Master List of Linkage Lab Organizations' Contracts with Health Care Payers/Providers

FIRST LINKAGE LAB COHORT

Health Care Payer/ Provider	Criteria Used to Evaluate CBO	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
BAY AREA COMMUNITY SERVICES						
Alameda Alliance Health Plan	Utilization of emergency services based on baseline and after treatment	1 year with annual renewal	Medical respite (recuperative care beds for homeless adults exiting an in-patient acute care hospital stay who need more time to recover, off the streets), care coordination, and discharge meal program	100 clients in Alameda County; dual eligibles, homeless, high-utilizers	Fee-for-service (Fixed price per bed for set number of beds per year)	Contract ended Renewal under discussion
Sutter Hospital/ LifeLong Medical Care	Utilization of emergency services first 30 days post-in-patient discharge	1 year with annual renewal	Medical respite (recuperative care beds for homeless adults exiting an in-patient acute care hospital stay who need more time to recover, off the streets), care coordination, and discharge meal program	50-100 homeless clients at Sutter Hospital Alameda County	Fee-for-service (Fixed price per bed for set number of beds per year)	Implemented Negotiations are in progress to expand program

First Linkage Lab Cohort (Continued)

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CAMARILLO HEALTH CARE DISTRICT						
National managed care organization	Proven track record of established programs to reduce avoidable health care utilization of high-risk members	Ongoing	Case management, care transitions, health promotion self-management programs	Approximately 50 adult health plan members with complex chronic conditions	Fee-for-service	Implemented
Centers for Medicare & Medicaid Services (CMS) Community Care Transitions Program	Existing transitional care program in place; partnership or relationship with hospitals	18 months	Coleman Care Transitions Intervention	3,127 fee-for- service Medicare beneficiaries	Fee-for-service	Contract ended
Accountable Care Organization	Proven track record of established programs to reduce avoidable health care utilization for high risk patients	6 months	Coleman Care Transitions Intervention® pilot	63 Medicare beneficiaries	Fee-for-service	Contract ended
Medicaid Managed Care Organization	Proven track record in a specific hospital to reduce avoidable health care utilization of high-risk members	12 months	Coleman Care Transitions Intervention®, 30-day extension for complex cases, health promotions self-management program	Approximately 240 Medi-Cal members	Fee-for-service	Implemented

First Linkage Lab Cohort (Continued)

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Camarillo Health Care District – continued						
CMS Quality Improvement Organization	Proven track record for delivering high quality health promotion program outcomes and managing a network of providers	12 months	Diabetes education and empowerment health promotion self-management program	Approximately 250 Medicare eligible adults	Fee-for-service	Implemented
INSTITUTE ON AGING						
Kaiser Permanente	Geographic presence; service offerings	17 months	Community connector that would link identified Kaiser members to local community-based resources	40-60 members per month in San Francisco and Marin Counties; identified via a triage process to be at risk for high health care utilization (e.g., emergency room)	Monthly fixed fee	Contract ended
Health Plan of San Mateo (HPSM)	Formal RFP process	4 years	Intensive care management services (skilled nursing facility to home), coordination of services and waivers, management of referrals and assessments	Estimated 875 seniors and persons with disabilities in San Mateo County who have Medi-Cal only, as well as some with CareAdvantage/Cal MediConnect; mostly persons transitioning out of nursing facilities, but also some who need services and supports to remain in their homes	Year 1: Cost plus margin Years 2-4: Cost plus performance incentives	Implemented

First Linkage Lab Cohort (Continued)

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Institute on Aging – continued						
Sutter Health	Demonstrated experience administering Program of All-Inclusive Care (PACE) sites	3 years	Management consulting services to PACE programs with the goal of improving overall operations, financial outcomes, and quality of care	Two PACE centers serving 275 clients	Fixed monthly fee plus incentive	Implemented
Inland Empire Health Plan	Reference from Health Plan of San Mateo (HPSM)	3 months	Consulting regarding needs assessment and recommendations for developing program similar to Institute on Aging program with HPSM	Stakeholder engagement, internal and external subject matter experts, county partners	Fixed fee	Implemented
JEWISH FAMILY SERVICE OF LOS ANGELES						
Health Net	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	1 year	Psychosocial assessment, care plan and care plan implementation, and case management services	Older adults, complex case management	Fee per episode of care	Implemented
Care1st Heath Plan	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	1 year	Psychosocial assessment, care plan, and case management services	Older adults with complex case management needs	Fee per episode of care	Implemented

First Linkage Lab Cohort (Continued)

Health Care Payer/ Provider	Criteria Used to Evaluate CBO	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
Jewish Family Service of Los Angeles – continued						
Anthem Blue Cross	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	1 year	Assessment and case management services	Older adults with complex case management needs	Fee per episode of care	Implemented
L.A. Care	Ability to provide mandated assessments in the required time frame	1 year	Eligibility assessments for Community-Based Adult Services (CBAS)	200 members annually	Fee-for-service	Implemented
L.A. Care	Ability to provide assessments in the required time frame	1 year	Health risk assessments	At-risk plan members	Fee-for-service	Implemented
L.A. Care	Ability to handle complex case management for older adults and people with disabilities in a cost-effective manner	1 year	Psychosocial assessment, care plan, and case management services	Plan members with complex social-economic needs, for example, mental health disorders, homelessness, no financial resources	Fee-for-service	Implemented
L.A. Care	Ability to provide information and referrals	1 year	Case management (information and referrals)	Plan members with unmet needs	Fee per episode of care	Implemented
Center for Medicare and Medicaid Services (CMS)	Ability to provide evidence-based care transition services through partnership with hospitals	1 year	Care transitions services	Medicare fee-for-service patients being discharged from hospitals, at risk for re-admission; 3,300 patients served annually	Capitated payment per beneficiary	Contract ended

First Linkage Lab Cohort (Continued)

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Jewish Family Service of Los Angeles – continued						
CMS and Cedars-Sinai Medical Center	Ability to provide evidence-based care transition services through partnership with hospitals	1 year	Expand care transition services to patients discharged from Cedars-Sinai Medical Center	Medicare fee-for-service patients discharged from hospital, at risk for re-admission	Capitated payment per beneficiary	Contract ended
Cedars-Sinai Medical Center	Ability to provide warm handoff and anchor patients in the community	1 year	Behavioral Health Transition Care Navigator pilot	Annually, 100 older adult hospital patients with psychiatric diagnosis who need connections to community resources	Cost reimburse-ment	Implemented
Comprehensive Community Health Centers	Ability to provide consultation and direct services that will achieve greater integration of services	2 years	Behavioral health and community social service case management for patients at four FQHCs; integration of primary care, behavioral health, and social services	Patients at four clinics who need linkages to community resources to help achieve medical stability	Program rate plus additional fee for patients who receive case management	Contract ended
St. Francis Medical Center and St. Vincent Medical Center	Ability to provide care transition services for patients discharged from the hospital with chronic health conditions	Month-to-month	Pilot post-discharge services	Dual eligible Medi-Cal/ Medicare patients at high risk for readmission, with chronic health conditions	Hourly rate with a cap on hours	Contract ended

First Linkage Lab Cohort (Continued)

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Jewish Family Service of Los Angeles – continued						
California Hospital, UniHealth Foundation	Ability to address unmet social-economic needs through case management and support	3 years	Behavioral health transition care and community-based care management	Hospital patients with complex social-economic needs, for example, mental health disorders, homelessness, no financial resources	Cost reimburse-ment	Implemented
SynerMed	Ability to address unmet social-economic needs through case management and support	1 year	Assessment, care planning and case management	Plan members with complex social- economic needs, for example, mental health disorders, homelessness, no financial resources	Cost per episode of care	Implemented
SILICON VALLEY INDEPENDENT LIVING CENTER						
Santa Clara Family Health Plan	Only Independent Living Center in the county with track record of successful transition from skilled nursing facilities, acute care, and sub- acute care to home	1 year with annual renewal	Care coordination and nursing home transition and diversion services	Older adults and people with disabilities residing in nursing home; high utilizers of urgent care and hospitals	Fee-for-service	Implemented
Anthem Blue Cross	Only Independent Living Center in the county with track record of successful transition from skilled nursing facilities, acute care, and sub- acute care to home	1 year with annual renewal	Care coordination and nursing home transition and diversion services	Older adults and people with disabilities residing in nursing home; high utilizers of urgent care and hospitals	Fee-for-service	In development

First Linkage Lab Cohort (Continued)

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ST. PAUL'S SENIOR SERVICES						
Care1st	St. Paul's offered comprehensive post-acute care	1 year with annual renewal	All social and medical post-acute care for 30 days; could be extended to 60 days if approved by Care1st	Over age 55, medically frail, with limited social supports	Package for set level of care, or individual services as requested by Care1st team	Never implemented

SECOND LINKAGE LAB COHORT

Health Care Payer/ Provider	Criteria Used to Evaluate CBO	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
ASIAN AMERICANS FOR COMMUNITY INVOLVEMENT						
Santa Clara Family Health Plan	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Integrated primary care and behavioral health for patients at our Federally Qualified Health Centers (FQHCs) at two locations	Patients with mild to moderate mental health diagnoses	Medi-Cal / Medicare rates for services rendered	Implemented
Santa Clara County Valley Health Plan	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Integrated primary care and behavioral health for patients at our FQHCs at two locations	Patients with mild to moderate mental health diagnoses	Medi-Cal / Medicare rates for services rendered	Implemented
Physicians Medical Group of San Jose	Ability to deliver high quality, culturally sensitive integrated care	1 year with annual renewal	Primary Care and integrated behavioral health services	Patients needing primary care and behavioral health services	Per member per month	Implemented
ALZHEIMER'S FAMILY SERVICES CENTER						
Monarch HealthCare	History of clinical excellence in caring for patients with dementia; evidence of positive clinical/ health outcomes for patients.	1 year with annual renewal	Joint study to analyze the impact of adult day health care on patient measures (e.g., ER visits, falls)	Monarch members diagnosed with dementia who may benefit from AFSC's programs and services	Fixed fee per member per day	Implemented

Second Linkage Lab Cohort (Continued)

Health Care Payer/ Provider	Criteria Used to Evaluate CBO	Contract Timeline	Service Package	Population to Be Served	Pricing Structure	Implementation Status
MEALS ON WHEELS AND SENIOR OUTREACH SERVICES (MOWSOS)						
Blue Shield of California contracted Partners in Care, which sub-contracted with MOWSOS	Ability to address social determinants of health that relate directly to mental health issues	1 year with annual renewal	Social support for high-risk patients with chronic conditions after they leave the hospital	Seniors and older adults with chronic conditions who could benefit from 30 days of in-home visits from a social worker	Fixed fee per member per month	Implemented
ST. BARNABAS SENIOR SERVICES (SBSS)						
White Memorial Medical Center (WMMC)	Interest in expanding WMMC's Vive Bien program to SBSS's service area and clients	1 year	Health education pilot for seniors in the community through the hospital's Vive Bien Senior Wellness Program	Older Adults at SBSS Echo Park Senior Center and Mid-City Senior Center, age 60+	No fee during pilot	Implemented