CalViva Health 2017 Utilization Management/ Case Management Mid-Year Evaluation

Created: January 14th, 2017
Updated: September, 6, 2017

CalViva Health
2017 UM/CM Plan

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1. Compliance with Regulatory & Accreditation Requirements

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1.1 Ensure that qualified licensed health professionals assess the clinical information used to support UM decisions.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Qualified licensed and trained professionals make UM decisions.	HN has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. HN HCS (for nurses) National Credentialing (for physicians) and Pharmacy (for pharmacists) maintain records of health professionals' licensure and credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for RNs	Monthly As needed Ongoing Ongoing Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Provide continuing education opportunities to staff for 2017 : • Palliative Care • How to approach end of life with cultural competence • Fraud Waste, and Abuse • Advanced Non- Small Cell Lung Cancer offerings from Continuing Clinical Education department. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Ongoing. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRRtesting. In place and up to date. Conduct training for RNs Ongoing within team structure and delivered by Plan Training team.	None	New hire training increased to 4 weeks to provide additional training for role specific activities for Medical Management staff.	Ongoing Started 7/7/2017 Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.2 Review and coordinate UM compliance with California legislative and regulatory requirements	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Review new legislation and regulations, either through e-mail or department presentation. Ongoing with EPCO attendance and dissemination throughout MM. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Up to date Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. Up to date	Multiple changes regarding the Mega Reg with policy updates.	Continue to assess implications of changes in regulation and update our policies and procedures to reflect.	Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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1.3 Separation of Medical Decisions from Fiscal Considerations	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	DHS, DMHC, and CMS, at a minimum, require that Medical Decisions made by MDs and RNs are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with distribution of affirmative statement about financial incentives to members, practitioners, providers and employees.	Circulate to all MDs and RNs an attestation that states: ▪ Utilization Management decisions are based on medical necessity and medical appropriateness. ▪ Health Net and CalViva do not compensate physicians or nurse reviewers for denials. ▪ Health Net and CalViva do not offer incentives to encourage denials of coverage or service. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or RNs based on any potential to deny care.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Attestations on file for all staff with activities on target for 2017. Attestations circulated on 12/5/2016. Will circulate again in December 2017. .	None	None	December 2017
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1.4 Periodic audits for Compliance with regulatory standards	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turn around time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with HNCS staff on issues revealed during the file review process.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards are identified, CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented PMR meeting. DHCS audit conducted in April 2017. Awaiting final report.	None	None	Ongoing
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1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS).	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN State Health Programs MDs interact with the MMCD Division of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program ▪ Provides HN with in-depth information regarding contractual programs ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings Ensures participation by RMDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each RMD. HN and CalViva remain a strong voice in this body with participation on key workgroups	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2017. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue, Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None	To review feedback from DHCS	Ongoing Ongoing
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	State Health Programs Health Services reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs CMD, Regional Medical Directors, Director of Health Services and Health Services Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2017 UMCM Program Description Write and receive CalViva approval of 2016 UMCM Work Plan Year-End Evaluation Write and receive CalViva approval of 2017 UMCM Work Plan. Write and receive CalViva approval of 2017 UMCM Work Plan Mid-Year Evaluation Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2017 Q 1 2017 Q 1 2017 Q 3 2017 Ongoing Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva Policies and Procedures were reviewed during 2017 and submitted to the appropriate regulatory agencies. 2016 UM/CM Annual evaluation completed. 2017 Program Description and Work Plan completed in Q1 2017.	None	Policies updated with Mega Reg requirements including revised definition of medical necessity. Will continue to monitor for any additional changes and update policies as needed.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

2. Monitoring the UM Process

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and Trend authorization requests month to month. Tracking includes number of prior authorization requests submitted, approved, deferred, denied, or modified. Turnaround times (TAT) Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	. The Management team reviews monthly reports to ensure expectations are met in 2017, trends and results discussed during Monthly Medical Management Department KPI meeting. Activities are all on target for 2017.	Challenges with recruiting for licensed staff.	Modified recruiting strategies to include broadening positions to include LVN/RN candidates. Mailing campaign conducted and utilizing online recruiting sites to reach a broader candidate pool. All Prior Authorization openings have been filled August 2017	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request. (Turn Around Times =TAT)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and Trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of turnaround times (TATs). Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining	Ongoing

Health Net

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ TOO SOON TO TELL	**CalViva TAT 2017** January- 99.3% February 98.5% March 100% April 91% May 100% June 94% Average 97.1%	In April 2017, had one provider who submitted 200 requests for benefit exceptions in one day. Requests were subsequently rescinded by provider, but some of the requested cases fell short of TAT. In June 2017, two clinical positions remained open. During the month of June, we experienced average volume of authorizations with this staff shortage which contributed to decreased production	Modified recruiting strategies to include broadening positions to include LVN/RN candidates. Mailing campaign conducted and utilizing online recruiting sites to reach a broader candidate pool. Staff offered OT to continue to maintain production To place into formal CAP following review of historical TAT data.	Ongoing
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2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals (AxisPoint Health) involved in UM decision-making	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	HN administers AxisPoint Health InterQual® IRR Tool to physician and non-physician UM reviewers annually Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool for physicians and 90% for non-physician staff.	<u>Physician IRR</u> Administer Physician IRR test using case review method and AxisPoint Health's InterQual® IRR tool in Q3-4 2017 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using AxisPoint Health's InterQual® IRR tool in Q3-4 2017	Q4 2017 Q4 2017

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Annual Interqual updates to be scheduled November/December. IRR testing for both non-clinical and MD scheduled for completion in December 2017.	None	None	December 31, 2017
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2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turn Around Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21.	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	**Totals:** Overturn 39 Partial Uphold 5 Uphold 52 Withdrawal by Member 2 Grand Total 98 **Appeal Percentages** Overturn: 39.80% Uphold: 53.06% Partial Uphold: 5.10% Withdrawal by Member: 2.04% Turn Around Time Compliance: 97.6%	Turn-around time compliance for Appeals below goal of 100% (2 cases) related to staffing variations.	A & G leadership initiated immediate and long-term interventions to correct staffing issues. Continue to monitor.	Ongoing
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3. Monitoring Utilization Metrics

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3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Health Net Central Medical Directors and Health Care Services manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting <u>2017 Goals</u>: TANF: 216.6 SPD: 1129.7 Key Metrics (SPD, Non-SPD, MCE) • Bed Days/K • ER visits/K • All Cause Readmits within 30 days • % 0-2 day admits • C-Section Rates	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services and community resource needs and Transition Care Management and Discharge Programs. Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Complex Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development. All internal thresholds will be reviewed and possibly revised for 2017.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	**Bed Day Goal** TANF=216.6 SPD= 1128 MCE= TBD **Bed Days Actual** TANF=105.0 SPD=967 MCE=357 Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Complex Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development. All internal thresholds will be reviewed and possibly revised for 2017.		None	None	Ongoing Ongoing Ongoing December 31, 2017
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3.2 Over/under utilization	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS PPG profile reports are made available quarterly and one metric for over utilization (ER/K), and two metrics for underutilization, (All Cause Readmits w/in 30 days) and Specialty referrals are assessed on a biannual basis	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. Identify possible fraud, waste and abuse issues. Report any issues to the Compliance Department Thresholds for 2017 are under evaluation. <u>Referral Rates: Specialist</u> HN average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non SPD and MCE members by PPG. HN average referral rates are determined and the bottom10% are identified as outliers. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the RMD to determine if a CAP is indicated. CAPS are monitored by delegation oversight then to document implementation and need for follow up.	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Development of PPG specific data Dashboard Reports. These reports are produced quarterly and presented at the CalViva Management Oversight meeting. The reports are derived from claim data and accordingly are produced after the claim time lag is no longer an issue. (approximately 4 -5 months).	None	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. Identify possible fraud, waste and abuse issues. Report any issues to the Compliance Department Thresholds for 2017 are under evaluation	Ongoing Ongoing Ongoing Ongoing
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3.3 HN SHP Medical Director MRU and Provider Dispute Unit review of ER, ambulance high dollar, Cotiviti and potential CCS claims	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Emergency Room visits often are not for valid emergency conditions and do not meet Title 22, Section 53855 parameters Inpatient LOC may be inappropriate Hospital charges may include unbundling and non-benefit items Claims for both inpatient and ER visits may be CCS carve-out program responsibility Codes not allowed by Medi-Cal may be submitted, as well as unbundling of codes in excess of CMS and CCI rules.	Medi-Cal claims units are sending high-cost and questionably inappropriate claims to respective State Health Programs Medical Directors for timely line-item review to monitor quality of care provided, to identify inappropriate utilization patterns and to ensure that members are connected to other public programs such as CCS. Claim review remains an important activity for HN medical directors to control cost, prevent fraud, and direct provider to the correct payer for the carve out programs. MRU areas of importance are: CCS identification. Trauma reviews. ER visits for ambulatory care sensitive conditions.	Review potential CCS responsibility Review of non-approved inpatient care for medical necessity. Review claims denied for bundling edits, other inconsistent billing patterns according to Claims policy, Cotiviti policy, and industry standard payment rules Cotiviti denials will be reviewed in 2017 Review for quality of care issues and inappropriate utilization Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations	Ongoing

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Medical necessity and appropriateness of billings continue to be appropriately monitored and adjudicated. Review potential CCS responsibility Review of non-approved inpatient care for medical necessity. Review claims denied for bundling edits, other inconsistent billing patterns according to Claims policy, Cotiviti policy, and industry standard payment rules Cotiviti denials will be reviewed in 2017 Review for quality of care issues and inappropriate utilization Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations	None	Monthly cross collaborative meetings with clinical MRU, non-clinical MRU, and Claims to identify process improvement opportunities in operational process.	Ongoing Ongoing Ongoing Ongoing December 31, 2017 Ongoing
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3.4 PPG Profile	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____ She o	Profiles provide PPGs threshold data based on Health Net CalViva data and comparative performance data to help them measure and improve their UM and QI performance.	Medi-Cal PPGs with greater than 1,000 non-SPD, 1000 MCE or 500 SPD Medi-Cal members are produced quarterly and evaluated .bi-annually for possible over/under utilization. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS 6. % of 0-2 day admissions 7. C-section rates	CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2017. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the RMD to determine if a CAP is indicated. CAPS are monitored by delegation oversight then to document implementation and need for follow up <u>Referral Rates: Specialist</u> HN average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non SPD and MCE members by PPG. HN average referral rates are determined and the bottom10% are identified as outliers.	Ongoing

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Health Net

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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Dashboard reports are in place. Narrative report for Q2 reviewed at MOM meeting on 9/5/17. CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2017. Further analysis will be initiated by the RMD for PPG's identified to be potential outliers and a Corrective Action Plan (CAP) will be requested when indicated. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	Membership growth and changing regulations	Internal thresholds under re-evaluation.	Ongoing Ongoing Ongoing Ongoing Ongoing
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4. Monitoring Coordination with Other Programs and Vendor Oversight

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4.1 Integrated Case Management Program (ICM)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner optimizes physical and emotional health and well-being and improves quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Report referrals to appropriate internal and external programs. Enhance Key Indicator reporting to report, track and trend Integrated Case Management Activities monthly Track and Trend Case Management activities and acuity levels (including complex) monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs	Dedicated staff of RNs, CM Assistants, and LCSWs to perform ICM Further reinforcement of predictive modeling to increase engagement of members.	Ongoing

Created: January 14th, 2017
Updated: September, 6, 2017

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Dedicated staff in place to support CalViva members. Continue monitoring staff and referral volume to adjust staffing resources to support the population as needed. Modified the Key Indicator Report to align with standardized CM reporting. CalViva members managed in the Top One Percent (TOP) Program have also been transitioned to the dedicated CalViva team. TOP members were previously managed by a different designated team. The unable to reach volume is one aspect of the Key Indicator Report which is monitored monthly. The overall percentage of referrals to Integrated Case Management where the member was unable to be reached was 65% (594/906) from January through June. The overall percentage of members who declined to enroll in Integrated Case Management was 24% (218/906) for that same time period. Support processes have been modified to promote successful outreach. The engagement rate has improved significantly starting in June. Total managed members in this program January through June was 263.	Primary reason for decline into our Integrated Case Management Program case volumes is due to members who are screened and decline services and those we are unable to reach.	Processes were modified to ensure all available contact information is available to the CM making outreach. To support identification and referral of members with complex and serious medical conditions in September we will begin to implement use of the information in the new Health Information Form to identify members who may benefit from CM.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

Created: January 14th, 2017
Updated: September, 6, 2017

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program Monitor inpatient and NICU utilization for this population, to tailor interventions going forward.	Assess member's level of Social Support and refer to appropriate community resources, as needed. PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Support provider completion of PNIP forms and complete outreach to members identified as "high-risk"	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The average number of referrals per month, January through July, was 15. The average engagement rate for that period was 31% and the total number of members managed was 68. Staff will be attending Motivational Interviewing classes to facilitate greater engagement. The CM and the Quality teams have partnered to evaluate the adoption of the StartSmart for Baby Program to support early identification of pregnant members and increase the number of referrals to Perinatal CM. In the interim we recently started utilizing other sources to identify members for the program including pre-delivery admissions on the inpatient daily census.	None	We are collaborating with our Perinatal Initiative Committee to assist our QI department with outreach to high risk members identified from the PNIP forms received. Our HROB CM's outreach members identified by their providers as having a high-risk pregnancy, and to those who's risk status is unknown due to incomplete forms.	
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
4.3 Disease Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program ☐ Other _____	The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy/ encounter claims, health appraisal results, data collected through the UM or case management process, and member or provider referrals. Evaluation of outcome data from HEDIS® -like measures. Review/analyze DM partner annual report	Transitioning vendors and expanding the program from three to five conditions: asthma, diabetes, cardiovascular artery disease, chronic obstructive pulmonary disease, and heart failure. Notify PCPs of their patients identified or enrolled in the disease management program. Focus on streamlining hand-off between Disease Management and the Integrated Case Management programs. (Modification of the referral form and member referral process is in process.) Review of member materials and scripts by the Compliance and Cultural & Linguistics departments and DHCS before going to press. Ongoing program monitoring to assure that reporting needs are met. Monitor the monthly reports and enrollment statistics.	Ongoing

Created: January 14th, 2017
Updated: September, 6, 2017

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	1. Continued work on the transition of the Disease Management program to another vendor. 2. Bi-Annual mailings are sent to the Providers to notify them of their patients who are enrolled in Disease Management program. 3. Annual Vendor Delegation Oversight Audit of the current vendor to be started in September, 2017. 4. Ongoing program monitoring to ensure appropriate enrollment and the reporting needs are met. Complex Case Management was insourced from the vendor in September 2016. Monthly CM meetings are held with CalViva during which the Key Indicator Report and other process activities are monitored and opportunities for improvement are addressed. The number of unique eligible members referred to CM from January through July was 938. CM has collaborated with Provider Relations in their efforts to engage targeted provider groups in identifying members for case management. CM is in process of creating a CM services section for the CalViva "Rainbow" provider guide.	None	1. Disease Management transition from the current vendor to Envolve PeopleCare (EPC). Collaborating with the stakeholders to ensure a smooth and seamless transition. The new vendor's collaterals are being appropriately branded, going through the compliance, cultural and linguistic process, and the CVH approval process. 2. Review of the current vendors collaterals by appropriate departments (Clinical team, Compliance and Cultural and Linguistics) before mailing. 3. Completion of the Delegation Oversight Audit and appropriate follow up as needed. 4. Continued weekly Issues and Oversight meetings	1. Transition Date: 2018 2. July, 2017 and ongoing 3. October, 2017 4. Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2017 Planned Interventions	Target Completion Date
4.4 MD interactions with Envolve Pharmacy Solutions (EPS)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. SHP MDs and the CalViva Health Chief Medical Officer work with EPS to refine RDL/Formulary and injectable guidelines to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with EPS to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with EPS to improve CCS ID using pharmacy data SHP MD's and EPS continue with interventions, to adopt DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the HN Medi-Cal plan.	Monthly check write review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements	Ongoing

Created: January 14th, 2017
Updated: September, 6, 2017

Health Net

CalViva HEALTH

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Continue active engagement with pharmacy, Medical Directors meet with pharmacy on a quarterly basis to review reports, discuss utilization of medications and discuss proposed formulary and pre-authorization guideline changes. Continued narcotic prior authorization requirements with review of prior authorizations is reviewed at the quarterly Medical Director/pharmacy meeting for changes in trends.	None	Continue with regular meetings.	Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2017 Planned Interventions	Target Completion Date
4.5 Manage care of CalViva members for Behavioral Health	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to monitor and improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Participate in cross functional team to improve coordination of care. Review data that indicates when a member was referred to the County for services. Review data that indicates when a PCP has referred a member to a BH provider.	Ongoing

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Updated: September, 6, 2017

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	876 calls from members 1/1/17-6/30/17. 210 of 876 calls were sent to clinical care managers for assessment. Of these, 8 of 210 were referred to the County for SMHS services. MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions.	Unable to determine at this time how many were from PCP/PPG because of reporting system issues.	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care MHN Provider Relations is actively pursuing to initiate new contracts with psychiatrists in the three CV counties. They are offering higher rates to incent them to join the MHN network. MHN has also contracted with one telehealth provider who can provide psychiatric services, and is in the process of contracting with more.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2017 Planned Interventions	Target Completion Date
4.6 Behavioral Health Performance Measures	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to monitor and improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	18 PQIs were submitted for CalViva members to date. **Summary Narrative for Membership & Appointment Accessibility** Q1 2017 CalViva membership was 354,904 (a 0.05% increase over Q4 2016). - There were 0 Life-Threatening Emergent cases. - There were 0 Non Life-Threatening Emergent cases. - There was 1 Urgent case and the timeliness standard was met. Q2 2017 CalViva membership was 355,348 (a 0.1% increase over Q1 2017). - There was 1 Life-Threatening Emergent case and the timeliness standard was met. - There were 0 Non Life-Threatening Emergent cases. - There were 0 Urgent cases.	None	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

5. Monitoring Activities for Special Populations

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
5.1 Monitor of CCS identification rate.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CASHP will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Coordinators and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Medi-Cal utilizes a 70% factor to account for CCS age band.	CCS identification and reporting continues to be a major area of focus for SHP. Continue current CCS policies and procedures. Identification through claims review, concurrent review, prior authorization, case management, pharmacy, and member services (welcome calls and CAMHI screening tool) Improve coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Continue to monitor the rate of CCS identification and follow the current planned interventions. The CCR team screens every inpatient admission, under their review, for CCS eligibility. Any person under the age of 21 with a complex medical condition is screened for potential CCS eligibility. Cases identified as potentially eligible or confirmed eligible for CCS services are referred to the local CCS office. The CCRNs collaborate directly with the local CCS office to ensure coordinated services and expedited access to care through CCS paneled providers and/or Specialty Care Centers.	None	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2017 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UMCM program. Monitor HRA completions	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into multiple programs, including Complex Case Management, Pharmacy program to prevent hospital readmission, Ambulatory Case Management, and 5 Disease Management gateway conditions. Continue to meet all requirements for SPDs and utilize all programs to support them, including Integrated Case Management.	Ongoing

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<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The identification, risk stratification, and assessment performed during member enrollment into the DM, or Integrated Case Management Program addresses the HRA reassessment requirement. Health Net Monitors this activity through reporting by Axis Point formerly known McKesson.

SPD Days/1000 January – June 2017

<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>1079.2</td><td>1129.7</td></tr>
<tr><td>Kings</td><td>243.7</td><td>1129.7</td></tr>
<tr><td>Madera</td><td>852.6</td><td>1129.7</td></tr>
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</td>
<td></td>
<td>TCM efforts are ongoing and continue.

CalViva high risk members are identified via predictive modeling and through referrals from CCR to support TCM post-acute outreach to CalViva's highest risk members.

Continue on-site concurrent review at the Central Valley's highest volume hospitals.

Continue to track the effectiveness of various case management initiatives on readmissions, hospital utilization, pharmacy and disease management</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2018</td>
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