days.

Data:
31 of the 40 (78%) cases in the review were identified as having communication with the member/responsible party about the care transition process within two business days. To validate this measure the following data was reviewed: case management notes as evidenced by screen shots from electronic medical records and hard copies of case management care plans.

Analysis:
Of the 9 cases that did not meet this element, 7 were due to the medical group with the software system upgrade. Two were admissions that occurred over the weekend and communication occurred at the next business day.

The OneCare benchmark for this measure is 90%. The benchmark was not achieved.

Opportunity for Improvement:
Since the benchmark was not achieved, there is an opportunity to improve communication with the member or their responsible party regarding the care transition process.

Intervention:
Review of transition data identified one physician medical group as the driver in low performance for this measure. During the timeframe of analysis, this particular group underwent a care management system upgrade. The system upgrade resulted in the group's inability to provide timely communication of the care transition process because the group uses an electronic medical record system that generates the care plan and transmits the care plan from setting to setting. As a result of poor performance, this group was placed on corrective action and is being monitored post-upgrade.

OneCare will review the process for communicating with members over the weekend. The process at each PMG will be analyzed and specific intervention activities will be developed to ensure that timely communication occurs. OneCare will identify and share best practices for meeting this factor.

Communicating with the Member/Responsible Party about Changes to the Member's Health Status and Plan of Care within Two Business Days (Element B, Factor 2):

The concurrent review nurse or case management nurse at the PMG communicates with the member or responsible party regarding changes to the member's health status and plan of care within two business days. Communication with the member includes review of the care plan and instructions for a safe transition.

Data:
32 of the 40 (80%) cases in the review were identified as having communication with the member/responsible party about changes to the member's health status and plan of care within two business days. To validate this measure the following data was reviewed: case management notes as evidenced by screen shots from electronic medical records and hard copies of case management care plans.

Analysis:

Of the eight cases that did not meet this element, seven were due to the medical group with the software system upgrade. One was due to an admission that occurred over the weekend and communication occurred at the next business day.

The OneCare benchmark for this measure is 90%. The benchmark was not achieved.

Opportunity for Improvement:
Since the benchmark was not achieved, there is an opportunity to improve communication with the member or their responsible party regarding changes to the member's health status and plan of care.

Intervention:
Review of transition data identified one physician medical group as the driver in low performance for this measure. During the timeframe of analysis, this particular group underwent a care management system upgrade. The system upgrade resulted in the group's inability to provide timely communication of the care transition process because the group uses an electronic medical record system that generates the care plan and transmits the care plan from setting to setting. As a result of poor performance, this group was placed on corrective action and is being monitored post-upgrade.

OneCare will review the process for communicating with members over the weekend. The process at each PMG will be analyzed and specific intervention activities will be developed to ensure that timely communication occurs. OneCare will identify and share best practices for meeting this factor.

Providing Each Member Who Experiences a Transition with a Consistent Person or Unit to Support the Member Through Transitions within Two Business Days (Element B, Factor 3):

The PMG assigns each member who experiences a transition with a consistent person of unit to support the member through transitions within two business days. The assigned contact person is a concurrent review nurse or case manager.

Data:
33 of the 40 cases (83%) in the review demonstrated that each member who experiences a transition is assigned a consistent person or unit. To validate this measure the following data was reviewed: case management notes as evidenced by screen shots from electronic medical records and hard copies of case management care plans, letters about the case management process, and phone logs.
Analysis:
Each of the seven cases that did not meet the standard was due to the physician group that underwent a software system upgrade. The OneCare benchmark for this measure is 90%. The benchmark was not achieved.

Opportunity for Improvement:
Since the benchmark was not achieved, there is an opportunity to improve the provision of a consistent point of contact to each member who experiences a transition.

Intervention:
Review of transition data identified one physician medical group as the driver in low performance for this measure. During the timeframe of analysis, this particular group underwent a care management system upgrade. The system upgrade resulted in the group's inability to provide timely communication of the care transition process because the group uses an electronic medical record system that generates the care plan and transmits the care plan from setting to setting. As a result of poor performance, this group was placed on corrective action and is being monitored post-upgrade.

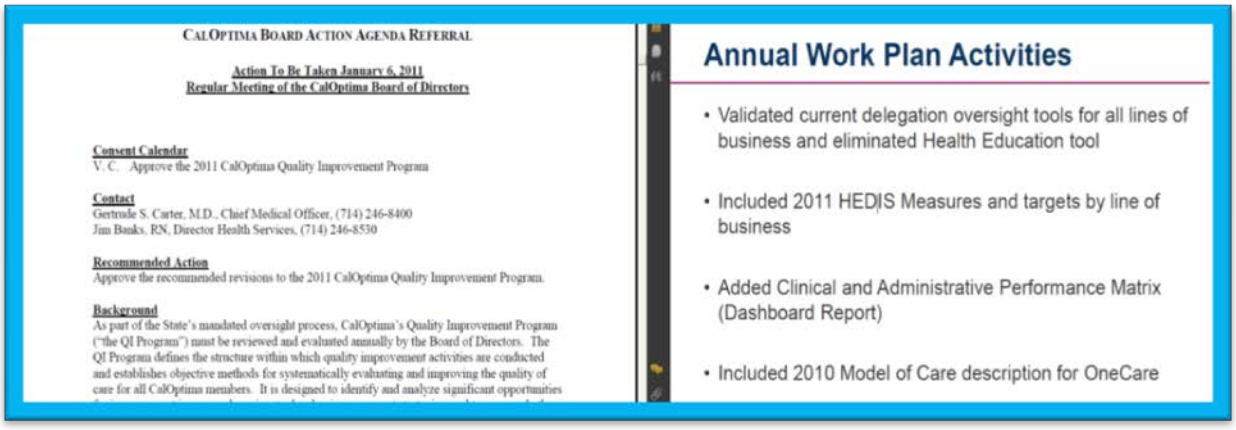
Conclusion:
An analysis of OneCare's performance on managing care transitions identified an opportunity for improvement with one contracted physician medical group, in particular. During the analysis period this group underwent an upgrade of its care management software system. The system upgrade was a barrier to this group's ability to communicate the care transition process in a timely manner. The group was placed on corrective action to ensure timely transition post-upgrade. In the future, any physician group that undergoes a care management system upgrade will be required to submit a plan to ensure timely transitions prior to the upgrade.

In addition, OneCare is exploring options to ensure timely transitions over the weekend. Possible interventions may include: use of the on-call clinical staff to monitor unplanned transitions over the weekend to ensure timely transitions and communication regarding the transition, strengthening coordination with facility discharge planning staff and/or assigned physician.

d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.)

OneCare's model of care evaluation is documented in written format in a stand-alone document. This document is presented to the QIC, at least annually, and is also preserved as part of the QIC minutes. Both the model of care evaluation and QIC minutes are also maintained in electronic formats on OneCare's data system. This data system is archived nightly. Archives are copied and stored at an off-site location in electronic formats and on data tapes.

A copy of the Board agenda item and slide presentation pertaining to the Model of Care is provided below:



CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 6, 2011
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
V. C. Approve the 2011 CalOptima Quality Improvement Program

Contact
Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400
Jim Banks, RN, Director Health Services, (714) 246-8530

Recommended Action
Approve the recommended revisions to the 2011 CalOptima Quality Improvement Program.

Background
As part of the State's mandated oversight process, CalOptima's Quality Improvement Program ("the QI Program") must be reviewed and evaluated annually by the Board of Directors. The QI Program defines the structure within which quality improvement activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities

Annual Work Plan Activities

- Validated current delegation oversight tools for all lines of business and eliminated Health Education tool
- Included 2011 HEDIS Measures and targets by line of business
- Added Clinical and Administrative Performance Matrix (Dashboard Report)
- Included 2010 Model of Care description for OneCare

Components of the Model of Care may also be evaluated and documented separately in the form of QI projects. Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

As a guide, project teams may choose to use the Quality Improvement Project Details template. For formal CMS Quality Improvement projects, completion of an official QIP Reporting Template is required. OneCare QI work teams also utilize the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) form to maintain documentation for its internal QI activities. Each QI team is required to document QI activities in a standardized format. These plans are updated at least monthly and are available for CMS review as requested.

QI Projects are reported on a quarterly basis to OneCare's Quality Improvement Committee. Detailed minutes are taken for each committee meeting. Documentation includes a summary of data and information, committee discussion, actions and responsible parties.

For example, adequacy of the provider network is assessed as part of OneCare's Access and Availability process. These standards are reviewed and documented in a separate analysis that is stored electronically. A copy of the report is provided below:

CALOPTIMA'S AVAILABILITY, LANGUAGE AND ACCESSIBILITY ANALYSIS

Introduction

CalOptima aims to monitor our members' ability to obtain health care services. In order to determine this, CalOptima routinely conducts the following studies:

Availability Study: This study takes a geographical look at the average distance a member must travel to reach the nearest provider. CalOptima uses this study to determine whether CalOptima and CalOptima contracted health networks are compliant with the

availability standard of having a provider within ten (10) miles or thirty (30) minutes from the member's residence. This study identifies the percentage of members who have access to at least one provider within 10 miles of their home address.

Language Study: This study collects language data of CalOptima providers and CalOptima members to determine if there is adequate provider coverage by language for CalOptima non-English speaking members. CalOptima uses this study to determine if there are members who do not have access to a provider who speaks their language. This study identifies the ratios of providers: members for the following languages: Spanish, Vietnamese and Farsi (for Medi-Cal only).

Accessibility Study: This study takes a look at Daytime Appointment Scheduling and After Hour Access at CalOptima provider offices. CalOptima uses this study to determine whether CalOptima contracted providers are compliant with CalOptima accessibility standards. This study identifies the types of care/appointments by health networks that do not meet CalOptima accessibility standards.

The analysis of these three studies aims to identify possible gaps in CalOptima's health care services. CalOptima plans develop quality improvement activities to address these gaps and work to provide full coverage to all CalOptima members.

AVAILABILITY STUDY
Study Project Conducted by: CalOptima Network Operations

EXECUTIVE SUMMARY
The standard is considered in compliant if:

a) 90% or more of group/health network meet the "one (1) PCP within 10 miles" availability standard.
b) 90% or more of group/health network meet the "one (1) Specialist within 10 miles" availability standard.

Analysis
OneCare
Most health networks and medical groups met the "one (1) PCP within 10 miles" and the "one (1) Specialist within 10 miles" standard. Edinger Medical Group had the highest rate of 100.0% for all quarters for the specialist availability standard. However, they did not meet the PCP availability standard in April 2010 with 85.7% and in July 2010 with 86.7%.

Summary and Areas for Improvement
Across all programs, most health networks and medical groups *did* meet the standard of having 90% or more of group/health network meet the "one (1) PCP within 10 miles" standard across all programs and across all quarters in 2010. Specialists were also included in the study and all specialists *did* meet the same standard. The lowest health

network or medical group total rate is 99.4% and the highest health network or medical group total rate is 100.0% looking at each quarter for PCPs and Specialists.

Only PCPs from the Edinger Medical Group as part of the OneCare Program *did not* meet the availability standard in Q2 (4/1) and Q3 (7/1) of 2010 with 85.7% and 86.7%, respectively. As a result, Edinger Medical Group will be an area of focus for this standard.

Plan of Action

For each area where a health network or medical group did not meet standard, CalOptima will implement the following plan of action.

1) Continue to monitor and re-assess compliance for health networks that did not meet the standard (rate below 90%).
2) If a health network or medical group does not meet the standard for four consecutive quarters, CalOptima Network Operations department will outreach and contract with more providers.

Language Study

Study Project Conducted by: Network Operations

EXECUTIVE SUMMARY

This language study looks at the ratio of members who speak the non-English language to providers who speak the same non-English language to determine if there are any areas where member to provider ratio for a threshold language is too high and needs attention.

CalOptima has three threshold languages, Spanish, Vietnamese and Farsi, identified on the Medi-Cal Eligibility Data System (MEDS) as the primary language of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR, Section 1810.410 (f) (3). CalOptima currently does not have any official standards in regards to these threshold languages. However, CalOptima has applied a general standard for member to PCP ratio which is 50:1for all threshold languages in order to establish a point of comparison. The standard is considered in compliant if the member to provider ratio is less than 50:1 for each threshold language.

Analysis

OneCare

CalOptima met the language standard for all languages for OneCare. Vietnamese has the highest member to provider language ratios with ratios between 3:1 to 4.1. Spanish has the lower ratio at 2:1.

Summary and Areas for Improvement

Across all programs, most health networks and medical groups had member to provider language ratios below the 50:1 member to provider language ratio and did meet the language standard. For the OneCare, all health networks and medical group met the language standard.

Plan of Action

For each of the languages where a health network or medical group had a high member to provider language ratio at 50:1 and above, CalOptima will implement the following plan of action.

1) Continue to monitor and re-assess language data for health networks with high member:provider language ratio
2) CalOptima Network Operations department will consult high member:provider language ratios when outreaching to contract with more providers.

Appointment Accessibility Study
Study Project Conducted by: DataStat

EXECUTIVE SUMMARY

CalOptima maintains a series of standards for appointment accessibility for each program set forth in three policies: GG# 1600, MA# 7007, HF# 4405 and the Department of Managed Health Care (DMHC) Timeliness Standards. (Please see polices for accessibility standards.)

OVERALL DATA RESULTS BY PROGRAM

Program: OneCare

OneCare providers met 13 of the 19 accessibility standards. OneCare providers did not meet standards for routine prenatal visits, urgent behavioral specialty visits, in office wait times and average time for a person to answer the phone.

PLAN LEVEL ANALYSIS

Summary

The three CalOptima programs did not meet the following standards:

- Routine prenatal care during the first (1st) and second (2nd) trimesters
- Routine prenatal care during the third (3rd) trimester or for high-risk pregnancy
- Urgent specialty visit – within 2 days of referral approval
- In office wait time – less than fifteen (15) minutes before being taken into the exam room
- In office wait time – less than forty-five (45) minutes before being seen by a provider
- Average time for live person to answer the telephone is less than one minute

CAHPS

The OneCare Program was the only CalOptima program that was surveyed at the plan level by CMS in 2010. CMS conducted the Medicare Advantage Prescription Drug Plan and survey results indicated that "Getting Needed Care" and Getting Care Quickly" Composites are areas for improvement, since the composite rates were 3.5 and 3.06, respectively, and below the 2010 national average. Areas of concern under the composites are "getting appointments with specialists," "getting needed care, tests or treatment," "getting care needed right away," and "getting appointments." The low rates found in the OneCare CAHPS survey substantiate the findings in the Appointment Accessibility Survey.

Grievance and Resolutions

CalOptima reviewed data gathered from Grievance and Resolutions Services Department. Only approximately 5% of the grievances were categorized under Access. Grievances in this area were too low to substantiate this study.

OVERALL DATA RESULTS BY PROVIDER GROUP

A standard is considered in compliant if 80% or more of the practitioners from that group/health network met that particular standard. Responses of "refuse" or "don't know" were not included in compliance rates.

PCP Practitioners Performance

PCPs met all PCP only standards evaluated in accessibility. The highest rate of those meeting the standard is noted for the "routine physical exam or wellness visit," with 97.5% meeting the thirty day (30) standard. "Non-urgent acute care visit" exhibited the lowest percentage with only 94.2% of PCPs meeting the three (3) day standard. For the "urgent care visit" to be scheduled within twenty-four (24) hours and the "primary care visit" to be schedule within thirty (30) days, the rates are 96.8% and 97.1%, respectively.

Specialists (Non OB/GYN) Performance

Specialists met all specialist only standards evaluated. They performed well on all standards with compliance rates of 91.2% for "urgent specialty visits" within ninety-six (96) hours of referral approval and 89.8% for "routine specialty visit" within fifteen (15) days of referral approval.

Behavioral Health Specialist Performance

Behavioral Health specialists were compliant in 1 out of 2 the Behavioral Health only standards.

Behavioral Health specialists met the standards for "routine specialty visit" with 93.1% meeting the fifteen (15) day standard. These same practitioners did not meet the standard for "urgent specialty visit" with 76.9% meeting the two (2) day standard.

In Office Wait Times

All practitioners were not compliant with in office wait time standards. 52.5% of patients "waited less than fifteen (15) minutes before being taken into the exam room" and only

64.5% of patients "waited a total of less than forty five (45) minutes before being seen by a provider."

Telephone Accessibility During Business Hours

All practitioners were compliant in 1 out of 3 telephone accessibility during business hour standards. Practitioners met the standard for the "average time to return an urgent message" with 82.6% meeting the thirty (30) minute standard. All practitioners met the standard for the "average time to return a non-urgent message" with 100% meeting the twenty-four (24) hour standard. Practitioners did not meet the standard for the "average time for live person to answer the telephone" with 60.0% meeting the one minute standard.

After Hours Performance

All practitioners met all "After Hours" standards. They performed well on all standards with scores that all fell in between 90-100%.

Group Level Analysis

Summary

Most health networks and medical groups did not meet the following standards:

- Routine prenatal care during the first (1st) and second (2nd) trimesters
- Routine prenatal care during the third (3rd) trimester or for high-risk pregnancy
- Urgent specialty visit – within 2 days of referral approval
- In office wait time – less than fifteen (15) minutes before being taken into the exam room
- In office wait time – less than forty-five (45) minutes before being seen by a provider
- Average time for live person to answer the telephone is less than one minute

CAHPS

OneCare: In 2010, CalOptima conducted the Medicare Advantage Prescription Drug Plan at the group level. Survey results indicated that "Getting Care Quickly Composite" is an area for improvement, since the composite rate was 68.0, below the 80.0 standard rate that was set by CalOptima. Within the composite, rates were low for "got appointment for care as soon as you thought you needed" at 77.7 and "were seen within 15 minute of appointment time" at 58.1. The rate was also low for "easy to get appointments with specialists" at 79.3 in the "Getting Needed Care" composite. The low rates on appointment times found in the OneCare CAHPS survey substantiate the findings in the Appointment Accessibility Survey.

Grievance and Resolutions

CalOptima reviewed data gathered from Grievance and Resolutions Services Department. Only approximately 5% of the grievances were categorized under Access. Grievances in this area were too low to substantiate this study.

Plan of Action

For each area where a health network or medical group did not meet standard, CalOptima will implement the following plan of action.

1) Work with providers to implement interventions.
2) All health networks and medical groups that received a rate below 80% will be required to submit a corrective action plan to CalOptima for that particular standard.
3) CalOptima will re-assess compliance for all standards pertaining to prenatal care and in office wait times

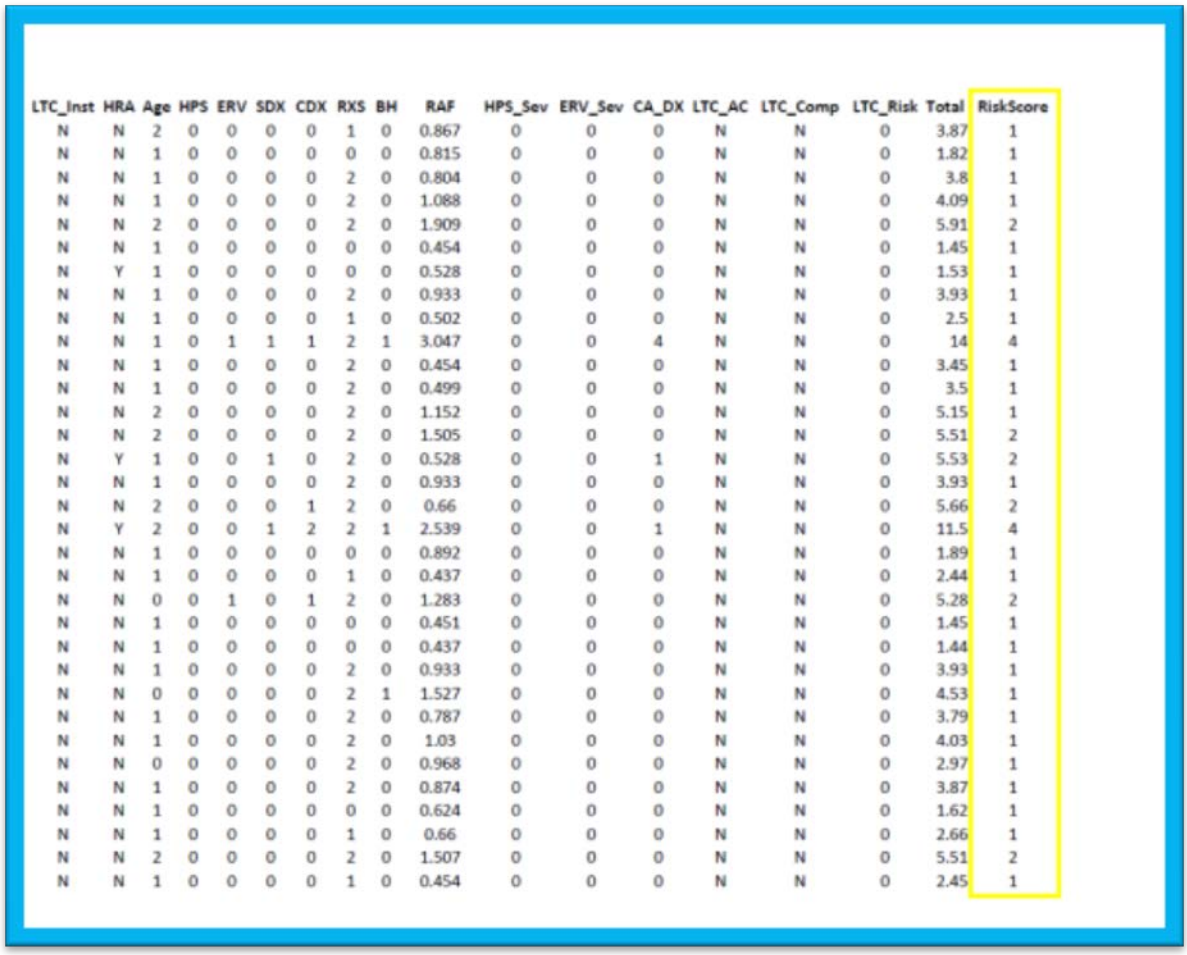
Conclusion

All health networks and medical groups will be provided results from this study and be made aware of their availability, language, and accessibility performance. Study results will be presented at the next Utilization Management Committee and the Quality Improvement Committee thereafter. In addition, the results will be presented at the Quality Assurance Committee.

OneCare will continue to conduct this study on an annual basis to determine future availability, language, and accessibility performance. At that time, the following will take place to improve data collection and strengthen study design:

1) Improve data quality
2) Develop a process to handle each variety of practice types
3) Operationalize standards
4) Refine survey tool

Evaluation of the Model of Care in regards to members' risk levels is documented on a monthly basis in the form of electronic reports. An example of a report is provided below. The report indicates each member and their risk level as of that month.



LTC_Inst	HRA	Age	HPS	ERV	SDX	CDX	RXS	BH	RAF	HPS_Sev	ERV_Sev	CA_DX	LTC_AC	LTC_Comp	LTC_Risk	Total	RiskScore
N	N	2	0	0	0	0	1	0	0.867	0	0	0	N	N	0	3.87	1
N	N	1	0	0	0	0	0	0	0.815	0	0	0	N	N	0	1.82	1
N	N	1	0	0	0	0	2	0	0.804	0	0	0	N	N	0	3.8	1
N	N	1	0	0	0	0	2	0	1.088	0	0	0	N	N	0	4.09	1
N	N	2	0	0	0	0	2	0	1.909	0	0	0	N	N	0	5.91	2
N	N	1	0	0	0	0	0	0	0.454	0	0	0	N	N	0	1.45	1
N	Y	1	0	0	0	0	0	0	0.528	0	0	0	N	N	0	1.53	1
N	N	1	0	0	0	0	2	0	0.933	0	0	0	N	N	0	3.93	1
N	N	1	0	0	0	0	1	0	0.502	0	0	0	N	N	0	2.5	1
N	N	1	0	1	1	1	2	1	3.047	0	0	4	N	N	0	14	4
N	N	1	0	0	0	0	2	0	0.454	0	0	0	N	N	0	3.45	1
N	N	1	0	0	0	0	2	0	0.499	0	0	0	N	N	0	3.5	1
N	N	2	0	0	0	0	2	0	1.152	0	0	0	N	N	0	5.15	1
N	N	2	0	0	0	0	2	0	1.505	0	0	0	N	N	0	5.51	2
N	Y	1	0	0	1	0	2	0	0.528	0	0	1	N	N	0	5.53	2
N	N	1	0	0	0	0	2	0	0.933	0	0	0	N	N	0	3.93	1
N	N	2	0	0	0	1	2	0	0.66	0	0	0	N	N	0	5.66	2
N	Y	2	0	0	1	2	2	1	2.539	0	0	1	N	N	0	11.5	4
N	N	1	0	0	0	0	0	0	0.892	0	0	0	N	N	0	1.89	1
N	N	1	0	0	0	0	1	0	0.437	0	0	0	N	N	0	2.44	1
N	N	0	0	1	0	1	2	0	1.283	0	0	0	N	N	0	5.28	2
N	N	1	0	0	0	0	0	0	0.451	0	0	0	N	N	0	1.45	1
N	N	1	0	0	0	0	0	0	0.437	0	0	0	N	N	0	1.44	1
N	N	1	0	0	0	0	2	0	0.933	0	0	0	N	N	0	3.93	1
N	N	0	0	0	0	0	2	1	1.527	0	0	0	N	N	0	4.53	1
N	N	1	0	0	0	0	2	0	0.787	0	0	0	N	N	0	3.79	1
N	N	1	0	0	0	0	2	0	1.03	0	0	0	N	N	0	4.03	1
N	N	0	0	0	0	0	2	0	0.968	0	0	0	N	N	0	2.97	1
N	N	1	0	0	0	0	2	0	0.874	0	0	0	N	N	0	3.87	1
N	N	1	0	0	0	0	0	0	0.624	0	0	0	N	N	0	1.62	1
N	N	1	0	0	0	0	1	0	0.66	0	0	0	N	N	0	2.66	1
N	N	2	0	0	0	0	2	0	1.507	0	0	0	N	N	0	5.51	2
N	N	1	0	0	0	0	1	0	0.454	0	0	0	N	N	0	2.45	1

e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.)

The Medical Director of OneCare has primary oversight responsibility for monitoring and evaluating the model of care effectiveness. She does this with support from quality staff including the Quality Improvement Manager and Quality Improvement Nurse Specialist. OneCare does not use quality improvement consultants in the monitoring and evaluation of the Model of Care.

The process to analyze and select target areas for quality improvement activities is as follows:

On an annual basis, OneCare reviews results for clinical preventive and outcome measures. Results are compared to selected benchmarks and established goals. Any measure that falls

below annual goals is reviewed by the Quality Improvement Work Group Steering Committee. This committee selects focus areas for quality improvement initiatives and assigns selected areas to the appropriate Quality Improvement Work Team for barrier analysis, intervention, and evaluation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by internal Clinical Quality Improvement Committee (CQIC)

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
   Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement
   Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

   Once the requirement has been met for both significant and sustained improvement on any given project, there is no other CMS reporting requirement related to that project. OneCare may internally choose to continue the project or to go on to another topic.

Their respective roles and functions are described below:

- **Medical Director, OneCare**
  - **Experience & Education Requirements:**
    - Board Certified Physician with a current, valid, unrestricted California license has a Master's in Public Health

        - The Medical Director has over 25 years experience in case management

    - **Roles and Responsibilities:**
        - Oversight responsibility for the delivery of medical services for OneCare members
        - Quality Improvement projects and new programs
        - Provider education regarding Clinical Practice Guidelines
        - Consultant and conduit for the delegated entities
        - Manages medical aspects of contracts for services, oversees authorization for service and quality assurance for OneCare
        - Reviews complex cases and participates in the ICT process
        - Ensure policies and procedures are compliant with regulatory and accreditation requirements
        - Review of all appeals and second level provider grievances
        - Reviews Model of Care measures against established goals and benchmarks
        - Identifies opportunities for improvement and leads teams to effectuate enhancement to the Model of Care

- **Director, Case Management**
    - **Experience & Education Requirements:**
        - Director of Case Management: Registered Nurse, Bachelor Degree in Nursing with a valid California license and Certification in Case Management (CCM)
        - The Director has over 17 years experience in case management

    - **Roles and Responsibilities:**
        - Coordinate the Case Management and Disease Management program including the overall planning, promotion, implementation and evaluation of services to assure compliance regulatory and accreditation requirements
        - Responsible for planning, implementing and directing utilization management, case management, and disease management services
        - Assist in the development and implementation of quality improvement activities
        - Develop staffing and budget plan and monitor resource allocation for the department

- **Manager, Case Management**
    - **Experience & Education Requirements:**
        - Registered Nurse, Bachelor Degree in Nursing with a valid California license and CCM
        - The Manager has over 10 years experience in case management

    - **Roles and Responsibilities:**
        - Responsible for the daily operations and activities of the OneCare clinical team
        - Responsible for the oversight of the OneCare Special SNP (Special Needs Plan) processes to ensure compliance with regulatory and accreditation requirements

        - Works with the Director/Medical Director to develop, implement and evaluate the department's OneCare policies, procedures, processes and program structure
        - Manages the daily activities and performance of the OneCare team, included but not limited to; Care Transition, care coordination/case management and coordination of benefits/services
        - Works closely with delegated groups to assure the effectiveness and efficiency of the program
        - Evaluates need and provides educational training to staff and delegated entities
        - Identifies opportunities to enhance operation al aspects of the Model of Care

- **QI Manager**
    - **Experience & Education Requirements:**
        - Registered Nurse, Public Health Nurse with a valid California license
        - The Manager has over 35 years experience in clinical and administrative management including quality improvement, utilization management, credentialing, and facility site reviews

    - **Roles and Responsibilities:**
        - Responsible for all quality management and peer review functions such as quality of care monitoring, credentialing, facility site review, and delegation oversight
        - Direct the credentialing processes linked with physician profiling
        - Measurement and reporting use of Clinical Practice Guidelines
        - Educate OneCare staff and external customers on quality initiatives
        - Participates in, workgroups that address both clinical and non-clinical internal activities for which OneCare must demonstrate improvement to meet its contractual requirements

- **Quality Improvement Nurse Specialist – Delegation Oversight**
    - **Experience & Education Requirements**: Licensed Vocational Nurse with over thirty years of clinical and administrative experience including delegation oversight and quality improvement

    - **Roles and Responsibilities:**
        - Auditing of the QI-related components delegated to the HMOs, PHCs, SRGs and PMGs, and
        - Supporting the annual HMO, PHC, SRG and PMG delegation oversight monitoring;
        - Ensuring regulatory compliance and oversight for all CalOptima's lines of business, including OneCare requirements for quality;
        - Acting as the liaison for HMO, PHC, SRG and PMG quality and related quality activity compliance; and,
        - Providing monitoring, maintenance and feedback to the HMOs, PHCs, SRGs and PMGs related to quarterly and semi-annual report submissions for QI, Utilization Management, and
        - Review of Denial letters for all lines of business.

f. Describe how the MAO will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.)

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees.
- Health Network Forums, Medical Director meetings, and other ongoing ad-hoc meetings.
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioner and member) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request.

Improvements in the Model of Care are communicated in the provider and member newsletters, face-to-face meetings, webpage announcements, and via fax.

OneCare provides training on an as-needed basis regarding specific aspects of the Model of Care. An example of a face-to-face meeting to communicate improvements to the care transition process is listed below:

A CalOptima Health Plan

onecare

All your prescriptions. All your benefits. One simple plan.

OneCare TRANSITION CARE TEAM

Ginny Gamel, RNC, CCM
OneCare Clinical
01/06/10

onecare

All your prescriptions. All your benefits. One simple plan.

TRANSITION CARE IS A SHARED RESPONSIBLITY

- The movement of members from one healthcare practitioner or setting to another as their condition and care needs change
- Occurs at multiple levels
  - Within Settings
    - Primary care ⇔ Specialty care ⇔ICU ⇔ Ward
  - Between Settings
    - Hospital ⇔ Sub-acute facility/SNF ⇔Ambulatory clinic ⇔ Home
  - Across health states
    - Curative care ⇔ Palliative care/Hospice
    - Personal residence ⇔ Assisted living

All your prescriptions. All your benefits. One simple plan

TRANSITION CARE PLANNING AT THE BEGINNING OF ENROLLMENT

- Enrollment
  - Do we know of any planned care that will be an issue?
- Data Mining
  - Where can we find information to share?
    - MediCal Data, Claims, Encounter, Pharmacy
- Risk Identification
  - What does it all mean?
    - Information drives your intervention
    - Health Risk Assessment, Known Diagnosis, Previous history

All your prescriptions. All your benefits. One simple plan

- Risk Stratification
  - Classifications
    - High, Moderate, Low
    - Ongoing as the members healthcare needs change
- Shared Information
  - All members 01/01/2010
  - New member enrollment going forward

All your prescriptions. All your benefits. One simple plan

TRANSITIONS AT THE GROUP LEVEL

- Act on information shared by CalOptima OneCare
  - Intentional Approach
  - Proactive interventions based on Risk Level
- UM/CCR Identification
  - Planned transition: Preventive Approach
  - Unplanned transition
    - Supportive
    - Reduction of second transition
    - Prevention of re-admission

All your prescriptions. All your benefits. One simple plan

TRANSITIONS AT THE GROUP LEVEL cont…

- Case Management Identification
  - Planned transition: Preventive Approach
  - Unplanned transition: supportive and reduction of second transition
- Members Self Refer
  - Take the opportunity to screen and act on the interaction
- OneCare Case Management
- Transition Care Team Referral
  - Shared knowledge
  - Multidisciplinary recommendations

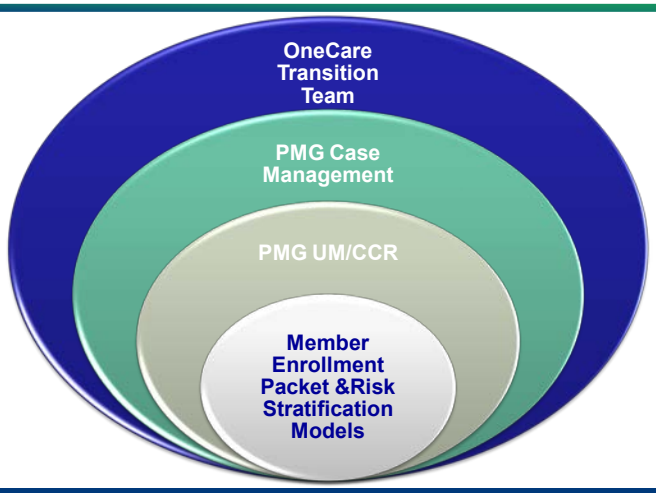
All your prescriptions. All your benefits. One simple plan

OneCare Transition Care Team

- Specific Referral Criteria
- Mandatory PMG participation
- Case Conference Format
- Quick Turn Around
- Individualized Care Plan Developed
- PMG Implementation of the ICP
- Outcomes driven
- Seamless to the member
  - *We are on the same team*
- Feedback it Critical
- Communication, Communication, Communication

All your prescriptions. All your benefits. One simple plan

A PICTURE PAINTS A 1000 WORDS

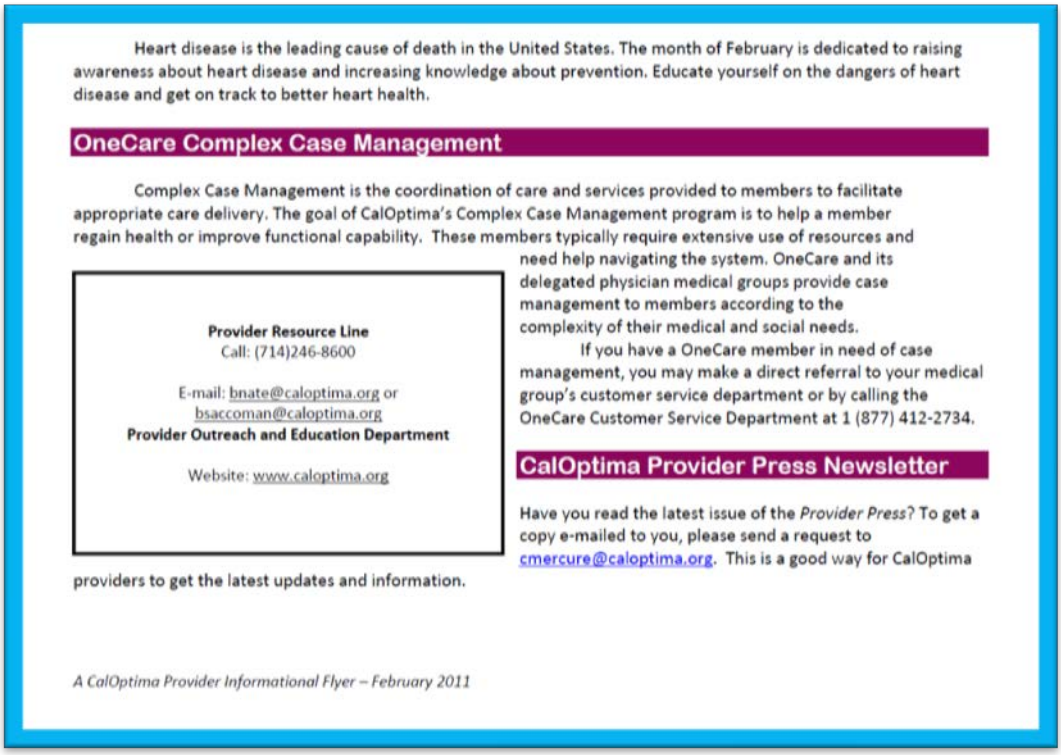


All your prescriptions. All your benefits. One simple plan

NOW WHAT?

- Incremental evaluation
- Consistent communication and feed back
- Review of systems and process at the three month mark
- Did it change the members picture?
- CMS audit expected
- Regroup and look for additional improvement opportunities

Below is an example of a provider fax outlining complex case management as part of the Model of Care. The Provider Update is sent via fax on a monthly basis to highlight aspects of OneCare's clinical programs. Detailed information is also included in the provider newsletter which is published quarterly.



Heart disease is the leading cause of death in the United States. The month of February is dedicated to raising awareness about heart disease and increasing knowledge about prevention. Educate yourself on the dangers of heart disease and get on track to better heart health.

OneCare Complex Case Management

Complex Case Management is the coordination of care and services provided to members to facilitate appropriate care delivery. The goal of CalOptima's Complex Case Management program is to help a member regain health or improve functional capability. These members typically require extensive use of resources and need help navigating the system. OneCare and its delegated physician medical groups provide case management to members according to the complexity of their medical and social needs.

If you have a OneCare member in need of case management, you may make a direct referral to your medical group's customer service department or by calling the OneCare Customer Service Department at 1 (877) 412-2734.

Provider Resource Line
Call: (714)246-8600

E-mail: bnate@caloptima.org or
bsaccoman@caloptima.org
Provider Outreach and Education Department

Website: www.caloptima.org

CalOptima Provider Press Newsletter

Have you read the latest issue of the *Provider Press*? To get a copy e-mailed to you, please send a request to cmercure@caloptima.org. This is a good way for CalOptima providers to get the latest updates and information.

A CalOptima Provider Informational Flyer – February 2011

Announcements are also available on OneCare's Provider website. An inventory of provider updates is listed below. Updates are provided on a monthly basis.

Attachment 4: Most Current MOU between CalOptima & OCHCA Behavioral Health

ATTACHMENT 4: Most Current MOU between CalOptima and OCHCA Behavioral Health

MEMORANDUM OF UNDERSTANDING

between
ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE PLAN

CalOPTIMA

and

ORANGE COUNTY HEALTH CARE AGENCY/Behavioral Health Services/ Mental Health Plan
(HCA/MHP)

May, 2001 **Supersedes: July, 2000**

PURPOSE: The Orange County Health Care Agency/Behavioral Health Services/ Mental Health Plan (HCA/MHP) and CalOPTIMA are partners in facilitating access to prompt evaluation, diagnosis, treatment and follow-up of mental illness for Medi-Cal beneficiaries who are CalOPTIMA members. This Memorandum of Understanding delineates the responsibilities of both programs for provisions for services as they related to mental illnesses. Through collaboration, communication and the free exchange of program/provider/client information (within limits of confidentiality) full cooperation will be achieved which meets the needs of both programs.

MENTAL HEALTH PLAN SERVICES: The HCA/MHP provides a full spectrum of specialty mental health services for the evaluation, diagnosis, treatment and follow up of mentally ill adults and seriously emotionally disturbed children and youth who meet medical necessity criteria as defined by the State Department of Mental Health.

CalOPTIMA: Orange Prevention and Treatment Integrated Medical Assistance Program is local public agency which, by statute, has been granted the responsibility of operating a county organized health system for Orange County. CalOPTIMA coordinates the provision of certain health care services, including non-specialty mental health services, to most Orange County Medi-Cal beneficiaries using managed care principles. Managed care promotes the practice of preventive medicine by integrating the delivery and financing of health services. CalOPTIMA members are provided services through one of the subcontracting health plans or through CalOPTIMA Direct. CalOPTIMA Direct is CalOPTIMA's managed fee-for-service program for special populations within the

CalOPTIMA program. These special populations include, but are not limited to: transitional members (i.e., newly eligible or other members in the process of transitioning to a contracted health plan), members with a share of cost and members who receive both Medicare and Medi-Cal.

Aid codes included under the CalOPTIMA program as of 3/1/00:
Family/Child/Adult: 0A, 01, 02, 03, 04, 08, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 30, 32, 33, 34, 35, 38, 39, 4A, 4F, 4G, 47, 5X, 54, 59, 6X, 6Y, 7A, 7X,, 72, 8P. 8R, 81, 82, 86, 8P, 8R
Aged/Blind/Disabled: 10, 14, 16, 17, 18, 20, 24, 26, 27, 28, 36, 6A, 6C, 6N, 6P, 6R, 6V, 6W, 60, 64, 65, 66, 68
Long Term Care/Foster Care/MI/MN/Share of Cost: 13, 23, 53, 4c, 4k, 40, 42, 45, 5k, 17, 27, 37, 63, 67, 83, 87

Aid codes included under the HCA/MHP as of 3/1/00:

Family/Child/Adult: 0A, 01, 02, 03, 04, 08, 3A, 3C, 3G, 3H, 3P, 3R, 30, 32, 33, 34, 35, 36, 37, 38, 39, 47, 54, 59, 7A, 79, 81, 82, 86
Aged/Blind/Disabled: 10, 14, 16, 17, 18, 20, 24, 26, 27, 28, 36, 6a, 6c, 60, 64, 65, 66, 67, 68, 8g
Long Term Care/Foster Care/MI/MN/Share of Cost: 13, 23, 63, 4c, 4k, 40, 42, 45, 5k, 83, 87

Aid codes that are added to CalOptima's contract, from time to time, by DHS are also incorporated into this MOU.

CATEGORY	LOCAL MENTAL HEALTH PLAN (MHP)	MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)
Liaison (MHP & Plan responsibilities) **PL#00-01 REV., pages 20-21,22, and 23** **Contract: LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver**	The MHP will provide and maintain responsibility for: Medication treatment for metal health conditions that would not be responsive to physical health care based treatment and those conditions that do not meet Plan medical necessity criteria. Consultation services to Plan providers particularly PCPs about specialty mental health issues and treatments, including medication consultation. Medication induced reactions from medications prescribed by MHP providers. The MHP liaison will coordinate activities with the Plan and will notify the MHP providers of the roles and responsibilities of the MHP Liaison.	The Plan Liaison will coordinate activities with the MHP and will notify its Plan providers of the roles and responsibilities of the Plan Liaison. The Plan Liaison will meet with the MHP at least quarterly to resolve issues regarding appropriate and continuous care for member. The Plan will be responsible for communicating suggestions for MOU changes to the Plan leadership and the MHP Liaison. The Plan will also communicate MOU changes to the State Department of Health Services, and Plan providers. At the discretion of the Plan, the Liaison may represent the Plan in the dispute resolution process. The Plan will provide the MHP with the phone numbers of its member services,

	The MHP will meet with the Plan at least quarterly to resolve issues regarding appropriate and continuous care for members. The MHP Liaison will be responsible for communicating suggestions for MOU changes to the MHP leadership and Plan Liaison. The MHP will also communicate MOU changes to the State Department of Mental Health and MHP providers. At the discretion of the MHP, the Liaison may represent the MHP in the dispute resolution process. The MHP will assist and provide the Plan with the phone numbers that the plan may utilize to assist its members to access mental health member services.	provider services, and support programs that provide liaison services. With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, Plan member, clinical, or other pertinent information will be shared between the Plan and the MHP and its providers to ensure coordination of care.
Ancillary Mental Health Services **PL#00-01 REV., pages 6 and 11**	The MHP will provide ancillary physical health services to Plan members when medical necessity criteria are met. The MHP will provide hospital based ancillary services which include but are not limited to electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a psychiatric inpatient hospital other than routine services.	The Plan will provide ancillary services to the Plan members receiving MHP services when medically necessary. The Plan will provide covered ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Cultural and Linguistic Services **Title 9: Section 1810.410 and 1810.405 [d]** **PL#00-01 REV., page 20** **Contract Req.: LI Section 6.10 CP Section 6.10 COHS Sec. 8.13 GMC Sec.9.9** **Title 22: LI/CP Sec 53876 COHS Waiver GMC Sections 53920.5(8) and 53923(7)**	The MHP will comply with the cultural competence and linguistic requirements. The MHP will provide: A statewide toll-free telephone number available 24 hours a day, seven days a week, with language capability in all the languages capability in all the languages spoken by the members of the MHP. Interpreter services in threshold languages at key points of contact available to assist members whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages will be determined on a countrywide basis. The MHP may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:	The Plan will ensure compliance with Title 6 of the Civil Rights Act of 1964, which prohibits recipients of federal financial assistance from discrimination against persons based on race, color, or national origin. The Plan will provide 24-hour access to interpreter services for all members at all provider sites within the Plan's network wither through telephone language services or interpreters. The Plan will provide the following services to those Member groups at: Key points of contact- Medical Advice and urgent Care telephone, face-to-face encounters with providers. Non-medical membership services, orientations, and appointments. **Types of Services-** Interpreters Translated signage Translated written materials, including the

	The MHP has determined, for a language that is a threshold language on a countrywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not. The MHP will provide referrals for members who prefer to receive services in that threshold language, but who initially access services outside the applicable area, to a key point of contact that does have interpreter services in that threshold language. The MHP will also provide the literature used by the MHP to assist members in accessing services including, but not limited to the beneficiary brochure required by Section 1810.50[c](1), and health education materials used by the MHP in threshold languages, based on the threshold languages in the county as a whole.	Membership Service Guide, enrollee information, welcome packets, and marketing information. Referrals to Culturally and Linguistically appropriate community service programs. The Plan will provide standards and performance requirements for the provision of linguistic services, and will monitor the performance of the individuals who provide linguistic services.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Clinical Consultation and Training **Title 0 Section 1810.370 and 1810.415[a]** **PL#00-01 REV., pages 5, 20 and 22** **Contract: CP & LI Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	The MHP will provide and make available clinical consultation and training, including consultation and training on psychotropic medications, available to meet needs of a beneficiary whose mental illness is not being treated by the MHP. The MHP will include consultation on Medications to Plan members via consultation with the member's PCP whose mental illness is being treated by the Plan. Clinical consultation between the MHP and the Plan will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by the MHP to the Plan on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the Plan.	(Redundant) The Plan will provide clinical consultation and training to the MHP or their providers of mental health services on a member's physical health condition. Such consultation will include consultation by the Plan to the MHP on medications prescribed by the Plan for a Plan member whose mental illness is being treated by the MHP, and consultation by the MHP to the Plan providers on psychotropic drugs prescribed by the MHP for the Plan member whose mental illness is being treated by the Plan.
Confidentiality of Medical Records	The MHP will arrange for appropriate management of a member's mental health care, including the exchange of medical records information with a member's other	The plan will arrange for appropriate management of a member's care, including the exchange of medical records information; with a member's other

Title 9 Section 1810.370, 1810.415[b] and 1810.440[c] **AB 416 Personal Information: Disclosure** **SB 19 Medical Records: Confidentiality** **PL00-01 REV., pages 7, 20, 21 and 23** **Contract: LI & CP Sections 6.7.3.3 & 6.7.9.1 CHOS Waiver CMC 7.6.2**	healthcare providers or providers of specialty mental health services. The MHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participating in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member. The release of information dose not apply to the disclosure or use of the information by a law enforcement agency when required for an investigation of unlawful activity, or for the licensing certification or disclosure is otherwise prohibited by law.	healthcare providers or providers of specialty mental health services. The Plan will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization by the member. The plan will not release any information pertaining to a member's mental health treatment without a signed release form the member and a signed written statement by the requester describing the information requested, its intended use or uses, the length of time during which the information will be kept before begin destroyed or disposed of, and a statement that the information will not be used for other purposes and will be destroyed within the designated timeframe. The timeframe may be extended, provided that the Plan is notified of the extension, the reasons for the extension and additional intended uses and the expected date that the information will be destroyed.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
		The release of information dose not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.
Diagnostic Assessment **Title 9, Sections 1810.205 and 1830.210**	The MHP will <u>provide evaluation</u>, triage, and when authorized, specialty mental health services to the Plan members whose psychological conditions would not be responsive to mental health or physical health care by their PCP. The MHP will evaluate a member's symptoms, level of impairment and focus of intervention to determine if a member meets medical necessity criteria for specialty mental health services. When medical necessity criteria is met, the MHP will arrange for an appointment with the appropriate provider and will relay appointment information to the member. When medical necessity criteria is not met, the MHP staff will refer the member back to the referring PCP and notify the	The Plan will arrange and pay for appropriate medically necessary assessments of Plan members to identify co-morbid physical and mental health conditions, to: Rule out general medical conditions causing psychiatric symptoms. Rule out mental disorders and/or substance-related disorders caused by a general medical condition. Identify and treat those general medical conditions that are causing or exacerbating psychiatric symptoms. The PCP will be advised to identify and treat non-disabling psychiatric conditions that may be responsive to primary care, i.e.: mild to moderate anxiety and/or depression, if within the scope of practice of the PCP.

	Plan and/or refer the member to community service as appropriate. Individual mental health providers may arrange for records transfer by direct communication with the referring physician or will request the records through the Plan Liaison.	The member's PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the member to specialty physical health care for such treatment.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Emergency Services & Care- Emergency Room Facility Charges and Professional Services Title 9, Section 1810.370 and 1820.225 **PL#00-01 REV., pages 9, 10 and 11** **Contract:** **LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	**The MHP will be responsible for the facility charges resulting form the** emergency services and care of a Plan member whose condition meets the MHP medical necessity criteria when such services and care **do result in the admission** of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately but is included in the per diem rate for the inpatient stay. The MHP will be responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services **do not result in the admission** of the member for psychiatric inpatient hospital services at that facility or any other facility. The MHP will cover and pay for the professional services of a mental health specialist provided in an emergency room to a Plan member whose condition meets the MHP medical necessity criteria or when the mental health specialist services are required to assess whether the MHP medical necessity is met.	**The plan will cover and pay for the facility** charges resulting from the emergency services and care of a Plan member, whose condition meets the MHP medical necessity criteria, when such services and care do **not result in the admission** of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility. The Plan will cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care or a member whose condition meets the MHP medical necessity criteria. Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition dose not meet MHP medical necessity criteria will be assigned as follows: The Plan will cover and pay for the facility charges and the medical professional

	Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition does not meet the MHP medical necessity criteria will be assigned as follows: Payment for professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal fee-for-service system.	services required for the emergency services and care of a Plan member whose condition dose not meet MHP medical necessity criteria and such services and care **do not result in the admission** of the member for psychiatric inpatient hospital services.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Home Health Agency Services **Title 9, Section 1810.247 and 1810.355** **T-22, sections 51146 & 51337** **PL# 00-01 REV., pages 6, 7, and 12** **Contract:** **LI & CP Sections 6.7.3.3 & 6.7.9.1 COH Waiver GMC Sec. 7.6.2**	The MHP will notify the Plan of members who need home health services or who are receiving home health services through the Home and Community Based Services Waiver Program (HCBS) or the In-Home Supportive Services Program (IHSS). The MHP will pay for mental health services solely related to the included mental health diagnoses, or if the MHP determines a Plan member requires necessary Specialty Mental Health Services. The MHP is not responsible to provide or arrange for Home Health Agency Services as described in Title 22, Section 51337.	The plan will cover and pay for home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members. A homebound Plan member is a patient who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relative short duration, e.g., for a short walk prescribed as therapeutic exercise. The Plan is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a Plan member. For example, the plan would not be obligated to provide home health agency services for the purpose of medication monitoring when those services are not typically medically necessary or for a patient who is not homebound.

		Home health agency services are prescribed by Plan providers to treat mental health conditions of Plan members are the responsibility of the plan.
Hospital Outpatient Department Services **PL# 00-01 REV., pages 9 and 13**	The MHP will be responsible for the payment of specialty mental health services provided by hospital outpatient departments for Plan members who meet medical necessity criteria for specialty mental health services will be reasonably available and accessible to Plan members.	The Plan will cover and pay for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contract with its subcontractors and the Department of Health Services (DHS). Separately billable outpatient services related to electroconvulsive therapy, such as anesthesiologist services are the contractual responsibility of the Plan.
Laboratory, Radiological, and Radioisotope Services **Title 9, Sections 1810.355 and 1810.370** **Title 22, Sections 51311 & 51313**	Prescribed drugs as described in Title 22, Section 51313 and laboratory radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the MHP, **except** when provided as hospital based ancillary services. Medi-Cal members may obtain Medi-Cal covered prescriptions drugs and	The Plan will be responsible for providing medical necessary laboratory, radiological, radioisotope services, described in the Title 22, Section 51311. The Plan will cover and pay for these services to plan members who require the specialty mental health services of the MHP or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis
CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Contract: **LI & CP Sections 6.7.33 & 6.7.9.1** **COHS Waiver GMC Sec. 7.6.2**	Laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP. The MHP will coordinate with the pharmacies and Plan as appropriate to assist members in receiving prescription drugs, and laboratory services, prescribed through the MHP including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the Authorizing entity in accordance with the authorizing entity's procedure. Information will be disseminated to the MHP providers primarily through quarterly provider meetings conducted by the MHP staff. Secondly, targeted outreach will be extended to interested providers in the form of written communication and/or office visits to present a review of the claims process.	And treatment of Plan member's mental health condition. The Plan will also cover and pay for these services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan will coordinate these services with the member's specialty mental health provider.
Medical Transportation Services (Emergency and Non-Emergency) **Title 9, Sections 1810.355 and 1810.370**	The MHP will not be responsible for medical transportation services, **except**, when the purpose is to transport a beneficiary from one psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24-hour care	The Plan will cover and pay for all medically necessary emergency and non-emergency medical transportation services for Plan members including emergency and non-emergency medical transportation services required by members to access Medi-Cal

Title 22, Section 51323 **PL# 00-01 REV., page 13** **Contract:** **LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	facility because: ▪ The services in the facility to which the beneficiary is being transported will result in lower cost to the MHP. ▪ Of the lack of beds at the initial psychiatric facility. Medi-Cal fee-for-service will pay to transport the beneficiary to the closest facility.	covered metal health services. Non-emergency medical transportation services are covered when Plan authorization is obtained. The Plan will cover and pay for medically necessary non-emergency medical transportation services, when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP when Plan authorization is obtained.
Medical Necessity Criteria **Title 9, Sections 1820.205, 1830.205(b)(1) and 1830.210** **Pl#00-01 REV., page 16**	The MHP will provide or arrange and pay for specialty mental health services to Medi-Cal members served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met. Medical necessity criteria, is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. The MHP will accept	Members Plan members who diagnoses are not included in the applicable listing of MHP covered diagnoses may obtain specialty mental health services through the Medi-Cal fee-for-service system. Plan members whose mental health diagnoses are covered by the MHP whose conditions do not meet the program impairment and intervention criteria are not eligible for specialty mental health care under the Medi-Cal program. These members are eligible for care from a
CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
Contract: **LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	referrals received through beneficiary self-referral or through referral by another person or organization.	Primary care or other physical health provider. The Medi-Cal fee-for-service system will deny claims from mental health professionals for such members.
Nursing Facility Services **PL# 00-01 REV., pages 14 and 15** **Title 9, Section 1810.345**	The MHP is not responsible for nursing facility services. However, the MHP will arrange and pay for all medically necessary specialty mental services, (typically visits by psychiatrists and psychologists) in a skilled nursing facility.	Skilled nursing facility services with special treatment programs for the mentally disordered are covered by the Medi-Cal Fee For Service program. These services are billed to the Medi-Cal fee-for service system using accommodation codes 11, 12, 31, and 32, for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs)
Pharmaceutical Services and Prescribed Drugs (Out-Of-Plan Services) **Title 9, Sections 1810.310, 1810.355, 1810.345 and 1810.350 (b) and (c)** **Title 22, Sections 51311 and 51313** **PL# 00-01 REV., page 11 and 12** **Contract:** **LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	The MHP is not responsible to cover and pay for pharmaceutical services and prescribed drugs, including all medically necessary Medi-Cal psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services. However, the MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist the members in receiving prescription drugs and laboratory services prescribed through the MHP, including, ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. The MHP will utilize the existing services	The Plan will cover and pay for pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal members, including medically necessary Medi-Cal covered psychotropic drugs included in the Plan's contract, **except** when provided as inpatient psychiatric hospital based ancillary services or otherwise excluded under the Plan contract. The Plan will cover and pay for psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions. A plan may apply established utilization

	of the Plan's laboratory or the services of the Plan's contracted laboratory providers, as needed in connection with the administration and management of psychotropic medications.	review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrics. Application of utilization review procedures should not inhibit a Plan member's access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan will ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. The plan will not cover and pay for prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists; unless these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
		Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD policy letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made though the Medi-Cal fee-for-service system whether these drugs are provided by a pharmacy contracting with the Plan or by a fee-for-service pharmacy provider.
Psychiatric Inpatient Hospital Services **Title 9, Sections 1810.350 and 1820.205** **PL# 00-01** **Pages 13 and 14** **Contract:** **LI & CI Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	The MHP will be responsible for psychiatric Inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c). Psychiatric Inpatient Hospital Services for a fee-for-service Medi-Cal hospital will include: Routine hospital services All hospital based ancillary services, Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal hospital will include: Routine hospital based ancillary services, and Psychiatric inpatient hospital professional services. The MHP will utilize the Plan contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for Plan members unless otherwise covered by the hospital's per diem rate.	The Plan will cover and pay for all medically necessary professional services to meet the physical health care needs of Plan members who are admitted to the psychiatric ward of a general acute care hospital or a freestanding licensed psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations. The Plan is not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (MHP)	MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)
Physician Services **Title 9, Sections 1820.240, 1810.355, 1820.205 and 1830.205** **Title 22, Section 51305** **PL# 00-01 REV., page 9**	The MHP will not be responsible to provide or arrange and pay for physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in section 1810.240, Psychiatrist Services, even if the services are provided to treat a diagnosis included in the Title 9, Sections 1820.205 or 1830.205.	The Plan will cover and pay for physician services, **except** the physician services of mental health specialists, even if the services are provided to treat an included health diagnosis. The Plan will cover and pay for physician services, except the physician services of mental health specialists, related to the delivery of outpatient mental health services, which are within the PCPs scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses, whose conditions do not meet necessity criteria. The Plan is not required to cover and pay for physician services provided by Psychiatrists, Psychologists, Licensed Family, and Child Counselors, or other specialty metal health providers. When medically necessary, the Plan will cover and pay for physician services provided by specialists such as Neurologists.
Provider Network and Member Education **PL#00-01 REV., page 3** **Contractual requirements for both the MHPs and Plans**	The MHP will credential and contract with sufficient numbers of licensed mental health professionals to maintain a MHP provider network sufficient to meet the needs of plan members. The MHP will assist with identification of MHP providers who have the capacity and willingness to accept Plan reimbursement to serve the needs of Plan members who do not meet the MHP medical necessity criteria and require services outside the	The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental health services as required by contract. The Plan will utilize the MHP to identify MHP providers who are willing to accept Medi-Cal

	scope of practice of the PCP. The MHP will continually monitor the MHP provider network to ensure beneficiary access to quality mental health care. The MHP will assist the Plan in arranging for a specific MHP provider when the Plan is unable to locate an appropriate mental health service provider for a Plan member. The MHP will also assist the Plan to develop and update a list of provider or provider organizations to be made available to Plan members. Any updates to the list will be provided to the Plan at the quarterly MOU meetings or as changes occur to the list.	fee-for-service reimbursement to provide services for Plan members who do not meet MHP medical necessity criteria for MHP services and require services outside the scope of practice of the PCP. The Plan will request assistance from the MHP whenever the Plan is unable to arrange for an appropriate MHP provider for a Plan member. The Plan is unable to arrange for an appropriate MHP provider or provider organization as recommended by the MHP. For those services that do not meet the MHP medical necessity criteria, a copy of the referral will be kept in the member's referral chart. The Plan will collaborate with the MHP to
CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
		develop and maintain a list of providers or provider organizations to be made available to Plan members. Amendments to the list will be provided to the MHP at the quarterly MOU meetings or as changes occur to the list.
Referrals **Title 9, Sections 1810.355, 1810.370, 1810.405 and 1830.205 (b)(1)** **PL#00-01 REV., pages 5, 8, 16, 22 and 23** **Contract: LI & CI Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	The MHP will accept referrals from the Plan staff, Plan providers and Plan Medi-Cal members for determination of MHP medical necessity. When <u>medically necessity criteria are met,</u> the MHP will arrange for specialty mental health services by a MHP provider. In the case of self-referrals form providers other than the member's PCP, in which the planned specialty mental health services involves a MHP psychiatrist, the MHP will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information. When <u>medically necessity criteria are not met</u>, or if it is felt that the member's mental health condition would be responsive to physical health care based treatment, the MHP will refer the member back to the Plan and the referring physician with the assessment results, diagnosis, need for service and/or recommendations for an appropriate provider to treat the member's symptoms. These referrals will be made through the Plans referral for to assist in providing referrals to other sources of care for services not covered by the MHP.	The plan will maintain responsibility for physical healthcare based primary metal health treatment, which includes: Basic education, assessment, counseling, and referral and linkage to other services for all Plan members. The Plan will refer to the MHP for an assessment and appropriate services when: An assessment is needed by the MHP to confirm or arrive at a diagnosis included in the responsibilities of the MHP. The Plan identifies mental health conditions not responsive to physical healthcare based primary mental health treatment. After the PCP's diagnostic assessment, the Plan or PCP will refer those members whose psychiatric condition would not be responsive to physical health care, to the MHP to determine if MHP medical necessity criteria are met. The MHP will inform the Plan and Plan provider when a member does not meet the MHP criteria and will provide results of psychological assessment and treatment recommendations. The Plan will arrange for primary mental health services within the PCP's scope of practice. When the MHP informs the Plan and Plan provider that a member's health condition has stabilized and that maintenance of the

	Referrals may include a provider with whom the member has a patient-provider relationship, or a provider in the area that has indicated a willingness to accept referrals. This will include but is not limited to Federally Qualified Health Center (FQHC), a Rural Health Clinic and Indian Health Clinic, or an Indian Health Clinic, if such clinics exist in the County of Orange. The MHP is not required to ensure a member's access to physical health care based treatment or to treatment from a licensed mental health professional for diagnoses not covered by the MHP.	condition would be responsive to physical healthcare based treatment, the Plan will refer for primary mental health services within the PCP's scope of practice. Some specialty mental health services will continue to be covered and provided through Medi-Cal fee-for-service program for a specified set of diagnoses specifically excluded from the MHP responsibility.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
	When the MHP has provided specialty mental health services and has determined that the member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare treatment results, diagnosis, need for ongoing service and recommendation for an appropriate provider to treat the member's symptoms. The MHP will utilize the Plan's referral authorization form and with the member's consent will inform the PCP of services provided and/or medications prescribed. The MHP will attempt to coordinate information with the member's other health care provider and ensure that the contact with the Plan is made.	The Plan will utilize the Plan's referral authorization form and will ensure that coordination and contact with the MHP is made. In case that there is no provider available to perform the needed service, after obtaining prior authorization the PCP will refer the member to a non-plan provider for services.
Resolution of Disputes **Title 9, Section 1850.505** **PL#00-01 REV., Page 23** **Contract:** **LI & CP Sections 6.7.3.3 & 6.7.9.1 COHS Waiver GMC Sec. 7.6.2**	The MHP will provide a resolution of dispute process in accordance to Title 9, Section 1850.505. When the MHP has a dispute with the Plan that cannot be resolved to the satisfaction of the MHP, concerning the obligations of the MHP, or the Plan, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the resolution to the State Department of Mental Health (DMH). A request for resolution by either department will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: A Summary of the issue and a statement	The Plan will provide a resolution of dispute process in accordance to Title 9, Section 1850.505, and the contract between the Plan and the State Department of Health Services (DHS). When the Plan has a dispute with the MHP that cannot be resolved to the satisfaction of the Plan, concerning the obligations of the MHP or the Plan under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the Plan may submit a request for resolution to the DHS. A request for resolution by either department will be submitted to the respective department within 30 calendars days of the completion of the dispute resolution process between both parties. The request for resolution will contain the

	of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service. History of attempts to resolve the issue. Justification for the desired remedy. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The	following information: A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the beneficiary and the expected rate of payment for each type of services. History of attempts to resolve the issue. Justification for the desired remedy. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party
CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
	Notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the MHP and the Plan will not delay medically necessary specialty mental health services, or related prescription drugs and laboratory, radiological, or radioisotope services to members, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process offered by the Plan or to request a fair hearing.	within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days, or the departments will decide the dispute solely on the documentation filed by the initiating party. A dispute between the Plan and the MHP will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to members, when delay in the provision of services is likely to harm the Plan member. Nothing in this section will preclude a Plan member from utilizing the Plan's problem resolution process for members or any similar process offered by the MHP or to request a fair hearing.
Service Authorizations	The MHP will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the MHP for services that meet MHP medical necessity criteria. This will be done through the MHP Access program or a MHP linkage agency. Services will be rendered according to the MHP responsibility. Emergency services will be provided in accordance with State and Federal laws and regulations. MHP case management staff will be available to assist in coordinating care, including service authorizations.	The Plan will utilize it Utilization Management procedures to authorize medical assessment and/or treatment services by providers who are credentialed by the plan and contracted with the Plan Partner or delegated entity for covered physical health care services. The Plan and/or its delegated entities will authorize all medically necessary inpatient and outpatient medical assessment, consultation, and/or treatment services required for Plan members and coordinate with the MHP for those members receiving care from the MHP. Plan utilization or case management staff will be available to assist in coordinating

	If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.	care and obtaining appropriate service authorizations. If a dispute occurs between the member and the plan or MHP, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.
Services Excluded from Coverage	The MHP will not be responsible to provider or arrange and pay for the following services:	The plan is not responsible to arrange and pay for the services listed below to its member in accordance to the MOU and as

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**

	• Medi-Cal services are not specialty mental health services,
	• Out-of-State Specialty Mental Health Services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.
	• Specialty Mental Health Services, provided by a hospital operated by the department of the State Department of Developmental Services.
	• Specialty Mental Health Services provided to a beneficiary eligible for Medicare prior to the exhaustion of the beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRG) when the DRG reimbursement covers administrative day services according to Medicare (Part A).
	• Psychiatric Inpatient Hospital Services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a).
	• Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:
	  • Psychiatrist and Psychologist services provided by adult day health centers.
	  • Home and Community Based Waiver Services
	  • Specialty Mental Health Services authorized by the CCS program to treat CCS eligible members
	  • LEA Services
	  • Specialty Mental Health Services provided by FQHCs, Indian Health Centers, and Rural Health Clinics.
		Contractually required.
		• Medi-Cal services, that are specialty mental health services.

	• Home Health Agency Services per Title 22 Section 51337 M embers whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable	

CATEGORY	LOCAL MENTAL HEALTH PLAN (MHP)	MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)
	provisions of Title 22 Division 3 Subdivision 1.	
Services fort the Developmental Disabled	The MHP will refer members with developmental disabilities to Regional Centers for psychiatric medical services such as respite are, out-of-home placement, supportive living services, etc., if such services are needed. When appropriate, the MHP will inform the plan, its delegated entity, and the PCP of such referrals.	The Plan's PCPs will refer members with developmental disabilities to Regional Centers for psychiatric and non-medical services such as respite care, out-of-home placement, supportive living services, etc, if such services are needed.
Specialty Mental Health Services Providers and Covered Specialty Mental Health Services (EPSDT)	The MHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 is eligible for EPSDT supplemental services. If these criteria are met, the MHP will be responsible for arranging EPSDT supplemental services provided by specialty mental health professionals. The MHP will pay for EPSDT supplemental services that are part of the member's specialty mental health services to their PCP for referral to CCS. If neither EPSDT supplemental services or MHP medical necessity criteria are not met, the MHP will refer children who have	When the Plan determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, the Plan will refer the child to the PCP for treatment of conditions within the PCPs scope of practice. Referrals to the MHP for an appropriate linked program will be made for treatment of conditions outside the PCPs scope of practice. The Plan will assist the MHP and members by providing links to known community providers of supplemental services. The Plan will also provide all medically necessary professional services to meet the physical health care needs of Plan members

	a CCS eligible condition requiring specialty mental health services to their PCP referral to CCS. Children who do not have a CCS eligible condition will be referred to their PCP with recommendations for mental health treatment and the MHP will inform the Plan and the delegated entity of the referral. Hospitals not affiliated with the MHP may provide psychiatric inpatient hospital services to Medi-Cal members in emergency situations Fee-for-Service rates established by regulation. The MHP will also provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205 and 1830.205 or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met.	admitted to a general acute care hospital, psychiatric ward or to a freestanding licensed psychiatric inpatient hospital. The initial health history and physical assessment will be performed and processed within 24 hours of admission to the psychiatric unit.

CATEGORY	**LOCAL MENTAL HEALTH PLAN (MHP)**	**MEDI-CAL MANAGED CARE HEALTH PLAN (Plan)**
	The MHP will not be required to provide or arrange for any specific specialty mental health services, but, will ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as required or applicable. The MHP will provide specialty mental health services only to the extent the beneficiary is eligible for those services, based on the beneficiary's Medi-Cal eligibility under Title 22.	

Plan = CalOptima and its subcontracting health networks
MHP = Orange County Health Care Agency
DHS = State Department of Health Services
DMH = Department of Mental Health

Term: This Memorandum of Understanding may be altered through mutual consent of both parties and will be reviewed annually.

Signatures:

Health Care Agency

_____ ____/____/____
Douglas C. Barton Date
Deputy Agency Director,
HCA Behavioral Health Services

CalOptima

_____ ____/____/____
Mary Dewane Date
Chief Executive Officer

_____ ____/____/____
Date

Maria I. Marquez
Interim Division Manager
Adult Mental Health Services

_____ ____/____/____
Joyce Munsell, R.N. Date

Executive Officer,
Health and Human Services

Attachment 5: Behavioral Health/Primary Physician Patient Care Communication Form

ID IMPRINT

Behavioral Health/Primary Physician Patient Care Communication Form

Patient Name:	Medical Record Number (MRN):	Phone:	D.O.B.

Primary Physician Information		**Behavioral Health Clinician Information**	
Name:		Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:

SENT TO: ☐ **Primary Care Physician** ☐ **Behavioral Health Clinician** **REFERRAL STATUS**: ☐ Routine ☐ Urgent

PURPOSE: ☐ Consultation ☐ Evaluation ☐ Update ☐ Assumption of Care

Accepting responsibility of care for the patient's conditions identified in this referral? ☐ Yes ☐ No Initials: _____

To be completed by Behavioral Health Clinician

☐ Statement of Problem/Needed Services: ☐ Response to PCP Request:

Psychotropic Medications

Medication	Dosage/Frequency	Date Dose Initiated:	Medication	Dosage/Frequency	Date Dose Initiated

BH Clinician Signature: **Date:**

To be completed by Primary Care Physician

☐ Statement of Problem/Needed Services: ☐ Response to BH Request:

Medical Treatment Medications

Medication	Dosage/Frequency	Date Dose Initiated	Medication	Dosage/Frequency	Date Dose Initiated

PCP Signature: **Date:**

Comments (Cultural/Language and other special needs – PLEASE NOTE ALLERGIES):

INSTRUCTIONS

ALL USERS

An "Authorization to Exchange Protected Health Information" is required prior to sending/faxing this form.

Fill out patient's name, California Identification Number (CIN #), telephone number, and date of birth.

Fill out the name, address, phone number, and fax number, for both the PCP and the Behavioral Health Clinician in the designated areas, regardless of which provider is initiating the communication.

REQUESTING/REFERRING

Primary Care Physician (PCP) – Requesting/Referring to Behavioral Health (BH) Clinician:

1. Fill out PCP name, address, phone #, and fax #.
2. Check "SENT TO" BH Clinician box, and Check the appropriate REFERRAL STATUS box (Routine or Urgent).
3. Indicate purpose of communication:
   - Consultation – PCP requires the expertise of the BH Clinician to complete physical medicine evaluation.
   - Evaluation – PCP requires BH Clinician to evaluate patient's mental health symptoms, and render an opinion.
   - Update – PCP is providing a status update to the BH Clinician.
   - Assumption of Care – PCP is requesting the BH Clinician to assume care for the patient's identified conditions.

Do not document in the first box on the form

4. Go to second box "to be completed by the Primary Care Physician." Check "statement of Problem/Needed Services" box.
5. Document in narrative form, brief patient history, overview of current signs and symptoms, and communication needs.
6. Document all pertinent medications, their respective dosages and frequencies, including the date these dosages were initiated.
7. Sign and date.
8. Add information on cultural issues and/or allergies in the box at the bottom of the page as required.

Behavioral Health Clinician (BH) – Requesting/Referring to Primary Care Physician (PCP) :

1. Fill out BH Clinician's name, address, phone #, and fax #.
2. Check "SENT TO" the PCP box, and Check the appropriate "REFERRAL STATUS" box (Routine or Urgent).
3. Indicate purpose of communication:
   - Consultation – BH Clinician requires the expertise of the PCP to complete mental health evaluation.
   - Evaluation – BH Clinician requires PCP to evaluate patient's medical symptoms, and render an opinion.
   - Update – BH Clinician is providing a status update to the PCP.
   - Assumption of Care – BH Clinician is requesting the PCP to assume care for the patient's identified conditions.
4. Go to first box "to be completed by the Behavioral Health Clinician." Check "statement of Problem/Needed Services" box.
5. Document in narrative form, brief patient history, overview of current signs and symptoms, and communication needs.
6. Document all pertinent medications, their respective dosages and frequencies, including the date these dosages were initiated.
7. Sign and date.

Do not document in the second box on the form

8. Add information on cultural issues and/or allergies in the box at the bottom of the page as required.

RESPONDING

Primary Care Physician (PCP) – Responding to request from Behavioral Health(BH) Clinician:

If request is for assumption of care, check box indicating "yes" if care will be accepted, or "no" if care will not be accepted. If "no," document basis for decision at this time in #2 below. Initial in designated area.

Do not document in the first box on the form

1. Go to second box "to be completed by the Primary Care Physician". Check the "Response to BH Request" box.
2. Document response to BH request in narrative form.
3. Document all pertinent medications, their respective dosages and frequencies, including the date these dosages were initiated.
4. Sign and date.
5. Add information on cultural issues and/or allergies in the box at the bottom of the page as required.

Behavioral Health (BH) Clinician – Responding to request from Primary Care Physician (PCP):

If request is for assumption of care, check box indicating "yes" if care will be accepted, or "no" if care will not be accepted. If "no," document basis for decision at this time in #2 below. Initial in designated area.

1. Go to first box "to be completed by the Behavioral Health Clinician". Check the "Response to PCP Request" box.
2. Document response to PCP request in narrative form.
3. Document brief BH treatment plan and frequency of treatment. Document estimated length of treatment.
4. Document all pertinent medications, their respective dosages and frequencies, including the date these dosages were initiated.
5. Sign and date.

Do not document in the Second box on the form

6. Add information on cultural issues and/or allergies in the box at the bottom of the page as required.

The completed "Authorization to Exchange PHI" accompanying the BH/PPPC Communication Form permits a response to the initiator of the form without further authorization. The initiator of this form will notify the recipient if the patient withdraws this authorization prior to the receipt of the requested response.

Attachment 6: Beacon Fax Cover

CalOptima
A Public Agency
Better. Together.

1120 West La Veta Avenue | Orange, CA 92868 | www.caloptima.org
Main: 714. 246. 8400 | Fax: 714. 246. 8492 | TDD: 714. 246. 8523

FAX:

To: Case Management Triage From: _____

Fax: (714) 571-2455 Fax: _____

Phone: (714) 246-8686 Phone: _____

Date: 2/21/2012

Subject: Beacon Referral to CalOptima Case Management

Number of pages: 1 of

Comments:

MEMBER NAME: _____ **Caller Name (if different):** _____

CIN#: _____ **Member's Health Plan:** _____

Member Phone Number: _____ **Caller Phone Number (if different):** _____

☐ **NOA**: ☐ **Excluded Diagnosis with medical case management needs**

☐ **Included Diagnosis not meeting impairment and/or intervention criteria**

☐ **Case Management Referral**

☐ **Inappropriate Referral for mental health evaluation (Please list medical procedure which requires the evaluation)**

ATTACHED:

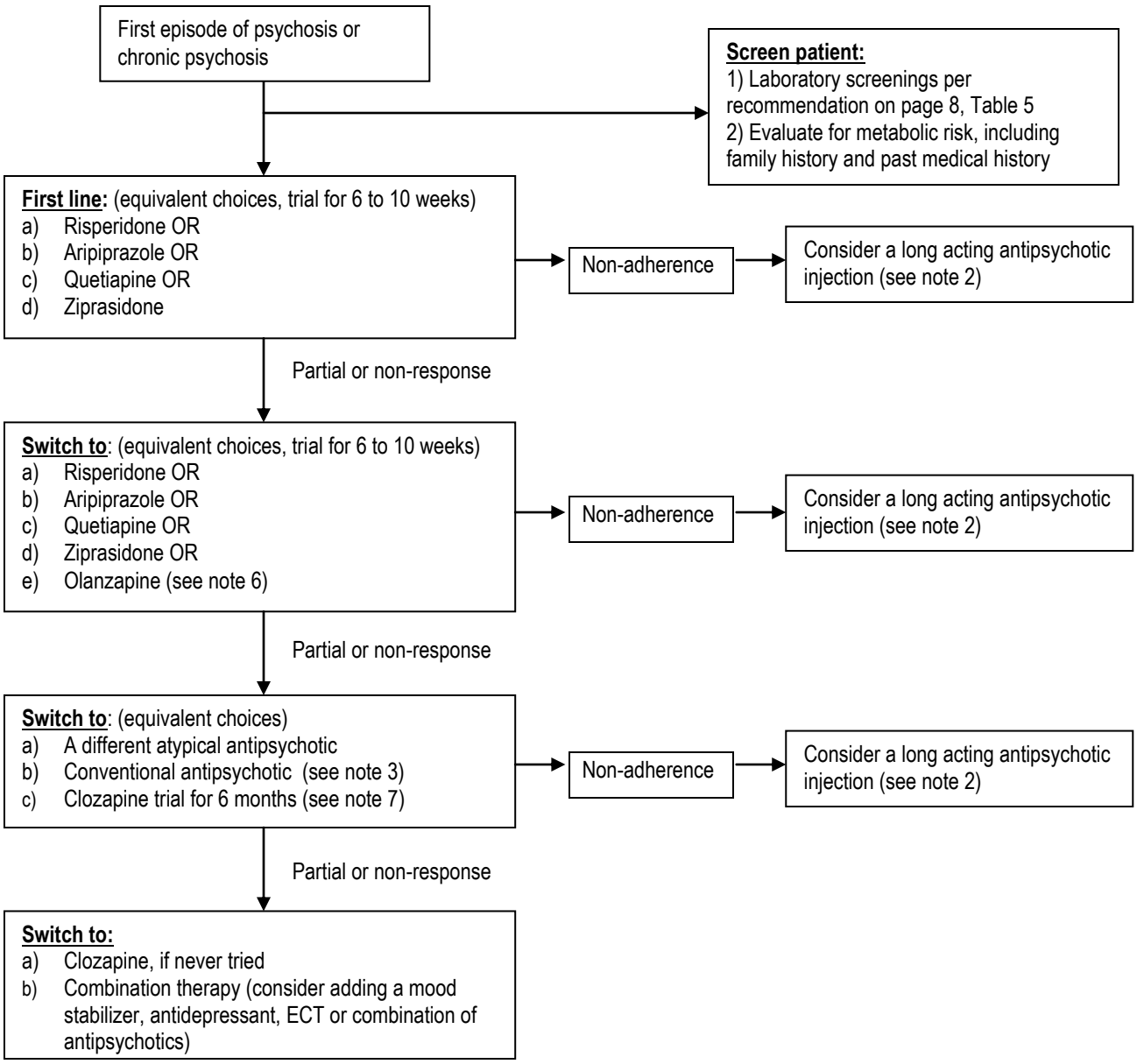
☐ Medi-Cal Specialty Mental Health Program NOA
☐ Member Assessment
☐ Pertinent Clinical Documentation
☐ Other ____

Rev. 3/11

Attachment 7: CalOptima Atypical Antipsychotic Guidelines

GUIDELINES FOR THE USE OF ATYPICAL ANTIPSYCHOTICS IN ADULTS

January 2012



Notes:

1) Antipsychotic monotherapy is the recognized standard for the treatment schizophrenia*;* pharmacological justification for polypharmacy is weak**.** Combining medications adds to cost of treatment, increases potential for adverse effects, may make adherence more challenging, and increases possibility of unfavorable drug reactions. However, rational co-pharmacy may be acceptable in the short term when one antipsychotic is being tapered/discontinued while the new antipsychotic is being initiated/titrated or when methodical trials have demonstrated the combination is safe and effective for the patient.
2) If a patient is non-adherent to oral antipsychotic therapy, consider a long acting antipsychotic preparation, such as haloperidol decanoate, fluphenazine decanoate, or Risperdal Consta®, or Invega Sustenna® after demonstrating the oral formulation to be safe and effective for the patient.
3) Prioritize the use of newer generation antipsychotic medication for new antipsychotic medication starts and for patients not responding to, or having problematic side effects on, conventional antipsychotic medication. For patients with severe positive symptoms or violence/aggression, consider typical antipsychotic therapy. Patients should not be subjected to numerous trials of newer generation antipsychotics before considering use of a conventional antipsychotic such as haloperidol (or other conventional agents).
4) Patients eligible for clozapine trial: sub-optimal response or adverse events to 2 or more antipsychotics.
5) Utilize current approaches to clinical assessment to determine response to medication and whether medication changes are indicated. Such assessments should include the presence and severity of positive and negative symptoms, Global Assessment of Function (GAF), EPS/tremor, weight gain, elevated lipids, elevated glucose and tardive dyskinesia,
6) Olanzapine is not preferred as a first line therapy due to high risk of cardiometabolic adverse effects. It may be indicated if a patient has been stable on it and is properly monitored for cardiometabolic adverse effects, or if a patient has tried and failed other second generation agents, such as risperidone, aripiprazole, ziprasidone or quetiapine.
7) Patients are eligible for clozapine therapy if they have experienced suboptimal response or adverse events to ≥2 antipsychotics. Clozapine may be indicated if a patient has been stable on it and is properly monitored for cardiometabolic and hematologic adverse effects.

GUIDELINES FOR THE USE OF ATYPICAL ANTIPSYCHOTICS

Atypical antipsychotics are generally first line agents for the following patients:*

- All patients with **new onset** of a chronic psychotic disorder, based on the tentative or working diagnosis, recognizing that in some patients there may be inadequate data to distinguish between a brief reactive psychosis or a drug-induced psychosis and first presentation of schizophrenia.
- All patients with symptoms of **tardive dyskinesia**. While atypical antipsychotics may pose a lower risk of causing tardive dyskinesia than conventional antipsychotics, long-term data with these newer agents are still limited. Therefore, the use of these agents should be limited to patients in whom the use of an antipsychotic is indicated.
- Patients with **extrapyramidal symptoms** from conventional antipsychotic agents, unresponsive to an anti-parkinson agent at therapeutic doses and one other agent (benzodiazepine, propranolol, amantadine, etc.).
- **Treatment-refractory patients**, defined as patients who have negative or positive symptoms that significantly impair function despite an adequate trial with a conventional antipsychotic (at least 7 mg/day of haloperidol equivalents for at least four weeks).
- **Patients with co-occurring psychiatric and substance use disorders.** Atypical antipsychotics are preferred because they are less likely to cause movement disorders, dysphoria, and increased drug cravings that have been associated with conventional antipsychotics.[1]

***Clozapine** is the most effective agent in treatment-refractory psychotic patients. Clozapine is FDA indicated for the management of severely ill schizophrenic patients who fail to respond adequately to standard drug treatment for schizophrenia. Because of the significant risk of agranulocytosis and seizures associated with its use, clozapine should be used only in patients who have failed to respond adequately to treatment with appropriate courses of standard drug treatments for schizophrenia, either because of insufficient effectiveness or the inability to achieve an effective dose due to intolerable adverse effects from those drugs.[2] In addition, clozapine is a non-preferred first-line agent because of its increased rate of metabolic complications.

***Olanzapine** is considered as second-line choice because of its increased rate of metabolic complications.

Atypical antipsychotics do not appear to be effective for all patients who have responded to conventional antipsychotics, therefore the following issues need to be considered in switching a patient from a conventional agent to an atypical agent:

- The risk/benefit of the switch, given that some patients will not respond to the new agent.
- The urgency of the switch: if the switch is not urgent then both agents should be cross-tapered over several weeks with close monitoring for the emergence of new symptoms.

*****Antipsychotic monotherapy is the recognized standard for the treatment of schizophrenia; pharmacological justification for polypharmacy is weak. Combining medications adds to cost of treatment, increases potential for adverse effects, may make adherence more challenging, and increases possibility of unfavorable drug reactions. However, rational co-pharmacy may be acceptable in the short term when one antipsychotic is being tapered/discontinued while the new antipsychotic is being initiated/titrated.**

*****Adults with serious mental illness are at significantly higher risk for a variety of health problems including diabetes, CVD and hypertension. Atypical antipsychotics may increase vulnerability to metabolic complications, making monitoring according to the guidelines an essential component of antipsychotic medication management.**

Table 1: Antipsychotic Medication Overview[3]									
Antipsychotic Agent	**Dosage Forms**	**Equiv. Dose* (mg/d)**	**Usual Adult Dose (mg/d)**	**Maximum Adult Daily Dose (mg)**	**Sedation Incidence**	**Extrapyramidal Symptoms**	**Anti-cholinergic Effects**	**Orthostatic Hypotension**	**Comments**
Aripiprazole (Abilify®, Abilify Discmelt®)	Tablet, Orally disintegrating tablet	7.5	10-30	30	Low	Low	Very low	Very low	Low weight gain; activating
	Solution	5.25-9.75							
Asenapine (Saphris®)	Sublingual tablet	--	10-20	20	Moderate	Low	Very low	Low / moderate	Low weight gain; activating
Chlorpromazine	Tablet	100	200-1000	1000	High	Moderate	Moderate	Moderate / high	
	Injection			--					
Clozapine (Clozaril®, FazaClo®)	Tablet, Orally disintegrating Tablet	100	75-900	800	High	Very low	High	High	~1% incidence of agranulocytosis; weekly-biweekly CBC required; potential for weight gain, lipid abnormalities, and diabetes
Fluphenazine	Tablet	2	0.5-20	40	Low	High	Low	Low	
	Solution		2.5-10	10					
	Injection, long-acting		12.5-25	100					
Haloperidol (Haldol®)	Tablet	2	0.5-20	20	Low	High	Low	Low	
(Haldol® Decanoate)	Injection, long-acting		50-200mg/ month	450mg/month					Initial doses > 100mg should be administered separately 3 to 7 days apart. Haloperidol decanoate is in a sesame seed oil base and should be administered ONLY by IM injection; it MUST NOT be given IV.
Iloperidone (Fanapt™)	Tablet	--	12-24	24	Low	Low	Very low	Low / moderate	
Loxapine (Loxitane®)	Capsule	10	25-250	100	Moderate	Moderate	Low	Low	
Lurasidone (Latuda®)	Tablet	--	40-80	80	Moderate	Low/Moderate	Low	Low	Contraindicated with strong CYP3A4 inducers/inhibitors. Take with food.
Olanzapine (Zyprexa IntraMuscular®, Zyprexa®, Zyprexa Zydis®)	Solution, Tablet, Orally disintegrating Tablet	5	5-20	20	Moderate / high	Low	Moderate	Moderate	Potential for weight gain, lipid abnormalities, diabetes
Olanzapine Pamoate (Zyprexa®	Injection, long-acting		210-405mg/ month	405mg/month					

Table 1: Antipsychotic Medication Overview[3]									
Antipsychotic Agent	**Dosage Forms**	**Equiv. Dose* (mg/d)**	**Usual Adult Dose (mg/d)**	**Maximum Adult Daily Dose (mg)**	**Sedation Incidence**	**Extrapyramidal Symptoms**	**Anti-cholinergic Effects**	**Orthostatic Hypotension**	**Comments**
Relprevv™)									
Paliperidone (Invega®)	Tablet, extended release	--	3-12	15	Low / moderate	Low	Very low	Moderate	Active metabolite of risperidone
Paliperidone Palmitate (Invega Sustenna®)	Injection, long-acting		39-234mg/ month	234mg/month					
Perphenazine	Tablet	10	16-64	64	Low	Moderate	Low	Low	
Quetiapine (Seroquel®, Seroquel XR®)	Tablet; tablet, extended release	75	50-800	800	Moderate / high	Very low	Moderate	Moderate	Moderate weight gain; potential for lipid abnormalities; diabetes
Risperidone (Risperdal® Risperdal M-tabs®)	Solution; tablet; tablet, orally disintegrating	2	0.5-6	8	Low / moderate	Low	Very low	Moderate	Low to moderate weight gain; potential for diabetes
Risperidone Microspheres (Risperdal® Consta®)	Injection, long-acting		25-50mg/ 2 weeks	100mg/month					
Thioridazine	Tablet	100	200-800	800	High	Low	High	Moderate / high	May cause irreversible retinitis pigmentosa at doses >800 mg/d; prolongs QTc; use only in treatment of refractory illness
Thiothixene (Navane®)	Capsule	4	5-40	50	Low	High	Low	Low / moderate	
Trifluoperazine	Tablet	5	2-40		Low	High	Low	Low	
Ziprasidone, Ziprasidone Mesylate (Geodon®)	Capsule	60	40-160	160	Low / moderate	Low	Very low	Low / moderate	Low weight gain; contraindicated with QTc-prolonging agents. Take with food
	Solution		10-20	40					
*The reference point used for the column titled "Equiv. Dose (mg/d)" is Chlorpromazine 100mg.									

Table 2: Atypical Antipsychotic Dosage Forms and Dosing Recommendations		
Drug	**Available Dosage Forms**	**General Adult Dosing Recommendation**
Aripiprazole (Abilify®, Abilify Discmelt®)	2mg, 5mg, 10 mg, 15 mg, 20 mg, and 30 mg tablets 1mg/ml oral solution 10 mg, 15 mg ODT	*Initial*: 10-15 mg qd *Titration*: may be increased to a maximum of 30 mg/day after 2 weeks For the treatment of schizophrenia, doses higher than 15mg/d were not found to be more effective in clinical trials[4]
Asenapine (Saphris®)	5mg, 10mg SL tablets	*Initial:* 5 mg bid *Titration:* may be increased up to 10mg bid after 1 week *Max dose:* safety above 10mg BID has not been demonstrated in clinical trials
Clozapine (Clozaril®, FazaClo®)	12.5mg, 25 mg, 50mg, 100 mg, 200mg tablets; generics available 25 mg, 100mg ODT	*Initial*: 12.5 mg qd-bid *Titration*: increased by 25–50 mg every 1-3 days as tolerated to 300-500 mg/d in bid dose within 2-4 weeks *Max dose*: 900 mg/day
Iloperidone (Fanapt®)	1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg tablets Also available in titration pack of 1mg, 2mg, 4mg and 6mg tablets	*Initial:* 1mg bid on day 1 *Titration:* 2, 4, 6, 8, 10, and 12 mg bid on days 2, 3, 4, 5, 6, and 7 respectively *Max dose*: 12mg bid
Lurasidone (Latuda®)	40mg, 80mg tablets	*Initial dose:* 40mg qd with food *Titration:* not required *Max dose:* 80mg/day
Olanzapine (Zyprexa IntraMuscular®, Zyprexa®, Zyprexa Zydis®, Zyprexa® Relprevv™)	2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg tablets; generics available 5mg, 10mg, 15mg, 20mg ODT; generics available 10mg/vial IM; generic available 210mg/vial, 300mg/vial, 405mg/vial (powder for reconstitution)	*Initial (oral)*: 5-10mg qd *Titration (oral)*: Increase by 5-10 mg/day at 1-week intervals *Max dose (oral)*: 20 mg/d however doses higher than10mg/day were not demonstrated to be more efficacious than the 10mg/day dose[5] *IM injection:* 5-10mg IM then repeat every 2-4 hours up to 30mg/day *Long Acting Injection:* *Initial:* 150 to 300 mg every 2 weeks or 405 mg every 4 weeks Doses more than 405 mg every 4 weeks or 300 mg every 2 weeks have not been evaluated in clinical trials
Paliperidone (Invega®, Invega Sustenna®)	1.5mg, 3mg, 6mg, 9mg tablets 39mg/0.25mL, 78mg/0.5mL, 117mg/0.75mL, 156mg/mL, 234mg/1.5mL long acting injection	*Initial (oral):* 6mg qd *Titration (oral):* not required *Max dose (oral):* 12mg/day *IM injection:* 234 mg IM (deltoid muscle only) on day 1 and 156 mg 1 week later. Following the second dose, monthly maintenance doses can be administered in the deltoid or gluteal muscle. Recommended maintenance

Table 2: Atypical Antipsychotic Dosage Forms and Dosing Recommendations		
Drug	**Available Dosage Forms**	**General Adult Dosing Recommendation**
		dose is 117 mg IM monthly (39 to 234 mg based on individual patient tolerability and/or efficacy)
Quetiapine (Seroquel®, Seroquel XR®)	25 mg, 50 mg, 100 mg, 200 mg, 300 mg and 400 mg IR tablets 50 mg, 150 mg, 200 mg, 300 mg and 400 mg ER tablets	*IR Initial*: 25mg bid *IR Titration:* increase by 25-50 mg bid every 1-2 days to target dose of 400-600 mg[6] *ER Initial:* varies depending on indication, but generally 300mg once daily, preferably in the evening *Titration: ER:* Dose increases can be made at intervals as short as 1 day and in increments of 300 mg/day within a dosage range of 400 to 800 mg/day. *Max for IR and ER:* 800 mg/day
Risperidone (Risperdal® Risperdal M-tabs®, Risperdal Consta®)	0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg tablets 0.5 mg, 1 mg, 2 mg, 3 mg and 4 mg ODT 1 mg/ml oral concentrate solution 25mg, 37.5mg, 50mg long acting injection	*Initial (oral):* 1 mg qd-bid *Titration (oral):* Increase by 0.5-1 mg/day every 1-3 days *Target dose*: 4-5 mg/day; can be given once daily if patient tolerates orthostasis *Long-acting injection:* *Initial:* 25mg IM every 2 weeks, continue oral tablets for 3 weeks *Titration:* increase dose no more frequently than every 4 weeks
Ziprasidone (Geodon®)	20 mg, 40 mg, 60 mg, 80 mg capsules 20 mg/ml vials for IM injection	*Initial:* 40 mg bid with food; *Titration*: Increase by 20 mg bid every 2-3 days to 60-80 mg bid with food (Elderly initial dosing: 20mg bid with food) IM injection: 10mg q2hrs or 20mg q4hrs up to 40mg/day

Table 3: Atypical Antipsychotic Class Issues		
Metabolic Complications		**Treatment**
Obesity	Weight gain is a prominent side effect of atypical antipsychotics. The onset can occur early in treatment and continue to increase even a year later. Patients that experience weight gain are more likely to be noncompliant and request discontinuation of the agent. The comparative risk profile suggests that weight gain is most profound with clozapine and olanzapine while aripiprazole and ziprasidone confer only limited liability. Quetiapine and risperidone likely are intermediate in their effects on weight.	The management of metabolic side effects and cardiovascular risk should involve lifestyle modifications (diet, exercise, smoking cessation), consideration of a switch to a lower risk atypical antipsychotic, and drug therapy targeting the metabolic side effect including antiglycemic and lipid lowering therapy.
Diabetes mellitus	Atypical antipsychotics can cause diabetic ketoacidosis, worsening of pre-existing diabetes, new onset diabetes, and hyperglycemia. The exact mechanism is unknown however it may be linked to a direct toxic effect on the pancreas, impairment of insulin receptors/glucose transporters, weight gain, 5-HT_{1A} antagonism, or hypothalamic dopamine antagonism. Analogous to weight gain the risk is highest with clozapine and olanzapine, lower with quetiapine and risperidone and minimal with ziprasidone and aripiprazole.	
Dyslipidemia	The effect on serum lipids is less clearly elucidated, however it seems to occur in concert with weight gain, thus clozapine and olanzapine carry the highest risk, quetiapine and risperidone carry intermediate risk, and ziprasidone and aripiprazole carry the least risk. The primary effect is on increasing triglycerides with secondary effects on increasing total and LDL cholesterol while decreasing HDL cholesterol.	

Table 4: Metabolic Complications of Atypical Antipsychotics: Results from the CATIE Study*						
Reference value compared to baseline	**Olanzapine**	**Quetiapine**	**Risperidone**	**Ziprasidone**	**Clozapine**	**Aripiprazole**
Weight Change (lbs/month)	2	0.5	0.4	-0.3	0.5	_
HbA1c (%)	0.4	0.04	0.07	0.1	0.1	_
Blood Glucose (mg/dl)	13.7	7.5	6.6	2.9	13.2	0.90
Total Cholesterol (mg/dl)	9.4	6.6	-1.3	-8.2	7.3	-0.7
Triglycerides (mg/dl)	40.5	21.2	-2.4	-16.5	52.6	0.6
*Data for clozapine[7] and aripiprazole[8] are from separate sources						

Table 5: Cardiometabolic Monitoring for Atypical Antipsychotics[9,10,11]						
	Baseline	**4 weeks**	**8 weeks**	**12 weeks**	**Quarterly**	**Annually**
Personal/Family Hx	X					X
Weight (BMI)	X	X	X	X	X	
Waist circumference	X					X
Blood pressure	X			X		X
Fasting plasma glucose	X			X		X
Fasting lipid profile	X			X		X
*More frequent assessments may be warranted based on clinical status. Table 5 lists the minimum level of monitoring recommended for cardiometabolic risk assessment.						

Polypharmacy:

- Antipsychotic monotherapy is the recognized standard for the treatment of schizophrenia
- Pharmacological justification for polypharmacy is weak.
- Polypharmacy has been associated with higher antipsychotic doses, longer hospitalizations, and higher risk of adverse effects when compared to symptom severity matched patients receiving monotherapy.[12]
- No data to determine whether any particular pattern of receptor blockade is useful for control of psychosis*;* assertion that a specific combination of medications will provide superior results cannot be substantiated
- Safety and efficacy of this practice are generally untested and unproven
- Combining medications adds to cost of treatment, may make adherence more challenging, and increases possibility of unfavorable drug reactions
- Note: rational co-pharmacy may be acceptable in the short term when one antipsychotic is being tapered/discontinued while the new antipsychotic is being initiated/titrated or when methodical trials have demonstrated the combination is safe and effective for the patient.

APPENDIX A: ANTIPSYCHOTIC ADVERSE EFFECT MANAGEMENT	
The following recommendations are for patients with a good response to an agent, but who have significant side effects.	
Refractory EPS (bradykinesia or muscle rigidity)	Treat with anticholinergic agent (e.g., benztropine, diphenhydramine). If ineffective, switch to a different anticholinergic agent or to amantadine, or consider a switch to a different antipsychotic agent (quetiapine has the lowest risk of EPS).
Akathisia	Consider propranolol or a benzodiazepine, or consider a switch to a different antipsychotic agent (such as quetiapine, which has the lowest risk of EPS).
Neuroleptic malignant syndrome	Wait and monitor for at least two weeks after recovery from NMS before re-challenging with any antipsychotic agent. Consider another newer generation antipsychotic; avoid depot formulations of antipsychotic.
Hyperprolactinemia/Sexual side effects	Consider quetiapine (alternative agents: olanzapine or ziprasidone or aripiprazole).
Insomnia/agitation	Eliminate stimulants (including caffeine), educate regarding sleep hygiene, or consider short duration benzodiazepine (also consider switch to olanzapine or quetiapine).
Weight gain, increased lipids, increased glucose	If switching to a more favorable cardiometabolic antipsychotic such as aripiprazole or ziprasidone is not an option, move forward with treating metabolic adverse effects per current clinical practice guidelines.
Tardive Dyskinesia	Assess through AMES. Monitor closely and make changes to causative agent. Conduct a risk/benefit discussion with patient regarding treatment options.

References

[1] Brown. (2003). Cocaine and amphetamine use in patients with psychiatric illness: a randomized trial of typical antipsychotic continuation or discontinuation. Journal of Clinical Psychopharmacology, 23(4), 384-8.
[2] Clozaril. [package insert]. East Hanover, NJ: Novartis; October 2011.
[3] DRUGDEX® System [Internet database]. Greenwood Village, CO: Thomson Healthcare. Accessed January 2012.
[4] Abilify. [package insert]. Princeton, NJ: Bristol-Myers Squibb Company/Otsuka America; February 2011.
[5] Zyprexa. [package insert]. Indianapolis; IN: Eli Lilly and Co; December 2009.
[6] Small, J. G., Hirsch, S. R., et al. (1997). Quetiapine in patients with schizophrenia. Archives of General Psychiatry. 54:549-57.
[7] McEvoy, J.P., Lieberman, J. A., Stroup, T. S., et al. (2006). Effectiveness of Clozapine Versus Olanzapine, Quetiapine, and Risperidone in Patients With Chronic Schizophrenia Who Did Not Respond to Prior Atypical Antipsychotic Treatment. American Journal of Psychiatry.163:600-10.
[8] BMS and Otsuka Pharmaceutical Inc data on file 2004.
[9] American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Diabetes Care. 2004 Feb; 27(2): 596-601.
[10] De Hert, M, Cohen, D, Bobes, J, et al. (2011). Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. World Psychiatry. 10(2), 138-51.
[11] Nasrallah, H. A., Black, D. W., Goldberg, J. F., et al (2008). Issues associated the use of atypical antipsychotic medications. Supplement to Current Psychiatry. S24-28.

Modified from the San Francisco General Hospital
Atypical Antipsychotic Guidelines for Adults, 2006
http://www.sfdph.org/dph/files/cbhsdocs/MHPdocs/AtypicalAntipsychoticGuidelines102006.pdf

Attachment 8: Partnership for Choice

Attachment 8: Description of Partnership for CHOICE

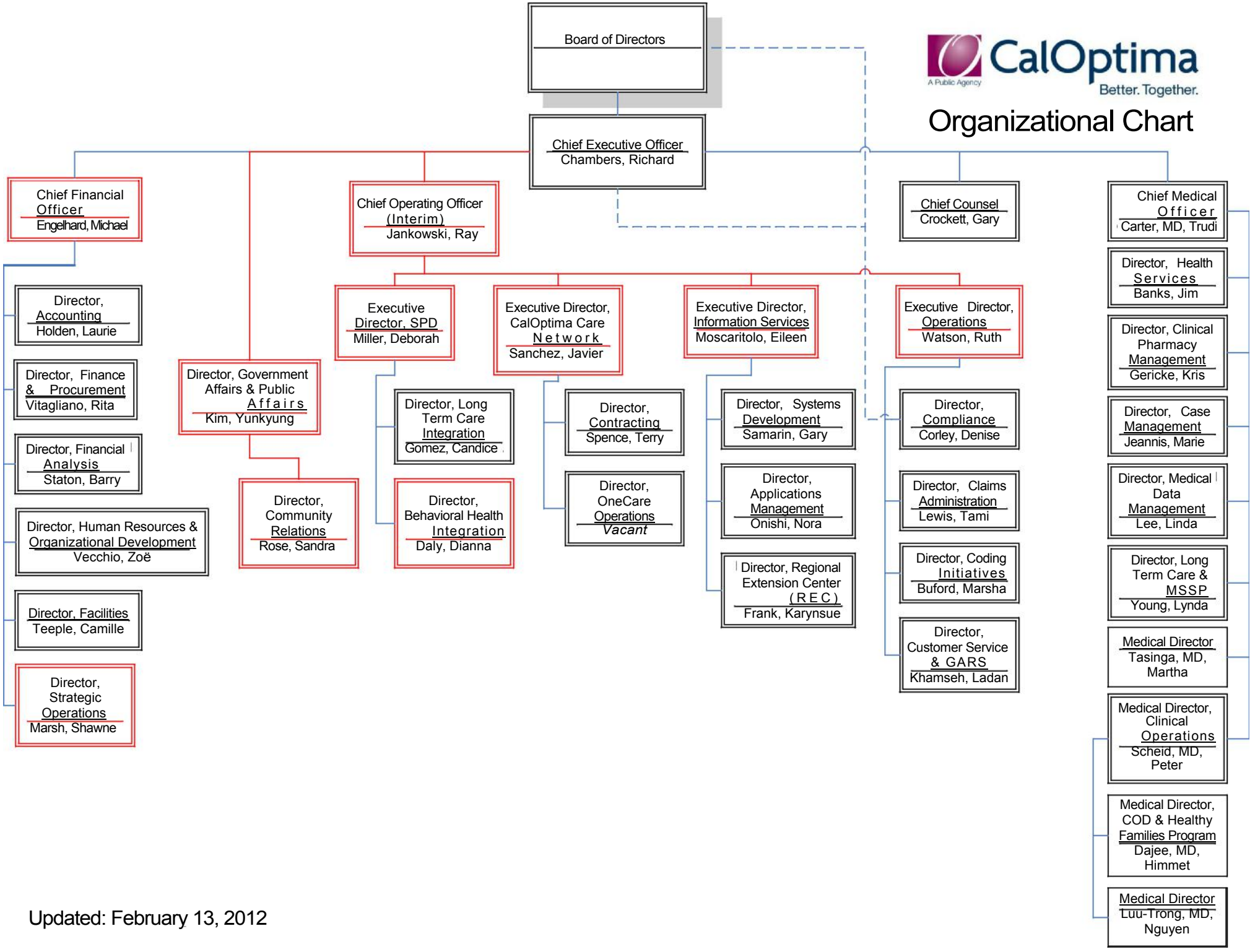
Established in 2005, the Partnership for CHOICE serves as an advisory group to CalOptima for long-term care integration activities and comprises representatives from county agencies, non-profit health and social service providers, and consumer advocate groups. It was the Partnership for CHOICE that recommended CalOptima pursue a grant opportunity to establish an Aging and Disability Resource Center (ADRC) in Orange County. Once CalOptima received the grant, the Partnership for CHOICE helped established a sub-committee to develop the program. The Partnership for CHOICE has also played a vital role in CalOptima's efforts to launch the first Program of All-Inclusive Care for the Elderly (PACE) in Orange County. The PACE Development Advisory Group was established in 2011 and is a sub-committee of the Partnership for CHOICE. Similar to the ADRC and PACE, CalOptima anticipates establishing a Duals Demonstration advisory group, as a sub-committee of the Partnership for CHOICE, to will provide input on program operations.

Partnership for CHOICE includes representation from the following agencies:

- Abrazar, Inc.
- Acacia Adult Day Services
- Age Well
- Alzheimer's Association
- Area Board XI
- Caregiver Resource Center
- Community SeniorServ
- Council on Aging Orange County
- Dayle McIntosh Center

- Disability Rights Legal Center
- Family Support Network
- Goodwill of Orange County
- Orange County Adult Day Services Coalition
- Orange County Community Services
- Orange County Health Care Agency
- Orange County IHSS Public Authority
- Orange County Office on Aging
- Orange County Social Services Agency
- Pacific Islander Health Partnership
- Regional Center of Orange County

Attachment 9: CalOptima Organizational Chart



Updated: February 13, 2012

DEBORAH A. MILLER

SUMMARY OF QUALIFICATIONS

An experienced health care executive who:

- Has proven ability to lead organizational change during uncertain times and daunting circumstances
- Promotes the effectiveness of the management team and organization by identifying short-term and long-range issues and risks; by providing information and commentary pertinent to deliberations; recommending options and courses of action; implementing strategic plans and operational decisions
- Uses ability to rapidly analyze issues in combination with understanding of organizational dynamics and human behavior to lead teams to consensus and action resulting in strategic decisions and effective solutions
- Collaborates effectively with all stakeholders including board of directors, management team, direct reports, work groups, government and community representatives
- Protects the stability and reputation of the organization by complying with accreditation and regulatory requirements
- Maintains operations by initiating, coordinating and enforcing policies and procedures
- Consistently demonstrates commitment to fulfilling the organizational mission and to providing quality of care and service to all stakeholders

Health Sector Experience: significant healthcare operations experience in both non-profit and for profit organizations, 7 years experience as hospice general manager (executive director), 12 years experience in Medicare health plan operations as senior vice president; broad understanding of managed care and delegated health management model; extensive success in working with state and federal regulators; dedication to quality improvement, participated in successful JCAHO accreditation and NCQA accreditation preparation; significant experience designing and operating Dual Special Needs Plan

Innovative Visioning: envisioned, designed and implemented geriatric focused case management programs that reduce hospital utilization and improve member satisfaction while allowing the company to survive a potentially catastrophic regulatory change affecting its business model

Census building, Sales and Marketing:
Grew Los Angeles based hospice from average daily census of 150 to over 250 using branded sales program and a "we all sell" philosophy; significantly expanded Medicare health plan demonstration program resulting in significant increase in revenues and member retention

Fiscal Accountability: P&L responsibility for all aspects of a large hospice program, first general manager within a for-profit national hospice plan to achieve a 20 % profit margin while improving quality of care; budgetary responsibility for multiple business units within a Medicare and Medicaid certified health plan

Human Resources: Created a model salary structure and career path for social workers and nurses resulting in improved ability to recruit and retain staff; created model retention incentive strategy during a business crisis; inspired dozens of staff to pursue higher education to meet business needs of organization; responsible for more than 400 staff; built staff loyalty and improved performance using mentoring, delegation of key projects, staff recognition, plain old "encouragement" and personal accessibility

DEBORAH A. MILLER

EDUCATION

- UCLA, Master of Social Work Degree, MSW, with honors
- California State University Long Beach, Bachelor of Social work, BSW degree
- Extensive executive education courses and seminars

LICENSURE

- Licensed Clinical Social Worker, LCSW California, active in good standing
- Extensive continuing education related to social work license

PROFESSIONAL EXPERIENCE

CalOptima, Orange, California 2011-present
Executive Director
Programs for Seniors and Persons with Disabilities

- Executive responsible for development of programs addressing the long term care needs of persons dually eligible for Medi-Cal and Medicare including PACE and the California Dual Eligible Demonstration Pilot for Orange County

SCAN HEALTH PLAN, Long Beach, California 1999-present
Senior Vice President of Health Care Services

- Senior executive team member responsible for health care operations, operational efficiency, containment of administrative costs and contributor to strategic plan
- Responsible for business units managing home and community based services program, disease management, case management, Special Needs Plans, Utilization Management, Quality Management, Geriatric Practice Innovation, MSSP (Medi-Cal case management program)

Vitas Health Care, Torrance, California Branch 1992-1999
General Manager (executive director)

- Responsible for all aspects of Medicare and Medi-Cal certified hospice program including census growth, quality and utilization management, financial management, regulatory compliance, staff recruitment, hiring, performance evaluations and community liaison

OTHER ACTIVITIES

- **GSWEC**, Geriatric Social Work Education Consortium-board of counselors member
- **OLLI**, Life Long Learning Institute, California State University Long Beach—advisory board member
- **Field Placement Supervisor**—UCLA, CSULB, USC, CSULA
- **California Department of Health Care Services,** California Community Choices advisory board member

Attachment 10: Resume of Duals Demonstration Project Manager

DEBORAH A. MILLER

3622 Petaluma Ave.
Long Beach, CA 90808

Cell: (562) 544-0498
miller.deborah752@gmail.com

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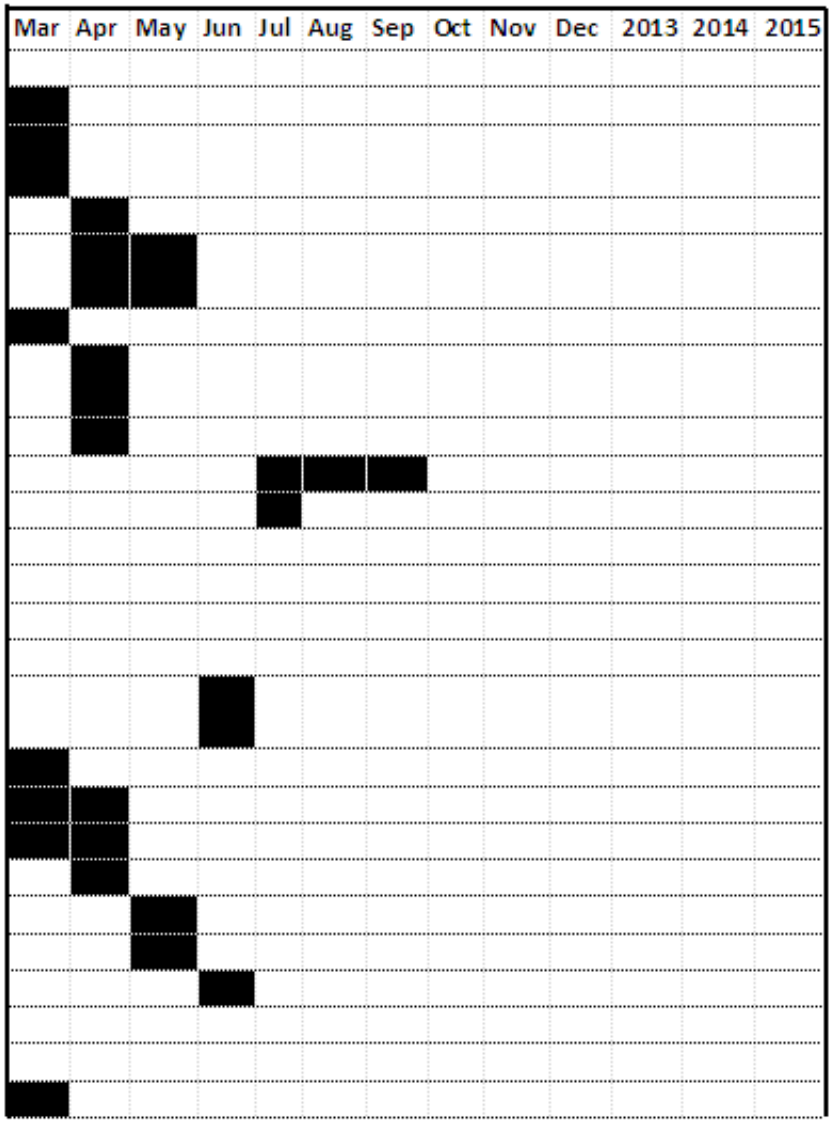
- **Field Placement Supervisor**—UCLA, CSULB, USC, CSULA
- **California Department of Health Care Services,** California Community Choices advisory board member

Attachment 11: Preliminary Operational Plan

Attachment 11: Preliminary Operational Plan



DHCS/CMS Milestones

Demonstration sites announced

DHCS draft Demonstration proposal released for 30-day state comment period

Comment period closed

Draft Demonstration proposal submitted to CMS for 30-day federal comment period

CMS releases Part D formulary submission in HPMS

CMS releases contract year 2013 Parts C and D final call letter

CMS releases 2013 MTMP in HPMS

CMS and State conduct readiness review

Demonstration plan selection completed

CalOptima Milestones

Application Process

Preparation for CMS and State readiness review completed

NOIA submitted

Pending contract number obtained from CMS

Application for CMS User ID submitted

Part D formulary submitted

MTMP submitted

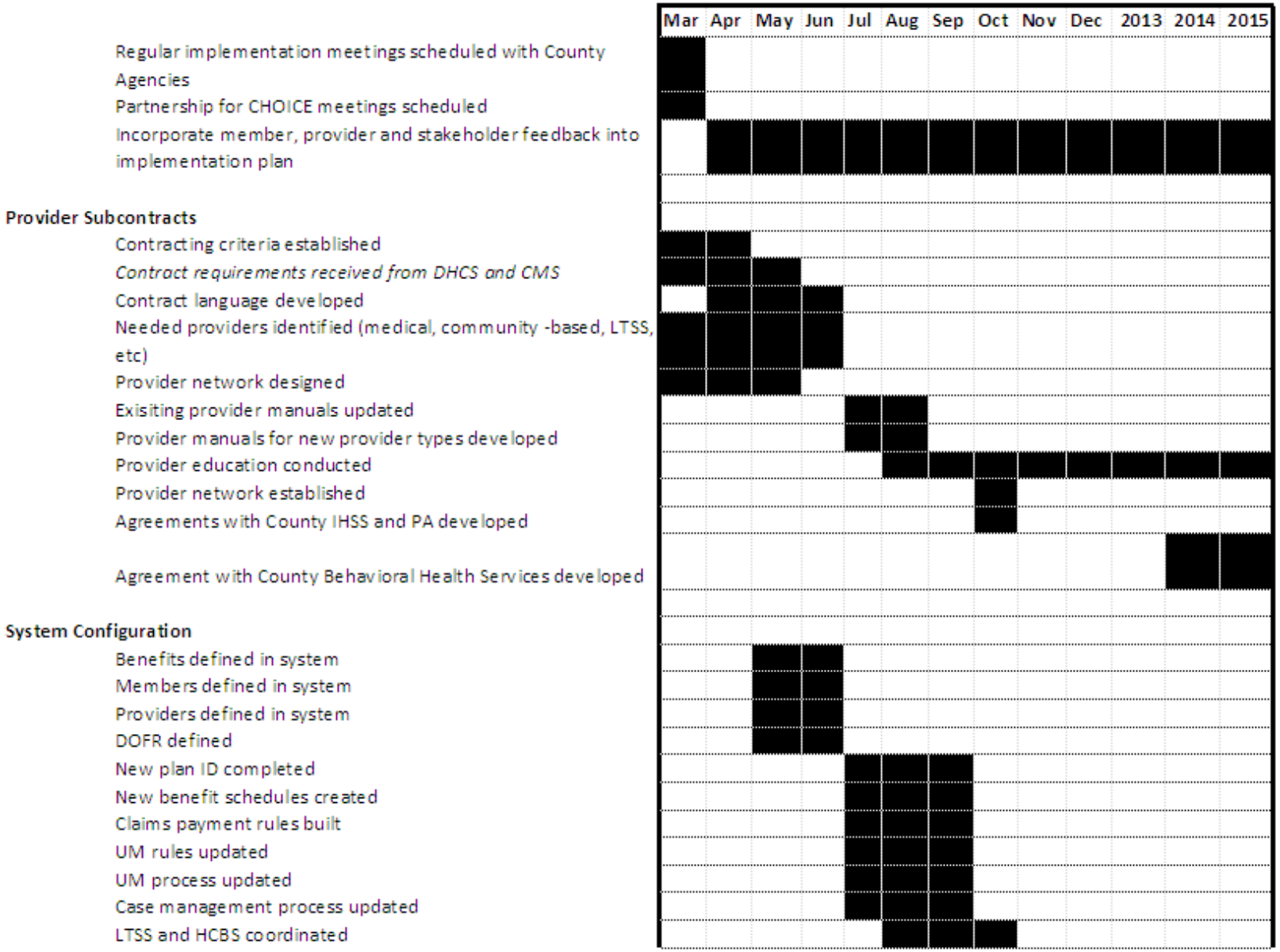
Part D formualry crosswalk submitted

Proposed plan benefit package submitted

Stakeholder Engagement

Stakeholder engagement plan finalized

Attachment 11: Preliminary Operational Plan



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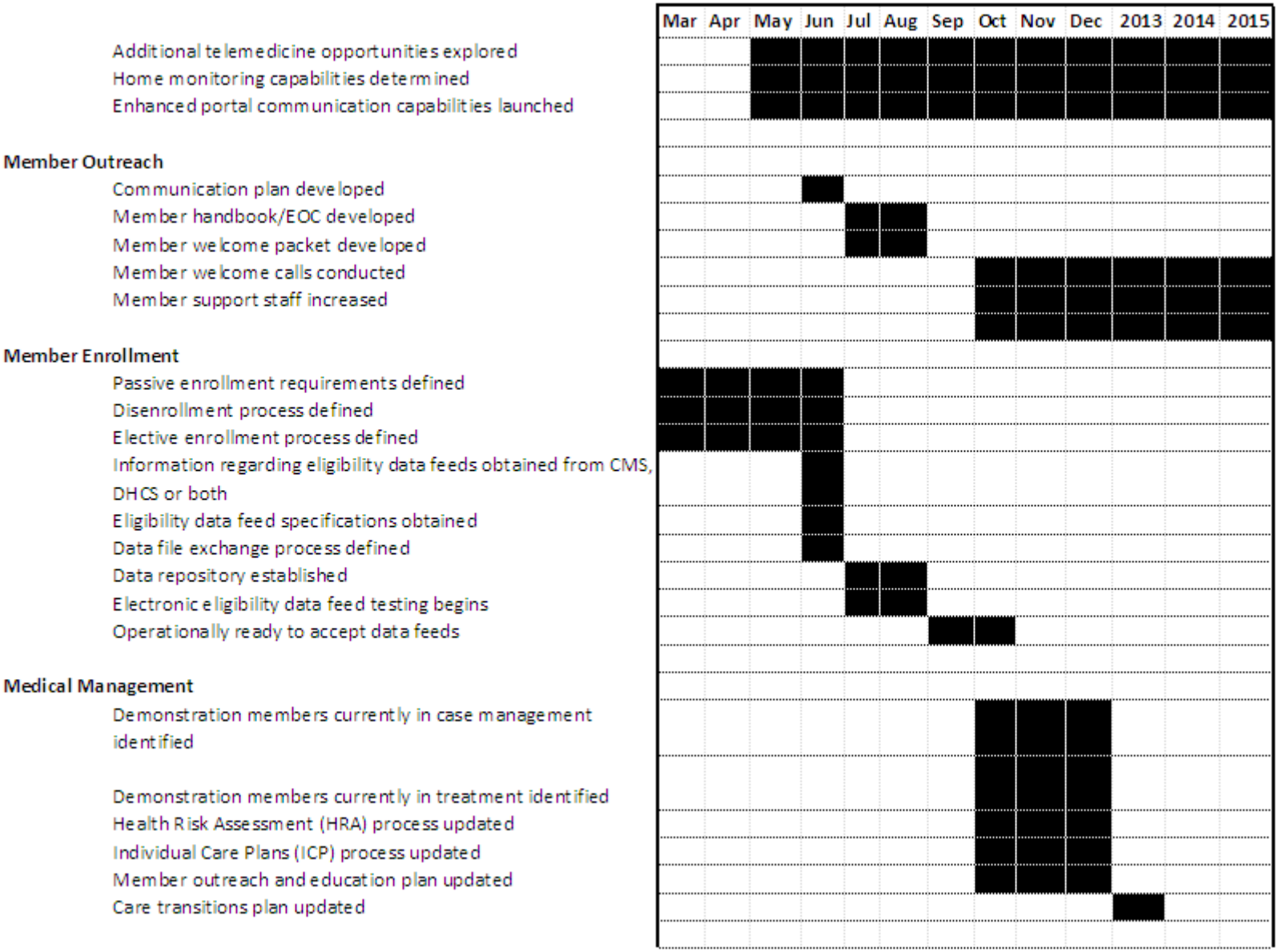
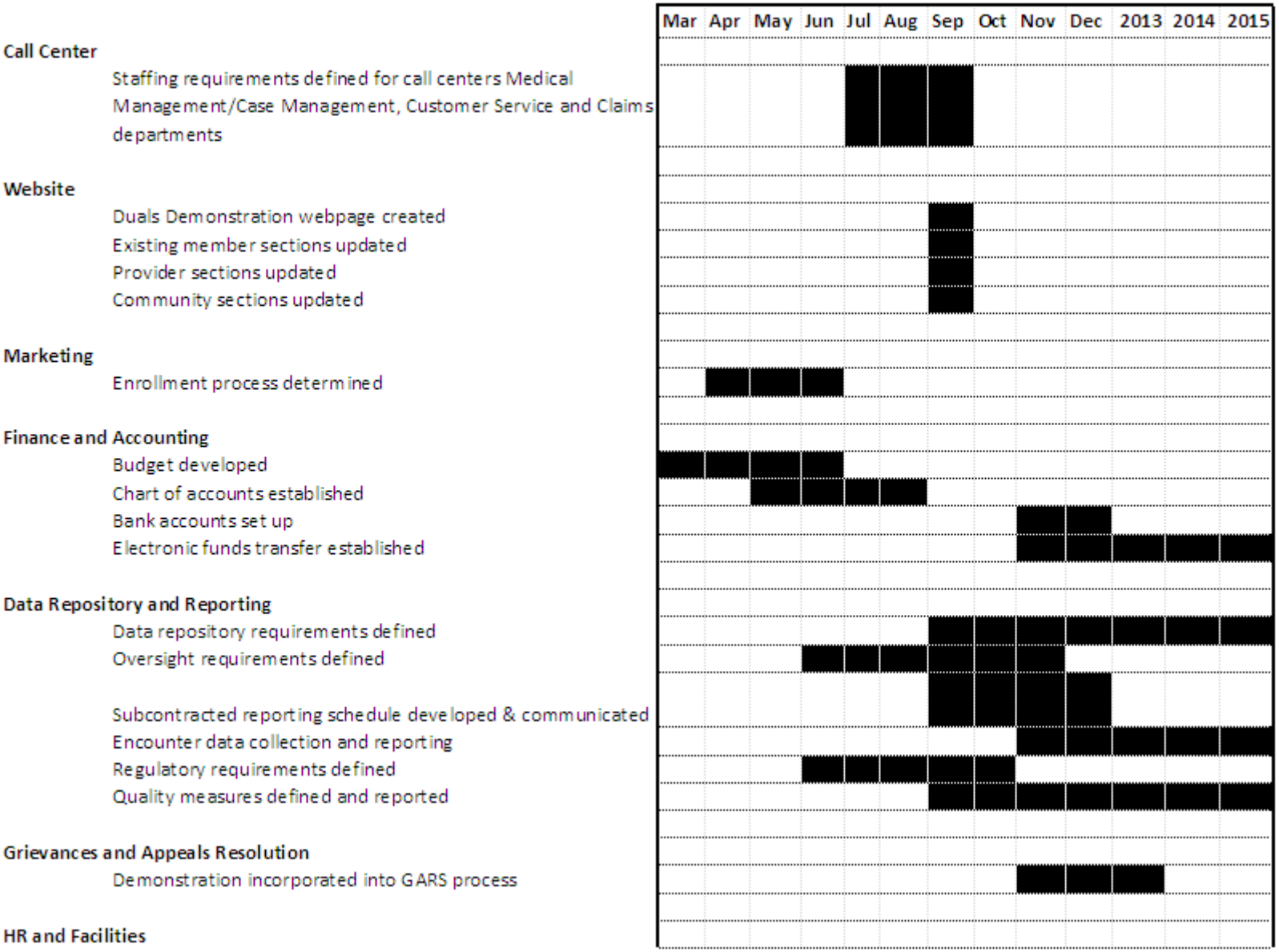


Attachment 11: Preliminary Operational Plan



Attachment 11: Preliminary Operational Plan

Staff up plan developed
Space plan developed
New on-boarding process developed (if needed)
Equipment needs determined (computers, phones, etc)

Communication

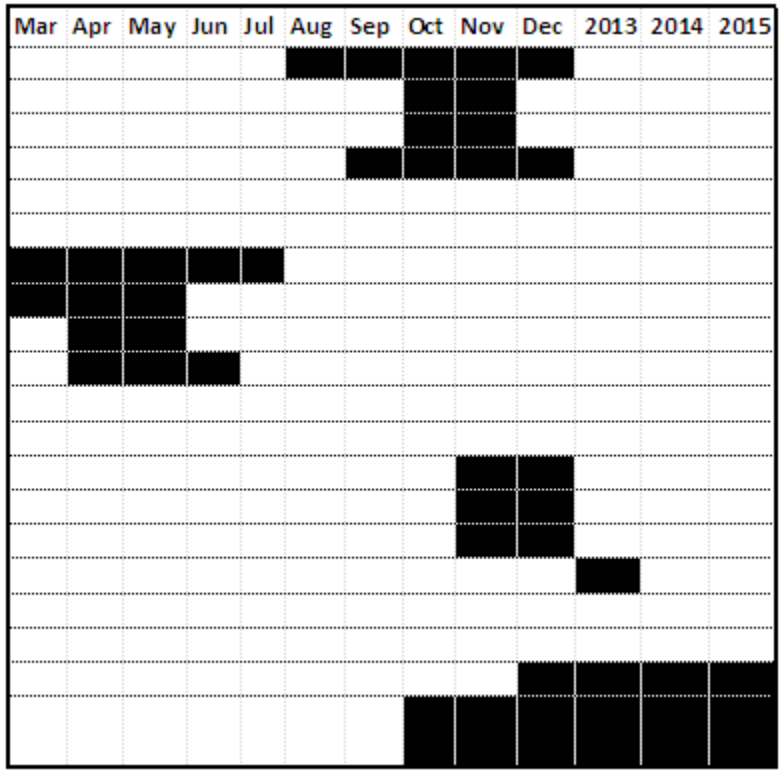
Stakeholder communication plan developed
Contracts communication plan developed
Provider communication plan developed
Marketing and communication plan developed

1/1/2013 Go-Live Implementation and Training

Member trainings conducted
Provider training conducted
Internal staff training conducted
DEMONSTRATION SERVICES BEGIN

Post Go-Live

Training needs re-assessed
Incorporate member, provider and stakeholder feedback into post-implementation plan



Attachment 12: DMHC Letter of Good Financial Standing

DEPARTMENT OF
Managed
Health Care

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

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

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Julie Bomgren
Manager, Government Affairs
CalOptima
1120 West La Veta Avenue
Orange, CA 92868

Re: Letter of Standing – Orange County Health Authority

Dear Ms. Bomgren:

On February 8, 2012, you requested a letter regarding Orange County Health Authority's ("OCHA") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] OCHA 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, OCHA is licensed, and permitted to operate in the State of California, as a Knox-Keene health care service plan.

A review of the Enforcement Action Database shows that there are currently zero enforcement actions involving OCHA. 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 OCHA and OCHA 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 OCHA was issued on October 12, 2009. There were no identified deficiencies from this Routine Medical Survey. The next Routine Medical Survey is due to begin April 17, 2012.

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

Please contact me with any questions or concerns.

Sincerely,

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

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Kelly Gaspar, Division of Licensing
Anna Kyumba, Division of Financial Oversight

Attachment 13: HEDIS 2012 List of Measures

HEDIS 2012 List of Measures
Sorted by Acronym

ACRONYM	Measure	MC	HF	OC	SNP	H/A	CMS Star★	DHCS MC	Accred MC 2010
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	X				A		X	X
AAP	Adults' Access to Preventive/Ambulatory Health Services (AAP)			X		A	★		
ABA	Adult BMI Assessment			X		H	★		
ABX	Antibiotic Utilization (ABX)			X		A			
ADD	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	X				A			X
AMB*	Ambulatory Care (AMB)	X		X		A		X	
AMM	Antidepressant Medication Management (AMM)	X		X	X	A			X
ART	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)			X		A	★		
ASM	Use of Appropriate Medications for People with Asthma (ASM)	X	X			A			X
AWC	Adolescent Well-Care Visits (AWC)	X	X			H		X	
BCR	Board Certification (BCR)			X	X	A			
BCS	Breast Cancer Screening (BCS)	X		X		A	★	M	X
CAB	Call Abandonment (CAB)			X		A			
CAP*	Children and Adolescents' Access to Primary Care Practitioners (CAP)	X	X			A		X	
CAT	Call Answer Timeliness (CAT)			X		A			
CBP	Controlling High Blood Pressure (CBP)	X		X	X	H	★		X
CCS	Cervical Cancer Screening (CCS)	X				H		X	X
CDC	Comprehensive Diabetes Care (CDC)	X		X		H	★	X	X
CHL	Chlamydia Screening in Women (CHL)	X	X			A			X
CIS	Childhood Immunization Status (CIS)	X	X			H		X	X
CMC	Cholesterol Management for Patients with Cardiovascular Conditions (CMC)	X		X		H	★		X
COA	Care for Older Adults (COA)				X	H	★		
COL	Colorectal Cancer Screening (COL)			X	X	H	★		
CWP	Appropriate Testing for Children With Pharyngitis (CWP)	X	X			A			X
DAE	Use of High-Risk Medications in the Elderly (DAE)			X	X	A			
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)			X	X	A			
EBS	Enrollment by State (EBS)			X		A			
ENP	Enrollment by Product Line (ENP)			X		A			
FSP	Frequency of Selected Procedures (FSP)	X		X		A			
FUH	Follow-Up After Hospitalization for Mental Illness (FUH)	X		X	X	A			X
GSO	Glaucoma Screening in Older Adults (GSO)			X	X	A	★		
IAD	Identification of Alcohol and Other Drug Services (IAD)		X	X		A			
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)			X		A			
IMA*	Immunizations in Adolescents (IMA)	X	X			H		X	
IPU	Inpatient Utilization-General Hospital/Acute Care (IPU)	X		X		A			
LBP	Use of Imaging Studies for Low Back Pain (LBP)	X				A		X	X
LDM	Language Diversity of Membership (LDM)			X		A			
LSC	Lead Screening in Children (LSC)	M	X			H		M	

ACRONYM	Measure	MC	HF	OC	SNP	H/A	CMS Star★	DHCS MC	Accred MC 2010
MPM*	Annual Monitoring for Patients on Persistent Medications (MPM)	X		X	X	A	★	X	X
MPT	Mental Health Utilization (MPT)		X	X		A			
MRP	Medication Reconciliation Post-Discharge (MRP)				X	H			
OMW	Osteoporosis Management in Women Who Had a Fracture (OMW)			X	X	A	★		
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			X	X	A			
PCE	Pharmacotherapy Management of COPD Exacerbation (PCE)			X	X	A			
PCR	Plan All-Cause Readmissions (PCR)			X	X	A	★		
PPC	Prenatal and Postpartum Care (PPC)	X				H		X	X
RCA	Relative Resource Use For People with Cardiovascular Conditions (RCA)			X		A			
RCO	Relative Resource Use For People with COPD (RCO)			X		A			
RDI	Relative Resource Use For People with Diabetes (RDI)			X		A			
RDM	Race/Ethnicity Diversity of Membership (RDM)			X		A			
RHY	Relative Resource Use For People with Uncomplicated Hypertension (RHY)			X		A			
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	X		X	X	A	★		X
TLM	Total Membership (TLM)			X		A			
URI	Appropriate Treatment for Children With Upper Respiratory Infection (URI)	X	X			A		M	X
W15	Well-Child Visits in the First 15 Months of Life (W15)	M	X			H		M	
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	X	X			H		X	
WCC	Weight Assessment; Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)	X				H		X	
None	All-Cause Readmission - Statewide Collaborative QIP measure	X				A		X	X

*New to Medi-Cal - was HF or OC previously

**New measure for HEDIS2012 - or new to CalOptima

★ Measure that is used in the CMS Star Ratings

H **Hybrid**

A **Admin**

Attachment 14: NCQA Accreditation Survey Status

Subject: FW: 2011 NCQA HPA Accreditation ASC Confirmation (CA07701)
Attachments: Internet Access Options_updated.doc; 2011 Two-Day On-Site Agenda.docx; 2011 HPA Guidelines for Successful Survey.docx; Hotel Suggestion Form 2011.doc

Importance: High

From: Shaetiah Preston [mailto:SPreston@ncqa.org]
Sent: Monday, January 09, 2012 11:52 AM
To: Lee, Linda
Cc: Amy Veazey
Subject: 2011 NCQA HPA Accreditation ASC Confirmation (CA07701)
Importance: High

Dear Colleague,

Please be advised that **Amy Johnson Veazey** has been assigned to serve as the Accreditation Survey Coordinator (ASC) for **Orange County Health Authority - dba CalOptima**'s upcoming NCQA Accreditation Survey. In this role, **she** will be your primary point of contact at NCQA for any questions related to your survey preparations.

We have reserved the date of **June 11, 2012** for the completed submission of your organization's Interactive Survey System (ISS) tool, and your on-site survey has been scheduled for **August 6 – 7, 2012**. The off-site evaluation and assessment process will take place in the eight weeks preceding your on-site survey. It is critical that you provide all required information as requested.

Approximately five weeks after submission, your ASC will facilitate a conference call between representatives of your organization and the survey team to discuss your Survey Tool (ST) documentation. The conference call is tentatively scheduled to occur **July 16, 2012** at **3:00 PM** eastern time. Please tentatively reserve this date and time. Your ASC will confirm the date and time and also provide further details regarding the call.

If you have not yet purchased a Survey Tool for your applicable product, 2011 Health Plan Accreditation, please contact NCQA to do so immediately.

If you are seeking Health Plan Accreditation for both your MCO and PPO products, upon submission of your completed application, you should have received one or more Health Plan Accreditation Survey Tools. The number of survey tools you receive will depend on a number of factors including whether functions are performed by the same staff for your PPO as well as your MCO product, whether policies and procedures are the same for both products and whether or not both of your products assume the same organization name. Please contact NCQA's Customer Service Department at (888) 275-7585 if you have not received your Health Plan Accreditation Survey Tool(s).

In preparation for this survey, we would like to suggest that you open the ISS and locate the following information:

- In the black navigation bar, click the ***Help & Instructions*** tab. Please read and become familiar with the *General Instructions* and *Instruction for the Standards and Guidelines and Survey Tool* prior to entering information into the survey tool. You may download a printer friendly version of these documents if you wish. Please pay particular attention to information related to uploading documents to NCQA once your Survey Tool is complete. The upload process may take up to several hours and it is important that you plan accordingly in order to meet your submission deadline.

- In the blue navigation bar, click the ***Appendices*** tab and download the *Guidelines for a Successful Survey, UM File Review Instructions, and Credentialing File Review Workbook*

- In the blue navigation bar, click the **Survey Tool** tab and locate *the* ***Complex Case Management*** *file review worksheets and instructions*. The workbook is located under QI 7, elements F & G.

- In the blue navigation bar, click the ***Survey Tool*** tab and locate the ***Measures Workbook*** The workbook is located under QI 7, elements H & I.

- The ***Guidelines for Successful Survey*** provides you with guidance about the overall survey process and timeframes for when documents are due.

- The ***File Review Instructions*** provides you with instructions on how to prepare the information for the file reviews that will take place during your onsite survey. Please review the information and submit it according to the timeframes outlined.

- **Uploading Documents**: Before you submit your survey tool, you must upload all referenced documents. Please refer to the demonstration located under the help & instructions tab within the ISS for uploading documents. This demonstration shows how to upload documents linked to elements in your survey tool from your network to the ISS server.

- The number of **File Review and Delegation Estimate Forms** you need to provide will depend on a number whether functions are performed by the same staff for your PPO as well as your MCO product and whether policies and procedures are the same for both products. If the PPO products are administered differently than your MCO products, you will need to submit two separate forms **(one for each product)** four weeks prior to your submission date.

- The following file reviews will take place during your onsite survey.
  - UM denial
  - Appeal
  - Emergency Room
  - Complex Case Management
  - Credentialing and Recredentialing

- In the blue navigation bar, click the ***Organization Background*** tab and complete the required information for all three tabs prior to ISS submission for **each respective submitted survey tool**

Amy will be working closely with the selected survey team to coordinate all review activities. The names of your survey team and recent work histories will be provided electronically, approximately 10 weeks prior to your planned ISS submission. The surveyors assigned to your survey will remain at your offices for approximately 2 days. We ask that each surveyor be provided with access to the Internet through high-speed access or an analog phone line, source documents related to any delegation oversight, and other materials as indicated.

Again, thank you for electing to participate in an NCQA Accreditation Survey. We look forward to working with you in this process. If you have any questions, please contact **Amy** directly at (304) 421-1701 or email **veazey**@ncqa.org

The following documents are attached:

- **Guidelines for Successful Survey**
- **Sample agenda:** Please return completed draft agenda to your ASC at least 4 weeks prior to submission.
- **Hotel suggestion form:** Please return completed form at least 4 weeks prior to submission.
- **Internet Access Options Questionnaire:** Please return completed form to your ASC at least 4 weeks prior to submission.

Sincerely,

Shaetiah L. Preston
Analyst, Survey Management
NCQA
1100 13th Street, NW
Suite 1000
Washington, DC 20005
(202) 596-9092 (Direct Dial)
(202) 955-3599 (Fax)
spreston@ncqa.org

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Attachment 15: Stakeholder Involvement

Attachment 15 Stakeholder Involvement

CalOptima certifies that it meets three of the five mandatory qualification requirements for stakeholder involvement as demonstrated below.

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

   CalOptima received more than 25 letters of support from the community, indicating broad-based support for CalOptima's participation in the Demonstration. Among the organizations that submitted letters of support are Area Board XI, Orange County IHSS Public Authority, Coalition of Orange County Community Health Centers, CalOptima health networks, Orange County Aging Services Collaborative made up of more than 33 organizations serving older adults, and Dayle McIntosh Center, Orange County's independent living center. CalOptima also received strong letters of support from State Assembly, State Senate, and Congressional offices. Refer to *Attachment 16: Letters of Support*.

2. **The Applicant sought and accepted community-level stakeholder input into the development of the Application, with specific examples provided of how the plan was developed or changed in response to community comment.**

   CalOptima has strong ties with the community and relies on a broad spectrum of stakeholders for input and guidance. During the RFS submission process, CalOptima solicited and obtained much feedback from its stakeholders. More specifically, the plan was developed or changed in the response to stakeholder comment by:

- Working with the Orange County Social Services Agency (SSA) and IHSS Public Authority in developing the approach and response regarding In-Home-Supportive Services;
- Seeking input from the Orange County Community Services regarding ways to work together throughout the Demonstration to improve the coordination of social support services;
- Meeting with the Orange County Health Care Agency in coordinating a response to behavioral health services and begin developing a longer term plan for integration ; and;
- Ensuring that the RFS in both draft and final form were distributed among all stakeholders in the community electronically and through in-person meetings.

The majority of stakeholders expressed their support for the Demonstration, as evidenced by the letters of support attached. Stakeholders also indicated how they would like to work with CalOptima to accomplish the goals of the Demonstration, and also provided suggestions for how to operationalize and implement the Demonstration.

CalOptima will continue to seek and incorporate feedback from stakeholders, and will update and coordinate with stakeholders through regularly scheduled meetings and other open forums.

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

CalOptima undertook a multi-faceted approach to stakeholder involvement to ensure that the broadest possible range of stakeholders was able to partner with CalOptima in the

development of the Demonstration proposal. CalOptima has met with representatives from county agencies, providers, hospitals, nonprofit organizations, member advocates, policy makers, and others. More than 25 meetings were held in January and February 2012 to inform stakeholders about the demonstration and to listen to ideas, input and any concerns about the impact of the Demonstration to Orange County.

CalOptima met with leaders at the County of Orange, including:

- The Honorable Janet Nguyen, Board of Supervisors, First District and member of the CalOptima Board of Directors
- Tom Mauk, County Executive Officer
- Bob Miller, Executive Director, IHSS Public Authority
- Mark Refowitz, Director, Health Care Agency, Behavioral Health Services and his senior staff
- Dr. Michael Riley, Director, Social Services Agency and his senior staff
- Karen Roper, Director, OC Community Services
- Bob Wilson, Deputy Director, Health Care Agency and his senior staff

CalOptima also received valuable input from its provider community, policy-makers, consumers, and community representatives at multiple meetings, including:

- Area Board XI Task Force
- CalOptima Legislative Luncheon
- CalOptima Member Advisory Board meeting
- CalOptima Provider Advisory Board monthly meetings
- CalOptima Health Network meetings

- CalOptima Managed Care meetings organized by the Hospital Association of Southern California
- Community Alliance Forum
- Orange County Aging Services Collaborative
- Orange County Adult Day Services Coalition
- Orange County Medical Association Board meetings
- Partnership for CHOICE meeting

In addition to the meetings listed above, CalOptima sought more in-depth stakeholder feedback through a series of stakeholder interviews. CalOptima contracted with Health Management Associates to conduct 17 stakeholder interviews with a wide range of stakeholders including; CalOptima Board Members, Orange County government leaders, CalOptima providers, member advocates and representatives from community-based organizations that serve older adults and/or persons with disabilities.

The meetings and interviews identified above represent the beginning of CalOptima's activities to obtain community input. CalOptima is fortunate to have strong working relationships with so many community partners and will continue to seek and incorporate their input, and the input of other affected stakeholders, as this process moves forward.

Attachment 16: Letters of Support

ABRAZAR
Embrace · Educate · Empower
7101 Wyoming St. Westminster, CA 92683
Phone: (714) 893-3581 Fax: (714) 893-4819

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

ABRAZAR, Inc. is a thirty-six year old community based organization serving non English and limited English speaking Spanish and Vietnamese individuals throughout Orange County. Our agency has worked with CalOptima since its inception and has been an integral partner in the development of the MediCal managed care model, OneCare and the consolidation of the Multipurpose Senior Services Program for seniors. Ninety percent of the populations we serve at our two community centers are MediCal and Medicare recipients. CalOptima's efforts to integrate dual eligibles would greatly benefit thousands of our children, adults and seniors.

ABRAZAR
Embrace · Educate · Empower
7101 Wyoming St. Westminster, CA 92683
Phone: (714) 893-3581 Fax: (714) 893-4819

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Gloria O. Reyes
President and CEO

Area Board XI

Office of the California State Council on Developmental Disabilities

To protect and advocate for the civil, legal and service rights of persons with developmental disabilities.

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

On behalf of Area Board XI, I am writing to express our strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Area Board XI is the Orange County office of the state and federally-funded California State Council on Developmental Disabilities. The area boards, created in 1969 by the California legislature, are mandated to protect and advocate for the civil, legal and service rights of people with developmental disabilities and their families.

Area Board XI has worked with CalOptima since it began serving Orange County residents and has found its staff to be dedicated, effective, enthusiastic, and committed to its members and its mission. CalOptima's collaborative spirit and work on behalf of the community has

resulted in substantive improvements in the ability of people with disabilities to access timely and appropriate medical care. A core member and active participant of Area Board XI's Health Care Task Force since its inception, CalOptima's responsiveness to medical issues critical to people with developmental disabilities and their families has made a substantive difference in the lives of this traditionally underserved community.

Area Board XI fully supports CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. We look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County

Sincerely,

Susan Eastman
Executive Director
Area Board XI

2000 E. Fourth Street, Suite 115, Santa Ana, CA 92705 Tel.: 714.558.4404 Fax: 714.558.4704 Email: abxi@pacbell.net

Arta
Western Medical Group

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I have worked closely with CalOptima since 1996 as the V.P. of Medical Management of Arta Western. I have extensive knowledge of CalOptima's infrastructure and their ability to manage and care for frail, disabled members who require complex coordination and management of care. CalOptima has been identifying opportunities for taking steps towards integration during their entire history and this move is a natural next step in a process that makes sense for the frail members in our community.

Arta
Western Medical Group

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Karen Brandenburg, RN, BSN
V.P. of Medical Management
Arta Western Medical Group

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FAX (909) 627-1841

Assembly
California Legislature

CURT HAGMAN
ASSISTANT REPUBLICAN LEADER
ASSEMBLYMAN, SIXTIETH DISTRICT

COMMITTEES
INSURANCE
JUDICIARY
PUBLIC SAFETY
RULES

JOINT COMMITTEES
JOINT LEGISLATIVE AUDIT

February 9, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

A dream of mine is to see a comprehensive integrated and coordinated care system for our dual eligible population – with an option to opt out if desired. A system that will meet all of the member's needs – including, but not limited to, routine health services, mental and behavioral health, as well as personal needs. Through this demonstration project, it is my hope that health care costs will be reduced with no cost-sharing need from the member.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Curt Hagman
California State Assembly, 60th Assembly District

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0073
(916) 319-2073
FAX (916) 319-2173

WEBSITE
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Assembly
California Legislature

DIANE L. HARKEY
ASSEMBLYWOMAN, SEVENTY-THIRD DISTRICT

COMMITTEES
VICE CHAIR: APPROPRIATIONS
BANKING AND FINANCE
BUDGET
PUBLIC EMPLOYEES, RETIREMENT AND SOCIAL SECURITY
REVENUE AND TAXATION

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Diane L. Harkey
Assemblywoman, 73rd District

ORANGE COUNTY OFFICE • 29122 RANCHO VIEJO RD., SUITE 111 • SAN JUAN CAPISTRANO, CA 92675 • (949) 347-7301 • FAX (949) 347-7302
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Assembly
California Legislature

ALLAN R. MANSOOR
ASSEMBLYMEMBER, SIXTY-EIGHTH DISTRICT

COMMITTEES
CO-CHAIR: LEGISLATIVE ETHICS
VICE CHAIR: PUBLIC EMPLOYEES, RETIREMENT AND SOCIAL SECURITY
BUDGET
BUDGET SUBCOMMITTEE #1, HEALTH AND HUMAN SERVICES
HEALTH

February 14, 2012

Toby Douglas
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Toby,

On behalf of the constituents of the 68th Assembly District, I would like to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

As a member of the Assembly Health Committee, I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County. If you have any further questions or concerns, you can contact either myself or my staff at (714) 668-2100 or send an email to Assemblymember.Mansoor@assembly.ca.gov.

Sincerely,

Allan R. Mansoor
Assemblymember, 68th District

Tony Mendoza ASSEMBLYMEMBER FIFTY-SIXTH DISTRICT

California Legislature

February 16, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

I am writing to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima currently has in place many of the components you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site.

CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the best performing Medi-Cal managed care plans in quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Since I took office, my staff has worked closely with CalOptima. On a monthly basis, CalOptima hosts legislative briefings where they inform all Orange county stakeholders of their operations and current legislative updates. CalOptima has demonstrated excellent member care and always works well with their members, providers, elected representatives and outside agencies to address our constituent concerns to better improve their services. My office works with many health organizations from both Los Angeles and Orange Counties and I can think of no other organization more deserving than CalOptima to receive the dual eligible demonstration project.

CAPITOL OFFICE: STATE CAPITOL, P. O. BOX 942849, SACRAMENTO, CA 94249-0056 (916) 319-2056 FAX (916) 319-2156
DISTRICT OFFICE: 12501 E. IMPERIAL HIGHWAY, SUITE 210 NORWALK, CA 90650 (562) 864-5600 FAX (562) 863-7466
E-MAIL: assemblymember.mendoza@assembly.ca.gov **WEB SITE:** www.assembly.ca.gov/mendoza

Tony Mendoza ASSEMBLYMEMBER FIFTY-SIXTH DISTRICT

California Legislature

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

TONY MENDOZA
Assemblymember

TM:yo

CAPITOL OFFICE: STATE CAPITOL, P. O. BOX 942849, SACRAMENTO, CA 94249-0056 (916) 319-2056 FAX (916) 319-2156
DISTRICT OFFICE: 12501 E. IMPERIAL HIGHWAY, SUITE 210 NORWALK, CA 90650 (562) 864-5600 FAX (562) 863-7466
E-MAIL: assemblymember.mendoza@assembly.ca.gov **WEB SITE:** www.assembly.ca.gov/mendoza

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FAX (714) 526-7278

Assembly
California Legislature

CHRIS NORBY
ASSEMBLYMAN, SEVENTY-SECOND DISTRICT

COMMITTEES
VICE CHAIR, EDUCATION
APPROPRIATIONS
TRANSPORTATION
JOINT LEGISLATIVE AUDIT
LOCAL GOVERNMENT

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

As a member of the Orange County Board of Supervisors for seven years, I was impressed with the quality and efficiency of services provided by the highly-professional staff at CalOptima. Since my election to the Assembly in 2010, CalOptima has only further reinforced my respect for the high level of performance they provide to Orange County's families, seniors and persons with disabilities.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Chris Norby

CHRIS NORBY
Assemblyman, 72nd District

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0067
(916) 319-2067
FAX (916) 319-2167

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HUNTINGTON BEACH, CA 92647
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FAX (714) 843-8375

Assembly
California Legislature

JIM SILVA
ASSEMBLYMEMBER, SIXTY-SEVENTH DISTRICT

COMMITTEES
VICE CHAIR, RULES
MEMBER
ARTS, ENTERTAINMENT, SPORTS, TOURISM AND INTERNET MEDIA
ETHICS
GOVERNMENTAL ORGANIZATION
HEALTH

February 13, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception,CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Jim Silva

Jim Silva,
California State Assemblymember

1200 N. Knollwood Circle
Anaheim, CA 92801
714-220-0224
Fax 714-220-1374
www.CommunitySeniorServ.com

community SENIOR SERV™
Helping maintain independence & well-being

February 22, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has many of the components that you wish to include in the Demonstration Project in place. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Community SeniorServ works with CalOptima as a community partner serving low income older adults as well as ADHC transition planning and as a community referral partner on the Aging & Disability Resource Center

United Way

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Holly Hagler
Chief Executive Officer

LORETTA SANCHEZ
47TH DISTRICT, CALIFORNIA

WASHINGTON OFFICE
1114 LONGWORTH BUILDING
WASHINGTON, DC 20515-0546
(202) 225-2965
(202) 225-5859 FAX

DISTRICT OFFICE
12397 LEWIS STREET, SUITE 101
GARDEN GROVE, CA 92840-4695
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(714) 621-0401 FAX

E-mail:
Loretta@mail.house.gov

Website:
www.house.gov/sanchez

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEES:
RANKING MEMBER, STRATEGIC FORCES
EMERGING THREATS AND CAPABILITIES
OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON HOMELAND SECURITY
SUBCOMMITTEES:
BORDER AND MARITIME SECURITY
COUNTERTERRORISM AND INTELLIGENCE

JOINT ECONOMIC COMMITTEE

February 15, 2012

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

Re: Congressional Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

As the U.S Congresswoman representing California's 47th District, it is my pleasure to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that are to be included in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site.

CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to seeing the implantation of this important program in Orange County, for CalOptima and most importantly the clients it serves.

Sincerely,

Loretta Sanchez
Member of Congress

DAYLE MCINTOSH
DISABILITY RESOURCE CENTERS
Changing Lives One at a Time

February 8, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

For more than 35 years, Dayle McIntosh Center (DMC) has been a leading advocacy organization for persons with disabilities living in Orange County. DMC provides a comprehensive array of services focused on fully integrating disabled persons into the community. In addition, DMC has worked very closely with Cal Optima with the ADRC grant to provide significant experience in developing, organizing and facilitating educational public forums and strategic planning meetings for consumers and community groups.

As the County Organized Health System for Orange County, CalOptima provides Medi-Cal benefits to more than 375,000 beneficiaries, including more than 53,000 persons with disabilities. Dayle McIntosh Center fully supports CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Dolores Kollmer
Executive Director
Dayle McIntosh Center

February 13, 2012

Toby Douglas, Director
California Department of Health Care Services
Post Office Box 997413
Sacramento, California 95899-7413

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

From the beginning, CalOptima has been diligent to take careful and incremental steps to promote integration across the continuum of care. CalOptima has in place many of the components that should be included in the Demonstration Project.

>CalOptima's Medicare Advantage Speical Needs Plan, OneCare, provides care for nearly 13,000 of Orange County's dual eligibles.

>CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County.

>Cal Optima is the lead agency for the county's Aging and Disability Resource Center (ADRC).

>Cal Optima is the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange.

>Cal Optima will soon open Orange County's first Program of All Inclusive Care for the Elderly (PACE) site.

As a member of the CalOptima Member Advisory Board, I am proud to state that CalOptima is recognized throughout the state and nationally as a model for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Family Support Network serves over 7,800 individuals a year, the vast majority of which have either Medi-Cal or Healthy Families Insurance through CalOptima. As we serve families who have children with special needs, it is very important that these very needy children receive appropriate health care. CalOptima strives to provide quality, coordinated care. For the past several years, I have worked on several subcommittees and served on the Member Advisory Committee and have continually been impressed with the concern CalOptima has for its members and its willingness to listen to consumer input.

I fully support CalOptims's application and look forward to working with CalOptima staff to develop a model that meets the needs of Orange County residents.

Sincerely,

Linda M. Smith
Executive Director

181 W. Orangethorpe Ave
Suite D
Placentia, CA 92870
Phone: (714) 854-7762
Fax: (714) 854-7765
fsnca@sbcglobal.net
familysupportnetworkca.com

Federal Tax ID #: 33-0248195

GOODWILL OF ORANGE COUNTY
The Face of Independence

410 North Fairview
Santa Ana, CA 92703

voice: 714.547.6301
tty/tdd: 714.543.1873
fax: 714.541.6531

ocgoodwill.org
shopgoodwill.com

February 10, 2012

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

Re: CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express our strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions. Goodwill of Orange County (Goodwill) sees multiple benefits under this project for our community.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Goodwill is a long time community partner with CalOptima. The people we serve are recipients of CalOptima's excellent service coordination. In addition we regularly partner with CalOptima on various projects to further improve the health of our community.

On behalf of our organization I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Dan S. Rogers
President & CEO

Grove Harbor Medical Center Pharmacy
12555 Garden Grove Blvd., #102
Garden Grove, Ca 92843
FAX (714) 636-7708
(714) 636-0593

Feb. 16, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demo Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I am a member of the CalOptima Medical Provider Advisory Committee representing the Pharmacists in Orange County. I am supportive of efforts to integrate care for the dual eligible populations.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

John L. Silberstein
Owner, R.PH.

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

On behalf of the CalOptima Member Advisory Committee (MAC), I am pleased to provide this letter of support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions. The MAC is comprised of dedicated **professionals** within the Orange County health care community. The goal of the MAC is to provide recommendations, review programs, and discuss how CalOptima can best fulfill its mission from the member's perspective.

CalOptima already has in place many of the components that you wish to include in the Demonstration Project. **MAC committee members know firsthand the importance of providing integrated services to its most vulnerable members.**

CalOptima's programs already serving vulnerable populations include the Medicare Advantage Special Needs Plan, OneCare, the Multipurpose Senior Services Program (MSSP), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations.

As the MAC Chair, I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Roseanne Kotzer, MSW, ASW

Roseanne Kotzer
Chair, CalOptima Member Advisory Committee

Gloria Reyes
Member, CalOptima Member Advisory Committee

Monarch HealthCare®
A Medical Group, Inc.

February 14, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

CalOptima has worked diligently for many years to integrate programs that deliver high quality healthcare services. Today, CalOptima offers these services to over four hundred thousand Med-Cal and thirteen thousand OneCare Medicare Advantage Special Needs (SNP) members. Monarch HealthCare is a large Independent Practice Association (IPA) headquartered in Irvine, California aligned with over 2,300 physicians who care for approximately 200,000 HMO and FFS members throughout Orange County, California including 25,000 Medi-Cal and 6,000 OneCare SNP members.

Monarch is an industry leader and has participated in numerous innovative programs designed to deliver higher quality, more efficient healthcare services for Medicare and Commercial beneficiaries. Most recently, Monarch was selected by the Center for Medicare and Medicaid Innovation to participate as one of only 32 "Pioneer Accountable Care Organizations" nationally. As a leader, we recognize the healthcare delivery system must change to provide healthcare services in a more effective and less costly manner.

We support CalOptima's efforts to integrate the dual eligible beneficiaries of Orange County under their model and are committed to supporting CalOptima to meet the deadlines and requirements. By combining the full continuum of services under a single benefit package, and delivering services through an organized coordinated delivery system, accountability and efficiencies will be achieved. Moreover, member satisfaction and enhanced health outcomes should be realized while moving patients from the institutional setting to home and community-based resources.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima, in conjunction with coordinated care delivery

systems like Monarch, has in place many of the components that you wish to include in the Demonstration Project.

We fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligible beneficiaries. We are excited about participating in this demonstration, and will assist CalOptima to develop a model that meets the specific needs of Orange County and the people we serve.

Sincerely,

Jay J. Cohen, MD
Executive Chairman
Monarch HealthCare, A Medical Group, Inc.

Orange County
Aging Services
COLLABORATIVE

OCASC Member Agencies Include:

ABRAZAR, Inc.

Acacia Adult Day Services

Age Well Senior Services

AltaMed Health Services

Alzheimer's Association, Orange County Chapter

Alzheimer's Family Services Center

Caregiver Resource Center – Orange

Community SeniorServ, Inc.

Council on Aging – Orange County

Irvine Health Foundation

OC Adult Day Services Coalition

Rebuilding Together – Orange County

Saint Jude Medical Center/Senior Center

South County Adult Day Services

UCI MIND

February 8, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

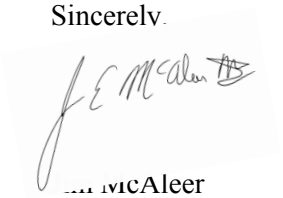
The purpose of this letter is to express our strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

Our mission is to create and maintain an integrated network of services that address the needs of older adults and their caregivers in Orange County. CalOptima has been an active member of the Collaborative since our inception. They have worked on every project the Collaborative has ever taken on.

We fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. We look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,



Jim McAleer
OCASC Facilitator

oc adult day services coalition
trusted solutions for care

A Day Away Adult Day Health Care – La Mirada

Acacia Adult Day Services – Garden Grove

AltaMed Adult Day Health Care – Cypress

Alzheimer's Family Services Center – Huntington Beach

Commonwealth Adult Day Health Care Center – Buena Park

Community SeniorServ, Inc. (CSS) Adult Day Health Care Centers
- CSS – Anaheim
- CSS – Santa Ana/Tustin
- CSS – Buena Park Senior Day Care Center

Easter Seals Senior Adult Day Services – Brea

Irvine Adult Day Health Services – Irvine

Mount of Olives Senior Day Care Center – Mission Viejo

Regent West Adult Day Health Care Center – Santa Ana

Rehabilitation Institute of Southern California (RIO) Adult Day Health Care Centers
- RIO – Fullerton
- RIO – Orange

Leo Fessenden Adult Day Health Care Center – San Clemente

Sarang Adult Day Health Care – Cypress

South County Adult Day Services – Laguna Woods

Sultan Adult Day Health Care – Anaheim

Wise Silver Center – Santa Ana

February 7, 2012

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

RE: CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

I am writing on behalf of twenty adult day services programs who make up the membership of the OC Adult Day Services Coalition here in Orange County. Combined, our Centers serve over 2,000 frail elders and disabled adults. As you can imagine we are hopeful that the new CBAS Program will be successfully transferred to CalOptima. Our members have been partnering with CalOptima for years, and feel that CBAS will be successfully implemented by CalOptima. Most importantly, those we serve will be well treated and get the care they need and deserve.

The purpose of this letter is to express our support for CalOptima becoming a Dual Eligible Demonstration Project. We are aware that CalOptima is submitting a Request for Solutions. Though there are still questions to be answered, we know from experience that CalOptima has the leadership, experience and commitment to make the Project successful -- both for the State and for the people who will be served.

CalOptima has worked toward integration of services for many years and has a readiness to implement this Demonstration Project. We believe their One Care program is an excellent illustration of their ability to serve this population successfully. This, combined with CalOptima's successful coordination of the Multipurpose Senior Services Program (MSSP), implementation of the Aging and Disability Resource Center, and the now-forming wonderful PACE program all indicate strong leadership and excellent management. CalOptima has the ability to not only create a vision, they can make it happen. Lastly, but certainly not least,

CalOptima is truly a community partner; their focus is always about working with, as well as for, the community.

On behalf of all of our Centers, please accept our unqualified support for Orange County's CalOptima to become a Dual Eligible Demonstration Project in order to help us develop a model that meets the needs of our vulnerable populations in Orange County.

Sincerely,

Mallory Vega

Mallory Vega, President
OC Adult Day Services Coalition

C OC Adult Day Services Board of Directors

the Coalition
of Orange County Community Health Centers

Members:

AltaMed Health Services, Inc.

Birth Choice Health Clinics

Camino Health Center

Central City Community Health Center

CHOC Health Clinics

Children's Health Initiatives of OC

F.A.C.E.S., Inc.

Friends of Family Health Center

The Gary Center

Healthy Smiles for Kids of Orange County

HOPE Clinic - NMUSD

HURTT Family Health Center

La Amistad/Puente a La Salud Health Centers

Laguna Beach Community Clinic

Lestonnac Free Clinic

Livingstone CDC

Nhan Hoa Comprehensive Health Center

Planned Parenthood of Orange & San Bernardino Counties

Serve The People Community Health Center

Share Our Selves Free Clinic

Sierra Health Center

St. Jude Healthy Communities

UCI Family Health Centers

VNCOC /Asian Health Center

February 17, 2011

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan and OneCare already provide coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE). CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

The Coalition of Orange County Community Health Centers (the Coalition) is a consortium of safety net providers and key partners creating quality healthcare for vulnerable, underserved communities. The Coalition was founded in 1974. We are a non-profit organization designed to support and strengthen Orange County's network of licensed community clinics. For 38 years, the Coalition has served as a membership organization for freestanding, mobile community based non-profit clinics offering a forum in which clinic leaders can share ideas and concerns, as well as advocate for their patients and the health care services they provide.

Isabel Becerra
Chief Executive Officer

17701 Cowan, Suite 220, Irvine, CA 92614 • P: 949.486.0458 • F: 949.486.0425
www.ForHealthyOC.org

In preparation for the implementation of health reform, CalOptima has continually developed as a strong partner; particularly in the area of the primary care medical home model, healthcare technology, and effective and cost-efficient delivery of services. This opportunity would allow CalOptima to expand the range and depth of healthcare services to the individuals and communities we serve together.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Isabel Becerra
Chief Executive Officer
Coalition of Orange County Community Health Centers

Orange County IHSS Public Authority

1505 E. Warner Ave. Santa Ana, CA 92705 Phone: 714 825-3174 Fax: 714 835-3001

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

The OC IHSS Public Authority (PA) has been participating with CalOptima for the last 8 years in varying ways, discussing and giving guidance on implementing ideas, organizational structures and development; that may one day have a significant Long Term impact on the Services and Programs Seniors and Persons with Disabilities (SPD) use and need in order to live as independently as possible, for as long as possible and avoid the high cost of institutionalized care.

The basic functions of the OC IHSS PA are to Comply with WIC Section 12300, et seq. and Title 1, Division 7, Section 1-7-1 et seq. of the Codified Ordinances of the County of Orange; Act as the "employer of record" for IHSS individual providers (IPs) serving the IHSS recipients, for the purposes of collective bargaining only; Provide assistance to IHSS recipients in finding IPs through the establishment of a Registry;

Orange County IHSS Public Authority

Investigate qualifications and background of potential IHSS Registry providers as permitted by law and maintain Department of Justice (DOJ) records in accordance with DOJ policies and procedures. We assure compliance with all applicable Federal, State and local laws, regulations and codes.

The PA conducts all IHSS Program Provider Enrollment on behalf of the Orange CountyIHSS Program in accordance with instructions received from the CDSS and SSA. This includes, but may not be limited to:

Distribute Provider Enrollment forms to providers to complete;

Review Provider Enrollment forms submitted by providers for completeness and correctness;

Review and copy provider identification;

Conduct required Provider Orientation;

Obtain signed Provider Enrollment Agreement from providers who attend orientation;

Distribute instructions and forms required for IHSS providers to be fingerprinted and undergo criminal background check by the California Department of Justice (DOJ);

Enter data into Case Management, Information, and Payrolling System (CMIPS) as required;

Provide adequate administrative, supervisory and support personnel to carry out the provisions of this Agreement;

Provide COUNTY with information needed in preparing the COUNTY's billing to the CDSS for State and Federal share of AUTHORITY costs. This information will be provided within five (5) business days of the request;

Submit monthly reports regarding implementation of provider enrollment activities on a form approved by COUNTY by the fifteenth (15th) business day following the month of service delivery;

Assist COUNTY in developing and submitting to the CDSS and the California Department of Health Services (CDHS) materials required for CDSS and CDHS approval of AUTHORITY budget;

Perform all services required under this Agreement within the standards of the Performance Measures developed by the IHSS Advisory Committee and approved by COUNTY;

Consult with, and provide staff support to, the IHSS Advisory Committee;

Provide recipient input into AUTHORITY program and policy development through the IHSS Advisory Committee; and

Hire staff as approved in AUTHORITY budget following AUTHORITY's Personnel Rules developed and maintained by COUNTY's County Executive Office/Human Resources. AUTHORITY's Executive Director shall have the authority to employ and terminate AUTHORITY staff.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Robert Miller

Robert Miller, Executive Director

Rhys Burchill
21081 White Horse Lane
Huntington Beach, CA 92646-7050
714) 536-3578 rburchill@socal.rr.com

February 9, 2012

Toby Douglas
Director, California Department of Health Care Services
1501 Capitol Avenue, MS0000
Sacramento, CA 95899-7413

Dear Mr. Douglas,

I write to extend my full support for CalOptima's Application for the CA Dual Eligible Demonstration Project.

I am the parent of a daughter who has Rett syndrome and is a beneficiary of both Medi-Cal and Medicare. I am also a retired professional who, 20 years ago, conducted a study concerning how responsive Medi-Cal was in meeting the needs of persons who are developmentally disabled. Bottom line: medically related publicly funded benefits having a criteria of "medical necessity" were not designed to serve persons with chronic, unique medical conditions. Persons with developmental disabilities do not "improve'" nor do they conveniently die. They are living and each often requires multiple medical experts, more time and better communication. The "medical necessity" criteria in no way relates to the adoption, nationally, of public policy that promotes closure of institutions and emphasizes maximum independence in our communities.

Sixteen years ago I didn't expect much from CalOptima. In fact, adding "managed care" to a system that was abysmal at best, Orange County's community of advocates banded together to seek out and locate every single flaw in a new managed health care system we felt sure would be worse than even the most critical could envision.

There were barriers. But, we were amazed to find that CalOptima actually seemed to want to sincerely work with us and there also appeared to be genuine concern about individuals who had previously experienced physicians who would not talk to them … some parents confided to me that their child had never been physically touched by their specialist.

We are committed to ensure that CalOptima will be the best Dual's Demonstration Project in California. This is based upon what we have seen CalOptima do during the past 16 years.

Sincerely,

Rhys Burchill

CAPITOL OFFICE
STATE CAPITOL
ROOM 5052
SACRAMENTO, CA 95814
TEL 916-651-4034

DISTRICT OFFICE
2323 NORTH BROADWAY
SUITE 245
SANTA ANA, CA 92706
TEL 714-558-4400
FAX 714-558-4111

SENATOR.CORREA@SENATE.CA.GOV

California State Senate

SENATOR LOU CORREA

THIRTY-FOURTH SENATE DISTRICT

COMMITTEES
CHAIR
PUBLIC EMPLOYMENT AND RETIREMENT
SELECT COMMITTEE ON CALIFORNIA-EUROPEAN TRADE
SELECT COMMITTEE ON MANUFACTURED HOMES AND COMMUNITIES
SELECT COMMITTEE ON YOUTH EMPOWERMENT AND YOUTH SERVICES AND GANG PREVENTION
VICE-CHAIR
VETERANS AFFAIRS
MEMBER
BANKING, FINANCE AND INSURANCE
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

February 8, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

I am writing to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

CalOptima serves vulnerable populations in Orange County with Medi-Cal and Medicare. CalOptima provides various coordinated care programs such as the: Multipurpose Senior Services Program site for Orange County's Aging and Disability Resource Center, the Medi-Cal Behavioral Health Administrative Services Organization for Orange County, and is on its way to opening Orange County's first Program of All Inclusive Care for the Elderly site. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures.

I have collaborated with CalOptima through their Community Alliance Program which brings together community-based organizations, health care providers, policy makers, and other individuals/organizations that care about community health.

I strongly support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Luis Correa

LOU CORREA
California State Senator, 34th District

DEPUTY CHIEF OF STAFF
CYNTHIA QUIMBY

CONSULTANTS
KEVIN GILHOOLEY
EMANUEL PATRASCU
WADE PENG
BETTY JO WOOLLETT

California State Senate

TOM HARMAN
SENATOR
THIRTY-FIFTH SENATE DISTRICT

COMMITTEES
RULES
VICE CHAIR
JUDICIARY
VICE CHAIR
PUBLIC SAFETY
TRANSPORTATION
& HOUSING

February 17, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

On behalf of the constituents of 35th Senate District, I am pleased to extend my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site.

Additionally, CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Tom Harman

TOM HARMAN
Senator, 35th District

CAPITOL OFFICE: STATE CAPITOL • SACRAMENTO, CA 95814 • TEL (916) 651-4035 • FAX (916) 445-9263
DISTRICT OFFICE: 950 SOUTH COAST DRIVE, SUITE 240 • COSTA MESA, CA 92626 • TEL (714) 957-4555 • FAX (714) 957-4560

St. Jude Medical Center
ST JOSEPH HEALTH SYSTEM

February 15, 2012

101 East Valencia Mesa Dr.
Fullerton, California 92835-3875
714.871.3280 **Tel**

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligibles. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

I am a member of the CalOptima Medical Provider Advisory Committee representing the Community Health Centers of Orange County and oversee the St. Jude Medical Center Community Clinics. Representing primary care safety net providers for underserved persons in the County, I am supportive of efforts to integrate care for the dual eligible populations.
I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Barry Ross

Barry Ross, RN, MPH, MBA
CalOptima Medical Provider Advisory Committee Member
Vice President, Healthy Communities, St. Jude Medical Center

UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

Center of Excellence in Elder Abuse and Neglect

Program in Geriatrics
101 The City Drive South
Bldg 200, Ste 835, Rt 81
Orange, CA 92868

February 21, 2012

Sandra Rose
CalOptima
1120 West LaVeta Ave., Suite 200
Orange, CA 92868

Dear Ms. Rose:

The University of California, Irvine's Center of Excellence (CoE) on Elder Abuse and Neglect is pleased to support the application of CalOptima for California's Dual Eligible Demonstration Project.

CalOptima is a strong partner to the Center of Excellence on Elder Abuse and Neglect. They are a member of our Orange County Coalition on Elder Abuse Prevention, have participated in several elder abuse prevention outreach programs sponsored by UCI, and have shown their support of our work in numerous other ways. We are happy to show our support of them in this letter.

When, in our work, we need reliable, quick and up-to-date information on aging and disability resources in Orange County, we turn to CalOptima's ADRC. They have an excellent reputation. We have appreciated their commitment to elder and disabled adult abuse prevention. We look forward to continuing to work alongside CalOptima to insure that older adults and adults with disabilities in Orange County live with dignity and without abuse or neglect.

Thank you.

Sincerely,

Mary Twomey

Mary Twomey, MSW
Co-Director
Center of Excellence
On Elder Abuse & Neglect

Kerry Burnight, Ph.D.

Kerry Burnight, Ph.D.
Chair, Orange County Elder Abuse Coalition
Co-Director, Elder Abuse Forensic Center

Date February 22, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

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The United Care Medical Group is one IPA which has had contract with CalOptima since 1995 to provide Health Care for Medi-Cal patients, Healthy Families and One Care in few months.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Cau Van Vo, MD., FACOG
President of United Care Medical Grou

Family Choice Medical Group

7631 Wyoming St., Suite 201 - Westminster, CA 92683
Tel: (714) 898-0765 ▪ Fax: (714) 898-0610

February 22, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

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The purpose of this letter is to express my strong support for CalOptima's application for California's Dual Eligible Demonstration Project Request for Solutions.

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Family Choice Medical Group has been dedicated to providing the highest level of commitment and support for its physicians since 1984. We provide the community with high quality health care in a courteous, compassionate manner to enhance the quality of life. We have been working with CalOptima for the past 18 years.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligibles and other vulnerable populations. I look forward to working with CalOptima and its partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Toan Q. Tran, M.D.
President

Attachment 17: Roster of Public Agencies Filing

State of California
Secretary of State

STATEMENT OF FACTS
ROSTER OF PUBLIC AGENCIES FILING
(Government Code section 53051)

FILED
In the office of the Secretary of State
of the State of California
NOV 23 2011
(Office Use Only)

Instructions:

1. Complete and mail to: Secretary of State, P.O. Box 942877, Sacramento, CA 94277-0001 (916) 653-3984
2. A street address must be given as the official mailing address or as the address of the presiding officer.
3. Complete addresses as required.
4. If you need additional space, attach information on an 8½" X 11" page, one sided and legible.

New Filing ☐ Update ☑

Legal name of Public Agency: Orange County Health Authority

Nature of Update: New Board Member

County: Orange

Official Mailing Address: 1120 West La Veta Avenue, Suite 200, Orange, CA 92868

Name and Address of each member of the governing board:

Chairman, President or other Presiding Officer (Indicate Title): Chairman

Name: Edward Kacic Address: 1120 West La Veta Avenue, Suite 200, Orange, CA 92868

Secretary or Clerk (Indicate Title): Clerk

Name: Suzanne Turf Address: 1120 West La Veta Avenue, Suite 200, Orange, CA 92868

Members:

Name: (See Attached) Address:
Name: Address:
Name: Address:
Name: Address:
Name: Address:

RETURN ACKNOWLEDGMENT TO: (Type or Print)

NAME: CalOptima
ADDRESS: ATTN: Suzanne Turf, Clerk of the Board
1120 W. La Veta Avenue, Suite 200
CITY/STATE/ZIP: Orange CA 92868

November 14, 2011
Date

Signature

Suzanne Turf, Clerk of the Board
Typed Name and Title

SEC/STATE NP/SF 405 (REV. 05/09)

Attachment to:
Statement of Facts, Roster of Public Agencies Filing
Orange County Health Authority

NATURE OF UPDATE (Continued):

Board Member	Address
Chung The Bui, M.D.	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Mary Anne Foo	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Edward Kacic	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Jim McAleer	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Adriana Moreno	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Janet Nguyen Orange County Board of Supervisors, First District	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Lee Penrose	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Margarita Pereyda, M.D.	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
David L. Riley	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868
Alternate Board Member: John M. W. Moorlach, C.P.A. Orange County Board of Supervisors, Second District	1120 W. La Veta Avenue, 2nd Floor, Orange, CA 92868

I hereby certify that the foregoing transcript of 2 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

DEC 20 2011

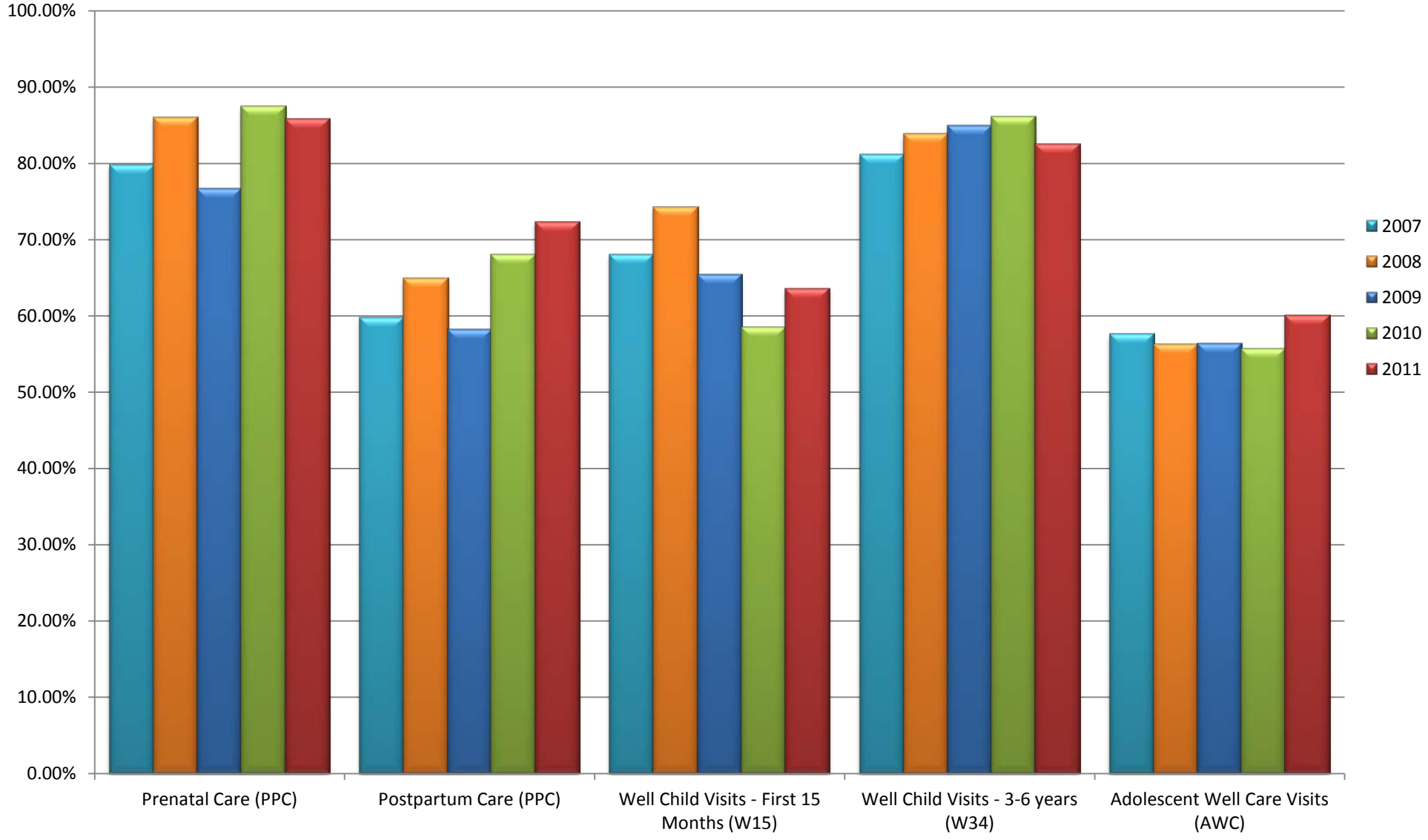
Date: _____

Debra Bowen

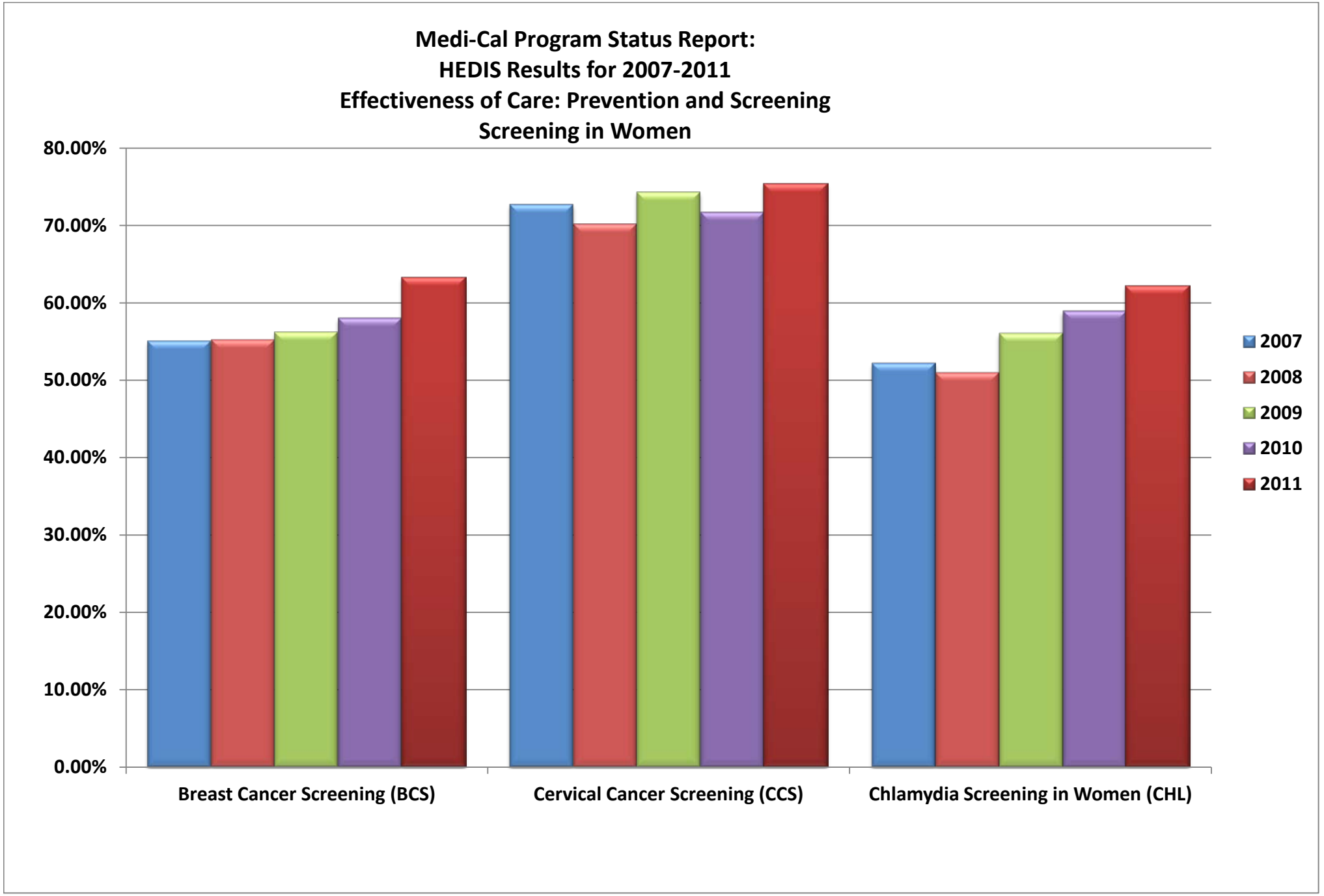
DEBRA BOWEN, Secretary of State

Attachment 18: HEDIS Trend Results

Medi-Cal Program Status Report:
HEDIS Results for 2007 - 2011
Access/Availability of Care (PPC) - Use of Services (AWC, W15, W34)

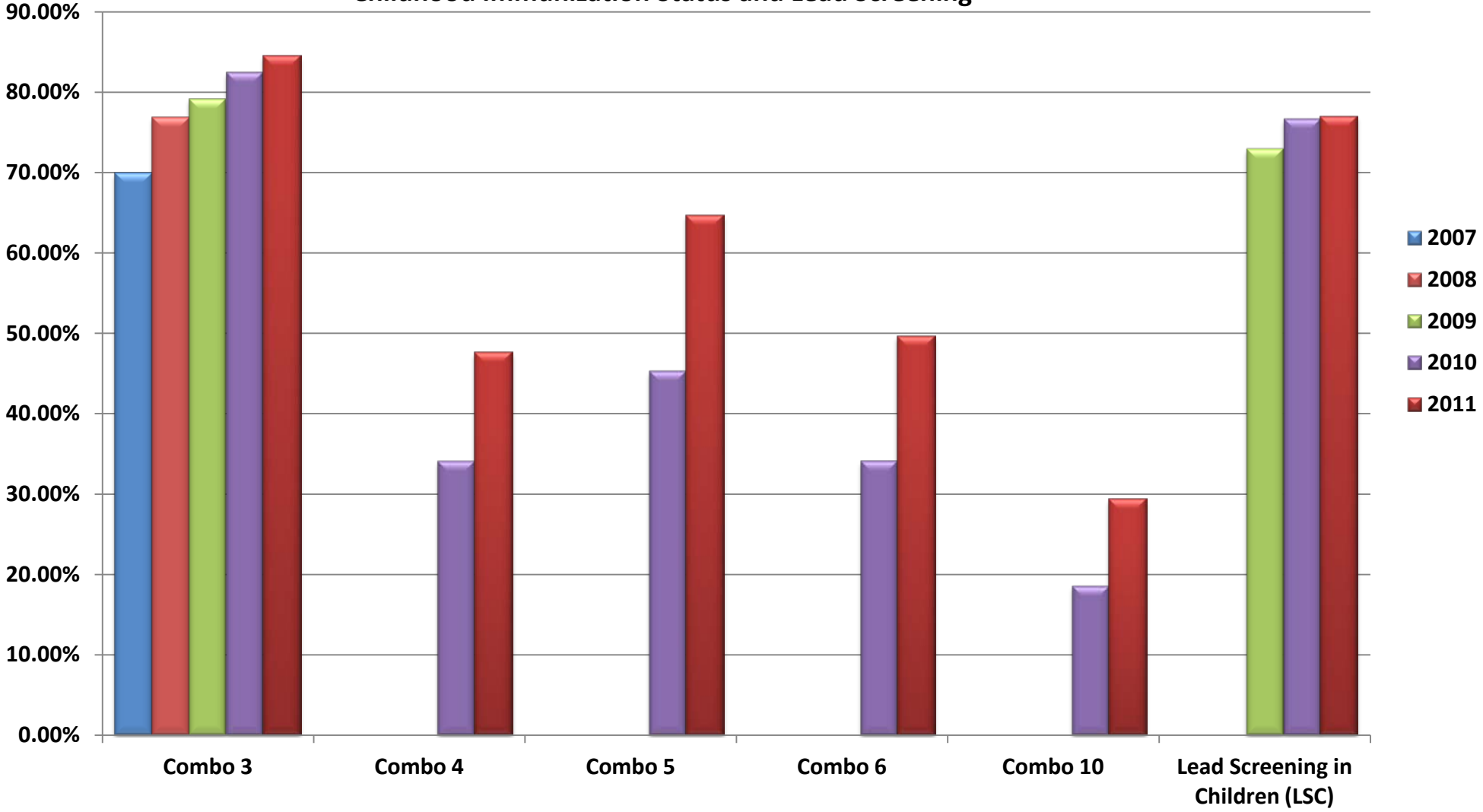


Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006



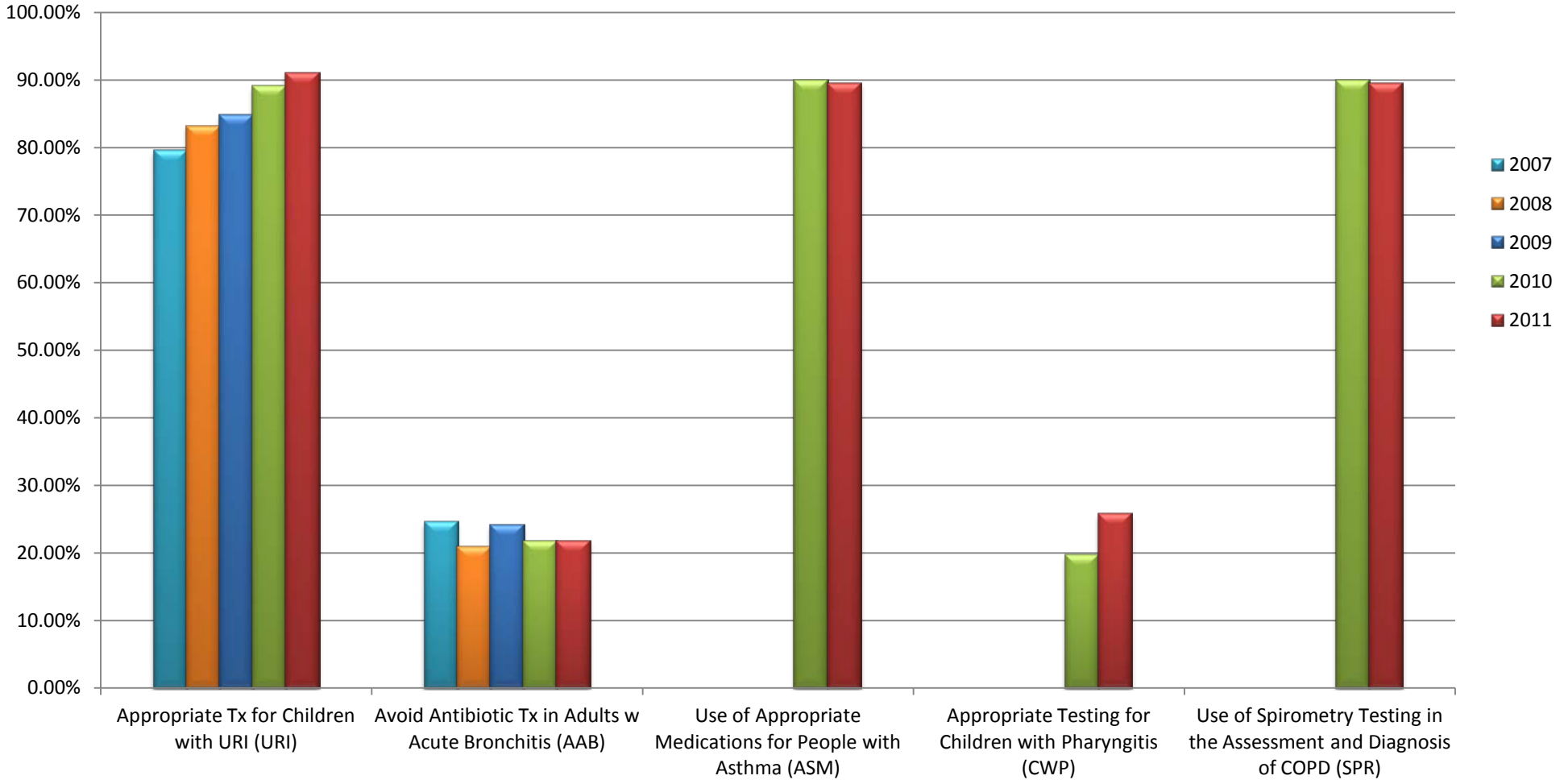
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Prevention and Screening
Childhood Immunization Status and Lead Screening



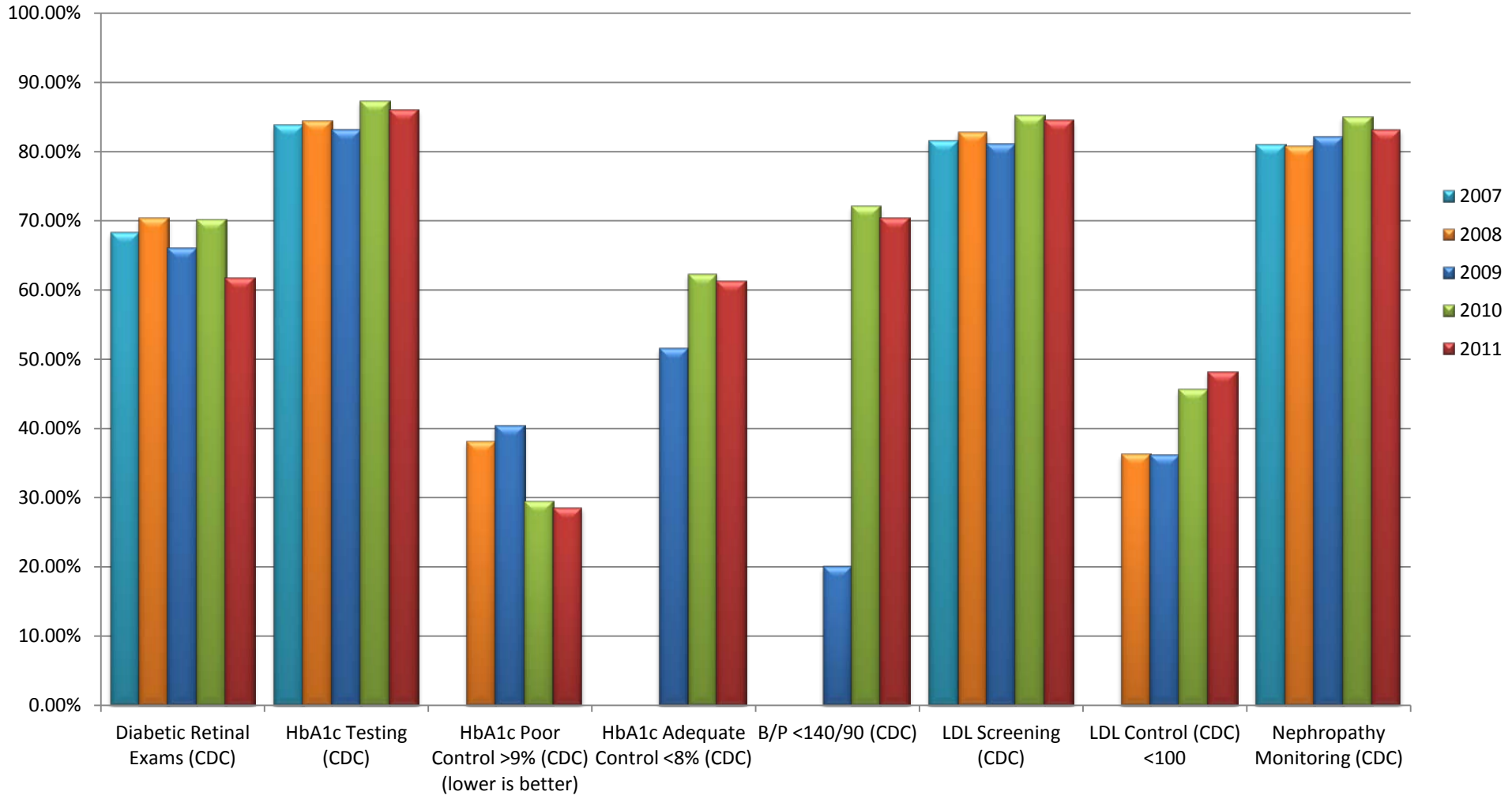
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Respiratory Conditions



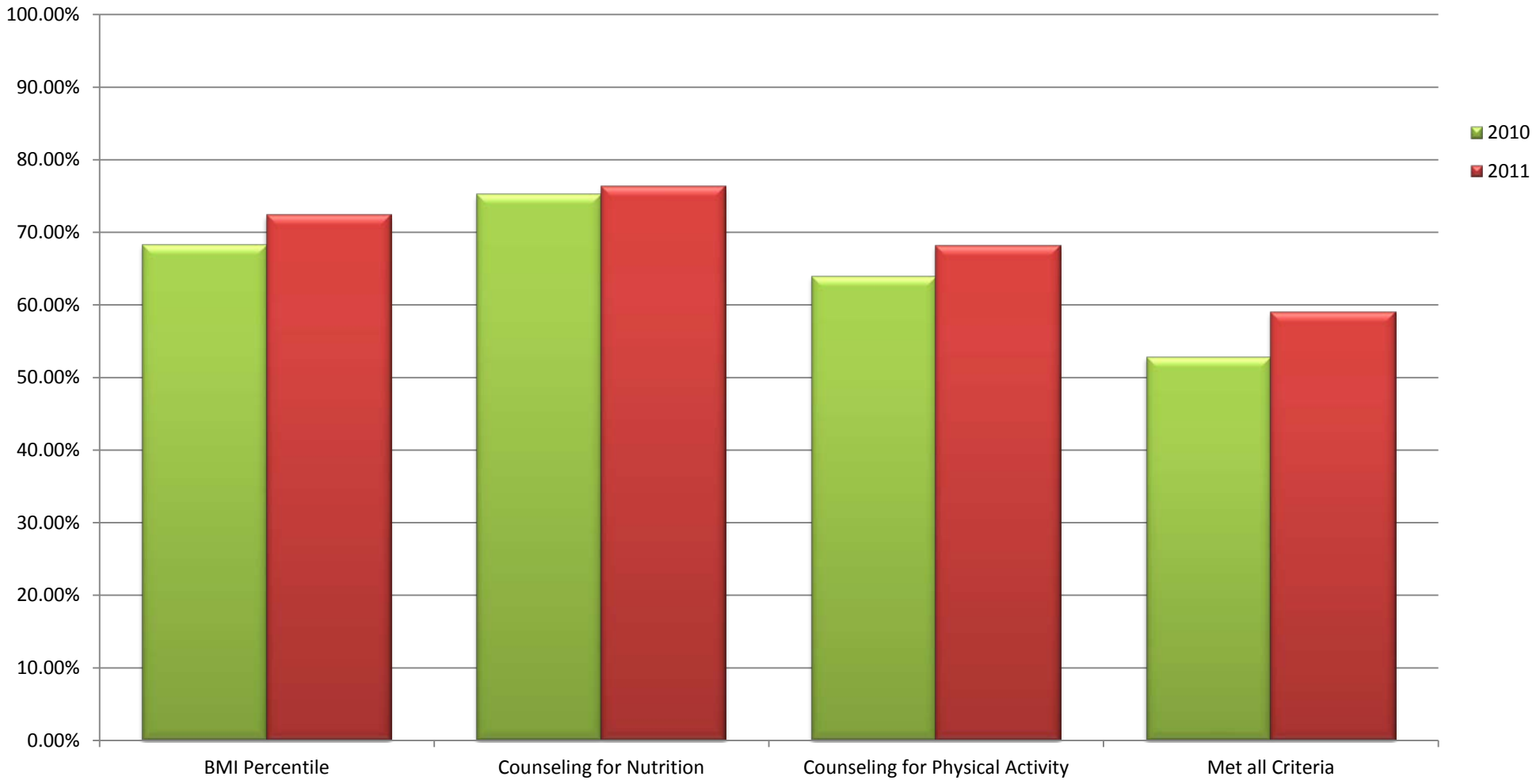
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Diabetes



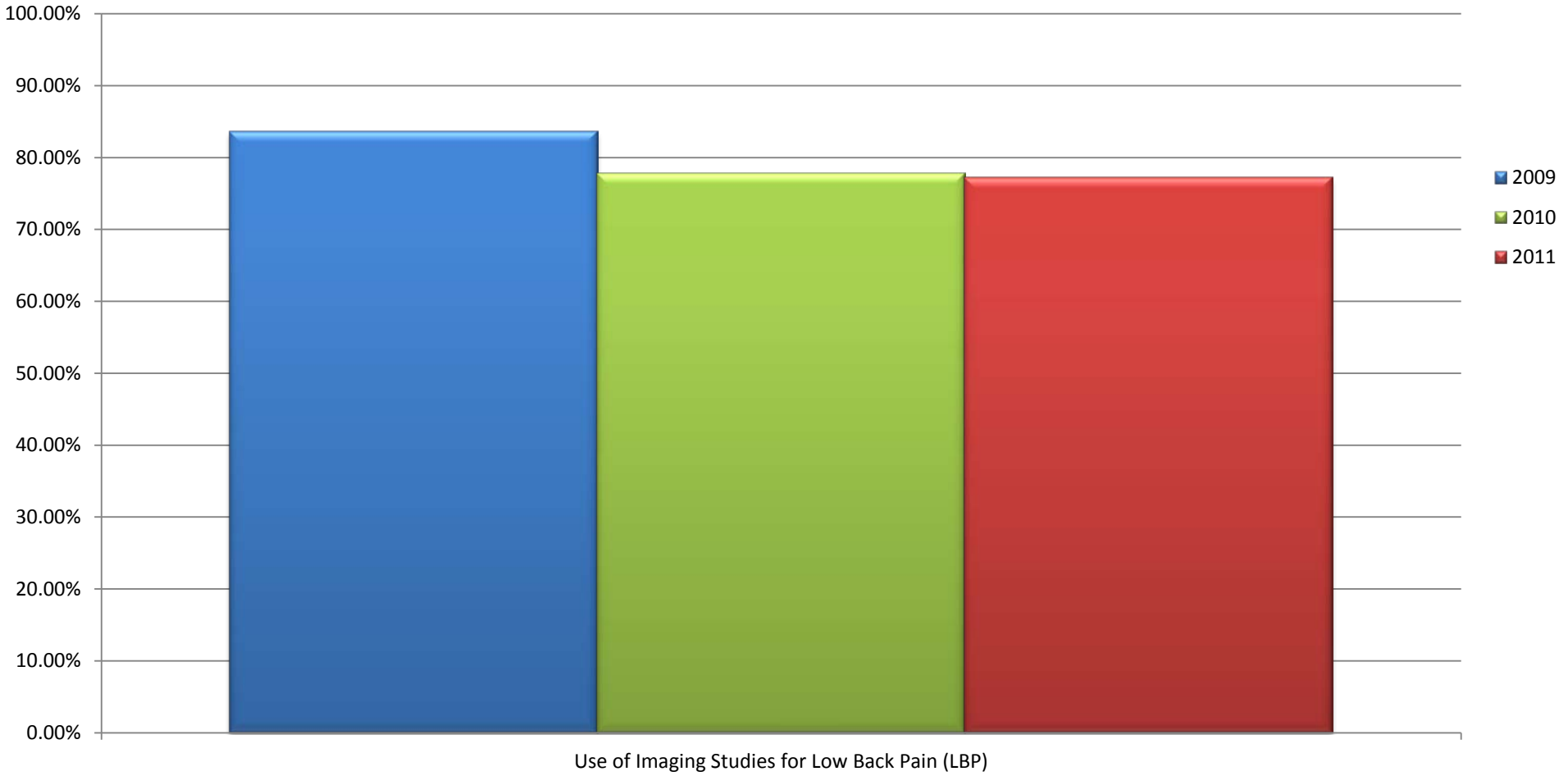
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2010 - 2011
Effectiveness of Care: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents



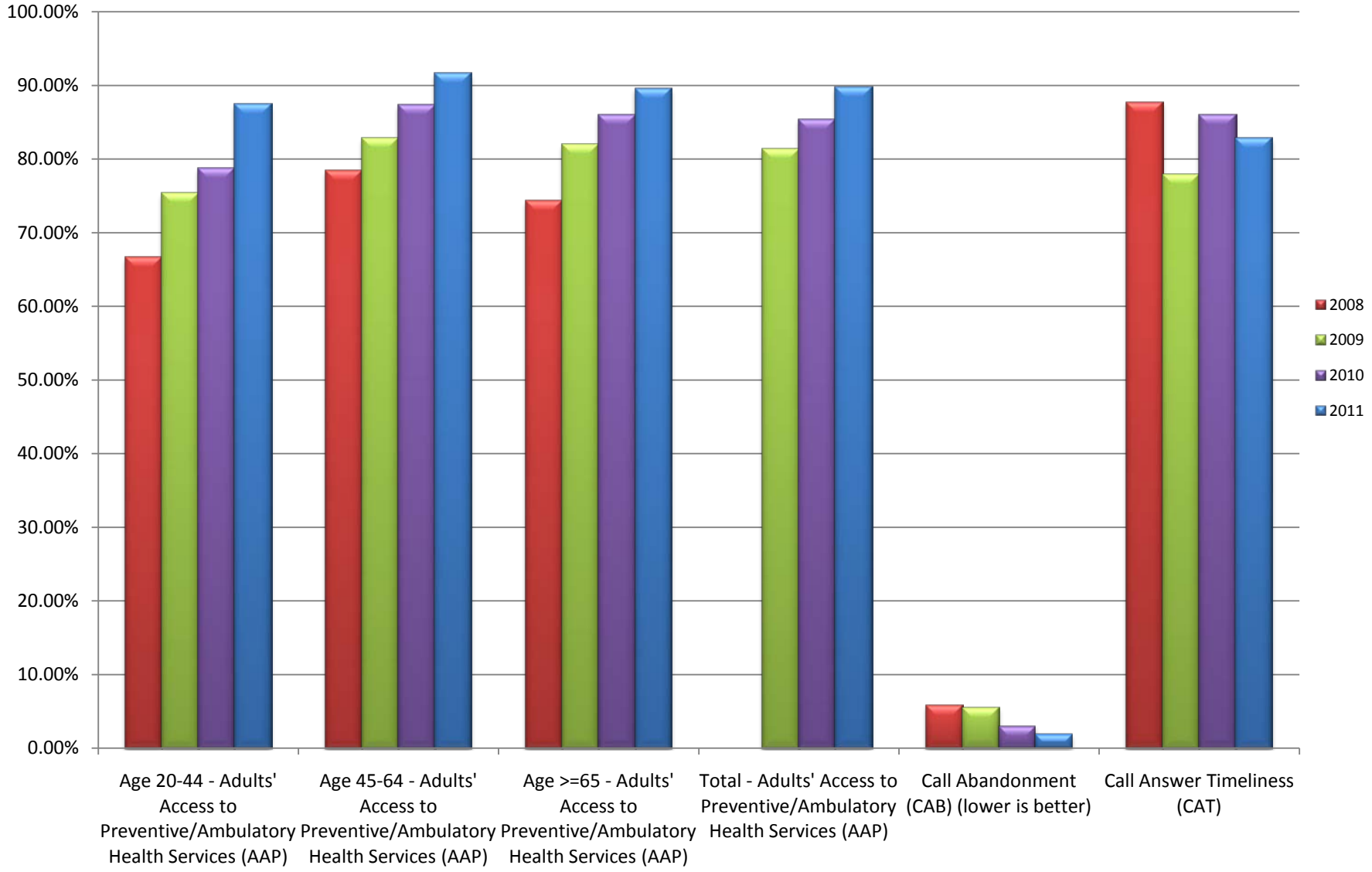
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2009-2011
Effectiveness of Care: Musculoskeletal Conditions

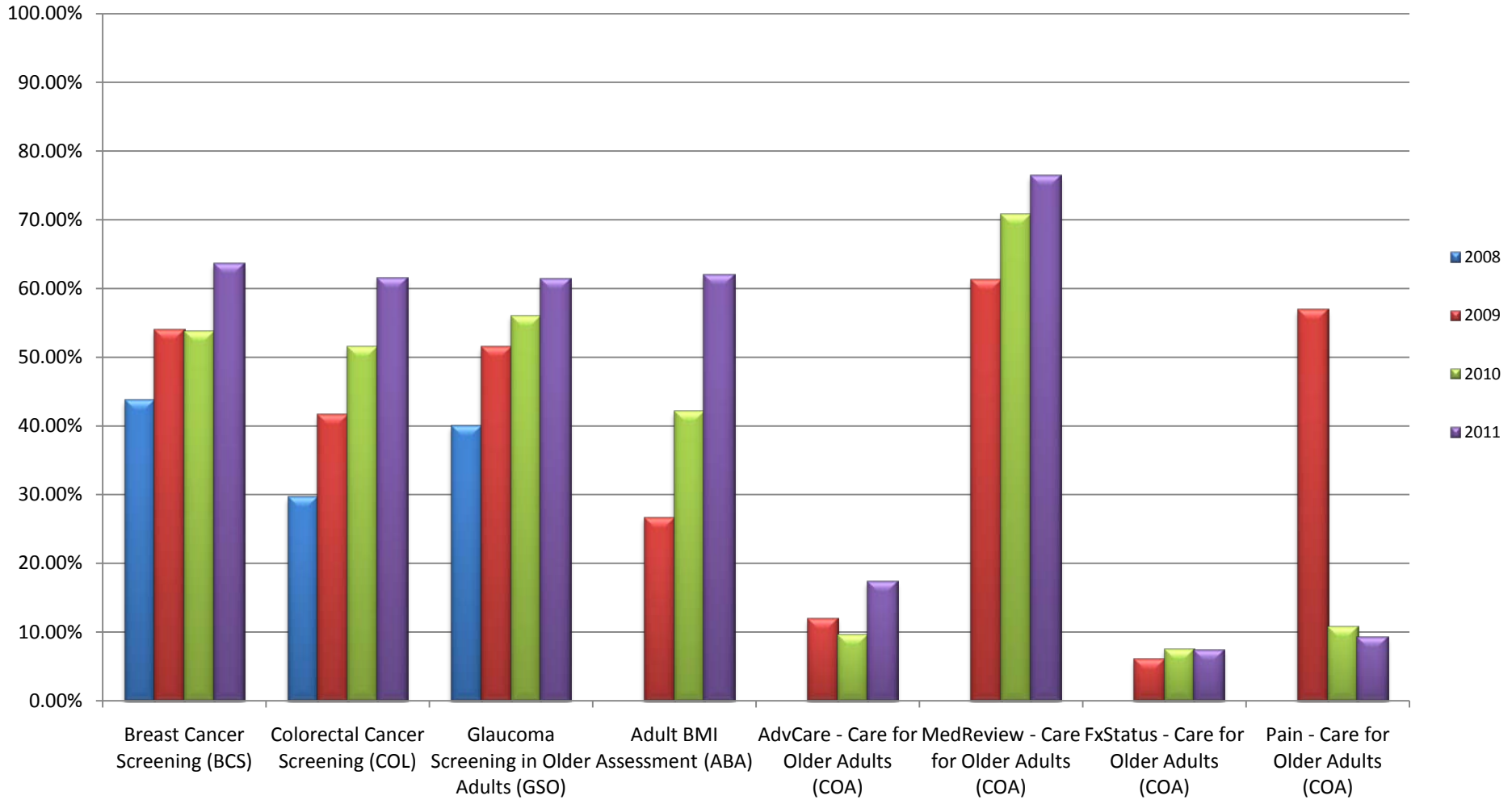


Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

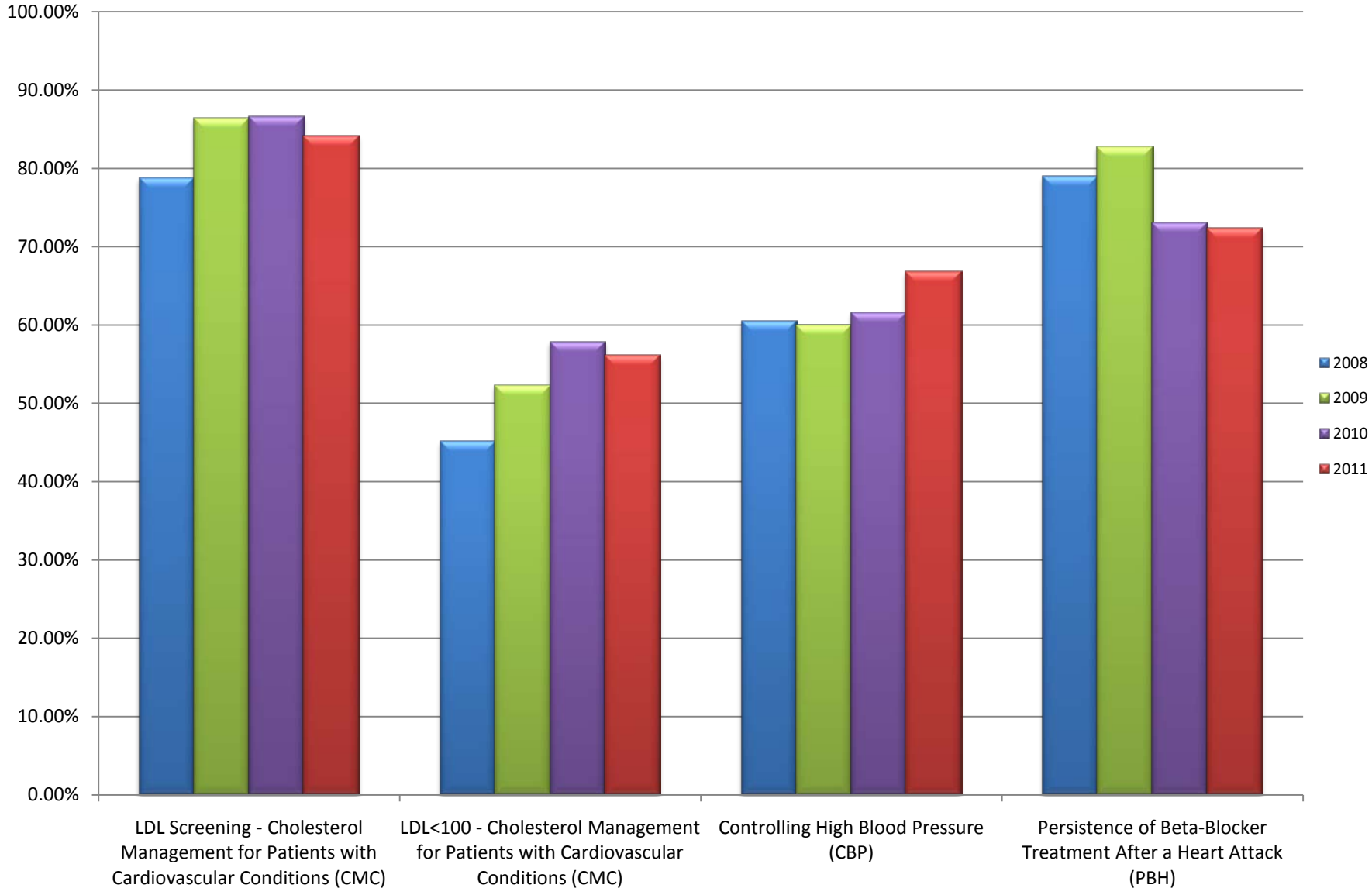
OneCare Program Status Report:
HEDIS Results for 2008-2011
Access/Availability of Care



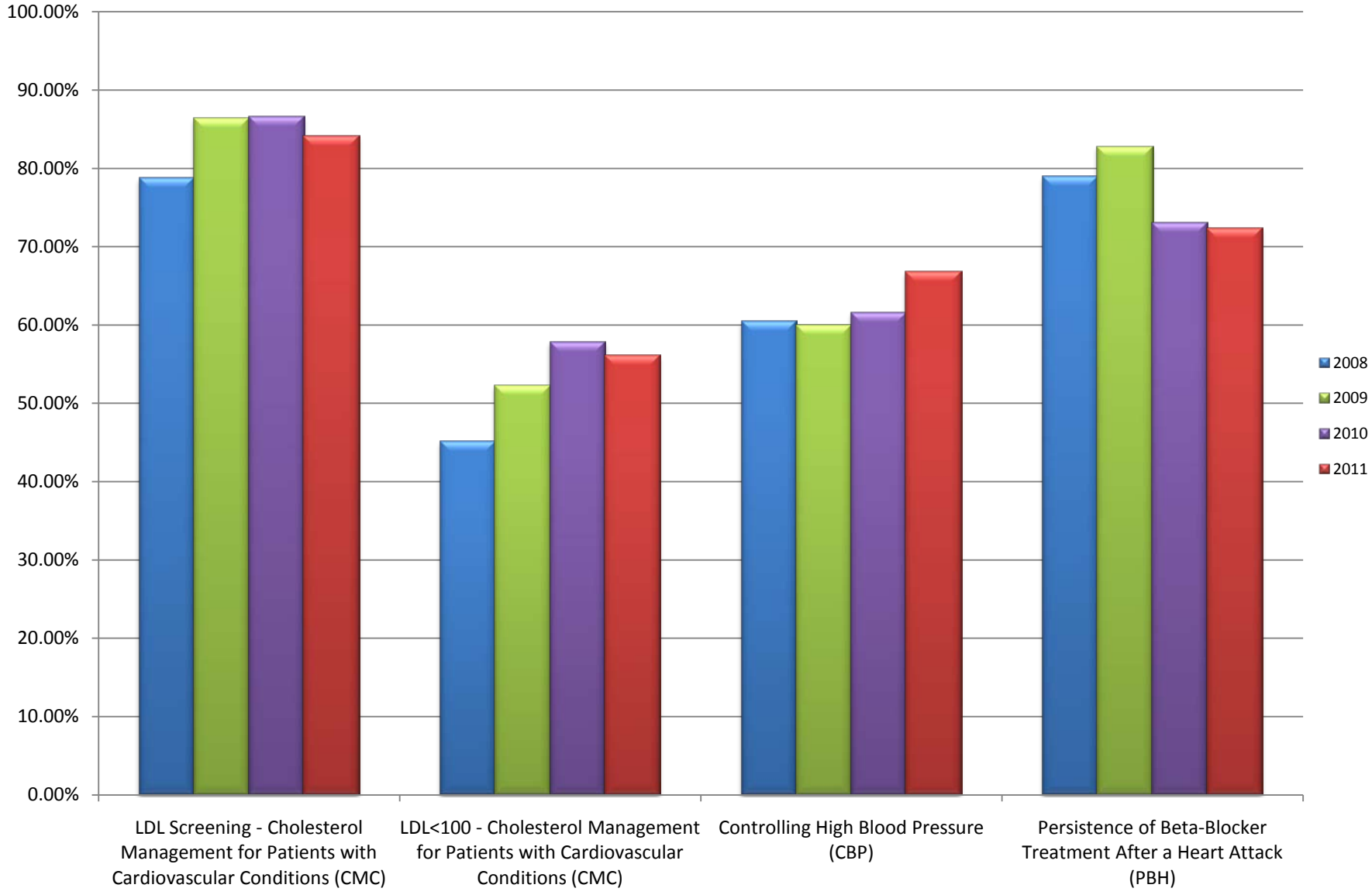
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Prevention and Screening



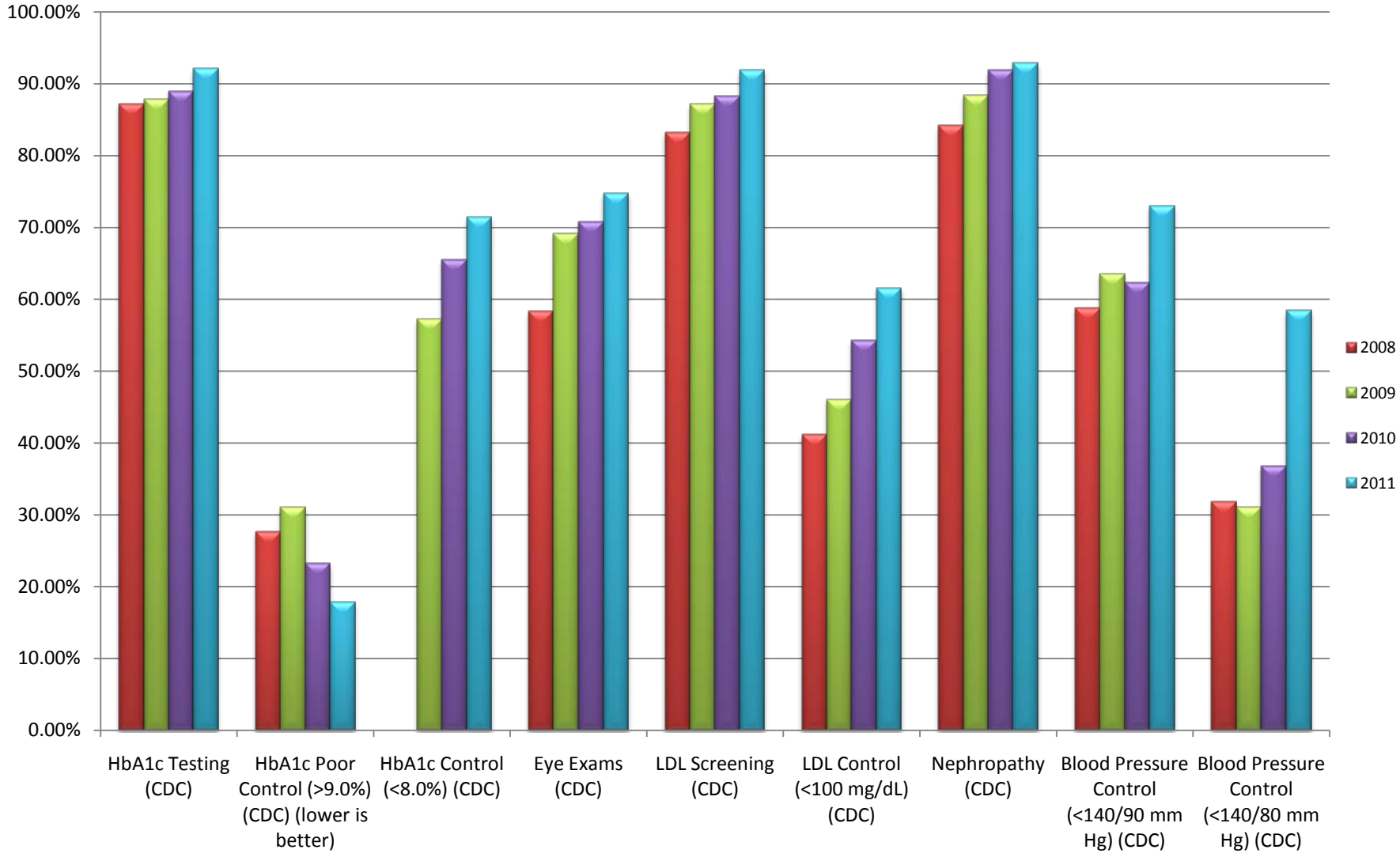
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Cardiovascular Conditions



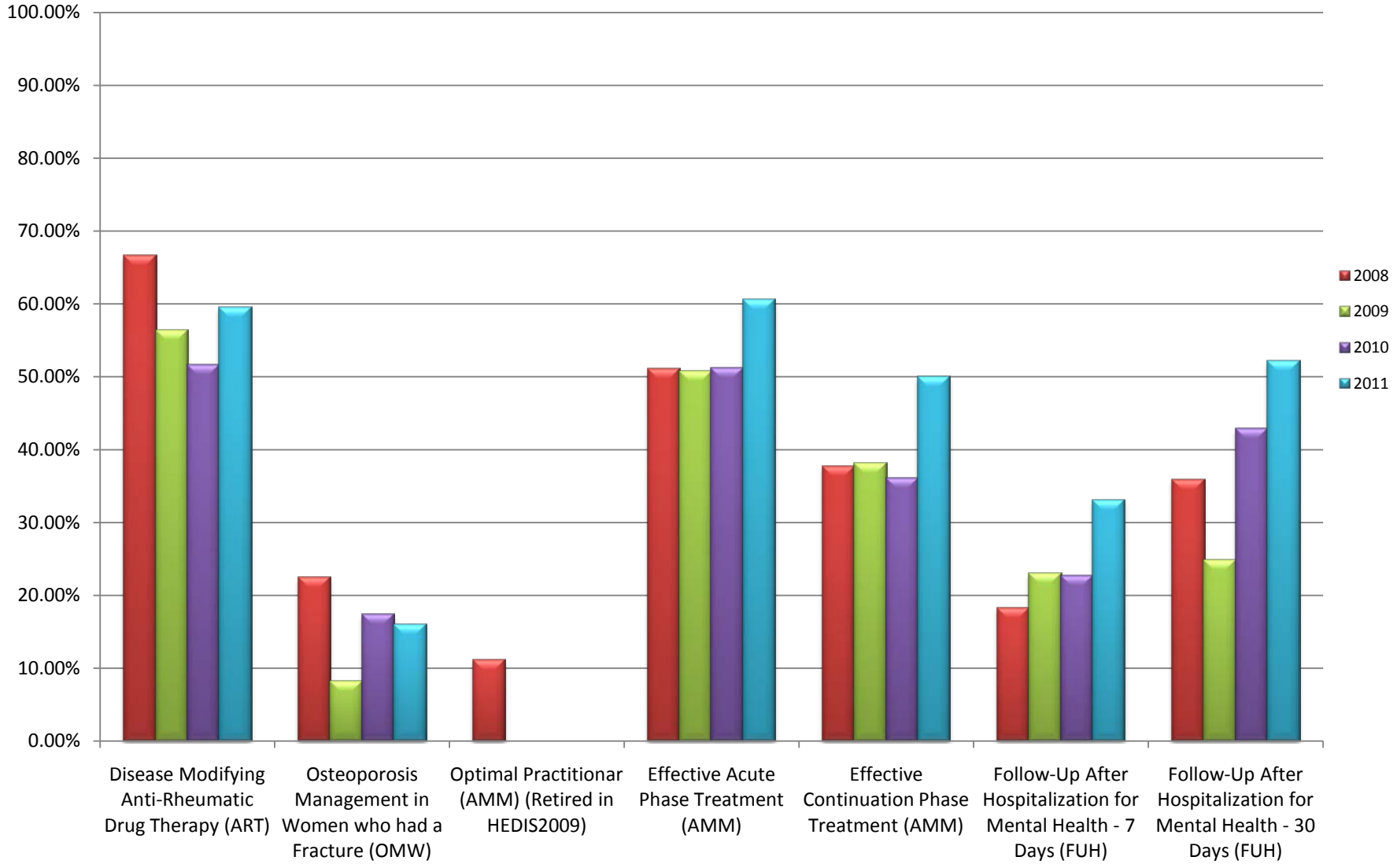
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Cardiovascular Conditions



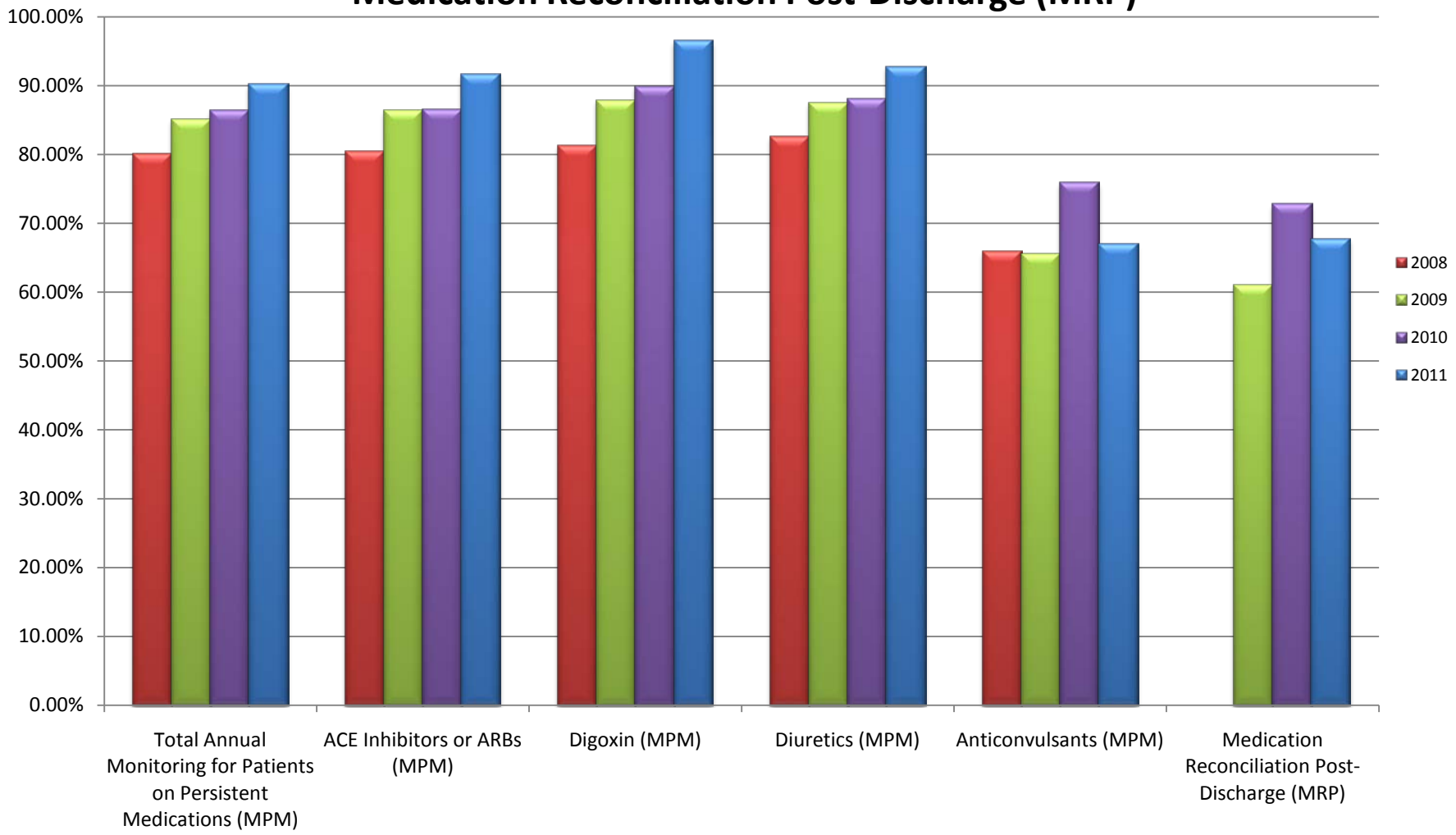
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Diabetes



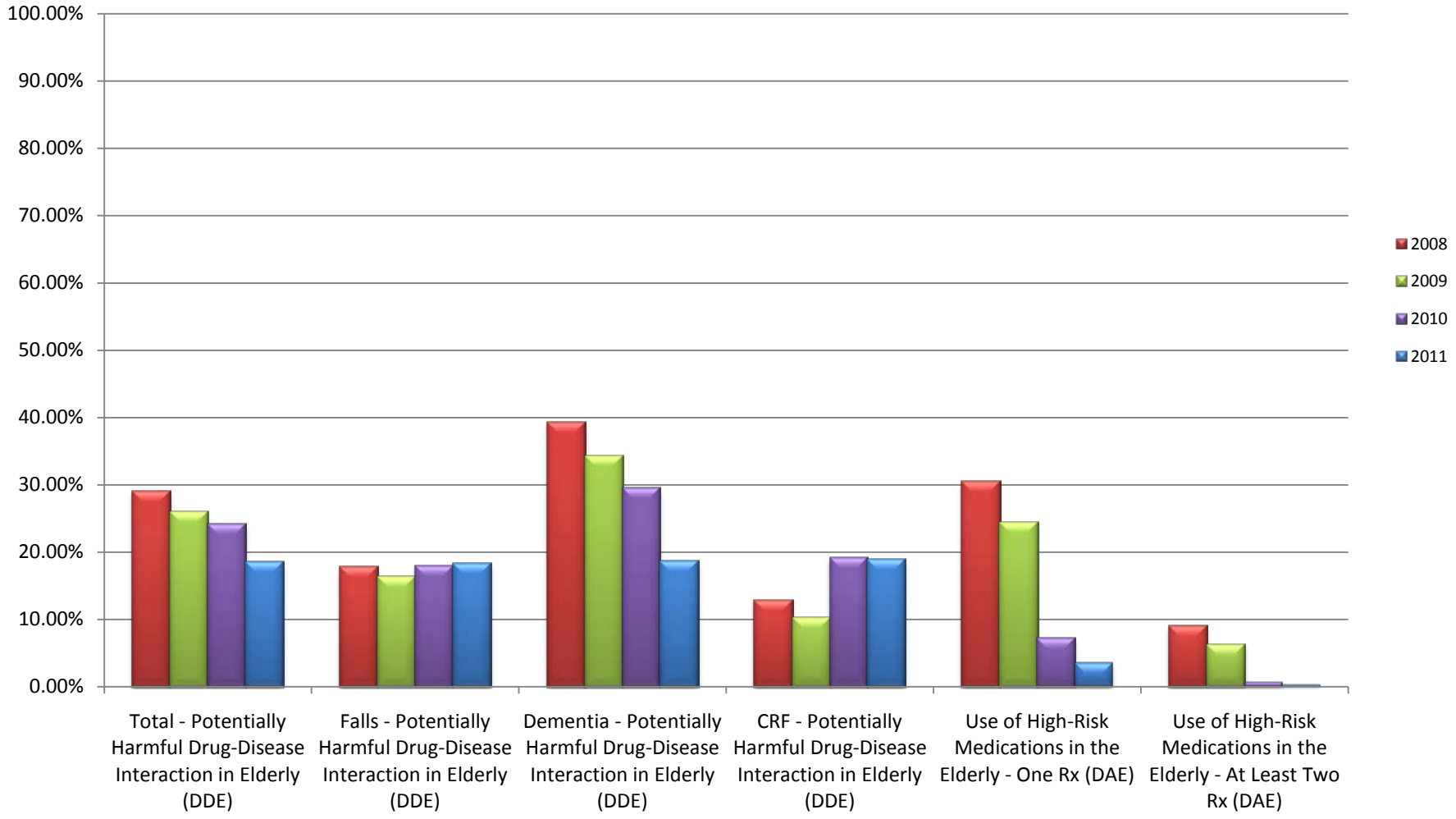
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: MusculoskeletalART,OMW Behavioral HealthAMM,FUH



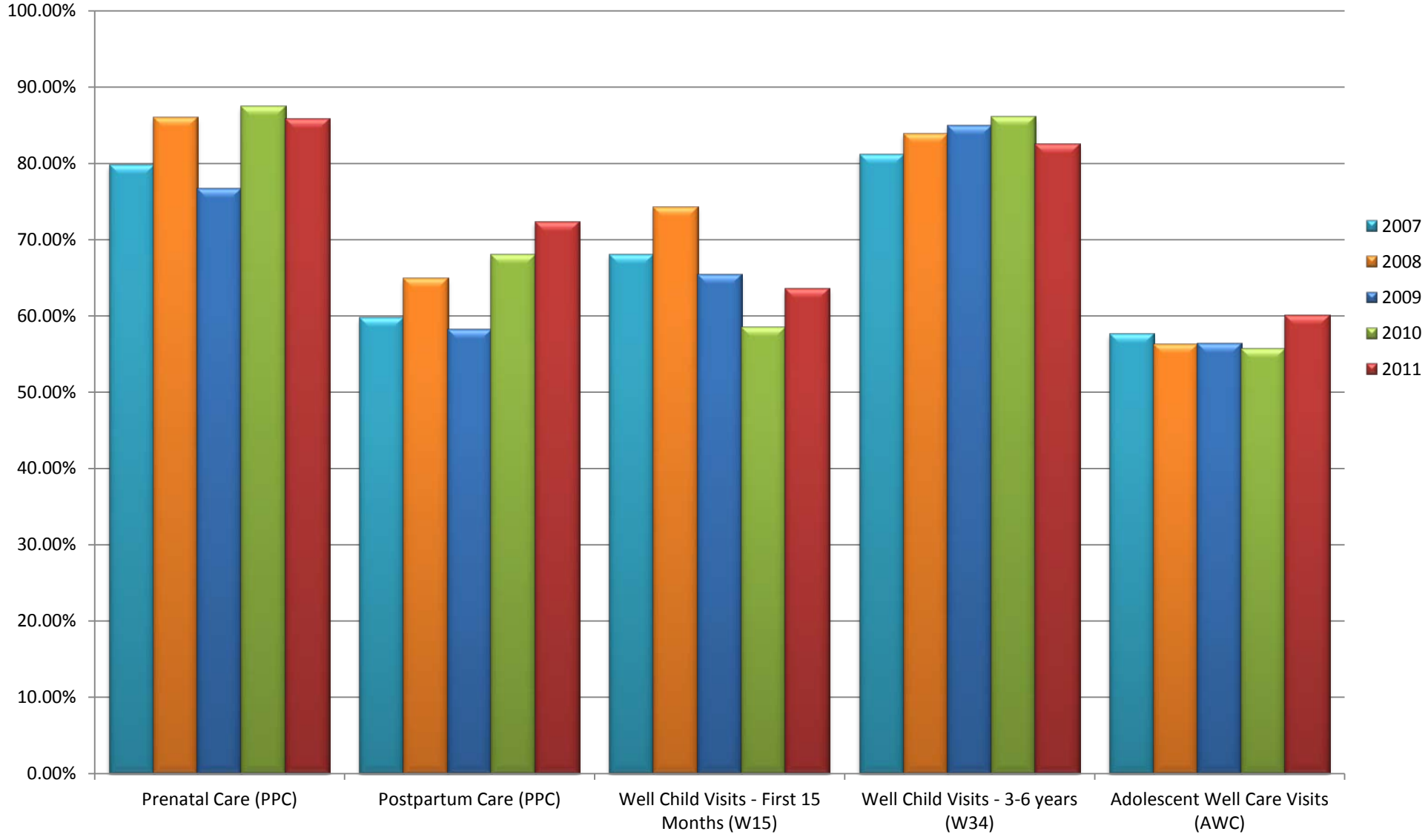
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Medication Management
Total Annual Monitoring for Patients on Persistent Medications(MPM); Medication Reconciliation Post-Discharge (MRP)



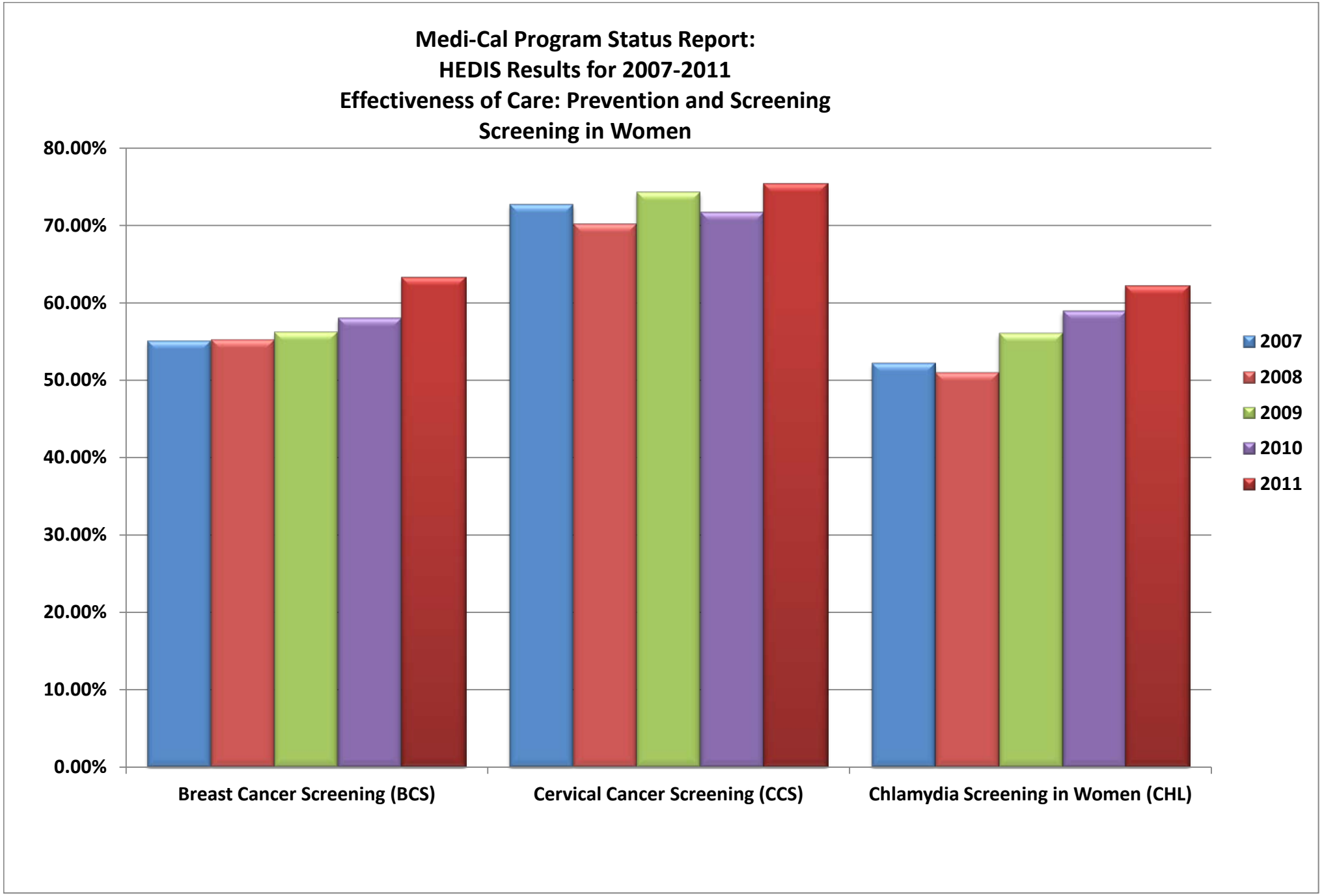
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Medication Management
Harmful Interactions and High Risk Medications in the Elderly (DDE and DAE)



Medi-Cal Program Status Report:
HEDIS Results for 2007 - 2011
Access/Availability of Care (PPC) - Use of Services (AWC, W15, W34)

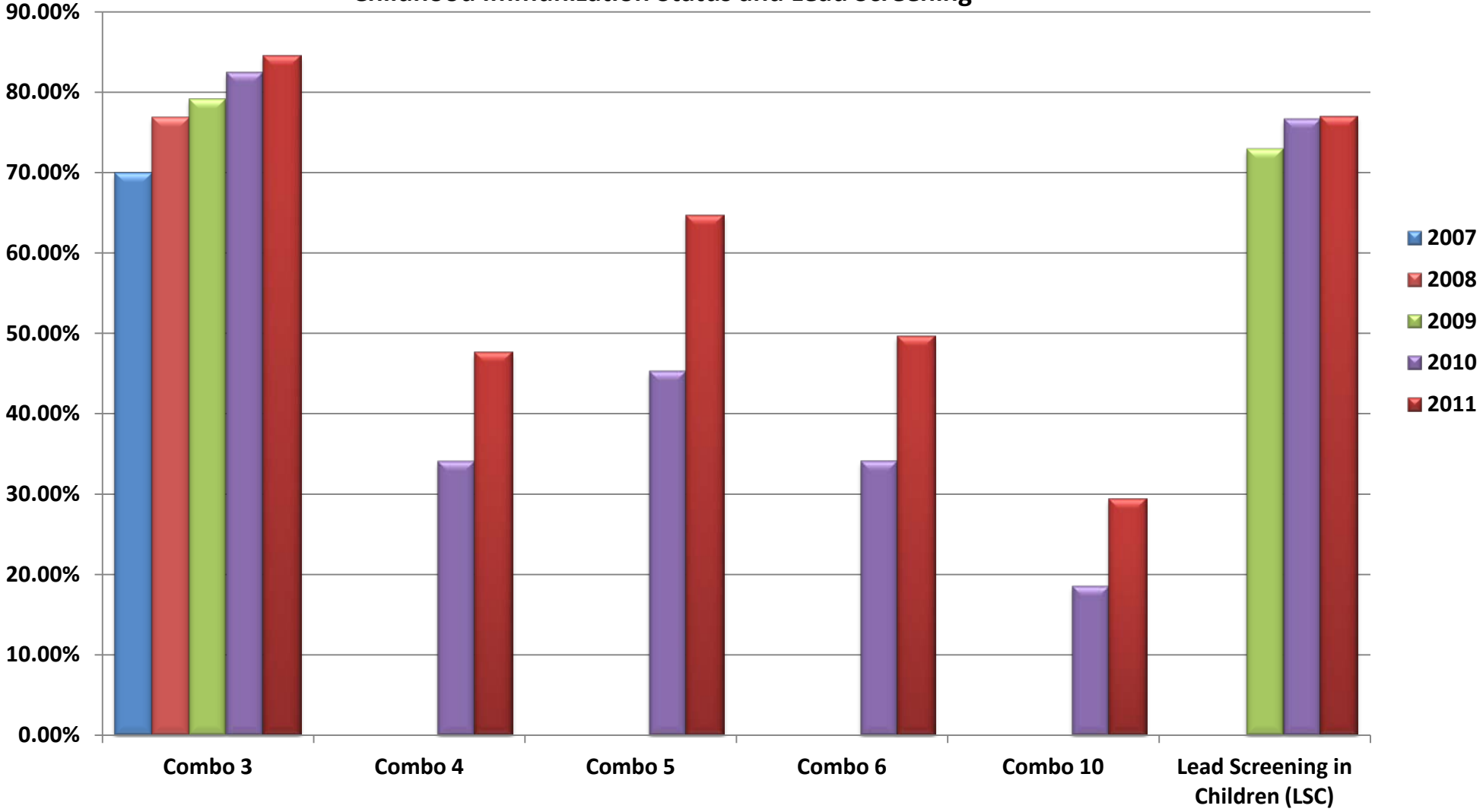


Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006



Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Prevention and Screening
Childhood Immunization Status and Lead Screening



Comments:
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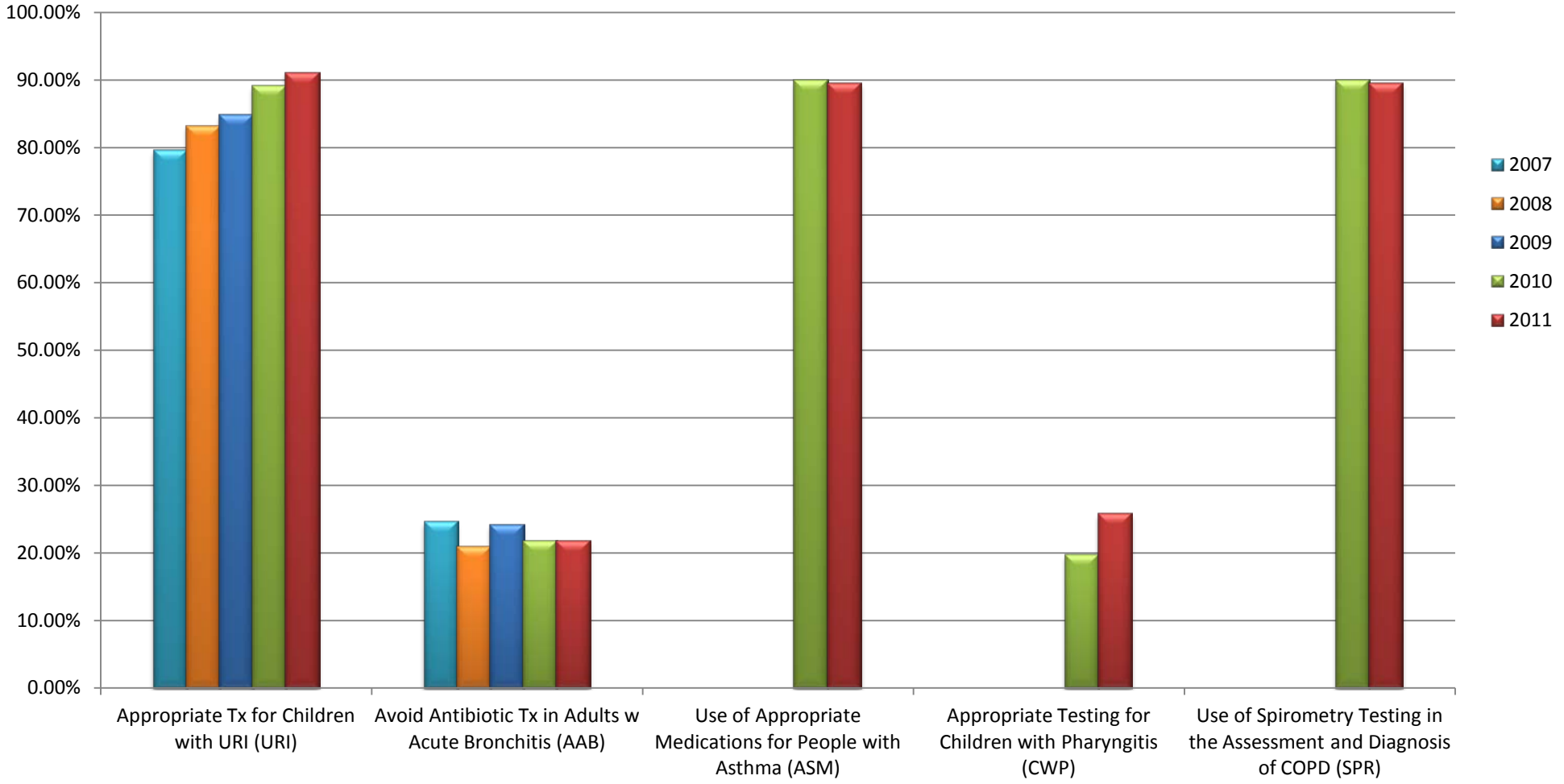
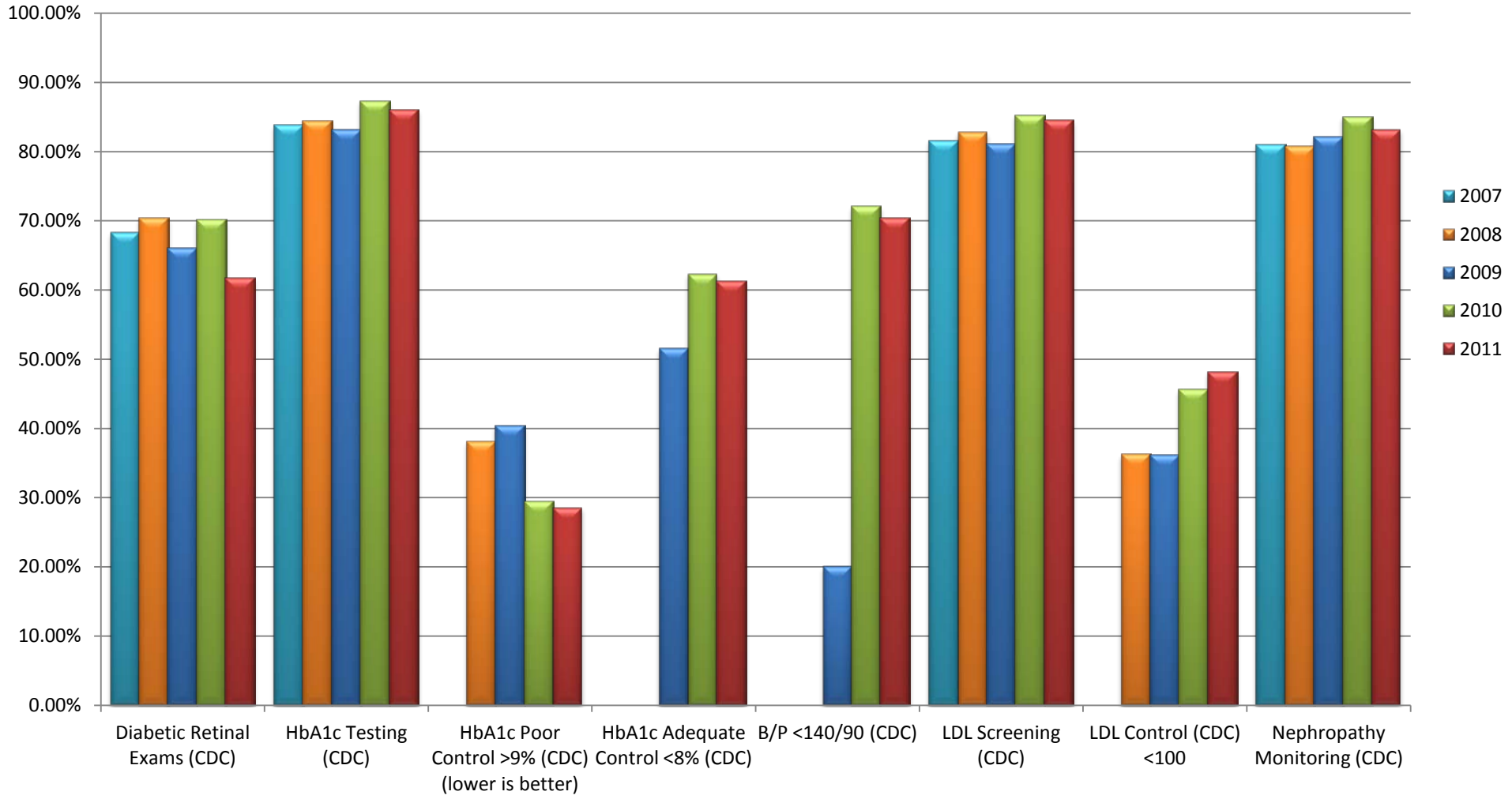
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Respiratory Conditions



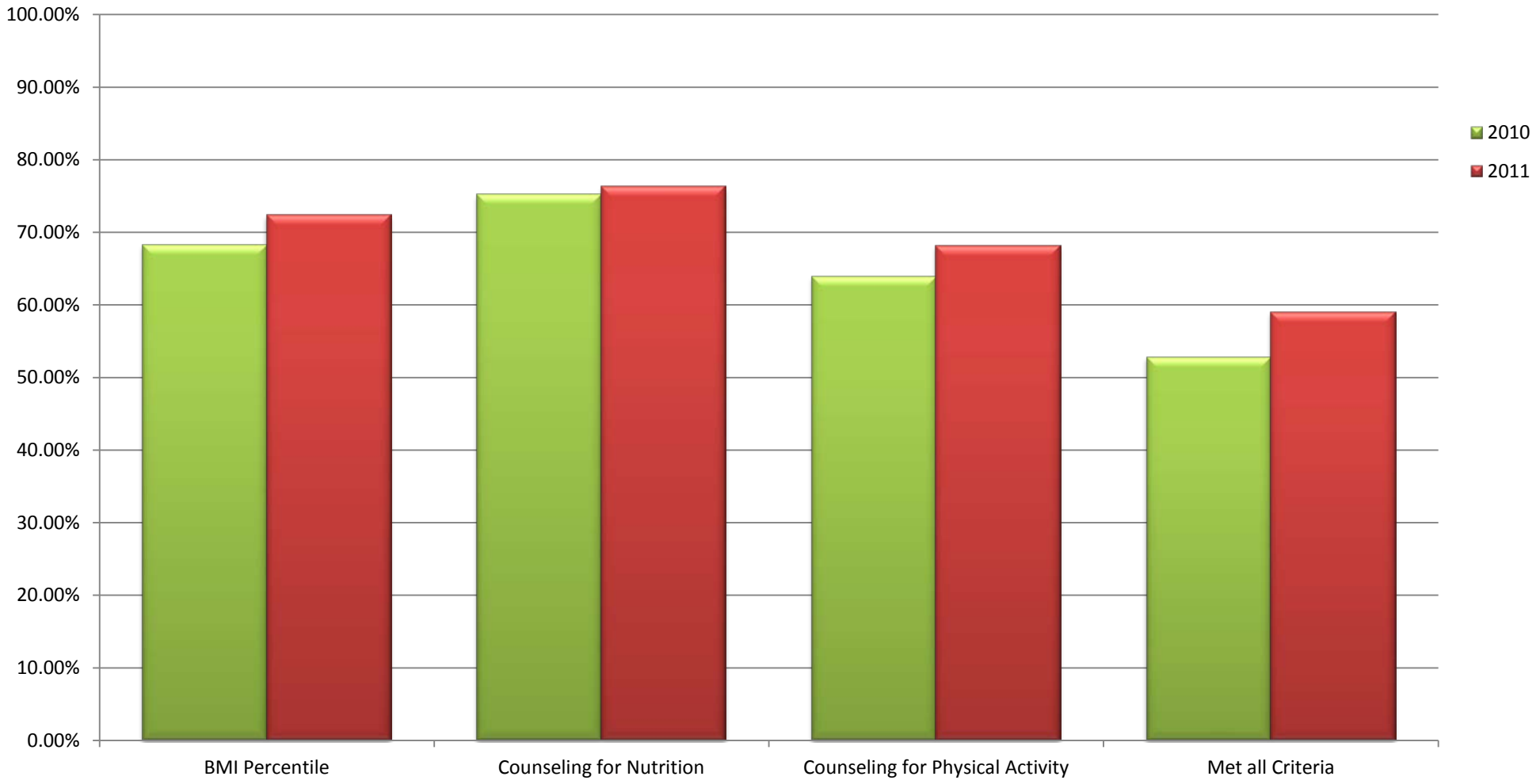
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2007-2011
Effectiveness of Care: Diabetes



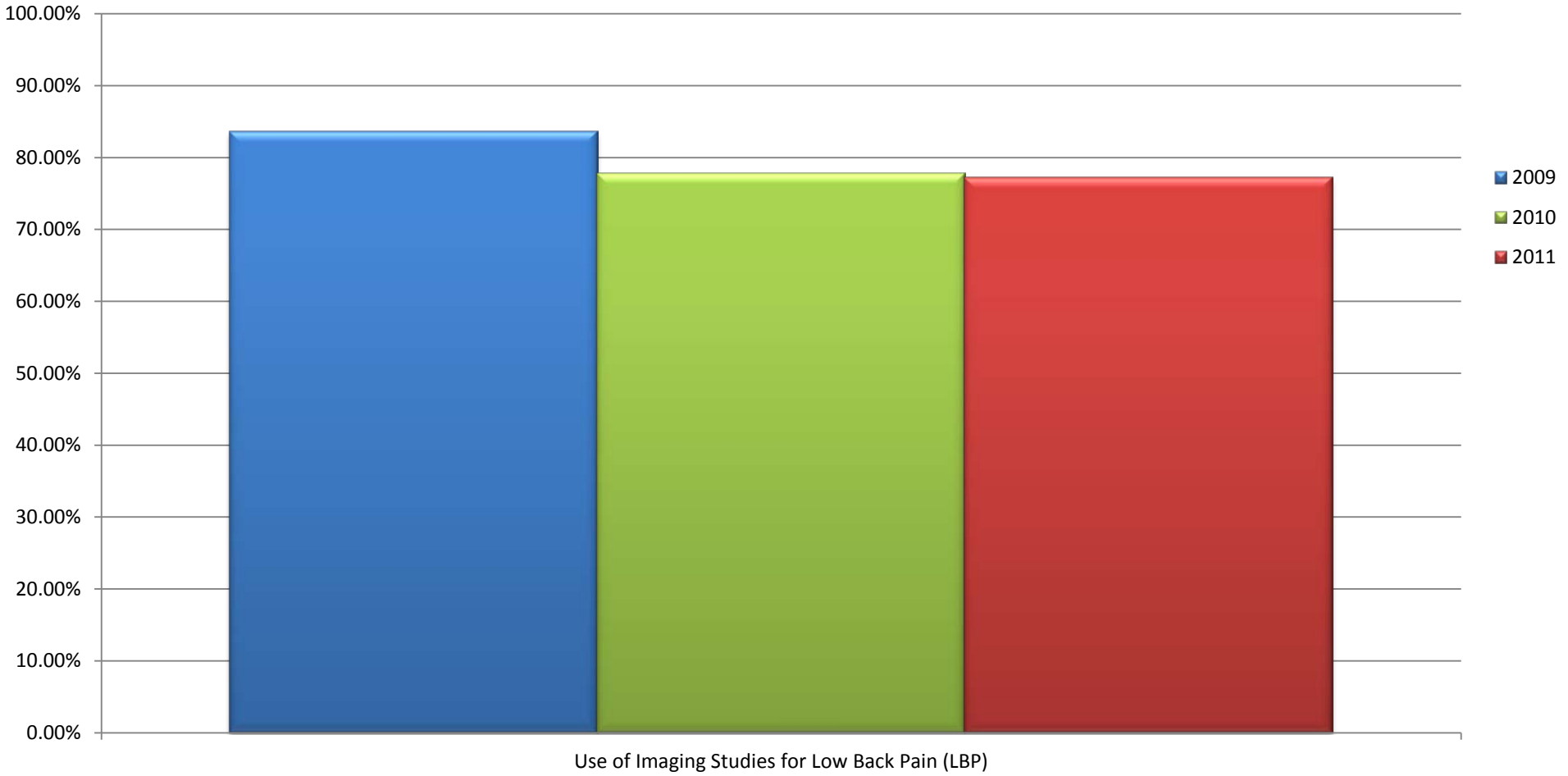
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2010 - 2011
Effectiveness of Care: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents



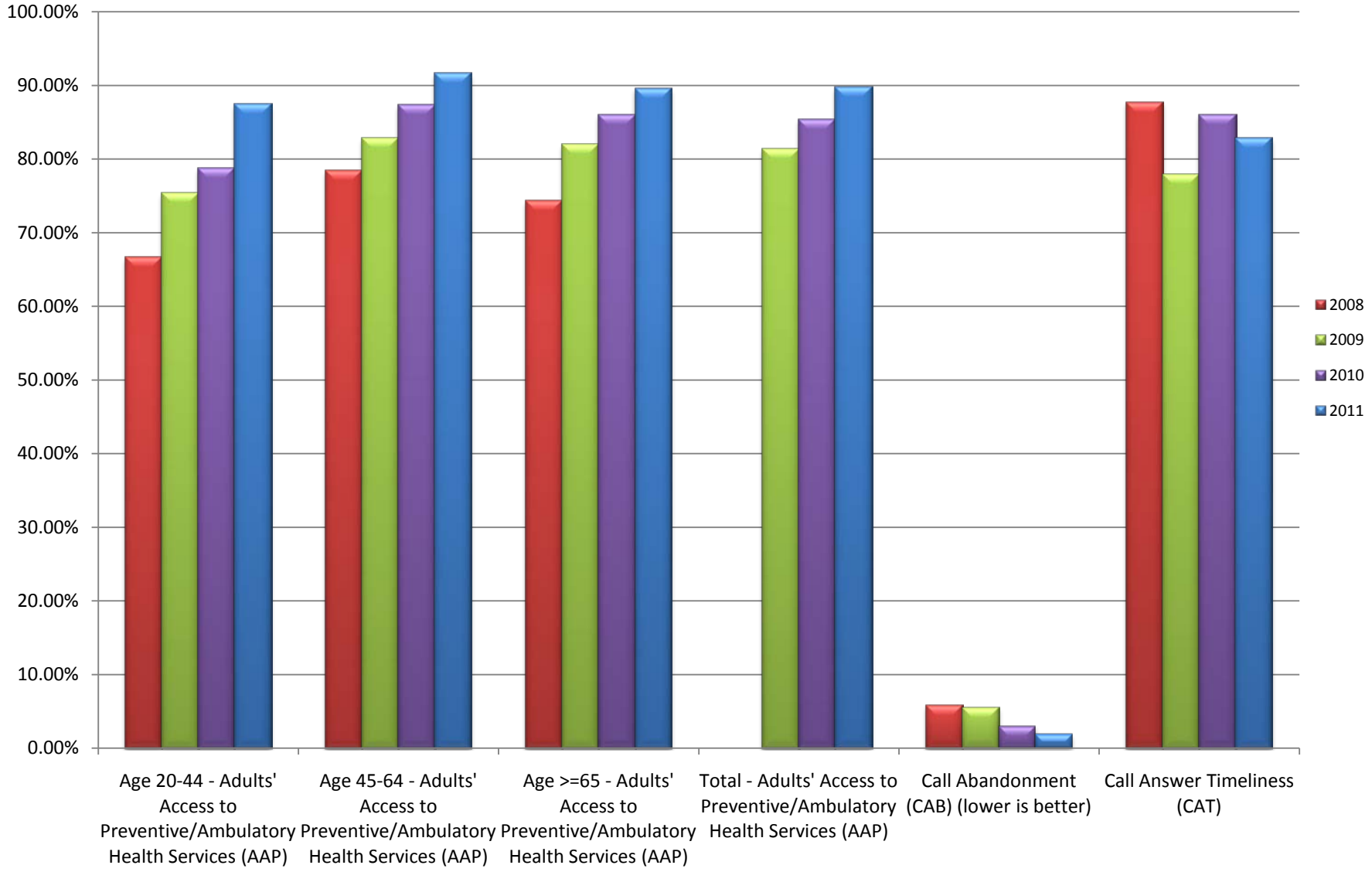
Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

Medi-Cal Program Status Report:
HEDIS Results for 2009-2011
Effectiveness of Care: Musculoskeletal Conditions

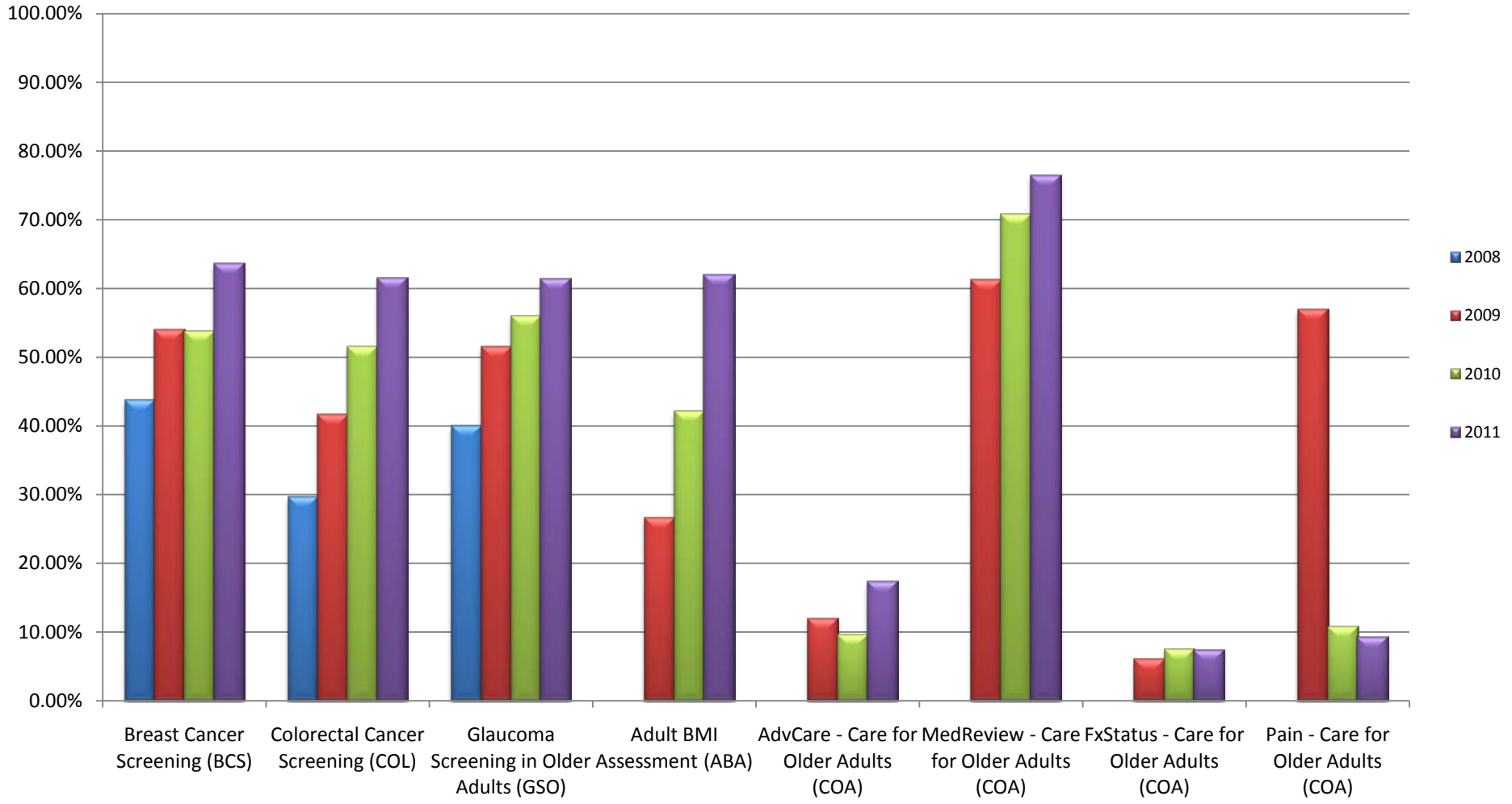


Comments:
Hybrid Measures affected by - Member lock-in effective Fall 2004 and improved provider chase process implemented in 2006.
Admin and Hybrid Measures affected by Exclusion of Medi-Medi Dual Eligibles in 2006

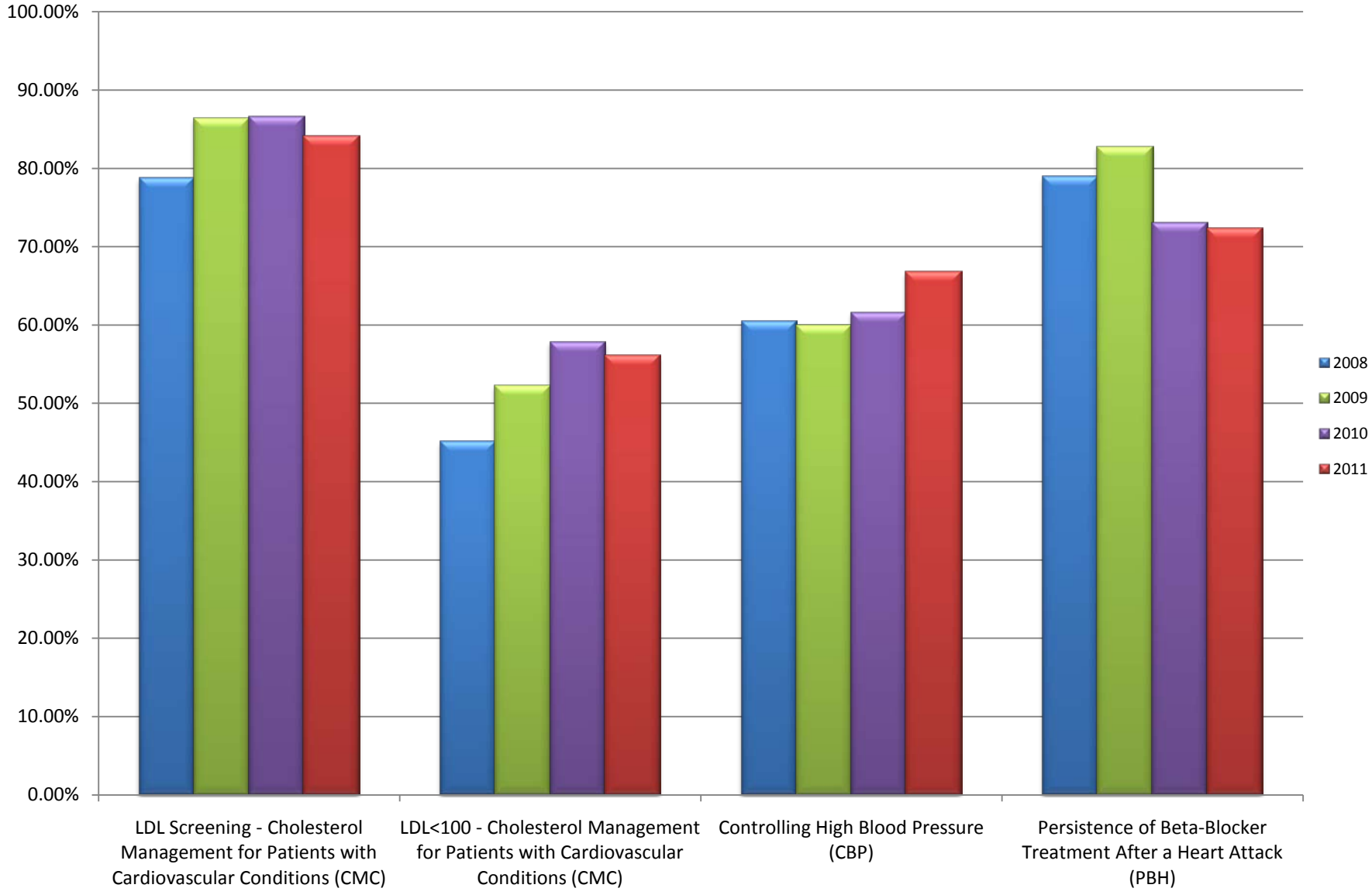
OneCare Program Status Report:
HEDIS Results for 2008-2011
Access/Availability of Care



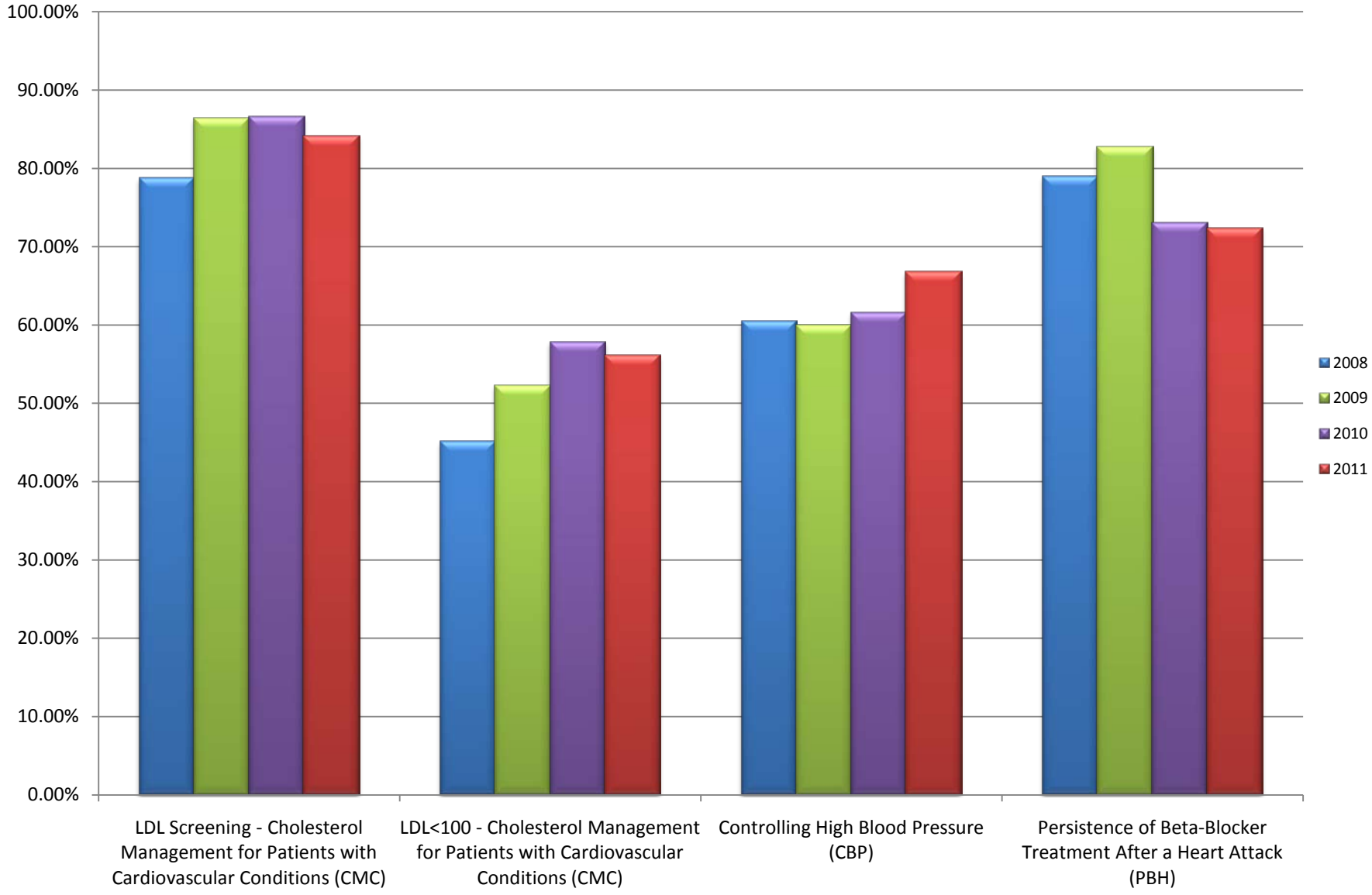
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Prevention and Screening



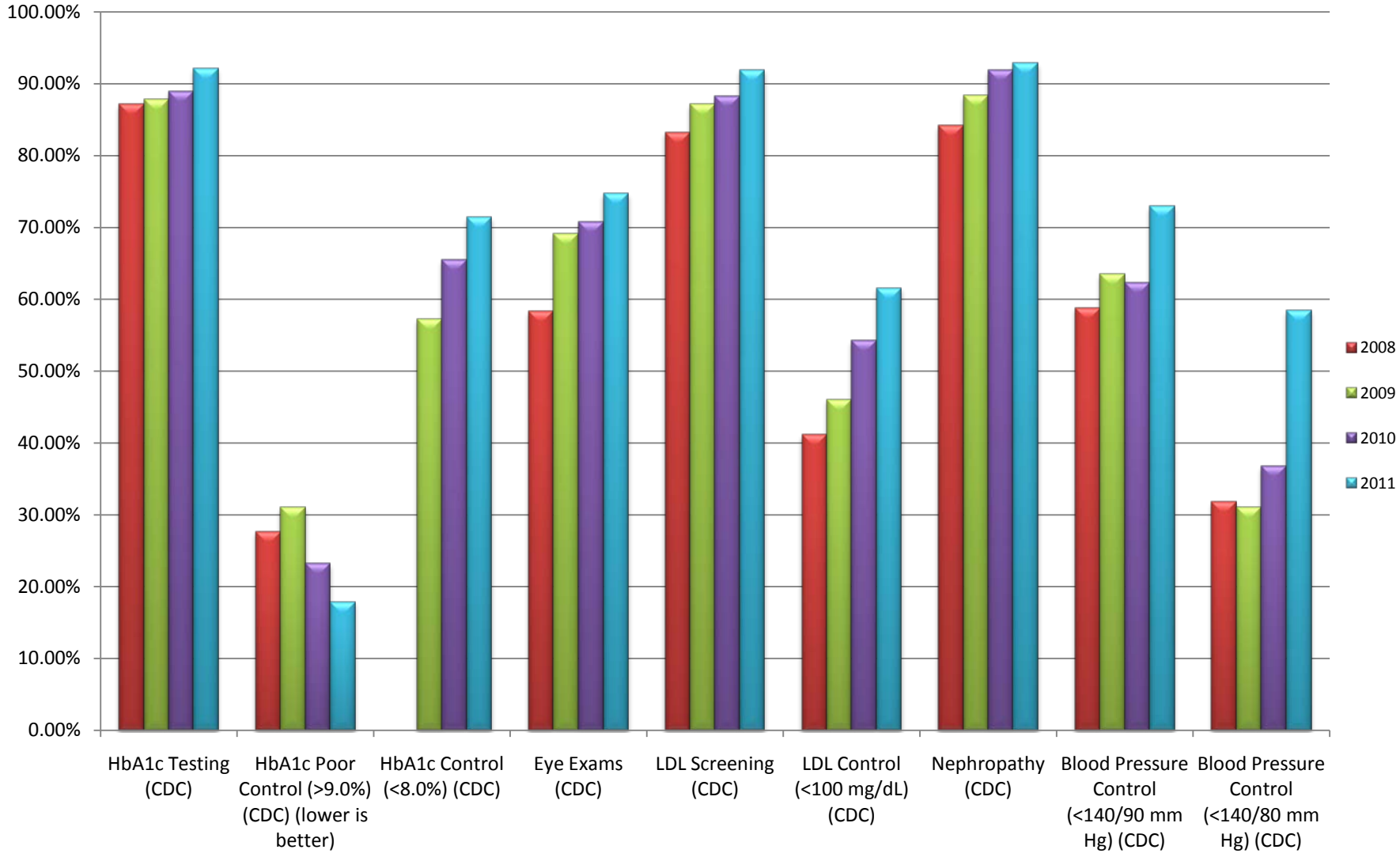
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Cardiovascular Conditions



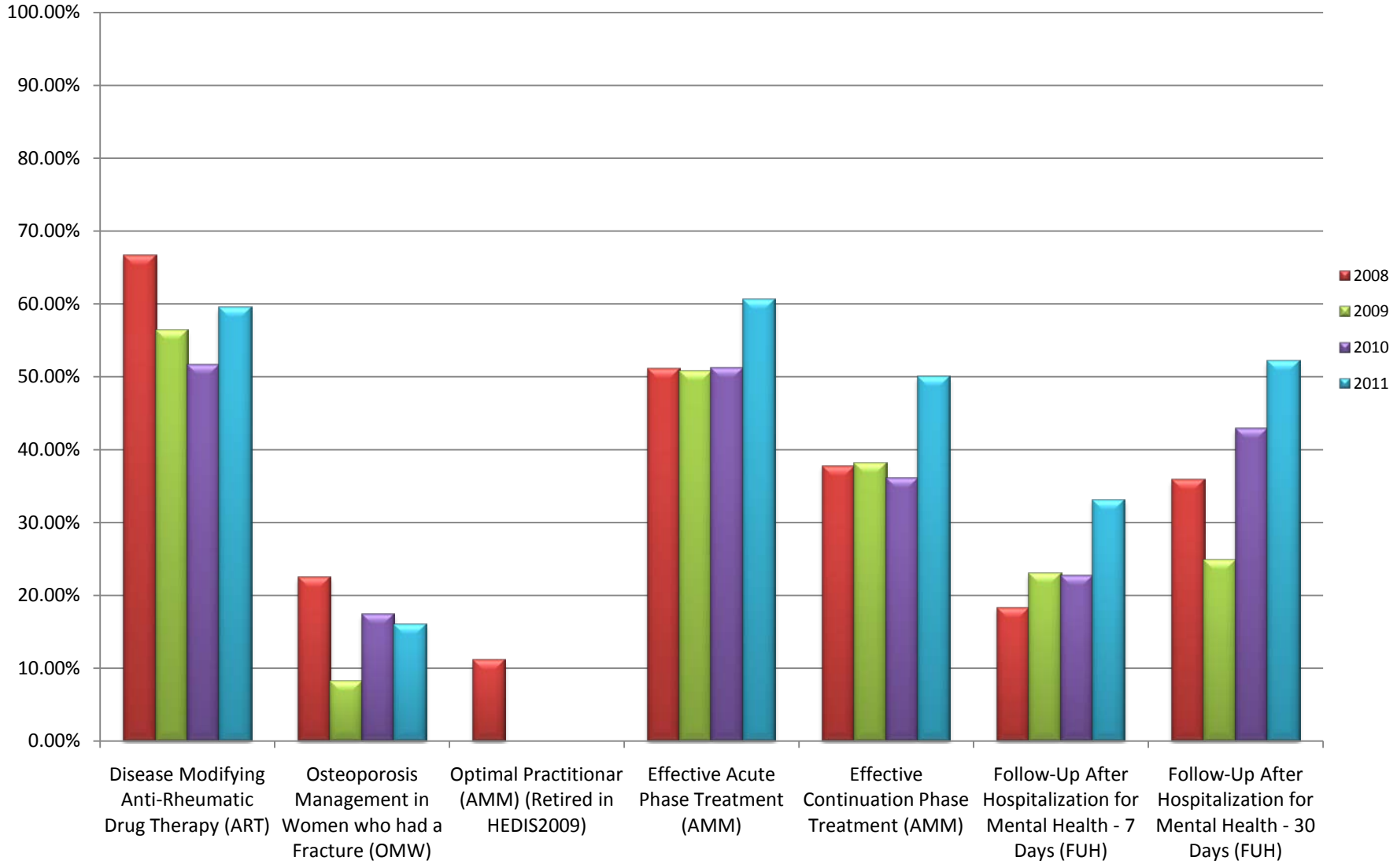
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Cardiovascular Conditions



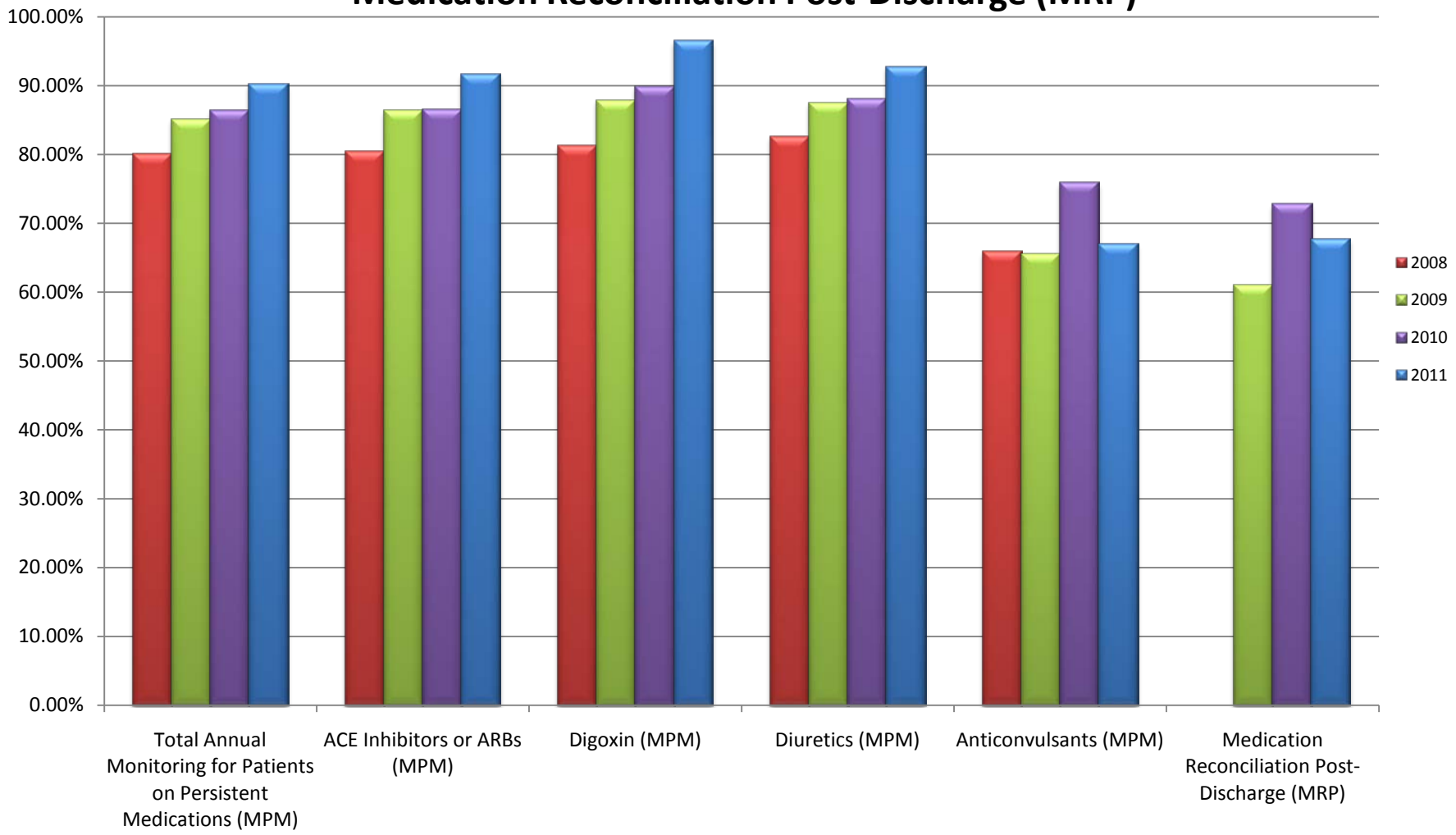
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Diabetes



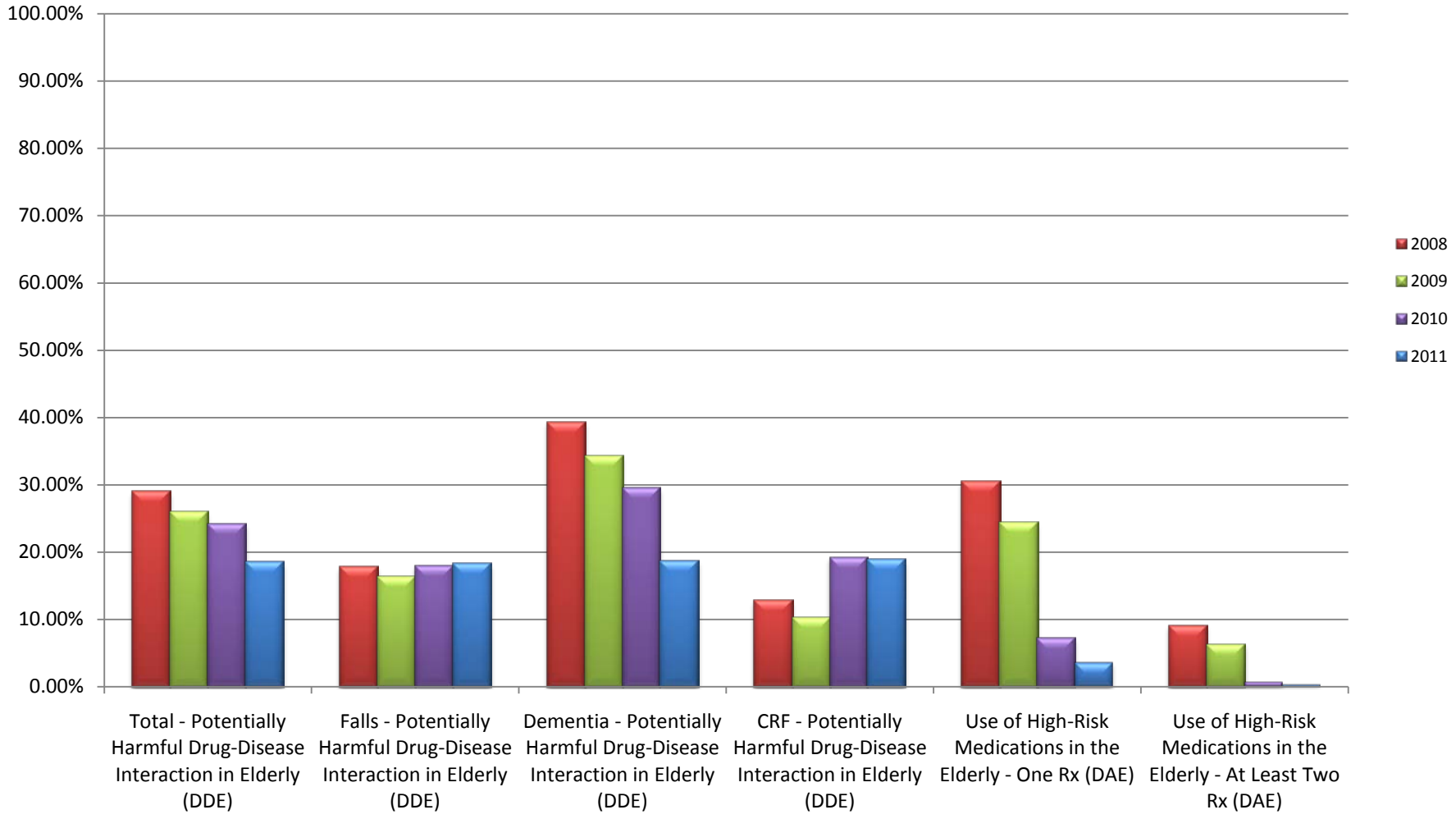
OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: MusculoskeletalART,OMW Behavioral HealthAMM,FUH



OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Medication Management
Total Annual Monitoring for Patients on Persistent Medications(MPM); Medication Reconciliation Post-Discharge (MRP)



OneCare Program Status Report:
HEDIS Results for 2008-2011
Effectiveness of Care: Medication Management
Harmful Interactions and High Risk Medications in the Elderly (DDE and DAE)



Attachment 19: NCQA Certification for D-SNP

-----Original Message-----
From: HPMS Web [mailto:hpms@cms.hhs.gov]
Sent: Friday, May 27, 2011 11:57 AM
To: Hubler, Kurt; Dwiers, Sharon
Cc: SNP Applications; Corley, Denise; HPMS Helpdesk
Subject: H5433 - SNP Conditional Approval - Dual-Eligible - Medicaid Subset - $0 Cost Share

May 27, 2011

Richard Chambers
Chief Executive Officer
ORANGE COUNTY HEALTH AUTHORITY
1120 W. La Veta Avenue
Orange, CA 92868

Re: Conditional Approval of SNP Application
H5433 - ORANGE COUNTY HEALTH AUTHORITY - Dual-Eligible - Medicaid Subset - $0 Cost Share

Dear Richard Chambers:

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

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

Your Quality Improvement Program Plan passed.

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

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

Element Summary

Element 1	4
Element 2	12
Element 3	12
Element 4	12
Element 5	20
Element 6	16
Element 7	16
Element 8	20
Element 9	15
Element 10	8
Element 11	23
Total Points	158
Total Possible Points	160
Score	98.75%

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

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

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

Thank you for your interest in participating the SNP program and we look forward to working with you to fulfill our mission of providing Medicare and Medicaid beneficiaries with access to affordable specialized

services and benefits. Please contact your Regional Office Account Manager if you have questions concerning your SNP proposal application.

Sincerely,

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

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

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: October 27, 2011

TO: All Medicare Advantage Organizations

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

SUBJECT: Special Needs Plan (SNP) Model of Care (MOC) Approval Process Scoring Criteria for Contract Year 2013

Included with this memorandum is the *Special Needs Plan Approval Process Scoring Criteria for Contract Year 2013* that provides guidance to Medicare Advantage (MA) organizations regarding specific criteria that will be used by the National Committee for Quality Assurance (NCQA) to evaluate and approve SNP models of care for contract year (CY) 2013 consistent with 42 CFR §§ 422.4(a) (iv), 422.101(f), and 422.152(g).

For CY 2013, only the following categories of SNPs are required to submit their MOCs for approval: (1) new SNPs, (2) existing SNPs that wish to expand their service areas in CY 2013, and (3) SNPs whose CY 2012 MOCs were granted approval for one year. We note that the MOC approval information for each SNP operating in CY 2012, including those whose MOCs were approved for one year, can be found on the SNP Model of Care Approval Process webpage at: https://www.cms.gov/SpecialNeedsPlans/03_SNPMOC.asp#TopOfPage. SNPs required to submit their MOCs for approval for the CY 2013 cycle will submit their MOCs as part of the MA application process in the same manner as for CY 2012. We will provide further guidance and instructions with the MA applications for CY 2013.

In CY 2013, the NCQA SNP approval process will continue to be based on scoring each of the 11 clinical and non-clinical elements of the MOC in the SNP proposal. The elements and scoring criteria are described in detail in the attached scoring criteria document *Special Needs Plan Approval Process Scoring Criteria for Contract Year 2013*. Please note that we are not revising the elements or scoring criteria for CY 2013.

Additionally, the benchmarks for the SNP approval process will remain the same for CY 2013. A passing score is seventy (70) percent. We will continue to implement a multi-year approval process that will allow plans to be granted a longer approval period based on higher MOC scores. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher on NCQA's evaluation of their MOC are granted SNP approval for three (3) years.

- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range on NCQA's evaluation of their MOC will be granted SNP approval for two (2) years.
- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range on NCQA's evaluation of their MOC will be granted SNP approval for one (1) year.

Since the SNP approval process has been incorporated into the general MA application process, SNPs will have two opportunities to cure their MOCs, in parallel with the overall MA application process.

For detailed guidance on the application and approval requirements that currently apply to SNPs, please refer to section 40 of Chapter 16b of the Medicare Managed Care Manual (Publication 100-16) located on our website at http://www.cms.gov/Manuals/IOM/list.asp.

Similar to the CY 2012 cycle, we intend to conduct, in conjunction with NCQA, several Open Door Forum Technical Assistance (TA) sessions to assist SNPs with their MOC submissions. Information on these TA sessions will be forthcoming. We will also be holding an industry listening session to discuss the CY 2012 MOC approval process to help inform the process for future years.

We look forward to continuing to work with MA organizations to ensure that they can offer SNP products for CY 2013 consistent with the specific requirements articulated in this memorandum and the attached document.

Attachment 20: County Letters

County of Orange
SOCIAL SERVICES AGENCY
888 N. MAIN STREET
SANTA ANA, CA 92701-3518
(714) 541-7700

February 21, 2012

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

Re: Letter of Support for CalOptima's Application for California's Dual Eligible Demonstration Project

Dear Mr. Douglas:

The purpose of this letter is to express my support for CalOptima's application for California's Dual Eligible Demonstration project Request for Solutions.

Since its inception, CalOptima has taken careful and incremental steps to promote integration across the continuum of care. CalOptima already has in place many of the components that you wish to include in the Demonstration Project. CalOptima's Medicare Advantage Special Needs Plan, OneCare, already provides coordinated care for nearly 13,000 of Orange County's dual eligible. CalOptima is the Multipurpose Senior Services Program (MSSP) site for Orange County, the lead agency for Orange County's Aging and Disability Resource Center (ADRC), the Medi-Cal Behavioral Health Administrative Services Organization for the County of Orange, and is well on its way to opening Orange County's first Program of All Inclusive Care for the Elderly (PACE) site. CalOptima is recognized throughout the state and country as a model health plan for providing care to vulnerable populations. CalOptima consistently ranks among the highest performing Medi-Cal managed care plans in terms of quality measures and is rated a 4-star plan overall in the Medicare Star quality rating system.

As the administrator of the Orange County In-Home Supportive Services Program, the Social Services Agency has a long history of delivery of community-based long term care support services to the elderly and disabled. This experience has convinced us of the value of improving the coordination of care and services to this vulnerable population. We have worked closely with CalOptima for many years and are confident of their ability to collaborate with other long term care providers and to deliver high quality services.

I fully support CalOptima's efforts to develop a coordinated and integrated system of care for dual eligible and other vulnerable populations, consistent with our mutual agreement that changes to IHSS will depend upon the concurrence of all parties. I look forward to working with CalOptima and its other partners to develop a model that meets the specific needs of Orange County.

Sincerely,

Michael L. Riley, Ph.D.
Director
Social Services Agency

c: Wendy Aquin, Director, Adult Services & Assistance Programs, SSA
Carol Mitchell, Deputy Director, Adult Services, SSA