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CalViva Health 2018

Utilization Management/ Case Management Work Plan

Updated March 9th 2018

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Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date

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.	☒ Medi-Cal	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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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
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1.2 Review and coordinate UM compliance with California legislative and regulatory requirements	☒ Medi-Cal	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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1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	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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1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround 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. File Audits completed the month following each quarter	Ongoing April 2018, July 2018, October 2018, January 2019

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1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS).	re Advantage PPO ☒ Medi-Cal	HN 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 MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. 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 2018. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

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1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☒ Medi-Cal	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 2018 UMCM Program Description Write and receive CalViva approval of 2017 UMCM Work Plan Year-End Evaluation Write and receive CalViva approval of 2018 UMCM Work Plan. Write and receive CalViva approval of 2018 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 2018 Q 1 2018 Q 1 2018 Q 3 2018 Ongoing Ongoing

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2. Monitoring the UM Process

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2.1 The number of authorizations for service requests received	☒ Medi-Cal	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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2.2 Timeliness of processing the authorization request. (Turn Around Times =TAT)	☒ Medi-Cal	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 UM TAT Summaries due the month following on the 10th of each month.

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2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	HN administers McKesson 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	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2018 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2018	Q3-4 2018 Q3-4 2018

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2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	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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3. Monitoring Utilization Metrics

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3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	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 ▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days <u>2018 Goals</u>: Bed Days/K SPD: 1129.7 MCE: 325 TANF: 216.6 Average length of acute care stays SPD: 5.1 MCE: 4.7 TANF: 4.8 Admit/KSPD: 241.4 MCE:62.1 TANF:49.6	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, Integrated 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 2018.	Ongoing

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3.2 Over/under utilization	☒ Medi-Cal	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 6. CCR Goals are: SPD:20 MCE:10 TANF:7 7. % 0-2 day admits 8. C-Section Rates 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. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 208 are under evaluation. <u>Referral Rates: Specialist</u> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom10% are identified as outliers. (*pending approval from DHCS/DHMC.) PPG's are identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors.	Ongoing

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3.3 PPG Profile	☒ Medi-Cal	Profiles provide PPGs threshold data based on 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 0-2day 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 2018. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the MD 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> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom10% are identified as outliers (*pending approval from DHCS/DHMC.)	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)	☒ Medi-Cal	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. Monitor Key Indicator report to track and trend Integrated Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, CM Assistants, and LCSWs to perform ICM Implement report to monitor new member referrals to ICM based on information from the Health Information Form. Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. Review outcome measures quarterly.	Ongoing

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4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	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 . Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 21 and 56 days after delivery compared to pregnant members who were not enrolled in the program	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Expand Pregnancy Program activities to include consolidation of provider forms used to identify high risk members, increase outreach to high risk member through education packets, text reminders, etc. Implement use of the Notification of Pregnancy (NOP) form by members, and related reports to increase identification of moderate and high-risk members for referral to the Pregnancy Program. Monitor volume of referrals based on NOP activity. Review outcome measures quarterly.	Ongoing

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4.3 Disease Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	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 to new vendor and continuing to concentrate on three conditions: asthma, diabetes, 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. 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

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4.4 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the 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 Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data SHP MD's and Pharmacy continue to mirror the DHCS narcotic prescribing quantity limits. This is to	Monthly check write review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids.	Ongoing

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		prevent fraud and abuse and prevent adverse selection to the CalViva Medi-Cal plan.			

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4.5 Manage care of CalViva members for Behavioral Health	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides.	Ongoing

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4.6 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to 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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5. Monitoring Activities for Special Populations

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5.1 Monitor of CCS identification rate.	☒ Medi-Cal	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 %. Goal: HN identifies 5% of total population for CCS eligibility.	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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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2018 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements.	☒ Medi-Cal	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 the appropriate program, such as Integrated Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including Integrated CM, Disease Management and Care Coordination.	Ongoing

CalViva Health
2018 UM/CM Plan

Attachment N

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				