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August 10, 2012

Mr. Jay R. Easterling
Deputy Director
ODJFS/OCA
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414

Re: Request for Additional Information related to the Ohio Department of Job and Family Services Request for Application JFSR# 1213-07-8038

Dear Mr. Easterling:

In response to your letter dated August 8, 2012, Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield (Anthem) is providing the Ohio Department of Job and Family Services (ODJFS) with additional information to support Anthem's experience with institutional long-term care (LTC) services and long-term services and supports under its Medicare line of business in the State of California. The information provided herein also serves to clearly indicate that assertions regarding Anthem's LTC experience made by another applicant are unfounded.

As part of Anthem's Request for Application (RFA) response, Anthem used the experience of its affiliated company, CareMore Health Plan (CareMore), which operates Medicare Advantage (MA) and MA Special Needs Plans (SNPs) in California. WellPoint, Anthem's parent company, owns CareMore Health Group.

In Appendix B of the RFA, the instructions state:

An Applicant must report experience and compliance as required in this Appendix. This may include the experience/compliance of the Applicant and/or any entity within its corporate family and/or a partner as defined in Section III.A of this RFA.

The RFA defines "corporate family" as:

Corporate Family: The parent company for whom the Applicant is a subsidiary and any subsidiary of the parent company or Applicant. All such entities must be

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shown on the Table of Organization that the Applicant is required to submit as part of Appendix A of the application.

Per the instructions provided by the RFA, the use of CareMore's experience for the purposes of Anthem's application is valid and accurate.

CareMore offers an Institutional SNP (I-SNP) called CareMore Touch in Los Angeles, Orange and Santa Clara counties in California. CareMore Touch is a health plan specially designed for beneficiaries, including those dually eligible for Medicaid and Medicare, living in a nursing home or in a community or assisted living facility requiring the same level of care as someone in a nursing home. The CareMore Touch comprehensive care system offers benefits, services and care designed to enhance the overall health and well being of nursing home residents.

Medicare Advantage plans that provide services to special needs individuals (including institutionalized beneficiaries, dual eligibles, and/or individuals with severe or disabling chronic conditions) are called "Specialized MA plans for Special Needs Individuals," or SNPs. SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. SNPs may be any type of Medicare Advantage Coordinated Care Plan, including a health maintenance organization, or a local or regional preferred provider organization plan.

I-SNPs are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for the mentally retarded (ICF/MR), or an inpatient psychiatric facility. I-SNPs may also enroll MA eligible individuals living in the community, but requiring an institutional level of care, known as Institutional Equivalent SNPs. Additional information about I-SNPs is available from the Centers for Medicare and Medicaid Services (CMS) website:

<http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/InstitutionalSNP.html>

The protest of another applicant in response to the RFA contends that Anthem should not receive points related to Anthem's LTC experience in the State of California under Anthem's Medicare line of business. That applicant's protest inaccurately references page 35 of the Medicare and You handbook—related to Medicare Parts A and B—and errs in assuming that the Medicare program does not provide authority for health plans to provide services for LTC members. In fact, the applicant should have referenced the correct section of the Medicare and You handbook which applies to Medicare Advantage plans, or Medicare Part C. This section,

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which starts on page 70 of the handbook, clarifies that MA plans are required to provide “all services of Original Medicare except for hospice”, and “may offer extra coverage” as well. We provide the following information to confirm CareMore’s experience with serving the institutional LTC population in California:

Appendix B, Section 1: Evidence of providing LTC Institutional Services during CY 2010

As part of CareMore’s Touch health plan in California, CareMore exclusively enrolls members residing in nursing facilities or who live in the community but require the same level of care as nursing home residents. In CY 2010, CareMore’s Touch plan was offered in Los Angeles, Orange and Santa Clara counties in the State of California. To provide evidence of CareMore’s Touch plan in these counties during CY 2010, we provide excerpts from the plan’s Medicare Evidence of Coverage. This document is part of the required Medicare marketing materials that are approved by CMS on an annual basis. The Evidence of Coverage is sent to members on an annual basis.

See Exhibit 1: Excerpts of CareMore Touch 2010 Evidence of Coverage for Los Angeles and Orange counties for information related to the eligibility criteria to enroll in the Touch program and the service area.

Members must reside in CareMore-contracted nursing facilities to ensure that there is direct oversight from the health plan regarding the delivery of services and care provided to members. This type of contractual arrangement allows CareMore to engage in specific audit activities with contracted nursing facilities, allows for CareMore staff to work directly with nursing home staff, and ensures that important member information is shared between the health plan and the facilities. In CY 2010, CareMore contracted with 56 facilities across the Los Angeles, Orange and Santa Clara counties for the Touch plan.

Appendix B, Section 1: Evidence of providing LTC Institutional Services during CY 2011

During CY 2011, CareMore did not make any substantive changes to the Touch health plan. Eligibility requirements and level of benefits and services remained the same to ensure that members’ medical, personal, social and safety needs are met. See Exhibit 2: Excerpts of CareMore Touch 2011 Evidence of Coverage for Los Angeles and Orange counties for information related to the eligibility criteria to enroll in the Touch program and the service area. In CY 2011, CareMore contracted with 63 facilities across the Los Angeles, Orange and Santa Clara counties for the Touch plan.

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Appendix D, D-1, Entry 1: Does the Applicant have at least 12 months of experience as of March 31, 2012 with providing and coordinating the following benefits as part of its care management program? Long Term Supports and Services

CareMore's Model of Care (MOC) illustrates the care management infrastructure that is in place to provide for and coordinate long term services and supports for members residing in institutions or who live in the community but require the same level of care. The MOC is a requirement for all Special Needs Plans, and must meet approval from the National Committee for Quality Assurance (NCQA). The NCQA approval process requires health plans to meet specific requirements related to 11 clinical and non-clinical elements:

1. Description of the SNP-specific Target Population
2. Measurable Goals
3. Staff Structure and Care Management Goals
4. Interdisciplinary Care Team
5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols
6. Model of Care Training for Personnel and Provider Network
7. Health Risk Assessment
8. Individualized Care Plan
9. Communication Network
10. Care Management for the Most Vulnerable Subpopulations
11. Performance and Health Outcome Measurement

CareMore's Model of Care was developed in 2010 for its Touch plan and was reviewed by both CMS and NCQA. Beginning in 2011, the Model of Care underwent a rigorous evaluation and scoring process that is noted above. The CareMore 2011 Model of Care received approval from the NCQA with a score of 91.25%. See Exhibit 3: H0544 – SNP Conditional Approval – Institutional. By achieving a score of 85% or higher, CareMore has secured an approval, beginning on January 1, 2012, from NCQA to operate the Touch health plan in California for three years. For more information on the NCQA approval process for the MOCs, please visit the NCQA website:

<http://www.ncqa.org/tabid/1452/Default.aspx>

We have provided excerpts from CareMore's model of care for its Touch plan to provide evidence of providing long term services and supports as part of its care management program. See Exhibit 4: Excerpts of 2011 CareMore Model of Care.

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Appendix D, D-1, Entry 3: Does the Applicant have at least 12 months of experience as of March 31, 2012 with providing and coordinating the following benefits as part of its care management program? *Long term services and supports*

Appendix D, D-1, Entry 3 is specific to Anthem's Medicare line of business in Indiana. The ODJFS letter requests information only related to "Anthem's claims of its Medicare line of business in California". Thus, we have limited our response in this letter specifically to our California Medicare line of business. If we have misinterpreted ODJFS' request, then we will provide information expeditiously on the Indiana Medicare line of business.

Appendix D, D-2, Entry 1: Does the Applicant have at least 12 months of experience as of March 31, 2012 providing comprehensive care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting)?

As mentioned above, and as indicated in the MOC, CareMore provides extensive and comprehensive care management services to members enrolled in the Touch health plan in California. The Touch health plan was in operations throughout CY 2010 and CY 2011 and is presently in operations for CY 2012, which confirms that CareMore has more than 12 months of experience providing comprehensive care management to enrollees receiving long term institutional care. CareMore's MOC provides documentation of the care management services that are in place for CareMore's Touch members.

Appendix D, D-12.b: In the table, provide the following information about a care management program evaluation that was conducted for a Medicaid Long Term Care population for which the Applicant provided care management services.

As stated previously, the Touch membership includes dual eligible beneficiaries. All Touch members are managed as high-risk members based on their acuity and/or the complexity of their medical conditions, and thus all members are provided with care management services once enrolled in the Touch plan. Given the fact that dually eligible individuals receive both Medicare and Medicaid services, the inclusion of an evaluation of the care management services provided in the Touch plan is appropriate for this question.

Very truly yours,



Suzanne K. Richards

SKR/mlo

EXHIBIT
tabbles®
1

EVIDENCE of
COVERAGES

Los Angeles & Orange Counties 2010

H0544_100909A CHP (10/09);
Contract Number H0544



CAREMORE
T O U C H
HMO

Getting started as a member of CareMore Touch

Medicare & Medicaid Services) must approve CareMore Touch each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your three eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you are entitled to Medicare Part A
- -- and -- you are enrolled in Medicare Part B

- -- and -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- -- and -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who are living in a nursing home or in a community or assisted living facility and require the same level of care as someone in a nursing home. If you no longer meet the special eligibility requirements of our plan, your membership in this plan will end after a 30 day notice. You will receive a notice from us informing you of the end of your membership and your options. If you have any questions about your eligibility, please contact Member Services.

Section 2.2

What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

Chapter 1

Section 2.3 Here is the plan service area for CareMore Touch

Although Medicare is a Federal program, CareMore Touch is available only to individuals who live in our plan service area. To stay a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these parts of counties in CA: Los Angeles, the following zip codes only

Los Angeles County

90001	90027	90053	90081	90222	90270	90313	90637	90715
90002	90028	90054	90082	90223	90274	90397	90638	90716
90003	90029	90055	90083	90224	90275	90398	90639	90717
90004	90030	90056	90084	90230	90277	90501	90640	90723
90005	90031	90057	90086	90231	90278	90502	90650	90731
90006	90032	90058	90087	90232	90280	90503	90651	90732
90007	90033	90059	90088	90233	90291	90504	90652	90733
90008	90034	90060	90089	90239	90292	90505	90659	90734
90009	90036	90061	90091	90240	90293	90506	90660	90744
90010	90037	90062	90093	90241	90294	90507	90661	90745
90011	90038	90063	90094	90242	90295	90508	90662	90746
90012	90039	90065	90096	90245	90296	90509	90665	90747
90013	90040	90066	90097	90247	90301	90510	90670	90748
90014	90041	90068	90099	90248	90302	90601	90671	90749
90015	90042	90069	90101	90249	90303	90602	90701	90755
90016	90043	90070	90102	90250	90304	90603	90702	90801
90017	90044	90071	90103	90251	90305	90604	90703	90802
90018	90045	90072	90174	90254	90306	90605	90706	90803
90019	90046	90074	90185	90255	90307	90606	90707	90804
90020	90047	90075	90189	90260	90308	90607	90710	90805
90021	90048	90076	90201	90261	90309	90608	90711	90806
90022	90050	90078	90202	90262	90310	90609	90712	90807
90023	90051	90079	90220	90266	90311	90610	90713	90808
90026	90052	90080	90221	90267	90312	90612	90714	90809

Getting started as a member of CareMore Touch

Our service area includes these parts of counties in CA: Los Angeles, the following zip codes only

Los Angeles County

90810	91010	91107	91201	91334	91412	91608	91744	91791
90813	91011	91108	91202	91335	91413	91609	91745	91792
90814	91012	91109	91203	91337	91416	91610	91746	91793
90815	91016	91110	91204	91340	91423	91611	91747	91795
90822	91017	91114	91205	91341	91426	91612	91748	91797
90831	91020	91115	91206	91343	91436	91614	91749	91799
90832	91021	91116	91207	91344	91501	91615	91750	91801
90833	91024	91117	91208	91345	91502	91616	91754	91802
90834	91025	91118	91209	91346	91503	91617	91755	91803
90835	91030	91121	91210	91352	91504	91618	91756	91804
90840	91031	91123	91214	91353	91505	91702	91765	91841
90842	91040	91124	91221	91356	91506	91706	91766	91896
90844	91041	91125	91222	91357	91507	91711	91767	91899
90845	91042	91126	91224	91393	91508	91714	91768	
90846	91043	91129	91225	91394	91510	91715	91769	
90847	91046	91131	91226	91395	91521	91716	91770	
90848	91050	91175	91316	91401	91522	91722	91771	
90853	91051	91182	91324	91402	91523	91723	91772	
90888	91066	91184	91325	91403	91526	91724	91773	
90895	91077	91185	91326	91404	91601	91731	91775	
90899	91101	91186	91327	91405	91602	91732	91776	
91001	91102	91187	91328	91406	91603	91733	91778	
91003	91103	91188	91329	91407	91604	91734	91780	
91006	91104	91189	91330	91408	91605	91735	91788	
91007	91105	91191	91331	91409	91606	91740	91789	
91009	91106	91199	91333	91411	91607	91741	91790	

Contact CareMore Touch Member Services at: 1-800-589-3147 (TDD: 1-800-577-5586*) 5

*This number is for people who have difficulties with hearing or speech. You need special telephone equipment to use it.

Chapter 1

Our service area includes these parts of counties in CA: Orange, the following zip codes only

Orange County

90620	92655	92803	92838	92886
90621	92683	92804	92840	92887
90622	92684	92805	92841	92899
90623	92685	92806	92842	
90624	92701	92807	92843	
90630	92702	92808	92844	
90631	92703	92809	92845	
90632	92704	92811	92846	
90633	92705	92812	92850	
90680	92706	92814	92856	
90720	92707	92815	92857	
90721	92708	92816	92859	
90740	92710	92817	92861	
90742	92711	92821	92862	
90743	92712	92822	92863	
92605	92725	92823	92864	
92615	92728	92825	92865	
92626	92735	92831	92866	
92627	92780	92832	92867	
92628	92781	92833	92868	
92646	92782	92834	92869	
92647	92799	92835	92870	
92648	92801	92836	92871	
92649	92802	92837	92885	

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state that is still within our service area, you must call Member Services in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

If you plan to move out of the service area, please contact Member Services.

6 Contact CareMore Touch Member Services at: 1-800-589-3147 (TDD: 1-800-577-5586*)

Chapter 1: Getting started as a member of CareMore Touch

EVIDENCE of
COVERAGE

Los Angeles & Orange Counties 2011

H0544_101056A CHP EOC File & Use (10252010)
Contract Number H0544
AEOCLAOTCH11



CAREMORE
T O U C H
HMO SNP

Section 1.4 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how CareMore Touch covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in CareMore Touch between January 1, 2011 and December 31, 2011.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve CareMore Touch each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you are entitled to Medicare Part A
- -- and -- you are enrolled in Medicare Part B
- -- and -- you do not have End Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- -- and -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who live in nursing homes. To be eligible for our plan, you must reside in a nursing home or you are living in the community but require the same level of care as someone in a nursing home.

Please contact our customer service department at 1-800-589-3147 for current contracted facilities.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
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- Medicare Part B is for most other medical services, such as physician’s services and other outpatient services.

Section 2.3 Here is the plan service area for CareMore Touch

Although Medicare is a Federal program, CareMore Touch is available only to individuals who live in our plan service area. To stay a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these parts of counties in California: Los Angeles and Orange, the following zip codes only:

Orange County

90620	90721	92648	92706	92782	92811	92832	92844	92865
90621	90740	92649	92707	92799	92812	92833	92845	92866
90622	90742	92655	92708	92801	92814	92834	92846	92867
90623	90743	92683	92710	92802	92815	92835	92850	92868
90624	92605	92684	92711	92803	92816	92836	92856	92869
90630	92615	92685	92712	92804	92817	92837	92857	92870
90631	92626	92701	92725	92805	92821	92838	92859	92871
90632	92627	92702	92728	92806	92822	92840	92861	92885
90633	92628	92703	92735	92807	92823	92841	92862	92886
90680	92646	92704	92780	92808	92825	92842	92863	92887
90720	92647	92705	92781	92809	92831	92843	92864	92899

Los Angeles

90001	90009	90017	90027	90036	90044	90053	90061	90071
90002	90010	90018	90028	90037	90045	90054	90062	90072
90003	90011	90019	90029	90038	90046	90055	90063	90074
90004	90012	90020	90030	90039	90047	90056	90065	90075
90005	90013	90021	90031	90040	90048	90057	90066	90076
90006	90014	90022	90032	90041	90050	90058	90068	90078
90007	90015	90023	90033	90042	90051	90059	90069	90079
90008	90016	90026	90034	90043	90052	90060	90070	90080

Los Angeles (continued)

90081	90245	90311	90661	90806	91020	91129	91330	91501
90082	90247	90312	90662	90807	91021	91131	91331	91502
90083	90248	90313	90665	90808	91024	91175	91333	91503
90084	90249	90397	90670	90809	91025	91182	91334	91504
90086	90250	90398	90671	90810	91030	91184	91335	91505
90087	90251	90501	90701	90813	91031	91185	91337	91506
90088	90254	90502	90702	90814	91040	91186	91340	91507
90089	90255	90503	90703	90815	91041	91187	91341	91508
90091	90260	90504	90706	90822	91042	91188	91343	91510
90093	90261	90505	90707	90831	91043	91189	91344	91521
90094	90262	90506	90710	90832	91046	91191	91345	91522
90096	90266	90507	90711	90833	91050	91199	91346	91523
90097	90267	90508	90712	90834	91051	91201	91352	91526
90099	90270	90509	90713	90835	91066	91202	91353	91601
90101	90274	90510	90714	90840	91077	91203	91356	91602
90102	90275	90601	90715	90842	91101	91204	91357	91603
90103	90277	90602	90716	90844	91102	91205	91393	91604
90174	90278	90603	90717	90845	91103	91206	91394	91605
90185	90280	90604	90723	90846	91104	91207	91395	91606
90189	90291	90605	90731	90847	91105	91208	91401	91607
90201	90292	90606	90732	90848	91106	91209	91402	91608
90202	90293	90607	90733	90853	91107	91210	91403	91609
90220	90294	90608	90734	90888	91108	91214	91404	91610
90221	90295	90609	90744	90895	91109	91221	91405	91611
90222	90296	90610	90745	90899	91110	91222	91406	91612
90223	90301	90612	90746	91001	91114	91224	91407	91614
90224	90302	90637	90747	91003	91115	91225	91408	91615
90230	90303	90638	90748	91006	91116	91226	91409	91616
90231	90304	90639	90749	91007	91117	91316	91411	91617
90232	90305	90640	90755	91009	91118	91324	91412	91618
90233	90306	90650	90801	91010	91121	91325	91413	91702
90239	90307	90651	90802	91011	91123	91326	91416	91706
90240	90308	90652	90803	91012	91124	91327	91423	91711
90241	90309	90659	90804	91016	91125	91328	91426	91714
90242	90310	90660	90805	91017	91126	91329	91436	91715

Los Angeles (continued)

91716	91733	91745	91754	91768	91775	91790	91799	91896
91722	91734	91746	91755	91769	91776	91791	91801	91899
91723	91735	91747	91756	91770	91778	91792	91802	
91724	91740	91748	91765	91771	91780	91793	91803	
91731	91741	91749	91766	91772	91788	91795	91804	
91732	91744	91750	91767	91773	91789	91797	91841	

If you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

CAREMORE
 HEALTH PLAN

ISSUER: <(80840)> EFF. DATE: <XX/XX/XX>
 ID #: <XXXXXXXXXX> D.O.B.: <XX/XX/XX>
 MEMBER NAME: <XXXXXXXX XXXXXXXX>

RxBIN#: <XXXXXX> PHARMACY ID #: <XXXXXXXXXX>
 RxPCN: <XXXX>
 Rx Grp#: <XXXXXXXX>

PERSON CODE: <X
 <H0544> <PBP>

Medicare^R
 Prescription Drug Coverage

For verification of eligibility or benefits please call:
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 (for hearing impaired).

Please mail claims to: CareMore Health Plan
 ATTN: Claims Dept.
 P.O. Box
 Artes, CA 91702-0366

Provider Inquiries: 1-800-577-7011

Pre-authorization is required for all non-emergent hospital admissions. Please Call: 1-877-211-6653

PCP NAME:
 <XXXXXXXXXXXXXXXXXXXXXXXXXX, M.D.>
 PCP PHONE #: <(XXX) XXX-XXXX>
 IPA/MG: <med-grp>

PCP's do not authorize Inpatient/Hospital admissions.

OPHTH: <XXXXXXXXXXXXXXXXXXXXXXXXXX, M.D.>
 OPHTH PHONE #: <(XXX) XXX-XXXX>

COPAYMENTS:
 EMERGENCY ROOM: <\$XX> OFFICE VISIT: <\$XX>
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As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

From: [HPMS Web](#)
To: [Cindy Lynch](#); [Leeba Lessin](#)
Cc: [Cindy Lynch](#); [SNP Applications](#); [HPMS Helpdesk](#)
Subject: H0544 - SNP Conditional Approval - Institutional - Institutional (Facility) and Institutional Equivalent (Living in the Community)
Date: Friday, May 27, 2011 11:53:24 AM

May 27, 2011

Leeba Lessin
 Chief Executive Officer
 CAREMORE HEALTH PLAN
 12900 Park Plaza Drive
 Suite 150
 Cerritos, CA 90703

Re: Conditional Approval of SNP Application
 H0544 - CAREMORE HEALTH PLAN - Institutional - Institutional (Facility) and Institutional Equivalent (Living in the Community)

Dear Leeba Lessin:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has conditionally approved your organization's application to offer/expand a Special Needs Plans for 2012 Application and SNP Service Area Expansions posted in January 2011. This conditional approval includes any employer/union-only group waiver plan proposals (i.e., "800-series" plan benefit packages) submitted by your organization under the same application number.

The following are the overall scores you received for your Quality Improvement Program Plan and Model of Care evaluation:

Your Quality Improvement Program Plan passed.

Final Score

Element	Factor	Score
1	a	4
2	a	3
2	b	4
2	c	4
3	a	4
3	b	4
3	c	4
4	a	4
4	b	3
4	c	3
5	a	4
5	b	4
5	c	3
5	d	4
5	e	3
6	a	4
6	b	4
6	c	3
6	d	3
7	a	4
7	b	4
7	c	4
7	d	3

8	a	4
8	b	3
8	c	3
8	d	4
8	e	4
9	a	4
9	b	4
9	c	4
9	d	3
10	a	4
10	b	3
11	a	4
11	b	3
11	c	3
11	d	4
11	e	4
11	f	4

Element Summary

Element 1	4
Element 2	11
Element 3	12
Element 4	10
Element 5	18
Element 6	14
Element 7	15
Element 8	18
Element 9	15
Element 10	7
Element 11	22
Total Points	146
Total Possible Points	160
Score	91.25%

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.

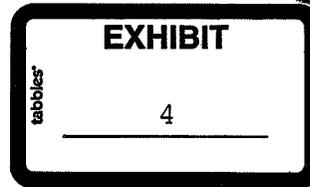
Please note that a SNP can only be offered in an MA-approved service area. If you have applied for a new MA-approved service area, approval of your new SNP or SNP SAE is contingent upon approval of the new MA service area. If your MA service area has not been approved due to unresolved deficiencies, 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



Purpose

The purpose of this Care Management Plan is to document the model of care for the Institutionalized population enrolled in CHP's I SNP, Touch.

Care Management Organization and Philosophy

CareMore started as a HealthCare System focused on the needs of the frail and chronically ill, especially patients with the most complex and costly diseases. It was not until later that CareMore became CareMore Health Plan (CHP) and applied for its license as a Special Needs Plan. From the onset, CHP has been organized and run with the goal of improving the health and well-being of patients.

- A team of employed clinicians are trained to care for frail and chronically ill patients. The team becomes the primary facilitator of care plans to ensure efficiency and continuity of services.
- Clinical Leaders continue to be involved in direct patient care and are committed to keeping the philosophy of CHP patient-oriented. They are responsible for the performance of CHP clinicians, network providers, and the entire community-based healthcare system.
- Clinical programs are premised on evidenced-based medicine. They are designed with well thought-out outcomes reporting for continuous quality improvement and then solidified using clinical protocols, measures, and training.
- All non-clinical Directors and above are required to participate in a clinical orientation, which includes exposure to interdisciplinary teams, interaction with clinical departments, and rounds with CHP clinicians.
- The clinical model continues to evolve because of innovative ideas from CHP's clinical team. Their involvement in healthcare delivery and its issues, combined with available CHP resources, empowers and inspires them to make improvements to the healthcare system.

CHP's "Philosophy of HealthCare" guides improvements to the clinical model and propels it forward. CHP believes:

- The frail and chronically ill require ***overtly coordinated*** care with a personal ***care plan*** that takes into account their multiple conditions and treats them ***simultaneously***.
- Providing ***care at a patient's home*** is required to create care coordination and a setting where care habits of patients can be sustained.
- Clinicians in key roles must be ***confident generalists***, persistent and deliberate, with competence as clinical decision makers, communicators and team players.
- All providers of service have a ***buy-in for the system of care***, not just their individual capabilities.

- A complete care continuum requires equal **attention to medical, social, psychological and pharmacological needs** of the patient.
- An **explicit approach to care** is required for each chronic condition, for high-frequency acute episodes, and for end-of-life.
- An **obsessive attention to detail** in both micro matters (individual care) and macro matters (care programs) permits optimal outcomes.
- A **willingness to thoughtfully challenge the status quo** provides windows of insight into clinical innovation and care pattern redesign, which can optimize patient health and comfort, and conserve financial resources.

An example of CHP's clinical model is how healthcare is delivered to members enrolled in CHP's institutional product, Touch. From the date a member enrolls in Touch, CHP's Touch members receive more care.

- When the member becomes effective with CHP's Touch product:
 - A NP is immediately assigned to assess and provide long-term care and case management services for the patient.
 - CHP' NPs are trained to:
 - Care and coordinate services for extremely frail patients with multiple complex medical and socio-economic conditions.
 - Bring resources to patients and their families and improve their quality of life.
 - Address end of life issues and hospice needs.
 - Within a month of the member's effective date:
 - The NP performs an initial face to face patient assessment and comprehensive physical exam, including a history & physical, review of medications, assessment using multiple screening tools (e.g. depression scale, mini mental status exam, pain scale), and review of advanced directives and codes status.
 - The NP will request medical records to gather additional information on the patient as needed.
 - The NP will arrange for any necessary mobile diagnostic testing and podiatry to be performed at the patient's nursing, assisted living, or board and care setting.
 - The NP also communicates with the family and/or durable power of attorney (DPOA), the Primary Care Physician, and facility staff to gather information, updates them on the plan of care, and serve as a point of contact regarding the patient's health status, issues, and needs.
 - Because of the initial assessment and comprehensive exam, the NP establishes the plan of care.
 - The plan of care may be reviewed by the Medical Director and assessed at regular Interdisciplinary Team meetings.
 - The plan of care continues to be reviewed regularly and as frequently as daily depending on the acuity of the patient. The frequency of NP visits is adjusted as the patient's condition changes.
 - The NP and/or Touch Medical Director will arrange for Specialists, as needed, to see the patient at a nursing home or living in the community

but requiring the same level of care as someone in a nursing home. In instances where the Specialist cannot see the patient in their home setting, the NP will arrange for transportation or the family to take the patient to their appointment.

- On an on-going basis:
 - The NP continues to see the patient, coordinates their plan of care, and arrange for needed services.
 - If a patient has an acute event, skilled need, or elective surgery:
 - CHP's Hospitalists will take over the care of the member while hospitalized and coordinate services.
 - CHP's Hospitalists work in close collaboration with the Touch Medical Director or NP to ensure continuity.

As a result of CHP's Touch Clinical Programs, CHP's readmission rate is 40% less than national averages. This is due to the teamwork, systems, rigor, and standardization that are part of CHP's clinical model.

Element 1: Description of SNP-specific Target Population

For this model of care, CHP is targeting patients that live in the assisted living, board and care, or group home setting with an institutional level of care. Our target population also includes institutional patients living in contracted and qualified institutional facilities.

The Community Based I-SNP

- The attributes of the community based patient living in the assisted living, board and care, and group home setting include:
 - Increasing need for 24/7 assistance and monitoring for such things as medication management, safety and fall prevention, and general care giving services
 - Significant physical and cognitive decline
 - Require assistance with multiple ADLs
 - Inability to thrive independently in the residential home
 - Complex medical management required

To address the unique attributes of this patient population, our model of care includes the delivery of many primary care services within their home settings. For the Institutional model of care, CHP is targeting patients that live in the nursing home care setting.

The Institutional Extended Care Facility Based I-SNP

- The attributes of the Extended Care Facility patient, or nursing home patient include:
 - A large percentage of custodial dual eligibles
 - Significant physical and cognitive decline
 - Require assistance with multiple ADLs

- Inability to live independently in the community setting, i.e. residential home or assisted living community
- complex medical management required

To address the unique attributes of this patient population, CHP contracts with nursing homes to assist in the delivery of our model of care. This population benefits from enhanced care through weekly nurse practitioner visits and additional benefits and services designed to address their needs.

CHP's model of care is largely driven by experience that these patients typically have many of the following conditions:

- Alzheimer's; Vascular, Senile and other forms of Dementia
- Clinical Depression
- De-conditioned
- Multiple Co-morbidities resulting in frailty and decreased function

Additionally a large population of these patients:

- Do not see their Primary Care Physician on a regular basis
- Have not been engaged in end of life planning
- Are not aware of the progression of their multiple disease processes
- Have difficulty accessing preventative services
- Have never been given true informed consent about their medical problems
- Have never had their families included in the plan of care

The typical provider network supporting these patients:

- Does not have a systematic way of intervening on patients to prevent admissions or readmissions, and to provide smooth care transitions
- Is not resourced or incentivized to keep patients out of the hospital (for example: Nursing homes frequently send patients with an acute change in condition to the hospital, rather than providing aggressive treatment at the bedside)
- Frequently does not address patients' severe psychosocial issues and/or non compliance
- Does not have coordination of specialty care

An example of this target population is one of our frail, elderly patients living in the community at an ALF who developed a vulvar mass and groin swelling. She was a very private woman and refused well-woman exams and health care maintenance. On examination, she had obvious cancer. Outpatient evaluation and eventual surgery was done at UCLA, returning back to her home, the ALF, for further outpatient treatment, which included radiation therapy. Informed consent was given every step of the way, and we simply matched the medical care desired with the medical care this patient actually received. Our patient predictably slowly deteriorated and eventually was transferred to a skilled nursing facility for IV fluids. During this SNF stay, the Member opted to go back home to her ALF with Hospice/End of Life Care. She died a few weeks later in her own home/ALF.



Every aspect of this example was coordinated by her treating Nurse Practitioner and the Touch Medical Director. Our goal of care is to truly become a part of the patient’s family, and you can see from this example that we did.

Element 4: Interdisciplinary Care Team (ICT)

CHP’s ICTs are dedicated to populations of patients with:

- Institutionalized patients
- High risk patient management (e.g. severe psychosocial issues, medically complex, end of life)
- Hospitalized and skilled level patients
- Chronic conditions

These teams continue to evolve under the leadership of CareMore Senior Medical Officers and Directors responsible for improving patient care.

For CHP’s population of Institutionalized members, the ICT includes:

- Nurse Practitioners
- Family Practice
- Care Managers
- Hospitalists
- Other Specialties as indicated (e.g. Mental Health, Podiatry, End of Life)

Element 4a:

The Touch ICT is led by the Touch Medical Director.

- CHP’s Touch ICT was determined based on the medical, psychosocial, and care transition needs of institutionalized patients. The composition of the ICT includes specialists that can meet those needs. For example, Mental Health providers were included to address the increasing behavioral issues noted with the progress of Dementia.
- The Touch ICT operates under clinical protocols based on evidenced based medicine with input from multiple disciplines (e.g. Cardiology, Endocrinology, Internal Medicine, Podiatry, etc.); these protocols are customized for Touch, however also use the expertise of CHP’s other chronic care (e.g. Diabetes Management) and frail programs.

ICT Member	Role
Nurse Practitioners	<ul style="list-style-type: none"> ▪ Perform initial and annual health risk assessments ▪ Bring in other ICT members as necessary ▪ Develop the care plan, by collaborating with other ICT members ▪ Management of chronic co-morbid conditions

ICT Member	Role
	<ul style="list-style-type: none"> ▪ Follow patients post hospitalization and update care plan as necessary ▪ Review and manage preventative services
Internist/Hospitalist	<ul style="list-style-type: none"> ▪ Manage hospitalized patients and develop discharge plans ▪ Consult with NP on difficult cases ▪ Assess and treat fall risk patients ▪ Perform case reviews, with NP Clinical Managers and NPs
Case Managers	<ul style="list-style-type: none"> ▪ Support Internist / Hospitalists ▪ Coordinate discharge plans ▪ Support Nephrologists and Dialysis Centers to coordinate urgently needed services
Home Health Therapists	<ul style="list-style-type: none"> ▪ Provide strength and exercise training, with programs tailored to patient specific needs
Ophthalmologists	<ul style="list-style-type: none"> ▪ Assess and manage patients visual needs
Social Worker	<ul style="list-style-type: none"> ▪ Assess and coordinate resources to support patient's psychosocial needs.
Registered Dietician	<ul style="list-style-type: none"> ▪ Educate patients and develop patient specific dietary plans
Podiatry	<ul style="list-style-type: none"> ▪ Assess and manage foot problems ▪ Provide protective foot wear
Mental Health	<ul style="list-style-type: none"> ▪ Assess and manage patient's clinical depression and other psychological needs.

Element 4b:

Based on our targeted population, it is physically challenging for patients to physically attend an ICT meeting. To address this, the plan of care is managed on an on-going basis by the Nurse Practitioners who visit the patients at their home or facility at least weekly and more frequently as needed. Another option is to meet with the patient and the family/DPOA onsite at their home with the appropriate ICT members, which may include Nurse Practitioner, Medical Director, Psychiatry, Social Worker, Case Manager, Facility Executive Director, Director of Nurses, and Wellness Coordinators through the Nurse Practitioner. Based on the results of the health risk assessment or as clinically indicated by the Nurse Practitioner, other disciplines will assess the patient (e.g. Mental Health will assess patients who are identified as depressed using a PHQ9 screening tool). The majority of a beneficiaries' interaction with the Touch ICT is face to face, however it is customized to the patient and may be telephonic as necessary. The Nurse Practitioner also works with patients and their families to educate them on their disease process and manage uncontrolled blood sugars, wounds, high LDL levels, and other complicating chronic conditions such as COPD.

CHP facilitates patient participation in the ICT by providing onsite meetings in the home setting with patient, family members, and clinical staff to review the plan of care. In addition clinical staff can offer telephonic options to join the ICT discussions, allowing patients and family members to participate who are unable to physically attend.

About 50% of our patients have cognitive impairment ranging from mild to severe. Our standard is to communicate with the family or DPOA on admission and with any change of condition. It is through this process that we include the patient and family through the ongoing ICT process.

Element 4c:

The ICT meets monthly to evaluate and review patients and oversee the performance of the Touch Program. Oversight of the Touch ICT is done using a team approach to evaluate performance and develop interventions and innovative care solutions through on-going assessment of quality results, clinical practices, and operational performance. In this role, the team:

- Assesses the Individualized Care Plans
- Reviews clinical program performance reports, case management statistics (if applicable), results of chart review processes, and the status of health risk assessments and care plans
- Evaluates clinical practice issues, and cost and utilization trends as appropriate; as an example, the team is assessing issues related to end of life care and hospice referrals
- Is responsible for the clinical protocols, including any additions and improvements resulting from new evidenced based clinical practice guidelines, nationally recognized protocols, and/or findings after assessment of the above
- Reports their progress to the Senior Medical Officers and Medical Directors who are ultimately responsible for the performance of the programs

The Clinical Coordinator is responsible for:

- Setting up and documenting the proceedings of the Touch ICT meetings; these meetings are calendared at the beginning of each year.
- Maintaining the meeting minutes, and disseminating them to the team via e-mail
- Making sure that all stakeholders have necessary reports. For example: the status of Health Risk Assessments is distributed to team members to make sure that all new enrollees receive an assessment timely.

CHP communicates with patients and family members regarding scheduling of ICT meetings through the NP during their weekly visits. Outcomes of the ICT meetings are communicated to the patient through the care plan and stored within the patient's chart.

The Touch ICT also works virtually using a variety of communication tools including Patient QuickView, Portal and Electronic Medical Record (EMR) Systems. These

systems communicate the patient's medical conditions and treatment needs, along with information on services being provided by all of CHP's providers (within and outside of the ICT). For example, Touch patient medications and active problem list are maintained in Patient QuickView (PQV); members of the ICT have access to PQV so they can understand patient's conditions and medications. Touch ICT members conference on difficult cases, and also regularly conduct random chart reviews to assess how the TOUCH ICT is performing.

Additionally CHP has an ICT, which is called the CareMore Intervention Team (CIT), dedicated to patients with severe psychosocial issues and end of life needs and ICTs for patients who are hospitalized and skilled level. These teams meet at a minimum of weekly to manage and assess the complex needs of these vulnerable populations. These teams are comprised of:

- Medical Supervisors
- Nurse Practitioners
- Specialists, if applicable
- Hospitalists, Board Certified in Internal Medicine
- Case Managers
- Mental Health Professionals
- Social Workers
- Other Professionals as needed (e.g. Dieticians)

These meetings are calendared at the beginning of the year by the Case Manager. This team has a census of patients that it works from, which is managed by the Case Manager and distributed to the team members prior to and during meetings; this census includes some high level details on the case. Additionally, specific details on the assessments and care plan for these patients is maintained in the Case Management System, CCA and EMR.

Element 7: Health Risk Assessment

Element 7a:

CHP uses a standardized HRA for its institutionalized SNP members, in order to assess members for all of their chronic conditions.

As part of the HRA process, standardized assessment questions, screening tools, guidelines and protocols are used to identify patients and determine appropriate interventions. For example:

- All institutionalized patients are automatically considered frail, and followed closely for monitoring, coordination and intervention.
- Screening for chronic conditions identifies patients requiring additional treatment for diseases such as: diabetes, chronic kidney disease, and osteoporosis
- Medical, functional, cognitive, and psychosocial needs are assessed through a:
 - Review of systems
 - Diagnostic tests

- Collection of medical and psychosocial history
- Functional assessment
- Medical exam
- and the following screens:
 - PHQ9 Depression screening identifies patients requiring treatment for depression; this screen asks patients to rate how often they are bothered by specific types of problems, such as: feeling tired or having little energy, thoughts that you would be better off dead.
 - A miniCog and MMSE screen identifies dementia; this screen includes several orientation questions, tests recall, tests attention and calculation, and language. .
 - Community Assessment Risk Screen (CARS) identifies patients with an increased risk for hospitalization; this screen scores hospitalization risk using the number of medications a patient is on, the history of hospitalization and emergency room usage, and the number of chronic and/or high risk conditions
 - A fall risk screen identifies patients at risk for falling and requiring additional assessment by CHP's Extensivists; this assessment includes asking patients information on their history of fall as well as assessing their gait and eye sight.
 - On site lab testing, including a comprehensive metabolic panel and if a patient is diabetic, also blood sugars and urine
 - A pain assessment scale identifies patients requiring additional treatment
 - A Barthel Index of Activities of Daily Living identifies patients with functional needs; for example: feeding, bathing, grooming.
- Nurse Practitioner protocols indicate the treatment protocols for each chronic condition, along with preventative service guidelines

Element 7b:

CHP believes that a face-to-face assessment provides the most thorough results and will achieve better outcomes and adherence to a care plan. The Touch NP will go to the patient's home or facility to perform the HRA. In instances when a member cannot provide the requested information to complete the HRA thoroughly, the POA is contacted to assist in completion, and/or information is gathered from treating clinicians, labs and medication data stored in CHP's Patient QuickView and Electronic Medical Records applications.

Due to the frailty of the Touch patients, each beneficiary is contacted by the Touch nurse practitioner for their initial Health Risk Assessment. While CHP has an internal goal of completing the HRAs within 30 days of enrollment, CHP also monitors to ensure compliance within 90 days and annually thereafter using reports produced by the Data Analytics team that mirror the requirements set forth as part of Part C Reporting requirements. Reassessment occurs regularly as the Touch NPs see these patients; CHP has a goal, which it monitors during its ICT meetings that Touch patients are seen weekly, which allows the Touch NP to regularly update the assessment and care plan.

Element 7c:

The NPs review, analyze, and stratify the health care needs of each patient. This is done using the HRA guidelines, validated screening tools (e.g. Barthel Index of Activities of Daily living) and clinical protocols that are part of the formalized NP Standardized Procedures. The ICT had input into the NP Standardized Procedures, to ensure the appropriate intervention is arranged for. For example: the Mental Health Team performs an additional assessment on patients:

- who score > 15 on the PHQ9 Depression screen
- score < 27 MMSE or
- who have a major psychiatric illness (e.g bipolar).

Touch nurse practitioners focus on the primary care of the member. These NPs are trained to care for patients under protocol, and also have access to the entire ICT who they consult with on cases. Other members of the ICT will also become involved as needs dictate, for example: pharmacists may be brought in to analyze drug interactions, evaluate polypharmacy and to determine if there are superior alternate therapies; a Cardiologist will be consulted on difficult cases, like unstable angina and CHF that is not responding despite optimal medical management.

CHP collects, analyzes and reports completion of Health Risk Assessments (HRA) regularly. All HRAs for institutionalized patients are performed as a face-to-face assessment at the patient's residence, assisted living, or board and care facility. In addition to the EMR, paper questionnaires are used in specific settings. In addition to being recorded in EMR, the paper HRA is maintained in the patient's chart.

CHP reconciles outstanding HRAs regularly through reconciliation and compliance reports; these are monitored for completion by management who follow up on outstanding HRAs. The Health Risk Assessment is evaluated at least annually to ensure that it covers critical elements of CHP's clinical programs.

Element 7d:

Members of the ICT, provider network and beneficiaries are notified of the results of the HRA through visit notes and care plans. The visit note is comprehensive and includes details on:

- Past medical / surgical history
- Social history
- Allergies
- Medications
- Review of systems – lists all positives
- Vital signs
- Lab results from a complete metabolic panel, and blood sugar testing if diabetic
- Physical exam of the eyes, ears, nose, throat, heart, lungs, vascular system, abdomen, extremities, orientation, balance & gait
- Health maintenance history

- Depression scale score
- Community assessment risk score
- Assessment and plan
- Education
- Referrals
- Other recommendations

They also receive a copy of the patient's care plan. Notes are faxed to Primary Care Physicians and stored in the Electronic Medical Records systems for ICT members to view. Beneficiaries are provided a copy of their Care Plan during a regular weekly visit by the NP; if the beneficiary is cognitively impaired, these Care Plans are also provided to the POA via mail or telephonically.

CHP continues to reassess members with:

- Uncontrolled chronic conditions (e.g. HbA1C > 8)
- Identified as being frail

Based on CHP's protocols or as deemed appropriate by one of CHP's Nurse Practitioners or Extensivitists.

Furthermore, CHP periodically runs reports to identify members who may benefit from more frequent monitoring. For example, members are identified with HbA1c > 8 (which indicates uncontrolled diabetes), members on Coumadin or Warafirin who are not being monitored, COPD patients who are not being seen regularly by a Pulmonologist. Institutionalized patients are reassessed frequently during the Nurse Practitioner visits. At that time, additional interventions may be identified. Additionally, if an institutionalized patient becomes hospitalized, CHP's Medical Director gets involved to ensure the transition and continuity of care occurs smoothly.

Our model of care specifically communicates with the DPOA/family member after the initial evaluation monthly and any change of condition. This is communicated to the Medical Director, Lead Nurse Practitioner or DPCS, and PCP. The treating Nurse Practitioner communicates ICT results to the facility to ensure proper implementation of the plan of care.

Element 8: Individualized Care Plan

Element 8a:

Every new institutionalized patient is assigned to a Touch Nurse Practitioner at the beginning of their enrollment month. Individualized Care Plans are developed with the patients and their care givers. The Care Plan is created after the Health Risk Assessment is completed, along with the patient vitals, labs, and history & physical. The patient and Touch NP jointly review the HRA results and develop the Care Plan to meet the specific needs of a patient considering the patient specific barriers, preferences and limitations (e.g. cultural), care giver resources available, etc. For

example, a patient experiencing episodes of urinary incontinence will be referred to the incontinence program to receive education and treatment for the underlying problem as well as incontinence supplies as appropriate.

The Touch provider is required to complete their patient's initial plan of care during the first 90 days the member is effective with CHP, after they complete the HRA. The initial plan of care is developed with the Touch Medical Director and discussed with the ICT. The patient is given a copy of their Care Plan after completion of the HRA.

Element 8b:

The Individualized Care Plan includes elements like:

- Diagnostic test results, along with goals for these results and when the next test is due. This includes results for common conditions as well as specific co-morbidities, for example: each Touch patient will have a Care Plan with LDL test results, goals, and next test due dates but only patients with Diabetes will have a Care Plan with Hb A1C test results, goals, and next test due dates.
- Preventive screenings like mammography and colonoscopies, when they were last done and the next due date.
- Medications, their dosages and the reason for taking.
- Immunization history and needs
- Individual goals for things like how and when to access the Touch nurse practitioner; there also may be individual goals for co-morbid conditions, for example: if a patient has COPD, they may be given breathing exercises to follow at home.
- Nutrition and Health Management guidelines for things like what type of diet to follow and symptoms to watch for, along with what to do if the patient experiences these symptoms.
- Referrals and additional benefits and services to access (such as the incontinence program), and when the next scheduled follow up is with the Touch NP.
- A sickness plan.
- Other recommendations.
- Note: as part of CHP's End of Life Initiative being developed in 2011, a more robust End of Life Care Plan will be included.

Element 8c:

CHP Touch NPs develop and review the Individualized Care Plans and involve the Touch ICT based on the needs of the patient. The care plan is revised and updated based on the assessment of the NP with each visit.

- The Touch NP uses the Health Risk Assessment and Nurse Practitioner guidelines that protocolize what should be in the care plan and when to involve other members of the ICT. A follow-up visit is scheduled weekly. For example:

- The Mental Health Team is involved when a member scores > 15 on a PHQ9 Depression Screen and the Podiatrist will be involved if the patient has a foot condition that needs to be assessed or treated.
- Patients with ulcers will be scheduled to be seen by the NP and home health for wound management, and could be followed up as often as daily, depending on the severity of the wound or if the patient is unable to care their wound.
- Patients with CHF, with a New York Heart Association Functional Class of IV will be followed up regularly by the NP.
- Patients with COPD will be followed according to protocol based on their COPD functional class, for example stage IV will be reviewed monthly.

The previous care plan will be reviewed, updated with new information, and revised to incorporate any new needs. For example: a member, who has fallen, may need an assistive device and strength training.

CHP measures the development of the Individualized plan of care by monitoring care plan completion and Nurse Practitioner activities during regular Interdisciplinary Care Team (ICT) Meetings that assess CHP's Touch (Institutionalized) population of members. The ICT also monitors the details of the plan of care for patients who are not progressing toward goals.

The NP continues to follow the patient regularly and updates the plan of care as necessary. Issues requiring ICT collaboration are discussed during on-going ICT meetings. The plan of care is maintained in the patient's chart as part of the HRA visit note. Patients, or their DPOA, are provided a copy of their Individualized Care Plan.

Element 8d:

A copy of the patient's Individualized Care Plan is retained by CHP in the patient's chart and a copy is forwarded to the patient's PCP. CHP will be working towards communicating patient goals through its Patient QuickView system, which is available to all contracted and employed providers, in the future. A patient's Individualized Care Plan is updated as least annually, and more as clinically indicated. A copy of the Individualized Care Plan is provided to the patient or DPOA when completed.

CHP's Chief Information Officer and Vice President of Clinical Operations oversee protection of documentation and maintenance of records. This is done through Policies and Procedures and back up procedures for clinical data. For example, CHP's IT's Preservation backup and restoration policy provides the process protocol for ensuring our data is protected and recoverable for enterprise applications such as EMR (NextGen). This policy, DS4.9 Backup and Restoration Policy, includes the following guidelines:

- Backup scheduling includes frequency and types of backups (Incremental, differential, and Full)
- Automated data retention tools such as NetBackup, BackupExec, and Commvault for Backups of CareMore databases / filesystems.
- Backup Status reports.
 - Offsite storage routing to Archive America for retention.
 - Offsite Encryption policy for offsite storage.
 - Offsite Retention period of 10 years.

CHP continues to strive to improve the care plan process for its patients. In 2010, CHP's Touch Program incorporated best practice protocols from CHP's chronic illness and preventative clinical programs (e.g. fall prevention, diabetes). We are currently:

- Upgrading the Electronic Medical Records system to support additional HRA and care plan elements.
- Evaluating alternative ways to communicate the care plan to patients and their PCPs.

Element 8e

CHP communicates with patients and family through the NP during their weekly visits. Plan of care and any care plan revisions are communicated to the patient through NP and stored within the patient's chart.

The Care Plan can be accessed by the Touch ICT, MAO and pertinent network providers using a variety of communication tools including Patient QuickView, Portal and Electronic Medical Record (EMR) Systems. These systems communicate the patient's medical conditions and treatment needs, along with information on services being provided by all of CHP's providers. For example, Touch patient medications and active problem list are maintained in Patient QuickView (PQV); clinicians have access to PQV so they can understand patient's conditions and medications. In addition the Nurse Practitioner coordinates and collaborates care with the beneficiary, the ICT, MAO, and pertinent network providers.

The ICT has access to the care plan:

- A CHP employee or contracted specialist will access the care plan directly in CHP's EMR; this information is populated when the provider accesses a patient's medical record.
- Network providers receive this information via faxed after the health risk assessment is completed annually.

For example:

- Mental Health professionals have access to screening results.
- Hospitalists and case managers can view results of all labs, physical exam, and assessments.

- PCPs are provided with a complete summary of medications, lab results, screening results, etc. and the full care plan.
- The NP may contact a provider directly if a patient is high risk and there is a problem in the HRA that they want to address immediately. For example: they may call the Mental Health Provider if a patient has uncontrolled agitation that is not responding to medication.

Patients are able to access their Care Plan through the facility medical record, or a copy is mailed directly to the patient. The patient's specific needs are captured in the care plan, and are reviewed with the patient verbally by the NP during the HRA visit. For example:

- Lab results will be reviewed with the patient, and goals will be discussed if they are not within range.
- The NP will review the preventative services needed, like flu and pneumonia vaccines and administer them as appropriate.
- The NP will review their medical conditions, and the plan of care to address them, including referrals.
- The NP will review self management goals to make sure the patient and care giver understand the goals and reinforce their importance.

CHP continues to strive to improve the care plan process for its members. In 2010, CHP:

- Added infrastructure to the chart review process to conduct more rigorous assessment of patients who are not making progress towards improving their condition
- Enhanced member surveys to obtain feedback from members on CHP's care plan process
- Enhanced clinical systems to communicate patients Individualized Care Plan goals

Element 9: Communication Network

CHP has many communication tools to communicate amongst the plan, providers, beneficiaries, and public and regulatory agencies.

Element 9a & c:

CHP's communication network is overseen by CHP's Medical Officers and Information Technology Department to evolve clinical systems. CHP has made significant investments in its clinical systems over the past 3 years, and has deployed this technology to employed clinicians, network providers and case managers. These communication systems facilitate access to health information, coordination of care, and improvements in access and utilization of services.

Meeting communication networks include:

- Face to face meetings

- Web based technology – CHP is using this technology to deploy many of its training initiatives.
- Video conferencing - for example: many of CHPs Neighborhood ICT meetings are conducted using video conferencing so Medical Officers from the home office in Cerritos can participate and provide feedback.
- Audio conferencing technology - Hospitalists, Medical Officers and Case Managers use audio conferencing on a daily basis to review the cases and develop the care plan for hospitalized patients.

The technologies to support meetings were deployed over the last 3 years. Meetings are preserved in documented meeting minutes. The meeting minutes are stored on CHP shared drives to access in the future as evidence of care. For example: the ICT meetings are documented in meeting minutes; after the meeting the minutes are distributed to the participants via e-mail and a copy is retained on a shared drive in a folder dedicated to that ICT.

Clinical systems include:

- Portal for service requests (authorization) and clinical quality reminders
 - All physicians are on line with CHP using an application called “the portal”
 - The portal supports:
 - Services requests for authorizations, and communication of their determinations by CHP.
 - Secure e-mail messaging between CHP and the physicians, and among the physicians themselves.
 - Clinical quality reminders for 20 different preventative tests/procedures or treatment recommendations.
 - This includes reminders of when preventative tests are due, like mammographies and colonoscopies.
- iPhone Technology for e-mail and cell phone communications between CHP employed clinicians and support staff.
 - Every CHP clinician is issued an iPhone for communication with other CHP staff.
 - CHP’s IT Department is working with the clinicians to evolve this technology to include access to medical databases of patient information and evidenced based medicine protocols.
- Clinical Care Advance (CCA) for case management programs and outreach programs.
 - CCA is a Trizetto system that is customized by CHP to support its clinical model
 - Case Management uses this system to manage hospitalized patients, coordinate care transitions, ensure consistent post discharge follow-up (phone calls, appointments, etc.), and follow high-risk patients. The system:
 - Stores nursing notes on hospitalizations, CHP’s discharge plan, and follow up care.
 - Queues the case managers for the appropriate level of follow-up and timeframe, and tasks activities between case managers.

- Additional clinical programs are currently being added to CCA, including CIT and more outreach programs.
- Electronic Medical Records (EMR) for employed clinicians charts (implementation planned for Touch in 2010).
 - EMR is a NextGen system that is customized by CHP to support its face to face clinical programs
 - CHP clinicians use this system as the common patient chart, which assists in communication of clinical data and care plans for patients enrolled in various CHP clinical programs
 - EMR supports on line lab ordering, e-prescribing and chronic condition tracking
 - CHP customized templates within EMR to follow developed protocols and ensure consistent care
 - EMR automatically documents the staff member's identification and the date and time of the interaction with the member.
- Patient QuickView for centralized viewing of member data by CHP employees and Network Physicians.
 - Patient QuickView is an internet application developed by CHP to store clinical data in a central repository from multiple systems, including filled prescriptions, lab values, enrollment, demographics, claims history, authorization data, clinical reminders, and transportation.
 - This repository provides clinicians with health information provided by all treating providers who work with CHP, which provides a wealth of information on the care being provided to their patients.
 - Patient QuickView is used by CHP clinicians and contracted PCPs and specialists.
 - This application also facilitates the ICTs by providing all team members with access to the medications, lab results, lab fills and missed fills, treating providers, and chronic conditions of all CHP enrollees. This application will evolve to include care plan goals in the future.
 - The deployment of Patient QuickView continues to evolve and will be deployed to Emergency Departments in 2010 to improve access to crucial patient health information.
- CareMore website (development in process for provider portion)
 - CHP's clinical model from both the physician and office staff's perspective.
 - Clinical programs and how they work.
 - Access to clinical support services (e.g. case management)
 - Physician newsletter
 - Provider manual
 - Forms
 - News and updates
 - Orientation materials
 - Contacts
 - Upcoming member events and communications
 - This website will continue to evolve.

All CHP systems are backed up to preserve the information as evidence of care, via IT's Preservation backup and restoration policy provides the process protocol for ensuring our data is protected and recoverable for enterprise applications such as EMR (NextGen). This policy, DS4.9 Backup and Restoration Policy, includes the following guidelines:

- Backup scheduling includes frequency and types of backups (Incremental, differential, and Full)
- Automated data retention tools such as NetBackup, BackupExec, and Commvault for Backups of CareMore databases / filesystems.
- Backup Status reports.
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 - Offsite Encryption policy for offsite storage.
 - Offsite Retention period of 10 years.

Element 9b:

These systems connect the plan, providers and members by giving access to information so they can coordinate on patients needs, understand the care being provided by others, and understand how CHPs benefits and services can best benefit the patients. For example: by looking at Patient QuickView, any provider can view all of the medications filled by a patient and prescribed by other providers. They also can view all of the diagnostic tests ordered, and the results of lab tests; this often results in diagnosing a patient quicker and thereby improving the quality of care; it also prevents redundant tests from being ordered, thereby preserving benefits for all members.

For example, providers are connected through:

- Patient QuickView, any provider can view all of the medications filled by a patient and prescribed by other providers. They also can view all of the diagnostic tests ordered, and the results of lab tests; this often results in diagnosing a patient quicker and thereby improving the quality of care; it also prevents redundant tests from being ordered, thereby preserving benefits for all members. This is especially useful when a member is hospitalized; for example the provider can tell that an echocardiogram was provided and call to get a copy of the results rather than wait to perform another test.
- EMR, members of the ICT can view all patient assessments and medical records and contribute to a common patient care plan. For example: the Case Manager can look up the past assessments a member had to give information to the Hospitalist seeing the patient in the hospital a better picture of their health conditions; they may, for example, not know a patient has a past history of heart attacks.
- CHP's website, providers have access to information on patient benefits and CHP services.

Members are connected via various means, such as:

- Member events hosted at various facilities, for example Nutritional and chronic disease education sessions; during these sessions, members learn more about topics that are crucial to their disease states and can ask members of the ICT questions relevant to their health.
- CHP member portal
- Post enrollment kits, which review benefits and how to access services. For example: members can get assistance with getting their prescriptions filled.
- Their annual care plan, which is provided after their HRA assessment. This is a record of the benefits and services as well as the goals for their care, which they can use as a reference.

All of this information is then available to regulatory agencies when they need information from CHP as evidence of care (such as appeals) or to support other regulatory activities.

Element 9d:

CHP's Model of Care Training and Communications team has oversight responsibilities for the monitoring and evaluating the effectiveness of the model of care. This team includes staff from Clinical Operations, Provider Network, Sales, Member Services and Product. This team evaluates feedback gathered from CHP's clinical leaders, including Medical Officers/Directors and Clinical Directors, along with Provider Network Directors and General Managers and incorporates it into new and updates to communications. Monitoring occurs through a variety of forums, including: periodic audits, feedback from providers, and regular review of clinical program communication materials, systems and tools.

CHP's General Manager hosts a Physician Advisory Committee to get feedback and improvement ideas on communications; for example:

- Pharmacy reports – feedback was incorporated from the committee into a redesign.
- CHP's wireless monitoring (blood pressure and weight (for CHF)) reports – again feedback was incorporated from the committee into a redesign.
- Communications from the Hospitalists to PCPs regarding admissions – the committee was queried on the best method to communicate with PCPs to validate that CHP's current protocol was working
- Also, there is a general query of this committee every meeting to identify additional areas for improvement.

Medical Officers/Directors are in regular contact with community PCPs, specialists and facility personnel to ensure proper communication on a daily basis; for example to:

- Obtain feedback on how the ICT is working with them.
- Answer any questions they have on the model of care.
- Find out if the communications are helping them to take care of patients.

These Medical Officers/Directors work in CHPs neighborhoods so they are able to work with the local ICTs and provider network teams to resolve any needs immediately and forward updates to materials to the Model of Care Training and Communications team.

Provider Network Directors host small neighborhood meetings with organized provider groups at a minimum of quarterly; in these meetings:

- Communications and reports are reviewed, so providers can clarify any questions on the information real time.

Provider Network Directors and their staff are also available to answer questions 1 on 1 with providers. They will forward any feedback to the Model of Care Training and Communications team if they find materials that need to be revised.

A formal survey is planned to be distributed to providers mid-year 2011.

Member Services and Sales representatives of the Model of Care Training and Communications team will bring feedback from their departments to the team for evaluation. This includes information gathered from Sales and Member Services interactions with members and prospects, as well as Member Surveys.

New communications describing benefits and services to beneficiaries are submitted to for feedback and approval by regulators prior to use.

Element 10: Care Management for the Most Vulnerable Subpopulations

All institutionalized patients are considered vulnerable beneficiaries or “extremely frail” patients under CHP’s clinical model.

Element 10a:

CHP identifies vulnerable beneficiaries or “frail and chronically ill” patients in several ways:

- Based on stratification from the Health Risk Assessment and physical exam, as well as several screening tools. For example, fall risk screens, depression screens, and activities of daily living screens identify at risk patients.
- All ESRD, CHF, COPD patients on oxygen and Institutionalized members are considered vulnerable and closely managed by NPs.
- From referrals by PCPs and CHP Clinical Programs
 - PCPs are both trained on and incentivized to refer their patients into CHPs programs for patients who are frail and with chronic conditions. A PCP report card is produced which shows the participation levels of each PCPs patients based on their qualification for each program (e.g. % of Institutionalized patients being managed by a CHP Touch NP; % of Coumadin patients being

managed by CHP's Coumadin program); the purpose of this Report Card is to engage PCPs in getting patients enrolled in the programs.

- As a result of hospitalization by CHP Extensivists. At the time of discharge, the Extensivist (Hospitalist) designates a patient as being Red, Yellow or Green; the Red patients are the most vulnerable and require more intensive follow up by the Touch nurse practitioner and the Case Manager.
- Through data queries (e.g. HbA1c > 8, members on Coumadin, COPD members not accessing Pulmonary Care) that identify members who are not being managed. The results of these data queries are provided to an "Outreach Team" in Case Management. Members with these at risk conditions, who are not participating in CHP's clinical programs, are contacted and enrolled; if they refuse to enroll, the member's PCP is contacted and asked to work with the patient to enroll them in the program.
- By performing case reviews on patients with readmissions and frequent emergency room visits. This is done in the monthly Touch ICT meetings. The teams are provided with lists of readmitted patients and those with > 3 emergency room visits during the year; the Case Manager, along with the Regional Medical Officer/Director reviews these lists and the entire team evaluates whether there is an appropriate care plan.

Element 10b:

Because of the frailty of institutionalized patients, under CHP's clinical model they are provided with the following additional services and benefits to meet their needs:

- CHP Clinical programs for institutionalized patients (including: on-site delivery of services such as rehab, labs, X-rays, podiatry, etc.).
- Regular NP visits for management of chronic conditions and frailty; these visits are a minimum of weekly and more frequently for patients with multiple hospitalizations and at risk conditions (e.g. wounds that are slow to heal)
- 24 hour access to a Nurse Practitioner; NPs are available to patients to answer any of their questions and help guide them if they are experiencing symptoms. Every Touch patient and care giver is given this phone number as part of their care plan.
- Clinical programs for patients admitted to the hospital (including Hospitalists/Extensivists and case management services).
- Clinical programs for frail and medically complex patients; e.g.
 - Acute hospitalization and SNF management by CHP Hospitalists/Extensivists. CHP Hospitalists/Extensivists round on patients in inpatient and skilled settings to oversee their hospital stay, as well as ensure they are connected to CHP's model of care at the time of discharge. The CHP Hospitalist/Extensivist also sees the patient after discharge until the patient is clinically stable and all outpatient follow up is complete.
 - Fall prevention by CHP Hospitalists/Extensivists; when patients have fallen or at risk for falling, a CHP Extensivist performs a comprehensive assessment of their medications, gait, and eye sight to identify and resolve any contribution

- factors to their falling. As a result of this assessment, patients are often prescribed assistive devices, and/or referred to strength training programs.
- Anti-coagulation monitoring; this program runs out of CHP's CareMore Care Centers. Patients Coumadin levels are monitored, as frequently as several times a week, and adjusted until their INR level stabilizes within range.
 - Mental health program; CHP has psychiatrists, therapists, and mental health NPs who address mental and substance abuse issues in a coordinated fashion.
 - Specialized Strength Training Programs; CHP has strength training programs run by Fitness Instructors specially trained in geriatrics and chronic conditions including: ESRD, Heart Disorders, COPD and Back Pain. As part of these programs, patients are provided a customized Fitness Program, using equipment specially designed for seniors and frail patients, tailored to their individual needs. This program is different than Fitness Center memberships designed for seniors; it is focused on developing strength, mobility and stability for patients. It also has exercises designed for specific chronic conditions that improve functioning, as well as monitor patients while exercising.
 - CareMore Intervention Team support for patients with complex psychosocial issues. This is an Interdisciplinary Care Team of Medical, Mental Health, Social Workers, and Case Managers who collaborate and intervene on patients with the most severe psychosocial issues; they have been successful in improving patient outcomes and compliance using a variety of tactics including: placement, coordinating with community resources, and addressing elder abuse.
 - Additionally, institutionalized patients are provided with expertise, assessment tools, protocols, and monitoring of outcome and health status measures supporting CHPs chronic SNPs, and clinical programs (e.g. diabetic care, hypertension management, and congestive heart failure monitoring).
 - Specially designed benefits for this population (e.g. home health services, over the counter products, affordable generics, Caregiver on-line resources, incontinence program).

In 2011, CHP has several clinical initiatives geared at further enhancing the services provided to vulnerable beneficiaries. These include:

- An End of Life Care Program being designed to provide differing tiers of services based on patient need
- A Clinical Program Variability Reduction Initiative focused on CHP's clinical intervention on populations of patients with Diabetes, CHF, ESRD, and those who are hospitalized.
- A pilot program for Dementia patients and their families
- A pilot program using predictive modeling software to identify high risk patients that are not currently involved in CHPs programs for patients who are frail

CHP's entire clinical model is designed to support frail and chronically ill patients by providing:



- Proactive Intervention: integration and coordination of care that fosters compliance.
 - Intimacy of Contact: to manage complexity which requires constant knowledge of the patient's condition.
 - Speed of Action: resources available and mobile to adequately intervene.
- The clinical programs, along with the staff and processes supporting them (e.g. staff roles, ICTs, measurements of the clinical model measurements), are designed with the above goals in mind. CHP selected these goals because it is a competency that is largely missing from today's healthcare system, and CHP believes that this focus will have the greatest impact on the health and well-being of its patients.