ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you deserve.

# Alameda Alliance for Health

## Request for Solution
## California Dual Eligible Demonstration

**February 24, 2012**

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# Request for Solution
# California Dual Eligible Demonstration
# Table of Contents

# Request for Solution
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# Appendix List

Attachment A: Dual Eligible Demonstration Model of Care (modified)

Attachment B: Job Description for Exec. Dir. of Dual Programs

Attachment C: RFS Proposal Checklist Supporting Documentation*
Mandatory Qualifications Criteria

1. Alliance for Health Knox Keene License
2. Good Financial Standing Letter from DMHC
3a. Medicare D-SNP License
4. Medi-Cal Fully Executed Contract
7a. List of all Medicare/State of California Sanctions and Penalties - Last 5 Yrs
8a. List of all DHCS-Established Quality Performance Indicators - Last 3 Yrs
8b. List of all MA-SNP Quality Performance Requirements - Last 3 Yrs
12. Letters of Support from the Community Confirming the Alliance Accepted Community-Level Stakeholder Input
12. Narrative of All Activities Designed to Obtain Community Input Including Specific Examples of How the Plan Developed in Response to Community Comment

*Support documentation is available in alternative formats upon request. Please contact Sierra Gross at SGross@alamedaalliance.org to make a request.

Applicant Name: Alameda Alliance for Health Date: February 24, 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. | X | |
| 2 | Applicant is in good financial standing with DMHC. (Attach DMHC letter) | X | |
| 3a | Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years. | X | |
| 3b | Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014. | | See 3a |
| 4 | Applicant has a current Medi-Cal contract with DHCS. | X | |
| 5 | Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care. | X | |
| 6 | Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals. | X | |
| 7a | Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment. | X | |
| 7b | Applicant is not under sanction by Centers for Medicare and Medicaid Services within California. | X | |
| 7c | Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California. | X | |
| 8a | Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. | X | |
| 8b | Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements. | X | |
| 9 | Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration. | X | |
| 10 | Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration. | X | |

Signature: _____

Applicant Name: Alameda Alliance for Health Date: February 24, 2012

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

Signature: _____

Applicant Name: Alameda Alliance for Health Date: February 24, 2012

| | Criteria for Additional Consideration | Answer | Additional explanation, if needed |
|---|---|---|---|
| 1a | How many years experience does the Applicant have operating a D-SNP? | 3+ | The Alliance began operating its D-SNP in 2008 |
| 2 | Has the Plan reported receiving significant sanction or significant corrective action plans? How many? | No | |
| 3 | Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success? | Unclear | There were some areas where there were improvements, and others where there were declines in rates. The declines in rates are largely attributed to data capturing issues and HEDIS vendor issues. The Alliance has contracted with a new HEDIS vendor for 2012 which should improve rates and has focused efforts for improving HEDIS rates using various strategies including provider outreach, member outreach, and education. In 2009-2010, the Alliance SNP membership grew from 500 to 4000. During this time, some of the Alliance HEDIS results improved, others did not. With most of SNP membership being relatively new to organized care delivery, current trends (positive or negative) cannot be validly attributed. |
| 4 | Does the Plan have NCQA accreditation for its Medi-Cal managed care product? | No | We are currently preparing for NCQA accreditation. |
| 5 | Has the Plan received NCQA certification for its D-SNP Product? | No | We are currently preparing for NCQA accreditation for our D-SNP product. |
| 6 | How long has the Plan had a Medi-Cal contract? | 15 years | |
| 7 | Does the plan propose adding supplemental benefits? If so, which ones? | Yes, contingent on the results of | The Alliance proposes to provide the same supplemental services currently available to its SNP |

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| | | | |
|---|---|---|---|
| | | rate negotiations | members. The decision on whether these supplemental services will be covered benefits will depend on the results of rate negotiations. Currently, the Alliance provides the following supplemental services to its SNP members.<br><br>**Transportation** - 24 one way trips (authorization rules may apply) sedan<br>Medi-Cal - mostly public transportation - bart/bus/paratransit<br>**Dental** - $0 for the following routine services<br>* oral exams<br>* 1 cleaning every 6 months<br>* 1 fluoride treatment every 6 months<br>* 1 x-ray every 3 years<br>Co-pays apply for some comprehensive dental services Limitations and exclusions apply<br>**Vision** - Medi-Cal beneficiary may be eligible for eyeglasses if they are under the age of 21, pregnant, or living in a skilled nursing facility.<br>For other members - up to 1 pair of glasses every 2 years<br>-up to 1 pair of contacts every 2 years<br>-up to 1 pair of lenses every 2 years<br>-up to 1 frame every 2 years<br>$100 limit for eye wear every 2 years |
| 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? | No | We have all major county agencies represented on the Steering Committee. A county process is necessary to secure the letters and we did not have sufficient time for such as process. |

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Applicant Name: Alameda Alliance for Health Date: February 24, 2012

| | | | |
|---|---|---|---|
| 9 | Does the Plan have a draft agreement or contract with the County IHSS Agency? | No | The Alameda County Social Services Agency is a representative on the Steering Committee, but the timeframe is insufficient to collaborate on a draft agreement. |
| 10 | Does the Plan have a draft agreement or contract with the County agency responsible for mental health? | No | Same situation as with IHSS. See response above. |
| 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 | We intend to contract with all SNP and PACE programs currently serving dual eligible beneficiaries in Alameda county. We also intend to contract with LTSS providers that currently serve dual eligible beneficiaries in Alameda county as well as Alameda County Behavioral Health Services Agency. |

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Applicant Name: Alameda Alliance for Health Date: February 24, 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. | X | |
| 2.3.1 | Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics. | X | |
| 5.1 | Applicant will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review. | X | |
| 5.2.1 | During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS. | X | |
| 5.3.3 | Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review.<br>○ A detailed operational plan for beneficiary outreach and communication.<br>○ An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs.<br>○ An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand. | X | |
| 5.6.1 | Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU. | X | |
| 6.1.1 | Applicant will report monthly on the progress made toward implementation of the timeline. | X | |
| 7.7 | Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries. | X | |
| 7.8 | Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. | X | |
| 7.9 | Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data. | X | |
| 8.3 | Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available. | X | |

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## Executive Summary

Alameda Alliance for Health (Alliance) has been serving Medi-Cal beneficiaries in Alameda County since 1996 as the local initiative in a "two plan" model county. The Alliance has also continuously operated a Medicare Advantage Special Needs Plan (SNP) focusing on dual eligibles since 2008. Alameda County dual eligible beneficiaries also have two additional SNPs and two Programs of All-Inclusive Care to the Elderly (PACE) as their choices for health care delivery. This proposal builds on the expertise and experience that the Alliance and these plan partners have developed in collaborating with complex patient populations and their network of providers. The Alliance Dual Eligible Demonstration (DE Demonstration) seeks to build from this foundation to include additional options for dual eligible beneficiaries to secure comprehensive coordinated care and services, while honoring the role of the beneficiary in directing need their health care needs.

Seniors in Alameda County represent just over 11% of the population, or 159,700 people. They tend to be isolated (38% live alone) and have a lower income (half have less than $15,053 in social security income,) with a high level of poverty (16% receive SSI, with half taking in less than $9,400 per year). Medicare enrollment for Alameda County is approximately 145,000 persons. In Alameda County, the dual population covered by both Medicare and Medi-Cal (over and under 65) is just over 45,000 persons. This includes partial dual beneficiaries who are not enrolled in Medicare Parts A, B, and D. The Alliance project intends to cover full benefit duals, eligible for Medicare Parts A, B, and D and Medi-Cal for enrollment into the DE Demonstration.

Substantial changes will be necessary in the current health delivery model for dual eligible beneficiaries in order to better manage and coordinate their services including the incorporation of community long-term services and supports, as well as the expansion of behavioral health services, into a new integrated delivery system. The Alliance and its plan partners' experience in managing and supporting a county-wide network of external health care providers demonstrates the strong

management and experience necessary to successfully develop and integrate the additional and expanded network of providers.

The Alliance DE Demonstration will seek to support the many seniors who have already developed a "web" of social support services by causing minimal disruption to these relationships while simultaneously supporting individuals who have been unable to adequately direct their care because of the complexity and fragmentation of the current delivery system. The Alliance and its community partners will utilize an integrated care model for coordinating the full continuum of medical, behavioral health, and long-term supports and services (LTSS) with multi-disciplinary/multi-agency person-centered care coordination as a central unifying component. Alameda County's integrated care model will support consumers and their caregivers in self-directing their care/services with an emphasis on broad consumer choice. The integrated care model will ensure continuity of care and strongly promote the ability of dual eligible beneficiaries to remain in their homes and communities by providing the appropriate level of services and supports.

The Alliance project intends to cover full benefit duals, eligible for Medicare Parts A, B, and D and Medi-Cal. This proposal outlines a 3 year progressive phase-in of behavioral health services in an effort to ensure sufficient time to develop an effective integration model with behavioral health stakeholders. For those beneficiaries choosing to enroll in the Alliance plan, the Alliance proposes to offer supplemental services and benefits currently provided under its SNP, contingent upon the results of rate negotiations for the DE Demonstration. Other plan partners will also outline the supplemental services and benefits offered to any beneficiary choosing to enroll in their demonstration option. Reinvestment of cost savings will add supplemental services and benefits to the DE Demonstration with a focus on increasing social services and supports, such as those provided through the Multipurpose Senior Services Program (MSSP) and the expansion of best-practice models currently operating in Alameda County, as outlined below.

## 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.**

In January 1996, the Alameda Alliance *for* Health became the first health plan in California to begin operations under the Two-Plan Model. The Alliance is Alameda County's local initiative with Anthem Blue Cross taking the role of the commercial plan. As of January 2012 the Alliance serves over 140,000 low income members through its Medi-Cal, Healthy Families, Alliance Group Care, and Alliance CompleteCare programs. Since 2008, the Alliance has served dual eligible beneficiaries through its CompleteCare, a Medicare Advantage Special Needs Plan (SNP) targeting duals. The Alliance CompleteCare (CompleteCare) currently serves over 4,300 members.

Also in 2008, the Alliance began managing the health care of the severely disabled, former residents of Agnews Developmental Center who were transitioned into community homes, most of whom are dual eligible beneficiaries. Both the Alliance CompleteCare and Agnews populations have highly complex medical and behavioral healthcare needs that require a great deal of care management and coordination. The Alliance's experience with these members has greatly increased its competency to serve similar populations with complex needs for coordinated care.

Under the terms of the California 2010 Section 1115 Waiver, the Alliance had to meet new enhanced requirements such as access and performance improvement in order to transition Alameda County's Medi-Cal only Seniors and Persons with Disabilities (SPD) into its Medi-Cal Managed Care membership. Because of its experience with CompleteCare, the Alliance was well positioned to meet plan readiness requirements. Although these SPDs are not dual eligible beneficiaries, this experience helps further prepare the Alliance for serving the dual eligible community because like dual eligibles, SPDs have more complex healthcare needs requiring services that go beyond traditional medical services. As of January 2012, the Alliance has successfully transitioned almost 11,000 Medi-Cal only Seniors and Persons with Disabilities.

Alameda County's commercial plan, Anthem Blue Cross, does not operate a SNP nor PACE in Alameda County. However, dual eligible beneficiaries can choose to have their Medicare benefits provided on a fee-for-service basis and their Medi-Cal services within managed care. Anthem Blue Cross and the Alliance have these dual eligible beneficiaries enrolled in their Medi-Cal Managed Care products. The Alliance is managing the care of over 7,600 dual eligible beneficiaries who have volunarilty enrolled in its Medi-Cal Managed Care product.

The DE Demonstration plan partners have developed similar expertise in serving the dual eligible community, including Alameda County's PACEs. PACE is a fully integrated, comprehensive provider of a full continuum of care that includes both medical and long-term supports and services (LTSS) in a seamless, coordinated manner to the dual eligible beneficiaries who meet nursing facility level of care. Alameda County's PACEs have been serving this population for the past 20 years and include On Lok, the organization on which the PACE model is based, and the Center for Elders' Independence (CEI) which has operated in Alameda county since 1992.

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

Similar to all the DE Demonstration plan partners, providing coordinated services to dual eligible beneficiaries directly corresponds to the Alliance's mission, as reflected by the Alliance's decision in 2008 to create a SNP targeting this exact population. The mission of the Alliance is to provide managed care services to Medi-Cal recipients and other lower-income beneficiaries through a network of public and private providers as a partner in Alameda County's health care safety net system. Historically, the Alliance's mission has focused on the coordination of medical services within the health care delivery system. More recently, the Alliance has learned through serving its SNP and Agnews members that the needs of these populations extend beyond medical services. The critical role of behavioral health and social services and supports in promoting quality of life, avoiding long term care placement, and improved health outcomes make the incorporation and

integration of these services a strategic match in ensuring the Alliance continues to progress in its mission. The expansion of the Alliance's current SNP infrastructure to include these services will ensure this progress.

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

The DE Demonstration project has been designed to meet two sets of goals, those set out by SB 208, and those described by DHCS in the Request for Solutions (RFS). As will be outlined in greater detail in Section 4, Question 4.1, the unifying element of the Alliance's DE Demonstration will be a multidisciplinary/multi-agency, person-centered coordinated care model. The Alliance will develop and expand its current network of providers to include new service providers in the area of long-term supports and services (LTSS). The organizations providing LTSS will be incorporated into the coordinated care model. The person-centered coordinated care model utilizing a multidisciplinary/multi-agency approach will coordinate benefits and support access as well as ensure improved continuity of care and services as required under SB 208 and the RFS.

The use of Interdisciplinary Care Teams (ICTs) in the care coordination model will ensure the Alliance DE Demonstration meets the additional goals outlined in SB 208 and the RFS. As will be further outlined in Section 4 and the Alliance modified "Model of Care", the DE Demonstration's ICT will have dual eligible beneficiaries and their caregivers as the central element in decision-making. An ICT works together with the member in planning care from their discipline-specific perspectives. Through shared staff conferencing and by consulting with each other, the interdisciplinary team and the member gain new insights for addressing problems and have the opportunity to produce a holistic plan of care for the client. Team members make decisions about services in collaboration with the member and other disciplines. Team members are able to identify and integrate aspects of care and service delivery into their practice that are most important to the members they serve. ICT goals include the minimization of complications associated with

hospitalization and/or sub-acute inpatient stays and the maintenance and improvement of the functional level of patients. The ICT model, which is built around the beneficiary, will ensure these individuals self-direct their care while providing high quality services**.**

As with most members, when it is their desire to remain in their home and the community, the ICT model promotes increased utilization of home- and community-based services in lieu of institutionalization because the ICT integrates the care and services that are most important to the members they serve. Dual eligible beneficiaries with meaningful decision-making who want to remain in their homes will gravitate to the provision of services and supports that help them remain in their homes and communities and the ICT's role is to support this effort.

The aim of the Alliance DE Demonstration program is to implement a system of care coordination that will provide comprehensive coverage of medical benefits and long-term supports and services. This design will allow close integration of services and move towards a seamless system that will improve consumer satisfaction because of the greater authority and information provided to dual eligible beneficiaries on self-directing their care and services and the increased efficiency and ease of a more organized delivery system.

In terms of optimizing the use of Medicare, Medi-Cal and other State and County resources, a three-way contract where Medicare and Medi-Cal resources are blended into one rate will ensure that Alameda's DE Demonstration meets this goal. In addition, The Alliance will propose a risk sharing arrangement structured in a manner that retains shared savings for the Alliance and its DE Demonstration partners for reinvestment in supplemental services. In order to provide these supplemental services, the Alliance DE Demonstration must optimize the use of federal, state and local resources.

**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.**

The Alliance DE Demonstration is based on a person-centered coordination care model for integrating the full continuum of medical, behavioral health, and long-term supports and services with multidisciplinary and multi-agency case management as a central unifying component. The Alliance DE Demonstration program's integrated care model will support consumers and their caregivers in self-directing their care with an emphasis on broad consumer choice. The integrated care model is designed to ensure continuity of care and strongly promote the ability of dual eligible beneficiaries to remain in their setting of choice, including their homes and communities, by providing the appropriate level of services and supports.

The proposed DE Demonstration will cover Alameda County relying on the network of health care providers that are now part of the Alliance (1,700 doctors, 15 hospitals, 29 community health centers, and more than 200 pharmacies) and expanding to include a new network of long-term supports and services providers (See Section 2, Question 2.1.2) as well as behavioral health and substance use providers (See Section 3, Question 3.1). Where participants may be seeing non-Alliance contracted providers, credentialing and contracting with these fee-for-service providers will be pursued in order to ensure continuity of care to dual eligible beneficiaries (See Section 7, Question 7.3).

Current estimates indicate that the potential universe of dual eligibles is close to 45,000 individuals in Alameda County. This group includes a number of individuals ineligible for the DE Demonstration because they are enrolled in only Medicare Part A or B. The Alliance helps educate and assist individuals who are missing Part A or B to apply for Part A or B, where appropriate. Those individuals securing enrollment in both parts of the Medicare program will become eligible for the DE Demonstration. Non full dual eligible beneficiaries will be enrolled in the Coordinated FFS model, outlined below.

Dual eligible beneficiaries are now offered the choice to enroll in organized health care delivery for both their Medi-Cal and Medicare benefits through one of three existing SNPs or two PACEs. The CEI and On Lok provide the PACE options and the Alliance CompleteCare, Health Net's Seniority Plus Amber II and Kaiser Permanente's Senior Advantage provide the SNP options for Alameda County's dual eligible beneficiaries.

In the DE Demonstration, the Alliance will act as the single accountable agency with other plan partners taking part as either full participating subcontractors, PACE partners or as alternative demonstration options for Alameda's dual eligible population. The Alliance and full participating plan partners will provide parallel services to DE Demonstration consumers including coordinated case management or care coordination. To facilitate comprehensive integration and coordination, full participating plan partners will agree to work with the Alliance to develop interoperable case management systems. The Alliance will make its case management software and its provider portal broadly available to support this effort (See Section 7.1 for more information on software and provider portal). Full partners will work with the Alliance to finalize policies and procedures on coordinated case management specifically for DE Demonstration participants.

The Alliance has begun discussions with the following plans to invite their participation as full DE Demonstration Plan Partners: CEI (PACE), Kaiser Permanente Senior Advantage (SNP), and On Lok (PACE). These plans along with the Alliance CompleteCare represent the majority of integrated Medicare/Medi-Cal plan options for Alameda's current dual eligible beneficiaries. The Alliance has also begun discussions with Anthem Blue Cross, Alameda County's commercial plan, on collaborating and cooperating with DE Demonstration efforts, particularly in the area of network development.

On Lok and CEI are committed to participation in Alameda Alliance's DE Demonstration. Under the Demonstration, PACE eligible, DE Demonstration participants will be informed of their

ability to select PACE as a plan option. Federal statute and regulations require PACE organizations to operate under a three-way agreement between CMS and the state Medicaid agency to receive capitated payments from Medicare and Medi-Cal directly from these payor sources. These PACE partners will continue to receive these direct payments, but the DE Demonstration will collaborate with PACE partners in other areas described throughout this proposal.

The Alliance has also engaged Kaiser in preliminary discussions on a DE Demonstration partnership. The Alliance strongly supports continuity of care for dual eligible members already enrolled in organized delivery systems and therefore, the Alliance supports allowing current SNP members to be grandfathered into their existing SNP, unless the member actively requests a change at open enrollment. Based on the information provided on the D-SNP/Dual Demonstration call organized by DHCS on February 15, current SNP members will not be subject to a disruption in their current SNP enrollment and will instead be part of a grandfathering process.

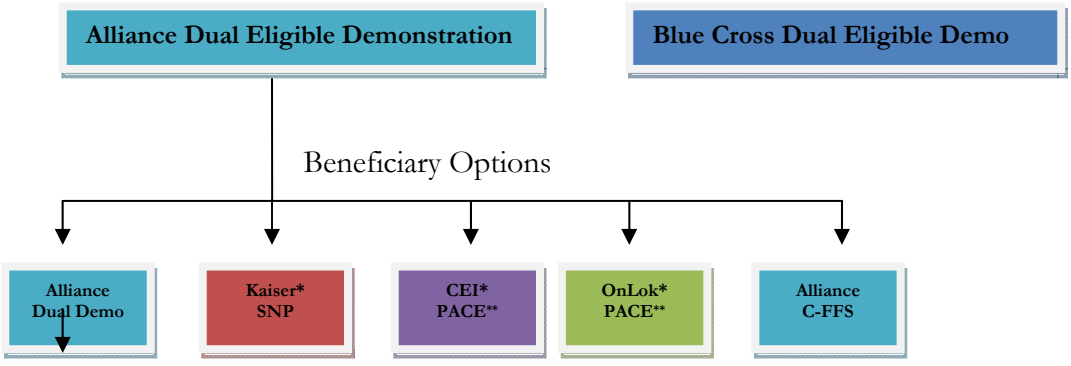
In discussions with Kaiser, the Alliance and Kaiser are considering a collaboration to ensure Kaiser's grandfathered members have access to the LTSS and behavioral health services provided to their DE Demonstration counterparts. Kaiser has also been invited to participate in the Alliance DE Demonstration as a subcontractor entitled to assignment of new dual eligible beneficiaries as a DE Demonstration full plan partner.

As mentioned previously, a central unifying component of the DE Demonstration will be multidisciplinary, multi-agency case management, coordinated through the use of interoperable technology and other shared communication tools. Developing unified interoperable infrastructure for coordinated case management and information sharing will be critical because the care coordination of dual eligible consumers will be assigned, through delegation and other arrangements, to the most appropriate DE Demonstration partner. (See Section 4, Question 4.1)

The Alliance DE Demonstration will also expand the choices for beneficiaries by adding participation in a "Coordinated Fee-For-Service" option. The Coordinated Fee-For-Service option will be available for dual eligible consumers who "opt out" of organized care delivery for Medicare and instead, decide to remain in fee-for-service for this portion of their care. Under the DE Demonstration, these individuals will be enrolled in Medi-Cal managed care and access the enhanced case management benefit via the DE Demonstration in order to coordinate their care. DE Demonstration participants who choose Medicare fee-for-service and Medi-Cal managed care will be assigned to the Alliance's Medi-Cal managed care product for Medi-Cal benefits such as most long-term care, including Medicare ineligible nursing home stays and home and community-based services.

The DE Demonstration will seek to include the organizations currently operating dual eligible SNPs or PACE programs as full plan partners. Those organizations choosing to not participate will retain all dual eligible beneficiaries enrolled in their programs when the DE Demonstration is implemented. The plan partners in the DE Demonstration believe this model will provide consumers with broad choice in making their decision on how to receive their care and services.

**Demonstration Options**




*The Alliance will be discussing participation in its Dual Eligible Demonstration with these plans and soliciting their participation.
**Only dual eligible beneficiaries meeting PACE eligibility requirements can choose to be enrolled in these programs.

In the DE Demonstration, for those beneficiaries choosing the Alliance as their plan, the Alliance proposes to provide the same supplemental services currently available to its SNP members. SNP supplemental services include dental, vision and transportation services. Whether these supplemental services will be covered will depend upon the results of the rate negotiations with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

In addition to these supplemental services, the models and services utilized in the Multipurpose Senior Services Program (MSSP) serving Oakland, Berkeley, Piedmont and Emeryville and the City of Fremont, Aging and Family Services will be targeted for replication in Year 2 and beyond. These two models currently serve seniors including dual eligible beneficiaries in only a few cities or hubs. In year 2 and ongoing, the Demonstration will seek to reinvest cost savings in order to create additional hubs for these service models. Eventually, the success of this effort could result in these supplemental services existing county-wide.

Another best practice the Demonstration will seek to replicate through reinvestment of cost savings is the mental health co-location model currently underway in Eastmont Clinic. (See Section 3, Question 3.3)

The Alliance also proposes to include the supplemental services of a social worker or licensed clinical staff for Community Based Adult Services (CBAS) providers assigned the case management function for former ADHC beneficiaries determined ineligible for CBAS services. The Alliance and ADHC providers transitioning to CBAS are concerned that this vulnerable population will quickly deteriorate without this additional support. In addition, the unbundled services of former ADHC providers/CBAS providers are also being evaluated as potential Demonstration supplemental services in outgoing years. The evaluation will focus on the purchase of supplemental

unbundled services intended to create additional cost savings while increasing the quality of care to duals.

Discussion of the integrated benefit package is included in Question 1.2.2.

**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.)**

If selected as a pilot county, the Alliance will enter into a three-way contracting arrangement with CMS and DHCS for the entire scope of Medicare and Medi-Cal benefits. Since the Alliance has already operated a SNP, the Alliance has a history of integrating the benefits offered in both programs and will expand this integration to include, medical and mental health benefits, pharmacy benefits, and long-term supports and services. The Alliance DE Demonstration will develop its own parallel infrastructure building from the existing SNP, which will be subsumed in the DE Demonstration. CompleteCare's infrastructure for will be expanded to include the new Alliance DE Demonstration full scope of services and benefits. Claims processes, member and provider services, pharmacy including a Part D formulary and LTSS will be expanded to address the new integrated benefit package and staff training will focus on the DE Demonstration product including the fully integrated continuum of services.

The Alliance has significant experience in maintaining distinct benefit products and providing the same high quality services regardless of the financial model. In addition to operating a Medi-Cal managed care product and a SNP, the Alliance also operates a commercial product for IHSS workers and acts as a Third Party Administrator for Alameda County's Low Income Health Program. The Alliance also operates a Healthy Families product. All of these products have different benefit packages and are managed as unique product lines.

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

The Alliance's SNP implemented an evidenced-based Model of Care (MOC) for its members on January 1, 2010, in compliance with CMS regulations. SNP plan partners were also required to

meet these requirements. The DE Demonstration model is based on the evidence-based SNP MOC. Under this model, case managers use evidence based clinical guidelines as the basis for disease state assessment and care plan development. Clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources.

The MOC also uses several methods to ensure that its contracted providers are informed of and monitored on the requirements to use evidence-based clinical practice guidelines and nationally recognized protocols as the basis for healthcare decisions including:

- The plan's provider contracts and the Quality Improvement Program stipulate that providers are expected to follow professionally recognized standards of practice and use evidence-based clinical practice guidelines.
- Plan approval of services that require authorization is based on medical necessity compared with Medicare Coverage Guidelines and nationally recognized clinical guidelines.
- The plan's Grievance and Appeal and Potential Quality of Care Issue processes may reveal atypical or unacceptable practice situations or patterns and provide an opportunity for the plan to intervene with providers that are not using evidence-based clinical practice guidelines and nationally recognized protocols as the basis for healthcare decisions.
- The 30-year-old PACE model is considered evidence-based.

**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.**

Based on the demographics of the county's dual eligible beneficiaries, the DE Demonstration will provide access to care to some of the most medically vulnerable residents of the State.

The DE Demonstration model will target these beneficiaries and ensure that they receive individualized care and services specifically intended to promote positive outcomes. A primary function of the Interdisciplinary Care Team described in Question 1.1.3 will be the development of an Individual Care Plan (ICP). The ICP will be the tool used to ensure individualized care and services that address risk factors, prevent health disparities, and reduce the effect of multiple co-morbidities. An ICP is developed for each member that includes measurable objectives and timetables to meet a member's medical and psychosocial needs that are identified in a comprehensive assessment. The DE Demonstration will be expanded to include the need for long-term supports and services. The comprehensive ICP describes the services necessary to attain or maintain the member's highest practicable physical, mental, and psychosocial well-being. It describes any services that would otherwise be required, but are not provided due to the member's exercise of rights, including the right to refuse treatment. It is developed within a short time frame after completion of a comprehensive assessment. The development of the ICP includes the participation of the member, the member's family or the member's legal representative. It must be approved by the interdisciplinary team, communicated to the attending provider, and other appropriate staff with responsibility for the member and other appropriate staff in disciplines as determined by the member's needs.

The comprehensive assessment will also be used to help identify high risk members including those with multiple co-morbidities. The ICP for vulnerable members specifically looks at the concurrent presence of two or more chronic diseases or conditions, dual diagnoses, and the major health care implications associated with this disease condition and address the needs through multiple interventions including Medication Therapy Management, control of hypertension, smoking cessation program, foot care, ophthalmology care, urinary incontinence and depression.

Plan partners use similar processes to address disparities and improve care. For example, PACE has almost a 30-year history of successfully managing the care for high-risk dual eligible beneficiaries afflicted with multiple co-morbidities while maintaining high quality of care and patient satisfaction at reduced costs. PACE will be one of the options for those individuals who are eligible for a nursing facility level of care and would benefit from a fully integrated model.

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

The Home Health SPA seeks to provide health homes to enrollees with multiple chronic conditions. To be eligible for health home services, Medi-Cal beneficiaries must have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, and substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition.

As long as the DE Demonstration beneficiary is determined eligible for health home services, the DE Demonstration model parallels the type of provider arrangements, the types of services and the general framework outlined in the Health Home SPA.

The program is specifically based on an Interdisciplinary Care Team model linked with coordinated community service provision. As will be described further in Section 4, one entity will be designated as the lead care coordination home for each beneficiary. Most, if not all, care coordination entities meet the requirements to be a health home. The health home services that are eligible for the 90% FMAP include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services, if relevant; and the use of health information technology (HIT) to link services. All of these services will be part of the Alliance DE Demonstration.

The Alliance DE Demonstration specifically follows CMS guidance that establishes standards for the SPA through building capacity for a "whole-person" approach to care. CMS expects SPA programs to provide quality-driven, cost-effective, and culturally appropriate person- and family-centered health home services, take responsibility for coordinating and providing access to preventive and health promotion services; coordinate mental health and substance use services; implement comprehensive care management, care coordination and transitional care across settings; focus on chronic disease management; emphasize individual and family supports, including referrals to community and social supports; and coordinate long-term supports and services. All of these elements are also part of the Alliance DE Demonstration.

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

The DE Demonstration is based on a variety of assumptions that could present a range of potential challenges. The most pronounced obstacle will be the implementation of this entire process within the designated timeframe. Although ultimately doable, there is concern that the dual eligible beneficiary community will not be given sufficient time to fully engage and understand this transition. A critical element in preparing for the DE Demonstration will involve working closely with organizational representatives to this community in order to ensure they are prepared to assist their constituency with information and support. The Alliance encourages CMS and State to invest resources to support a broad education and dissemination effort on these demonstrations.

Another challenge area will be developing and monitoring a non-medical provider network. This is a new area for the Alliance and most Alliance plan partners. The Alliance and plan partners will look to PACE partners and the many well-established long-term supports and services providers in Alameda County to assist us in development of this network.

The need for massive and sophisticated information sharing and interoperability will present yet another significant challenge. The Alliance hopes to address this concern through the

development of HIPAA compliant joint policies and procedures and intense collaboration between internal information technology experts.

Rate setting will be another challenge since these specific dual eligible populations have likely never received organized care delivery. Furthermore, the management of non-medical services will also be new to the Alliance. The Alliance will propose a risk sharing arrangement structured in a manner that retains shared savings for the Alliance and its DE Demonstration partners for reinvestment in supplemental services, also offers shared savings to DHCS and CMS that increase after the first two years, and provides loss protection to the Alliance that reduces after the first two years of uncertainty. The savings shared with DHCS and CMS will be focused on the up-front savings that discussions indicate will already be embedded in the capitation rates by virtue of them being set lower than the historical combined Medi-Cal fee-for-service and Medicare expenditures.

## Section 2: Coordination and Integration of LTSS

### Section 2.1: LTSS Capacity

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

The main mechanism in the DE Demonstration linking medical care and long-term care services and supports (LTSS) will be the multidisciplinary/multi-agency, person-centered care coordination model, briefly discussed previously and discussed more fully in Section 4. Section 4 will explain the importance of developing a unified interoperable infrastructure for coordinated case management and information sharing because the case management or care coordination of dual eligible consumers will be assigned, through delegation and other arrangements, to the most appropriate DE Demonstration partner. The Alliance will actively seek out agencies and establish or expand its formal relationships in order to enhance its network to include LTSS providers including contracting with LTSS providers to perform the lead person-centered coordinated care function.

As part of the person-centered care coordination model, the DE Demonstration would seek to identify and provide additional supports to those participants most at risk of institutionalization. These individuals would be identified through the following opportunities:

- Risk stratification of all DE Demonstration participants at enrollment and annually,
- Referrals from weekly inpatient concurrent review meetings,
- Identification of members that suffer a catastrophic health event during the year,
- Referrals from the use of a high risk case management algorithm, and
- Monitoring of high dollar in/outpatient claims.

Those participants identified at greatest risk of institutionalization will be provided with high risk case management or high risk care coordination services. High risk case management services will be the primary coordination mechanism used to keep DE Demonstration participants in their homes and communities for as long as possible. The DE Demonstration high risk case management program will build on this service within the Alliance's SNP, CompleteCare. All plan partners also currently provide high risk case management for their dual eligible members.

High risk case management services in CompleteCare are intended to support beneficiaries in their homes and community include general care coordination activities such as arranging for the involvement of appropriate clinicians, access to care, care process coordination, documentation of care, member involvement and follow-up. Services that support movement and activity to strengthen self-reliance and provide intrinsic benefits are also included as well as social support systems. If the member and their social network are strong, the health actions in the care plan include the participation of family and friends. The weakness or absence of a network is also recognized and addressed.

Member and outcome-oriented goals are obtained during initial assessment and throughout the ongoing Member-Case Manager relationship, which direct the agreed upon health actions and

individual member motivation. Using a member-centered approach, members actively participate in and assume responsibility for their care. The clinical condition may preclude full self- sufficiency and self-management, but even modest increases in self-reliance, as evidenced in concrete behaviors that are part of a contract with high risk case management members, can have a significant positive impact.

The integration of long-term supports and services in the DE Demonstration will expand the arsenal of coordinated services available to keep DE Demonstration participants in their homes and in the community. Except with PACE plans, these critical services are not currently available to dual eligible beneficiaries as part of an organized health care delivery system. The DE Demonstration will seek incorporate them into the delivery system and thus maximize their impact in preventing institutionalization through their full integration in the high risk case management program.

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

Building from the Alliance's existing provider networks, the Alliance will expand its network by contracting with a sufficient number of LTSS providers to cover the dual population in Alameda County. Currently the Alliance CompleteCare program includes medical specialists, skilled nursing facilities, dialysis facilities, and mental health specialists to ensure that CompleteCare members have access to providers with the expertise necessary to treat their medical and behavioral health conditions.

In developing the DE Demonstration network, the Alliance will target those LTSS and behavioral health providers currently serving the dual eligible beneficiary community. The Alliance will request from DHCS a complete list of current Medi-Cal fee-for-service LTSS and behavioral health providers and from CMS a list of all Medicare providers in Alameda County. These community providers will be surveyed about their current services to dual eligible beneficiaries, their

interests in expanding their scope of services and whether they want to participate in the DE Demonstration. Provider eligibility will follow the Alliance's existing credentialling process, unless this function is delegated to another entity such as the Public Authority, and an evaluation of the providers' ability to meet standards outlined by DHCS as well as the Alliance. All participating providers will need to meet information sharing requirments and commit to participation in data collection as outlined by the Alliance. These commitments will be focused on meeting DHCS requirements for monitoring and evaluation of the DE Demonstation through a "pay to play" process with data collection and information sharing being the price of participation in the network.

Many of these providers have established geographic- or health condition- based formal and informal relationships that will shape the DE Demonstration's LTSS provider network. Initally, the aim of the DE Deomonstraion project will be to arrange for existing service providers to cover participants by directly contracting with those providers already offering high quality services. In the out years, the Alliance will both expand the capacity of the service network and identify and spread successful examples of best practices.

For example, the City of Fremont Human Services Department, Aging and Family Services offers extensive benefits and services for this population including a senior help line, emotional support, in-home assessments and care coordination, the Community Ambassador Program for Seniors, a health promoter program, paratransit and a caregiver support program. This agency serving the southern part of the county, the Fremont, Union City, Newark and Hayward areas, will be the contracted hub providing long-term supports and services as well as contracted person-centered care cooordination for many of the Tri-City (and Hayward) dual eligible beneficiaries enrolled in the Demonstration.

The Alliance will also collaborate with Anthem Blue Cross by adding CareMore, a subsidiary of Anthem, as a contract site once it establishes services in Alameda County. The CareMore Care

Center is a care model for pro-active, integrated health that combines wellness and medical supervision. CareMore Care Centers offer personalized health planning that ensures that all members receive the individualized attention they need. CareMore staff is specially trained in the areas of senior health care.

In order to secure economies of scale and as the single accountable entity, the Alliance will administer the long-term social supports and services benefit for any full plan partner lacking the capacity to provide these non-medical services to their assigned beneficiaries. In order to provide this service coordination, the Alliance will seek a small portion of premium payments from full plan partners. In addition, in order to gain adequate expertise in the delivery of LTSS, the Alliance will retain full responsibility for the administration of its assignees' LTSS.

Because the Alliance will be working with SNP plans that, like the Alliance, lack familiarity with LTSS and may also not be interested in developing this network, the Alliance intends to build the entire LTSS network for some of the full participating plans. Although the Alliance believes some full plan partners will develop or already have their own network, the Alliance will build the capacity to offer the full scope of these services as a carve-out benefit to plan partners. This model will allow full plan SNP partners to continue to serve the dual eligible population with their existing SNP product. This model will also allow full plan partners to develop their own LTSS network if it is in their business interests to do so.

In order to enhance consumer choice and participation in serving this complex population, some full plan partners will offer the full scope of services to dual beneficiaries either on their own, such as the PACE partners, or by collaborating with the Alliance to ensure access to comprehensive LTSS. In this model, the integration of enhanced case management or care coordination services will necessitate a negotiation among plan partners to determine appropriate roles for each entity in care coordination.

For example, most plan partners will want a level of control over the enhanced case management function such as selection of the case manager. However, for those individuals whose utlization falls primarily in the area of LTSS, it may be more appropriate to have a case manager assigned from within the LTSS network. Plan partners participating in this model will develop joint policies and procedures to address this situation in a manner that supports the principles of integrated services, continuity of care, consumer self-direction and promoting home and community-based services.

As with the Alliance's current provider network, the Alliance will enter into rate setting negotiations with LTSS providers in order to establish an appropriate capitated payment for services. The capitated reimbursement arrangement will be based on the outcome of the three-way contract negotiation with CMS and DHCS. The Alliance hopes to secure the baseline spending information from DHCS and CMS in order to better inform these negotiations.

Negotiation with SNP plan partners will depend on whether these plans will offer a fully integrated benefit package that includes LTSS benefits or utilize the Alliance's LTSS network for the provision of the comprehensive benefit package. As mentioned previously, PACE plan partners will continue to be reimbursed under their three-way contract between themselves, CMS and DHCS.

**Question 2.1.3 Describe how you would use Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.**

As an expansion of its function in CompleteCare, the Alliance will act as the single point of entry and use its infrastructure to support the processing of enrollment and assessment forms. The screening process now used in the Alliance CompleteCare program would be the basis for conducting assessments under the DE Demonstration program. In this model, staff contact the member to complete the Health Risk Assessment (HRA) and use the information to develop an Individualized Care Plan (ICP). One of the purposes of the ICP is to describe the services that are to

be furnished to attain or maintain the member's highest practicable physical, mental, and psychosocial well-being including a description of LTSS services. More information on the ICP can be found in Question 2.1.5.

Building from this existing HRA and in order to facilitate appropriate assignment for care coordination, full participating partners in the DE Demonstration will collaborate in the development of a unified base assessment tool or adjust the tool created by DHCS in order to address the Alameda County context. Agencies participating in the DE Demonstration will be trained on completing enrollment forms as well as the assessment tool and act as virtual single points of entry. Interoperable technology will be adopted for entry of enrollment and assessement information in a HIPAA compliant format allowing for protected information sharing.

The assessment function will also be one of the primary mechanisms used to integrate PACE plan partners into the DE Demonstration. As the single point of entry, the Alliance will perform assessments identifying PACE eligible dual beneficiaries. Based on these assessments, dual beneficiaries will be informed of their option to enroll with PACE plan partners and referred to these partners in accordance with their choice. PACE plan partners will use the Alliance's assessment determining PACE eligibility to meet state requirements. The Alliance and PACE plan partners estimate this process will identify approximately 500 dual eligible beneficiaries that are both PACE eligible and interested in pursuing this choice each year. PACE plan partners will share encounter data and any other information necessary to include these beneficiaries in the DE Demonstration evaluation. The Alliance and PACE plan partners will develop a Memorandum of Understanding in order to formalize this arrangement. New enrollment from this Single Point of Entry process does not change the complete carve out of existing PACE beneficiaries from the DE Demonstration.

To further ease the administrative burden on the dual eligible beneficiary, there is also the opportunity to streamline some of the administrative processes at the Two Plan level. The Alliance and Blue Cross can collaborate to develop common contracts and forms to be used among respective DE Demonstration plan partners. This is not unlike how the Alliance and Blue Cross partner to do Facility Site Reviews and Medical Record Reviews on providers who contract in both networks. In order to avoid each plan conducting the same review on the same provider, the Alliance and Blue Cross established a Memorandum of Understanding that allows one plan to accept the review results of the other plan. In this way, the plans can work together to streamline and reduce duplicatve efforts.

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

As part of its stakeholder engagement process to develop the Alliance's DE Demonstration proposal, the Alliance has engaged with numerous LTSS providers and LTSS consumer groups. The Alliance also has direct experience working with LTSS providers and staff through a number of its existing products and programs:

- The CompleteCare (SNP) program includes partnerships with 16 skilled nursing facilities, which form the basis of the Alliance's experience in working with clients in institutional settings and more importantly, in transitioning individuals back to the community.
- The CompleteCare delivery system focuses on maintaining members in the community and therefore includes 10 home health agencies, 24 durable medical providers, and 23 occupational therapy and physical therapy providers.
- The Alliance has made a concerted effort to work closely with Alameda's Adult Day Health Centers (ADHCs), now Community-Based Adult Services (CBAS), providers to coordinate the transition of this benefit into managed care.

- The Alliance offers a commercial health coverage product specifically to IHSS workers. A strong relationship with this population and the Public Authority has been built through this experience.
- In collaboration with the Regional Centers, the Alliance has transitioned successfully to home based settings a largely dual eligible population of beneficiaries from Agnews Developmental Center. Maintaining their in-home support services, Part D pharmacy services, and physician in-home delivery of care.

DE Demonstration plan partners have similar experience with LTSS providers. For example, PACE organizations have a long history of working with institutional care providers including acute care facilities and skilled nursing facilities. The PACE interdisciplinary teams, which include the participants' primary care provider, continue to assess PACE participants who require placement in institutional settings and oversee the care provided in these facilities in coordination with facility staff. In collaboration with PACE partners, the DE Demonstration will evaluate the need to build capacity to provide these services.

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

The discussion regarding high risk case management included in the answer to Question 2.1.1 describes the integrated care the DE Demonstration will provide to individuals living in institutional settings. The DE Demonstration would rely on the Interdisciplinary Care Team (ICT) to develop an Individualized Care Plan (ICP) focused on transitioning these individuals into the community. The ICP would include measurable, realistic objectives and as mentioned previously, the ICP would address at a minimum five basic issues. 1) Describe the services that are to be furnished to attain or maintain the member's highest practicable physical, mental, and psychosocial

well-being. 2) Describe any services that would otherwise be required, but are not provided due to the member's exercise of rights, including the right to refuse treatment. 3) Develop an ICP within a short timeframe after completion of the comprehensive assessment. 4) Obtain approval of the ICP by an Interdisciplinary Care Team, communicate the ICP to the attending provider, and other appropriate staff with responsibility for the member and other appropriate staff in disciplines as determined by the member's needs. 5) Include the participation of the member, the member's family or caregiver or the member's legal representative.

In terms of transitioning institutionalized beneficiaries interested in returning home, the Alliance and Anthem Blue Cross have begun discussions on collaborating to evaluate appropriate agency partners specifically dedicated to lead the transition process. The Alliance and Anthem Blue Cross will evaluate existing agencies with recognized expertise in this highly specialized area. For example, Independent Living Systems goes into institutional settings and evaluates member satisfaction and interest in transitioning home or to alternative care settings. Their highly specialized team determines the viability of any alternative options based on member assessment. At the local level, the City of Oakland and the City of Fremont are sites for the Multipurpose Senior Services Program (MSSP), which works with seniors who are certifiable for nursing home placement but wish to remain in their communities. The Center for Independent Living and East Bay Innovations perform similar activities in Alameda County. The Alliance and Anthem Blue Cross will jointly evaluate the qualification of agencies to support the transition of institutionalized dual members to alternative settings and possibly partner in contracting for this service.

**Section 2.2: IHSS**

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

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

**•County IHSS social workers will use the Uniform Assessment tool and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams.**
**•Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.**
**•County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration.**
**•IHSS providers will continue to be paid through State Controller's CMIPS program.**
**•A process for working with the County IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.**

Please See the Dual Eligible Demonstration Certification Checklist.

**Question 2.2.2 With consideration of the LTSS Framework in Appendix E that emphasizes consumer choice, and in consideration of the approach taken in Year 1 as described above, please describe the interaction with the IHSS program through the evolution of the Demonstration in Years 2 and 3. Specifically address:**
**•A proposed care coordination model with IHSS, including the referral, assessment, and care coordination process.**
**•A vision for professional training for the IHSS worker including how you would incentivize/coordinate training, including with regards to dementia and Alzheimer's disease.**
**•A plan for coordinating emergency systems for personal attendant coverage.**

For IHSS services, the DE Demonstration will develop a contract with the IHSS Public Authority focused on information sharing to support care coordination. In Year 1, the Alliance will assist the Alameda County Social Service Agency in surveying over 17,000 IHSS providers to gauge their existing health care experience and their interest in receiving training to become part of a Interdisciplinary Care Team. Based on the outcome of the survey in Year 1, the Alliance will fund a small Health Navigator training program and trainings on assistive technology for IHSS workers interested in this professional development opportunity. Assistive technology training will target those workers supporting beneficiaries with these unique needs that could benefit from support with their current assistive technology. In order to receive the free Health Navigator training, IHSS workers must commit to act as volunteer Health Navigators in future Demonstration years. The role of Health Navigators will be discussed in Question 2.3.2 below. The Alliance will also contract

with the Center for Independent Living to conduct systematic provider training for the Demonstration network, including IHHS workers.

The DE Demonstration will also explore the alignment of IHSS' social workers with specific DE Demonstration providers and case managers. IHSS social workers currently carry a case load of approximately 380 consumers, most are dual eligible beneficiaries. They conduct face-to-face assessments utilizing a social model and determine the appropriate number of IHSS hours for eligible consumers. In order to enhance the role of these professionals in the Interdisciplinary Care Teams, IHSS social workers will collaborate with the same providers and same case managers as much as possible.

In the Alliance's stakeholder engagement process, dual eligible beneficiaries repeatedly emphasized their reliance on the critical support provided by IHSS workers and their interest in preserving this program as is. In response to this very loud message from the beneficiary community, the Alliance aims to have a delegated contractual arrangement with the Public Authority in the final years of the DE Demonstration. The arrangement will include requirements on information sharing in order to support the DE Demonstration's care coordination function. The Public Authority will have the responsibility to maintain the IHSS workforce and provide IHSS services including the coordination of any emergency systems.

**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 See the Dual Eligible Demonstration Certification 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, and others) that support living in the home and in the community.**

The person-centered care coordination model emphasizes an Interdisciplinary Care Team (ICT) developing an Individualized Plan of Care, which will include an assessment of need for any

necessary community social programs that support living in the home and in the community. A function within the ICT will be a Health Navigator. Connecting beneficiaries to appropriate community social services programs will be the role of the Health Navigator. The DE Demonstration project will also use a Care Advisor Unit specifically designed to assist in making appointments and linking members with community services.

The Health Navigator promotes member satisfaction and access to services through outreach activities to DE Demonstration participants, and by providing accurate and timely information regarding benefits and community resources. The Health Navigator provides first-line non-clinical care coordination services and refers members to other social and medical services provided through community partners.

The Care Advisor Unit is a call center staffed by Care Advisors dedicated to the DE Demonstration members. The Care Advisors make welcome/Outbound Enrollment Verification calls to all new members after receiving the enrollment request. They ensure the members understand their benefits, make community referrals to social and medical services provided through community partners, and assist with transportation and interpreter services. Most Care Advisors will be bilingual to accommodate DE Demonstration members' language needs, including Spanish, Cantonese and Vietnamese.

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

Established organizations such as the Center for Independent Living, Through the Looking Glass and others will be approached as possible contracted Health Coaches for the DE Demonstration. The Health Coach is responsible for contacting participants to provide necessary health coaching to reduce or eliminate high-risk behaviors and encourage adoption of habits that are conducive to a higher quality of life. Health Coaches also work with members to identify their

health-related goals and support them in attaining them. The Alliance will seek to recruit partners with the greatest level of specialized expertise to address the needs of the participant population. The Alliance will also be contracting with the ILC to conduct trainings for the DE Demonstration provider network.

The Alameda County Social Services Agency, which oversees the Area Agency on Aging, has been a partner in the community stakeholder process working to develop the DE Demonstration, and will continue to be involved as a member of the DE Demonstration Steering Committee. The Alliance will also be using the AAA's county needs assessment to inform its understanding of the needs of aging populations including the dual eligible community.

Alameda County is not currently served by an Aging and Disability Resource Connection pilot site.

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

The Alliance has solicited senior housing providers to be part of the stakeholder group developing this proposal. Satellite Housing, which operates over two dozen senior housing properties in Alameda County, is a partner in the proposal development. Other large housing operators would include Mercy Housing, ECHO Housing, and the Alameda County Housing Authority. Using Satellite as a model, the DE Demonstration will look to identify social services staff, activities directors, project manager level staff liaisons, and resident services coordinators. The aim is to identify individuals who work with residents and are willing to assist in the development of outreach and education campaigns specifically targeting DE Demonstration eligible individuals.

These efforts would include providing housing sites with literature about the DE Demonstration and health education materials regarding chronic disease management (such as diabetic diet and nutrition information, smoking cessation or foot care) and environmental issues

such as fall prevention. In properties focused on low income seniors, the DE Demonstration will coordinate Health Navigators (community education and outreach staff) to participate in specific outreach activities, general interest events such as health fairs, and programs sponsored either by health plan partners or community service network partners.

DE Demonstration PACE partners have long-standing relationships with all types of housing providers including affordable senior housing, residential care, and assisted living facilities, as well as continuing care retirement communities. All of these types of housing providers are a source of referrals for entering PACEs as well as partners to PACE to provide housing to eligible individuals. Because of their long established relationship with all forms of senior housing providers, PACE routinely refers both current participants, and even those ineligible for PACE seeking information from PACE, to the appropriate housing providers. The DE Demonstration intends to learn from this model and consider replication, if possible.

**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.**

The Alliance's SNP, CompleteCare, and all other plan partners already provide seamless and coordinated access to a full array of mental health and substance use benefits covered by Medicare and Medi-Cal. The only Medi-Cal benefits not fully integrated into the Alliance's SNP are county specialty mental health services and some institutional care services. Since the DE Demonstration will build from the Alliance's existing SNP as well as SNPs and PACEs operating in Alameda County, significant focus will be on how to best integrate these few, highly specialized carve-out services.

In addition to working closely with the Alameda County Behavioral Health Care Services Agency (BHCS) on integration of carve-out benefits, the PACE plan partners can also impart their experience with successful integration of these specialized benefits. PACEs currently provide a full array of mental health and substance use benefits to PACE participants needing such services. PACE is a fully integrated model that provides services that are traditionally carved-out from Medi-Cal health plans. Both CEI and On Lok, Alameda's PACE programs, have a dedicated director of behavioral health, supported by psychotherapists, psychologists, psychiatrists, and behavioral health staff. The DE Demonstration will rely on the expertise of plan partners in designing an integration model.

As the integration model for the few critical carve-out services is being developed, the Alliance and full plan partners will continue to provide seamless, coordinated care with all other mental health and substance use services. The Health Risk Assessments described in Section 2 screen DE Demonstration participants for mental health/substance use needs. Behavioral health high risk members are identified using the algorithm developed by experts at OptumHealth, the Alliance's behavioral health business partner. The Alliance has collaborated with OptumHealth, an NCQA accredited organization, to develop an algorithm to identify enrollees at high risk using the depression, anxiety and cognitive functioning screening questions included in the HRA.

As has been mentioned in several areas throughout this proposal, dual eligible beneficiaries identified at risk of or in need of behavioral health services will seamlessly access the full array of mental health and substance use benefits through the DE Demonstration's person-centered care coordination model. The model will utilize Interdisciplinary Care Teams (ICTs) and Individualized Care Plans (IPCs) to ensure coordinated and seamless access to mental health and substance use benefits covered by Medicare and Medi-Cal. Behavioral health providers are and will continue to be active participants on ICTs and in the development of ICPs for these beneficiaries.

Warm hand-offs to behavioral health/substance use providers are functions of the ICT. Team members understand, appreciate, and collaborate with all necessary disciplines and providers. The ICT formed for dual beneficiaries with needs for mental health/substance use services will inform the member that the health screening process has identified them as someone who might benefit from taking advantage of the behavioral health care services to which they are entitled. An ICT member will then offer to "warm transfer" the beneficiary to mental health/substance use providers.

**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).**

Because the Alliance is planning a phased-in approach for integrating specialty mental health services, the Alliance will evaluate the need for additional personnel with specialized training such as a Mental Health Director as the integration model is developed. The Alliance currently maintains procedures for monitoring the coordination and quality of medical care provided to all beneficiaries including, but not limited to, all medically necessary mental health and substance use services. The Alameda County SNPs have all developed Quality Improvement Plans (QIPs) that have been approved by CMS and the QIPs will form the basis of quality assurance for mental health and substance use services for SNPs and the Alliance's Demonstration plan. As mentioned, both CEI and On Lok, Alameda County's PACEs have a dedicated director of behavioral health that oversees the quality of PACE mental health and substance use services.

Specialty mental health services for Medi-Cal members, currently carved out of the Alliance's contract with DHCS, are coordinated under a Memorandum of Understanding (MOU) executed with the local Alameda County Behavioral Health Care Services (BHCS). Through this relationship, the Alliance has worked with BHCS Directors to identify and address challenges that members and consumers face when accessing physical and behavioral health care services. BHCS' Medical Director was recently added to the Alliance's Health Care Quality Committee to strengthen this

relationship further and to incorporate BHCS' expertise in the Alliance's quality and utilization discussions. The Alliance will continue to work with BHCS and expand the scope of the existing MOU in Years 2 and 3 of the DE Demonstration, discussed further below.

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

As discussed under multiple questions, multidisciplinary, team-based care coordination will be a central tenet of the Alliance DE Demonstration with mental health and substance use providers as core team members for those beneficiaries identified with these needs.

The Alliance DE Demonstration also promotes the co-location of services and has identified a best practice for replication. LifeLong Medical Care - Eastmont is co-located at the Alameda County Behavioral Health Care Services (BHCS) Community Support Center at Eastmont Town Center in East Oakland. In 2010, BHCS received a grant from the Substance Abuse and Mental Health Services Administration which enabled this integration. LifeLong's primary care office is embedded in the physical heart of the Community Support Center (CSC) to provide onsite access to primary care services for consumers with serious mental illness (SMI) receiving behavioral health, case management and other support services at the CSC.

This site is part of a community wide effort in Alameda County to integrate primary care and behavioral health services in a variety of community based settings in order to address the significant unmet needs of consumers with SMI who historically do not get primary, preventive or chronic disease care. In addition to integrating primary care, behavioral health and case management services, LifeLong and CSC collaborate to offer health and wellness education services designed to empower consumers to take responsibility for their health and build self-management capacity. This holistic model is intended to eliminate fragmentation of services and increase utilization and access to care, and ultimately improve health for consumers with SMI.

Communication and care integration is facilitated through protocols, professional consults, standing meetings and data exchange which promote timely sharing of information and joint care planning. For example, weekly Interdisciplinary Care Team meetings allow for inclusive care plan development and case conferencing. LifeLong maintains up to date medical records that are accessible to BHCS staff. Conversely, LifeLong providers have access to BHCS mental health records for consumers under their care.

Data is being collected to evaluate the impact of this integrated model of care for consumers with SMI, including primary care utilization and outcome measures with a focus on chronic disease management, reduction in smoking/substance use, and preventive health care. The DE Demonstration will utilize this evaluation to support the reinvestment of shared savings to replicate the Eastmont co-location model in other areas of the county.

Among the many physician partners currently serving Alliance dual eligible members, the Alliance also contracts with the county federally qualified health clinics (FQHCs) who offer beneficiaries co-location of mental health and physical health services at a number of FQHC clinic sites.

**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.**

As part of its stakeholder engagement process to develop this proposal, the Alliance has worked with BHCS and consumer organizations such as the Disability Rights Education and Defense Fund. The DE Demonstration intends to have these organizations represented in its Steering Committee, the entity that will be charged with oversight of the DE Demonstration. The Alliance also convened a community forum on the DE Demonstration on February 6, 2012, where representatives of local advisory committees, dual eligible beneficiaries and other stakeholders were invited and 45 individuals attended. The Alliance has made a commitment to keep these attendees as well as other interested stakeholders informed as this process progresses. In addition as will be

discussed further in Section 5, the Alliance will be securing input from consumers through the Alliance's Member Advisory Committee.

**Section 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.)**

In Year 1, the Alliance and the Alameda County Behavioral Health Care Services Agency (BHCS) will develop and implement a process to request consent from dual eligible beneficiaries on information sharing. Dual eligible beneficiaries under the care of BHCS have heightened regulatory protections and additional barriers that must be carefully addressed in order to maintain strong consumer protections. The Alliance and BHCS will establish the infrastructure to data share by the end of Year 1. Data sharing is a critical first step towards integration.

The dual eligible community receiving specialty mental health services is a diverse population with extremely complex needs. The following vignettes from BHCS exemplify this point.

1. P.S. is a 67-year-old widowed female. She is referred by her son for evaluation of possible hoarding, mood instability and poor sleep. Her son lives with her. He moved in a few years ago to help care for his mother's spouse, who had cancer. The stepfather passed away in 2009. More recently, she has been paranoid, accusing her son of stealing money from her wallet. She was seeing a private therapist in Castro Valley for about a year. The therapist can no longer see the client due to transportation issues. Needs counseling, medication management and case management.
2. M.P. is a 61-year-old widowed female, referred by a hospital after recent hospitalization due to suicidal ideation. She has poor home and community management/support and is socially isolated. She has Medicare. She is on long-term disability from the phone company

(reports she had a nervous breakdown on the job). She has opiate dependence and chronic pain. She needs to re-establish therapy with her provider and needs case management services.

The highly complex nature of these beneficiaries necessitates careful planning on an integration model to support their needs and services. Integration activities for Years 2 and 3 of the Demonstration are included in the response below.

**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**

After Year 1, BHCS and the Alliance will have implemented a system to allow for the exchange of information through the process described above. Currently, Specialty Mental Health Services for Medi-Cal members, excluded from the Alliance contract with DHCS, are coordinated under a Memorandum of Understanding (MOU) executed with BHCS. The Alliance will work with BHCS to expand the scope of this existing MOU to include integrated care coordination and establish a formal agreement on shared savings or lower medical costs resulting from care coordination. This effort will focus on working together to identify shared demonstration participants who could benefit from collaborative care management; strengthen systems to support real-time, routine data exchange; and the development of effective interventions to improve care coordination. The coordination and collaboration on meeting Year 2 measures will build on the BHCS' "Service Team" model. This model supports mental health consumer participants who want to increase their independence in employment, housing and the management of their health. Participants focus on completing goals intended to improve living situations, working situations, creation of support networks, etc. BHCS Service Teams provide crisis, individual, group, family and

case management services. All Service Teams include case managers and a psychiatrist. Case management for DE Demonstration participants with primary mental health diagnosis will be done by BHCS.

In Year 3, behavioral health services will be fully integrated into Alameda's DE Demonstration through a delegated contract arrangement with BHCS.

**Section 4: Person-Centered Care Coordination**

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

The DE Demonstration Person-Centered Care Coordination (PCCC) model will be based on the Alliance's SNP Model of Care (MOC). All SNP plan participants are required to submit and secure approval for their MOC, which emphasizes PCCC. Similarly, the care for all PACE participants is managed by a fully integrated interdisciplinary team that semi-annually reviews the care plan for each individual participant and revises it as needed throughout the year when the participant's health status changes.

The PCCC model outlined in the modified MOC (see Attachment A) incorporates all the evidence-based elements of care coordination programs including Health Risk Assessments, Interdisciplinary Care Teams (ICTs), and Individualized Care Plans (IPCs) as described throughout this proposal. The ICTs and ICPs ensure that beneficiaries who are capable of self-directing their care are fully engaged in determining their own care delivery.

The unique element that the DE Demonstration will develop in order to best address the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among dual eligibles will be the multi-agency PCCC network of providers. All agencies contracted to lead PCCC efforts will collaborate with multidisclinary teams or ICTs through the use of interoperable technology and other shared communication tools. Developing a unified

interoperable infrastructure for coordinated case management and information sharing will be critical because the case management or care coordination of dual eligible consumers will be assigned, through delegation and other arrangements, to the most appropriate DE Demonstration partner.

Analogous to the single point of entry concept, is the concept of a sngle point of responsibility. Many dual eligible beneficiaries will require care and services from a variety of agencies. The agency that has the lead PCCC function will act as that single point of responsibility. In order to optimally coordinate care when there are numerous providers involved, there must be a single lead agency that functions as the single point of responsibility. This can be one of the providers in the PCCC network or it can be the Alliance. For example, the lead PCCC function for a dual consumer with a severe and persistent mental illness diagnosis would be most appropriately assigned to Alameda County Behavioral Health Care Services Agency (BHCS) and their evidence-based, best practice model utilizing Service Teams**.** This team would best lead the coordination of care for patients such as P.D. described below:

> P.D. is a 65-year-old female, referred to Behavioral Health Care Services for agitation, irritable mood, confusion, paranoia, and noncompliance with medication. She was detained after becoming combative with police. They described her apartment as in "shambles". She has had 2 hospitalizations since 2007. The most recent is from 1/25/12- 2/3/12. She reportedly has a long mental health history in Southern California. She has a son who lives locally, but he does not know much about his mother's illness.

While P.D. will require care from a variety of providers, BHCS' Service Team will act as the single point of responsibility or the primary "coordinator" of her care.

Alternatively, dual consumers eligible for CBAS and those ADHC participants determined ineligible may most effectively be case managed by their CBAS (formerly ADHC) provider,

including those entities with the infrastructure to address unique needs, such as the language and cultural competence available at the Hong Fook Centers of Family Bridges. Not understanding the hesitency of some ethnic populations to receive certain services or simply being unable to communicate because of language and/or cultural barriers present formidable barriers that can be overcome by incorporating those agencies formed for the exact purpose of serving these groups.

Other consumers, such as those with Alzheimers or dementia would be case managed by an agency with expertise in addressing the needs of these beneficiaries, such as the Alzheimer's Services of the East Bay.

A central hallmark of the Alliance's DE Demonstration will be to ensure that high quality PCCC is performed by the most effective practitioner within the most appropriate agency as determined in consultation with the consumer and their caregiver. DE Demonstration stakeholder convenings have made clear the diversity and complexity of the dual eligible community. The Alliance DE Demonstration for Alameda County seeks to address these unique needs and respect the expertise and experience of the many established agencies that have historically provided high quality care and services to these beneficiaries.

The Alliance will encourage full health plan partners to utilize the same multidiscipinary/multi-agency approach for PCCC services. A multidisciplinary approach to care coordination with active involvment of the participant and his/her caregivers are cornerstones of the PACE model of care. Full health plan partners will need to provide evidence-based, PCCC services that meet jointly developed policies and procedures as well as being in compliance with DHCS-developed standards for this service.

The jointly developed policies and procedures will include requirements regarding information sharing, coordination with ICTs, coordination with social supports and services as well as a framework for a uniform PCCC model. Because of the importance of this component, the

Alliance will withhold a small portion of premium payments from full plan partners to incentivize comprehensive collaboration on providing integrated PCCC. Withholds will be returned when full health plan partners comply with the jointly developed policies and procedures for PCCC.

Contracting for lead PCCC services with entities with expertise in serving dual eligible subgroups such as the disabled community and elderly ethnic communities will be one vehicle for addressing the wide diversity among the dual eligible community. The composition of the ICTs is another vehicle. The disciplines included in each beneficiary's ICT will be based on the dual beneficiary's disease condition as well as their functional and social needs. Though the disciplines represented in the ICTs may vary, some of the roles and functions will be consistent. ICTs will consistently include the functions of a Case Manager, a Health Coach and a Health Navigator – all described below. The case manager role and the function of a Health Coach and Health Navigator could be contracted through those qualified entities best suited to meet the unique needs of a specific sub-set of dual eligible beneficiaries.

- *Case Manager* - The Case Manager will provide services for DE Demonstration plan members with both short-term, stable, and predictable courses of illness as well as those with highly complex medical conditions where advocacy and coordination are required to reach an optimum functional level and autonomy. The Case Manager connects with providers, members, contracted vendors, community resources, and health plan partners to assess the member's health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. The Alliance will seek out established community agencies with a strong history of providing quality case management services to sectors of the dual eligible community and contract with these agencies to perform as the lead patient-centered care coordinator.

- *Health Coach* - The Health Coach is responsible for contacting participants and coaching

them to determine goals, reduce or eliminate high-risk behaviors, and encourage adoption of habits that are conducive to a higher quality of life. The Health Coach provides members with telephonic, email, or face-to-face support to meet their care plan goals. They also assist case managers with formulating service plans together with the clients, the primary care provider and other providers, and caregivers. Similar to the discussion regarding case management, established organizations such as the Center for Independent Living, Through the Looking Glass and others could become contracted Health Coaches for the dual eligible Demonstration.

The function of the Health Navigator has been discussed previously in Section 2, Question 2.3.2. As discussed in Section 2, the Alliance will spearhead a special training intiative involving training In-Home Supportive Services (IHSS) workers to perform Health Navigator functions.

As part of community stakeholder planning, a writing work group developed four profiles of senior or persons with disabilities that the DE Demonstration may serve. The work group was composed of a provider, community-based agency, and an advocate urged the inclusion of the profiles as a way to demonstrate that, as a group, the collective stakeholder group understands the populations' needs and expectations, the levels of care required, and the experience to help them. The following four profiles represent composites of actual clients.

*Profile One*

A.Z. is a low-income, elderly monolingual Afghan woman who lives at home in Fremont with her husband. She has diabetes, is overweight, and has slowed down over the years and seldom leaves her home. A.Z. has a primary care provider whom she seldom sees. She recently went to the emergency room due to her uncontrolled diabetes. Her symptoms included dehydration, drowsiness, and pain and tingling in her feet. A.Z.'s ER visit indicates a need for chronic disease self-management. She has had a hard time adhering to her screening and treatment regimen due to a language barrier and her focus on caring for her frail husband. A.Z is referred to the City of Fremont Health Promoter

Program where she is matched with a Health Promoter who speaks her language. After a risk assessment by a Public Health nurse, her bilingual Health Promoter will work with her to make sure she understands how to take care of her diabetes, including attending an evidence-based six-week Chronic Disease Self Management Class. A.Z. will also benefit from the Fremont Senior Wellness Program, called EnhanceWellness, that will continue support for 6 months to promote behavior changes to her exercise, diet and other weight management regimes to further help her control her diabetes and her weight. Her Health Promoter will also help her set up and attend regular screenings and other physician appointments.

*Profile Two*

L.M. is a 46-year-old woman who has a mobility disability and moderately high cholesterol and hypertension. She is highly self-directed and lives independently in Oakland. Before the recession, L.M. was an administrative assistant in the banking industry and used her Medicare coverage and a Medicare gap policy to obtain her health care. She lost her job three years ago and became a Medicaid beneficiary twelve months ago. As a result, she is at risk for homelessness and is having difficulty keeping her specialty care appointments, which are very important. L.M. needs assistance with several activities of daily living (ADLs). L.M.'s primary care provider is a specialist. Due to the rare condition that caused her mobility disability, her primary care provider (specialist) practices from a hospital-based specialty care clinic outside of Alameda County. L.M. has been going to this clinic since her teen years. In order to facilitate her care, the Alliance's Provider Services Department establishes an outpatient contract with the hospital that is several miles outside of Alameda County. The Alliance grants L.M. a standing referral to see her specialist so that her PCP does not have to continually obtain an authorization or referral. In order to better control and lower her moderately high cholesterol and hypertension, L.M. is advised to exercise. She is referred to an occupational therapist who has experience working with people who use mobility devices. L.M. is

also referred to BORP (Bay Area Outreach and Recreation Program), a local fitness program at the Ed Roberts Campus in Berkeley designed for people with disabilities. Lastly, L.M. is referred to the Center for Independent Living for peer support and assistance with housing and employment.

*Profile Three*

B.R. is a 55-year-old man who has sought care at LifeLong Medical Clinic (an FQHC) in the past. He is chronically homeless and often utilizes shelter care. He has a history of mental health and substance use disorder. B.R. also has diabetes, asthma, hypertension, and high cholesterol. He was recently hospitalized for a hypertensive emergency. B.R. has a variety of needs that require a high level of coordination. In order to address his dual diagnoses, B.R. is referred to Bonita House (a County Behavioral Health community subcontractor), which will serve as the lead agency in coordinating his care. Bonita House is a full service agency that provides a range of services that B.R. can benefit from such as intensive residential treatment, supported independent living programs, housing and supported employment, outpatient case management and clinic services. Through a Bonita House/Lifelong Medical Clinic partnership to co-locate behavioral health and primary care, B.R. can get his behavioral health and primary care services at the same site. Here B.R. will receive case management and counseling to address his numerous needs. To support B.R.'s case management, the Alliance Utilization Management staff will ensure that his Medicare and Medi-Cal behavioral health benefits are coordinated, inform his case manager of medical episodes such as ER visits and hospitalizations. Bonita House and Lifelong Medical Clinic will assist with his care transition planning.

*Profile Four*

S.C. is an 83-year-old woman who has lived in the same home for over 50 years. She is adamant about remaining in her home. She has COPD and congestive heart failure. She recently had a stroke and was discharged to home. Not long after that, S.C. fell and broke her hip. After this

hospitalization, she was discharged to a skilled nursing facility for rehabilitation with a plan to return to her home. She is unable to perform several ADLs such as bathing, toileting, or dressing without assistance. Due to her stroke and subsequent fall, S.C. needs appropriate durable medical equipment and a home safety check. She could also benefit from medication reconciliation to ensure that she is properly taking her prescription medications. The Alliance uses its contract with a local agency to arrange for a home evaluation to assess her safety and to present recommendations for improving safety. At the same time, the Alliance arranges for a physician to visit her home to make a co-assessment. S.C.'s home safety check reveals that some home modifications are necessary to prevent future falls. S.C. is determined to be potentially eligible for PACE. Her case manager explains this option to her and S.C. is very interested in enrolling with PACE. The Alliance completes the PACE assessment with primary care physician sign-off and S.C.'s sign-off. The enrollment paperwork is forwarded to the Center for Elder Independence to facilitate the State and CMS completion of S.C.'s enrollment in PACE.

**Question 4.2 Attach the model of care coordination for dual eligibles as outlined in Appendix C. This will not count against any page limit.**

See Attachment A.

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

Care coordination is a benefit that the Alliance provides in-house and through contracted arrangements with network providers. The Alliance network has the capacity to provide the full range of care coordination services including high risk case management to current members including new non-dual Senior and Persons with Disbilities members. Capacity will need to be built in order to ensure access to the entire targeted dual eligible population because of the high need for care coordination. Because of this need, the DE Demonstration will offer opportunities to contract with the Demonstration to provide PCCC, as discussed above.

Similar to the Alliance's plans to develop its LTSS network, the Alliance will first target those agencies currently serving the dual eligible beneficiary community. The Alliance will request from DHCS a complete list of current Medi-Cal fee-for-service providers and from CMS a list of all Medicare providers in Alameda County. In addition, as part of the stakeholder engagement process, the Alliance is broadly disseminating its interest in seeking out organizations with the capacity to support care coordination for DE Demonstration participants. In an Alameda County-based asset mapping process, these community providers will be surveyed about their current services to dual eligible beneficiaries or other similar communities, their interests in expanding their scope of services and whether they want to participate in the DE Demonstration. The collected information will be shared with plan partners interested in expanding their PCCC capacity.

The Alliance and plan partners already have well established processes in place for "qualifying" and monitoring network providers. In summary , this process includes:

- Monitoring providers to ensure use of nationally recognized practice guidelines when available;
- Ensuring providers are licensed and competent through a formal credentialing review;
- Requiring documentation of the process for linking members to services;
- Coordinating the maintenance and sharing of member health care information among providers, the ICT, and the plan.

Each plan partner will evaluate a provider's ability to meet standards outlined by DHCS as well as the plan partner. All participating providers will need to meet information sharing requirments and commit to participation in data collection as outlined by the Alliance in jointly developed policies and procedures.

The Alliance will also spearhead extensive education and cross training efforts for plan partner staff. The Alliance will contract with the Center for Independent Living to conduct

systematic provider training for the Demonstration network, including IHSS workers. Educational efforts will also include cross training among Interdisciplinary Care Teams within the multiple-agency structure. Teams will educate each other on the different disciplines, roles and responsibilities based on targeted population groups.

**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 see Dual Eligible Certification 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.**

The DE Demonstration will provide members with an Evidence of Coverage manual and Provider Directory upon their enrollment with the plan and annually thereafter. The DE Demonstration will also maintain a Website and ensure that the most recent benefit and provider network information is available to members and providers anytime. DE Demonstration plan partners follow similar processes and include additional support for provider selection. For example, DE Demonstration members choosing the Alliance as their plan are also encouraged to contact the Care Advisor Unit for assistance with choosing a specialist and coordinating referrals and appointments.

The Care Advisor Unit (CAU) was created as part of the Alliance CompleteCare SNP program and designed to provide proactive assistance in accessing care for any dual eligible beneficiary. In the DE Demonstration, the CAU and the Care Advisors who staff it will function much like it currently does for the SNP. The CAU will provide first-line, non-clinical care coordination services, including assisting members with obtaining covered Medicare and Medi-Cal benefits through the DE Demonstration provider network. The Care Advisors will make welcome/Outbound Enrollment Verification calls to all new members after receiving the enrollment

request. They will ensure that members understand their benefits, support member decision-making for community referrals to social and medical services provided through community partners, and assist with transportation and interpreter services. Most Care Advisors are bilingual to accommodate DE Demonstration members' language needs, including Spanish, Cantonese and Vietnamese.

Beneficiaries are also central in the decision-making functions of the Interdisciplinary Care Team (ICT). To solidify this role, a key component of the Interdisciplinary Care Team is to identify and integrate into their practice aspects of care and service delivery elements that are most important to the DE Demonstration members they serve. As described in Section 4, Case Managers and Health Coaches will work with members to obtain information that will be used to develop the Individual Care Plan. This includes obtaining the member's input on who should be a part of their ICT.

**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.**

The role of the beneficiary in the ICT will be the mechanism to ensure that dual eligible consumers effectively self-direct their care, when it is possible. The SNPs and PACEs currently operating in Alameda County all rely on ICTs to support consumers in care and service delivery. As mentioned above, a key component of the Alliance ICT model is to identify and integrate into their practice aspects of care and service delivery elements that are most important to the DE Demonstration members they serve. Care and social supports are planned by the ICT representing all appropriate health care and social support professionals. Dual eligible consumers have a central decision-making role on the team that the ICT works to optimize in serving beneficiaries.

Optimizing the ability of consumers to self-direct their care is promoted by the DE Demonstration's multidisciplinary/multi-agency person-centered care coordination model, described in Section 4. The lead PCCC participating in the ICT will be assigned to the agency that can most

effectively support the beneficiary in self-directing their care and support services. The critical importance of a consumer to self-direct their care and support services is best supported by ensuring that high quality PCCC is performed by practitioners within agencies that have historically served unique dual eligible sub-populations. The Alliance DE Demonstration seeks to respect and promote the many established agencies in Alameda County that have successful track-records in providing high quality services to disablied, elderly, culturally and linguistically-isolated populations, to name a few. These organizations will be charged with lead PCCC responsibilities including ensuring that consumers have an optimal role in care and service delivery decisions, regardless of their disease condition or functional and cognitive limitations.

**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.**

See Dual Eligible Certification 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.**

In 2011, the Alliance created its Accessible Service Commitment, which reads:

*Alameda Alliance for Health is committed to serving all of its members with respect and dignity. Our goal is to ensure that communications, physical spaces, services and programs are accessible to people with special needs, including visual, hearing, cognitive and physical disabilities.*

The Alliance has a strong commitment to accessibility, both in its physical facilities and in its programs (materials and communication assistance), as do all plan partners. The DE Demonstration project, as one of the Alliance's programs, would be included in this effort. For example, Question 5.3.2 will describe the inclusion of the Alliance's Cultural and Linguistic program in the DE Demonstration.

The Alliance also implements mechanisms to maintain an adequate, accessible network of primary care providers (PCP) and specialty care providers. Standards for the number and geographic distribution of PCPs and specialists are established and monitored for how effectively the network meets regulatory standards set forth by DHCS and the Department of Managed Health Care as well as the needs and preferences of the enrolled members. The Alliance assesses the cultural, ethnic, racial, and linguistic needs of members, and adjusts availability of network providers, if necessary.

Effective February 2011, DHCS mandated Medi-Cal managed care plans to use Facility Site Review Attachment C – Physical Accessibility Review Survey (FSR C) for all primary care providers, high volume specialists and ancillary service providers. Plans were also mandated to include accessibility information in the Provider Directory. FSR C assesses the physical accessibility of provider sites in an effort to ensure sufficient physically accessible providers for the SPD population. This SPD-specific effort will also support the ability of the DE Demonstration to ensure adequate accessibility for DE Demonstration participants.

The Alliance staff includes a FSR C Coordinator, who performs these assessments and determines whether Alliance provider sites meet basic access standards or currently have limited access. The Alliance has completed 95 audits and has 24 additional specialty providers scheduled to receive an FSR C survey in 2012. The DE Demonstration will incorporate this information to demonstrate compliance with network adequacy requirements in this area.

In addition, the Alliance has worked with the Disability Rights Education and Defense Fund (DREDF) as part of the DE Demonstration stakeholder engagement process. DREDF was a proponent of the FSR C process and has developed an assessment tool on physical accessibility. Using this tool and/or the FSR C as part of the network development process, the Alliance will weight accessibility in the selection of new providers and in the assignment process.

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

Language capacity and physical accessibility information will be included in the Provider Directory. Currently, sites participating in the FSR C survey receive the written summary of findings and a booklet on low cost actions to improve access. The results of the assessment are also publicly available on the Alliance's web site and this information is being incorporated into the Provider Directory. Alliance staff also have access to FRS C accessibility information and use this information when assisting members in selecting a provider.

**Section 5.3: Education and Outreach**
**Question 5.3.1 Describe how you will ensure effective communication in a range of formats with beneficiaries.**

The DE Demonstration will utilize the Alliance's Communications & Marketing Department to prepare and disseminate CMS- and DHCS-approved written plan information to DE Demonstration members and network providers. This information will be made available in accessible formats including large print, Braille, and audio versions, as well as versions of web pages designed with minimal graphics to facilitate reading programs. The Communications & Marketing Department staff identifies content needs and creates content that is accurate, reading-level appropriate, reflects brand standards, and meets regulatory guidelines. They also research, write, edit, and proofread content to ensure quality and effectiveness and collaborate with multiple departments to ensure consistency of messaging, tone, and voice throughout company communications. Key communication vehicles include brochures, information kits, Websites, member newsletters, member benefit materials, marketing materials, emails, and letters.

The DE Demonstration project will also expand its Care Advisor Unit, described in Question 5.1.1. The Care Advisors' principal responsibilities are to promote member satisfaction and access to services by 1) effectively communicating information, and 2) offering proactive support and care coordination. They perform outreach activities to new and established members, and will provide DE Demonstration participants with accurate and timely information regarding

benefits, community resources, availability of material in alternative formats, and accessibility information. Members will also to be asked to specify their preferred method and language of communication and these preferences will be stored in the Alliance's system of record and care management system.

**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.**

The Alliance will rely on its existing Cultural and Linguistic program to ensure that these needs are met. The Cultural and Linguistic program operates under the Quality Management Department. It reflects the Alliance's adherence and commitment to "National Standards for Culturally and Linguistically Appropriate Services in Health Care." The program conducts activities designed to assess and improve how well Alliance members are able to receive quality health care and will be expanded to assess the social support services that will be added. The program also conducts activities designed to assess whether any disparities or barriers exist that impede their ability to access care and services. These activities encompass efforts within the organization, as well as with Alliance members, providers, and Alliance community partners.

**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 See the Dual Eligible Demonstration Certification Checklist.

**Section 5.4: Stakeholder Input**
**Question 5.4.1 Discuss the local stakeholder engagement plan and timeline during 2012 project development/implementation phase, including any stakeholder meetings that have been held during development of the Application.**

In the spring of 2011, the Strategic Planning Committee of the Alliance Board of Governor designated Board member Marty Lynch, CEO of LifeLong Medical Care, to lead the Alliance's

effort on the DE Demonstration. The Alliance began bringing together community stakeholders in late 2011 to assist in the development of the Alliance DE Demonstration. The Alliance formed a Workgroup consisting of providers, plan partners, county agencies and consumer representatives. Organizations represented in these convenings include: 1) Adult Day Services Network of Alameda County, 2) Senior Services Coalition, 3) Satellite Housing, 4) Community Health Center Network, 5) Lifelong Medical Center, 6) Asian Health Services, 7) Alameda Health Care Services Agency , 8) Center for Elders' Independence, 9) On Lok, 10) Alameda County Behavioral Health Care Services Agency, 11) Alameda County Social Services Agency, 12) City of Fremont Human Services Department, 13) Disability Rights Education and Defense Fund, and 14) Center for Independent Living.

The Workgroup met twice in January 2012 with a subgroup also convening a third time. At the last two meetings, the Workgroup was given a draft DE Demonstration concept in order to provide feedback and insights. Changes in the draft concept including additional consumer protections and the development of carve-out options are directly attributable to Workgroup input. This Workgroup also met on February 17, 2012 to review the Alliance's response to the RFS. Input and recommendations from the Workgroup were again incorporated into the final RFS submission.

On February 6, 2012, the Alliance convened a community forum on the Dual Eligible Demonstration. The 45 participants including dual eligible consumers, advocates and providers were given an overview of the State's effort and asked to respond to several questions including which protections should remain in place, improvements that should be included in the Demonstration and how to continue to engage stakeholders in the development process. Protections regarding consumers self-directing their care and preservation of the IHSS consumer-focused model were two clear messages from this convening. Both of these elements have been incorporated into the final RFS submission.

In late January 2012, the Alliance also participated in a meeting convened by the Senior Services Coalition to discuss the DE Demonstration. That same month, the Alameda County Board of Supervisors Health Committee also held a hearing on the program. Speakers included Ingrid Lamirault, the Alliance's Chief Executive Officer, who described the Alliance's efforts to develop a DE Demonstration. The Alliance has also met with Kaiser Permanente and Blue Cross representatives to discuss the DE Demonstration.

Over the balance of 2012, the Alliance will convene quarterly meetings of the Workgroup to inform program implementation issues. This broad group of stakeholders will transition into the DE Demonstration's Steering Committee. The Steering Committee will be a Standing Committee of the Alliance Board and provide regular reports to the Board. All full plan partners will have a representative on the Steering Committee and dual beneficiaries will also be asked to participate. A plan representative and a provider, advocate or consumer representative will co-chair the Steering Committee.

The Alliance also intends to build on current community outreach efforts by creating two tracks for consumer engagement. One track will be focused on soliciting broad stakeholder feedback on DE Demonstration implementation issues. This track will consist of regularly scheduled quarterly community forums and will be coordinated to ensure Steering Committee participation. The second track will be dedicated to a massive communication effort to mitigate confusion among the dual eligible community. For this track, community engagement will intensify in the summer of 2012 in order to minimize misunderstandings regarding the phasing-in of passive enrollment into the DE Demonstration. The second track will be structured as an outreach and education campaign supported by insights gleaned from stakeholders participating in track one activities.

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

As mentioned in Question 5.4.1 above, stakeholder engagement will be institutionalized into the DE Demonstration through the creation of its Steering Committee. As mentioned, the Steering Committee will be a Standing Committee of the Alliance Board and provide regular reports to the Board throughout the three-year Demonstration.

Stakeholder engagement will also be institutionalized through the Alliance's Member Advisory Committee (MAC). The MAC is also a standing committee of the Alliance Board of Governors. The purpose of the MAC is to provide a link between the Alliance and the community and is comprised of members and community providers and advocates. The MAC advises the Alliance on the development and implementation of its cultural and linguistic accessibility standards and procedures. The committee's responsibilities include advising on cultural competency issues, and educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability. MAC membership will be expanded to reflect the DE Demonstration population in Alameda County. The MAC often serves as a springboard for ideas, initiatives, and programs and has proven to be very valuable to numerous planning activities of the Alliance.

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

Meaningful involvement of external stakeholders in the development and ongoing operation of the program will be secured through the Alliance's existing member and provider satisfaction efforts within its Quality Improvement Program (QI Program). The purpose of the Alliance Quality Improvement Program is to objectively monitor and evaluate the quality, appropriateness, and

outcome of care and services delivered to members of the Alliance and make changes based on this information.

The QI program measures member and provider satisfaction using several sources of satisfaction, including the results of the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, the Group Needs Assessment (GNA), complaint and grievance data, disenrollment and retention data, and other relevant data as available. These data are presented to the Board of Governors at quarterly and annual intervals. The plan may administer topic-specific satisfaction surveys depending on findings of other QI activities and studies. The QI Program is structured to continuously pursue opportunities for improvement and problem resolution.

QI Programs are required of all SNPs and similar requirements apply to PACE programs.

**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.**

As an expansion of its function in CompleteCare, the Alliance will act as the single point of entry and use its infrastructure to support the processing of enrollment and assessment forms. The Alameda DE Demonstration will seek to passively enroll dual beneficiaries with an informed "opt-out" option and will operate under a "flexible" six month lock-in. The flexible six month lock-in will allow consumers to transition between full plan partners participating in the Alliance DE Demonstration and the Coordinated Fee-For-Service Medicare and Medi-Cal managed care option at any point in time. In order to ensure consumers and their caregivers are fully informed of their choices including their ability to "opt-out" and the flexible six month lock-in, the Alliance will collaborate closely with consumers and consumer stakeholders on development of educational and enrollment materials.

As described in Section 1, Question 1.2.1, the Alliance and its SNP partners will retain their existing SNP membership, unless the member requests a change during open enrollment. These

members will be assisted by SNP partners and the Alliance in understanding how newly integrated benefits will be provided.

The Alliance will work with consumer representatives in order to ensure dual eligible beneficiaries and their caregivers have a meaningful process for opting-out of the DE Demonstration, a clear understanding of the Coordinated Fee-For-Service option as well as the other plan options. Enrollment is proposed to follow the SPD expansion process where participants are enrolled based on their month of birth (estimated at 2,500 persons per month) so enrollment can be spread over the entire year of 2013.

A dual beneficiary who is determined eligible for the Demonstration by the State will be informed of any additional Demonstration opportunity in Alameda County and given the option to enroll in either. Within the Alliance's DE Demonstration, a dual beneficiary will be educated on their choices among the plan partners as well as the Coordinated Fee-For-Service option. For example, On Lok and Center for Elders' Independence are committed to participation in the Alliance's Dual Demonstration. SB 208, the California state law authorizing the Dual Eligible Demonstration, mandates that PACE is available to eligible beneficiaries as a direct enrollment option. As a direct enrollment option, it is critical that individuals are informed of their ability to select PACE. For all dual eligible beneficiaries determined eligible for this program through the Alliance assessment process discussed in Section 2, Question 2.1.3, the DE Demonstration enrollment process will include information about PACE and ensure that PACE is listed as an option on the enrollment form.

Once the consumer and their caregiver become meaningfully informed of their options and make their own decision on a plan, the Alliance will facilitate the transition to this chosen plan. Alameda dual eligible consumers, who do not opt out and do not choose a plan after receiving

adequate information on their choices, will default into the Alliance DE Demonstration in order to ensure multiple options for assignment.

Once enrolled in the Alliance DE Demonstration, if the member does not select a plan, the Alliance will default the member to a plan. Default assignment will seek to first and foremost protect the consumer's continuity of care. An effort will be made to link beneficiaries to a partner plan by matching them with their highest utilized physician or physician group. If a clear match exists with a non-DE Demonstration plan, the Alliance will facilitate the transition of this consumer to that plan outside the Demonstration. Consumers without a demonstrated link with a physician or physician group will default into Alliance CompleteCare until objective quality criteria can be developed among plan partners to ensure adequate placement that rewards quality and member outcomes with more default membership. Full plan partners will collaborate on the development of default membership assignment and the Alliance will install firewalls between this function and other plan operations in order to ensure the integrity of this process for all participating plans.

In compliance with requirements regarding consumer protections, all dual eligible default assignees enrolled in the DE Demonstration will be carefully transferred from the fee-for-service (FFS) system to the assigned plan partner. Beneficiaries in the default process with complex medical conditions cared for by numerous providers will be given a "cooling off" period. During this time, they will continue to access their FFS providers until a comprehensive transition plan of care is developed by a DE Demonstration case manager. The plan of care will seek to maximize provider, medication, and treatment continuity of care.

This period can also be used to educate FFS providers about managed care plan participation opportunties and to enroll these providers into a plan's network. Assignment of dual eligible beneficiaries operating in the "cooling off" period will be facilitated by the expansion of the provider network to include FFS providers utilized by these beneficiaries.

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

The mandatory SPD enrollment process has generally gone smoothly at Alameda Alliance for Health. The Alliance has received fewer SPD access grievances than the majority of other plans. From July to September of 2011, only 10% (1) of Alliance SPD grievances were access related. The Statewide average for this time period was 31.1% (151). This low rate is attributable to the Alliance's Member Services Department actively seeking resolution to many access issues before those issues became actual grievances. This experience will help inform the enrollment of dual eligible beneficiaries into the Alliance's DE Demonstration. The Alliance also did relatively well in conducting Risk Stratification for new SPDs. Thirty-six percent (1,726) of new Alliance SPDs were successfully contacted via Outcomes, a third party administrator. Plans with in-house care management systems, allowing for direct communication between staff and members outperformed the Alliance in this area. Based on this experience, the Alliance anticipates shifting various services from delegated arrangements to in-house services for the DE Demonstration.

The Alliance's experience serving SPDs predates the mandatory enrollment of Medi-Cal only SPDs into managed care. Prior to June 2011, when mandatory SPD enrollment began, the Alliance served almost 15,000 Medi-Cal only SPDs who chose to voluntarily enroll in the plan. The Alliance was well positioned to meet the needs of these beneficiaries once the expansion began. The Alliance's experience serving these SPDs, as well as dual eligible members, has reinforced the importance of an integrated, organized, and coordinated system of care that extends beyond medical services and incorporates a broader range of services.

**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.**

Integral to the Alliance's effort to build an adequate network will be the identification of existing providers serving dual eligible beneficiaries through care coordination, LTSS and behavioral health/substance use services. In addition to the identification of these entities, the Alliance would also benefit from the fee-for-service payment rates for these providers and information on DHCS oversight, audit requirements and monitoring of quality, in particular for social support and service providers. The Alliance will need a clear understanding of reporting requirements, policies on data aggregation, accessibility, and provider qualification standards. The Alliance will also need utilization and any available risk data on each dual eligible beneficiary eligible for the Alliance's DE Demonstration.

**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 See Dual Eligible Demonstration Certification Checklist.

**Section 6: Organizational Capacity**
**Question 6.1 Describe the guiding principles of the organization and record of performance in delivery services to dual eligibles that demonstrate an understanding of the needs of the community or population.**

As discussed in Section 1, Question 1.1.2 and similar to all the DE Demonstration plan partners, providing coordinated services to dual eligible beneficiaries directly corresponds with the Alliance's mission and is reflected by the Alliance's decision in 2008 to create a SNP targeting this exact population. Plan partners such as SNPs and PACEs, all have years, and in the case of the PACEs decades, of direct experience delivering services to dual eligible beneficiaries.

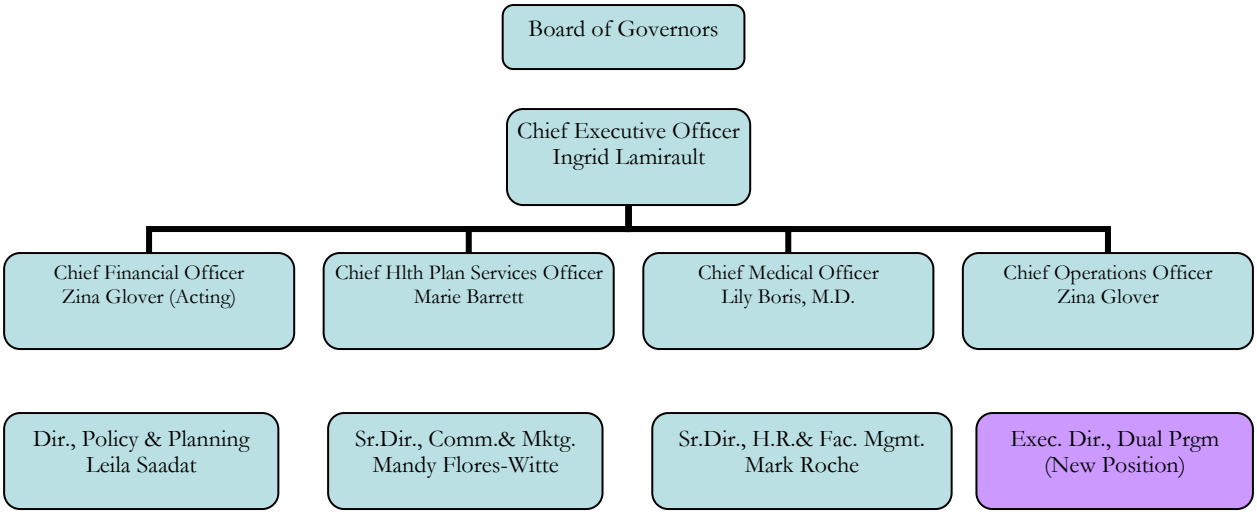
In addition to its SNP, the Alliance's record of performance in serving dual eligible beneficiaries includes, as mentioned, managing the health care of the severely disabled, former residents of Agnews Developmental Center who were transitioned into community homes in 2008. Both the Alliance's SNP and Agnews populations have highly complex needs that require a great

deal of care coordination and management. The Alliance's experience with these members has greatly increased its competency to serve the complex needs of the dual eligible population.

The Alliance also serves dual eligible beneficiaries receiving Medicare on a fee-for-service basis, who choose the Alliance to manage their Medi-Cal benefits. The Alliance is managing the care of over 7,600 dual eligible beneficiaries enrolled in its Medi-Cal managed care product.

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

**Alameda Alliance *for* Health Organizational Chart- Key Leaders**




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

Ingrid Lamirault is Chief Executive Officer of Alameda Alliance for Health and joined the Alliance as its CEO in 2003. Ms. Lamirault reports to a Board of Governors whose composition is determined by county ordinance and members are appointed by the Alameda County Board of Supervisors (for more detail about the Alliance's Board, please see Question 6.5). The entire Leadership Team, with the exception of two members, predate Ms. Lamirault's arrival to the Alliance. The Leadership is comprised of the following individuals, all of whom report directly to

the CEO: Zina Glover, Chief Financial Officer (Acting); Marie Barrett, Chief Health Plan Services Officer; Lily Boris, M.D., Chief Medical Officer; Zina Glover, Chief Operations Officer; Leila Saadat, Director, Policy & Planning; Mandy Flores-Witte, Senior Director, Communications & Marketing; Mark Roche, Senior Director, Human Resources & Facilities Management; and a new position that has yet to be filled, Executive Director, Duals Program. The Leadership Team is responsible for the guidance and overall management of the Alliance, which serves over 140,000 members through an extensive network of public and private physicians, hospitals, community health clinics, and pharmacies.

The Alliance Leadership Team has collaborated on the creation and on-going implementation of the Alliance's managed care products, most recently the creation of its SNP, CompleteCare in 2008. Since 2008, the Leadership Team has successfully managed the lives of dual eligible beneficiaries including assessment of their needs, maintaining an appropriate network and assisting beneficiaries in ensuring that their health care needs are met. The expertise established in the operation of this program will be leveraged to develop the Alliance's DE Demonstration product.

However, in the spirit of full disclosure, the Alliance currently does not have staff with sufficient experience with administering long-term care (LTC) and long-term care supports and services (LTSS) benefits, as these are not benefits that the Alliance has historically had to manage. Nonetheless, the Alliance has a plan to hire professionals with experience in these areas with medical, social services, and/or advocacy backgrounds. Recruitment will begin by outreaching to local LTC and LTSS providers and other experts. The recruitment will be done in earnest once notified that Alameda County is a pilot site. Some recruitment and job posting of new positions has already started because of the care coordination needs of seniors and persons with disabilities now mandatorily enrolled with the Alliance.

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

Julie Billman, Senior Consultant with Gorman Health Group, will be the Alliance's Interim Executive Director of Dual Programs. Her resume is included below:

**J. Billman Career Achievements**

- Project lead for enrollment and reconciliation during the implementation of Part D. Realized 600,000 PDP and 79,000 MAPD members.
- Director of Compliance for Medicare Private Fee-for-Service product implementation involved in all aspects of Medicare compliance for national product realizing in excess of 150,000 members.
- Director PDE for all Coventry products realizing an error rate of less than .5% for 2006 and 2007.
- Was an Operational Team Member specializing in enrollment, reconciliation, and operational functions for six Coventry Medicaid plans.
- Completed Service Area Expansion for Capital BlueCross HMO product for 2009.
- Presenter on the topic of Enrollment and Financial Reconciliation at the CMS Enrollment and Payment MA conference.
- Excellent department audit results with zero findings in the last 4 CMS audits for Enrollment and Reconciliation during time overseeing that department. Audit experience included CMS Medicare audits, CMS Financial Audits, OIG DIR audits, RADV and PDP audits, State Medicaid audits, HEDIS audits, and CCFP/ DPW audits on Title XX program.
- Highest departmental recognition Superior Achievement Award at Coventry. Qualifying results require high plan and coach recommendations and meeting or exceeding all department standards. Department has been nominated each year since the program began in 2001.

**J. Billman Career Experience**

**Gorman Health Group 02/11 to current: Senior Consultant**

- Consulting and Operational assessment for Gorman clients
- Providing Operational Expertise in areas of Operations and Revenue Management, MAPD, SNP, PDP lines of business
- Provide Compliance and Management Expertise
- Advised and trained clients on their operational, enrollment, reconciliation, and MSP/COB activity

**Capital BlueCross, 2500 Elmerton Ave, Harrisburg, PA 17177 01/08 – 02/11**

**Director Policy Analysis and Product Development (01/08 to current)**

- Monitor Operational Compliance with all Medicare Regulations
- Manage the Annual renewal process to include the PBP submission, ANOC/EOC preparation and mailing and all new year readiness activity
- Liaison between CMS, OIG, and other regulatory entities and the plan. Facilitate all regulatory audits.
- Ensure company oversight of MA and PDP products.
- Lead interdepartmental teams to implement regulatory changes

**Coventry Health Care, 3721 TecPort Drive, Harrisburg, PA 17106-7103 8/93 – 01/08**

**Director of PDE and Business Reporting (07/07 to 01/08)**

Corporate lead to manage the PDE Error resolution process with internal Coventry staff. Corporate lead to manage PDE process with external PDM. Managed corporate business reporting for Medicare products. Corporate lead coordinating HPMS reporting.

**Compliance Director (11/06 to 06/07)**

Compliance Implementation of PFFS and new MSA product. Document review and training for PFFS and Georgia MA plan. CMS Liaison for PFFS and Georgia MA plan. Agent Compliant management and CTM complaints, FWA abuse committee Chair

**Compliance Manager (07/06 to 11/06)**

Compliance Implementation of PFFS, Document Review and training for PFFS and Georgia MA plan. CMS Liaison for PFFS and Georgia MA plan.

**Business Manager Advantra/Government Programs Enrollment (11/01 to 07/06)**

Responsible for the implementation of Part D for enrollment and reconciliation in both stand alone and MA. Handled all business aspects of Business side of Project Management for enrollment and AR deliverables for existing and new systems. Managed transition process for business transferred to my department to include 6 existing Medicaid plans and 3 new Medicare start up plans and two acquisitions. Manage Service Center department that maintains Medicare enrollment, Medicaid enrollment, and Membership reconciliation. Manage relationships with Nine Coventry plans health plans for Medicare and Medicaid enrollment processing. Training to staff and Health plans on Medicare and Medicaid compliance and guidelines for enrollment and reconciliation.

**On-site Project Manager for MMC project. 6/99 – 10/01**

Responsible for overall project management of new software, beta testing and implementation, and process re-organization. Managing 3 consultants on site, 6 temps on site, and project day to day details through completion. Project Manager for the implementation of MMC solutions into the Medicare enrollment area to include software design, work flow and process redesign, budget management, Sr. Mgmt reporting, IS interactions for hardware support and daily/weekly status meetings. Project involved new software as well as department process reorganization. Worked with Central and Regional CMS office to resolve discrepancy. Worked with MMC2020 consultants in

project coordination supervising 3 staff and 4-6 temporary workers. Recovered more than 2.5 million dollars from 1999.

**Other Coventry Positions Held**

**Senior Service Representative Advantra Team 2 (7/97 to 5/99)**

**Supervisor Advantra Enrollment (9/95 to 6/97)**

**Promoted to Supervisor of Commercial Enrollment (12/94 - 9/95)**

**Education**

AA in Business Studies

BS in Health Services Administration

Please see Attachment B for Job Description Executive Director of Dual Programs

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

The Alliance has an independent Board of Governors that decides on major policies and oversees the administration of the Alliance. The Board reflects the diversity of both the provider and health care consumer communities in Alameda County. Board composition is determined by county ordinance and Board members are appointed by the Alameda County Board of Supervisors. The Alliance's current Board of Governors consists of twelve seats: a consumer, two physicians, two hospital representatives, a community clinic representative, a health services representative, a member of the Board of Supervisors, a labor seat, a pharmacy seat, and two at large undesignated seats.

The Alliance conducts its meetings in accordance with applicable open meeting laws. Board meetings are open to the public at large and the Alliance welcomes, encourages, and receives wide public input. As a public entity, the Alliance promotes the efficiencies of a business, while maintaining transparency and accountability to the community.

Accountability and oversight by the community for the implementation and operation of the DE Demonstration will also be facilitated with two standing committees to the Board: the Member Advisory Committee (MAC) and the Steering Committee. The purpose of the MAC is to provide a link between the Alliance and the community it serves. The MAC's responsibilities include advising on cultural competency issues, and educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability. The Steering Committee consists of dual eligible stakeholders including beneficiaries, providers, advocates and county agencies. This Committee is charged with oversight on the implementation of the DE Demonstration.

The Alliance administrative structure, which is in place to manage its existing multiple product lines, will also coordinate and support the DE Demonstration. The Alliance employs staff to perform various administrative functions for members through the Business Operations Department's Enrollment and Claims Units, the Care Advisor Unit (CAU), the Grievance & Appeals Unit, and the Communications & Marketing Department. Complete descriptions of the administrative functions of these units can be found in the modified Model of Care.

- **Business Operations Department's Enrollment Unit**

The Alliance's Business Operations Department's Enrollment Unit is responsible for processing enrollment and verifying eligibility of all new applicants.

- **The Claims Processing Unit**

The Alliance's Business Operations Department's Claims Unit has staff dedicated to processing, analyzing, and resolving claims and they are overseen by the Director of Claims. The Claims Processors are responsible for processing multiple claim types including but not limited to primary care claims, specialist claims, ancillary claims, long-term care claims, ESRD claims and hospital claims.

- **Care Advisor Unit**

The Care Advisor Unit is a call unit dedicated to CompleteCare members, and this function will be expanded to specifically serve DE Demonstration participants.

- **Communications and Marketing**

The Communications & Marketing Department prepares and disseminates written plan information to members, network providers and stakeholders. Key communication vehicles include brochures, information kits, Websites, member newsletters, member benefit materials, marketing materials, emails, and letters.

- **The Grievance & Appeals Unit**

The Grievance & Appeals (G&A) Unit processes and facilitates resolution of member and provider complaints. G&A Coordinators investigate member complaints, identify and promptly escalate potential quality of care issues, and coordinate investigations and resolutions with providers. The G&A Coordinators forward complaints that are appeals upheld by the Alliance, in whole or in part, to the Independent Review Entity within regulatory timeframes.

**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.**
**Question 6.1.2 Provide roles and responsibilities of key partners.**
**Question 6.1.3 Provide a timeline of major milestones and dates for successfully executing the operational plan.**

In collaboration with the entire Alliance Leadership Team and under direct oversight of the Alliance's Chief Executive Officer, Ingrid Lamirault, the Executive Director of Dual Programs will be the primary individual overseeing the development and implementation of the Alliance DE Demonstration. The following preliminary operational plan provides the draft work plan for the DE Demonstration including how the Alliance and its partners will ramp up in the first year, roles and responsibilities of key partners, and a timeline of major milestones.

### *Major Milestone I: Hire an Executive Director of Dual Programs*

A. Designate an Interim ED of Dual Programs in order to ensure Accountability until the Position can be Filled and Secure an ED of Duals Program (Feb 2012 – Apr 2012)

### *Major Milestone II: Formalize Governance Structure*

A. Develop Draft Charter including Key Stakeholder Participation and Size (Mar 2012 – Jun 2012)

B. Evaluate Participation by Key Stakeholders and Invite Individuals to Join the Steering Committee including at least one Dual Eligible Beneficiary (Jun 2012 – Sep 2012)

C. Convene Steering Committee to Elect Chairs, Establish Codes of Conduct, Schedule Meetings and other Necessary Logistics such as Setting-up Sub-Committees (Jun 2012 – Jan 2013)

### *Major Milestone III: Develop a DE Demonstration Business Plan*

A. Market Analysis: Dual Beneficiary Market in Alameda County including their Needs and an Estimate of the DE Demonstration potential Market Share, An Evaluation of how to best Leverage CompleteCare and Other Participating SNPs and PACEs (Mar 2012 – May 2012)

B. Support Program Design: In Collaboration with Community Partners, Develop Products and Services for Integrated Delivery of Care Including Consumer Protections and Any Applicable Provider Network Development. More Specific Product Design issues will also be discussed in other sections of this Operations Plan (Mar 2012 – May 2012)

C. Operations and Management: A Description of Core Operational Functions required to Support the New Initiative including: Enrollment and Disenrollment process, Appeals and Grievances, Claims, Customer Service, Provider Services, Care Management and Regulatory Compliance. Assess the Need for Additional Operational Capacity and an Assessment of how to Coordinate between Plan Partners and New Provider Networks. (Mar 2012 – May 2012)

D. Financial Management: Alliance's Financial Capacity and Projections for Undertaking the new Demonstration including Start-up Costs, Enrollment Estimates, Revenue and Expense Projections, Operating Margin/Loss as well as Relevant Risk Characteristics. The Plan should discuss Sound Financial Models for Blending Medi-Cal and Medicare Payments. (Mar 2012 – May 2012)

***Major Milestone IV: Finalize Plan Partnerships and Framework***

A. Engage Potential Plan Partners in Discussions Regarding the Dual Demonstration and the Plan Partnership Model (Feb 2012 – Feb 2012)

B. Formalize Plan Partner Relationship through Executing Arrangements or Extending Existing Arrangements including Commitments to Develop Joint Policies and Procedures on Consumer Protections, Data Sharing, PCCC, Carve-out Benefits and Premium Withholds. (Feb 2012 – Jun 2012)

C. Develop Coordinated Fee-for-Service Option (Feb 2012 – Jun 2012)

D. Develop an Adequate Rate for Dual Demonstration including Margins for Profit and Losses and how Resources will Flow to Plan Partners (Mar 2012 – Jan 2013)

E. Evaluate Joint Plan Network and Conduct Gap Analysis in Preparation for Readiness Review (May 2012 – Jul 2012)

***Major Milestone V: Establish Single Point of Entry***

A. Work with Consumer Groups to Develop Educational Materials that Ensure Consumer Understanding of Options and a Meaningful Process for Self-Directing Care. (May 2012 – Aug 2012)

B. Establish and Interoperable Data Entry Structure for Capturing Enrollment and Assessment Data (Jul 2012 – Jan 2013)

C. Collaborate with Key Stakeholders to Develop A Single Assessment Tool using DHCS Tool as a Starting Point (Jul 2012 – Oct 2012)

D. Train Plan and Provider Partners on Enrollment Process and Single Assessment Tool to assist with Data Entry to the Single Point of Entry (Aug 2012 – Jan 2013)

E. Develop the Default Assignment Structure to Ensure Consumer Protections including Continuity of Care for Non-selecting Beneficiaries (Jun 2012 – Aug 2012)

F. Develop Objective Quality Criteria to Reward Quality and Member Outcomes with more Default Membership (Jun 2013 – Jan 2014)

***Major Milestone VI: Develop Multidisciplinary/Multi-agency, PCCC Model***

A. Develop Joint Policies and Procedures with Plan Partners on PCCC Based on Standards Developed by DHCS (Mar 2012 – Jun 2012)

B. Identify Provider Partners to Perform PCCC including High Risk Case Management, Contract with PCCC Providers including Providers with Capacity to address unique Dual Sub-Populations. Facilitate Partners conducting DREDF or FSR C Survey in order to evaluate Accessibility to support Appropriate Beneficiary Assignment. (Mar 2012 – Aug 2012)

C. In Compliance with Joint Policies and Procedures Developed with Plan Partners, Develop Alliance-specific Policies and Procedures, in collaboration with Provider Partners, on PCCC Model including Appropriate Assignment for Lead PCCC Role based on Unique Beneficiary Needs, such as Behavioral Health, Cultural/Linguistic Competence and Functional Abilities. (Jun 2012 – Jan 2013)

D. Developing Unified Interoperable Infrastructure for PCCC and Information Sharing Supported by Alliance Case Management Software and Provider Portal (Jun 2012 – Jan 2013)

E. Finalize Cross Training for Providers Participating in multidiscipline PCCC (Sep 2012 – Jan 2013)

***Major Milestone VII: Integrate Long Term Care Services and Supports***

A. Contract with Existing Long-Term Care Supports and Services (LTSS) Providers Serving Dual Beneficiaries including "HUB" Contracts with Comprehensive LTSS Providers (Mar 2012 – Aug 2012

B. Develop Long-Term Social Service Benefit with Capacity to Serve Alliance Members and Members from other Interested Plan Partners (Mar 2012 – Aug 2012)

C. Develop full LTSS network and Offer this Benefit as a Carve-out to Plan Partners (Mar 2012 – Aug 2012)

D. Based on Gap Analysis Secure Additional Provider Partners to Address Gaps in Long-Term Care Supports and Services (Jun 2012 – Oct 2012)

E. Develop New Relationship with the Public Authority and IHSS Program in order to Facilitate the Transition of this Service to Managed Care. Contract with the Public Authority/IHSS Program to Ensure Information Sharing (Mar 2012 – Dec 2012) Develop and fund pilot Health Navigator

training and training on assistive technology for IHSS workers (Mar 2012 – Dec 2012) Evaluate Data and Experience from Yr 1 Pass-through and Engage the Public Authority in Transition Planning in a Manner that Preserves the Strong Consumer-Centric model (Oct 2013 – Jan 2015)

F. Steering Committee to Prioritize How Cost Savings will be Reinvested for Supplemental Services (Jan 2014 – Jan 2015)

***Major Milestone VIII: Integrate Behavioral Health Services***

A. Work with Alameda County Behavioral Health Care Services Agency (BHCS) to develop and implement a process to request consent from duals on information sharing (Mar 2012 – Jan 2014)

B. Jointly Develop Incentives Tied to Joint Performance on Process Measures and Outcome Measures (Jun 2013 – Jan 2015)

C. Work with BHCS to Develop a Delegated Arrangement and Transition Plan to Integrate Behavioral Health Services with all other Medi-Cal covered benefits (Jan 2014 – Jan 2015)

***Major Milestone IX: Evaluate Outcomes and Ensure Quality***

A. Conduct Plan Readiness Review Based on Dual Demonstration Requirements and Address Any Existing Deficiencies (Mar 2012 – Jan 2013)

B. Develop Expertise on Compliance with Dual Demonstration Requirements including Quality and Evaluation Benchmarks and Consumer Protections (Mar 2012 – Jan 2015)

C. Develop Joint Policies and Procedures on Submission of Enrollment and other Data Sets Necessary for Evaluation of Outcomes and Quality (Jun 2012 – Aug 2012)

D. Develop Plan for Monitoring and Compliance with Quality and Evaluation Benchmarks (Jun 2012 – Dec 2012)

E. Select one quality benchmark that all Demonstration partners can jointly seek to influence, such as readmission, and establish goals for each partner (Jan 2013 – Jan 2015)

***Major Milestone X: Implementation in 2013***

A. Prepare for Plan Readiness Review by Ensuring DE Demonstration meets all DHCS/CMS Requirements (Jun 2012 – Aug 2012)

B. Prepare Outreach and Education Materials with Consumer Representative Stakeholders and Secure DHCS/CMS Approval (May 2012 – Aug 2012)

C. Conduct Education and Outreach Campaign to Minimize Confusion of Dual Eligible Beneficiaries (Jul 2012 – Dec 2012)

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

See Please See the Dual Eligible Demonstration Certification Checklist.

**Section 7: Network Adequacy**

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

The Alliance already maintains a robust network of providers, including primary care providers, dialysis facilities, long-term care providers and mental health specialists to ensure that members have access to providers with the expertise necessary to treat their condition. The Alliance will build upon its current network developed to serve its Medi-Cal, IHSS and SNP members for the DE Demonstration.

The Alliance SNP meets network adequacy requirements for serving the dual eligible population and includes network facilities such as those delivering acute care laboratory services, radiography/imaging, long-term care, rehabilitation and specialty outpatient services. The network includes 1,485 providers with specialized expertise in cardiology, psychiatry, neurology, surgery and other medical specialists; drug counseling, clinical psychology and other behavioral specialists; nursing professionals and allied health professionals. All of these providers are required to collaborate with the Interdisciplinary Care Team, provide clinical consultation, assist with developing and updating Individual Care Plans and provide pharmacotherapy consultation.

For mental health services, the Alliance contracts with OptumHealth (formerly PacifiCare Behavioral Health). The OptumHealth provider network in Alameda County consists of over 800 mental health specialists who provide mental health, substance use and counseling services to

Alliance SNP members. For the DE Demonstration in addition to OptumHealth, the Alliance will develop a formal delegated arrangement with Alameda County's Behavioral Health Care Services Agency (BHCS). BHCS and OptumHealth will form the DE Demonstration's behavioral health and substance use network.

For dental care, the Alliance currently contracts with Liberty Dental, whose network consists of over 60 dentists in Alameda County.

As discussed in Question 2.1.2, building from the Alliance's existing provider networks, the Alliance will expand its network by contracting with LTSS providers to provide coverage for the dual population in Alameda County. In developing the DE Demonstration network, the Alliance will target those LTSS and behavioral health providers currently serving the dual eligible beneficiary community. The Alliance will request from DHCS a complete list of current Medi-Cal fee-for-service LTSS and behavioral health providers and from CMS a list of all Medicare providers in Alameda County. These community providers will be surveyed about their current services to dual eligible beneficiaries, their interests in expanding their scope of services and whether they want to participate in the DE Demonstration. Many of these providers have established geographic- or health condition- based formal and informal relationships that will shape the DE Demonstration's LTSS provider network. The aim of the DE Deomonstraion project will be to initally arrange for existing service providers to cover participants by directly contracting with those providers already offering high quality services. In the out years, the Alliance will both expand the capacity of the service network and identify and spread successful examples of best practices.

Ensuring adequate numbers of providers to care for Alameda's dual eligible community will also be facilitated through arrangements with the DE Demonstration full plan partners. In addition to building from the Alliance's SNP to provide access, the two other SNPs and two PACEs in Alameda County are also being asked to bring their networks into this collaboration. For example,

PACE organizations maintain networks that are certified and regulated by DHCS and CMS and include specialists, acute care facilities, clinical support, and other service providers, and as a plan partner, will able to meet the needs of DE Demonstration PACE eligible participants.

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

The fee-for-service method tends to rewards volume over value. For this reason, the Alliance is looking at capitation as a payment strategy that will allow for incentivizing quality care. The Alliance seeks to structure its capitated rates to provide high-value services and reward improved outcomes. Capitated arrangements include clear descriptions of responsibilities in the area of population management and how performance will be measured and rewarded. With capitated arrangements the Alliance sees improvements in access to preventive services, reductions in inappropriate utilization of resource-intensive services, and improvements in outcomes for chronically ill members, and increased provider and member satisfaction.

The Alliance will work with actuaries to design methodologies that are guided by the fairness principle of passing an appropriate portion of the Alliance's revenue from the three-way contract negotiated rate down to contracted providers using actuarially sound rate development practices. This approach should result in an actuarially sound downstream capitation rate that passes through all the appropriate assumptions regarding fee schedules, member benefit changes, member health status risk relative to the county, and any other changes that need to be considered. This methodology will treat the Alliance and its providers as partners.

In the three-way contract with CMS and DHCS, the Alliance will propose a risk sharing arrangement structured in a manner that, while retaining profit-based reinvestment opportunities for the Alliance and its provider partners, also provides the upfront shared savings to DHCS and CMS, and provides loss protection to the Alliance that reduces after the first two years of uncertainty.

The proposed risk-sharing parameters will incorporate two dimensions, namely (i) the changing profit/loss sharing percentages between the first two years versus future years as the uncertainties of the initial period give way to relative stability in subsequent years, and (ii) an asymmetric profit/loss sharing arrangement in the first two years to reflect the desired loss protection and profit opportunities for this complicated-to-manage population that thereafter transition into a symmetric profit/loss sharing arrangement by the third year.

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

The DE Demonstration will utilize the lessons learned from the transition of Seniors and Persons with Disabilities (SPDs) for encouraging providers who currently do not accept Medi-Cal to participate in the DE Demonstration. In early 2011 to prepare for this transition, the Alliance analyzed data from the State to determine which providers served the most fee-for-service (FFS) SPD patients. The Alliance contacted FFS providers to find out if they would be interested in joining the Alliance network, using the talking points developed in a recruitment letter and gathered information from the providers needed to generate a medical services agreement. The Alliance mailed medical services agreements to offices who expressed any interest in participation. The Alliance fast-tracked the credentialing applications for those who returned the agreements and made follow-up calls to those who did not return the agreements. The Alliance had a high response rate because, in part, the Alliance made many providers aware of the large volume of FFS SPD patients seeing them, raising their interest in retaining these patients.

The Alliance also relied on information from Seniors and Persons with Disabilities themselves as to which providers they were seeing. The Alliance took part in several outreach events where SPDs and their service providers were invited. Participants at these events were informed that they could call the Alliance Member Services Departments to find out if their providers were in the Alliance network. If their providers were not in the network, they could provide their providers'

information to Member Services Representatives, who would then inform the Provider Services Department for recruitment.

For the DE Demonstration project, information on FFS providers already serving dual eligible patients would need to be secured from DHCS on Medi-Cal providers and from CMS on Medicare providers and from dual eligible beneficiaries themselves. As described above, securing this information is part of the Alliance's general network development plan.

In addition, to assist the Alliance in supporting continuity of care for beneficiaries with complex medical condtions cared for by numerous providers and encouraging FFS providers to join the Alliance network, the Alliance will provide the "cooling off" period, described in Question 5.5.1. During this time, these beneficiaries will continue to access their FFS providers until a comprehensive transition plan of care is developed by a DE Demonstration case manager. The plan of care will seek to maximize provider, medication, and treatment continuity of care. This period will be used to educate FFS providers on managed care plan participation opportunties and to enroll these providers into a plan's network.

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

As discussed in Question 5.2.2., effective February 2011, DHCS mandated Medi-Cal managed care plans to use of Facility Site Review Attachment C – Physical Accessibility Review Survey (FSR C) for all primary care providers, high volume specialists and ancillary service providers. FSR C assesses the physical accessibility of provider sites in an effort to ensure sufficient physically accessible providers for the SPD population. This SPD-specific effort will also support the ability of the DE Demonstration to ensure adequate accessibility for DE Demonstration participants.

The Alliance staff includes a FSR C Coordinator, who performs these assessments and determines whether Alliance provider sites meet basic access standards or have limited access. Sites

participating in the FSR C survey receive the written summary of findings and a booklet on low cost actions to improve access.

In addition, the Alliance has worked with the Disability Rights Education and Defense Fund (DREDF) as part of the DE Demonstration stakeholder engagement process. DREDF was a proponent of the FSR C process and has developed an assessment tool on programmatic accessibility. Using this tool and/or the FSR C as part of the network development process, the Alliance will weigh accessibility in the selection of new providers and in the assignment process.

The Alliance will also spearhead extensive education and cross-training efforts for plan partner staff. The Alliance will contract with the Center for Independent Living to conduct systematic provider training for the Demonstration network, including IHHS workers. Educational efforts will also include cross-training among Interdisciplinary Care Teams within the multiple-agency structure. Teams will educate each other on the different disciplines, roles and responsibilities based on targeted population groups.

Finally, the DE Demonstration's multidisciplinary/multi-agency approach to patient-centered care coordination, described in Section 4, is intended to strengthen providers with the existing capacity to serve beneficiaries with various disabilities by contracting with these providers to perform PCCC and supporting their expansion.

DE Demonstration plan partners will also bring providers with capacity to serve beneficiaries with various disabilities. For example, all PACE clinical and adult day facilities and vehicles used for transportation are certified to be ADA compliant. PACE programs also modify member's homes to ensure there are ADA enhancements necessary for member safety such as grab bars and wheel chair ramps.

**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.**

See Response to Question 7.3 above.

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

The Comprehensive Program Description in Section 1.2, Question 1.2.1 outlines many of the proposed subcontracting arrangements including subcontracts and other arrangements with most of the SNPs and both PACEs currently operating in Alameda County. Pharmacy Part D benefits management will continue with MedImpact, the current Alliance contracted Pharmacy Benefits Manager.

Other proposed new subcontracting arrangements and many of the existing arrangements that will form the basis of the DE Demonstration network have also been outlined in the response to Question 7.1 above.

**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 See Dual Eligible Demonstration Certification 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 See Dual Eligible Demonstration Certification 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 See Dual Eligible Demonstration Certification 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 federal "meaningful use" health information technology (HIT) standards.**

The chief application of technology to ensure the provision of quality care is outlined in the Alliance's Quality Improvement Program (QI Program). All SNP and PACE partners have similar

efforts underway. The Alliance's QI Program employs a technology-supported, systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented and all quality studies are performed on any product line for which it seems relevant.

The Alliance uses several technology-based methods or studies to identify aspects of care that are the focus of QI activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members and others are identified through surveys and dialogue with Alliance member and provider communities (e.g., CAHPS and Group Needs Assessment). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone and all studies rely on technology to support analysis and data validation.

Staff summarize and analyze the data collected for studies to determine variance from established criteria, performance goals, and for clinical issues. Data is analyzed to determine the level of improvement or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Particular membership subsets may also be examined when they are deemed to be particularly vulnerable or at risk.

Based on these analyses, action plans are developed and implemented when problems or opportunities for improvement are identified as a result of monitoring of quality activities, population and reporting measures, or quality improvement projects. Each corrective action plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Utilizing similar technology-based methods, an evaluation of the effectiveness of the action is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and re-measurement. The evaluation of effectiveness is described quantitatively, in most cases, compared to previous measurement, with an analysis of meaningful improvement and statistical significance.

In terms of supporting network provider efforts to meet federal "meaningful use" standards, the Alliance is providing this support through a related activity. The Alliance has been working to help directly contracted providers meet NCQA Medical Home requirements. Patient-centered medical homes are key to the healthcare reform strategies of the present and future. The federal government has sought to have federal "meaningful use" standards parallel the requirements to be acknowledged as an NCQA patient-centered medical home. The Alliance is supporting its community practices in fulfilling the medical home function by including community physicians in the planning of the Alliance's new technological enhancements (such as web portals, case management tools, personal health records, and self-management supports) and providing financial incentives for securing this recognition.

**Question 7.10.2 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.)**

The Alliance's QI Program for its SNP is designed to address the diverse and complex needs of special needs dual eligible members found to be at high medical or social risk, including those who are frail/disabled, have multiple chronic illnesses, and/or are at the end of life. The DE Demonstration will utilize this existing infrastructure, which is supported by care technology.

The goals of the program are to: 1) Identify and flag these members early through health risk assessments, periodic member outreach, and monitoring of care patterns so that program interventions and resources can be focused on meeting the dual beneficiary member's needs and

preserving or restoring their quality of life to the extent possible; and (2) Provide high quality, cost-effective, evidence-based care in an expedient manner and in the most appropriate setting for the patient.

Each dual member will receive initial (within 90 days of enrollment) and annual health risk assessments to identify the medical, psychosocial, cognitive, and functional needs of each individual. Clinically knowledgeable personnel will analyze health risk assessments and reassessments, and stratify health needs for care planning. As has been described previously, the assessment results will form the basis of an Individualized Care Plan. Care plans will identify the vulnerable member's special needs. Results will be communicated to members, Interdisciplinary Care Teams, and pertinent providers.

These efforts will be strengthened by the Alliance's newly acquired case management software, which will be made available to DE Demonstration partners. The new software provides case, disease, and utilization management by allowing entities to utilize their proprietary clinical data and best practices to drive individualized care based on the unique characteristics of the different member populations served by the Alliance. The software's ability to streamline the clinical, administrative and technical components of care management programs will allow the Alliance to serve acutely ill, chronically ill, and at-risk members by creating a partnership between members and their providers to facilitate appropriate care decisions.

**Question 7.10.3 Describe how technologies will be utilized to meet information exchange and device protocol interoperability standards (if applicable).**

The primary technological tool that will be utilized to meet information exchange and devise protocol interoperability standards will be the Alliance's Provider Portal. The Alliance will create a Provider Portal on its web site that is available 24/7. This mechanism will ensure providers have tools and information necessary to effectively manage the care of their patients and at the same time, manage their performance contracts. The portal enables providers to conduct a wide range of self-

service transactions and inquiries in a secure online web environment. Administrative services available on the Provider Portal are: 1) provider-level demographic detail, 2) member eligibility detail, 3) benefit summary for eligible members, 4) claims detail, 5) submission and validation of authorizations, and 6) charges and insurance information.

Provider Portal clinical services are designed to facilitate a provider's access to the complete patient record. The portal presents screens that integrate relevant patient data from multiple data sources that can be connected to the health exchange or on a stand alone basis. The Provider Portal presents timely patient information to the patient's doctor and other members of a care management team. Clinical Services available on the Provider Portal are: 1) patient demographics, 2) medication histories, 3) changes in patient roster, 4) encounter/visit information, 5) reminders and alerts of preventive care need by patients, 6) electronic delivery of HEDIS reports, 7) "Gaps in Care" required by patients, 8) patient's involvement with disease management programs, 9) clinical messaging (doctor-to-doctor and doctor-to-patient), 10) integration with laboratory results, and 11) communication of changes in managed care contracts.

**Section 8: Monitoring and Evaluation**

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

**Question 8.1 Describe your organization's capacity for tracking and reporting on:**
**• Enrollee satisfaction, self-reported health status, and access to care,**

The Alliance has the capacity to measure member and provider satisfaction using several sources of satisfaction, including the results of the Consumer Assessment of Health Plan Satisfaction (CAHPS), the Group Needs Assessment (GNA), complaint and grievance data, disenrollment and retention data, and other data as available. As part of the Alliance's QI Plan, these data are presented to the Alliance's Health Care Quality Committee and Board of Governors at

quarterly and annual intervals. The Alliance may administer topic-specific satisfaction surveys depending on findings of other QI activities and studies.

DE Demonstration plan partners have similar capacity to track and report enrollee satisfaction. For example, all California-based PACE organizations participate in an annual PACE-specific participant satisfaction survey created by Vital Research. The survey is conducted by trained, multi-lingual Vital Research staff, on-site and in-person, with PACE participants who volunteer to be interviewed. The surveys measure participant satisfaction in the following 10 domains: transportation, center aides, home care, medical care, health care specialists, social workers, meals, rehabilitation therapy and exercise, recreation, and other indicators. PACEs track and report on these results.

The Alliance also has the capacity to track and report on self-reported health status, which is collected as part of the Health Risk Assessment (HRA) process and access to care information. The Alliance HRA tool has the capacity to capture self-reported health status as well as demographics, the consumer conditions/resources, nutrition status, health conditions and history, functional and cognitive needs, social resources, environmental assessment, caregiver assessment and other critical information.

Under its QI Program, the Alliance implements mechanisms to monitor and report on the adequacy of its primary care providers (PCP) and high volume specialty care providers. Standards for the number and geographic distribution of PCPs and high volume specialists are established and monitored for how effectively the network meets the access needs and preferences of the enrolled members. The Alliance assesses the cultural, ethnic, racial, and linguistic needs of members, and adjusts availability of network providers, if necessary.

In addition, the QI Program monitors and reports on access and availability of care including member wait times and access to providers for routine, urgent, emergent, and preventive,

specialty, and after-hour care. Access to medical care is ensured by monitoring compliance with wait time standards for provider office appointments, telephone calls, and appointment availability. The Alliance also has the capacity to track and report on the access and availability of the following services:

- Children's preventive periodic health assessments.
- Adult initial health assessments.
- Standing referrals to HIV/AIDS specialists.
- Sexually transmitted disease services.
- HIV testing and counseling.
- Minor's consent services.
- Pregnant women services.
- Chronic pain management specialists.

**• Uniform encounter data for all covered services, including HCBS and behavioral health services**

The Alliance has the capacity to collect and report on uniform encounter data for covered Medicare and Medi-Cal services including many HCBS and behavioral health services because of its operation as a SNP. Encounter data is submitted by delegated and/or capitated providers electronically or via paper claims. In order to ensure valid submission, the Alliance instructs all contracted providers on how to submit encounter data. The Alliance has recently acquired new core transaction software that will significantly improve its ability to track and report these data sources and will facilitate adding the few Medi-Cal benefits that the Alliance is not currently providing, but will be managing under the DE Demonstration. As attested in the Certification Checklist, the Alliance will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.

DE Demonstration plan partners will make similar efforts to provide complete and accurate encounter data. For example, California PACE organizations are actively engaged with DHCS to

finalize PACE-specific encounter data collection and financial reporting procedures which will result in uniform reporting for all California-based PACE organizations.

**• Condition-specific quality measures.**

Finally, the Alliance has the capacity to track and report on condition-specific quality measures. For example, the Alliance collects this type of information as part of The External Accountability Set Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) which are calculated, audited, and reported annually as required by DHCS, the Managed Risk Medical Insurance Board (MRMIB), and CMS. Additional measures from HEDIS are also reviewed. A root cause analysis is performed and corrective action plan initiated for any measure not meeting the DHCS Minimum Performance Level (MPL), MRMIB, CMS or national benchmarks, or are determined by the Alliance's Health Care Quality Committee to be significantly below expectations in comparison to benchmarks.

**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)**

The Alliance receives monthly eligibility files that include demographic characteristics such as age, language, ethnic, race, and gender. Other demographic information such as disability is recorded in other Alliance member files. The Alliance is capable of analyzing and reporting data on all of the dimensions listed above with the exception of sexual identity. This is not information that the Alliance currently collects. The collection of sexual identity information is one that will need to be discussed at a DE Demonstration Steering Committee meeting.

Demographic data is currently collected on all Alliance members and evaluated by demographic characteristics, as outlined in the Alliance's QI Program. The participants in the DE Demonstration will be tracked and evaluated in the same manner. As discussed in Question 7.1.1., the Alliance has the capacity to initiate studies based on analyses of demographic and epidemiologic

characteristics of Alliance members and other studies are identified through surveys and dialogue with Alliance member and provider communities (e.g., CAHPS and Group Needs Assessment). Staff summarize and analyze the data collected for studies to determine variance from established criteria, performance goals, and for clinical issues. Data is analyzed to determine the level of improvement or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Particular membership subsets may also be examined when they are deemed to be particularly vulnerable or at risk.

The Alliance has the existing capacity to collect and evaluate a variety of data sources and data modes. The three most critical data sources include claims, enrollment and encounter data. The Information Technology (IT) Department is responsible for scrubbing and mapping processes that ensure data integrity and that the data loaded into the Alliance's Information Warehouse (HAL) is valid, reliable and complete. The IT Department creates various views or databases within HAL, which simplifies data extraction.

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

Please See Dual Eligible Demonstration Certification Checklist.

**<u>Section 9: Budget</u>**

**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 Alliance DE Demonstration project is being developed as an extension and expansion of its existing D-SNP program, CompleteCare. Not only will the new program serve perhaps ten times as many participants (30,000-40,000 in comparison to 4,000), it will also require the creation of new networks of community service providers. In order to realize the goals of the Demonstration, this ten-fold expansion will need to be completed in one year's time. The scope and expedited

nature of the DE Demonstration necessitates significant infrastructure support in order to implement successfully. The following is a list of priority areas of need:

- The primary capital available to DE Demonstration participants will come from the three-way, negotiated contract between the lead plan, in this instance the Alliance, with DHCS and CMS. In order to strengthen the ability of lead plans to integrate services for the highly complex and diverse dual eligible community, risk sharing arrangements should be structured in a manner that incentivize and provide appropriate protections for participants. The risk sharing arrangement should offer shared savings to DHCS and CMS that are limited to the upfront savings that the RFS indicates will already be embedded in the capitation rates in Year 1 and that increase after the first two years. This arrangement should provide loss protection to lead plans that reduces after the first two years of uncertainty. Loss protection is an excepted mechanism to utilize when plans are asked to take on populations with limited history in organized health care delivery, such as the dual eligible community.

- The costs associated with developing interoperability for the necessary information sharing systems are difficult to estimate. The Alliance is already acquiring new case management software, developing a robust provider portal and upgrading its core transaction system. These IT initiatives will provide the Alliance with greater functionality to create interoperable interfaces. Additional infrastructure to support the technical aspects of creating these interfaces across the DE Demonstration network as well as other necessary technological linkages will be critical to ensuring success of many key integration components.

- A lesson learned from the expedited transition of the Seniors and Persons with Disabilities (SPDs) into managed care is the importance of mass education and additional supports for the impacted beneficiaries. The short timeframe to implement the SPD process left beneficiaries confused and according to consumer representatives, in some counties the transition has

compromised the continuity of care of some SPDs. The Alliance strongly urges CMS and DHCS to provide resources to community-based organizations serving dual eligible beneficiaries to conduct education and outreach in order to mitigate the confusion and support the transition process. The Alliance is also proposing in its DE Demonstration to maintain a "cooling off" period for high need beneficiaries seeking care from numerous providers. The DE Demonstration recommends maintaining these beneficiaries in the fee-for-service system until a comprehensive transition plan can be prepared. Contributing assistance and resources for this important transition planning is another area DHCS and CMS should consider.

- As part of the DE Demonstration, the Alliance intends to reinvest savings in supplemental services that expand cost effective, best practice models that demonstrate improved quality. CMS and DHCS should seek to maximize the ability of DE Demonstration lead plans to invest in similar efforts by allowing plans making these reinvestment commitments to retain a greater percentage of shared savings.

- CMS and DHCS should consider providing support to providers for improved accessibility. The Alliance DE Demonstration will provide accessibility trainings planned through collaborations with CIL and DREDF. These trainings will support existing providers interested in expanding to serve the DE Demonstration participants and new providers in the Alliance's DE Demonstration network. DHCS and CMS should consider providing matching funds to support providers in improving their accessibility.

# Attachment A

# Dual Eligible Demonstration Model of Care

Written Narrative Description of SNP Model of Care

Modified for Dual Eligible Demonstration

## CONTENTS

### Sections



### Attachments



### Definitions / Acronyms

## ALAMEDA ALLIANCE JOINT POWERS AUTHORITY (JPA) WRITTEN NARRATIVE DESCRIPTION OF THE SPECIAL NEEDS PLAN MODEL OF CARE

**Alameda Alliance Joint Powers Authority (the plan) has contracted with the Centers for Medicare and Medicaid Services (CMS) to provide healthcare services to Medicare Advantage Special Needs Plan (SNP) beneficiaries in the state of California. The plan began offering services to this specific population on January 1, 2008, when it launched Alliance CompleteCare (DED). CompleteCare will provide the infrastructure for the Alliance to build a Dual Eligible Demonstration.**

**CMS established SNPs as part of the Medicare Modernization Act of 2003 as a new type of Medicare + Choice plan focusing on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual-eligibles, and beneficiaries with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple co-morbid conditions, at risk for poor outcomes and high costs due to inefficient and inadequate DEDess to care. California's Dual Eligible Demonstration targets this same population with the intent to integrate more services and better align incentives between Medicaid and Medicare. The plan is privileged to serve this sector of the eligible Medicare beneficiary population.**

**This document outlines the *Alliance Dual Eligible Demonstration Model of Care (DED MOC)*, which describes, as per CMS requirements, the care and services provided to the Dual Eligible Demonstration (DED) members.**

**The DED MOC supports the overall mission of the plan, which is to provide continuous, comprehensive, high quality health care and social support services to Medi-Cal and Medicare recipients and traditionally underserved children, families and individuals, in partnership with a network of public and private providers and to support the integral role of traditional and safety net providers.**

## DESCRIPTION OF THE DED SPECIFIC TARGET POPULATION

**The plan implemented an evidenced-based MOC program for its DED members on January 1, 2010, in compliance with CMS regulations. The age range of the current membership is:**

| Age Range | Number of Members | Percent of Membership |
|---|---|---|
| 20 - 24 | 27 | 0.77% |
| 25 - 34 | 180 | 5.11% |
| 35 - 44 | 333 | 9.45% |

| | | |
|---|---|---|
| 45 - 54 | 535 | 15.19% |
| 55 - 59 | 286 | 8.12% |
| 60 - 64 | 246 | 6.98% |
| 65 - 69 | 586 | 16.64% |
| 70 - 74 | 548 | 15.56% |
| 75 - 79 | 367 | 10.42% |
| 80 - 84 | 237 | 6.73% |
| 85 - 99 | 177 | 5.03% |
| TOTAL | 3522 | 100% |

**The DED target population consists of 45,000 dual eligible beneficiaries in Alameda county. A percentage of these individuals may not be eligible for DED membership because these individuals are not enrolled in both Medicare Parts A and B. Full Medicare eligibility and enrollment is necessary for DED eligibility.**

**All DED members are offered the opportunity to opt in/out of participation in the MOC and a Health Risk Assessment (HRA).**

**The plan maintains networks with appropriate providers and specialists for the DED population.**

**A plan of care that identifies goals and objectives, including measurable outcomes, as well as specific services and benefits to be provided, is developed for all DED members. DED members who agree to participate in the MOC will be involved in their MOC plans when feasible.**

**An interdisciplinary care team provides guidance and oversight to the management of care.**

**CMS requires that the Medicare Advantage Organization (MAO) has a written care management plan that describes the model of care, that it documents implementation of the care management plan for CMS review during surveillance activities and audits, and that the MAO complies with SNP-specific reporting requirements.**

### Most Vulnerable Members

**DED members include vulnerable individuals who are:**

- **Frail**
- **Disabled**
- **Developing end-stage renal disease after enrollment**
- **Near the end-of-life**
- **Experiencing multiple or complex chronic conditions**

**NOTE: Please see Section 11, Care Management for the Most Vulnerable Population, in this document, which further describes DED's vulnerable population and includes definitions of the frail and elderly.**

**Members are stratified into three tiers according to risks identified during their initial health risk assessment, claims, encounter, and pharmacy data.**

### Risk Stratification Tiers

**Tier 1 - members that are relatively healthy – very well managed disease state; have support network in place and require minimal assistance; require educational materials or minimal coordination of care**
**Tier 2 - members that may have several disease states; may have minimal to no support network; and require some case management intervention**
**Tier 3 - members that have multiple disease states, frequent ER visits, inadequate support systems or life threatening illness (ESRD); require extensive case management**

**Current risk stratification for those ACC members who have completed their HRA is as follows:**

| HRA Tier | Members |
|---|---|
| Tier 1 | 728 |
| Tier 2 | 1572 |
| Tier 3 | 71 |

## MEASURABLE GOALS

### Measurable Goals

**Overall, the goal of the DED MOC is to promote self-management and help members regain optimum health or improved functional capability, in the right setting and cost effectively.**

**We realize the measurement of outcomes is a critical step in identifying the success of a program, specifically with respect to dual eligible members' improvement in not only their health, but awareness of and use of services and appropriate providers within the network, and optimal benefit utilization.**

**The Interdisciplinary Care Team (ICT) and the plan's Quality Improvement department:**

A. **Monitors MOC goals and effectiveness of care for DED members through defined processes that measure health outcomes and quality indicators. These goals include:**
    1. **Improve access to medical, mental health, LTSS and social services**
    2. **Improve access to affordable care**
    3. **Improve coordination of care through plan care managers**
    4. **Provide seamless transitions of care across healthcare settings, services, providers, HCBS.**
    5. **Improve access to preventive health services**
    6. **Ensure appropriate utilization of services**
    7. **Ensure cost-effective service delivery**
    8. **Improve member health outcomes through:**
        a. **Reducing hospitalizations and skilled nursing facility (SNF) placements**
        b. **Improved self-management and independence**
        c. **Improved mobility and functional status**
        d. **Improved pain management**
        e. **Improved quality of life as self-reported and perceived by Special Needs individuals**
        f. **Improved satisfaction with health status and services**

B. **Evaluate the effectiveness of care to ensure an evidenced-based MOC.**

C. **Prepare an annual report of MOC Effectiveness for review and approval by the plan's Health Care Quality Committee and for inclusion in the annual plan Quality Improvement Program Evaluation.**

**Data collected on DED member outcomes includes:**

- **Reduced hospitalizations**
- **Improved self-management and independence**
- **Improved mobility and functional status**
- **Improved pain management**
- **Improved quality of life as self-reported**
- **Improved satisfaction with health status and health services**

**Member outcome data is documented in Individualized Care Plans (ICPs), updated Health Risk Assessments (HRAs), member utilization data, and in member surveys, e.g. CAHPS and HOS.**

**Data collected on quality indicators includes:**

- **Improved access to medical, mental health, LTSS and social services**

- **Improved access to affordable care**
- **Improved coordination through single point of care management**
- **Improved transition of care across settings, providers and HCBS**
- **Improved access to preventive health services**

**Data is collected on MOC structure or processes such as:**

- **Improved services delivery through a competent provider network with specialized expertise**
- **Improved coordination of care through use of an ICP**
- **Improved coordination of care through management by an ICT**
- **Improved utilization of services through identification and stratification of health risks**
- **Improved coordination of care through effective communication among providers, members, and the ICT**

**DED MOC effectiveness is measured through data collected on:**

- **Improvement in access to care (CAHPS results)**
- **Improvement in member health status (HOS results)**
- **Staff implementation of the comprehensive health risk assessment (ILS performance reports)**
- **Implementation of an ICP (ILS performance reports)**
- **Provider network of specialized expertise (access and availability surveys)**
- **Use of evidence-based practices**
- **Use of a communication system**

**DED MOC effectiveness will be improved through these mechanisms:**

- **DED quality staff will track and trend DED MOC performance measure results and report findings and recommendations for action to the ICT and the plan's Health Care Quality Committee (HCQC).**
- **The ICT and the HCQC will analyze performance measure results and provide guidance on which improvement activities should be included in the annual quality work plan.**

**DED maintains quality improvement data for CMS review to enable:**

- **Members to compare health coverage options**
- **CMS to monitor the DED MOC effectiveness**

**Improvements in the DED MOC are communicated to DED stakeholders through provider and member newsletters, Web portal announcements, the annual**

quality improvement work plan evaluation, press releases, and periodic plan reports to the community.

## STAFF STRUCTURE AND CARE MANAGEMENT ROLES

The plan employs staff to perform various **administrative functions** for DED members, through the Business Operations department's Enrollment and Claims units, the Care Advisor Unit (CAU), the Grievance & Appeals Unit, and the Communications & Marketing department. Below are descriptions of the roles and responsibilities of each functional area and the support it provides to the overall administration of DED.

### Business Operations Department's Enrollment Unit

The plan's Business Operations department's Enrollment Unit is responsible for processing enrollment and verifying eligibility of all new DED applicants. Specifically, the plan has two Enrollment Specialists and may need to add additional Enrollment Specialist who process all enrollment forms and one manager who oversees the operations of the unit. Enrollment forms are accepted as the paper-based Individual Enrollment Request Form, as faxed or PDF forms attached to an e-mail, as forms received through the Medicare Online Enrollment Center (OEC), and also as enrollment requests via telephone. Enrollment forms are received in-person or in the mail and are immediately date stamped upon receipt. The Enrollment Unit verifies that all CMS required fields on the DED Enrollment Form are completed before processing an enrollment. The Enrollment Unit also processes online forms received via the Medicare OEC through the www.medicare.gov Web site and the 1-800-MEDICARE call center for enrollment into Medicare Advantage plans. The date and time "stamped" by the Medicare OEC serve as the application date for purposes of determining the election period and enrollment effective date. The Enrollment Unit retrieves enrollment requests via the Medicare OEC on a daily basis. Upon receipt of a completed enrollment application, the enrollment is processed. Once the application has been scanned and saved, the Enrollment Unit works with the Sales and Care Advisor Unit to perform Outbound Enrollment Verification calls.

### The Claims Processing Unit

The plan's Business Operations department's Claims Unit has four individuals, and may need to add other individuals, dedicated to processing, analyzing, and resolving DED claims and they are overseen by the Director of Claims. The Claims Unit is comprised of one Claims Processor, a Claims Analyst, an Administrative Assistant and a Supervisor who oversees the operations of this unit. The DED Claims Processor is responsible for processing multiple claims types including but not limited to primary care claims, specialist claims, ancillary claims, long term care claims, ESRD claims and hospital claims. They ensure that the claims are either paid, denied or pended based on Medicare rules, regulations, policies, procedures and contracts. The Medicare Claims Analyst

audits the Claims Processor, runs reports, reviews and processes all Medicare claim reconsiderations and/or notices of provider appeals. They answer complex Medicare phone calls from providers and will give detailed explanations of claims decisions. The Administrative Assistant keeps track of the inventory and ensures that all claims in which the financial responsibility is carved out to one of our delegated entities is forwarded over to the appropriate party on a daily basis. This individual forwards the date stamped claims with a letter informing the entity that the attached claims are their financial responsibility. The Supervisor oversees the day-to-day processes of everyone within the unit and provides guidance on complex provider issues and/or claims.

**Care Advisor Unit**

The Care Advisor Unit has seven Care Advisors, additional Care Advisors may be added, who staff a call unit dedicated to the DED members. The Care Advisors' principal responsibilities are to promote member satisfaction and retention by performing outreach activities to new and established members, and providing accurate and timely information regarding benefits and community resources. They provide first-line, non-clinical care coordination services, including assisting members to obtain covered Medicare and Medi-Cal benefits through the DED provider network. The Care Advisors make welcome/Outbound Enrollment Verification calls to all new members within 15 calendar days of the plan receiving the enrollment request. They ensure the members understand their benefits, make community referrals to social and medical services provided through community partners, and assist with transportation and interpreter services. They encourage members to utilize DED programs to promote self-management of their chronic conditions, including case management, medication therapy management, and disease management services. Most Care Advisors are bilingual to accommodate DED members' language needs, including Spanish, Cantonese and Vietnamese.

Care Advisor Unit Example: P. W. is a new member who recently moved from Arizona, with existing dental and mental health problems. His support at home is limited to his daughter who both works and attends school. His dental problems are acute, preventing normal eating. The Care Advisor helped this member select a primary care physician, dentist and oral surgeon; obtain immediate appointments; obtain transportation for appointments; and authorization for short-term nutritional supplements. The Care Advisor supplied the member with information to apply for emergency food stamps. Dental issues are now resolved, and P. W. has agreed to see a mental health specialist.

**Communications and Marketing**

The Communications & Marketing department prepares and disseminates CMS-approved written plan information to DED members and network providers. The department has one Copywriter & Content Manager and one Production & Traffic

**Manager overseen by the Senior Director of Communications & Marketing. Additional staff may be necessary. They identify content needs and create content that is accurate, reflects brand standards, and meets regulatory guidelines. They also research, write, edit, and proofread content to ensure quality and effectiveness and collaborate with multiple departments to ensure consistency of messaging, tone, and voice throughout company communications. Key communication vehicles include brochures, information kits, Web sites, member newsletters, member benefit materials, marketing materials, emails, and letters.**

**The Grievance & Appeals Unit**

**The Grievance & Appeals (G&A) Unit processes and facilitates resolution of member and provider complaints. There are two staff members in the G&A Unit overseen by the Manager, Quality Oversight. Additional staff may be necessary. The G&A Coordinators, overseen by the manager, investigate and resolve member complaints (either grievances or appeals) according to the appropriate regulatory timeframes. As part of this investigation and resolution process, they are responsible for contacting the member for additional information and/or to provide updates, as indicated, responding to expedited/urgent complaints in a timely fashion. G&A Coordinators investigate member's complaints, identify and promptly escalate potential quality of care issues, coordinate investigations and resolutions with providers. Coordinators prepare and submit all complaints/appeals to the Utilization Management/Pharmacy Unit, escalate complaints about services or operations at the plan to an immediate supervisor. The supervisor forwards the complaint to the appropriate departmental manager for resolution of service dilemmas. The G&A Coordinators are also responsible for confirming that the physician making the final decision for the proposed resolution of a complaint has not participated in any prior decisions related to a denial of service or complaint about service denial, as well as educating members and providers on basic plan policies, documenting investigation and resolution in IT systems, and creating and maintaining files of written correspondence, including provider response and member acknowledgement/resolution letters. The G&A Coordinators forward complaints that are appeals upheld by the plan, in whole or in part, to the Independent Review Entity within regulatory timeframes.**

**The Chief Medical Officer (CMO) has the primary responsibility for the complaint system and receives periodic updates from the Associate Medical Director and at Health Care Quality Committee (HCQC) meetings on the operation of the complaint system and reporting procedures to identify emerging patterns and to improve overall policies and procedures. The HCQC meets quarterly to review and address identified problems in member complaints including, but not limited to, grievances related to access to care, quality of care, and appeals related to**

**denial of services. Complaint data is aggregated and analyzed on a quarterly and annual basis to identify trends and opportunities for quality improvement. The CMO reports these data annually to the plan's Board of Governors.**

**The plan employs or contracts with the following additional staff to perform clinical and non-clinical functions that coordinate care for members across various settings and providers:**

A. **The plan employs and contracts with specific staff to perform a variety of clinical functions that support the care management and care coordination needs of its DED members. Medical Services and Utilization Management (UM) staff are managed by a Masters-prepared RN with care management experience. UM staff that perform concurrent review and collaborate on discharge and transition of care planning of inpatient acute/skilled admissions are licensed RNs.**

B. **The plan contracts with Healthways, an NCQA and URAC accredited healthcare company, for complex case management of high risk ACC members. Healthways' RN case managers work closely with members, their primary care providers, and the health plan. The case managers develop ICPs that include goals and interventions to improve members' health status and self-management skills. This service will be provided by the Alliance for DED members.**

C. **The plan contracts with Independent Living Systems (ILS) to contact each ACC member upon enrollment and annually, and encourage them to complete a Health Risk Assessment and develop/implement an Individualized Care Plan (ICP) to improve their health status and self-management skills. The plan sends ILS monthly data files that contain claims, eligibility, pharmacy data and member inpatient admissions, transfers and discharges. ILS conducts all initial and annual Health Risk Assessments for ACC members and creates an ICP populated based on encounter data and the HRA, using propriety ILS algorithms. The ILS RNs and LVNs then review the ICP with the ACC member and coordinate any needed services for the member. All ACC members are touched by phone quarterly or less frequently depending on their needs. ILS RNs and LVNs also review daily facility discharge data to direct outreach to members newly discharged from acute, skilled or rehabilitation facilities to identify member needs around self-care, medication management, and follow-up medical care. ILS RNs and LVNs review monthly ACC member pharmacy data, identify members with potential medication issues (10+ medications), and contact the members to refer them to a Medication Therapy Management (MTM) Program operated by the plan's contracted**

**pharmacy benefit management company, MedImpact. This service will be provided by the Alliance for DED members.**

D. **The plan maintains contracts and agreements with community providers and agencies, both medical and behavioral health, which offer a wide range of services that support DED members' care management and care coordination needs. DED network providers deliver medical services. DED contracts with OptumHealth to provide both mental health and social services to DED members. DED members have access to the Care Advisor Unit (CAU), which is a member services call center specific for DED members. CAU staff assist DED members with care coordination needs such as making provider appointments, obtaining transportation to health-related appointments, connecting with available community resources like the Food Bank, housing and financial assistance, and resolving medication dispensation problems.**

**The plan uses both employed and contracted staff to perform administrative and clinical oversight functions for the health care and social support services provided to its DED members. The plan is in compliance with all State and federal regulations that stipulate the type of professional licensure/certification required of individuals for specific management and staff positions. Compliance is verified in the following ways:**

A. **The plan's Human Resources (HR) department verifies the licensure/certification of prospective employees before they are hired and begin work. All job descriptions include competency statements that are used to evaluate the employee's performance.**

B. **Licensed/certified employees are required to maintain their professional credentials and present evidence of renewed licensure/certification to their manager and the HR department at appropriate intervals.**

C. **Professional licensure/certification/accreditation of the plan's contracted providers and vendors is verified before the initial contract is executed, upon renewal, and for clinicians, at the time of initial and recredentialing every three years.**

D. **The plan's Credentialing Unit, under the direction of the Chief Medical Officer (CMO), conducts the credentialing process in accordance with NCQA standards.**

E. **The plan contracts with an NCQA accredited Credential Verification Organization (CVO) to conduct primary source verification (PSV) on all contracted providers who require credentialing by the plan.**

**F. Provider networks contracted with the plan and delegated for credentialing are required to perform the same oversight and use the same standards to verify professional licensing and competency.**

**G. Additionally, the plan performs annual audits of its delegated providers/vendors with a tool that employs NCQA standards for oversight of clinical and administrative functions.**

**H. The plan ensures provider use of clinical practice guidelines and professional standards of practice through the mechanisms described below in Section 6, Provider Network/Specialized Expertise and Use of Clinical Practice Guidelines and Protocols.**

**I. Responsibilities of the Chief Medical Officer and the Director of Quality Management are to perform clinical oversight for:**

1. **Interdisciplinary Care Team (ICT) meetings**
2. **Delivery of care and pharmacotherapy planned by the ICT**
3. **Coordination of care across settings**
4. **Appropriate and timely clinical services**
5. **Appropriate follow-up for services and benefits provided**
6. **Seamless transition of care for services provided across settings and providers**

**J. The plan's Health Care Quality Committee, under the direction of the CMO, is responsible for oversight of the quality of health care services, including appropriateness and timeliness.**

**K. The CMO and the Pharmacy Director monitor and analyze monthly claim, encounter, and utilization data through a variety of report mechanisms.**

**L. Both the Grievance and Appeals and Potential Quality Issues processes provide a further opportunity to monitor the administrative and clinical functions related to care management and care coordination of DED members.**

**M. The plan's Compliance department manages healthcare information related to medical, mental health and social services to ensure maintenance and sharing of healthcare records per CMS regulations and policies. It is responsible for maintaining corporate HIPAA compliance. This department also performs administrative oversight for plan operation policy development and statutory and regulatory compliance.**

**N. The Peer Review and Credentialing Committee is responsible for provider competency and current licensure review as well as quality of care issues that affect provider credentials.**

**O. Staff in the Provider Services department assist in maintaining communication with contracted providers and provider performance oversight.**

## INTERDISCIPLINARY CARE TEAM (ICT)

| Interdisciplinary Care Team | Role/Responsibility |
|---|---|
| Member/Patient | • Generally in their late sixties or older, or is younger and disabled<br>• Generally has chronic health problems requiring team interventions, multidisciplinary approach<br>• Generally requires assistance with ADLs/socio-economic support or disease process education<br>• Typically has financial issues<br>• May have caregiver/family support issues<br>• May have access to care issues |
| **Interdisciplinary Care Team** | **Role/Responsibility** |
| Family/Caregiver(s)/IHSS provider | • May be spouse, sibling, adult child, grandchild, niece or nephew, or the system itself. (A caregiver may be geographically separated but wish to participate as an active member of the team)<br>• May be close personal friend or court appointed legal guardian<br>• IHSS provider assists with activities of daily living/ may provide protective supervision |
| Speech/Physical or Occupational Therapist—may also be cardiac or pulmonary rehab | • Episodic team member<br>• Licensed<br>• Sets goals such as to help patients learn, regain or maintain functional skills needed for daily activities or strengthening<br>• As much as possible, encourages independent functioning on the part of the patient is in ADLs/IADLs, etc.<br>• Goal of PT is to keep patients mobile, relieve pain and improve functioning |

| | |
|---|---|
| | • **Physical therapists help patients with gait retraining, use of assistive devices (such as walkers), and exercises to promote strength, flexibility and improved range of motion**<br>• **Educated to assess and intervene where problems exist with speech, language, communication, verbal fluency and swallowing**<br>• **Can also assess/intervene with cognitive communication problems such as those found in memory loss/Alzheimer or attention disorders** |
| **Mid Level Provider (from network provider's office/representative of that office)**<br>**Nurse Practitioner or Physician's Assistant** | • **Must work under physician supervision (laws vary state-to-state)**<br>• **Works as physician representative or designated staff**<br>• **May work in inpatient, outpatient or long term care settings** |

| **Interdisciplinary Care Team** | **Role/Responsibility** |
|---|---|
| **Physician (MD/DO)** | • **May be Medical Doctor or Doctor of Osteopathic Medicine**<br>• **May have specialized training in the care of older adults (geriatrics)**<br>• **May be certified in a specialty area by the American Board of Medical Specialists (MDs) or American Osteopathic Association (DOs)**<br>• **Generally, Medical Directorship of long term care facilities is held by a physician**<br>• **Educated to diagnose and treat health related problems** |
| **Dentist** | • **Ad hoc member, dependent upon member's needs**<br>• **May be either DDS (Doctor of Dental Surgery) or DMD (Doctor of Dental Medicine)**<br>• **Educated to diagnose and treat problems of the mouth, gums and teeth** |

| | |
|---|---|
| **Social Worker** | • **Help patients deal with a multitude of issues relating to retirement, low income, caregiver needs, resource referrals (such as Meals on Wheels), family relationships, etc.**<br>• **Many specialize in particular areas such as hospice or elder care, etc.** |
| **Pharmacist** | • **Educated to dispense medications prescribed by physicians, APNs and PAs; and act as a resource to these providers regarding appropriate medication selection**<br>• **Counsel patients regarding medication use, potential interactions, dosage and side effects of medications**<br>• **May compound (or mix ingredients) to form medications for patients**<br>• **Medication Therapy Management interaction with PBM/benefit design**<br>• **Prescription/medication compliance** |
| **Behavioral Health/Substance Use Provider** | • **Ad hoc member, dependent upon member's needs**<br>• **May be psychotherapists, psychologists, psychiatrists, drug counselor**<br>• **May have specialized training in the care of older adults (geriatrics)**<br>• **Educated to diagnose and treat behavioral health and substance use problems** |
| **HCBS Provider** | • **Ad hoc member, dependent upon member's needs**<br>• **May be a MSSP or CBAS provider**<br>• **Provide long-term social and health care management**<br>• **Arrange for and monitor use of community services**<br>• **Certify beneficiaries as eligible for HCBS services** |

| Interdisciplinary Care Team | Role/Responsibility |
|---|---|
| Dietician | • Educated to help plan and supervise nutritional programs for individuals/groups<br>• Can assess nutritional needs and suggest interventions where appetite, weight loss and disease states are problematic |
| Care Manager (RN/LPN/Social Worker) | • Licensed when applicable<br>• LPN is a Licensed Practical (or Vocational) Nurse; an RN is a Registered Nurse<br>• Are required to manage/coordinate and document all areas of the Individualized Care Plan (ICP)<br>• Either nurse can support and be the manager of the ICP |

## Definition of Interdisciplinary Care

An interdisciplinary care team works together with the member/client/patient in planning care from their discipline-specific perspectives. Through shared staff conferencing and by consulting with each other, the interdisciplinary team and the member/client/patient gain new insights for addressing problems and have the opportunity to produce a holistic plan of care for the client.

## Key Components of the Interdisciplinary Care Team

- Team members understand, appreciate, and collaborate with other disciplines and providers.
- Team members make decisions about services in collaboration with the DED member and other disciplines, rather than dividing care decisions by discipline or setting.
- Team members have a thorough understanding of their own profession.
- Team members understand how their varied experiences affect the way they provide care and services.
- Team members understand how the different approaches to practice can be integrated for the benefit of the DED member.
- Team members are able to identify and integrate into their practice aspects of care and service delivery that are most important to the DED members they serve.

## General Success Factors for Interdisciplinary Care Teams

- Knowledge of expertise and role of other team members and how these interrelate.
- Focus on needs of DED members.
- Recognition of and respect for specialized skills and contributions of each team member.
- Shared charts and information regarding DED members.
- Trust is valued.
- Open communication and resolution of disagreements in a civilized manner (no hidden agendas).
- Work atmosphere is relaxed and supportive.
- Collaboration and cooperation are cornerstones of success.
- Commitment to common goals and to team members.
- Coordination of services.

## Interdisciplinary Care Teams Goals

- A commitment to interdisciplinary care for elderly patients who present with complex medical problems.
- The minimization of complications associated with hospitalization and/or sub-acute inpatient stays.
- The identification of and attention to medical, psychosocial and environmental needs.
- The maintenance and improvement of the functional level of patients.
- The provision of cognitive stimulation and socialization activities.
- The provision of expert interdisciplinary medical care and support service management.
- The communication of medical and support service information to designated providers upon discharge to home or other facilities and/or for issues that arise in the patient's current residence.

## The Care Manager (CM) shall:

A. Conduct initially and periodically a comprehensive, accurate, assessment of each member's functional capacity.

B. At the time each member is discharged from an inpatient setting, discuss with the member: the member's understanding of the discharge orders and compliance with and possible variation in the Individualized Care Plan (ICP) as required, such as follow-up appointments with specialty/primary providers.

C. Ensure that the comprehensive assessment of a member's needs describes the member's capability to perform daily life functions and

**significant impairments in the functional capacity. The comprehensive assessment shall include at least the following information:**

1. **Medically defined conditions and prior medical history**
2. **Financial status measurement**
3. **Physical and mental functional status**
4. **Sensory and physical impairments**
5. **Nutritional status and requirements**
6. **Special treatments or procedures**
7. **Mental and psychosocial status**
8. **Discharge potential; applicable to acute/sub-acute or rehab settings**
9. **Activities potential**
10. **Rehabilitation potential**
11. **Cognitive status**
12. **Drug therapy**

**D. The CM shall:**

1. **Conduct comprehensive assessments within a reasonable time frame, but no less than 90 days after the date of admission to the program.**
2. **Promptly notify DED after any significant change in the member's physical or mental condition.**
3. **Encourage the member to contact the primary/specialty provider with any significant physical or mental health changes.**

**E. The CM shall ensure:**

1. **The results of the assessment are used to develop, review and revise the member's comprehensive plan of care.**
2. **An ICP is developed for each member that includes measurable objectives and timetables to meet a member's medical and psychosocial needs that are identified in the comprehensive assessment.**

**F. The comprehensive ICP shall:**

1. **Describe the services that are to be furnished to attain or maintain the member's highest practicable physical, mental, and psychosocial well-being.**
2. **Describe any services that would otherwise be required, but are not provided due to the member's exercise of rights, including the right to refuse treatment.**

3. **Be developed within 30 days after completion of the comprehensive assessment.**
4. **Be approved by an interdisciplinary team, communicated to the attending provider, and other appropriate staff with responsibility for the member and other appropriate staff in disciplines as determined by the member's needs.**
5. **Include the participation of the member, the member's family or the member's legal representative.**

## PROVIDER NETWORK/SPECIALIZED EXPERTISE AND USE OF CLINICAL PRACTICE GUIDELINES AND PROTOCOLS

**DED maintains a robust network of providers, including medical specialists, dialysis facilities, LTSS providers and mental health specialists to ensure that DED members have access to providers with the expertise necessary to treat their medical and mental conditions as well as their functional and social needs.**

### DED Provider Network Composition and Management

**A. Network facilities:**

1. **Acute care facility Laboratory**
2. **Radiography/imaging facility**
3. **Long-term care facility**
4. **Rehab facility**
5. **Specialty outpatient clinics**

**B. Providers with specialized expertise:**

1. **Medical specialists (cardiology, psychiatry, neurology, surgery, etc.)**
2. **Behavioral specialists (drug counseling, clinical psychology, etc.)**
3. **Nursing professionals**
4. **Allied health professionals**

**C. Provider requirements for DED members and the MOC are to:**

1. **Collaborate with the interdisciplinary care team**
2. **Provide clinical consultation**
3. **Assist with developing and updating ICPs**
4. **Provide pharmacotherapy consultation**

## Physicians

**The table below outlines the provider network as of December 2010**

| Specialty | Number of Providers | Specialty | Number of Providers |
|---|---|---|---|
| Allergy/Immunology | 12 | Neurology | 40 |
| Anesthesiology | 23 | Nuclear Medicine | 3 |
| Cardiology | 27 | Obstetrics | 1 |
| Cardiovascular Disease | 23 | Obstetrics & Gynecology | 97 |
| Cardiovascular Surgery | 2 | Ophthalmology | 69 |
| Chiropractor | 11 | Orthopedic Surgery | 41 |
| Dentist | 1 | Otolaryngology (ENT) | 16 |
| Dermatology | 29 | Pain Management | 3 |
| Emergency Medicine | 41 | Pathology | 8 |
| Endocrinology | 8 | Physical Medicine/Rehab | 12 |
| Family Practice | 6 | Physical Therapist | 5 |
| Gastroenterology | 27 | Plastic Surgery | 9 |
| General Practice | 28 | Podiatrist | 5 |
| General Surgery | 54 | Primary Care | 406 |
| Geriatrics | 1 | Psych-Neurology | 5 |
| Gynecology Oncology | 2 | Pulmonary Disease | 18 |
| Gynecology Only | 3 | Radiation Oncology | 21 |
| Hand Surgery | 7 | Radiology | 105 |
| Hematology | 5 | Registered Dietician | 1 |
| Hematology/Oncology | 32 | Rheumatology | 15 |
| Hospitalist | 76 | Speech Therapist | 1 |
| Infectious Disease | 11 | Thoracic Surgery | 8 |
| Internal Med | 84 | Urology & Urological Surgery | 24 |
| Nephrology | 41 | Vascular Surgery | 9 |
| Neurological Surgery | 8 | **Total** | **1485** |

### Ancillary Providers and Facilities

| Provider Type | Number of Providers |
|---|---|
| Clinical Laboratories | 12 |
| Dialysis Centers | 12 |
| Durable Medical Equipment | 24 |
| Home Health Agencies | 10 |
| Home Health Infusion | 1 |
| Hospitals | 12 |
| Occupational and Physical Therapy | 23 |
| Orthotics and Prosthetics | 2 |
| Portable X-ray and Lab | 1 |
| Skilled Nursing Facilities | 16 |
| **Total** | **113** |

### Mental Health and Dental Networks

For mental health services, DED contracts with OptumHealth (formerly PacifiCare Behavioral Health). The OptumHealth provider network in Alameda County consists of over 800 mental health specialists who provide mental health, substance abuse and counseling services to DED members. The DED will add Alameda County Behavioral Health Services Agency to its mental health network.

For dental care, DED contracts with Liberty Dental, whose network consists of over 60 dentists in Alameda County.

### LTSS Network

The DED will expand its current LTSS network by adding HCBS providers including MSSP and CBAS agencies. The DED will contract with the Alameda County Social Service Agency to add 17,000 IHSS providers to its LTSS network.

**DED provider network management policies and practices include:**

- **Prioritize contracting with board-certified providers**
- **Monitor network providers to ensure they use nationally recognized clinical practice guidelines when available**
- **Ensure that network providers are licensed and competent through a formal credentialing review**
- **Document the process for linking members to services**
- **Coordinate the maintenance and sharing of member health care and social service information among providers, the interdisciplinary care team, and DED**

**Professional licensure/certification/accreditation of DED's contracted providers and vendors is verified before the initial contract is executed, upon renewal, and for clinicians, at the time of initial credentialing and recredentialing every three years. The plan's Credentialing Unit, under the direction of the Chief Medical Officer (CMO), conducts the credentialing process in accordance with NCQA and CMS standards. The plan contracts with a Credential Verification Organization (CVO) to conduct primary source verification (PSV) on all contracted providers who require credentialing by the plan. The verifications include checking the following databases: federal Office of the Inspector General; Medical Board of California; California Board of Registered Nursing; National Practitioner Database; Medicare and Medi-Cal, DEA; and multiple professional specialty databases.**

**Provider networks contracted with the plan and delegated for credentialing are required to perform the same oversight and use the same standards to verify professional licensing and competency per the DED delegation agreement. Additionally, DED performs annual audits of its delegated providers/vendors with a tool that employs NCQA and CMS standards for oversight of clinical and administrative functions.**

**DED Provider Network Composition and Management**

**The plan operates as an HMO network with the primary care provider acting as a "gatekeeper" for each assigned member. The primary care provider is able to refer members for most services within the network without the need for a prior authorization. DED ensures that primary care providers and members are aware of what services are covered and which providers are available to accept referrals.**

**DED authorizes medically necessary care to non-contracted providers if the required service is not available within the DED network. DED provides members with an Evidence of Coverage manual and Provider Directory annually, and provides members with these documents upon their enrollment with the plan.**

**DED also maintains a Web site and ensures that the most recent benefit and provider network information is available to members and providers 24/7.**

**Members and providers are also encouraged to contact the plan for assistance with finding a specialist and coordinating referrals and appointments. The Care Advisor Unit is available to provide this level of assistance and guidance. In 2010, the Care Advisor Unit received and successfully resolved 489 benefit and provider network inquiries and appointment scheduling assistance requests from members and providers.**

**As mentioned previously, one of the DED provider requirements is to collaborate with the Interdisciplinary Care Team for DED members.**

**Care and support services are planned by an interdisciplinary team representing all appropriate health care and social support professionals.**

### ICT Composition

A. **The primary ICT includes:**
    1. **Medical expert – DED Medical Director and the member's primary care provider**
    2. **Behavioral health expert – OptumHealth staff**
    3. **Social services expert – may have expertise in LTSS**
    4. **Members and family**

B. **Additional members include:**
    1. **Pharmacist – DED staff with Pharm. D.**
    2. **Nursing professionals – DED staff with RNs, MSNs**
    3. **Health educator**
    4. **Network/community providers in consultation with ICT:**
        a. **Disease management specialist**
        b. **Restorative therapist**
        c. **Nutrition specialist**
        d. **Medical specialist**
        e. **Dentist**

### ICT Purpose

**The purpose of the Interdisciplinary Care Team (ICT) is to optimize the health and well being of all DED members, including the most vulnerable, by coordinating and facilitating quality care while minimizing fragmentation of health care and social service delivery. The team's approach is based on effective population health management and preventive care.**

**The ICT care planning process ensures that each member's care and treatment is planned appropriately for the member's needs and severity of condition, impairment, disability or disease.**

**The ICT establishes a care-management system in which the care and treatment planning process is timely, systematic, and comprehensive and incorporates input from all disciplines deemed appropriate.**

**The DED MOC Interdisciplinary Care Team (ICT) collaborates with providers and requests that they provide clinical consultation, assist with developing and updating Individualized Care Plans (ICPs), and provide pharmacotherapy consultation. Primary care providers are given copies of the ICPs for their patients and invited to discuss the care plans with their patients and provide feedback to the ICT.**

**The roles and responsibilities of the ICT team members include but are not limited to:**

A. **Entire team:**
    1. **Prepare for the care planning meeting, as indicated, by reviewing the status of the member, searching for problems, issues and concerns to address in the team meeting.**
    2. **Facilitate member/family participation in developing and reviewing the ICP via interaction with the primary care provider and the Care Manager.**
    3. **Ensure ICP interventions are designed to educate, empower and facilitate the member to exercise his or her rights and responsibilities. In addition, ICPs action steps to include the provision of information and support to the member in making choices regarding his/her health, where indicated.**
B. **Entire team to ensure the ICP facilitates the member and/or designated representative with:**
    1. **Understanding of the disease process, chronic illness, and/or disability.**
    2. **Recognition of his/her role as the daily self-manager.**
    3. **IHSS provider, family and caregivers engagement in the member's self-management.**
C. **Entire team to encourage primary care provider to:**
    1. **Review and provide feedback on ICPs.**
    2. **Discuss the ICP with their patient.**
    3. **File ICP in the patient's chart.**
D. **Registered Nurse Care Manager:**

1. **Develops, monitors, and modifies ICPs and ensure that:**
    a. **Special emphasis is placed on appropriateness of interventions, combinations of interventions and member historical information.**
    b. **Once ICPs are approved, a Care Coordinator, under the direction of the Case Manager, reviews the ICP collaboratively with the client allowing for input/modification as requested by either client or caregiver.**
    c. **During this process, the Care Coordinator determines the most appropriate resources to provide the services needed; however, as the ICP is developed collaboratively, the client has the option to choose from the network of service providers.**
2. **Reviews and re-evaluates the ICPs to determine effectiveness, quality of service(s) and performance to ICP goals/outcomes.**
3. **Maintains ICPs. ICPs are re-assessed annually at a minimum and, if necessary, updated to reflect changes in member needs.**

**E. DED staff, under the guidance of the ILS Case Manager, reviews the ICP with the member and:**

1. **Ensures ICPs explore financial options and eligibility for services.**
2. **Ensures ICPs provide information about and assist member in maintaining and establishing community links.**

**F. Social Worker Liaison:**

1. **Ensures HRA includes complete basic psychosocial, environmental and economic assessments.**
2. **Ensures ICP provides for on-going coordination of psychosocial services.**

**G. Behavioral Health/Substance Use Liaison (OptumHealth):**

1. **Provides assessment and coordination of mental health, alcohol and/or drug abuse services.**
2. **Coordinates supportive counseling as appropriate.**

**H. HCBS Liaison:**

1. **Ensures ICP includes necessary long-term social and health care management**
2. **Arrange for and monitor use of community services**

**I. Pharmacist:**

1. **Reviews member's medication profile.**

2. **Supports the assessment of the effectiveness of medications including intended effect, side effects, and member knowledge and method of administration.**
3. **Supports reviewing of the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination.**

J. **Care Advisor Unit (CAU):**

**Refers members to the ITC when additional care coordination and/or other services are required.**

K. **Plan Team coordinator/facilitator:**

1. **Schedules, arranges, and conducts the meeting.**
2. **Prepares and distributes agenda before the meeting and ensures that agenda is followed during the meeting.**
3. **Ensures that all team functions are assigned to various team members.**
4. **Summarizes and organizes the ideas discussed to gain commitment.**
5. **Helps the team use its time on issues on which the whole team is needed.**
6. **Encourages everyone to participate throughout the discussion.**

**DED provider network management policies and practices include the requirement to monitor network providers to ensure use of nationally recognized clinical practice guidelines when available. This policy will be reviewed annually by the Chief Medical Officer to ensure MOC effectiveness and includes the following activity. Monitoring the provision of services ensures that:**

- **Providers adhere to nationally recognized clinical practice guidelines in clinical care**
- **Clinical services are appropriate and timely**
- **There is follow-up on provision of services and benefits**
- **Care is seamlessly transitioned across settings and providers**
- **Conduct targeted medication and medical record reviews**

**DED uses several methods to ensure that its contracted providers are informed of and monitored on the requirements to use evidence-based clinical practice guidelines and nationally recognized protocols as the basis for healthcare decisions.**

- **The plan's provider contracts and the Quality Improvement Program stipulate that providers are expected to follow professionally recognized**

**standards of practice and use evidence-based clinical practice guidelines.**

- **The plan's Health Care Quality Committee endorses network provider use of two clinical practice guidelines each year; current guidelines are Diabetes and Asthma.**
- **Plan approval of services that require authorization is based on medical necessity compared with Medicare Coverage Guidelines and nationally recognized clinical guidelines.**
- **The plan licenses and uses the Milliman Care Guidelines to evaluate medical necessity for requested services.**
- **Providers are asked to supply additional clinical documentation and/or professional citations when initial authorization requests do not meet specific Milliman Care Guideline criteria.**
- **Provider utilization practice patterns (member utilization, claims encounter and pharmacy data) are continuously monitored by the plan's Medical Director in conjunction with the Peer Review and Credentialing Committee.**
- **A focused medical record review may be conducted by the plan when unusual practice patterns or quality of care incidents are identified that are inconsistent with professionally recognized standards of practice.**
- **Contracted primary care and OB/GYN providers undergo both a facility site review and a medical record review as part of initial credentialing and recredentialing every three years. These audits afford the plan another opportunity to monitor a provider's use of evidence-based clinical practice guidelines and nationally recognized protocols.**
- **The plan's Grievance and Appeal and Potential Quality of Care Issue processes may reveal atypical or unacceptable practice situations or patterns and provide an opportunity for the plan to intervene with providers that are not using evidence-based clinical practice guidelines and nationally recognized protocols as the basis for healthcare decisions.**

## MODEL OF CARE TRAINING

### Objectives

- **To ensure that all employees receive training regarding the DED MOC and supporting requirements as defined by all applicable laws and regulations.**
- **To ensure that each employee understands the overall requirements set forth by CMS regarding the plan administration of a DED and the required supporting documents such as this MOC.**
- **To ensure that each employee understands that failure to meet these regulatory mandates can result in disciplinary action including termination.**
- **To ensure that related entities, contractors and subcontractors are familiar with the DED MOC and their responsibilities as described herein and those mandated by the CMS.**

**Structure**

- **To the extent feasible, training is tailored to specific job requirements and or relationship to the employee/entity or provider role of participation within DED itself and subsequently to the DED MOC.**
- **In the initial phase of the program, the plan's Health Plan Services staff in conjunction with department heads and Compliance develop a training matrix, complete with learning objectives and materials.**
- **Existing training programs will be evaluated, and key compliance concepts will be integrated into those courses in order to reinforce the message that compliance to DED requirements cannot be separated from other responsibilities.**
- **The Compliance Officer will interact with management at all levels on a regular basis to evaluate training needs to support the administration of DED as required by the plan's contractual obligation with CMS.**
- **Training records will be maintained to validate training activities, attendance at training as well as to identify new training needs.**

**The goal of the plan's training and education program is to equip the health plan employees with the knowledge they require to excel in their designated roles. The plan maintains educational program training materials, which include presentation materials for initial and annual staff training and orientation that can be customized to the level of the employee and the applicable regulations for their individual position. The plan is currently investigating computer based training citing the Medicare Advantage program regulatory requirements.**

## Staff Training

**Each plan department Director, Manager, and Supervisor is responsible for oversight of the DED MOC training for their respective departments. The materials provided for such training are approved by the plan's Health Services department and Compliance Officer prior to distribution. In addition to monitoring employee completion of the initial and annual training requirements, each departmental leader is responsible to provide training on individual responsibilities related to the implementation of staff specific components of the DED MOC. This training may be offered in a classroom, teleconference, or self-study environment as appropriate.**

**The typical training topics include, but are not limited to the following:**

- **Medicare Advantage 101**
- **Definition of a DED**
- **Regulatory requirements for the administration of a DED plan as defined by CMS**
- **Understanding the designated population to be served, their needs and support**
- **Requirements of the MOC**
- **Operational process differences for the DED line of business**
- **Structure and process requirements as defined by NCQA**
- **NCQA training materials, which may be located at http://www.ncqa.org/tabid/1304/Default.aspx**
- **HEDIS required data**
- **Data submission requirements as set forth by CMS**

**Please see Attachment One: Alliance CompleteCare Training Documentation. This training will be adapted for a DED Training.**

## Staff Training Documentation

- **Training documentation must include the date, topics covered, and names of attendees of each session.**
- **Employees must sign the attendance roster at each training session.**
- **Evidence of training documentation is maintained in a centralized location, and will be made available to government inspectors/investigators upon request.**

## Frequency of Training

- **Training is an ongoing process. The Health Plan Services department determines the timelines for training and assesses when additional training is necessary. At a minimum, DED Model of Care training will occur no less than annually.**
- **Employees, providers and applicable entities are required to receive additional training when there are changes in the laws or regulations that affect their duties.**
- **If changes in laws or regulations directly affect an employee's duties, the employee will receive training regarding these changes within 30 business days.**

### Provider Network Training

**Provider training on the DED MOC is offered in-person as well as in writing. Providers have access to information and policies on DED through the Provider Manual.**

**Providers shall be notified of changes and regulatory revisions ongoing through the provider newsletter articles and faxed provider updates.**

**In-person presentations on the DED MOC can be conducted as requested by any provider or specialty groups. Typical topics for the provider ACC training in 2011 included:**

- **The ACC MOC**
- **Managing transitions of care**
- **Coordinating Medicare and Medi-Cal benefits**
- **Promoting preventive care**
- **2010 QI SNP program results**
- **Improving member satisfaction**
- **2010 HRA results**
- **Medication Therapy Management Program**
- **Fall risk management**
- **Improving access to care**
- **Behavioral health**
- **HEDIS SNP measures**

**Similar trainings will be organized for DED providers. For those providers, employees or applicable entities, if training is not completed in a timely manner,**

**which is described as within 60 days of the scheduling of a training session or presentation, they are given two follow-up opportunities within 45 calendar days. If this training is not fulfilled, the provider, or applicable entity will receive a written notice of such with deficiency with an offer of material to be mailed. Plan employees will be addressed separately according to the plan's Human Resources department.**

## HEALTH RISK ASSESSMENT

**The Health Risk Assessment (HRA) tool used by ACC to identify the specialized needs of its members was developed in collaboration with the ACC contracted vendor, Independent Living Systems (ILS). Please see Attachment Two: Health Risk Assessment. The DED HRA will be based on the uniform assessment tool being developed by DHCS, adapted to meet the Alameda County context.**

**Following an outbound verification call, DED staff contact DED enrollees to schedule the initial HRA. Telephonic outreach to complete the HRA with new DED members occurs within 90 days of member enrollment. If the member was not able to be reached after multiple attempts, the attempts are documented and the HRA is mailed to the member within 10 days of the last telephonic attempt. A postage paid return envelope is provided to assist the member with returning the information. The same process is followed for established DED members to complete the reassessment HRA annually.**

**Information/data collected from the HRA is combined with Hierarchical Condition Codes (HCC), Risk Adjustment Factor (RAF) data, pharmaceutical data and other applicable plan data if available, to stratify members into appropriate risk level based on chronic conditions, functional needs and inpatient utilization.**

**The Care Manager and clinical support staff, in collaboration with the plan's Interdisciplinary Care Team (ICT), use information, such as described below, within the HRA to evaluate members for development of the ICP:**

- **Evaluation of clinical, family structure, activities of daily living and psychosocial information through review of HRA results, risk assessment scores, interviews with the member or family/caregiver, review of medical information, and communication with the member's primary care physician and other clinical practitioners.**
- **Identification of current and potential problems and care needs based on the initial assessment.**

- **Development of an individual plan of action and appropriate community-based services and care facilities.**
- **Determination of the need for add-on services and benefits and incorporation into the ICP such as community based services or supplies.**

**The following information areas are addressed by the HRA tool:**

- **Demographics**
- **Consumer conditions/resources**
- **Nutrition status**
- **Health conditions and history (medical, psychosocial, behavioral health)**
- **Functional and cognitive needs**
- **Special services**
- **Medications**
- **Caregiver assessment**
- **Social resources**
- **Environmental assessment**
- **Preventive health services**

**The HRA section answers are weighted (e.g. health conditions 35%, medications 10%, and social resources 5%) and, when scored, generate the following risk stratification tiers:**

**Tier 1 - members who are relatively healthy – very well managed disease state, have support network in place and require minimal assistance – require educational materials or minimal coordination of care**

**Tier 2 - members who may have several disease states, may have minimal to no support network and require some case management intervention**

**Tier 3 - members who have multiple disease states, frequent ER visits, inadequate support systems or life threatening illness (ESRD) – require extensive case management**

**Review of the HRA tool's effectiveness is an iterative process. Monitoring of completion rates, with full trending, is completed monthly and shared with the plan. DED staff identify barriers to tool completion as well and work with members to overcome such obstacles for completion of accurate data. The DED Care Management department reviews ICP interventions that are triggered directly from the HRA tool for appropriateness, connectivity to health plan**

**programs and adherence to preventive health guidelines. The DED Manager of Care Management compiles all barriers and intervention feedback and presents these to the health plan Interdisciplinary Care Team (ICT) for review no less than on a quarterly basis. Feedback from the ICT is used to modify the HRA tool with final approval given by the plan.**

**Health Risk Assessment (HRA) Work Flow Narrative**

**On the 10th day of each month, the plan's IT department places on the plan's secure FTP site a DED eligibility file and DED claims data file.**

**DED staff are responsible for downloading the files. Within five business days, telephonic outreach for HRA completion begins.**

**A real-time daily report detailing HRA completion rates, both aggregate and individual, is available to the plan.**

**DED staff use the following data to develop ICPs:**

- **Alliance claims, pharmacy, and encounter data**
- **Alliance inpatient census reports**
- **Results of the HRAs**
- **DED member input during communications with customer service staff**

**Customer service staff communicate the ICPs to DED members by phone, once they are developed. The plan's interpreter line or bilingual staff are used, when needed.**
**The plan is responsible for providing claims, encounter and pharmacy data, and the inpatient census reports as well as conducting the HRAs, either directly or though contract providers.**
**All HRAs are conducted telephonically and in person. Mailings are also done, if needed. Telephonic HRAs are done in two phases:**
**Phase 1 - three telephonic attempts:**

- **Attempt 1, during M-F, 8 a.m.-5 p.m.**
- **Attempt 2, during M-F, 8 a.m.-5 p.m.**
- **Attempt 3, during M-F, 8 a.m.-5 p.m.**

**Phase 2 - consists of two telephonic attempts and a mailing, if needed:**

- **Attempt 1, during M-F, 8 a.m.-5 p.m.**
- **Attempt 2, during Saturday, 10 a.m.-3 p.m.**
- **Mail HRA, if needed**

**Phases 1 and 2 are completed with 60 days.**

**Additional attempts to contact members who have not completed the HRA will be made throughout the year based on continued eligibility verification.**

### HRA Risk Stratification

**The founding data chosen by ILS were based upon data feeds using standard predictive modeler software. Integral to any predictive software are the claims, pharmacy and lab data feeds that are typically updated monthly. Though these are an excellent foundation for identifying existing and potential disease states, the modeler falls short as it only addresses the diagnostic piece of a member's profile.**

**The predictive data elements that are gathered from claims, encounter and pharmacy files are loaded and member-reported data gathered from an HRA is added.**

**The HRA data, along with the standard modeler data feeds, is then weighted and predicts the overall severity of the member's health and social condition. This ultimately stratifies the member into one of three tiers. The members scored within the highest tier are defined as those most at-risk for frequent hospitalizations or further deterioration in their disease state or condition.**

**This risk stratification process results in an ICP formulation that is distributed to all members of the Interdisciplinary Care Team (ICT). ICT members may include, but are not limited to the following:**

- **Member**
- **Plan or community pharmacist**
- **Care Manager**
- **Plan Medical Director**
- **Primary care physician and applicable specialist**
- **Community social worker**
- **HCBS provider**
- **Dietician**
- **Dentist**
- **Religious support personnel**
- **Patient and/or caregiver**
- **Restorative therapy providers**
- **Mental health providers**

**An ICP with the tier information is created and distributed to a Case Manager and the primary care physician of the member. The entire program is designed to prevent members from escalating to a higher tier and whenever possible, assist with stabilizing or improving the member's overall condition. The ICP blends the data of the HRA and clinically accepted standards of care algorithms for development of goals and objectives, goal dates and treatment plans with the**

**addition of pharmacy, mental health and community resource provider information.**

### Individualized Care Plan (ICP) Distribution and Work Flow

A. **The plan has ongoing enrollment, demographic, pharmacy, claims, and encounter data.**

B. **The plan will generate an ICP in collaboration with the member, using the member's response to the annual HRA, as well as pharmacy, claims, and encounter data.**

C. **The ICT will update the electronic ICP following transition events, feedback from the primary care provider, and/or other changes in baseline pharmacy, claims and encounter data, and as otherwise indicated.**

D. **The primary care provider will be informed annually to:**

   1. **Provide input on the ICP**
   2. **Review the ICP with the patient**
   3. **File the ICP with the patient's chart**

E. **The plan administers and manages the ICP, with support community resources and the primary care provider.**

F. **The Interdisciplinary Care Team (ICT) will review and approve all ICP interventions.**

G. **The plan staff will present the ICPs to the ICT for review and approval as they ICPs become available.**

H. **The ICT will accept case conference referrals from the member or member's caregiver; the member's primary care provider or other providers; the Care Advisor Unit; hospital UM/Discharge Planning staff, and DED staff.**

I. **The electronic versions of the ICP may be viewed by: the plan's Quality and Care Management staff, Community Health Care Network (CHCN), and/or Hill Physicians through a secure ICP portal. Primary care providers, delegated groups and plan staff may provide input, referrals and additional information to the ICT to improve care management.**

## INDIVIDUALIZED CARE PLANS (ICP)

**DED team members work with the member and/or the member's caregiver and primary care physician to create an individualized care plan (ICP) that is specific to the needs of the member and mitigate any risks identified. The ICP includes a set of attainable goals and measurable outcomes, i.e. preventive health services delivered to the member. The care is also intended to increase self-management, improve mobility and functional status, reduce any pain and create an improved satisfaction with health status and healthcare services that result in improved quality of life perception. A sample copy of an ICP used by ACC may be viewed under Attachment Three: Individual Care Plans. The DED ICP will be based on the processes developed for ACC members.**

### Development of the Individualized Care Plan (ICP)

**When formulating the ICP, DED gathers pertinent data from the following sources:**

- **HRA**
- **Enrollment/demographic information**
- **Pharmacy utilization and claims**
- **Encounter data and claims**
- **Input from the member and the member's caregiver, if applicable**
- **Input from the primary care provider**

**Below is a narrative description of the work flow for the implementation and maintenance of the ICP:**

**The ICP includes:**

- **Goals and objectives**
- **Specific services and benefits to be provided**
- **Measurable outcomes**

**The ICP is:**

- **Developed for each member by the care management staff using a proprietary algorithm.**
- **Documented in the DED Web portal.**
- **Available to ICT members, plan staff, and network primary care providers at all times through the Web portal.**

- **Customized based on a member's claim/encounter history and responses to the initial and annual HRA survey questions.**
- **Reviewed and approved by the ICT.**
- **Available for primary care providers to place member's medical record.**
- **Developed with input from specialists who provide member care.**
- **Reviewed no less than annually or when health status changes, to assess attainment of goals and objectives and revised as required. Should a member encounter a sentinel event or acute episode that alters the current ICP, DED staff conduct appropriate updating and revisions to the ICP.**
- **Members/caregivers who complete the HRA and agree to contact from the plan are informed about their ICP and encouraged to participate in the ICP process.**
- **Communicated to member and caregiver during each telephone contact and to providers no less than annually.**
- **In compliance with HIPAA and professional standards**

**Communication Flow of the Individualized Care Plan (ICP)**

**Communication flow for the developed ICP is also critical to the success of meeting the goals and objectives of the plan. Below is the narrative description of the communication flow as it relates to the ICP:**

A. **DED collects ongoing enrollment, demographic, pharmacy, claims, and encounter data.**
B. **DED generates an ICP in collaboration with the member, using the member's response to the annual HRA, as well as pharmacy, claims, and encounter data.**
C. **The ICT will update the electronic ICP upon direction from the primary care provider, following transition events and/or other changes in baseline pharmacy, claims and encounter data, and as otherwise indicated.**
D. **The primary care provider will be informed as needed but no less than annually to:**
    1. **Provide input on the ICP**
    2. **Review the ICP with the patient**
    3. **File the ICP with the patient's chart**

E. **The ICT will review and approve all care plan interventions annually or more frequently if the member's risk stratification tier changes.**

F. **DED staff will present the ICPs to the ICT for review and approval as the ICTs become available. Currently the process is as follows:**

1. **The plan develops reports that guide the ICP process.**
2. **The plan conducts an analysis of member health care needs based on their reports.**
3. **The plan reviews its findings with the ICT to promote the ICT's understanding of this member population.**
4. **The categories or types of the most frequent member health care concerns are identified and addressed.**
5. **The two most common health concerns identified at the Tier 1 and Tier 2 levels are food scarcity and behavioral health issues.**
6. **The ICT secures clinical expertise and expert guidance in order to ensure the appropriate care plan interventions are developed and implemented.**
7. **The ICT oversees the development and implementation of ICP interventions.**

G. **The electronic versions of the ICP may be viewed by: the plan's Quality and Care Management staff, Community Health Care Network (CHCN), and/or Hill Physicians through a secure ICP portal. Primary care providers, delegated groups and plan staff may provide input, referrals and additional information to the ICT to improve care management.**

### Development of the ICP for High Risk Members

**DED has a separate, distinct process for the development of the ICP for members who are stratified as high risk. The following is a narrative description of this work flow:**

A. **ICPs are reviewed for common member health concerns unique to Tier 3 members. These include polypharmacy and the need for "total" assistance for performance of activities of daily living.**

B. **Each quarter, the ICT will hold a case conference on members identified as high risk using both the Standard and Behavioral Health High Risk algorithm. Typical members discussed in the case conference include:**

1. **Members across all three tiers are discussed at ICT meetings, with the majority of the focus on the Tier 3 members.**
2. **Members at high risk for depression, anxiety, and poor cognitive functioning.**

3. **Members newly discharged from the hospital or skilled setting.**
4. **Members scheduled for elective surgery.**
5. **Members with poly-pharmacy (10+ medications).**

C. **Appropriate follow-up action will be identified and assigned to team members for follow-up action, as indicated.**

H. **Standard high risk members are identified using the following screening criteria: Tier 3 (highest risk) members without a primary care provider visit within the last 12 months. Additional screening criteria may include:**

1. **High dollar admissions (for example, >$50,000)**
2. **Poly-pharmacy**
3. **Avoidable emergency room visits (visits for conditions that fail to meet the criteria for emergent or urgent care)**
4. **Avoidable re-admissions**
5. **High volume utilization patterns**
6. **Sentinel events**
7. **Multiple co-morbidities**

**Behavioral Health High Risk Members**

**Behavioral health high risk members are identified using the algorithm developed by experts at OptumHealth, DED's behavioral health business partner. This algorithm is designed to identify new members within 30 days of taking the HRA.**

**Behavioral health high risk members will receive the following outreach by DED staff who will document actions taken in the member's care plan:**

- **Care management staff will inform the member that the health screening process has identified them as someone who might benefit from taking advantage of the behavioral health care services to which they are entitled. DED has contracted with OptumHealth for these services.**
- **DED staff will then offer to "warm transfer" the member to OptumHealth, which is at 1-888-789-7110 (available 24 hours a day / 7 days a week).**
- **If the member declines the warm transfer, DED staff will inform the member that they would like OptumHealth to follow-up with the member. DED staff will ask at what number OptumHealth should contact them, and if OptumHealth may leave a detailed voice mail message at that number if they are not able to reach the member. The member must agree to the follow-up. DED staff will then contact OptumHealth for appropriate intervention.**

- **If the member refuses the warm transfer and outreach by OptumHealth, DED staff will encourage the member to contact OptumHealth when convenient, and that OptumHealth staff are available by phone 24/7. DED will inform the member they can call OptumHealth at 1-888-789-7110, 24 hours a day / 7 days a week.**

**Frail and Most Vulnerable Members**

**DED also has a separate distinct process for the development of the ICP for members who are identified as frail or most vulnerable. Most vulnerable members are defined as:**

- **Frail**
- **Disabled**
- **Developing end-stage renal disease (ESRD) after enrollment**
- **Near the end-of-life**
- **Multiple or complex chronic conditions**

**Most vulnerable members are identified through:**

- **Risk stratification of all DED members upon enrollment and annually**
- **Referrals from weekly inpatient concurrent review meetings**
- **Referrals from the use of a high risk case management vendor algorithm**
- **Monitoring of high dollar in/outpatient claims**

**The ICP for vulnerable members will:**

- **Identify their most vulnerable members' special needs**
- **Address the needs of the most vulnerable through add-on benefits and services**
- **Document a member's caregiver and/or support system**

## COMMUNICATION NETWORK

**DED bases the communication process on integration steps for the MOC. As outlined below, communication begins in the following phases:**

***Step 1 – Operational Integration***

**The primary objective of Step 1 is to create a seamless operational integration of the workflow processes, member and provider rollout timeline, review of appropriate clinical guidelines, enrollee education materials, and enrollee and provider communications.**

***Step 2 – Provider Engagement***

**The primary objective of Step 2 is to obtain the necessary support of the provider(s) involved and needed support of the provider community. The provider engagement process includes mailing program announcement letters followed by informal calls from the plan's Medical Director to key providers and then conducting face-to-face program presentations with key providers and risk groups (as needed).**

***Step 3 – Member Engagement***

**Member engagement begins with a Sales Management Process that provides a means for Medicare/Medicaid dual-eligible individuals to become aware of DED through external sources: health professionals, media advertisement and community-based services. The solicitation process includes Medicare product seminars that provide prospective enrollees the opportunity to interact with Sales Representatives and obtain answers to questions and assistance in completing the enrollment form. An application receipt process reviews the election form for entitlement, completeness and accuracy. Completed applications are sent to the enrollment department for processing; incomplete applications are processed according to Medicare guidelines. The enrollment process includes maintenance of all Medicare-specific information, entitlement verification through CMS and generation of member correspondence. The plan performs outbound verification calls to ensure that those eligible for the DED have, in fact, intended to enroll and understand the rules applicable under the DED.**

**To meet the unique needs of members and providers, plan Member Services department staff are trained on the DED MOC, including coordination of benefits and the provider network, to effectively assist members and providers. This call center contact information is included on the member's ID card and is also staffed with bilingual employees for immediate access to interpretation services**

**The plan has a medical management system and a call center and member-friendly Web site for both members and providers. The communication systems consist in many formats of media to meet the needs of all that will be utilizing them and include but are not limited to:**

- **Member newsletters**

- **Provider newsletters**
- **Future provider portal in development**
- **Member online articles; health and wellness resources**

**Please see Attachment Four: Provider Bulletin and Attachment Five: Member Newsletter for examples.**

**In addition to Member Services department monitoring activities for efficiency and effectiveness, the Quality Improvement department monitors the quality of communication systems as part of the annual integrated member satisfaction report.**

**TruCare is the electronic system used by the DED Care Manager and Health Services staff. This system allows the sharing of information pertinent to the member to be seen by those staff at the health plan, the care management team.**

**This system also allows for review of data pertinent to members' care such as authorization of services and claims. Membership and provider data from the claims systems are fed into the medical management system on a daily basis to synchronize and facilitate the processes of review and authorization. In addition to following HIPAA privacy regulations, validity and consistency edits are employed throughout to ensure data.**

**This facilitates appropriate interventions and timely management for members in the MOC program. In addition to the electronic systems, the plan and the ICT utilize the following mechanisms to communicate with the member, provider and those involved ICP:**

- **Face-to-face meeting**
- **Telephone calls and messaging**
- **Email communications**
- **Audio-conferencing**
- **Web portal messaging**
- **Correspondence**
- **Mailed materials and publications**
- **Report submission**
- **Press releases**

**All plan directors and managers have oversight responsibility to monitor and evaluate communication effectiveness for their respective functions. Plan level communication effectiveness is assessed by monitoring the following sources:**

- **Member Advisory Committee feedback**
- **Member oral/written questions submitted to the Care Advisor Unit (CAU)**
- **Grievance and appeal submissions**
- **Provider feedback**

- **CAU feedback**

**Call center performance standards that DED vendors are responsible for:**

- **80% of calls must be answered within 30 seconds**
- **No more than 5% of incoming calls can be abandoned**

## CARE MANAGEMENT FOR THE MOST VULNERABLE POPULATION

**The plan defines the most vulnerable of their DED population as the elderly and frail.**

**Frailty is described as a state of high vulnerability for adverse health outcomes that include dependency on others, disability, falls, need for long-term care, and increased mortality. Frailty places an individual at high risk for stressors as a result of decreased physiologic reserves in addition to a dysfunctional physiologic system resulting in disruption within the person's homeostatic mechanism. Frailty includes generalized weakness, malnutrition, gait disorders, functional dependence, prolonged bed rest, pressure ulcers, weight loss, falls, confusion, dementia and delirium.**

**Disability is defined as inability to carry out, or dependency on others for, activities of daily living, independent activities of daily living and/or activities to improve the quality of one's life.**

**DED members may include the following individuals:**

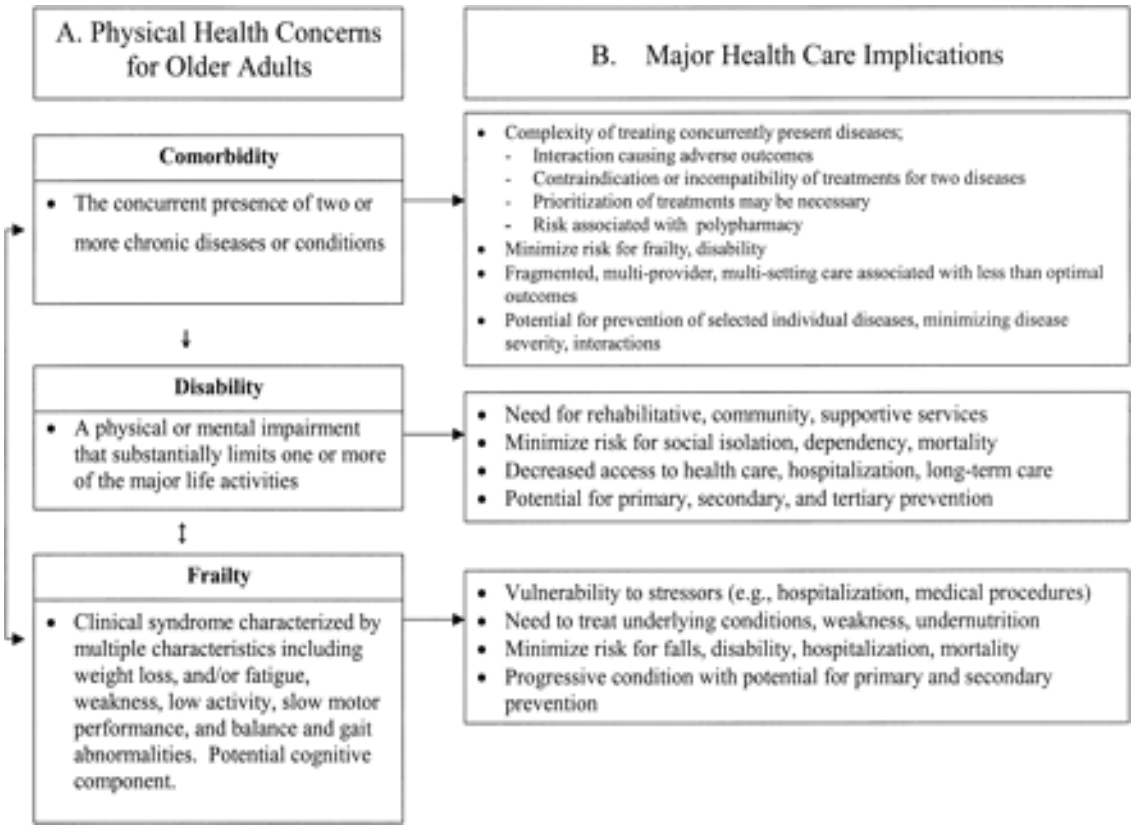
- **Individuals who have severe disability in two or more of the following domains or moderate disability in at least three or more of these domains: physical health, mental status, functional status, socio-economic status and residential environment; or**
- **Individuals who are disabled in two instrumental activities of daily living and one activity of daily living; or**
- **Individuals aged 85 years or older; or**
- **Older individuals who are homebound; or**
- **Older individuals with mental disorders such as dementia; or**
- **Older individuals with communication disorders; or**
- **Individuals with significant multiple chronic conditions such as arthritis, hypertension, heart disease, diabetes, osteoporosis, fracture, stroke, cancer (currently active), dementia, and Parkinson's disease; or**

- **Individuals who would qualify for long-term care services. These qualifications are usually defined based on severe chronic disease or disability involving substantial functional impairment.**

**DED's most vulnerable members are identified through the following opportunities:**

- **Risk stratification of all DED members upon enrollment and annually**
- **Referrals from weekly inpatient concurrent review meetings**
- **Referrals from the use of a high risk case management vendor algorithm**
- **Monitoring of high dollar in/outpatient claims**

**ICPs for vulnerable members will address:**




**This monograph adopted by DED assists in identifying the following co-morbidities/conditions and needs:**

- **Medication Therapy Management**
- **Control of hypertension**

- **Smoking cessation program**
- **Foot care**
- **Ophthalmology care**
- **Urinary incontinence**
- **Depression**
- **Functional assessment**
- **Exercise**
- **Diet**

**As noted above the DED shall provide care management to its vulnerable population through the ICT and the Care Manager. Their roles and responsibilities are as follows:**

**Key Components of the Interdisciplinary Care Team (ICT)**

- **Team members understand, appreciate, and collaborate with other disciplines and providers.**
- **Team members make decisions about services in collaboration with the DED member and other disciplines, rather than dividing care decisions by discipline or setting.**
- **Team members have a thorough understanding of their own profession.**
- **Team members understand how their varied experiences affect the way they provide care.**
- **Team members understand how the different approaches to practice can be integrated for the benefit of the DED member.**
- **Team members are able to identify and integrate into their practice aspects of care and service delivery that are most important to the DED members they serve.**

**General Success Factors for ICTs**

- **Knowledge of the expertise and roles of other team members and how these interrelate**
- **Focus on needs of DED members**
- **Recognition of and respect for specialized skills and contributions of each team member**
- **Shared charts and information regarding DED members**

- **Trust is valued**
- **Open communication and resolution of disagreements in a civilized manner (no hidden agendas)**
- **Work atmosphere is relaxed and supportive**
- **Collaboration and cooperation are cornerstones of success**
- **Commitment to common goals and to team members**
- **Coordination of services**

**ICT Goals**

- **A commitment to interdisciplinary team care for elderly patients who present with complex medical problems.**
- **The minimization of complications associated with hospitalization and/or sub-acute inpatient stays.**
- **The identification of and attention to medical, psychosocial and environmental needs.**
- **The maintenance and improvement of the functional level of patients.**
- **The provision of cognitive stimulation and socialization activities.**
- **The provision of expert interdisciplinary medical care management.**
- **The communication of medical information to designated health providers upon discharge to home or other facilities and/or for issues that arise in the patient's current residence.**

**The Care Manager shall:**

A. **Conduct initially and periodically a comprehensive, accurate, assessment of each member's functional capacity.**
B. **At the time each member is discharged from an inpatient setting, discuss with the member: the member's understanding of the discharge orders and compliance with and possible variation in the Individualized Care Plan (ICP) as required, such as follow-up appointments with specialty/primary providers.**
C. **Ensure that the comprehensive assessment of a member's needs describes the member's capability to perform daily life functions and significant impairments in the functional capacity. The comprehensive assessment shall include at least the following information:**
    1. **Medically defined conditions and prior medical history**
    2. **Financial status measurement**
    3. **Physical and mental functional status**

4. **Sensory and physical impairments**
5. **Nutritional status and requirements**
6. **Special treatments or procedures**
7. **Mental and psychosocial status**
8. **Discharge potential; applicable to acute/sub-acute or rehab settings**
9. **Activities potential**
10. **Rehabilitation potential**
11. **Cognitive status**
12. **Drug therapy**

**D. The CM shall:**

1. **Conduct comprehensive assessments within a reasonable time frame, but no less than 90 days after the date of admission to the program.**
2. **Promptly notify the DED after any significant change in the member's physical or mental condition.**
3. **Encourage the member to contact the primary/specialty provider with any significant physical or mental health changes.**

**E. The CM shall ensure that:**

1. **The results of the assessment are used to develop, review and revise the member's comprehensive ICP.**
2. **An ICP is developed for each member that includes measurable objectives and timetables to meet a member's medical and psychosocial needs that are identified in the comprehensive assessment.**

**F. The comprehensive ICP shall:**

1. **Describe the services that are to be furnished to attain or maintain the member's highest practicable physical, mental, and psychosocial well-being.**
2. **Describe any services that would otherwise be required, but are not provided due to the member's exercise of rights, including the right to refuse treatment.**
3. **Be developed within 30 days after completion of the comprehensive assessment.**
4. **Be approved by an interdisciplinary team, communicated to the attending provider, and other appropriate staff with responsibility for the member and other appropriate staff in disciplines as determined by the member's needs.**
5. **Include the participation of the member, the member's family or the member's legal representative.**

### Additional Benefits and Services

**DED offers members added benefits and services to meet their additional healthcare needs:**

- **Transportation Services: 24 one-way medically-related trips annually for DED members.**
- **Dental Benefit: diagnostic x-rays, preventive cleaning and services, restorative amalgam dental treatments, discounts for other services.**
- **DED members are enrolled in the Medication Therapy Management (MTM) program with quarterly medication reviews by a pharmacist.**
- **DED members are provided the hearing benefit for Medicare covered services.**
- **DED members have access to wellness programs and a covered annual wellness visit to their primary care provider in accordance with Medicare coverage guidelines.**

**The following table illustrates how the add-on benefits and/or services apply to the specialized needs of the most vulnerable DED members:**

| Additional Services | Frail | Disabled | ESRD Post-Enrollment | End-of-Life | Complex Chronic Conditions |
|---|---|---|---|---|---|
| Transportation | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dental | ✓ | ✓ | ✓ | | ✓ |
| MTM | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hearing Services | ✓ | ✓ | ✓ | ✓ | ✓ |

## PERFORMANCE AND HEALTH OUTCOME MEASUREMENT

**Evaluation of the effectiveness of this MOC is conducted on no less than an annual basis. Examples of DED's data used in this evaluation include access to services and member satisfaction.**

**Ongoing and annual data is collected, analyzed and reported to the Health Care Quality Committee (HCQC), which results in data analysis and recommendations**

**for quality improvement activities; projects and specialized services and benefits that may enhance the DED overall.**

**The data elements collected correspond with the goals of the DED MOC and include data from HEDIS, CAHPS, the HRA, utilization reports, appeals and grievances, surveys, delegation oversight, provider network, pharmacy services and DED's mental health partner.**

**Goals pertaining to this program overall may be based upon available benchmarks from NCQA, CMS, or internal standards. Corrective action plans will be implemented as indicated for internal departments, external vendors or delegated medical groups for data elements that do not meet performance standards as set forth in the plan's downstream provider agreements.**

**DED will submit the required data for quality reporting and:**

- **Collect, analyze and report data to measure health outcomes and indices of quality**
- **Evaluate the effectiveness of the care management plan to ensure an evidence-based MOC**

**Member health outcome data collected may include:**

- **Reduced hospitalizations and SNF placements**
- **Improved self-management and independence**
- **Improved mobility and functional status**
- **Improved pain management**
- **Improved quality of life as self-reported**
- **Improved satisfaction with health status and health services**

**Data may be collected on quality indices such as:**

- **Improved access to medical, mental health, LTSS and social services**
- **Improved access to affordable care**
- **Improved coordination of care through a single point of care management**
- **Improved transition of care across settings, providers and HCBS**
- **Improved access to preventive health services**

**Data may be collected on MOC structure or processes such as:**

- **Improved service delivery through a competent provider network having specialized expertise**

- **Improved coordination of care through use of an ICP**
- **Improved coordination of care through management by an ICT**
- **Improved utilization of services through identification and stratification of health risks**
- **Improved coordination of care through effective communication among providers, members, and the ICT**

## ATTACHMENT ONE: ALLIANCE COMPLETECARE TRAINING DOCUMENTATION

ALAMEDA Alliance FOR HEALTH

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PROVIDER SERVICES

### ALLIANCE PROVIDER UPDATE

Date: February 23, 2011

To: Alliance Providers and Medical Groups

From: Alliance Provider Services Department
Phone: (510) 747-4510, Fax: 1-877-747-4508
providerservices@alamedaalliance.org

Re: **Model of Care for Alliance CompleteCare Members**

Issue#: 11-01-01

---

The Alliance is pleased to inform you about our Model of Care program for Alliance CompleteCare members. This program has been in place since January 2010 and is designed to help our members better manage their health care. The Centers for Medicare and Medicaid Services (CMS) requires that we provide you with information about the program annually.

**What is Model of Care?**

Model of Care is a framework for organizing the health and social needs of each Alliance CompleteCare member. Each model of care is based on utilization data and input from our members.

**What are the Goals of Model of Care?**

Model of Care is meant to improve the health outcomes of Alliance CompleteCare members by:

- Reducing hospitalizations
- Improving self management and independence
- Improving access to medical treatment, mental health care, and social services
- Improving coordination of care across health care settings and providers

**How Does Model of Care Accomplish These Goals?**

The four main ways that these goals are accomplished are by:

- Providing Alliance CompleteCare members with the opportunity to complete a self-reported Health Risk Assessment (HRA) annually
- Using the results of the HRA and utilization data (medical, pharmacy, and lab claims) to create an Individualized Care Plan (ICP) for each member
- Maintaining an Interdisciplinary Care Team that monitors the ICPs and assists with care coordination
- Obtaining feedback from Primary Care Providers

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PROVIDER SERVICES

**What is a Health Risk Assessment (HRA)?**

- An HRA is an optional phone questionnaire given to Alliance CompleteCare members
- The HRA assesses the medical, psychosocial, cognitive, and functional needs of members
- HRAs are conducted within 90 days of enrollment and annually thereafter
- The results of the HRA help develop each member's Individualized Care Plan
- The Alliance has contracted with Independent Living Systems (ILS) to conduct the HRAs

**What is an Individualized Care Plan (ICP)?**

- Each member's ICP is developed by ILS using the results of the HRA as well as medical and pharmacy data provided by the Alliance
- Each ICP sets goals, objectives, and measurable outcomes
- ILS communicates the goals and objectives with both members and PCPs
- ICPs are updated at least annually

**The Alliance's Interdisciplinary Care Team**

Our Interdisciplinary Care Team is composed of:

- The Alliance's Chief Medical Officer and Alliance nurses
- A mental health expert from Optum Health Behavioral Solutions (formerly Pacificare Behavioral Health)
- The Alliance's Pharmacist and Health Educator, as needed

The role of the Alliance's Interdisciplinary Care Team is to:

- Analyze and incorporate the results of the initial and annual HRAs into the care plans
- Collaborate to develop and annually update member care plans
- Assist ILS, members, and providers with care coordination

**Model of Care and Primary Care Providers**

PCPs receive copies of their patients' ICPs. Feedback we get from PCPs is invaluable in making the Model of Care program as effective as possible. We encourage PCPs to:

- Provide the Alliance with feedback on the care plans
- Discuss the care plans with their patients
- File the care plans in their patients' charts


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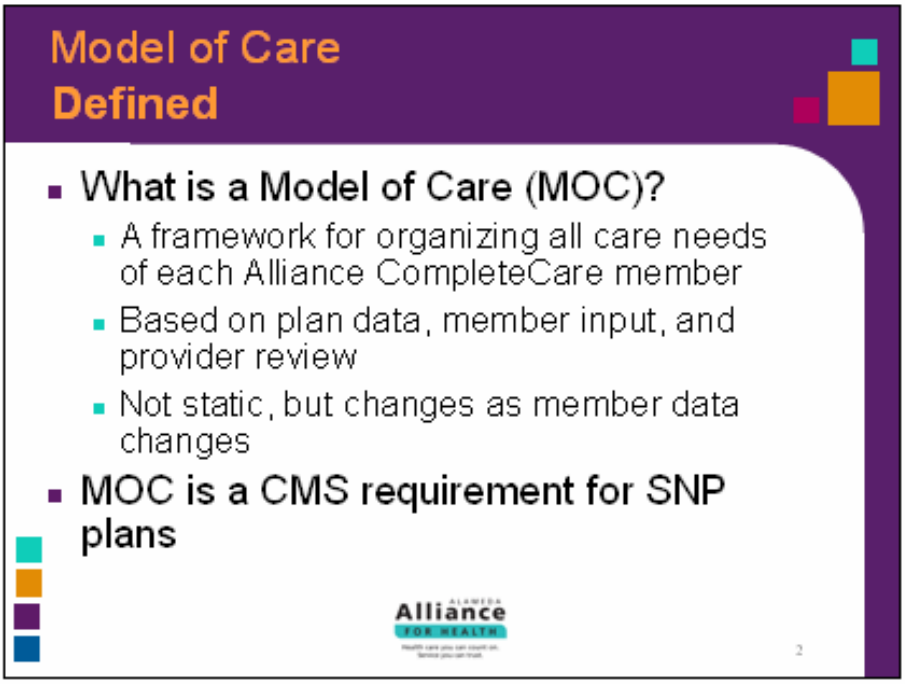
Alameda Alliance for Health
Model of Care Training for Alliance Staff
February 2011


Model of Care
Defined
What is a Model of Care (MOC)?
A framework for organizing all care needs of each Alliance CompleteCare member
Based on plan data, member input, and provider review
Not static, but changes as member data changes
MOC is a CMS requirement for SNP plans
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Model of Care
Goals
Improve Alliance member health outcomes:
Reduce hospitilization
Improved self management and independence
Improved mobility and functional status
Improved pain management
Improved quality of life as self-reported
Improved satisfaction with health status and health services
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Model of Care
Goals cont…
Improve access to medical, mental health, and social services
Improve access to affordable care
Improve coordination of care through an identified point of contact
Improve coordination of care across healthcare settings and providers
Improve access to preventative health services
Assure cost-effective service delivery
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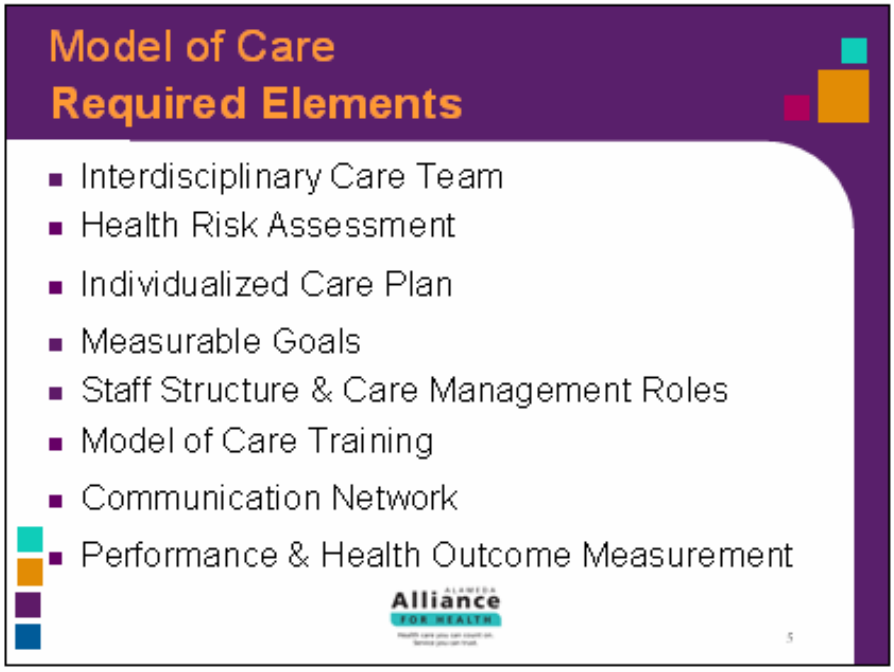
Model of Care
Required Elements
Interdisciplinary Care Team
Health Risk Assessment
Individualized Care Plan
Measurable Goals
Staff Structure & Care Management Roles
Model of Care Training
Communication Network
Performance & Health Outcome Measurement
Alliance
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5


Model of Care
Alliance's Interdisciplinary Care Team
The Alliance's Interdisciplinary Care Team is composed of:
Medical Experts (Alliance Medical Director and Nurses)
Mental Health Expert (Pacificare Behavioral Health Provider)
Social Services Expert
Member's PCP
Others as needed (Alliance Pharmacist, Health Educator, etc)
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Model of Care
Interdisciplinary Care Team cont…
Role of the Interdisciplinary Care Team:
Analyze and incorporate the results of the initial and annual health risk assessments into the care plan
Collaborate to develop and annually update each member's care plan
Assist with care coordination
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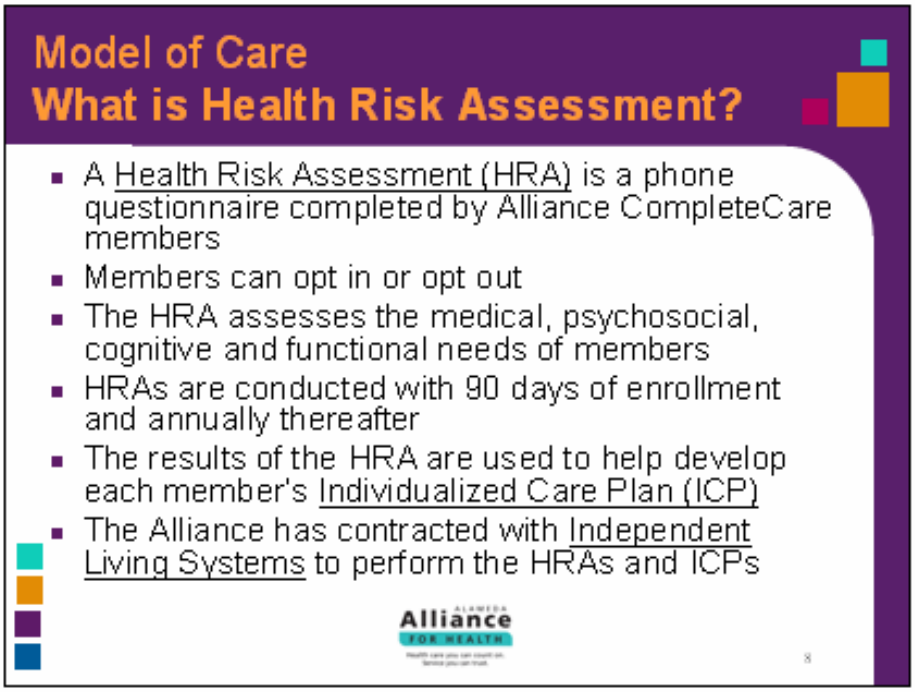
Model of Care
What is Health Risk Assessment?
A Health Risk Assessment (HRA) is a phone questionnaire completed by Alliance CompleteCare members
Members can opt in or opt out
The HRA assesses the medical, psychosocial, cognitive and functional needs of members
HRAs are conducted with 90 days of enrollment and annually thereafter
The results of the HRA are used to help develop each member's Individualized Care Plan (ICP)
The Alliance has contracted with Independent Living Systems to perform the HRAs and ICPs
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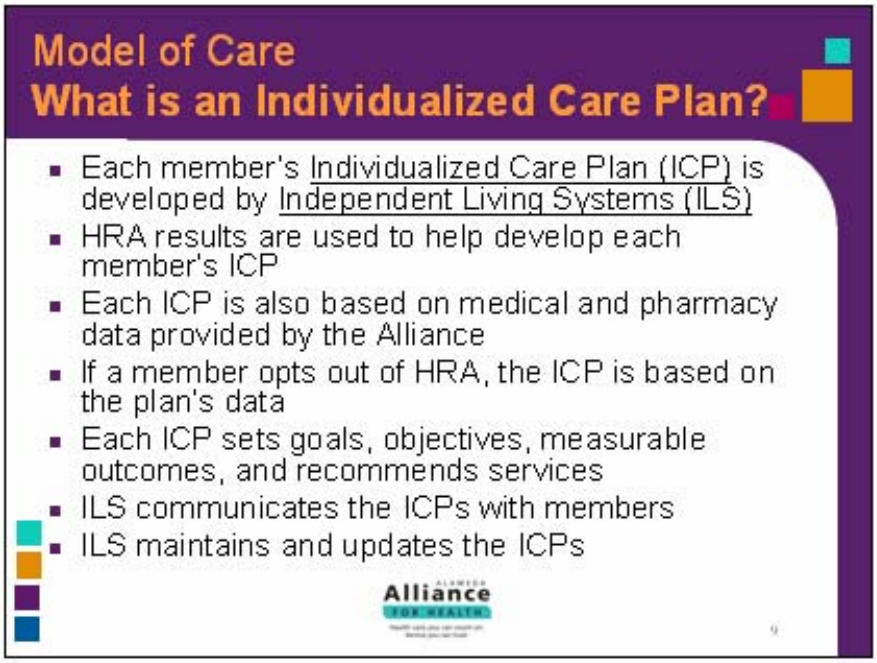
FOR HEALTH
8


Model of Care
What is an Individualized Care Plan?
Each member's Individualized Care Plan (ICP) is developed by Independent Living Systems (ILS)
HRA results are used to help develop each member's ICP
Each ICP is also based on medical and pharmacy data provided by the Alliance
If a member opts out of HRA, the ICP is based on the plan's data
Each ICP sets goals, objectives, measurable outcomes, and recommends services
ILS communicates the ICPs with members
ILS maintains and updates the ICPs
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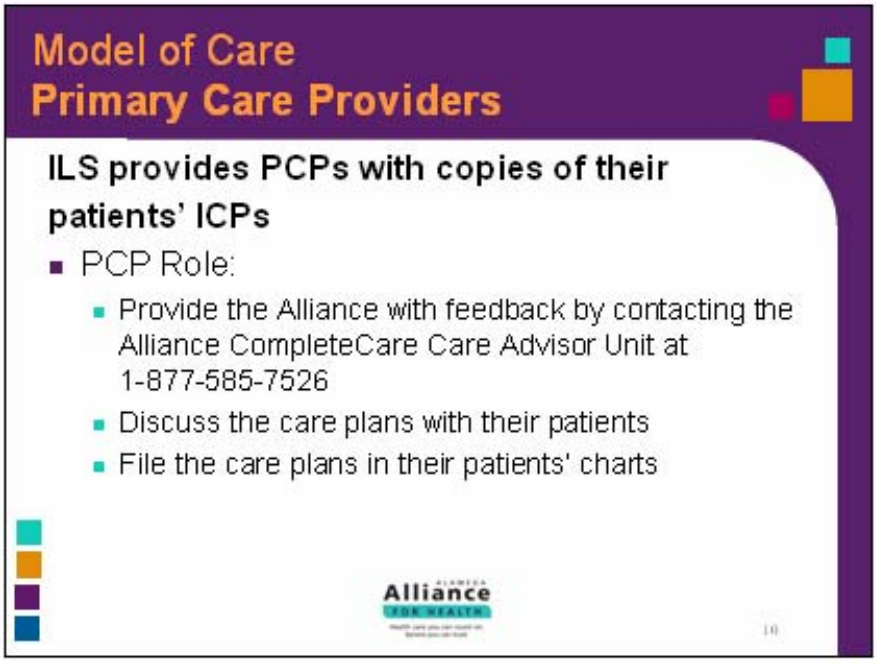
FOR HEALTH


Model of Care
Primary Care Providers
ILS provides PCPs with copies of their patients' ICPs
PCP Role:
Provide the Alliance with feedback by contacting the Alliance CompleteCare Care Advisor Unit at 1-877-585-7526
Discuss the care plans with their patients
File the care plans in their patients' charts
Alliance
FOR HEALTH

## Alameda Alliance for Health

**MODEL OF CARE TRAINING ATTESTATION SHEET FOR ALLIANCE STAFF**

| |
|---|
| **Training Toool: Powerpoint Presentation, "Model of Care Training for Alliance Staff"** |
| **Training Applies to: Alliance CompleteCare** |

| | Name | Title/Position | Signature | Date |
|---|---|---|---|---|
| 1 | Kathryn Chaney | Provider Services Coordinator | | 2/22/11 |
| 2 | Gary Smiley | Provider Services Rep | | 2/22/11 |
| 3 | Mirabelle Celario | Sr. Quality Improvement Nurse Specialist | mcelario | 2/22/11 |
| 4 | Katherine Ebido | Sr. Quality Improvement Nurse | KEbido | 2/22/11 |
| 5 | Kresnenda Jenkins | Provider Services Rep | | 2/22/11 |
| 6 | [illegible] | Provider Services Director | [illegible] | 2/22/11 |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
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Provider Services Department

## Alameda Alliance for Health

**MODEL OF CARE TRAINING ATTESTATION SHEET FOR ALLIANCE STAFF**

**Training Tool:** Powerpoint Presentation, "Model of Care Training for Alliance Staff"
**Training Applies to:** Model of Care for Alliance CompleteCare

| | Name | Title/Position | Signature | Date |
|---|---|---|---|---|
| 1 | JUDITH ROSAS | MEMBER SVC. REP. | | 5-5-11 |
| 2 | Adrian Leyva | MEMBER SVC REP | | 5-5-11 |
| 3 | J. DeGrano | Mgr Care Coord | | 5.5.11 |
| 4 | Crista Tran | CAM | | 5-5-11 |
| 5 | Araceli Villalobos | MSR Lead | | 5-5-11 |
| 6 | Ann Marie Pitman | MSR | | 5/5/11 |
| 7 | Loren Mariscal | MSR | | 5/05/2011 |
| 8 | Soraya Urbina | MSR | | 5/5/11 |
| 9 | Angie Yariri | NSD/TRAINER/QUALITY | | 5-5-2011 |
| 10 | Kim Rice | Lead MSR | | 5-5-2011 |
| 11 | Vanessa Swann | MSR | | 5-5-11 |
| 12 | Hilda Nevarez | CA | | 5-5-11 |
| 13 | Paula Rgandolopez | CA | | 5/5/11. |
| 14 | | | | |
| 15 | | | | |

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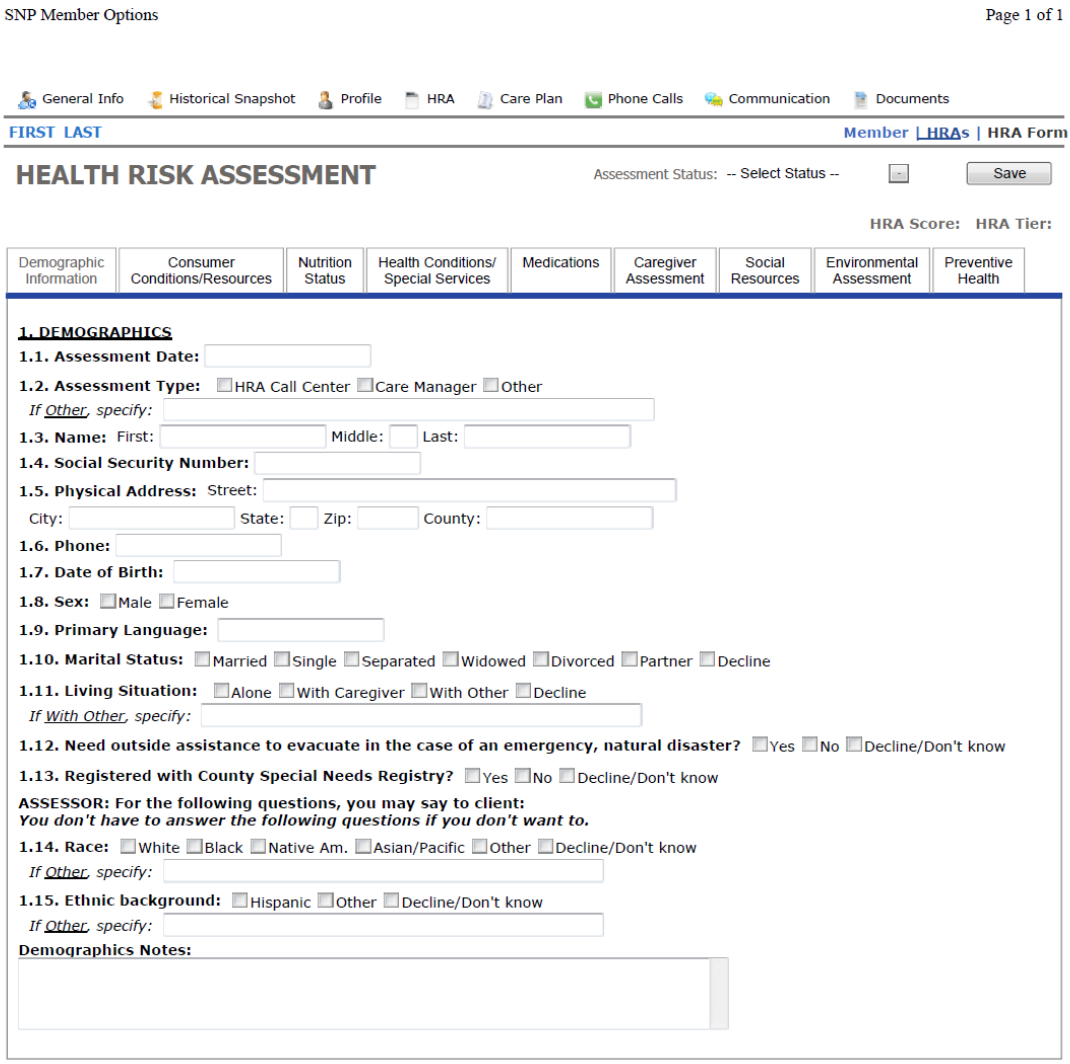
**Provider Services Department**

## ATTACHMENT TWO: HEALTH RISK ASSESSMENT



SNP Member Options Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST — Member | HRAs | HRA Form

**HEALTH RISK ASSESSMENT** Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**1. DEMOGRAPHICS**

**1.1. Assessment Date:**

**1.2. Assessment Type:** HRA Call Center Care Manager Other

*If Other, specify:*

**1.3. Name:** First: Middle: Last:

**1.4. Social Security Number:**

**1.5. Physical Address:** Street:

City: State: Zip: County:

**1.6. Phone:**

**1.7. Date of Birth:**

**1.8. Sex:** Male Female

**1.9. Primary Language:**

**1.10. Marital Status:** Married Single Separated Widowed Divorced Partner Decline

**1.11. Living Situation:** Alone With Caregiver With Other Decline

*If With Other, specify:*

**1.12. Need outside assistance to evacuate in the case of an emergency, natural disaster?** Yes No Decline/Don't know

**1.13. Registered with County Special Needs Registry?** Yes No Decline/Don't know

**ASSESSOR: For the following questions, you may say to client:**
***You don't have to answer the following questions if you don't want to.***

**1.14. Race:** White Black Native Am. Asian/Pacific Other Decline/Don't know

*If Other, specify:*

**1.15. Ethnic background:** Hispanic Other Decline/Don't know

*If Other, specify:*

**Demographics Notes:**

SNP Member Options Page 1 of 3

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST Member | HRAs | HRA Form

## HEALTH RISK ASSESSMENT

Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**2. CONSUMER CONDITIONS/RESOURCES.**

**2.1. MENTAL HEALTH.**

**ASSESSOR: Who is answering questions?** ☐Consumer ☐Other

*If Other, specify:*

**2.1.3.2. Immediate Recall.**
**ASSESSOR: The following question corresponds to the RECALL sub-section.**
**Say to client: *'I am going to say three (3) words that I want you to repeat after me'.***
**Say BALL, FLAG, TREE clearly and slowly, about 1 second each. Do not say them twice.**
**Then ask the client to repeat them.**

BALL: ☐Did Remember ☐Didn't Remember ☐Decline

FLAG: ☐Did Remember ☐Didn't Remember ☐Decline

TREE: ☐Did Remember ☐Didn't Remember ☐Decline

**Immediate Recall Notes:**

**2.1.1. DEPRESSION.**

**ASSESSOR: Say to client:**
***I am going to ask you a few questions about how you have felt during the last month.***

**2.1.1.1. Are you basically satisfied with your life?** ☐Yes ☐No ☐Decline

**2.1.1.2. Do you feel that your life is empty?** ☐Yes ☐No ☐Decline

**2.1.1.3. Do you often get bored?** ☐Yes ☐No ☐Decline

**2.1.1.4. Are you in good spirits most of the time?** ☐Yes ☐No ☐Decline

**2.1.1.5. Are you afraid that something bad is going to happen to you?** ☐Yes ☐No ☐Decline

**2.1.1.6. Do you often feel helpless?** ☐Yes ☐No ☐Decline

**2.1.1.7. Do you feel you have more problems with your memory that most?** ☐Yes ☐No ☐Decline

**2.1.1.8. Do you feel full of energy?** ☐Yes ☐No ☐Decline

**2.1.1.9. Do you prefer to stay at home, rather than going out and doing new things?** ☐Yes ☐No ☐Decline

**2.1.1.10. Have you ever thought of ending your life?** ☐Yes ☐No ☐Decline

**Depression Notes:**

**2.1.2. ANXIETY.**

**ASSESSOR: Say to client:**
***I am going to ask you some more questions about how you have felt during the last month.***

**2.1.2.1. Do you feel nervous or anxious?** ☐Yes ☐No ☐Decline

**2.1.2.2. Do you worry a lot?** ☐Yes ☐No ☐Decline

**2.1.2.3. Do you feel restless?** ☐Yes ☐No ☐Decline

**2.1.2.4. Are you afraid of being alone?** ☐Yes ☐No ☐Decline

**2.1.2.5. Do you have difficulty making everyday decisions?** ☐Yes ☐No ☐Decline

**Anxiety Notes:**

**2.1.3. COGNITION.**

**2.1.3.1 Orientation.**
**ASSESSOR: Ask the following question slowly and clearly. Repeat as necessary.**
**Say to client: *'Can you tell me the day of the week, date and time?'***

Day of the week: ☐Correct ☐Incorrect ☐Decline

Date: ☐Correct ☐Incorrect ☐Decline

Time: ☐Correct ☐Incorrect ☐Decline

**Orientation Notes:**

**2.1.3.2 Immediate Recall.**
**ASSESSOR: The question corresponding to this sub-section has already been asked at the beginning of the Mental Health section.**

**2.1.3.3 Recall.**
**ASSESSOR: Say to client: *'Can you repeat the three (3) words I previously asked you to remember?'***

BALL: ☐Did Remember ☐Didn't Remember ☐Decline

FLAG: ☐Did Remember ☐Didn't Remember ☐Decline

TREE: ☐Did Remember ☐Didn't Remember ☐Decline

**Recall Notes:**

**2.2. PHYSICAL HEALTH.**

**2.2.1 GENERAL INFORMATION.**

**2.2.1.1. How would you rate your overall health at the present time?**

☐Excellent ☐Good ☐Fair ☐Poor ☐Decline

**2.2.1.2. Compared to a year ago, how would you rate your health?**

☐Much Better ☐Better ☐About Same ☐Worse ☐Decline

**2.2.1.3. How much do your physical problems stand in the way of your doing the things you want to do?**

☐Not at All ☐Occasionally ☐Often ☐All the time ☐Decline

**2.2.1.4. Is medical care readily available for you?**

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.1.5. Is transportation to medical care readily available?**

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.1.6. Do your finances/insurance permit access to healthcare and medications?**

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.1.7. How is your vision? (with glasses if used):**

☐Good ☐Fair ☐Poor ☐Blind ☐Decline

**2.2.1.8. How is your hearing? (with hearing aid if used):**

☐Good ☐Fair ☐Poor ☐Deaf ☐Decline

**2.2.1.9. How is your speech?**

☐Good ☐Fair ☐Poor ☐Gestures Signs ☐Unable ☐Decline

**2.2.1.10. How is your walking? (with device if used):**

☐Good ☐Fair ☐Poor ☐Chairbound ☐Bedbound ☐Decline

**Physical Health Notes:**

**2.2.2. FUNCTIONAL.**

**2.2.2.1. ACTIVITIES OF DAILY LIVING (ADL's).**

**ASSESSOR. Ask client: *How much help do you need with the following Activities of Daily Living?***

**2.2.2.1.1. BATHE:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with bathing. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.1.2. DRESS:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with dressing. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.1.3. EAT:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with eating. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.1.4. USE BATHROOM:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with using the bathroom. How often do you have adequate assistance?*

SNP Member Options Page 3 of 3

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.1.5. TRANSFER:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with transfer. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.1.6. WALKING/MOBILITY:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with walking/mobility. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**ADL's Notes:**

**2.2.2.2. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL's).**

**ASSESSOR. Ask client:** ***How much help do you need with the following Activities of Daily Living?***

**2.2.2.2.1. HEAVY CHORES:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with heavy chores. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.2. LIGHT HOUSEKEEPING:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with light housekeeping. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.3. USE PHONE:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with using the phone. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.4. MANAGE MONEY:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with managing money. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.5. PREPARE MEALS:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with preparing meals. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.6. SHOPPING:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with shopping. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**2.2.2.2.7. TAKE MEDICATIONS:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with taking medications. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

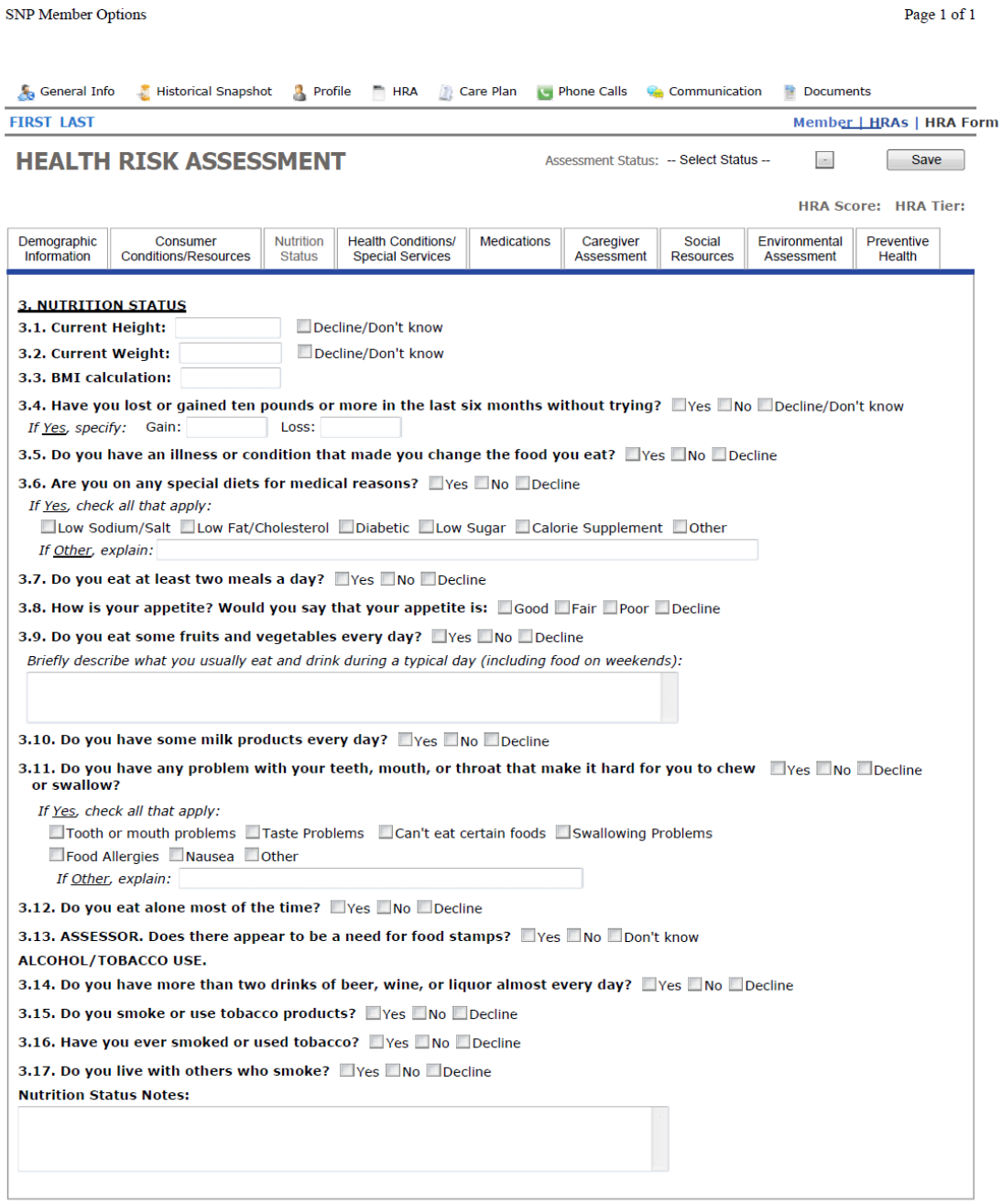
**2.2.2.2.8. USE TRANSPORTATION:**

☐No Help ☐Relies on Assistive Dev. ☐Supervision ☐Some Help ☐Total Help ☐Decline

*If you need supervision, some help or total help with transportation. How often do you have adequate assistance?*

☐Always ☐Sometimes ☐Rarely ☐Never ☐Decline

**IADL's Notes:**



SNP Member Options Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST Member | HRAs | HRA Form

**HEALTH RISK ASSESSMENT** Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**3. NUTRITION STATUS**

**3.1. Current Height:** ☐ Decline/Don't know

**3.2. Current Weight:** ☐ Decline/Don't know

**3.3. BMI calculation:**

**3.4. Have you lost or gained ten pounds or more in the last six months without trying?** ☐ Yes ☐ No ☐ Decline/Don't know

*If Yes, specify:* Gain: Loss:

**3.5. Do you have an illness or condition that made you change the food you eat?** ☐ Yes ☐ No ☐ Decline

**3.6. Are you on any special diets for medical reasons?** ☐ Yes ☐ No ☐ Decline

*If Yes, check all that apply:*

☐ Low Sodium/Salt ☐ Low Fat/Cholesterol ☐ Diabetic ☐ Low Sugar ☐ Calorie Supplement ☐ Other

*If Other, explain:*

**3.7. Do you eat at least two meals a day?** ☐ Yes ☐ No ☐ Decline

**3.8. How is your appetite? Would you say that your appetite is:** ☐ Good ☐ Fair ☐ Poor ☐ Decline

**3.9. Do you eat some fruits and vegetables every day?** ☐ Yes ☐ No ☐ Decline

*Briefly describe what you usually eat and drink during a typical day (including food on weekends):*

**3.10. Do you have some milk products every day?** ☐ Yes ☐ No ☐ Decline

**3.11. Do you have any problem with your teeth, mouth, or throat that make it hard for you to chew or swallow?** ☐ Yes ☐ No ☐ Decline

*If Yes, check all that apply:*

☐ Tooth or mouth problems ☐ Taste Problems ☐ Can't eat certain foods ☐ Swallowing Problems

☐ Food Allergies ☐ Nausea ☐ Other

*If Other, explain:*

**3.12. Do you eat alone most of the time?** ☐ Yes ☐ No ☐ Decline

**3.13. ASSESSOR. Does there appear to be a need for food stamps?** ☐ Yes ☐ No ☐ Don't know

**ALCOHOL/TOBACCO USE.**

**3.14. Do you have more than two drinks of beer, wine, or liquor almost every day?** ☐ Yes ☐ No ☐ Decline

**3.15. Do you smoke or use tobacco products?** ☐ Yes ☐ No ☐ Decline

**3.16. Have you ever smoked or used tobacco?** ☐ Yes ☐ No ☐ Decline

**3.17. Do you live with others who smoke?** ☐ Yes ☐ No ☐ Decline

**Nutrition Status Notes:**

SNP Member Options Page 1 of 2

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST Member | HRAs | HRA Form

## HEALTH RISK ASSESSMENT

Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**4. HEALTH CONDITIONS/SPECIAL SERVICES.**

**4.1. HEALTH CONDITIONS.**

**4.1.1. Allergies:** ☐Yes ☐No

*If Yes, specify:* ☐Penicillin ☐Sulfa ☐Iodine ☐Shellfish ☐Foods ☐Other

*If Other, explain:*

**4.1.2. Amputation:** ☐Yes ☐No

*If Yes, specify Site:*

*Upper Extremities:* ☐Left below elbow (LBE) ☐Left above elbow (LAE) ☐Right below elbow (RBE) ☐Right above elbow (RAE)

*Lower Extremities:* ☐Left below knee (LBK) ☐Left above Knee (LAK) ☐Right below knee (RBK) ☐Right above knee (RAK)

*Other site, explain:* ☐

**4.1.3. Arthritis:** ☐Yes ☐No

*If Yes, specify Type:* ☐Rheumatoid ☐Osteoarthritis ☐Other

*If Other, explain:*

**4.1.4. Asthma:** ☐Yes ☐No

**4.1.5. Bed Sore(s):** ☐Yes ☐No

*If Yes, specify:* ☐Heel ☐Elbow ☐Coccyx ☐Shoulder ☐Other

*If Other, explain:*

**4.1.6. Blood Pressure:** ☐Yes ☐No

*If Yes, specify:* ☐High ☐Low

**4.1.7. Broken Bones/Fractures:** ☐Yes ☐No

*If Yes, specify Site:*

*Upper Extremities:* ☐Left below elbow (LBE) ☐Left above elbow (LAE) ☐Right below elbow (RBE) ☐Right above elbow (RAE)

*Lower Extremities:* ☐Left below knee (LBK) ☐Left above Knee (LAK) ☐Right below knee (RBK) ☐Right above knee (RAK)

*Other site, explain:* ☐

**4.1.8. Cancer:** ☐Yes ☐No

*If Yes, specify Location:* ☐Lung ☐Skin ☐Colon ☐Other

*If Other, explain:*

**4.1.9. Dehydration:** ☐Yes ☐No

**4.1.10. Dementia:** ☐Yes ☐No

*If Yes, specify:* ☐Alzheimer's ☐OBS(Organic Brain Syndrome) ☐Other

*If Other, explain:*

**4.1.11. Dental Problems:** ☐Yes ☐No

**4.1.12. Diabetes:** ☐Yes ☐No

*If Yes, specify:* ☐IDDM ☐NIDDM

**4.1.13. Dizziness:** ☐Yes ☐No

**4.1.14. Emphysema/COPD:** ☐Yes ☐No

**4.1.15. Falls in past year:** ☐Yes ☐No

**4.1.16. Gallbladder Problems:** ☐Yes ☐No

**4.1.17. Gastrointestinal Problems:** ☐Yes ☐No

*If Yes, specify:* ☐Constipation ☐Diarrhea ☐Acid Reflux ☐Ulcers ☐Other

*If Other, explain:*

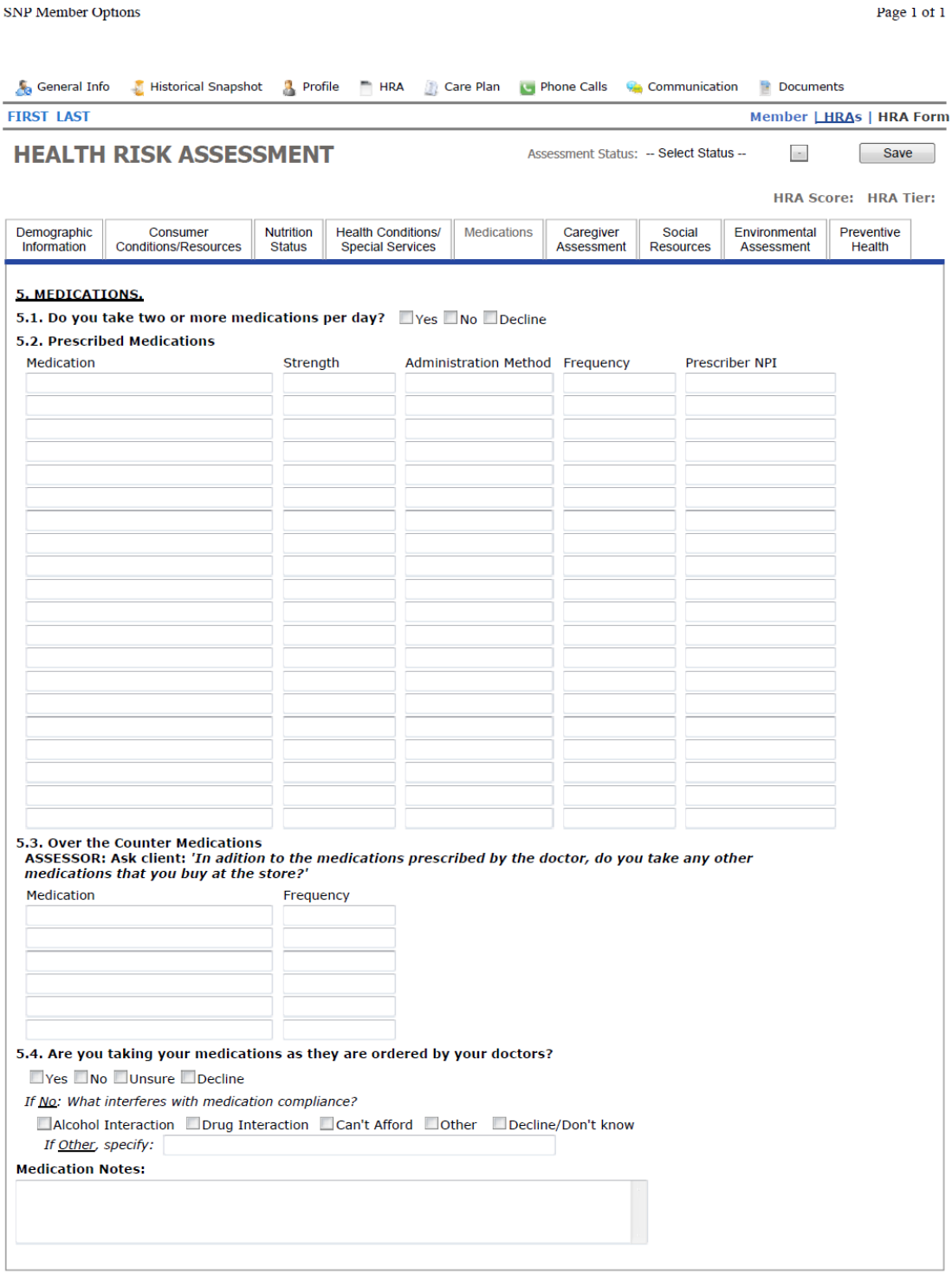
**4.1.18. Heart Problems:** ☐Yes ☐No

*If Yes, specify:* ☐CHF ☐MI ☐Pacemaker ☐Other

*If Other, explain:*

**4.1.19. Hearing Problems:** ☐Yes ☐No

**4.1.20. Incontinence:** ☐Yes ☐No



SNP Member Options

Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST

Member | HRAs | HRA Form

HEALTH RISK ASSESSMENT

Assessment Status: -- Select Status --

Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**5. MEDICATIONS.**

**5.1. Do you take two or more medications per day?** ☐ Yes ☐ No ☐ Decline

**5.2. Prescribed Medications**

| Medication | Strength | Administration Method | Frequency | Prescriber NPI |
|---|---|---|---|---|
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**5.3. Over the Counter Medications**

**ASSESSOR: Ask client:** ***'In adition to the medications prescribed by the doctor, do you take any other medications that you buy at the store?'***

| Medication | Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**5.4. Are you taking your medications as they are ordered by your doctors?**

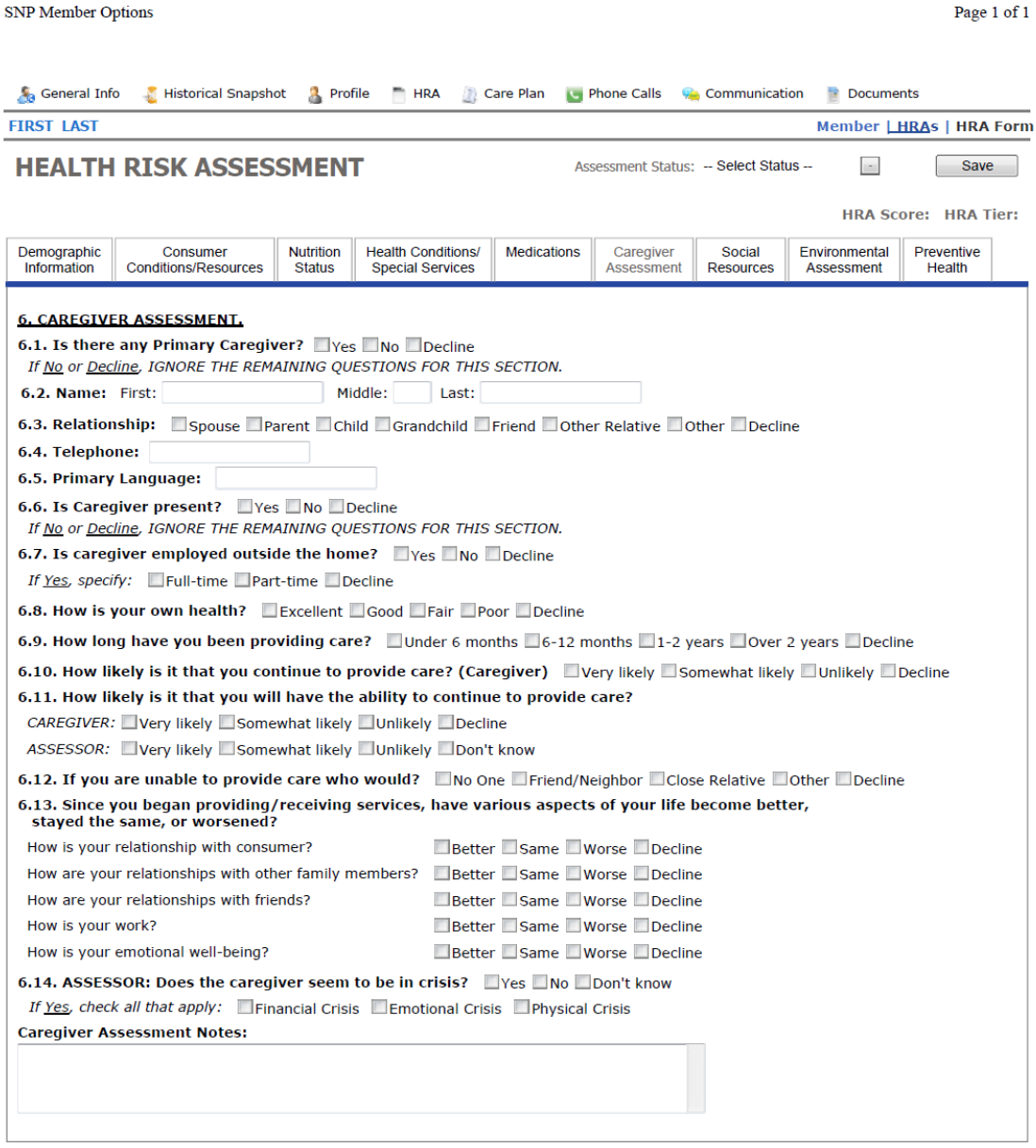
☐ Yes ☐ No ☐ Unsure ☐ Decline

*If No: What interferes with medication compliance?*

☐ Alcohol Interaction ☐ Drug Interaction ☐ Can't Afford ☐ Other ☐ Decline/Don't know

*If Other, specify:*

**Medication Notes:**



SNP Member Options Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST — Member | HRAs | HRA Form

**HEALTH RISK ASSESSMENT** Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**6. CAREGIVER ASSESSMENT.**

**6.1. Is there any Primary Caregiver?** ☐Yes ☐No ☐Decline

*If No or Decline, IGNORE THE REMAINING QUESTIONS FOR THIS SECTION.*

**6.2. Name:** First: Middle: Last:

**6.3. Relationship:** ☐Spouse ☐Parent ☐Child ☐Grandchild ☐Friend ☐Other Relative ☐Other ☐Decline

**6.4. Telephone:**

**6.5. Primary Language:**

**6.6. Is Caregiver present?** ☐Yes ☐No ☐Decline

*If No or Decline, IGNORE THE REMAINING QUESTIONS FOR THIS SECTION.*

**6.7. Is caregiver employed outside the home?** ☐Yes ☐No ☐Decline

*If Yes, specify:* ☐Full-time ☐Part-time ☐Decline

**6.8. How is your own health?** ☐Excellent ☐Good ☐Fair ☐Poor ☐Decline

**6.9. How long have you been providing care?** ☐Under 6 months ☐6-12 months ☐1-2 years ☐Over 2 years ☐Decline

**6.10. How likely is it that you continue to provide care? (Caregiver)** ☐Very likely ☐Somewhat likely ☐Unlikely ☐Decline

**6.11. How likely is it that you will have the ability to continue to provide care?**

*CAREGIVER:* ☐Very likely ☐Somewhat likely ☐Unlikely ☐Decline

*ASSESSOR:* ☐Very likely ☐Somewhat likely ☐Unlikely ☐Don't know

**6.12. If you are unable to provide care who would?** ☐No One ☐Friend/Neighbor ☐Close Relative ☐Other ☐Decline

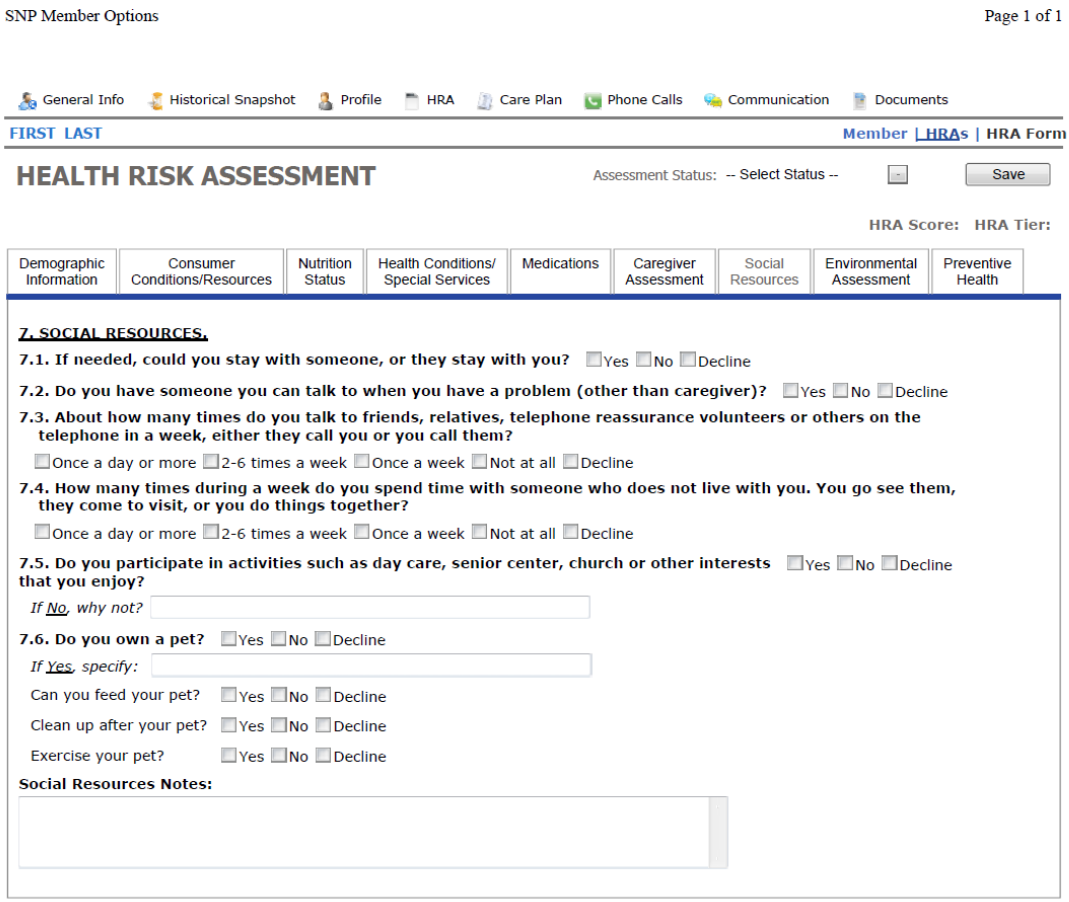
**6.13. Since you began providing/receiving services, have various aspects of your life become better, stayed the same, or worsened?**

| | | | | |
|---|---|---|---|---|
| How is your relationship with consumer? | ☐Better | ☐Same | ☐Worse | ☐Decline |
| How are your relationships with other family members? | ☐Better | ☐Same | ☐Worse | ☐Decline |
| How are your relationships with friends? | ☐Better | ☐Same | ☐Worse | ☐Decline |
| How is your work? | ☐Better | ☐Same | ☐Worse | ☐Decline |
| How is your emotional well-being? | ☐Better | ☐Same | ☐Worse | ☐Decline |

**6.14. ASSESSOR: Does the caregiver seem to be in crisis?** ☐Yes ☐No ☐Don't know

*If Yes, check all that apply:* ☐Financial Crisis ☐Emotional Crisis ☐Physical Crisis

**Caregiver Assessment Notes:**



SNP Member Options

Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST

Member | HRAs | HRA Form

HEALTH RISK ASSESSMENT

Assessment Status: -- Select Status --

Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**7. SOCIAL RESOURCES.**

**7.1. If needed, could you stay with someone, or they stay with you?** ☐Yes ☐No ☐Decline

**7.2. Do you have someone you can talk to when you have a problem (other than caregiver)?** ☐Yes ☐No ☐Decline

**7.3. About how many times do you talk to friends, relatives, telephone reassurance volunteers or others on the telephone in a week, either they call you or you call them?**

☐Once a day or more ☐2-6 times a week ☐Once a week ☐Not at all ☐Decline

**7.4. How many times during a week do you spend time with someone who does not live with you. You go see them, they come to visit, or you do things together?**

☐Once a day or more ☐2-6 times a week ☐Once a week ☐Not at all ☐Decline

**7.5. Do you participate in activities such as day care, senior center, church or other interests that you enjoy?** ☐Yes ☐No ☐Decline

*If No, why not?*

**7.6. Do you own a pet?** ☐Yes ☐No ☐Decline

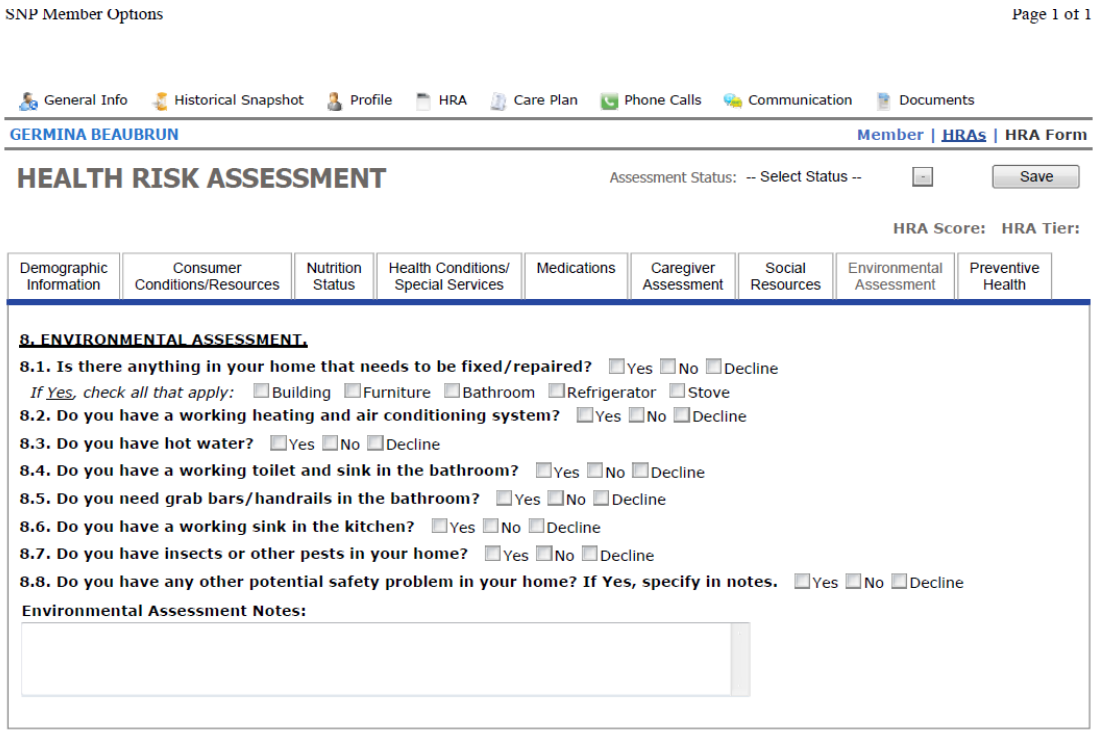
*If Yes, specify:*

Can you feed your pet? ☐Yes ☐No ☐Decline

Clean up after your pet? ☐Yes ☐No ☐Decline

Exercise your pet? ☐Yes ☐No ☐Decline

**Social Resources Notes:**



SNP Member Options Page 1 of 1

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

GERMINA BEAUBRUN Member | HRAs | HRA Form

HEALTH RISK ASSESSMENT Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**8. ENVIRONMENTAL ASSESSMENT.**

**8.1. Is there anything in your home that needs to be fixed/repaired?** ☐Yes ☐No ☐Decline

*If Yes, check all that apply:* ☐Building ☐Furniture ☐Bathroom ☐Refrigerator ☐Stove

**8.2. Do you have a working heating and air conditioning system?** ☐Yes ☐No ☐Decline

**8.3. Do you have hot water?** ☐Yes ☐No ☐Decline

**8.4. Do you have a working toilet and sink in the bathroom?** ☐Yes ☐No ☐Decline

**8.5. Do you need grab bars/handrails in the bathroom?** ☐Yes ☐No ☐Decline

**8.6. Do you have a working sink in the kitchen?** ☐Yes ☐No ☐Decline

**8.7. Do you have insects or other pests in your home?** ☐Yes ☐No ☐Decline

**8.8. Do you have any other potential safety problem in your home? If Yes, specify in notes.** ☐Yes ☐No ☐Decline

**Environmental Assessment Notes:**

SNP Member Options Page 1 of 2

General Info | Historical Snapshot | Profile | HRA | Care Plan | Phone Calls | Communication | Documents

FIRST LAST Member | HRAs | HRA Form

## HEALTH RISK ASSESSMENT

Assessment Status: -- Select Status -- Save

HRA Score: HRA Tier:

Demographic Information | Consumer Conditions/Resources | Nutrition Status | Health Conditions/ Special Services | Medications | Caregiver Assessment | Social Resources | Environmental Assessment | Preventive Health

**9. PREVENTIVE HEALTH.**

**9.1. GENERAL PREVENTIVE HEALTH MEASURES FOR ALL ADULTS.**

**9.1.1. CHOLESTEROL SCREENING.**

*Before 30: Initial screening. Ages 30-40: Check every other year. Over age 40: Check every year*

**Have you had a cholesterol check in the last year?** ☐Yes ☐No ☐Decline/Don't know

**9.1.2. RECTAL EXAM.**

*Every year after age 50.*

**Was your last rectal exam less than one year ago?** ☐Yes ☐No ☐Decline/Don't know

**9.1.3. COLONOSCOPY.**

*Every 10 year after age 50.*

**Have you had a colonoscopy within the last 10 years?** ☐Yes ☐No ☐Decline/Don't know

**Preventive Health For All Adults Notes:**

**9.2. PREVENTIVE HEALTH MEASURES FOR ADULT FEMALES.**

**9.2.1. SELF BREAST EXAM.**

*Every month after adulthood*

**Do you perform regular (monthly) self breast exams?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**9.2.2. BREAST EXAM BY HEALTH CARE PROFESSIONAL.**

*Every year after adulthood*

**Was your last breast exam by a doctor less than one year ago?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**9.2.3. MAMMOGRAM.**

*Ages 35-40: Baseline exam. Ages 40-50: Every other year. Age 50 and over: Every year*

**Was your last mammogram less than one year ago?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**9.2.4. PAP SMEAR.**

*Every year after adulthood*

**Have you had a pap smear in the last year?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**Preventive Health For Adult Females Notes:**

**9.3. PREVENTIVE HEALTH MEASURES FOR ADULT MALES.**

**9.3.1. TESTICULAR EXAM BY A HEALTH CARE PROFESSIONAL.**

*Every year after adulthood*

**Was your last testicular exam less than one year ago?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**9.3.2. PROSTATE EXAM.**

*Every year after age 45*

**Was your last prostate exam less than one year ago?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**9.3.3. PSA BLOOD TEST (Prostate cancer blood test).**

*Every year after age 45*

**Was your last PSA test less than one year ago?** ☐Yes ☐No ☐Decline/Don't know ☐N/A

**Preventive Health For Adult Males Notes:**

**9.4. ADVANCE DIRECTIVES.**

**9.4.1. Do you have a living will?**

*(A document that indicates your wishes regarding life support system).*

☐Yes ☐No ☐Decline/Don't know

**9.4.2. Do you have a health surrogate?**

*(A designated person who can make health decisions for you if you are unable).*

☐Yes ☐No ☐Decline/Don't know

**Advance Directives Notes:**

## ATTACHMENT THREE: INDIVIDUAL CARE PLAN SAMPLE

**Insert In Patient Medical Record**

### Case Management Plan of Care – 2/10/10

| ►Patient Information: | | | |
|---|---|---|---|
| Patient Name: | Jane Smith | Patient Preferred Language: | Spanish |
| ID: | 233314545675 | DOB: | 01/01/1932 |
| Care Giver Name: | Dorra Smith | Care Giver Phone #: | 954-222-3435 |
| PCP Name: | Dr. Joel Doctor | PCP Phone #: | 954-222-3434 |

►Case Management: Provide patient with individualized care management to attain improved coordination and continuity of care, thereby improving and/or maintaining overall health status.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| Patient at risk for transition due to no PCP visit w/in 6 months | Coordinate PCP visit | | | |
| **Goal** | **Frequency** | **Start Date** | **Completed Date** | **Goal Status** |
| Patient will visit PCP within 30 days of intervention | As Needed | 2/1/2010 | 2/30/20 | Met |
| **Assessment** | **Intervention** | | | |
| Patient recently discharged from hospital | Needs coordination with specialist for follow up visit | | | |
| **Goal** | **Frequency** | **Start Date** | **Completed Date** | **Goal Status** |
| Patient will visit specialist within 45 days of intervention | As needed | 2/1/2010 | 2/30/20 | Met |

►Physician Services: Provide patient access and coordination to appropriate physician services to address identified physical, medical, behavioral and mental health issues.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| Patient at risk for transition due to no PCP visit w/in 6 months | Coordinate PCP visit | | | |
| **Goal** | **Frequency** | **Start Date** | **Completed Date** | **Goal Status** |
| Patient will visit specialist within 45 days of intervention | As needed | 2/1/2010 | 2/30/20 | Met |
| **Assessment** | **Intervention** | | | |
| **Goal** | **Frequency** | **Start Date** | **Completed Date** | **Goal Status** |
| Additional intervention here | As needed | 2/1/2010 | 2/30/20 | Met |

To request modifications or updates to this care plan, please contact the Case Management Department at XXX-XXX-XXXX or fax updates to XXX-XXX-XXXX.

Page: 1 of 4

**Insert In Patient Medical Record**

## Case Management Plan of Care – 2/10/10

► Patient Information:

| | | | |
|---|---|---|---|
| Patient Name: | Jane Smith | Patient Preferred Language: | Spanish |
| ID: | 233314545675 | DOB: | 01/01/1932 |
| Care Giver Name: | Dorra Smith | Care Giver Phone #: | 954-222-3435 |
| PCP Name: | Dr. Joel Doctor | PCP Phone #: | 954-222-3434 |

► Medication Management: Provide patient with education for medication management and access to medication management systems to maintain optimal health.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| Patient will visit specialist within 45 days of intervention | As needed | 2/1/2010 | 2/30/20 | Met |

► Behavioral Health and Cognitive Health Management: Provide patient education on the importance of behavioral, mental and cognitive health services and coordinate these services for optimal health status.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

► Transportation: Provide patient with access to available transportation services for medical care and health maintenance.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

To request modifications or updates to this care plan, please contact the Case Management Department at XXX-XXX-XXXX or fax updates to XXX-XXX-XXXX.

Page: 2 of 4

**Insert In Patient Medical Record**

## Case Management Plan of Care – 2/10/10

► Patient Information:

| | | | |
|---|---|---|---|
| Patient Name: | Jane Smith | Patient Preferred Language: | Spanish |
| ID: | 233314545675 | DOB: | 01/01/1932 |
| Care Giver Name: | Dorra Smith | Care Giver Phone #: | 954-222-3435 |
| PCP Name: | Dr. Joel Doctor | PCP Phone #: | 954-222-3434 |

► Education: Provide patient with education related to identified disease process, chronic conditions, preventive care and self-management when appropriate

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

► Nutrition: Provide patient access to education and understanding of importance of nutrition including meal planning, healthy eating, diet and exercise.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

► Advanced Care Planning: Provide patient with information and education to develop Advanced Directive and related documents.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

To request modifications or updates to this care plan, please contact the Case Management Department at XXX-XXX-XXXX or fax updates to XXX-XXX-XXXX.

Page: 3 of 4

**Insert In Patient Medical Record**

## Case Management Plan of Care – 2/10/10

► Patient Information:

| | | | |
|---|---|---|---|
| Patient Name: | Jane Smith | Patient Preferred Language: | Spanish |
| ID: | 233314545675 | DOB: | 01/01/1932 |
| Care Giver Name: | Dorra Smith | Care Giver Phone #: | 954-222-3435 |
| PCP Name: | Dr. Joel Doctor | PCP Phone #: | 954-222-3434 |

► End of Life: Provide patient with information and resources to assist with transitioning to End of Life care.

| Assessment | Intervention | | | |
|---|---|---|---|---|
| | | | | |
| Goal | Frequency | Start Date | Completed Date | Goal Status |
| | | | | |

**Notes:**

Referred to Interdisciplinary Care Team (ICT) ☐ Date of referral: _____

| Case Manager | | | | |
|---|---|---|---|---|
| | | | | |

To request modifications or updates to this care plan, please contact the Case Management Department at XXX-XXX-XXXX or fax updates to XXX-XXX-XXXX.

Page: 4 of 4

Written Narrative Description of SNP Model of Care

Modified for Dual Eligible Demonstration

## ATTACHMENT FOUR: PROVIDER BULLETIN

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

**WHAT'S INSIDE**

- Pertussis Vaccinations for Students
- Formulary Updates Effective April 2011
- Compliance Update
- 2011 Health Ed Resource Directory
- Weight Watchers Coupons for Alliance Members
- Free Interpreter Services

APRIL 2011

Provider Bulletin

ALAMEDA ALLIANCE FOR HEALTH

# Pertussis Vaccinations Required for Students Entering Grades 7-12

**Starting July 1, 2011, a new California law will require all students entering grades 7-12 in both public and private schools to show proof of a Tdap booster shot on or after their 10th birthday before starting school.**

Some students received the Tdap on or after their 7th birthday during the pertussis epidemic. This dose will meet the new school requirement. Adolescents who received only the Td booster vaccine do not meet the new pertussis immunization requirement.

**Ensure Your Adolescent Patients Are Ready for School This Fall**
The California Department of Public Health (CDHP) recommends that providers protect patients against pertussis by taking the following actions:

- Send reminders to patients who have not yet received a Tdap booster, including those who have received a dose of Td but not Tdap.
- Order enough Tdap vaccine to immunize your patients affected by the law and ensure that you have adequate storage for any increase in Tdap orders.
- Immunize at every opportunity, including visits for mild illness or injury.

**Document Tdap Doses Clearly for Schools**
CDHP recommends that documentation of Tdap immunization include the patient's name, birth date, date of immunization, name of vaccine (Tdap), and the name of the immunizing physician or clinic. The documentation should be included in the patient's medical record and yellow immunization card.

**Ongoing Threat of Pertussis**
During 2010, over 8,000 cases of pertussis were reported in California. Though the new law affects adolescents entering grades 7-12, the Tdap vaccine is also recommended for adults because immunity wears off over time.

**Additional resources are available at:**

www.shotsforschool.org and
www.cdph.ca.gov/HealthInfo/discond/Pages/Pertussis.aspx

## UPDATES FROM MARCH 2011

***P&T Committee for Medi-Cal, Healthy Families, and Alliance Group Care***

The following changes to the Alliance formulary are effective April 11, 2011.

The formulary is available on the Alliance website at **www.alamedaalliance.org** and through ePocrates at **www.eProcrates.com**

You can download the Alliance Medication Request Form at **www.alamedaalliance.org**

**Drug Classes Reviewed:** *Attention Deficit Disorder, Diabetes,Hepatitis B, Fibromyalgia, Muscle Relaxants*

| Generic Name and Dosage Form | Brand Name | Updates |
|---|---|---|
| **Dexymethylphenidate (Immediate Release) Tablets** | Focalin | Add to Formulary with QL= 60 per month |
| **Dexymethylphenidate Sr Capsules, Guanfacine Sr Tablets (Methylphenidate Transdermal Patches)** | Focalin Xr, Intuniv (Daytrana) | Prior Authorization Required |
| **Atomoxetine Capsules** | Strattera | Prior Authorization Required |
| **Saxagliptin Tablets** | Onglyza | Prior Authorization Required |

QL = Quantity Limit

## You Can Help Stop Fraud, Waste, and Abuse

The Alliance complies with all applicable federal and State laws addressing false claims, including the Federal False Claims Act, the California False Claims Act, and the Deficit Reduction Act of 2005 (Section 6032).

The Alliance fosters a culture that promotes prevention, detection and resolution of situations that do not conform to these laws. If you have concerns about possible unethical business practices or potential illegal activity regarding our health plan, our providers, vendors or members, please report this information by contacting:

- Alliance Compliance Officer: 510-747-6189
- Alliance Compliance Hotline: 510-747-4576
- For Medi-Cal: Call the Department of Health Care Services Medi-Cal Fraud Reporting Line at 1-800-822-6222
- For Medicare Part C & D: Call 1-877-7SAFERX (1-877-772-3379); fax 410-819-8698; or write to Health Integrity Attention: MEDIC, 9240 Centreville Road Easton, MD 21601

Alameda Alliance for Health I April 2011 Provider Bulletin
2

## 2011 Health Education Resource Directory Available Online

The Alliance offers a variety of health education classes, support groups, and case management programs at no cost to Alliance members. To participate in one of these free programs, an Alliance member can call the Alliance's Health Promotions department at **510-747-4577** or in most cases, can call the program directly. Providers should encourage members to take advantage of these programs.

The 2011 Health Education Resource Directory provides a listing of these great resources, including:

Asthma Start - A case management program that provides in-home assessments for asthma triggers and teaches self-management skills for controlling asthma.

Breastfeeding Support Programs

Diabetes Education Classes

Domestic Violence Victims Assistance Programs

Smoking Cessation Classes

The directory is available on our website at **http://www.alamedaalliance.org**. Click on the "Wellness" tab, and then the "Resource Directory 2011" link. Providers can also contact Elizabeth Edwards, Director of Care Coordination, at 510-747-6178 to request a copy of the directory.

## Weight Watcher Coupons Now Available to Alliance Members

In an effort to encourage healthy eating habits and good weight management skills among Alliance members, the Alliance Health Education department now offers coupons for Weight Watchers to Alliance members. **A set of 10 coupons for group sessions is available to members free of charge!** If you have a patient who you think would benefit from the Weight Watchers program, please have the member call the Alliance Member Services department at **510-747-4567** (**TTY 711** for deaf callers) to request a set of coupons. Additional sets of 10 coupons are available if a member sends us a copy of their "weigh-in" page to confirm their participation.

*Please note that the Alliance does not cover Weight Watchers foods, cookbooks, or other items.*

## We're On the Web!

**At www.alamedaalliance.org & www.alliancecompletecare.org you can:**

- View our provider manuals
- Use our provider directory to find a provider
- Download forms
- Join our e-mail list
- And much more!

**Through our provider portal, contracted providers can:**

- Verify member eligibility
- View claim status
- View authorization status
- Access this information 24 hours a day!

## Medical Interpreters for Alliance Members

***Supporting access to care for the Alliance's diverse membership***

The Alliance provides interpreter services for all Alliance members. The Alliance strongly encourages the use of professional interpreters for its members. Professional interpreters reduce the chance of miscommunication that may result from using untrained interpreters, such as a patient's family member or friend. If a member declines interpreter services, please document the refusal in the medical record, as required by the California Department of Health Care Services and the California Managed Risk Medical Insurance Board.

**Two ways to request interpreter services:**

- Call the Alliance Member Services department at 510-747-4567 for an in-person interpreter, or
- Call the Alliance's interpreter vendor at 415-788-4159 for an interpreter by phone

Alameda Alliance for Health I April 2011 Provider Bulletin
4

## ATTACHMENT FIVE: MEMBER NEWSLETTER SAMPLE


# Give Medicine to Kids Safely

Chandra Wilson plays a doctor on TV. But the *Grey's Anatomy* star is a mom of three in real life. When her kids get sick, she gives them the right over-the-counter medicine. "Over-the-counter" means you don't need a prescription from your doctor.

This is still cold and flu season. So Chandra wants parents to use medicine safely. If your child is under age 4, do not use cough or cold medicine. Older children may take medicine to treat coughs, sore throats, runny noses and body aches.

### 5 TIPS FOR KIDS' MEDICINES

1. Follow directions on the label exactly.
2. Don't give adult medicine, like aspirin, to kids.
3. Only use medicine that treats your child's symptoms.
4. If your child has side effects, stop giving the medicine.
5. If you have questions, ask your pharmacist or doctor.

# Take Care of Moms

Your baby deserves a strong start in life! So see the doctor often during pregnancy and after your baby's birth. These visits are important for your health, too.

Visit your doctor soon after you find out you're pregnant. Your doctor will tell you how often to come back. Here are the basic guidelines:

- Weeks 4 to 28
  One visit every four weeks.
- Weeks 28 to 36
  One visit every two to three weeks.
- Weeks 36 to birth
  One visit each week.
- 3 to 8 weeks after birth
  One visit.

At the checkup after the baby is born, the doctor makes sure your body is healing. At every visit, ask your doctor questions and talk about your mood. Remember, your doctor is there to help.

HEALTH SMART

## Could You Have Lupus?

Lupus is a disease that makes a person's immune system attack the body's own tissues. Mostly women of color in their teens and 20s get lupus. Symptoms can include skin rashes, arthritis, fatigue and fever. These symptoms can come and go.

To learn more about lupus symptoms and treatments, go to couldihavelupus.gov or call 800-994-9662.

# Women Need These Tests

**Ladies, your sexual health matters. Get tested to stay safe and healthy.**

Cervical cancer is easy for women to prevent. Your doctor will use a Pap test to check for cancer. During the test, your doctor will examine your cervix and swab a few cells from it. The doctor will tell you if the cells are not normal.

Get your first Pap test before age 21 or within three years after having sex for the first time. Ask your doctor how often you should have a Pap test.

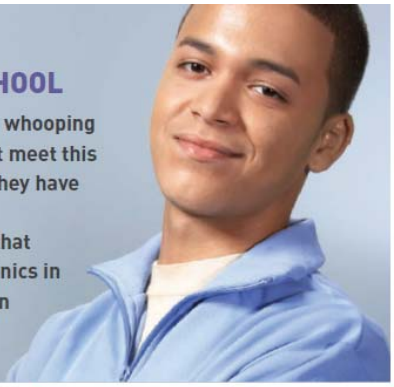
Chlamydia is a sexual disease. It is easily cured if you know you have it. Many women don't show symptoms. So, screening is your best bet. The doctor will test your urine or take a sample from your cervix. An antibiotic will clear the infection.

Your sexual health is worth protecting. These simple tests can keep you healthy.

**National Women's Health Information Hotline**
**1-800-994-9662**

2

## TEENS NEED WHOOPING COUGH VACCINE FOR SCHOOL



The state requires all kids going into grades 7 to 12 to show proof of a whooping cough (Tdap) vaccine for the 2011-12 school year. Students who do not meet this law will not be allowed to attend school until they provide proof that they have had the shot.

Visit the child's doctor to get vaccines and an exam if needed. Kids that do not have health insurance can get the shot at local public health clinics in Alameda County. Please visit acphd.org or call 888-604-4636 to find an up-to-date listing of these clinics.

# Focus on Kids With ADHD

Children with ADHD might not listen or follow directions well. It's not their fault. Be patient and help them focus. Here are some tips to help you. You can share them with your child's teacher and caregivers too.

**EYES.** Look your child in the eyes when you speak.

**EARS.** Take your child to a quiet place to talk. It is hard to focus in a loud, busy room.

**MOUTH.** Speak slowly. Give one direction at a time. Keep your voice calm. Clearly tell your child what you expect.

**BODY.** Kids who get 8 hours of sleep every night focus better. Make sure your child goes to bed and gets up at the same time every day. If your child takes medicine for ADHD, see your doctor often to be sure the medicine is working well.

3

**ASK** ABOUT HEALTH

**Q** I have a bad cold. Can the doctor give me an antibiotic to clear it up?

**A** No. Curing the common cold isn't that simple. Colds and flu are viruses. Antibiotics do not treat viruses. Antibiotics only treat illnesses caused by bacteria. Taking antibiotics when you don't need them makes them stop working later.

If your doctor says you need an antibiotic, follow the directions exactly. Finish all of the antibiotics. Don't stop because you feel better after a few days. The bacteria might still be alive in your body.

To feel better when you have a cold, drink lots of water and fruit juice, take over-the-counter medicine and wait. Your cold should go away in about 10 days. If it is not better then, call your doctor.

# Finding Care

**Your doctor can help you.**

For medical care or answers about health concerns, call your Primary Care Provider's (PCP) phone number listed on your Alliance member ID card. Your provider's office can assist you by phone during the day, after hours and on weekends. Your PCP's office can:

- ☑ Answer questions and advise you about whether you need medical care.
- ☑ Explain how and where to get care, or instruct you on self-care at home.
- ☑ Help you decide whether you need Emergency Care or Urgent Care, and how and where to get it.
- ☑ Tell you what to do if you need care when the medical office is closed.

## Welcome New Medi-Cal Members

Starting in June 2011, more seniors and people with disabilities in fee-for-service Medi-Cal will start to enroll in a managed care plan. We want the Alliance to be their plan of choice. We are getting ready for these new members by:

- → Growing our provider network.
- → Training our staff and providers on the needs of these members.
- → Helping members find doctors to meet their needs.
- → Using results from focus groups to reduce barriers to care.

# Dealing with Diabetes

Do you have diabetes? Diabetes can cause other serious health problems like heart or kidney disease. You need to be tested for these kinds of problems at least once a year. The sooner you know about them, the easier they are to treat. Ask your doctor how often you need these tests:

- → HbA1C test measures your blood-sugar control over the past few months.
- → Blood-fat test checks your cholesterol levels and your risk for heart disease.
- → Kidney-function tests.
- → Dilated eye exam checks for damage to your eyes.
- → Dental exam and cleaning protect your teeth and gums.

Your doctor should take your blood pressure and check your feet for sores at every visit. They should also teach you about the ways you need to manage your diabetes at home. Self-care includes your diet, hygiene and dental care, plus any meds or tests you take at home.

**We offer FREE diabetes help! Use the enclosed Wellness Program Request Form.**

4

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

## WELLNESS PROGRAM REQUEST FORM

Alameda Alliance for Health provides free health education. We want you to take charge of your health by having the best information possible. Please check off the topics that you want.

### WRITTEN MATERIALS:

- ❑ Alcohol and Other Substance Abuse
- ❑ Asthma
- ❑ Back Care
- ❑ Birth Control and Family Planning
- ❑ Diabetes
- ❑ Domestic Violence
- ❑ Exercise
- ❑ Good Eating
- ❑ Heart Health
- ❑ Parenting and Discipline
- ❑ Pregnancy and Childbirth
- ❑ Quit Smoking
- ❑ Safety
- ❑ Sexual Health

### REFERRALS FOR:

- ❑ Alcohol and Other Substance Abuse
- ❑ Breastfeeding Support
- ❑ HIV and STD Programs
- ❑ Violence Prevention

### CLASSES:

- ❑ Asthma
- ❑ Diabetes
- ❑ CPR
- ❑ First Aid
- ❑ Parenting
- ❑ Pregnancy and Childbirth
- ❑ Quit Smoking

### ID BRACELETS:

- ❑ Asthma
- ❑ Diabetes

### VIDEOS/DVDS (not available in all languages):

- ❑ Asthma Care
- ❑ Self Breast Exam
- ❑ Childbirth
- ❑ Exercise
- ❑ Parenting and Discipline

### SPECIAL BOOKS:

- ❑ What to Do When Your Child Gets Sick
- ❑ Family Self Care Guide (available in English/Spanish only)

Name (self): _____ Alliance ID Number: _____

Child's Name (if applicable): _____ Child's ID Number: _____

Address: _____

City: _____ Zip: _____

Daytime Phone #: _____ Language Preferred: _____

Provider Name (if applicable): _____

Are materials for: Adult ❑ Child ❑ Age of child: _____

**Send this form to:** Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502

**Or Fax this form to:** 510-747-4166 ■ **Or Call:** 510-747-4577 / CRS TTY 711

## ADDRESS AND PHONE CHANGES

**Have you moved or changed your phone number? If so, please call us at 510-747-4567. We need to update our records.**

## Don't Lose Your Coverage!

Complete your forms for:

- ☑ Medi-Cal Redetermination
- ☑ Healthy Families Program Annual Eligibility Review

Medi-Cal members get a packet of forms one month before their redetermination date. Complete and send the forms to Medi-Cal. If you don't complete the forms within 90 days, Medi-Cal may end your Medi-Cal coverage and you will have to re-enroll with the Alliance. If you have questions about the forms, call Social Services at 510-777-2300.

Healthy Families Program members get a packet of forms about 60 days before their Annual Eligibility Review. Complete and send the forms to Healthy Families by the due date to keep your child's health coverage. If you have questions about the forms, call Healthy Families at 888-439-4741.

For help filling out the forms, call the Alliance at 510-747-4567. We are here to help you!

## Important Phone Numbers

| | |
|---|---|
| **EMERGENCY** | **911** |
| Poison Control | 800-876-4766 |
| Alameda County Social Services | 510-639-1000 |
| Medi-Cal Plan Enrollment/Changes | 800-430-4263 |

**Alameda Alliance for Health**

| | |
|---|---|
| Main Number | 510-747-4500 |
| Member Services | 510-747-4567 |
| | (CRS TTY 711) |
| | Monday-Friday, 8 a.m.-5 p.m. |

**Alliance CompleteCare (HMO SNP) Medicare Plan**

| | |
|---|---|
| Care Advisors | 877-585-7526 |
| | (TTY 711 or 800-735-2929) |
| | 7 days a week, 8 a.m.-8 p.m. |

**Dental Care Services**

| | |
|---|---|
| Alliance CompleteCare Members: | |
| Liberty | 888-703-6999 |
| Healthy Families Members | 866-848-9166 |

**Vision Care Services**

| | |
|---|---|
| Medi-Cal Members: | |
| March Vision Care | 888-493-4070 |
| | (TTY 310-216-2309) |
| Healthy Families Members | 866-848-9166 |
| Group Care Members: EyeMed | 866-723-0514 |

**Behavioral Health Care Services**

| | |
|---|---|
| Alliance CompleteCare/Healthy Families/ | |
| Group Care Members | 800-999-9585 |
| Medi-Cal Members | 800-491-9099 |

## FREE LANGUAGE SERVICE

Friends and family should not interpret for you at your doctor visits. For free help with your language needs, call us at 510-747-4567.

If you need help reading this document, please call Member Services at 510-747-4567.
Si necesita ayuda para leer este documento, llame a Servicios al Cliente al 510-747-4567.
假如您看不懂本文件，需要協助或其他語文版本，請致電會員服務部，電話 510-747-4567。
Nếu quý vị cần được giúp đỡ đọc tài liệu này, xin gọi ban Dịch Vụ Hội Viên tại số 510-747-4567.

## DEFINITIONS AND ACRONYMS

**The following terms are used throughout this document.**

| | |
|---|---|
| "The Plan" | Alameda Alliance for Health / Alameda Alliance Joint Powers Authority (JPA) / the Medicare Advantage Organization (MAO) |
| ACC | Alliance CompleteCare |
| ADL | Activities of daily living |
| CAU | Care Advisor Unit (a member services call center only for DED members) |
| CBAS | Community-Based Adult Services |
| CM | Care Manager |
| CMO | Chief Medical Officer |
| DED | Dual Eligible Demonstration |
| DED MOC | Dual Eligible Demonstration Model of Care |
| DHCS | Department of Health Care Services |
| ESRD | End-Stage Renal Disease |
| G&A | Grievances & Appeals |
| HCBS | Home and Community Based Services |
| HCQC | Health Care Quality Committee |
| HRA | Health Risk Assessment |
| ICP | Individualized Care Plan |
| ICT | Interdisciplinary Care Team |
| IHSS | In-Home Supportive Services |
| ILS | Independent Living Systems |
| LTSS | Long Term Care Services and Supports |
| OEC | Medicare Online Enrollment Center |
| MSSP | Multipurpose Senior Service Program |
| MTM | Medication Therapy Management program |
| QI | Quality Improvement |
| SNP | Special Needs Plan |
| **UM** | Utilization Management |

# Attachment B

# Job Description
# Executive Director of Duals Programs

EXECUTIVE DIRECTOR DUAL PROGRAMS
JOB DUTIES

## POSITION SUMMARY

Leads, oversees, and supports programs and policy issues related to the plan's Dual Eligible Programs which include the Medicare Advantage Special Needs Plan and/or the Dual Demonstration Programs. Works cross-functionally across the organization and externally on all issues related to Medicare/Medi-Cal dual beneficiaries. Reports directly to Chief Operations Officer.

## EXAMPLES OF DUTIES

**1. Leadership/Coordination**

- Organizes and leads efforts to achieve effective and efficient coordination of Medicare/Medi-Cal-related activities across all departments.
- Is responsible to ensure all program operational requirements are carried out according to CMS and DHCS regulatory requirements.
- Consults with senior management in all functional areas to determine capabilities, needs, and gaps that could impact operational efficiency and/or capacity for membership growth in Dual Eligible LOB.
- Develops project work plans and leads interdisciplinary workgroups in planning, evaluating and implementing Medicare/Medi-Cal dual-specific projects and initiatives across departments.
- Provides leadership on Medicare/Medi-Cal dual staffing and functions, organization structure, and operational standards.
- Prepares and is accountable for the Medicare/Medi-Cal dual programs operations budget.

**2. External Relations**

- Overall responsibility for the relationship with the CMS and DHCS where it applies to dual eligibles, including coordination and submission of required reports/documents and associated plan responses.
- Fosters relationships with state and federal agencies and provides direction on Medicare/Medi-Cal dual programs -related issues and input for key policy decisions.
- Provides input to state and federal officials on strategies that promote integration and seamless administration of Medicare/Medi-Cal programs for dual eligibles.
- Participates in relevant national and local associations and committees related to Medicare/Medi-Cal dual programs.
- Acts as organizational spokesperson at community and other external events related to Medicare/Medi-Cal dual programs.

3. **Compliance**

- Works with compliance to monitor and communicate changes, proposed or actual, in Medicare and Medi-Cal laws, regulations, contracts and rulings that impact dual eligibles, SNP programs, or demonstration programs. Recommends implementation

steps to ensure maximum financial, service, and quality performance for Medicare/Medi-Cal dual programs while reducing non-compliance risks.
- Maintains knowledge of Medicare/Medi-Cal dual programs -related company policies and procedures and alerts Compliance Officer of non-compliance risks.

**4. Additional Specific Duties**

***Approval or Similar Application or Annual Contracting for Dual Demonstration Programs***

- Coordinates and ensures timely submission of Medicare SNP, Dual Demonstration programs, and Part D annual contract requirements to CMS, and DHCS as appropriate, including plan bid.
- Oversees and coordinates CMS and DHCS audit and monitoring activity where it relates to Medicare/Medi-Cal dual programs.

***Infrastructure Development***

- **P&Ps: Works with various departments with the company to** oversee the development and implementation of all policies and procedures applicable to the Medicare/Medi-Cal dual LOB. Ensures departments review and update their policies on an annual basis.
- **Product Meeting:** Leads an, at least monthly, Medicare/Medi-Cal Dual Products meeting to discuss changes to the program and cross department issues or areas of concern.
- **Contracts:** Participates in network development discussions/decisions, including development and negotiation of appropriate Medicare payment rates and financial contract provisions.
- **Bid:** Participates in bid development, creation of PBP software entry and bid submission or similar processes for Medicare/Medi-Cal dual programs.
- **Marketing:** Assists with development and implementation of Medicare/Medi-Cal dual programs marketing plan.
- **Medical Management:** Participates in discussions and decisions relevant to Medicare/Medi-Cal dual programs LOB.
- **Staffing:** Direct reports for any areas segregated to solely work on the Medicare/Medi-Cal dual programs. Assists department leaders/managers with recruiting and hiring of qualified staff.
- **Staff training:** Works with all areas to develop, update and implement in-house training for all staff on Medicare/Medi-Cal dual programs mission, health care delivery system, cultural sensitivity as applicable to the dually eligible population, and relevant state and federal regulations.
- **Provider training:** Assists in the planning and implementation of provider trainings on Medicare coding issues.
- **Part C and D Reporting or any Similar Regulatory Required Medicare/Medi-Cal Dual Programs Reporting:** Works with all relevant departments to ensure Part C and D reporting is submitted timely and accurately. Works with departments to implement corrective actions and improve outcomes where necessary.

- **CMS STARs any Similar Regulatory Required Medicare/Medi-Cal Dual Programs Quality Measures:** Works with the various area within the company to educate on STARs or any similar Medicare/Medi-Cal dual program quality improvement measures and ensure that all areas are addressing concerns related to quality measures.

**5. Additional Duties**

***Strategic Planning***

- Leads the development and implementation of multi-year strategy and business plan for Medicare/Medi-Cal Dual Programs LOB; identifies LOB priorities and success factors.
- Develops tactical business plans for Medicare/Medi-Cal Dual Programs including operational goals, performance targets, compliance targets, and implementation of best practices.
- Makes decisions on resolution and escalation of Medicare/Medi-Cal Dual Programs product, strategy and LOB performance issues, and works with the compliance area to complete risk analysis.
- Assesses the potential for development of other service offerings or enhancements to better integrate care for dual eligibles.

***Operational Oversight***

- Reports monthly performance standards for Medicare/Medi-Cal Dual Programs LOB and makes recommendations for improvement.
- Works with compliance to ensure that all corrective action plans (CAPs) are fully implemented.
- Approves all operational changes/decisions effecting Medicare/Medi-Cal Dual **Programs** LOB.
- **P&Ps:** Makes recommendations and approves changes to policies and procedures applicable to the Medicare/Medi-Cal Dual Programs LOB.
- **Contracts:** Participates in contracting discussions and negotiations; approves changes in financial or other significant provisions.
- **Network:** Reviews adequacy/efficiency of provider network and makes recommendations for change, if necessary.
- **Bid:** Participates in the development and submission of bid.
- Has oversight of the PBP software entry, SB creation, EOC/ANOC creation.
- **Marketing:** Monitors and makes recommendations regarding Medicare/Medi-Cal Dual Programs marketing activities and staffing.
- **Medical Management:** Participates in discussions and decisions relevant to Medicare/Medi-Cal Dual Programs LOB.
- **Customer Service:** Reviews performance of Medicare/Medi-Cal Dual Programs customer service staff and makes recommendations for change, if needed.
- **Staffing:** Assesses appropriateness of staffing levels and makes recommendations for change as needed. Assists department leaders/managers with recruiting and hiring of qualified staff.

- **Training:** Assesses need for additional provider/staff trainings and assists with planning and implementation.
- **Internal Departmental Oversight:** Works with the various departments that work on the Medicare/Medi-Cal Dual Programs LOB to set up appropriate oversight activity so each management area is aware of their ongoing compliance with CMS and DHCS rules and regulations, as related to the Medicare/Medi-Cal Dual Programs.

## OTHER MEDICARE/MEDI-CAL DUAL PROGRAM COMPLIANCE FUNCTIONS:

***Could be performed by other compliance staff (For example, a Medicare/Medi-Cal Dual Policy and Regulatory Analyst who reports to Executive Director Medicare/Medi-Cal Duals Program)***

1. **Medicare/Medi-Cal Dual Program Filings & Reports**
   - Coordinates and submits filings, reports, and ad hoc requests to state and federal agencies, including DMHC, DHS, and CMS.
   - Coordinates liaison activities between state and federal agencies/individual and Alliance's internal management teams related to filings, reports, and other ad hoc requests to state federal and local agencies.
   - Reviews all submissions for compliance with state and federal regulations.

2. **CMS Correspondence**
   - Monitors CMS and DHCS correspondence as it relates to the Medicare/Medi-Cal dual program and assesses relevance to Alliance.
   - Responds to CMS and DHCS correspondence as it relates to the Medicare/Medi-Cal dual program, as appropriate, in a timely manner.

3. **Dual Eligible Evidence of Coverage**
   - Coordinates development and approval of Medicare Evidence of Coverage and Annual Notice of Change or any similar documents for the Medicare/Medi-Cal dual programs and other cross-departmental documents, reports, and external requests for information.

4. **Medicare/ Medi-Cal Dual Program Analysis**
   - Develops, analyzes, and reports monthly performance standards for Medicare/Medi-Cal Dual programs.
   - Assists Executive Director in the development and implementation of company strategic/business plan for Medicare/Medi-Cal dual programs.
   - Implements a Medicare STARs or similar quality measurement dashboard and an operational dashboard and is able to report status on a monthly basis.

5. **Internal and External Audits**

- Conducts audits of internal Alliance Medicare/Medi-Cal dual -related activities and implementation of policies and procedures, analyzes results, and makes recommendations to address issues.
- Works with delegated oversight to ensure there are audits of delegated provider networks to ensure compliance with Medicare and DHCS requirements as related to the Medicare/Medi-Cal dual programs.
- Oversees the implementation of corrective action plans for Medicare/Medi-Cal dual LOB, monitors internal staff and provider networks to ensure appropriate compliance with corrective action plans and makes recommendations for completion.
- Coordinates Medicare and DHCS -related state and federal audit visits and response as they pertain to the Medicare/Medi-Cal LOB.

# Attachment C

# RFS Proposal Checklist Supporting Documentation
# Mandatory Qualifications Criteria

# RFS Proposal Checklist Supporting Documentation
# Mandatory Qualifications Criteria
# 1

## Alliance for Health Knox Keene License

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

**NONTRANSFERABLE AND NONASSIGNABLE LICENSE**
**HEALTH CARE SERVICE PLAN**

File No. 933-0440
Application No. 2005-5372
S-05-1550

Licensee: ALAMEDA ALLIANCE JOINT POWERS AUTHORITY
1240 South Loop Road
Alameda, CA 94502

IS HEREBY LICENSED AS A FULL SERVICE HEALTH PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICES ACT OF 1975, AS AMENDED ("ACT"), AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A FULL SERVICE HEALTH CARE PLAN TO OFFER SERVICES TO COMMERCIAL ENROLLEES WITHIN THE STATE OF CALIFORNIA IN THE COUNTIES PREVIOUSLY APPROVED FOR COMMERCIAL OPERATIONS OF ALAMEDA ALLIANCE FOR HEALTH (FILE NO.: 933-0328), SUBJECT TO THE PROVISIONS OF THE ACT AND THE IMPLEMENTING RULES OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE ADOPTED PURSUANT THERETO AND SUBJECT TO THE CONDITIONS ATTACHED HERETO AND INCORPORATED HEREIN, AND SHALL REMAIN IN EFFECT UNTIL SUCH TIME AS THE LICENSE IS SUSPENDED OR REVOKED BY ORDER OF THE DIRECTOR OR IS SURRENDERED.

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

Dated: December 1, 2005
Sacramento, California

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

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

**THIS LICENSE IS NOT TRANSFERABLE OR ASSIGNABLE**

**LICENSE**
FULL SERVICE HEALTH CARE SERVICE PLAN

ALAMEDA ALLIANCE FOR HEALTH
1850 Fairway Drive
San Leandro, California 94577

PLAN NO. 933-0328

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

THE LICENSE IS ISSUED SUBJECT TO THE CONDITION THAT PRIOR TO BECOMING OPERATIONAL, THE PLAN MUST SUBMIT EXECUTED PROVIDER CONTRACTS, INCLUDING COMPENSATION TERMS, FOR ALL PROVIDERS WHO HAVE SUBMITTED A LETTER OF INTENT TO PARTICIPATE, INCLUDING BUT NOT LIMITED TO, LABORATORY, PHARMACY, AMBULANCE SERVICES AND ALL OTHER ANCILLARY PROVIDERS REQUIRED BY THE ACT.

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

DATE: September 19, 1995
Los Angeles, California

GARY S. MENDOZA
Commissioner of Corporations

By _____
ANITA J. OSTROFF
Senior Corporations Counsel

AJO:ndd

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

File No. 933-0328
M/M No. 391-357-8138
Order No. S-496

Licensee: ALAMEDA ALLIANCE FOR HEALTH

**ORDER**
**APPROVING NOTICE OF MATERIAL MODIFICATION**

The terms of the Notice of Material Modification filed by the licensee on May 18, 1998, as amended, are hereby approved. This Order approves the licensee to contract as a participating plan in the Healthy Families Program administered by the Managed Risk Medical Insurance Board. The licensee is permitted to enroll Healthy Families members in the County of Alameda. This Order is effective as of the date below and is subject to the attached undertakings which are incorporated herein.

Dated: May 29, 1998
Sacramento, California

DALE E. BONNER
Commissioner of Corporations

By Barbara H. Yonemura
BARBARA H. YONEMURA
Senior Corporations Counsel

STATE OF CALIFORNIA – BUSINESS, TRANSPORTATION AND HOUSING AGENCY GRAY DAVIS, *Governor*

**DEPARTMENT OF CORPORATIONS**
**HEALTH PLAN DIVISION**
Sacramento, California

IN REPLY REFER TO:
FILE NO: 933-0159

March 7, 2000

**VIA FACSIMILE & U.S. MAIL**

Irene M. Ibarra
Chief Operations Officer
Alameda Alliance for Health
1850 Fairway Drive
San Leandro, CA 94577

Re: **ORDER OF APPROVAL** of Alameda Alliance for Health's Notice of Material Modification Number 303-347-9113

Dear Ms. Ibarra:

Enclosed please find the Order Number S-00-625, dated March 7, 2000, approving Notice of Material Modification Number 303-347-9113 regarding the addition of two new low-income commercial products.

Very truly yours,

BRIAN J. BARTOW
Corporations Counsel
(916) 323-0416
Email: BBartow@corp.ca.gov

cc: Mabel Wu, Corporations Examiner

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

File No. 933-0159
M/M No. 303-347-9113
Order No. S-00-625

Licensee: Alameda Alliance for Health

## ORDER

## APPROVING NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code Section 1352(b), the terms of the Notice of Material Modification filed by Licensee to add two new low-income commercial products is effective as of the date set forth below.

Dated: March 7, 2000
Sacramento, California

William Kenefick
Acting Commissioner of Corporations

By _____
for BARBARA H. YONEMURA
Supervising Counsel

RFS Proposal Checklist Supporting Documentation
Mandatory Qualifications Criteria
2

Good Financial Standing Letter from DMHC

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**

Deborah Girma, MPH
Manager, Government Relations
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Re: Letter of Standing – Alameda Alliance for Health and Alameda Alliance Joint Powers Authority

Dear Ms. Girma:

On February 8, 2012, you requested a letter regarding Alameda Alliance for Health ("AAH") and Alameda Alliance Joint Powers Authority's ("AAJPA") standing as licensees under the Knox-Keene Health Care Service Plan Act.[1] AAH and AAJPA make 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, both AAH and AAJPA are licensed, and permitted to operate in the State of California, as Knox-Keene health care service plans.

A review of the Enforcement Action Database shows that there are currently zero enforcement actions involving AAH and AAJPA. The plans are 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 AAH and AAJPA and both are 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 AAH and AAJPA was issued on April 4, 2009. There were no identified deficiencies from this

[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.

Routine Medical Survey. The next Routine Medical Survey is scheduled to begin October 16, 2012.

Please contact me with any questions or concerns.

Sincerely,

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

cc: Elia Gallardo, Alameda Alliance for Health
Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Bill Prather, Division of Licensing
Anna Belmont, Division of Financial Oversight

# RFS Proposal Checklist Supporting Documentation
# Mandatory Qualifications Criteria
# 3a

## Alliance Medicare D-SNP Approval

## Girma, Deborah

**From:** HPMS Web [hpms@cms.hhs.gov]
**Sent:** Friday, May 27, 2011 11:59 AM
**To:** Lamirault, Ingrid; Girma, Deborah
**Cc:** SNP Applications; HPMS Helpdesk; Stansbury, Jett
**Subject:** H7292 - SNP Conditional Approval - Dual-Eligible - Medicaid Subset - $0 Cost Share

**Follow Up Flag:** Follow up
**Flag Status:** Flagged

May 27, 2011

Ingrid Lamirault
Chief Executive Officer
ALAMEDA ALLIANCE JOINT POWERS AUTHORITY (JPA)
1240 South Loop Road
Alameda, CA 94502

Re: Conditional Approval of SNP Application
H7292 - ALAMEDA ALLIANCE JOINT POWERS AUTHORITY (JPA) - Dual-Eligible - Medicaid Subset - $0 Cost Share

Dear Ingrid Lamirault:

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 | | |
|---|---|---|
| 1 | a | 3 |
| 2 | a | 2 |
| 2 | b | 2 |
| 2 | c | 1 |
| 3 | a | 4 |
| 3 | b | 4 |
| 3 | c | 4 |
| 4 | a | 3 |
| 4 | b | 3 |
| 4 | c | 3 |
| 5 | a | 3 |
| 5 | b | 3 |
| 5 | c | 4 |
| 5 | d | 4 |
| 5 | e | 3 |
| 6 | a | 4 |
| 6 | b | 4 |
| 6 | c | 3 |
| 6 | d | 3 |
| 7 | a | 4 |
| 7 | b | 3 |
| 7 | c | 3 |

| | | |
|---|---|---|
| 7 | d | 3 |
| 8 | a | 4 |
| 8 | b | 3 |
| 8 | c | 3 |
| 8 | d | 4 |
| 8 | e | 3 |
| 9 | a | 3 |
| 9 | b | 4 |
| 9 | c | 4 |
| 9 | d | 2 |
| 10 | a | 3 |
| 10 | b | 3 |
| 11 | a | 2 |
| 11 | b | 2 |
| 11 | c | 2 |
| 11 | d | 2 |
| 11 | e | 2 |
| 11 | f | 2 |

Element Summary

| | |
|---|---|
| Element 1 | 3 |
| Element 2 | 5 |
| Element 3 | 12 |
| Element 4 | 9 |
| Element 5 | 17 |
| Element 6 | 14 |
| Element 7 | 13 |
| Element 8 | 17 |
| Element 9 | 13 |
| Element 10 | 6 |
| Element 11 | 12 |
| Total Points | 121 |
| Total Possible Points | 160 |
| Score | 75.63% |

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

RFS Proposal Checklist Supporting Documentation
Mandatory Qualifications Criteria
4

Alliance Medi-Cal Fully Executed Contract

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

TOBY DOUGLAS
*DIRECTOR*

EDMUND G. BROWN JR.
*GOVERNOR*

January 6, 2012

Ingrid Lamirault, CEO
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502-7954

Dear Ms. Lamirault:

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

**Contractor:** **Alameda Alliance for Health**
**Contract #:** **04-35399 A12 [Primary]**

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

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

Sincerely,

Rosemary Carranco, Contract Manager
Medi-Cal Managed Care Division

Enclosures

STATE OF CALIFORNIA

# STANDARD AGREEMENT AMENDMENT

STD 213A_DHCS (1/08)

☒ Check here if additional pages are added: 1 Page(s)

| Agreement Number | Amendment Number |
|---|---|
| 04-35399 | A12 |
| Registration Number: | |

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

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

Contractor's Name (Also referred to as Contractor)
Alameda Alliance For Health

2. The term of this Agreement is: July 1, 2004 through December 31, 2012

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

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

I. **Amendment effective date:** December 30, 2011

II. **Purpose of amendment:** This amendment extends the contract term to December 31, 2012. DHCS is obtaining a continuation of the services identified in the original agreement.

III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

IV. Paragraph 2 (term) on the face of the original STD 213 is amended to read: July 1, 2004 through ~~December 31, 2011~~**December 31, 2012**. All references to the former contract term of July 1, 2004 through December 31, 2011 in any exhibit incorporated into this agreement are hereinafter deemed to read July 1, 2004 through December 31, 2012.

(Continued on next page)

All other terms and conditions shall remain the same.

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

**CONTRACTOR**

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
Alameda Alliance For Health

By *(Authorized Signature)* ✍ [signature] — Date Signed *(Do not type)* 11-16-11

Printed Name and Title of Person Signing
Ingrid Lamirault, CEO

Address
1240 South Loop Road
Alameda, CA 94502-7954

**STATE OF CALIFORNIA**

Agency Name
Department of Health Care Services

By *(Authorized Signature)* ✍ [signature] — Date Signed *(Do not type)* 12/13/11

Printed Name and Title of Person Signing
Jane Ogle, Deputy Director, Health Care Delivery Systems

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

**CALIFORNIA Department of General Services Use Only**

☒ **Exempt per: W&I Code Section 14087.4**

V. **Exhibit E, Attachment 2, Program Terms and Conditions, Provision 11. Term is amended to read as indicated herein:**

**11. Term**

The Contract will become effective July 1, 2004, and will continue in full force and effect through ~~December 31, 2011~~**December 31, 2012** subject to the provisions of Exhibit B, provision 1. Budget Contingency Clause and Exhibit D(F), provision 9. Federal Contract Funds.

The term of the Contract consists of the following two periods: 1) The Operations Period shall extend from July 1, 2004 to ~~December 31, 2011~~ **December 31, 2012**, subject to the termination provisions of provision 14. Termination for Cause and Other Terminations, and provision 16. Sanctions, and subject to the limitation provisions of Exhibit B, provision 1. Budget Contingency Clause; and 2) The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to provision 13. Contract Extension, in which case the Phaseout Period shall apply to the six (6) month period beginning the first day after the end of the Operations Period, as extended.

The Operations Period will commence subject to DHCS acceptance of the Contractor's readiness to begin the Operations Period.

VI. **Exhibit E, Attachment 2, Program Terms and Conditions, Provision 13. Contract Extension is amended to read as indicated herein :**

**13. Contract Extension**

DHS will have the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHS may invoke up to ~~three (3)~~**Four (4)** separate extensions of up to twelve months each. The Contractor will be given at least nine (9) months prior written notice of DHS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHS of its intent to accept or reject the extension within five (5) Working days of the receipt of the notice from DHS.

VII. All other terms and conditions shall remain the same.

RFS Proposal Checklist Supporting Documentation
Mandatory Qualifications Criteria
7a

List of all Medicare/State of California
Sanctions and Penalties
Last 5 Yrs

Alliance CompleteCare SNP
Sanctions, Penalties, and Corrective Actions Issued by Medicare

**Sanctions or Penalties**

There were no Sanctions or Penalties Issued by Medicare to Alliance CompleteCare SNP.

**Corrective Action Plans**

There were no Corrective Action Plans related to Penalties or Sanctions

Alliance Medi-Cal
Sanctions, Penalties, and Corrective Actions Issued by State of California

**Sanctions or Penalties**

There were no Sanctions or Penalties Issued by the State of California to Alliance Medi-Cal.

**Corrective Action Plans**

There were no Corrective Action Plans related to Penalties or Sanctions

# RFS Proposal Checklist Supporting Documentation
# Mandatory Qualifications Criteria
# 8a

# List of all DHCS-Established Quality Performance Indicators - Last 3 Yrs

The first chart is from the Alliance's new vendor, Q Mark. Q Mark's analysis of our preliminary administrative rates demonstrate significant improvement from measures reported by our former vendor

There are three sets of rates included. First column is the final administrative rates for 2010. The second set of columns is Q Mark's re-run of the 2010 data. The third set of columns is the 2011 data.

The administrative rates on the re-run improve most measures (most notably the Childhood Immunizations and Timeliness of Prenatal Care).

Q Mark, Inc.
A subsidiary of Health Care Excel, Inc.

**Alameda Alliance - Annual Rate Compare 2012**
**MediCal**

| 2/12/2012 | | HEDIS 2011 | | | Q Mark | | | Q Mark | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure Description | | Admin Denom | Admin Num | Admin Rate | Admin Denom | Admin Num | Admin Rate | Admin Denom | Admin Num | Admin Rate | Rate Change |
| AAB | **Avoidance of Antibiotics - Adult Acute Bronchitis** | 205 | 132 | **35.61%** | 824 | 565 | **31.43%** | 741 | 518 | **30.09%** | **-1.34%** |
| ADD | **Follow-Up Children Prescribed ADHD Med.** | | | | | | | | | | |
| | Initiation | NR | NR | **NR** | NR | NR | **NR** | 243 | 46 | **18.93%** | **n/a** |
| | C&M phase | NR | NR | **NR** | NR | NR | **NR** | 62 | 8 | **12.90%** | **n/a** |
| AMM | **Antidepressant Medication Management** | | | | | | | | | | |
| | Acute | NR | NR | **NR** | NR | NR | **NR** | 0 | 0 | **0.00%** | **n/a** |
| | Continuation | NR | NR | **NR** | NR | NR | **NR** | 0 | 0 | **0.00%** | **n/a** |
| ASM | **Use of Appropriate Meds for People With Asthma** | | | | | | | | | | |
| | 5-11 yrs old | 221 | 206 | **93.21%** | 771 | 721 | **93.51%** | 934 | 870 | **93.15%** | **-0.37%** |
| | 12-18 yrs old | 177 | 154 | **87.01%** | 821 | 689 | **83.92%** | 404 | 348 | **86.14%** | **n/a** |
| | 19-50 yrs old | | | | | | | 581 | 446 | | **n/a** |
| | 51-64 yrs old | | | | | | | 310 | 264 | | **n/a** |
| | Total | 398 | 360 | **90.45%** | 1,592 | 1,410 | **88.57%** | 2,229 | 1,928 | **86.50%** | **n/a** |
| AWC | **Adolescent Well-Care Visits** | 16,991 | 4,522 | **26.61%** | 16,991 | 5,797 | **34.12%** | 18,512 | 7,118 | **38.45%** | **4.33%** |
| BCS | **Breast Cancer Screening** | 5,236 | 3,037 | **58.00%** | 5,249 | 3,013 | **57.40%** | 5,893 | 3,167 | **53.74%** | **-3.66%** |
| CAP | **Children and Adolescents' Access to PCP** | | | | | | | | | | |
| | Ages 12-24 months | 3,182 | 2,476 | **77.81%** | 3,182 | 2,900 | **91.14%** | 3,089 | 2,829 | **91.58%** | **0.45%** |
| | Ages 25 months - 6 years | 15,453 | 9,254 | **59.88%** | 15,453 | 12,685 | **82.09%** | 17,552 | 14,206 | **80.94%** | **-1.15%** |
| | Ages 7-11 years | 8,800 | 5,419 | **61.58%** | 8,800 | 7,103 | **80.72%** | 10,066 | 8,266 | **82.12%** | **1.40%** |
| | Ages 12-19 years | 11,866 | 6,611 | **55.71%** | 11,865 | 9,016 | **75.99%** | 12,620 | 10,063 | **79.74%** | **3.75%** |
| CBP | **Controlling High Blood Pressure** | NR | NR | **NR** | NR | NR | **NR** | 4,730 | 0 | **0.00%** | **n/a** |
| CCS | **Cervical Cancer Screening** | 14,834 | 9,110 | **61.41%** | 14,788 | 9,619 | **65.05%** | 16,525 | 10,551 | **63.85%** | **-1.20%** |
| CDC | **Comprehensive Diabetes Care** | | | | | | | | | | |
| | HbA1c Testing | 1,980 | 1,401 | **70.76%** | 2,857 | 2,064 | **72.24%** | 3,523 | 2,817 | **79.96%** | **7.72%** |
| | HbA1c Poor Control | 1,980 | 1,980 | **100.00%** | 2,857 | 1,768 | **61.88%** | 3,523 | 1,801 | **51.12%** | **-10.76%** |
| | HbAlc <8 | 1,980 | 0 | **0.00%** | 2,857 | 968 | **33.88%** | 3,523 | 1,546 | **43.88%** | **10.00%** |
| | Eye Exam | 1,980 | 317 | **16.01%** | 2,857 | 608 | **21.28%** | 3,523 | 960 | **27.25%** | **5.97%** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | LDL-C Screening | 1,980 | 1,046 | **52.83%** | 2,857 | 1,874 | **65.59%** | 3,523 | 2,653 | **75.31%** | **9.71%** |
| | LDL-C <100 | 1,980 | 0 | **0.00%** | 2,857 | 848 | **29.68%** | 3,523 | 1,255 | **35.62%** | **5.94%** |
| | Nephropathy | 1,980 | 1,388 | **70.10%** | 2,857 | 1,882 | **65.87%** | 3,523 | 2,669 | **75.76%** | **9.89%** |
| | BP Control <140/80 | 1,980 | 1 | **0.05%** | 2,857 | 2 | **0.07%** | 3,523 | 7 | **0.20%** | **0.13%** |
| | BP Control <140/90 | 1,980 | 1 | **0.05%** | 2,857 | 2 | **0.07%** | 3,523 | 9 | **0.26%** | **0.19%** |
| **CHL** | **Chlamydia Screening** | | | | | | | | | | |
| | Women ages 16-20 | 2,146 | 1,205 | **56.15%** | 2,080 | 1,216 | **58.46%** | 2,237 | 1,279 | **57.17%** | **-1.29%** |
| | Women ages 21-24 | 1,485 | 897 | **60.40%** | 1,450 | 901 | **62.14%** | 1,492 | 898 | **60.19%** | **-1.95%** |
| | Overall Total | 3,631 | 2,102 | **57.89%** | 3,530 | 2,117 | **59.97%** | 3,729 | 2,177 | **58.38%** | **-1.59%** |
| **CIS** | **Childhood Immunization Status** | | | | | | | | | | |
| | DTP | 3,305 | 262 | **7.93%** | 3,299 | 1,222 | **37.04%** | 3,629 | 2,539 | **69.96%** | **32.92%** |
| | IPV | 3,305 | 326 | **9.86%** | 3,299 | 1,505 | **45.62%** | 3,629 | 2,841 | **78.29%** | **32.67%** |
| | MMR | 3,305 | 595 | **18.00%** | 3,299 | 2,839 | **86.06%** | 3,629 | 3,289 | **90.63%** | **4.57%** |
| | HIB | 3,305 | 757 | **22.90%** | 3,299 | 1,840 | **55.77%** | 3,629 | 3,004 | **82.78%** | **27.00%** |
| | HepB | 3,305 | 317 | **9.59%** | 3,299 | 1,275 | **38.65%** | 3,629 | 2,570 | **70.82%** | **32.17%** |
| | VZV | 3,305 | 617 | **18.67%** | 3,299 | 2,831 | **85.81%** | 3,629 | 3,274 | **90.22%** | **4.40%** |
| | PCV | 3,305 | 257 | **7.78%** | 3,299 | 1,237 | **37.50%** | 3,629 | 2,542 | **70.05%** | **32.55%** |
| | HepA | 3,305 | 139 | **4.21%** | 3,299 | 908 | **27.52%** | 3,629 | 1,390 | **38.30%** | **10.78%** |
| | RotaV | 3,305 | 252 | **7.62%** | 3,299 | 968 | **29.34%** | 3,629 | 2,183 | **60.15%** | **30.81%** |
| | Flu | 3,305 | 311 | **9.41%** | 3,299 | 1,425 | **43.19%** | 3,629 | 2,213 | **60.98%** | **17.79%** |
| | Combo 2 | 3,305 | 250 | **7.56%** | 3,299 | 1,087 | **32.95%** | 3,629 | 2,277 | **62.74%** | **29.80%** |
| | Combo 3 | 3,305 | 235 | **7.11%** | 3,299 | 1,033 | **31.31%** | 3,629 | 2,210 | **60.90%** | **29.59%** |
| | Combo 4 | 3,305 | 101 | **3.06%** | 3,299 | 425 | **12.88%** | 3,629 | 1,058 | **29.15%** | **16.27%** |
| | Combo 5 | 3,305 | 189 | **5.72%** | 3,299 | 805 | **24.40%** | 3,629 | 1,816 | **50.04%** | **25.64%** |
| | Combo 6 | 3,305 | 170 | **5.14%** | 3,299 | 762 | **23.10%** | 3,629 | 1,671 | **46.05%** | **22.95%** |
| | Combo 7 | 3,305 | 90 | **2.72%** | 3,299 | 356 | **10.79%** | 3,629 | 902 | **24.86%** | **14.06%** |
| | Combo 8 | 3,305 | 74 | **2.24%** | 3,299 | 324 | **9.82%** | 3,629 | 832 | **22.93%** | **13.11%** |
| | Combo 9 | 3,305 | 142 | **4.30%** | 3,299 | 613 | **18.58%** | 3,629 | 1,412 | **38.91%** | **20.33%** |
| | Combo 10 | 3,305 | 68 | **2.06%** | 3,299 | 278 | **8.43%** | 3,629 | 725 | **19.98%** | **11.55%** |
| **CMC** | **Cholesterol Management** | | | | | | | | | | |
| | LDL-C Screening | NR | NR | **NR** | NR | NR | **NR** | 518 | 408 | **78.76%** | **n/a** |
| | LDL-C Level <100 | NR | NR | **NR** | NR | NR | **NR** | 518 | 225 | **43.44%** | **n/a** |
| **CWP** | **Appropriate Testing for Children with Pharyngitis** | 120 | 64 | **53.33%** | 1,104 | 556 | **50.36%** | 1,221 | 656 | **53.73%** | **3.36%** |
| **FUH** | **Follow-Up After Hospitalization for Mental Illness** | | | | | | | | | | |
| | 30-day follow-up Encounter | NR | NR | **NR** | NR | NR | **NR** | 0 | 0 | **0.00%** | **n/a** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 7-day follow-up Encounter | NR | NR | **NR** | NR | NR | **NR** | 0 | 0 | **0.00%** | **n/a** |
| **IMA** | **Immunizations for Adolescents** | | | | | | | | | | |
| | Meningococcal | NR | NR | **NR** | NR | NR | **NR** | 2,050 | 1,238 | **60.39%** | **n/a** |
| | Tdap/TD | NR | NR | **NR** | NR | NR | **NR** | 2,050 | 1,339 | **65.32%** | **n/a** |
| | Combo 1 | NR | NR | **NR** | NR | NR | **NR** | 2,050 | 1,129 | **55.07%** | **n/a** |
| **LBP** | **Use of Imaging Studies for Low Back Pain** | 216 | 34 | **84.26%** | 1,027 | 203 | **80.23%** | 919 | 139 | **84.87%** | **4.64%** |
| **MPM** | **Annual Monitoring for Patients on Persistent Meds** | | | | | | | | | | |
| | ACE inhibitors or ARBs | NR | NR | **NR** | NR | NR | **NR** | 3,358 | 2,847 | **84.78%** | **n/a** |
| | Digoxin | NR | NR | **NR** | NR | NR | **NR** | 103 | 88 | **85.44%** | **n/a** |
| | Diuretics | NR | NR | **NR** | NR | NR | **NR** | 2,415 | 1,998 | **82.73%** | **n/a** |
| | Anti-convulsants | NR | NR | **NR** | NR | NR | **NR** | 577 | 351 | **60.83%** | **n/a** |
| | Overall Total | NR | NR | **NR** | NR | NR | **NR** | 6,453 | 5,284 | **81.88%** | **n/a** |
| **PCE** | **Pharmacotherapy Management of COPD Exacerbation** | | | | | | | | | | |
| | Dispensed corticosteroid | NR | NR | **NR** | NR | NR | **NR** | 178 | 105 | **58.99%** | **n/a** |
| | Dispensed bronchodilator | NR | NR | **NR** | NR | NR | **NR** | 178 | 130 | **73.03%** | **n/a** |
| **PPC** | **Prenatal and Postpartum Care** | | | | | | | | | | |
| | Prenatal Care | 1,922 | 129 | **6.71%** | 1,905 | 1,138 | **59.74%** | 2,223 | 1,371 | **61.67%** | **1.94%** |
| | Postpartum Care | 1,922 | 884 | **45.99%** | 1,905 | 969 | **50.87%** | 2,223 | 1,099 | **49.44%** | **-1.43%** |
| **SPR** | **Spirometry Testing** | 48 | 15 | **31.25%** | 117 | 35 | **29.91%** | 192 | 61 | **31.77%** | **1.86%** |
| **URI** | **Appropriate Treatment for Children with URI** | 847 | 32 | **96.22%** | 6,019 | 255 | **95.76%** | 5,796 | 294 | **94.93%** | **-0.84%** |
| **W34** | **Well-Child Visits in the 3rd to 6th Years of Life** | 12,278 | 6,255 | **50.94%** | 12,280 | 7,849 | **63.92%** | 14,090 | 8,702 | **61.76%** | **-2.16%** |
| **WCC** | **Weight Assess/Nutrition/Phys Activity** | | | | | | | | | | |
| | BMI Percentile 3-11 yrs | 10,352 | 148 | **1.43%** | 17,442 | 1,335 | **7.65%** | 17,909 | 119 | **0.66%** | **-6.99%** |
| | BMI Percentile 12-17 yrs | 3,703 | 69 | **1.86%** | 7,044 | 469 | **6.66%** | 7,594 | 64 | **0.84%** | **-5.82%** |
| | BMI Percentile Total | 14,055 | 217 | **1.54%** | 24,486 | 1,804 | **7.37%** | 25,503 | 183 | **0.72%** | **-6.65%** |
| | Counseling for Nutrition 3-11 yrs | 10,352 | 165 | **1.59%** | 17,442 | 1,584 | **9.08%** | 17,909 | 364 | **2.03%** | **-7.05%** |
| | Counseling for Nutrition 12-17 yrs | 3,703 | 46 | **1.24%** | 7,044 | 617 | **8.76%** | 7,594 | 131 | **1.73%** | **-7.03%** |
| | Counseling for Nutrition Total | 14,055 | 211 | **1.50%** | 24,486 | 2,201 | **8.99%** | 25,503 | 495 | **1.94%** | **-7.05%** |
| | Counseling for Physical Activity 3-11 yrs | 10,352 | 146 | **1.41%** | 17,442 | 1,504 | **8.62%** | 17,909 | 84 | **0.47%** | **-8.15%** |
| | Counseling for Physical Activity 12-17 yrs | 3,703 | 66 | **1.78%** | 7,044 | 600 | **8.52%** | 7,594 | 37 | **0.49%** | **-8.03%** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Counseling for Physical Activity Total | 14,055 | 212 | **1.51%** | 24,486 | 2,104 | **8.59%** | 25,503 | 121 | **0.47%** | **-8.12%** |

## HEDIS Performance for Measurement Years 2008-2010 (Medi-Cal)

| HEDIS Measures | Alliance Measurement Year 2008 | Alliance Measurement Year 2009 | Alliance Measurement Year 2010 | Trends |
|---|---|---|---|---|
| Adolescent Well-Care Visits | 51.09% | 38.75% | 40.74% | Decrease since 2008 |
| Appropriate Testing for Children with Pharyngitis | 48.94% | Not reported | 53.33% | Increase in rates |
| Appropriate Treatment for Children With Upper Respiratory Infection | 91.07% | 94.93% | 96.22% | Steady increase in rates |
| Avoidance of Inappropriate Antibiotic Treatment in Adults With Acute Bronchitis | 23.27% | 29.80% | 35.61% | Steady Increase in rates |
| Breast Cancer Screening | 45.24% | 59.62% | 58.00% | Increase in rates |
| Cervical Cancer Screening | 69.55% | 62.09% | 67.65% | Fluctuation in rates |
| Childhood Immunization Status (Combo 2) | 82.18% | Not reported | 51.16% | Decrease in rates |
| Childhood Immunization Status (Combo 3) | 79.02% | 71.30% | 47.92% | Decrease since 2008 |
| Chlamydia Screening in Women | 14.80% | Not reported | 57.89% | Increase in rates |
| Comprehensive Diabetes Care: Blood Pressure Control <140/90 | 61.13% | 57.08% | 55.65% | Decrease since 2008 |
| Comprehensive Diabetes Care: Eye Exam (Retinal) Performed | 31.39% | 25.52% | 40.00% | Increase in rates |
| Comprehensive Diabetes Care: HbA1c Control < 8.0% | 40.51% | 36.89% | 40.00% | Steady |
| Comprehensive Diabetes Care: HbA1c Poor Control > 9.0% (lower rate is better) | 54.56% | 54.29% | 49.91% | Improvement since 2008 |
| Comprehensive Diabetes Care: HbA1c Testing | 74.64% | 77.49% | 84.00% | Steady increase in rates |
| Comprehensive Diabetes Care: LDL Control < 100 mg/dL | 35.22% | 29.47% | 34.09% | Fluctuation in rates |
| Comprehensive Diabetes Care: LDL Screening Performed | 75.91% | 70.30% | 74.26% | Fluctuation in rates |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 81.02% | 72.16% | 81.74% | Fluctuation in rates |
| Prenatal and Postpartum Care: Postpartum Care | 60.30% | 50.89% | 58.84% | Fluctuation in rates |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 66.75% | 60.49% | 64.65% | Fluctuation in rates |
| Use of Appropriate Medications for People with Asthma (Total) | 85.49% | Not reported | 90.45% | Increase in rates |
| Use of Imaging Studies for Low Back Pain | 82.91% | 87.06% | 84.26% | Some fluctuation in rates, but at 90th percentile |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 23.08% | Not reported | 31.25% | Increase in rates |
| Weight Asssessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- BMI Percentiles | N/A | 37.04% | 39.58% | Increase in rates |
| Weight Asssessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Counseling for Nutrition | N/A | 83.80% | 80.09% | Decrease in rates, but already at 90th percentile |
| Weight Asssessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Counseling Physical Activity | N/A | 60.42% | 55.79% | Decrease in rates but close to the 90th percentile |
| Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | 82.62% | 69.91% | 68.75% | Decrease since 2008 |

# CAHPS Trends for Alameda Alliance for Health for Medi-Cal

***Medi-Cal CAHPS (Adults)***

| CAHPS Composite | 2007 | 2010 | Benchmark* | Analysis Comments |
|---|---|---|---|---|
| Rating of all health care | Not comparable | 2.10 | 2.27 | Below the 25th percentile |
| Rating of personal doctor | Not comparable | 2.32 | 2.42 | Below the 25th percentile |
| Rating of specialist seen most often | Not comparable | 2.37 | 2.44 | Below the 25th percentile |
| Rating of health network | Not comparable | 2.19 | 2.38 | Below the 25th percentile |
| Getting needed care | Not comparable | 2.07 | 2.24 | Below the 25th percentile |
| Getting care quickly | Not comparable | 2.14 | 2.35 | Below the 25th percentile |
| How well doctors communicate | Not comparable | 2.46 | 2.54 | Below the 25th percentile |
| Customer service | Not comparable | 2.38 | 2.40 | Above the 25th percentile but did not meet benchmark |
| Shared decision making | Not comparable | 2.40 | 2.49 | Below the 25th percentile |

Note: The 2007 CAHPS results were based on a 1 to 10 rating scale and were not recoded to the 1 to 3 scale that were used in the 2010 results.

* The benchmark is the 50th percentile national benchmark provided by NCQA

***Medi-Cal CAHPS (Child)***

| CAHPS Composite | 2007 | 2010 | 2010 Benchmark* | Analysis Comments |
|---|---|---|---|---|
| Rating of all health care | Not comparable | 2.41 | 2.47 | Below the 25th percentile |
| Rating of personal doctor | Not comparable | 2.56 | 2.59 | Above the 25th percentile but did not meet benchmark |
| Rating of specialist seen most often | Not comparable | 2.49 | 2.53 | Above the 25th percentile but did not meet benchmark |
| Rating of health network | Not comparable | 2.45 | 2.55 | Above the 25th percentile but did not meet benchmark |
| Getting needed care | Not comparable | 2.13 | 2.34 | Below the 25th percentile |
| Getting care quickly | Not comparable | 2.30 | 2.59 | Below the 25th percentile |
| How well doctors communicate | Not comparable | 2.58 | 2.65 | Below the 25th percentile |
| Customer service | Not comparable | 2.27 | 2.37 | Below the 25th percentile |
| Shared decision making | Not comparable | 2.51 | 2.56 | Below the 25th percentile |

**Note: The 2007 CAHPS results were based on a 1 to 10 rating scale and were not recoded to the 1 to 3 scale that were used in the 2010 results.**

*** The benchmark is the 50th percentile national benchmark provided by NCQA**

# RFS Proposal Checklist Supporting Documentation
# Mandatory Qualifications Criteria
# 8b

## List of all MA-SNP Quality Performance Requirements - Last 3 Yrs

## HEDIS Performance for Measurement Years 2008-2010 (SNP)

| HEDIS Measures | Alliance Measurement Year 2008 | Alliance Measurement Year 2009 | Alliance Measurement Year 2010 | Trends |
|---|---|---|---|---|
| Annual Monitoring for Patients on Persistent Medications- ACE/ARBs | 80.25% | 86.57% | 85.45% | Increase in rates |
| Annual Monitoring for Patients on Persistent Medications- Anticonvulsants | Not enough in denominator | 77.50% | 64.79% | Decrease in rates |
| Annual Monitoring for Patients on Persistent Medications- Digoxin | Not enough in denominator | Not enough in denominator | Not enough in denominator | N/A |
| Annual Monitoring for Patients on Persistent Medications- Diuretics | 80.00% | 85.84% | 84.30% | Increase in rates |
| Annual Monitoring for Patients on Persistent Medications- Total | 79.73% | 85.78% | 83.69% | Increase in rates |
| Care for Older Adults- Advance Care Planning | 17.76% | 18.52% | 20.19% | Improvement in rates |
| Care for Older Adults- Functional Status Assessment | 35.51% | 34.49% | 38.28% | Slight increase in rates |
| Care for Older Adults- Medication Review | 71.03% | 73.84% | 54.06% | Decrease in rates |
| Care for Older Adults- Pain Screening | 70.09% | 31.48% | 20.19% | Decrease in rates |
| Colorectal Cancer Screening | Not enough in denominator | 49.22% | 49.06% | Steady rates |
| Follow-up After Hospitalization for Mental Illness- 30-Day Follow-Up | Not enough in denominator | Not enough in denominator | 13.51% | N/A |
| Follow-up After Hospitalization for Mental Illness- 7-Day Follow-Up | Not enough in denominator | Not enough in denominator | 13.51% | N/A |
| Glaucoma Screening | Not enough in denominator | 40.96% | 32.64% | Decrease in rates |
| Medication Reconcilliation Post-Discharge | 0.00% | 27.93% | 5.88% | Decrease in rates |
| Osteoporosis Management in Women Who Had a Fracture | Not enough in denominator | Not enough in denominator | Not enough in denominator | N/A |
| Use of High-Risk Medications in the Elderly- At Least Two Prescriptions | 9.91% | 13.06% | 10.61% | Steady rates |
| Use of High-Risk Medications in the Elderly- One Prescription | 33.33% | 37.82% | 34.81% | Some fluctuations in rates |

## HEDIS Performance for Measurement Years 2008-2010 (Medicare)

| HEDIS Measures | Alliance Measurement Year 2008 | Alliance Measurement Year 2009 | Alliance Measurement Year 2010 | Trends |
|---|---|---|---|---|
| Adult BMI Assessment | Not reported | 32.58% | 50.58% | Increase in rates |
| Adults' Access to Preventive/Ambulatory Health Services (20-44 years) | Not reported | 84.38% | 57.42% | Decrease in rates |
| Adults' Access to Preventive/Ambulatory Health Services (45-64) | Not reported | 81.30% | 59.67% | Decrease in rates |
| Adults' Access to Preventive/Ambulatory Health Services (65+) | Not reported | 76.61% | 62.31% | Decrease in rates |
| Adults' Access to Preventive/Ambulatory Health Services (Total) | Not reported | 78.83% | 60.92% | Decrease in rates |
| Annual Monitoring for Patients on Persistent Medications- ACE/ARBs | 80.25% | 86.57% | 85.45% | Increase in rates |
| Annual Monitoring for Patients on Persistent Medications- Anticonvulsants | Not enough in denominator | 77.50% | 64.79% | Decrease in rates |
| Annual Monitoring for Patients on Persistent Medications- Digoxin | Not enough in denominator | Not enough in denominator | Not enough in denominator | N/A |
| Annual Monitoring for Patients on Persistent Medications- Diuretics | 80.00% | 85.84% | 84.30% | Increase in rates |
| Annual Monitoring for Patients on Persistent Medications- Total | 79.73% | 85.78% | 83.69% | Slight fluctuations in rates |
| Antidepressant Medication Management | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Breast Cancer Screening | Not reported | 65.75% | 63.96% | Decrease in rates |
| Colorectal Cancer Screening | Not enough in denominator | 49.22% | 49.06% | Steady rates |
| Comprehensive Diabetes Care- BP <140/90 | Not reported | 61.25% | 58.58% | Slight decrease in rates |
| Comprehensive Diabetes Care- Eye Exam | Not reported | 28.33% | 44.33% | Increase in rates |
| Comprehensive Diabetes Care- HbA1c control <8.0% | Not reported | 52.92% | 43.27% | Decrease in rates |
| Comprehensive Diabetes Care- HbA1c Poor Control (>9.0%)- lower rate is better | Not reported | 38.75% | 48.02% | Increase in rates |
| Comprehensive Diabetes Care- HbA1c test | Not reported | 86.25% | 83.11% | Decrease in rates |
| Comprehensive Diabetes Care- LDL control <100 | Not reported | 42.08% | 37.20% | Decrease in rates |
| Comprehensive Diabetes Care- LDL test | Not reported | 77.08% | 79.68% | Increase in rates |
| Comprehensive Diabetes Care- Nephropathy Screening | Not reported | 87.92% | 86.54% | Steady rates |
| Comprehensive Diabetes Care-BP <130/80 | Not reported | 32.92% | 48.55% | Increase in rates |
| Disease Modifying Anti-Rheumatic Drug Tehrapy in Rheumatoid Arthritis | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Follow-up After Hospitalization for Mental Illness- 30-Day Follow-Up | Not enough in denominator | Not enough in denominator | 13.51% | N/A |

## HEDIS Performance for Measurement Years 2008-2010 (Medicare)

| HEDIS Measures | Alliance Measurement Year 2008 | Alliance Measurement Year 2009 | Alliance Measurement Year 2010 | Trends |
|---|---|---|---|---|
| Follow-up After Hospitalization for Mental Illness- 7-Day Follow-Up | Not enough in denominator | Not enough in denominator | 13.51% | N/A |
| Glaucoma Screening | Not enough in denominator | 40.96% | 32.64% | Decrease in rates |
| Initiation of AOD Treatment (13-17 Years) | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Engagement of AOD Treatment (13-17 Years) | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Initiation of AOD Treatment (18+ Years) | Not reported | Not enough in denominator | 29.85% | N/A |
| Engagement of AOD Treatment (18+ Years) | Not reported | Not enough in denominator | 1.49% | N/A |
| Initiation of AOD Treatment (Total) | Not reported | Not enough in denominator | 29.85% | N/A |
| Engagement of AOD Treatment (Total) | Not reported | Not enough in denominator | 1.49% | N/A |
| Osteoporosis Management in Women Who Had a Fracture | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Interactions in the Elderly: Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Interactions in the Elderly: Dementia + Tricyclic Antidepressants or | Not reported | Not enough in denominator | 42.22% | N/A |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Fall+Tricyclic Antidepressants or Antipsychotics | Not reported | Not enough in denominator | Not enough in denominator | N/A |
| Plan All-Cause Readmissions | Not a measure | Not a measure | 17.85% | N/A |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Total | Not reported | Not enough in denominator | 34.67% | N/A |
| Use of High-Risk Medications in the Elderly- At Least Two Prescriptions | 9.91% | 13.06% | 10.61% | Decrease in rates |
| Use of High-Risk Medications in the Elderly- One Prescription | 33.33% | 37.82% | 34.81% | Decrease in rates |

# CAHPS Trends for Alameda Alliance for Health for Medicare

***Medicare CAHPS***

| CAHPS Composite | 2010 | 2010 Benchmark* | 2011 | 2011 Benchmark* | Analysis Comments |
|---|---|---|---|---|---|
| Rating of all health care† | 8.47 | 8.48 | 8.30 | 8.62 | Decrease from 2010 and significantly less than the national average in 2011 |
| Rating of personal doctor† | 8.77 | 9.01 | 9.00 | 9.07 | Increase from 2010, but less than the national average in 2011 |
| Rating of specialist seen most often† | 8.90 | 8.85 | N/A | 8.91 | Not enough respondents for this category in 2011 |
| Rating of health network† | 8.47 | 8.40 | 8.50 | 8.60 | Increase from 2010, but less than the national average in 2011 |
| Getting needed care†† | 3.40 | 3.57 | 3.40 | 3.57 | Same performance as in 2010 and significantly less than the national average in 2011 |
| Getting care quickly†† | 3.14 | 3.24 | 3.16 | 3.28 | Increase from 2010, but significantly less than the national average in 2011 |
| How well doctors communicate†† | 3.61 | 3.69 | N/A | 3.71 | Not enough respondents for this category in 2011 |
| Customer service†† | 3.63 | 3.64 | 3.58 | 3.63 | Decrease from 2010 and less than the national average in 2011 |
| Getting needed prescription drugs†† | 3.64 | 3.71 | 3.67 | 3.74 | Increase from 2010 but less than the national average in 2011 |
| Getting information from the plan about prescription drug coverage and cost†† | 3.28 | 3.42 | 3.40 | 3.41 | Increase from 2010 but less than the national average in 2011 |
| Overall rating of drug coverage† | 8.46 | 8.35 | 8.80 | 8.52 | Significant increase from 2010 and significantly greater than the national average in 2011 |
| Willingness to recommend | 3.42 | 3.50 | 3.46 | 3.50 | Increase from 2010, but below the |

| | | | | | |
|---|---|---|---|---|---|
| plan for drug coverage† | | | | | national average in 2011 |

* The benchmark is the national average scores.
† Based on a 0-10 scale rating
†† Based on a 1-4 scale rating

**Alameda Alliance for Health - H7292**

**CY 2012 Medicare Plan Ratings**

The Medicare Program rates how well Medicare health and drug plans perform in different categories (for example, detecting and preventing illness, ratings from patients, patient safety, drug pricing and customer service). The information provided below is an overall plan rating of our plan's performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for prospective members, 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars shows how well our plan performs.

| | |
|---|---|
| ★★★★★ | means excellent |
| ★★★★ | means above average |
| ★★★ | means average |
| ★★ | means below average |
| ★ | means poor |

| **Alameda Alliance for Health - H7292** | |
|---|---|
| **Overall Plan Rating** | ★★★<br>3 Stars |
| | The Overall Plan Rating combines scores for the types of services each plan offers:<br><br>**What is being measured?**<br><br>• **For plans covering health services**, the overall score for quality of those services covers **36 different topics in 5 categories**:<br><br>◦ **Staying healthy**: screenings, tests, and vaccines: Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy.<br>◦ **Managing chronic (long-term) conditions**: Includes how often members with different conditions got certain tests and treatments that help them manage their condition.<br>◦ **Ratings of health plan responsiveness and care**: Includes ratings of member satisfaction with the plan.<br>◦ **Health plan member complaints and appeals**: Includes how often members filed a complaint against the plan.<br>◦ **Health plan telephone customer service**: Includes how well the plan handles calls from members.<br><br>• **For plans covering drug services**, the overall score for quality of those services covers **17 different topics in 4 categories**: |

- **Drug plan customer service**: Includes how well the drug plan handles calls and makes decisions about member appeals.
- **Drug plan member complaints and Medicare audit findings**: Includes how often members filed a complaint about the drug plan.
- **Member experience with drug plan**: Includes member satisfaction information.
- **Drug pricing and patient safety**: Includes how well the drug plan prices prescriptions and provides updated information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition.

- **For plans covering both health & drug services**, the overall score for quality of those services covers **all of the 53 topics listed above**.

**Where does the information for the Overall Plan Rating come from?**

- For quality of **health services**, the information comes from sources that include:
  - Member surveys done by Medicare
  - Information from clinicians
  - Information submitted by the plans
  - Results from Medicare's regular monitoring activities

- For quality of **drug services**, the information comes from sources that include:
  - Results from Medicare's regular monitoring activities
  - Reviews of billing and other information that plans submit to Medicare
  - Member surveys done by Medicare

**Why is the Overall Plan Rating important?**

The Overall Plan Rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance. Learn more about differences among plans by looking at the detailed ratings.

**Alameda Alliance for Health - H7292**

**CY 2011 Medicare Plan Ratings**

The Medicare Program rates how well Medicare health and drug plans perform in different categories (for example, detecting and preventing illness, ratings from patients, patient safety, drug pricing and customer service). The information provided below is an overall plan rating of our plan's performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for prospective members, 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars shows how well our plan performs.

| | |
|---|---|
| ★★★★★ | means excellent |
| ★★★★ | means above average |
| ★★★ | means average |
| ★★ | means below average |
| ★ | means poor |

| **Alameda Alliance for Health - H7292** | |
|---|---|
| **Overall Plan Rating** | ★★★<br>3 Stars |
| | The Overall Plan Rating combines scores for the types of services each plan offers:<br><br>**What is being measured?**<br><br>• **For plans covering health services**, the overall score for quality of those services covers **36 different topics in 5 categories**:<br><br>◦ **Staying healthy**: screenings, tests, and vaccines: Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy.<br>◦ **Managing chronic (long-term) conditions**: Includes how often members with different conditions got certain tests and treatments that help them manage their condition.<br>◦ **Ratings of health plan responsiveness and care**: Includes ratings of member satisfaction with the plan.<br>◦ **Health plan member complaints and appeals**: Includes how often members filed a complaint against the plan.<br>◦ **Health plan telephone customer service**: Includes how well the plan handles calls from members.<br><br>• **For plans covering drug services**, the overall score for quality of those services covers **17 different topics in 4 categories**: |

  - **Drug plan customer service**: Includes how well the drug plan handles calls and makes decisions about member appeals.
  - **Drug plan member complaints and Medicare audit findings**: Includes how often members filed a complaint about the drug plan.
  - **Member experience with drug plan**: Includes member satisfaction information.
  - **Drug pricing and patient safety**: Includes how well the drug plan prices prescriptions and provides updated information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition.

- **For plans covering both health & drug services**, the overall score for quality of those services covers **all of the 53 topics listed above**.

**Where does the information for the Overall Plan Rating come from?**

- For quality of **health services**, the information comes from sources that include:
  - Member surveys done by Medicare
  - Information from clinicians
  - Information submitted by the plans
  - Results from Medicare's regular monitoring activities

- For quality of **drug services**, the information comes from sources that include:
  - Results from Medicare's regular monitoring activities
  - Reviews of billing and other information that plans submit to Medicare
  - Member surveys done by Medicare

**Why is the Overall Plan Rating important?**

The Overall Plan Rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance. Learn more about differences among plans by looking at the detailed ratings.

**Alameda Alliance for Health - H7292**

**CY 2010 Medicare Health Plan Ratings**

The Medicare Program rates how well Medicare Advantage performs in different categories (for example, detecting and preventing illness, rating from patients, patient safety and customer service). The information provided below is a summary rating of our plan's overall performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for prospective members, 877-585-7526 (toll-free) or 800-735-2929 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars show how well our plans perform.

| | |
|---|---|
| ★★★★★ | means excellent |
| ★★★★ | means very good |
| ★★★ | means good |
| ★★ | means fair |
| ★ | means poor |

| **Alameda Alliance for Health - H7292** | |
|---|---|
| **Summary Rating of Health Plan Quality** | Not enough data to calculate summary score |
| | This summary rating gives an **overall score** on the health plan's quality and performance on **33 different topics in 5 categories**:<br>• **Staying healthy: screenings, tests, and vaccines.** Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy.<br>• **Managing chronic (long-term) conditions.** Includes how often members with different conditions got certain tests and treatments that help them manage their condition.<br>• **Ratings of health plan responsiveness and care.** Includes ratings of member satisfactions with the plan.<br>• **Health Plan member complaints, appeals, and choosing to leave the health plan.** Includes how often members have made complaints against the plan and how often members choose to leave the plan.<br>• **Health plan telephone customer service.** Includes how well the plan handles member calls. |

RFS Proposal Checklist Supporting Documentation
Mandatory Qualifications Criteria
12

# Letters of Support from the Community Confirming the Alliance Accepted Community-Level Stakeholder Input

**Senior Services Coalition**
of Alameda County



February 14, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

Senior Services Coalition of Alameda County is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. We have seen our input reflected in updated versions of the draft concept and will be reviewing a draft of the Alliance's response to the Request for Solutions on February 17, 2012.

The Alliance has also convened a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. These individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, Senior Services Coalition will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Wendy Peterson

Wendy Peterson, Director
Senior Services Coalition of Alameda County


c/o Alameda County Area Agency on Aging - 6955 Foothill Blvd., Suite 300 - Oakland, CA 94605

Community Health
Center Network
*Setting the standard for Community Health Care*

February 9, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

Community Health Center Network (CHCN) is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. We have seen our input reflected in updated versions of the draft concept and will be reviewing a draft of the Alliance's response to the Request for Solutions on February 17, 2012.

The Alliance has also convened a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. These individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, CHCN will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Ralph Silber
Chief Executive Officer

101 Callan Avenue, Suite 300 • San Leandro, California 94577
Phone: (510) 297-0200 • Fax: (510) 297-0209
Website: www.chcnetwork.com

CENTER FOR ELDERS' INDEPENDENCE

February 13, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

Re: Letter of Support for Alameda Alliance

Dear Director Douglas,

Center for Elders' Independence (CEI) is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. We have seen our input reflected in updated versions of the draft concept and will be reviewing a draft of the Alliance's response to the Request for Solutions on February 17, 2012.

The Alliance has also convened a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. These individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, CEI will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Peter Szutu
President & CEO
Center for Elders' Independence

**Tel:** 510-433-1150 **Fax:** 510-452-8836
Mailing Address: 510 - 17th Street, Oakland CA 94612
PACE Center Locations: 1955 San Pablo Ave. Oakland • 1497 Alcatraz Ave. Berkeley • 7200 Bancroft Ave. Oakland

LifeLong Medical Care
Health Services For All Ages

Mailing Address
P.O. Box 11247
Berkeley, CA 94712-2247

**LifeLong Administration**
**Member Services**
2344 Sixth Street
Berkeley, CA 94710
510-704-6010

**LifeLong Berkeley Primary Care**
2001 Dwight Way
Room 1363
Berkeley, CA 94704

**LifeLong Dental Care**
1860 Alcatraz Avenue
Berkeley, CA 94703

**LifeLong Downtown Oakland**
Supportive Housing Program
616 16th Street
Oakland, CA 94612

**LifeLong East Oakland**
10700 MacArthur Blvd
Suite 14B
Oakland, CA 94605

**LIfeLong Howard Daniel Clinic**
9933 MacArthur Blvd
Oakland, CA 94605

**LifeLong Over 60 Health Center**
3260 Sacramento Street
Berkeley, CA 94702

**LifeLong West Berkeley**
2031 Sixth Street
Berkeley, CA 94710

**LifeLong Adult Day**
**Health Centers**
1905 Novato Blvd
Novato, CA 94947

10700 MacArthur Blvd
Suite 14A
Oakland, CA 94605

February 9, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

LifeLong Medical Care is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. We have seen our perspective and input reflected in updated versions of the draft concept and will be reviewing a draft of the Alliance's response to the Request for Solutions on February 17, 2012.

The Alliance has also convened a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. These individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, LifeLong Medical Care will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Marty Lynch, PhD, MPA
Executive Director/CEO

On Lok Senior Health Services

1333 Bush Street, San Francisco, CA 94109-5611
p: 415-292-8888 f: 415 292 8745 www.onlok.org

February 15, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

On Lok Senior Health Services is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. We are writing to express our support for the Alliance efforts to participate in the Dual Eligible Demonstration.

As you know, On Lok began in San Francisco's Chinatown/North Beach neighborhoods of San Francisco and developed the national prototype for PACE (Program of All-inclusive Care for the Elderly). Our founders sought an alternative to nursing home care for frail seniors that would benefit them and their families, as well as our government. In 1997, in recognition of its success, PACE was established as a permanent Medicare provider and a voluntary state option under Medicaid. Today, On Lok's own PACE, called On Lok Lifeways, cares for almost 1,200 frail seniors in San Francisco, Southern Alameda and Santa Clara Counties. On Lok Lifeways has served frail seniors in Southern Alameda County since 2002. We are excited that our new state-of-the-art On Lok Lifeways' Peralta Center in Fremont is nearing completion and is scheduled for its grand opening in the early spring of 2012. The Peralta Center will be On Lok's second center in Fremont and is co-located with a new low-income senior housing facility developed by Eden Housing. The opening of our second center in Fremont underscores our commitment to serving the Southern Alameda County community.

On Lok continues to strive to develop innovative models to better integrate care for the most vulnerable in our communities. To that end, we are actively participating in the Alliance's Work Group to prepare the Dual Demonstration submission and attended the community forum to provide input from dual eligible beneficiaries and community members. We are committed to working with the Alliance on the implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

If you have any questions, please contact me at 415-292-8882 or redmondson@onlok.org.

Sincerely,

Robert Edmondson
Chief Executive Officer

1972
CIL
Center for
Independent Living
www.cilberkeley.org

*Berkeley office*
3075 Adeline St. Suite 100
Berkeley, CA 94703
(510) 841-4776 Voice
(510) 843-3101 TDD
(510) 841-6168 FAX

*Oakland office*
1904 Franklin St. Suite 320
Oakland, CA 94612
(510) 763-9999 Voice
(510) 444-1837 TDD
(510) 763-4910 FAX

*People with disabilities creating opportunity*

February 10, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

On behalf of the Center for Independent Living (CIL), I am pleased to write this letter in support of the proposal submitted by Alameda Alliance for Health (Alliance) for Dual Eligible Demonstration.

Founded in 1972 as a powerful force for social change, CIL was the nation's first disability-led services and advocacy organization to advocate that people with disabilities are the best experts on their lives and have a right to live independently in the community. We are committed to seeing the Duals integration occur in a manner that insures access to quality care and respects the rights of recipients to make choices about their own health.

In preparation for the duals transition to managed care, Alameda Alliance engaged stakeholders to design and deliver customized training in disability awareness for the company's employees, to glean input from consumers and providers via Alliance-sponsored forums, and provided consultation to key Alliance executives on improving patient care and services to dual eligible beneficiaries.

CIL is also a member of the Dual Eligible Demonstration Work Group that was formed in order to assist the Alliance in developing their submission for the Dual Eligibile Demonstration. We have provided critical input on draft concepts for the submission and have seen our advice reflected in updated versions. In addition to participating in the development of the Alliance's Dual Eligible Demonstration, CIL will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

CIL recognizes and respects the Alliance's efforts to have their managed care model reflect the values of the Independent Living Movement and look forward to our continued collaboration.

Sincerely,

Yomi S. Wrong
Executive Director

CITY OF Fremont

***Human Services Department | Administration***
3300 Capitol Avenue, P.O. Box 5006, Fremont, CA 94537-5006
510 574-2050 *ph* | 510 574-2054 *fax* | www.fremont.gov

February 13, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas;

The City of Fremont Human Services Department is participating in the work group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The City of Fremont has been providing direct services, including medical and supportive care coordination, to low income vulnerable, seniors for over 30 years. We are supportive of integrating medical care, long term care, and home and community based services to best meet the needs of this population, which frequently faces complex problems. While we do not underestimate the challenges of this task, we believe that Alameda County has innovative programs in place and an ability to develop a sustainable program. The working relationship with the Alliance staff has been productive and open and we will review the next draft of the Alliance's response to the Request for Solutions on February 17, 2012 prior to submission.

Human Services, Aging and Family Service staff recently participated in a Community Forum in which consumers and providers were able to offer input on the Request for Solutions. We feel this community driven approach will be reflected throughout Alameda County's implementation of the demonstration and will guide us in developing a comprehensive and financially efficient model that provides needed support and services to low income Medicare individuals.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, Fremont's Human Services Department, will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Suzanne Shenfil, Director
City of Fremont Human Services Dept

Disability Rights

Education & Defense Fund **DREDF**

February 15, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Participation for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

Disability Rights Education and Defense Fund (DREDF) has been taking part in the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. Our intention has been to continue advocating for the needs and viewpoint of the disability community, and so far the Alliance has been receptive to our suggestions and input, which have been reflected in updated versions of the draft concept. DREDF cannot attend the upcoming February 17, 2012 meeting during which the Work Group will be reviewing a draft of the Alliance's response to the Request for Solutions on February 17, 2012, but if possible will review that draft, and anticipate that the Alliance will give due consideration to any further thoughts that we can provide.

The Alliance has also convened a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. These individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries. Beneficiaries, in particular, shared their care coordination priorities, as well as their deep concerns about preserving key provider relations, consumer control in IHSS services, beneficiary protections, and necessary healthcare over time in the face of highly anticipated but unproven savings.

At this time, DREDF is seriously continuing to work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration, depending on our resources and availability, and on the ultimate outcome of the Alliance's Dual Demonstration submission.

Sincerely,

**MAIN OFFICE:** 3075 Adeline Street, Suite 210 • Berkeley, CA 94703 • 510.644.2555 • 510.841.8645 fax/tty • www.dredf.org

**GOVERNMENT AFFAIRS OFFICE:** 1825 K Street, NW, Suite 600 • Washington, DC 20006 |
*Doing disability justice*

Silvia Yee
Senior Staff Attorney

Alameda County
Social Services Agency

Lori Jones
Agency Director

Thomas L. Berkley Square
2000 San Pablo Avenue, Fourth Floor
Oakland, California 94612
510-271-9100 / Fax: 510-271-9108
ssadirector@acgov.org
http://alamedasocialservices.org

February 15, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas:

The Alameda County Social Services Agency (ACSSA) is a part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. The Dual Eligible Demonstration Work Group has met twice to provide input on draft concepts for the Alliance Dual Demonstration submission. In addition, ACSSA and the Alliance held a number of conversations and meetings focusing on the relationship between our systems. Our input is being incorporated into the Alliance's response to the Request for Solutions on February 17, 2012.

ACSSA is the administrative and assessment service delivery program for in-home supportive services (IHSS) for approximately 17,000 frail, elderly and disabled adults in Alameda County. ACSSA social workers provide thorough eligibility and intake assessments to potential clients and assist clients in hiring providers to help them with activities of daily living so they can remain safely in their homes. ACSSA are active participants in the statewide duals stakeholder process and our dual-eligible clients are indicating to us that they desire integrated managed care to better meet their needs. We look forward to partnering with the Alliance to ensure a seamless transition for our clients.

ACSSA and the Alliance have a demonstrated track record of collaboration and support since 1995 with the transition of Medi-Cal eligible Aid to Families and Dependent Children (AFDC) to managed care. The Alliance also provides insurance benefits for ACSSA's IHSS providers. Recently ACSSA and the Alliance collaborated on a survey of providers to determine their need for additional training that could help enhance care for IHSS clients.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, ACSSA will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee, and building upon a long-standing partnership, for the Demonstration.

Sincerely,

Lori Jones
Agency Director

alameda county
Adult Day Services Network

Tax ID#: 20-4704743

*Adult Day Services Network of Alameda County is a nonprofit, tax-exempt organization, incorporated under the laws of the State of California.*



February 17, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

**Re: Letter of Support for Alameda Alliance for Health Dual Eligible Demonstration**

Dear Director Douglas,

The Adult Day Services Network of Alameda County is part of the Work Group formed by the Alameda Alliance for Health (Alliance) to assist them in developing their submission for the Dual Eligible Demonstration. We have seen our input reflected in updated versions of the draft concept and will be reviewing a draft of the Alliance's response to the Request for Solutions on later today.

The Network also participated in a Community Forum attended by 45 community members including dual eligible beneficiaries and providers to the dual eligible community. Individuals and organizational representatives were asked to provide input on how the Alliance's Dual Eligible Demonstration can be consumer-driven and focus on improving care and services to dual eligible beneficiaries. Alliance staff showed great consideration for this input.

As an association of Adult Day Services providers, the Network has been working closely with Alameda Alliance for a year now, as we jointly prepared for the transition of SPDs into managed care and as we have prepared for the ADHC transition to CBAS. The Alliance has reached out and worked closely with the Alameda County ADHCs to help ensure a smooth transition for beneficiaries and a good working relationship with providers.

Our experience working with Alameda Alliance on ADHC issues and the Duals Demonstration project has demonstrated their commitment to creating systems of communication and care that meet the spectrum of needs of the Medi-Cal only and the Dual Eligible populations, and as such we strongly support their proposal to the Dual Eligible Demonstration.

In addition to participating in the development of the Alliance's Dual Eligible Demonstration, The Adult Day Services Network of Alameda County will work with the Alliance on implementation and continued operation of the project as a member of the Steering Committee for the Demonstration.

Sincerely,

Anne Warner-Reitz
Executive Director

510 17th Street, Suite 200, Oakland, CA 94612 (510) 883-0874 fax (510) 344-6356 www.adsnac.org

RFS Proposal Checklist Supporting Documentation
Mandatory Qualifications Criteria
12

# Narrative of All Activities Designed to Obtain Community Input Including Specific Examples of How the Plan Developed in Response to Community Comment

In the spring of 2011, the Strategic Planning Committee of the Alliance Board of Governor designated Board member Marty Lynch, CEO of LifeLong Medical Care, to lead the Alliance's effort on the DE Demonstration. The Alliance began bringing together community stakeholders in late 2011 to assist in the development of the Alliance DE Demonstration. The Alliance formed a Workgroup consisting of providers, plan partners, county agencies and consumer representatives. Organizations represented in these convenings include: 1) Adult Day Services Network of Alameda County, 2) Senior Services Coalition, 3) Satellite Housing, 4) Community Health Center Network, 5) Lifelong Medical Center, 6) Asian Health Services, 7) Alameda Health Care Services Agency , 8) Center for Elders' Independence, 9) On Lok, 10) Alameda County Behavioral Health Care Services Agency, 11) Alameda County Social Services Agency, 12) City of Fremont Human Services Department, 13) Disability Rights Education and Defense Fund, and 14) Center for Independent Living.

The Workgroup met twice in January 2012 with a subgroup also convening a third time. At the last two meetings, the Workgroup was given a draft DE Demonstration concept in order to provide feedback and insights. Changes in the draft concept including additional consumer protections and the development of carve-out options are directly attributable to Workgroup input. This Workgroup also met on February 17, 2012 to review the Alliance's response to the RFS. Input and recommendations from the Workgroup were again incorporated into the final RFS submission.

On February 6, 2012, the Alliance convened a community forum on the Dual Eligible Demonstration. The 45 participants including dual eligible consumers, advocates and providers were given an overview of the State's effort and asked to respond to several questions including which protections should remain in place, improvements that should be included in the Demonstration and how to continue to engage stakeholders in the development process. Protections regarding consumers self-directing their care and preservation of the IHSS consumer-

focused model were two clear messages from this convening. Both of these elements have been incorporated into the final RFS submission.

In late January 2012, the Alliance also participated in a meeting convened by the Senior Services Coalition to discuss the DE Demonstration. That same month, the Alameda County Board of Supervisors Health Committee also held a hearing on the program. Speakers included Ingrid Lamirault, the Alliance's Chief Executive Officer, who described the Alliance's efforts to develop a DE Demonstration. The Alliance has also met with Kaiser Permanente and Blue Cross representatives to discuss the DE Demonstration.