Item #9

Attachment 9.B

2019 Annual Quality Improvement
Year End Evaluation

CalViva Health
Quality Improvement
Work Plan 2019
End of Year Evaluation

2.12.20

CalViva Health 2019 Quality Improvement Work Plan

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CalViva Health 2019 Quality Improvement Work Plan

I. Purpose

The purpose of the CalViva Health's Quality Improvement Program Work Plan is to establish objectives for the QI Program and review clinical, service and safety related outcomes against the priorities and objectives established by the Program. An assessment of critical barriers is made when objectives have not been met.

II. CalViva Health Goals

1. We will anticipate, understand and respond to customer needs and be customer-driven in everything we do.
2. We will hire and retain the best people, create the best climate, provide the best tools to do the best job and build a spirit of warmth, friendliness and pride throughout the company.
3. We will dedicate ourselves to a standard of excellence in all of our customer relationships.
4. We will promote better outcomes for our customers through improved provider relationships and through the promotion of evidence-based health care.
5. We will provide efficient, simple and high quality administrative services that get things right the first time.
6. We will build excellent business systems and processes and demonstrate the highest degree of integrity in all aspects of the operation of our business.

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2019. The development of this document requires resources of multiple departments.

CalViva Health 2019 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CDC:	Comprehensive Diabetes Care
CM:	Case Management
CP:	Clinical Pharmacist
CVH:	CalViva Health
DHCS:	Department of Health Care Services
DM:	Disease Management
DMHC:	Department of Managed Health Care
DN:	Direct Network
FFS:	Fee-for-Service
HE:	Health Education
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
PCP:	Primary Care Physician
PIP:	Performance Improvement Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
QI:	Quality Improvement
SPD:	Seniors and Persons with Disabilities
UM:	Utilization Management

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)				
1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative
Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
Timely Appointment Access to Primary Care Physicians and Specialists is measured through eight metrics. The specific goal is 80% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the DMHC PAAS Tool and the CVH PAAS Tool.
Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 80% for all metrics. Timely Appointment Access is monitored using the ICE-DMHC PAAS Tool.
After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey. This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007 Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements	P	Q3- Q4	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q1 - Q4 Q2 - MY2019 Survey Prep Q3 – MY2018 Survey Results	CVH/HN

Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q1	CVH/HN
Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability.	P	Q3-Q4	CVH/HN
Complete a CAP as necessary – when CalViva providers are below standard; including additional interventions for providers not meeting standards two consecutive years.	P	Q3-Q4	CVH/HN
Annual review, update and distribution of Patient Experience Toolkit, After-Hours Script, Guidelines for compliance and Monitoring and Appointment Scheduling Tip sheet	P	Q1-Q4	CVH/HN
Conduct provider onsite office audits for all repeat noncompliant providers	P	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• MY2019 PAAS Survey: Survey being conducted by Sutherland Global beginning in September 2019. • Provider Updates: MY2018 Appoint Access and After-Hours Survey Results scheduled to go out August 2019. MY2019 PAAS and After-Hours Survey Prep distributed June 2019. • P&P PV-100 Accessibility of Providers and Practitioners): Updated required for TAR filing in Q1 2019. Updates approved at May Access WG meeting. • MY2018 CAP packets distributed to noncompliant providers and PPGs on 8/15/19. As part of this year's CAP, noncompliant providers and PPGs area being asked to attend a one session of the Timely Access to Care Provider Focused Training. An invitation was sent out to all PPGs and providers to attend one of three sessions that were offered in August and an additional three session are being offered November and two sessions in December. Additionally, providers who were noted as noncompliant last year will be subject to an in-office or phone audit during October/November to educate providers and ensure deficiencies have been corrected. • New QI Provider Toolkit published in May 2019 which replaced the Patient Experience Toolkit. New QI Toolkit will be sent out with all CAP packets..	• MY2019 Surveys concluded 12/31/19. • Provider Updates distributed in June & August 2019. Analysis of Provider Updates and mailings to be conducted in Q1 2020. • MY2018 CAPs sent in 8/15/19 and Improvement Plans received through 12/31/19. 16 CAPS were received in a timely manner, two Improvement Plans not received by 12/31/19. Continued follow-up to take place until received. • Provider Training webinars conducted August, November & December 2019. Total of 39 CalViva PPG/providers attended. • Provider audits - 22 provider office audits conducted 12/18-12/20/19. Nine provider telephone After-Hours audits conducted December 2019.

• Provider Onsite Audits – to take place in October 2019. Noncompliant providers subject to audit will be notified in September 2019. • RY2018 Results: Rates for RY 2019 cannot be compared to RY2018 due to change in survey methodology by DMHC. Metrics for RY19 include 11 measures overall, nine from PAAS and two from PAHAS. Five of the nine PAAS metrics were below the 80% threshold. One of the After Hours (PAHAS) measures was below the 90% threshold and one was above.	

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY 2018	Rate RY 2019 (populated mid-year)	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall= 90.1% Fresno= 87.7% Kings= 97.7% Madera= 94.9%	Overall= 82.1% Fresno= 85.7% Kings= 85.2% Madera= 62.5%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall= 64.0% Fresno= 68.8% Kings= 65.2% Madera= 55.5%	Overall= 68.1% Fresno=72.2% Kings= 73.7% Madera= 43.1%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	80%	Overall= 82.9% Fresno= 82.9% Kings= 81.4% Madera= 84.6%	Overall= 71.4 % Fresno= 74.2% Kings= 59.3% Madera= 81.3%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	80%	Overall= 60.7% Fresno= 68.3% Kings=52.3% Madera= 50.8%	Overall= 62.8% Fresno= 68.0% Kings= 44.4% Madera= 53.2%	CVH Performance RY2018	Improvement over CVH Performance RY2018

Access to First Prenatal Visit (PCP) – Within 10 business days of request	80%	Overall= 100% Fresno= 100% Kings= 100*% Madera= NR%	Overall= 90.3% Fresno= 94.4% Kings= 90.0% Madera=66.7*%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to First Prenatal Visit (SCP) – Within 10 business days of request	80%	Overall= 80.0% Fresno= 100% Kings= NR Madera= 33.3*%	Overall= 88.9% Fresno= 87.5% Kings= 100*% Madera= 100*%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall= 84.1% Fresno= 86.9% Kings= 60.0*% Madera= 66.7*%	Overall= 73.6% Fresno= 69.8% Kings= 85.2% Madera= 68.8%	CVH Performance Ry2018	Improvement over CVH Performance RY2018
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall= 91.3 % Fresno=93.4% Kings= 60.0*% Madera= 100*%	Overall= 88.5% Fresno= 85.2% Kings= 92.6% Madera= 93.8%	CVH Performance RY2018	Improvement over CVH Performance RY2018
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall= 89.0% Fresno= 83.3*% Kings= 100*% Madera=NR	Overall= 66.7*% Fresno= 60.0*% Kings= 100*% Madera=NR	CVH Performance RY2018	Improvement over CVH Performance RY2018
Appropriate After-Hours (AH) emergency instructions	90%	Overall= 94.3% Fresno= 93.6% Kings= 95.7% Madera= 98.2%	Overall= 93.9% Fresno= 95.2% Kings= 95.0% Madera= 80.5%↓	CVH Performance RY2018	Improvement over CVH Performance RY2018

AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P)	90%	Overall= 78.7% Fresno= 76.7% Kings= 87.0% Madera= 82.1 %	Overall= 82.0% Fresno= 82.3% Kings= 77.8% Madera= 85.0%	CVH Performance RY2018	Improvement over CVH Performance RY2018

*Denominator less than 10. Rates should be interpreted with caution due to the small denominator

↑↓ Statistically significant difference between RY2018 vs RY2017, p<0.05

NR – No reportable data

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Analysis: Intervention Effectiveness w Barrier Analysis	• Analysis of Provider Updates/mailings in Q1 2020. Goal is to send out fewer mailings to avoid provider fatigue. • Analysis of sending CAPs out to providers earlier (early Q3). Results become more relevant and issues can be addressed before next set of surveys takes place. Go forward basis Child Net CAPs and Improvement Plans will be addressed by Andrea Broughton/Racey Lefall at Health Net. • Continue Provider Training webinars throughout 2020 (schedule TBD. Analysis of data capture to take place in Q1 2020. • Continue provider office audits in 2020 and conduct earlier (September) so issues may be addressed before next set of surveys gets underway.
Initiative Continuation Status (Populate at year end)	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

1-2: Improve Member Satisfaction

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Member Experience for CalViva is monitored in two ways:

1. DHCS conducts a CAHPS survey every 3 years; results are posted the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx
2. HNCA QI CAHPS team helps to administer a scaled-back CAHPS survey to assess access areas of opportunity. This CalViva Access Survey is administered through SPH Analytics/Morpace. Final results are shared with PNM.

Member satisfaction is affected by member interaction with the providers, provider office staff, the plan, and vendor partners. Results are also impacted by member demographics and individual health status.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Through the DHCS-admnistered CAHPS survey, the following measures are evaluated:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Getting Needed Care (composite measure)
- Getting Care Quickly (composite measure)
- How Well Doctors Communicate (composite measure)
- Customer Service (composite measure)
- Shared Decision Making (composite measure)

Our goal for the CAHPS survey is to be at or above the Quality Compass 50th percentile.

On an annual basis, the CalViva Access Survey collects information on the following measures:

- Access to Urgent Care
- Access to Routine Care
- Access to Specialist Appointment
- Ease of Getting Care/Tests/Treatment

Our internal goal for the CalViva Access survey is to exceed previous year's performance

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**

Annually review, update, distribute and promote the 2018 Patient Experience(PE) Toolkit to providers	P	Q3-Q4 2019	CVH/HN
Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q3-Q4 2019	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the PE Toolkit to educate and empower members and improve their overall experience	P/M	Q3-Q4 2019	CVH/HN
Annually, review, update and enhance materials on Interpreter services 24/7 to remind providers of the availability of these services and how to access them	P	Q3-Q4 2019	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services	M	Q3-Q4 2019	CVH/HN
Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members	P/M	Q3-Q4 2019	CVH/HN
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3 2019	CVH/HN

Section B: Mid-Year Update on Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• The DHCS Administered CAHPS survey, results are not available to assess activities. • In Q1 and Q2 the toolkit materials were reviewed, and redundancies were identified in the materials. In order to simplify and streamline the information sent to providers, the materials were revised. The newly revised materials will be finalized in Q3 and distributed in Q4. • The CalViva Access survey, rates slightly improved except for getting urgent care and getting routine care. As resources allow, there will be a deeper dive into the access and availability of certain provider groups, and an assessment will be completed of which provider offices have Open Access Scheduling.	• Newly revised materials completed and launched Q4 2019. • Continued participation in Access and Availability workgroup to help identify opportunities for improved access to care for membership and other member satisfaction areas.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	RY Rate 2018	RY Rate 2019	Baseline Source	Baseline Value
Got urgent care as soon as needed	Improve YOY	81%	76%	RY 2018 Rate	81%
Got routine care as soon as needed	Improve YOY	68%	65%	RY 2018 Rate	68%
Ease to get specialist appointment	Improve YOY	55%	59%	RY 2018 Rate	55%
Ease of getting care/test/treatment	Improve YOY	74%	77%	RY 2018 Rate	74%
CAHPS Survey Measures	**Specific Goal**	**RY Rate 2016 (% always/usually)**	**RY Rate 2019 (% always/usually)**	**Baseline Source**	**Baseline Value**
Getting Needed Care	Exceed RY201 All Plans Medicaid Average 50th Nat'l = TBD	78%	79%	National Benchmark (50th Percentile)	83%
Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	74%	75%	National Benchmark (50th Percentile)	82%
How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	90%	88%	National Benchmark (50th Percentile)	92%
Customer Service	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	86%	National Benchmark (50th Percentile)	89%
Shared Decision Making	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	76%	National Benchmark (50th Percentile)	80%
Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average	69%	72%	National Benchmark	75%

	50th Nat'l = TBD			(50th Percentile)	
Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	77%	77%	National Benchmark (50th Percentile)	82%
Rating of Health Plan	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	72%	National Benchmark (50th Percentile)	77%
Rating of Specialist	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = TBD	TBD	83%	National Benchmark (50th Percentile)	82%

Analysis: Intervention Effectiveness w Barrier Analysis	Provider webinar held in Q3 to educate providers and clinic staff on what to expect around CAHPS survey, the importance of CAHPS, answer questions and inquiries to help sites improve patient satisfaction. Getting Needed Care and Getting Care Quickly improved but continues to be well below the national benchmark (50th percentile). Rating of Specialist exceeded the national benchmark (50th percentile). Regular CAHPS meetings with appropriate partners and departments impacting member experience will continue in 2020 to ensure member satisfaction is being considered through all activities. Will continue to monitor internal and external feedback on how to improve patient experience materials for members, providers, and staff.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

II.QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)				
2-1: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To reduce the number of prescriptions for antibiotics inappropriately prescribed to CalViva Health adult members diagnosed with acute bronchitis.

Rationale: Antibiotic resistance is both costly and a major public health issue, totaling up to $20 billion in direct healthcare costs.[1] Every year, at least 2 million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die as a result.[2] In general, antibiotic-resistant infections result in longer and/or more expensive treatments, longer hospital stays, additional doctor visits, and increased disability and mortality risk.[1] According to the CDC, the use of antibiotics is "the single most important factor leading to antibiotic resistance around the world."[3] Moreover, the CDC estimates 30 percent of unnecessary antibiotics are prescribed in outpatient clinics.[2]

Barriers to appropriate antibiotic prescribing include providers not ordering the appropriate laboratory tests to confirm if an antibiotic is needed, and patients demanding an antibiotic. [1] To help address these barriers, CalViva helps promote the Choosing Wisely® patient education materials and is also involved with the California Medical Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) annual campaign to promote appropriate antibiotic use among providers and patients. According to a meta-analysis published in the British Medical Journal patients prescribed an antibiotic for a respiratory infection consistently developed bacterial resistance to that antibiotic; this effect was greatest in the first two months immediately after treatment [pooled odds ratio 2.37 (CI 1.42-3.95)] but could persist for up to 12 months. This contributes to an increased number of organisms resistant to first line antibiotics, which may lead to increased use of second line antibiotics.[4] Therefore, it is crucial that providers have updated tools and information to ensure that antibiotics are not prescribed inappropriately or overprescribed.

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[1]Centers for Disease Control and Prevention (CDC). Antibiotic Resistance Threats in the United States, 2013. April 2013. Available at http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats- 2013-508.pdf. Downloaded January 17, 2014.
[2]Centers for Disease Control and Prevention. (2017). Antibiotic use in the United States, 2017: Progress and Opportunities. Atlanta, GA: US Department of Human Services. Retrieved from https://www.cdc.gov/antibiotic-use/stewardship-report/index.html.
[3]Centers for Disease Control and Prevention (CDC), Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.
[4]Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. (2010). Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. BMJ. 2010 May 18; 340:c2096.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.			
The HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates appropriate treatment of adults with acute bronchitis). Madera county baseline HEDIS result for RY 2017 was 18.26% and RY2018 was 24.58% which was 0.33% below the MPL (181 numerator events out of the 240 in the denominator).			
Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance clinic in Madera County to initiate targeted interventions to improve AAB rate. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County clinic to share results and receive updates on improvement activities. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Mail 2019 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use. Mailed by AWARE offices (Physicians For A Healthy California) to top 20% of antibiotic prescribers (MDs) identified in Fresno, Kings, and Madera Counties.	P	Q2, Q3	CVH/HN
Provider Relations to distribute AWARE Toolkit to targeted providers and mid-level clinicians identified as high prescribing for two or more consecutive years.	P	Q2, Q3	CVH/HN
Work with a high volume, low compliance clinics in Fresno County to initiate targeted interventions to improve AAB rate. (Submit PDSAs)	P	Q2	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1-Q2 2019, Medical management continued efforts with high volume, low compliance clinic in Madera County to monitor providers' compliance with measure and initiate follow up. • Regular meetings of the AAB Improvement team continue in the first six months of 2019 to review results of monitoring and evaluate the success of interventions and initiate modifications when indicated. • CalViva Medical Management participated in the Alliance Working for Antibiotic Resistance Education (AWARE) initiative	The PDSA Improvement Project was successfully completed for Madera. Due to this measure not being part of the Managed Care Accountability Set for RY2020, all interventions ended on July 31, 2019.

in which toolkits were mailed to the highest 20% of prescribing providers in Fresno, Kings, and Madera Counties. • CalViva Medical Management team enlisted the support of the Provider Relations Representatives to hand deliver the AWARE Toolkits and to the high volume, high prescribing physicians and mid-level clinicians identified in Madera and Fresno Counties. • In Q2, it was determined that the minimum performance level was exceeded in Madera County for the AAB measure (32.55%, which is above the 50th percentile 31.97) and the Robert Wood Johnson Virtual Clinic presentation had been provided to all larger provider groups in Madera who were identified as high prescribers. • Additionally, Fresno County was identified to have declining rates year over year for this measure (25.93%) and the potential to target several high-volume providers. Therefore, CalViva Health obtained approval from DHCS to move improvement efforts from Madera County to Fresno County in order to proactively address this measure through replication of interventions that were successful in Madera. This measure is not part of the 2020 MCAS	

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB)	Directional improvement to meet or exceed the MPL 27.63% (RY 2019)	Madera: 24.58%	Madera: 32.55%	RY 2017 CVH results	Madera: 18.26%
Analysis: Intervention Effectiveness w Barrier Analysis	The AAB measure is no longer on the DHCS MCAS and the project closed mid-year. **Successes**				

	• Outcome monitoring over time (6 months) revealed a change in prescribing practices at our targeted clinic and Madera County overall. A recent analysis of AAB non-compliant providers in Madera County in MY2019 revealed no trends and only singular cases not lending themselves to the simulation training which has been our major improvement initiative. **Barriers** • Per Diem providers are difficult to train due to irregular office hours, and limited engagement with clinic administration. • In Fresno, the providers were sensitive to the non-clinical trainer providing the simulation trainings; it was suggested by providers that training is conducted by clinical staff.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-2: Annual Monitoring for Patients on Persistent Medications (MPM)

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	Health Net QI Department and Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: Reduce the occurrence of preventable adverse drug events for CalViva Health members on Persistent Medications (MPM).

Rationale: High blood pressure is asymptomatic and is often dubbed as the "silent killer" (Association, 2018). The American Heart Association defines normal blood pressure as less than 120/80 mm Hg (Association, 2018)**.** In managing blood pressure, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight, limiting alcohol intake, and engaging in smoking cessation programs (Center for Disease Control and Prevention, 2018). However, for patients managing chronic diseases such as hypertension medication adherence is paramount in improving overall health benefits. Some of those medications include angiotensin converting enzyme inhibitors (ACE inhibitors or ACE-I) and angiotensin receptor blockers (ARBs) and diuretics. There is still not enough information on how to improve adherence in a cost-effective manner (Seabury, 2014). The CDC estimates that approximately over one million individuals are seen in emergency departments for adverse drug events in which case many are preventable (Centers for Disease Control and Prevention, 2017). As our members advance in age, there is a likelihood that they will take more medications to care for their chronic diseases. Therefore, it is imperative that this population not only adhere to their medication but seek regular care with their provider to make sure that their current medication is correct for them or adjust as needed by conducting routine laboratory tests.

Association, A. H. (2018,). *American Heart Association - Monitor Your Blood Pressure*. Retrieved December 29, 2018, from American Heart Association: https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure

Control, C. f. (2018). *Effective Diagnosis, Treatment, and Monitoring of Hypertension in Primary Care - Participant Guide Treatment of Hypertension.*

Centers for Disease Control and Prevention. (2017, June 19). Medication Safety Program. Retrieved January 23, 2018, from Adverse Drug Event Monitoring: https://www.cdc.gov/medicationsafety/program_focus_activities.html

Seabury, S. G. (2014). Understanding and Overcoming Barriers to Medication Adherence: A Review of Research Priorities. Journal of Managed Care and Specialty Pharmacy, 775-783.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS Measure, Annual Monitoring for Patients on Persistent Medications (MPM) will be used to evaluate the effectiveness of the interventions implemented for this measure. The measure evaluates the percentage of adults 18 years and older who have received at least 180 treatment days of ambulatory medication therapy of either ACE/ARBs or diuretics. Madera County's baseline HEDIS result for ACE/ARBs in RY 2017 was 82.64% and in RY 2018 was 84.74%. The baseline HEDIS results for diuretics in RY 2017 was 82.20% in RY 2018 was 84.88%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with high volume, low compliance clinic in Madera County to improve MPM rates (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with the clinic in Madera County to receive updates on improvement rates for MPM.	P	Q1, Q2	CVH/HN
Continue with in-home screening program MedXM to complete required MPM laboratory testing.	M	Q1-Q2	CVH/HN
Continue with member incentive to improve MPM laboratory rates countywide.	M	Q1-Q2	CVH/HN
MPM Provider Tip Sheets available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended treatment guidelines.	P	Q1	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)

• In Q1 & Q2 2019, Medical Management continued working with a high-volume, low compliance clinic in Madera County to improve final RY19 rates for MPM (ACE/ARBs and diuretics). The bundled approach to improvement was continued, which included appointment scheduling through utilization of the Provider Profile, text messaging to members, and point of service member incentive gift card. In addition, the clinic began placing test orders in the EMR and mailing lab slips to established patients who had been seen by their provider within the last six months and required testing only. • Medical Management continued with bi-weekly multi-disciplinary MPM Improvement Team meetings to discuss the success and challenges in the process, barriers, results, and other identified issues. • Medical Management also continued with the MedXM in-home screening program to assist members in completing their required laboratory screening. A seven MPM labs were completed through MedXM. • Through these PDSA interventions, 57.9% (22/38) members completed their annual laboratory testing which exceeded the SMART Aim of 40% • In an effort to continue supporting providers, the MPM Provider Tip Sheet was made available to providers via the health plan's portal. • Final RY19 HEDIS compliance rates indicate that ACE/ARBs exceeded the 50th percentile at 89.13% and diuretics exceeded the 50th percentile at 90.37%.	The PDSA Improvement Project was successfully completed for Madera. Due to this measure not being part of the Managed Care Accountability Set for RY2020, all interventions ended on July 31, 2019.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.97%	Madera: 84.74%	89.13%	RY 2017 CVH results	Madera: 82.64%

	(RY 2018)				
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 86.06% (RY 2018)	Madera: 84.88%	90.37%	RY 2017 CVH results	Madera: 82.20%

Analysis: Intervention Effectiveness w Barrier Analysis	The MPM measure is no longer on the DHCS MCAS and the project closed mid-year. **Successes** • The placement of the "HTN Lab" alerts in the clinic's scheduling system not only improved Camarena's MPM rates but also facilitated continued outreach for CVH members on a measure that will no longer be reported in RY2020, but remains a standard of care for medication safety. • The "HTN Labs" alert provided a methodology for the clinic to continue identifying their patients who require annual testing and monitoring completion rates over time. • A clinical champion and the support of Clinic leadership for quality initiatives improved implementation and the development of an internal clinic process to sustain the activity after the project ended. • Regular Data Check-ins continued to be a positive strategy for facilitating ongoing communication between the Plan and the providers regarding project progress toward goals throughout the intervention period. • Regular team meetings improved communication among the team members and provided an opportunity to identify and address barriers along the way. **Barriers** • The project required the clinic to validate member eligibility and assignment to the clinic, at times delaying the progress of the project. • In order to complete the testing members had to come to the clinic regularly, causing patient fatigue. • Testing also requires the clinic to maintain continuous communication with the members about their appointments, causing clinic fatigue. Incorrect or outdated member contact information is a barrier to the clinic reaching members via phone, and also to mailing clinic laboratory slips to members who established care with their provider.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-3: Comprehensive Diabetes Care (CDC)

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	Health Net QI Department and Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: To help members with diabetes maintain control over their blood sugar and minimize the risk of complications associated with this highly prevalent chronic disease through lifestyle changes, healthy behaviors and medication management.

Rationale: Diabetes occurs when the body has an inability to produce enough insulin to properly control blood sugar. When left untreated, this complex disease can increase the risk for heart disease, stroke, blindness, kidney disease and more (Comprehensive Diabetes Care, 2018). In managing chronic conditions such as diabetes, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight and managing their blood sugar, limiting alcohol intake, and engaging in smoking cessation programs (Control, 2018). A simple test to measure one's hemoglobin A1c can help identify if one has type 1 or type 2 diabetes (Mayo Clinic A1c Test) and can be the first step in managing this chronic condition. For people with diabetes, it is crucial to not only manage one's blood sugar but to manage their blood pressure in effort to prevent the onset of kidney disease known as diabetic nephropathy (Mayo Clinic A1c Test). Diabetes care involves many facets and applying the multi-disciplinary approach which involves the member, provider, family members, and other health care professionals are part of the treatment plan in helping one manage their diabetes for long-term (Diabetes Care, January)

Comprehensive Diabetes Care. (2018). Retrieved December 30, 2018, from NCAQ - National Committee for Quality Assuarance: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Control, C. f. (2018). *Effective Diagnosis, Treatment, and Monitoring of Hypertension in Primary Care - Participant Guide Treatment of Hypertension.*

Diabetes Care. (January, 14 2018). Retrieved 30 December, 2018, from American Diabetes Association: http://care.diabetesjournals.org/content/41/Supplement_1/S28

Mayo Clinic A1c Test. (n.d.). Retrieved December 2018, 30, from Mayo Clinic: https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The measure evaluates the percentage 18-75 years of age with diabetes (type 1 and type 2) who have had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- Eye exam (retinal) performed.
- Medical attention for nephropathy.

- HbA1c control (<8.0%).
- BP control (<140/90 mm Hg).
- HbA1c control (<7.0%) for a selected population*****.

Fresno County baseline HEDIS results for HbA1c in RY 2017 were 84.91% and in RY 2018 was 83.21%. The baseline HEDIS results for Medical Attention to Nephropathy in RY 2017 was 90.51% in RY 2018 was 87.10%.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) and nephropathy testing (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with Fresno County provider to receive updates on improvement rates for CDC HbA1c and nephropathy testing.	P	Q1, Q2	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for CDC sub HbA1c testing, and urine analysis.	P	Q1-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• In Q1 & Q2 2019, Medical Management worked with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) and nephropathy testing. • Medical Management continued during this same period to conduct bi-weekly meetings with the multidisciplinary Diabetes Improvement team in order to receive updates on progress with activities and modify these activities as needed. • In Q1, Medical Management completed its first PDSA cycle in which members either completed their testing or had an appointment scheduled to complete testing s through utilization of the Provider Profile and a member incentive. Through this intervention, 77% (66/90) of members completed their annual diabetic testing or scheduled an appointment which exceeded the SMART Aim of 50%.	• In Q3-Q4, Medical Management continued collaborating with same high volume low compliance provider in Fresno County to improve HbA1c testing rates. • Medical Management continued their bi-weekly meetings with the multidisciplinary Diabetes Improvement team to continue improving HbA1c testing rates as well as determine barriers or challenges that arose during this intervention process. • The team utilized the “Planned Care Visit” to test its efficacy for a longer duration of improving completion rates for HbA1c testing. Through this intervention, 57.1% (40/70) of members completed their HbA1c testing, which exceeded the SMART Aim of 50%.

• At the start of the next PDSA cycle, the Diabetes Improvement Team utilized recommendations from the IHI Chronic Disease Toolkit "Partnering in Self-management". The team utilized the Diabetes Toolkit to implement its second PDSA cycle with a focus on "The Planned Care Visit". This approach emphasizes preparing the diabetic patient for a successful office visit. The Planned Care Visit approach consists of Utilization of the Diabetes Call Script, CDC HEDIS Workflow for Nephropathy, and the Orange and Butler Planned Care Visit Workflow. Through this intervention, 82% (45/55) of the members contacted for a Planned Care Visit by using the Diabetes Call Script had an appointment scheduled, labs drawn, or ordered. This exceeded the SMART Aim of 80%. • RY19 HEDIS results indicate that the Nephropathy MPL of 88.56% was exceeded in Fresno County at 89.29%. However, efforts to meet the MPL for HbA1c testing will continue in Fresno County. The RY19 final result for Fresno County although improved over RY18 results at 84.43%, did not exceed the slightly higher MPL of 84.93% for HbA1c testing.	• Through the implementation of the Provider Incentives, providers are eligible to receive incentive payment for showing an improvement for HbA1c testing. Final reports for 2019 will not be completed until mid-year 2020. • 2019 Member Incentive: the plan offered $50 incentive to non-compliant members for completing three diabetes-related tests (HbA1c test, urine protein for Medical Attention for Nephropathy, and retinal eye exam). An incentive offer was made to 3,471 members via mailer; 345 members claimed the reward. • CalViva Health launched a live-call campaign to members from Fresno County who were identified as non-compliant for diabetes-related measures. During the call, the incentive and assistance with appointment scheduling was offered. In Q3 and Q4, 1,159 members were reached via the campaign. • One Stop Clinics took place in Q3 and Q4, and CalViva Health and 432 members completed their diabetes care during these events.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Comprehensive Diabetes Care – HbA1c Testing	Meet or Exceed DHCS MPL update 84.93% (RY 2018)	Fresno: 83.21%	84.43%	RY 2017 CVH results	Fresno: 84.91%
HEDIS® Comprehensive Diabetes Care – Medical Attention for Nephropathy	Meet or Exceed DHCS MPL update 88.56% (RY 2018)	Fresno: 87.10%	89.29%	RY 2017 CVH results	Fresno: 90.51%

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • Collaboration with a motivated staff and proactive provider resulted in members completing their required testing for HbA1c. • Panel Manager and the support of leadership for quality initiatives improved implementation for all. • The implementation of the Provider Profile along with the Planned Care Visit increased HbA1c testing and provided the clinic with resources to help educate members on the need for comprehensive care. • Final RY19 indicated that the CDC sub measure Medical Attention for Nephropathy exceeded the MPL, especially since this measure has a high benchmark to achieve for compliance rate. **Barriers:** • Members did not understand why they should come in for their testing. • Updated and accurate member assignment to the target clinic was a barrier to the program. Several members who needed to complete their required HbA1c testing were assigned to another clinic within the same clinic system, but this change was not yet updated in the data. **Lessons Learned:** • The Planned Care Visit and Diabetes Script Initiatives increased compliance with appointment completion. • A clinical champion, such as the Panel Manager, and support of the clinic's Quality Improvement leadership improves the success of implementation. • Receiving clinic data at designated check points during the PDSA cycle allowed for CDC Improvement Workgroup to address the insure of member/patient • Obtaining staff feedback is crucial to successful intervention implementation. The Medical Management Team scheduled bi-weekly meetings to hear staff successes, challenges, and solutions to barriers to maximize improvement efforts.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
2-4: Breast Cancer Screening (BCS)				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	Health Net QI Department and Health Net Health Education Department
Rationale and Aim(s) of Initiative				

Overall Aim: To increase and improve the survival rates of CalViva members in Fresno County who are diagnosed with breast cancer through early detection.

Rationale: Breast Cancer Screening tests are used to find cancer before a person has any symptoms. The American Cancer Society recommends the following cancer screening guidelines for most adults: women age 45 to 54 should get mammograms every year; women 55 and older should switch to mammograms every 2 years, or can continue yearly screening; and screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.1

Multiple barriers limit screening mammography among minority women. Pain and embarrassment associated with screening mammography, low income and lack of health insurance, poor knowledge about breast cancer screening, lack of physician recommendation, lack of trust in hospitals and doctors, language barriers, and lack of transportation were the most frequently identified barriers. Recognizing predictors of screening among minority women and addressing culturally specific barriers may improve utilization of screening mammography among these women.2

1 American Cancer Society. American Cancer Society Guidelines for the Early Detection of Cancer. Breast Cancer. May 2018. Available at: https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

2 Journal of the National Medical Association. (March 2010). Barriers related to mammography use for breast cancer screening among minority women. Accessed January 3, 2019 at: https://www.ncbi.nlm.nih.gov/pubmed/20355350

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Breast Cancer Screening (BCS) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. The baseline HEDIS result for RY 2018 was 52.71%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with a high volume, low compliance provider in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Organize Mobile Mammography Coach at high volume, low compliance clinic site in Fresno County.	M	Q1-Q4	CVH/HN

Health Education to distribute educational materials on the importance of breast cancer screening	M	Q1-Q4	CVH/HN
Implement Provider Incentives to close the gaps and Improve HEDIS rates for breast cancer screening.	P	Q1-Q4	CVH/HN
Implement direct member incentive for completion of breast cancer screening to improve rates	M	Q1-Q4	CVH/HN
Deploy cultural and linguistic strategies at targeted convenient and culturally competent clinic site to support members in accessing their breast cancer screening services. Strategies include: geo mapping analysis specific regions and zip codes where disparity is occurring, on site interpreters, transportation services, etc.	M	Q1-Q4	CVH/HN
Alternative or create partnership with imaging center.	P	Q1-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• In Q1 and Q2, 2019 Medical Management led a quality improvement project to address breast cancer screening in Fresno County. This Project is in collaboration with one high volume, low compliance clinic in Fresno County. • Initially, a high volume, low compliance clinic was identified and approached to engage in the project. Once the clinic leadership approved the project, the team identified use of a mobile mammography unit at the clinic site as a first intervention. • However as further analysis was conducted on the targeted clinic's membership as part of our usual practice, a disparity was identified for the Hmong population. This sub-group was found to have an 18% BCS completion rate compared to others and the MPL which is at 58%. After learning about the barriers that exist for women at this clinic through barrier analysis and Focus Groups with the assistance of C & L and Health Ed Staff, we decided to create a member-friendly approach that might be applicable to other clinics and counties. The goal for this PDSA Cycle was to determine if using a Member Centered Approach* while at mobile mammography events would improve rates in Fresno County.	• In Q3 and Q4, Medical Management staff continued efforts with high volume, low compliance clinic in Fresno County to monitor compliance with breast cancer screening (BCS). • Regular meetings of the multidisciplinary BCS Improvement team continued in 2019 to review results and interventions tested. • After reviewing the clinic data and performing a barrier analysis, the team identified a cultural disparity negatively impacting the clinic's BCS compliance rates among the Hmong speaking membership. Throughout Q3 and Q4, the health plan collaborated with the clinic to address the low compliance, through a member-centered approach to appointment and completion. The member-centered approach included: a non-compliant member scheduling (Provider Profile) tool, reminder calls, interpreters, point of service member incentive and coordinated supportive services (transportation, etc). • In Q4, due to the success of the BCS PDSA, the project was converted to a Disparity BCS PIP (Performance Improvement Project). Module 1 was submitted and passed HSAG/DHCS. The team developed a SMART AIM Goal for the project: "By June 30, 2021, increase the breast cancer screening rate among the Hmong speaking population assigned to the Greater Fresno Health Organization targeted sites in Fresno County from a baseline rate of

• The multidisciplinary BCS Improvement Team met bi-weekly to develop the approach, plan events and review and evaluate results of interventions tested. • For the total of the 9 Events: 224/310 (72.3%) patients completed their BCS. • A survey to identify the reason why the member completed their exam was implemented at the conclusion of each exam performed. The top three responses were: 1) a doctor recommended that I attend; 2) it was convenient for me (time, location); and 3) the support from staff. **Member Centered Approach-. We provided refreshments and had in-person interpreters according to preferred languages to greet patients as they arrived; interpreters assisted in completing registration paperwork; patients were taken to a private room with an interpreter to discuss the breast history form, if needed; and patients were walked over to the mobile mammography coach where the interpreter remained available for any questions*	19.2% to a goal rate of 28.8% (a statistically significant improvement)." • In Q4, the health plan, the clinic, a radiology center and community based organization (CBO) collaborated on identifying potential strategies to address the low compliance rates; such as implementing block scheduling of members. The health plan is collaborating with a transportation vendor to address any additional issues for the members completing their breast cancer screenings. • In Q4, CalViva Health is in the process of completing Module 2 which is due January 17, 2020 that includes a Process Map; Failure Modes and Effects Analysis (FEMA); Failure Modes Priority Ranking; and a Key Driver Diagram. CalViva Health is collaborating with the clinic, the radiology staff and CBO to identify gaps in the current process and develop potential interventions that will increase the breast cancer screening rates in Fresno County. • CalViva Health offered a $25 incentive to non-compliant members for completing a mammogram. An incentive offer was made to 8,213 members via mailer; 467 members claimed the reward. • CalViva Health conducted 6,002 live outreach calls to members from Fresno County who were identified as non-compliant for breast cancer screening. During a call the plan offered an incentive and assistance with appointment scheduling. • One Stop Clinics and mobile mammography events reached 645 members, who completed mammography.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value

HEDIS® Breast Cancer Screening	Meet or Exceed DHCS MPL update 58.08%	51.14%	51.12%	RY 2018 CVH results	Fresno: 51.0%

Analysis: Intervention Effectiveness w Barrier Analysis	The Quality Improvement PDSA was completed for Fresno County in June 2019. CalViva Health met and exceeded the goal of at least 15% of the targeted members completing their annual Breast Cancer Screenings. Of the 341 members, 112 members (33.0%) completed their BCS once they had been scheduled by the clinic staff. The BCS PDSA was converted to a Disparity PIP in September 2019. **Successes:** • Multidisciplinary teams continue to be critical to the success of a project. • Effective collaboration and clinic engagement contributed to the success of a project. **Barriers:** • Mobile mammography coach availability • Language barriers exist regarding some medical procedures and it may require several attempts to fully communicate to a member what a mammogram is and why it is important. • Fear of the breast cancer screening test and result. • **Lessons Learned**: • Culture and language are important factors to consider when planning a health screening event such as BCS; preparation is critical to success. • Including Culture and Linguistic, Health Education, and Provider Relations on our team allowed us to address potential barriers ahead of time. • Flexibility is important, often members do not arrive at their scheduled time and the team needs to be prepared to adjust the schedule to fit them in. Many members arrived in the morning regardless of appointment time and were accompanied by family.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)				
3-1: Improving Childhood Immunizations (CIS-3)				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☐ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To improve child health in Fresno County.

Rationale: Childhood immunizations are critical to community health, and favorably impact overall health outcomes. The increase in life expectancy during the 20th century is largely due to improvements in child survival. This increase is associated with reductions in infectious disease mortality due to immunizations. Childhood immunizations are proven to help a child stay healthy, protect them from serious illnesses such as polio, tetanus, and hepatitis, and avoid the potentially harmful effects of diseases like mumps and measles. According to HealthyPeople.gov, each birth cohort vaccinated with the routine immunization schedule saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by 9.9 billion, and saves 33.4 billion dollars in indirect costs.1

Therefore, CalViva Health has selected Childhood Immunizations Status – Combination 3 (CIS-3) in Fresno County for a Performance Improvement Project (PIP) topic. Childhood immunizations is a component of the seven priority focus areas (Foster Healthy Communities) identified by DHCS for the Medi-Cal Quality Strategy.2 The CIS-3 measure in Fresno, Madera, and Kings Counties are at/above the MPL RY 2018 (71.3%).

1 HealthyPeople.gov. (n.d.). Retrieved October 30, 2017, from Immunization and Infectious Diseases : https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases
2 Kent, J. (2017). 2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy). California Department of Health Care Services (DHCS).

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Childhood Immunization Status - Combination 3 (CIS-3), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified for completing the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR), three Hemophilic influenza type B (HiB); three hepatitis B, one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations on or before their second birthday. The baseline rate of 62.5% was determined based on the RY 2017 HEDIS hybrid data for one high volume, low preforming clinics in Fresno County.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 4), and monitor intervention effectiveness (Module 5).	P	Q1-Q2,Q3	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q3	CVH/HN
Implement direct member incentive for completion of childhood immunizations series to improve rates	M	Q1,-Q2,Q3	CVH/HN
Elimination of the double bookings option/implementation of walk-in/RN visits	M	Q1,Q2,Q3	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for Childhood Immunizations.	P	Q1,-Q2,Q3	CVH/HN
Provider Tip Sheets will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	P	Q2,Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 and Q2, CalViva Health led a Childhood Immunization (CIS-3), Performance Improvement Team in collaboration with one high volume, low compliance clinic in Fresno County. • The team implemented the first intervention of eliminating the double-booking option from provider scheduling templates (Monday through Friday) until the start of the work day. This is anticipated to allow space for patients to schedule same-day appointments for the needed immunizations and a Well-child Exam. The clinic also initiated "Nurse Only Visit" scheduling on designated days. These visits offered very flexible scheduling because the patient saw only the Medical Assistant in order to receive their immunization. Additionally, the clinic accommodated walk-in patients at their designated "Walk-in Only Clinics" on Saturdays. • It was determined that "Nurse Visit" was the preferred option for members. The final compliance rate is 68.7%.	• In Q3, CalViva Health Medical Management continued efforts with high volume, low compliance clinic in Fresno County to monitor providers' compliance with childhood immunizations (CIS-3). • In Q3, regular meetings of the CIS-3 Improvement team continued to review results of monitoring and evaluating the success of interventions and initiate modifications when indicated. • Regarding the first intervention, the elimination of double-booking/RN visits, the data collection from August 2018 to June 2019 reflected some variation, but has demonstrated steady positive results for the number of childhood immunizations completed. • The rate remained steady throughout 2018, and 2019 and has shown an increase since our intervention was initiated. The highest rate was achieved in April 2019 with a rate of 72.9%; and

• The second intervention was a $25 per member/per visit gift card incentive at point of service. • The member newsletter will be distributed to members in the Fall of 2019 to educate them on the importance of childhood immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • The Childhood Immunizations billing and coding sheet was provided to Providers. The development of a Provider Tip Sheet is pending revisions and future launch date.	the Performance Improvement Project ended with a rate of 68.7%. The intervention allowed parents with young children to have improved access to convenient visits with immunizations Monday through Friday. • The second intervention of a $25 per member/per visit incentive which was implemented in December 2018 has also had a positive impact on the childhood immunization rate. • Module 4 (both interventions) and Module 5 were submitted to HSAG/DHCS and were accepted, which included a detailed Intervention Progress Logs; Intervention Results; Run Charts; Key Driver Diagrams; updated Failure Modes and Effects Analysis Table; and updated Intervention Determination Table. • These interventions ultimately influenced the SMART Aim, "By June 30, 2019, increase the rate of childhood immunizations (CIS-3) among members that belong to a low compliance clinic in Fresno County, from 48.7% to 60.0%." • CalViva Health offered $50 incentive for completing immunization series for members who were non-compliant for CIS-10 measure. An incentive offer was made to 4,185 members via mailer; 210 rewards were claimed by members. • CalViva Health conducted monthly live outreach calls to parents / guardians of members who were identified as non-compliant for CIS-10 and were turning 2y.o. in next two months. Calls outreached to 2,639 members, during a call the plan offered an incentive and assistance with appointment scheduling. • CalViva Health One Stop Clinics completed services with 50 members.
Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1) **Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)** **Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)**	

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value
Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 60.0%	Fresno: 71.28%	69.59%	RY 2018 CVH results	Fresno: 48.7%

Analysis: Intervention Effectiveness w Barrier Analysis	The CIS-3 PIP exceeded the SMART Aim compliance rate of 60.0%, and the PIP ended in June 2019 with a rate of 68.7%. Based on validation findings from HSAG, there was confidence that the PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCP accurately summarized the key findings. **Successes** • Engaged with high volume Fresno County clinic sites to address childhood immunization gaps, and exceeded performance improvement project goal (60%) by reaching 68.7% compliance, despite project challenges. **Barriers** • Initially, we began the project with two clinic sites and after one year of the project CIS-3, one clinic had to drop out due to provider relocation. • This was followed by all new staff at the clinic and on our team, as the clinic was restructured after a change in ownership. • The clinic went through a change in scheduling and clinical software at all clinic sites. • These factors impacted the team's ability to initiate change, maintain support of leadership and team membership and our ability to sustain change after testing. • Offering an incentive for completing whole series of immunization at point of care is administratively burdensome to execute. **Lessons Learned:** • The team anticipated that once parents were notified that immunizations were offered on a walk-in basis, then the majority would choose this option over scheduling an appointment. Contrary to the team's hypothesis, the clinic has reported that none of the parents have chosen to walk-in, but have scheduled appointments with either the provider or RN. • The clinic reported fewer 'no shows' due to accessibility of convenient appointments times that fit parent schedules. • Staff turnover at the clinic requires new training for improvement projects, which can result in delays.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
3-2 Addressing Postpartum Visit Disparities				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**		☐ **Safety Clinical Care**
Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve maternal health in Fresno County.

Rationale: Postpartum care continues to be a priority in the 2019 DHCS Strategy for Quality Improvement in Health Care in the delivery of effective, efficient and affordable care under Medi-Cal Managed Care (Priority 2). DHCS has also adopted the strategy of eliminating health disparities in the Medi-Cal population (Priority 7).[1] The PIP proposed by CalViva Health addresses both priorities by aiming to develop interventions specifically for disparities within a population receiving postpartum care. Closing gaps in care due to disparity is also a priority for CalViva Health, which has developed a strategy to address disparities using the Robert Wood Johnson Foundation's definition of health equity:

Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.[2]

The postpartum visit is important for support of breastfeeding, screening for postpartum mood and anxiety disorders, follow-up of conditions such as diabetes and hypertension, and family planning. It is also often the only time to incorporate the essentials of care between pregnancies, integrate all relevant clinical information and provide information to the patient. Given the disparate rates between the Kerman and Mendota Clinics in Fresno County, and the opportunities identified through barrier analysis and literature review, postpartum care is a critical PIP disparities topic for CalViva in rural Fresno County.

[1] Kent, J. (2017). *2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy).* California Department of Health Care Services (DHCS).
[2]Braveman, P. E. (2017). What Is Health Equity? And What Difference Does a Definition Make? Princeton: Robert Wood Johnson Foundation.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Postpartum Care (PPC), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women who completed a postpartum visit including a pelvic exam or postpartum care on or between 21-56 days after delivery, as documented through either administrative data or medical record review. The HEDIS timeframe for postpartum care is from November 6, 2017 to November 5, 2018. The baseline rate of 50% was determined based on the RY 2017 HEDIS data for the high volume, low preforming clinic.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with a high volume, low compliance Clinic with identified disparity in Fresno County to continue to monitor postpartum care rates and disparity activity (Modules 4 and 5).	P	Q1,Q2,Q3	CVH/HN
Implement and monitor EMR OB Alert	M	Q1,-Q2,Q3	CVH/HN
Monitor the use of the revised ACOG OB History Form to address cultural issues	M	Q1,-Q2,Q3	CVH/HN
Provider Tip Sheet on Postpartum Care will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended postpartum care guidelines.	P	Q2,Q3	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores	P	Q1, Q2,Q3	CVH/HN
Implement Postpartum Member Incentive by sending a $25 gift card to members for whom we receive a correctly completed and timely Postpartum Care Notification Form from their provider in all CVH Counties	M	Q1, Q2,Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 and Q2 2019, Medical Management continued its partnership with a high volume, low compliance clinic with an identified disparity in Fresno County. The project team was focused on a clinic site located in Mendota, in a rural area of Fresno County. • The team's initial intervention focused on scheduling the postpartum visit within the correct timeframe after delivery (21-56 days) and involved the creation of an "OB Alert" in the clinic's electronic medical record (EMR). Barrier analysis revealed that clinic staff were unsure of the appropriate timing for the postpartum visit and historical data revealed visits occurring outside the recommended timeframe were common. This intervention required revision during the first six month of 2019 after the clinic went live with a new electronic medical record. The team approved a new workflow for staff where a postpartum	• In Q3-Q4, CalViva Medical Management continued to collaborate with a high volume, low compliance clinic with an identified disparity in rural Fresno County. • In Q3, Modules 4 (both interventions) and Module 5 were submitted to HSAG/DHCS and it was validated, which included a detailed Intervention Progress Logs; Intervention Results; Run Charts; Key Driver Diagrams; updated Failure Modes and Effects Analysis Table; and updated Intervention Determination Table. • The first intervention focused on placing an OB Alert set up as a Postpartum Visit appointment scheduling system for the 21-56 day Postpartum Visit to increase the number of visits completed within the HEDIS® timeframe. There were weekly reports with

visit would be scheduled for all pregnant women with an estimated delivery date (EDD) in the EMR. • The second intervention implemented was designed to facilitate integration of the mother's cultural preferences regarding the postpartum period into the plan of care. The intervention was developed after a barrier analysis was performed during several meetings with Mendota clinic patients, staff, and providers. It was determined that a cultural disparity existed for a sub-population of women from El Salvador which impacted compliance with the postpartum appointment. At the start of the PIP: Kerman Clinic rate: 73%; Mendota Clinic rate: 50%. • A revised OB History (ACOG) form was developed to prompt staff and providers to inquire about cultural preferences early in the pregnancy that may impact care and scheduling of the postpartum visit and document responses on the OB History form which follows the mother from diagnosis to delivery. From these meetings, it was determined that there was minimal cultural awareness related to postpartum practices among clinic staff and providers. • A Provider Tip Sheet was uploaded to the Provider Portal as a quick reference for providers. • Providers were offered an incentive to encourage outreach to members and completion of their postpartum visit. • Members were offered a $25 incentive to encourage the completion of their postpartum visit. • At the conclusion of this project, the timely Postpartum Visit compliance rate is 82%. The rate is calculated by: # Postpartum visits completed per month divided by # of deliveries per month on a rolling 12 month basis.	staff follow-up; reports were run for CalViva Health every two weeks. • To address cultural barriers, a revised OB History (ACOG) form was developed to prompt staff and providers to inquire about cultural preferences after delivery, and document responses for the member's medical record. A regular monthly chart audit of 30 random records occurred from October 2018 through June 2019, and the chart audit displayed 100% compliance rate by June 2019. • To support discussions around cultural practices, the providers and clinical staff were trained on motivational interviewing as well as cultural sensitivity. • A Community Action Group (CAG) was convened regularly in 2019, consisting of community partners and members that help identify and address cultural, linguistic and educational barriers inclusive of social determinants of health to support members' access to care. Through the CAG activities, the group identified four priorities for the Mendota community: 1) Health Care Access, 2) Patient experience, 3) Quality of Care and 4) Environment Resources. • At the completion of the PIP (June 2019), the clinic compliance rate for postpartum care was 82.0%. The final rate exceed the SMART Aim goal of 64%.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value

HEDIS® Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64.0%	Fresno: 59.2%	62.0%	RY 2018 CVH results	Fresno: 50.0%

Analysis: Intervention Effectiveness w Barrier Analysis	Based on validation findings from HSAG, there was confidence that the PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCP accurately summarized the key findings. **Successes:** • CalViva Health received the DHCS Disparities Award for the PPC Disparities PIP. • Engaged with high volume, rural clinic to exceed performance improvement project goal of 64.0%. • In-depth analysis of cultural barriers led to a new prenatal form, which was completed at 100% of the appointments as of the final data collection in July 2019. • Motivational interviewing and staff training to improve cultural competency engaged providers and staff at all levels. **Barriers:** • Clinic changed electronic medical records (EMR) during the project, and had IT staff turnover delaying the implementation of the first intervention (flagging in EMR). The medical management team worked with the new IT staff to implement the EMR alert in the system. • Staff needed continued education on flagging and alert system, which delayed the progress of the intervention. • Staff turnover required re-education of data collection to ensure consistent data monitoring • Providers needed re-education and encouragement to complete cultural section of the prenatal intake form, which resulted in slow progress of second intervention. **Lessons Learned:** • The provider profile was modified to include estimated gestational age and CIN as recommended by the clinic, requesting hospital delivery report for more current reporting. • Disparity data has been gathered to identify cultural barriers, and now the plan is determining how to improve processes to better communicate between staff and members. • Providers and staff at rural Fresno County clinic are beginning to identify patient preferences related to cultural beliefs which may results in changes in the plan of care/services in order to increase compliance with postpartum visits.
Initiation Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN	Distributing in the new member packet	☒	12/31/2019	On-going distribution of PGG in new member packet
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	CPGs are available on the provider library. Last sent out July 19, 2019.	☒	7/19/2019	Quality Management provider updates: Help Your Patients Achieve Better Health Outcomes was distributed to providers on 7/19/19
3. Implement CalViva Pregnancy Program and identify high risk members by Case Management	CVH/HN	Through Q2 221 members managed in PCM program, exceeding number managed in 2018. Quarterly average engagement rate remained constant at 25% across Q1 and Q2.	☒	12/31/2019	Program ongoing and December data pending. Through November 2019 437 members managed in PCM program. YTD engagement rate 27% - increased in Q4. Outcome measures for program – 75 members met inclusion criteria. Greater compliance in prenatal and post-partum visits with managed members, and lower preterm delivery of high risk members managed.
4. Promote CA Smokers' Helpline to smokers	CVH/HN	Conducted one mailing promoting the Helpline to identified CalViva Health's smokers.	☒	12/31/19	Conducted 2 mailings
5. Launch a Diabetes Prevention Program	CVH/HN	Pending approval of promotional materials before it can be launched.	☒	12/31/19	Pending revision to Scope of Work based on DHCS feedback.
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach	CVH/HN	Program transitioned fully to Envolve People Care (a Centene corporation) at the	☒	12/31/2019	Program transition began October 2018 and completed fully March 2019. Asthma,

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		end of March 2019. Program ongoing.			diabetes and heart failure programs offered, with diabetes OnDemand program in proposal phase.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN	CVH completed and received approvals during Q2 2019 on the following reports: 2018 End of Year Language Assistant Program and 2018 End of Year Work Plan, 2019 Program Description and 2019 Work Plan. For details on the 2018 outcomes and 2019 activities, please refer to C&L reports accordingly. Also completed / submitted the Language Assistance Program Assessment Report for the DMHC Timely Access Reporting.	☒	10/17/19	CVH completed and received approvals during Q4 2019 on the following reports: 2019 Mid-Year Language Assistant Program and 2019 Mid-Year Work Plan Evaluation Reports. For details on the mid-year reports, please refer to the individual reports accordingly.
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN	Surveys for MY2019 will begin in September 2019.	☒	12/31/19	Surveys completed on 12/31/19
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/HN	TAR filing submitted timely.	☒	4/30/19	TAR filing submitted timely
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	CVH/HN	Surveys were completed 12/31/2018. After receiving information from vendor, data will be analyzed, and CAP packets for noncompliant PPGs and providers will be sent out.	☒	12/31/19	CAP packets sent were mailed out 8/15/19 and Improvement Plans received by 12/31/19.(IP) due 9/16/19. Two Follow-up continues on outstanding IPs will be

Activity	Activity Leader	Mid-Year Update	Complete?	Year End (YE) Date	YE Update or Explanation *(if not complete)*
					followed up on until completed12/31/19.
5. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN	A&G will continue to assist members with obtaining timely access appointments and facilitate referrals as needed.	☒	12/31/2019	Data is a consistent component of UM/QI and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.
6. Group Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistics, Health Education and Quality Improvement (QI) programs.	CVH/HN	C&L continues to utilize GNA findings to develop and implement C&L priorities to ensure members, providers and staff have access to culturally and linguistically appropriate services, trainings and resources inclusive of language services. Next GNA report is scheduled for 2021.	☒	Q4 2019	Planning for the 2021 Population Needs Assessment initiated during Q4. Group Needs Assessment (GNA) name changed by DHCS to Population Needs Assessment (PNA).
7. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement: Analyze and inform Provider Network Management areas for increased contracting with a particular provider to improve availability. (Quarterly: next report 2020)	CVH/HN	C&L Geo Access report in progress and scheduled to be completed during Q3 2019.	☒	10/17/19	C&L Geo Access completed and approval received during Q4 2019. Report and provider data be zip code provided to PNM in Q4.
8. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-step outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	IHA was submitted for review and accepted at QIUM May and July 2019. Ongoing IHA 3-step outreach is reported on a quarterly basis.	☒	12/31/2019	Ongoing IHA 3-step outreach. Reported on a quarterly basis- identifying opportunities for improvement for compliance.
QUALITY AND SAFETY OF CARE					
Integrated Case Management	CVH/HN	Reports using Impact Pro stratification are used to	☒	12/31/2019	Program ongoing. Reports using Impact Pro stratification

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
• Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs Member Satisfaction		identify high risk members for CM. Q1 program outcomes include PH, BH, & TCM cases. 134 members met outcome inclusion criteria. Results of members managed: • Number of admissions and readmissions was lower; 27% difference • Volume of ED claims/1000/year decreased by 328 Member Satisfaction Survey - respondents reported 72.7% improvement in ability to care for self/family post CM (46.3%) vs pre CM (26.8%); 97.5% (39/40) of respondents reported CM exceed their expectations			are used to identify high risk members for CM. Q3 outcome data pending as based on claims data. Q1-Q2 program outcomes include PH, BH, & TCM cases. 259 members met outcome inclusion criteria. Results of members managed: • Number of admissions and readmissions was lower; 19% lower readmission rate • Volume of ED claims/1000/year decreased by 324
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN	Credentialing and Recredentialing reports received timely to QI Workgroup during Q1 and Q2. On target for credentialing and recredentialing goals.	☒	12/31/2019	Completed and compliant for Year 2019. Ongoing for 2020. Non-delegated and Delegated Credentialing (Delegation Oversight)
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH	CVH/HN	MHN QI created a practitioner newsletter	☒	12/31/19	MHN QI completed member satisfaction and provider

Activity	Activity Leader	Mid-Year Update	Complete?	Year End (YE) Date	YE Update or Explanation *(if not complete)*
(may include member satisfaction surveys, provider surveys, etc.)		specifically for CalViva Health practitioners (Jan.-June 2019), which highlighted the 2018 member satisfaction survey results. MHN QI continues to meet and collaborate with HN's Culture and Linguistics and Appeals and Grievances Departments to track, trend and investigate member grievances. MHN QI added appointment wait time reminders to MY 2019 Provider Appointment Availability Survey outreach letter and May Newsletter. Professional Relations is tracking and focusing on provider recruitment efforts using a new quarterly report of provider network changes and updated and corrected provider directory information based on outcome data from the MY2018 Provider Appointment Availability Survey			satisfaction surveys and reports by end of year as planned. Additionally, MHN QI partnered with HN to improve the execution of the MY 2019 provider appointment access survey (PAAS) by leveraging a shared services vendor to improve response rates. Actions planned in response to the results of these surveys will be captured in 2020 QI documents. MHN QI also added office wait time standards to the September MHN Provider Newsletter with goal of improving office wait time experience by members.
QUALITY IMPROVEMENT					
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure practitioner offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review	CVH/HN	Q3 and Q4 2018 monitoring and reporting completed. Q1 and Q2 2019 reports are in progress. Promoting and training on changing FSR/MRR requirements is	☒	12/31/2019	Reporting completed to DHCS in Q3 and Q4 as planned.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
Survey per MMCD Policy Letter 12-006 and 15-023		underway. Q3-Q4 planned work is on track.			
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	Ongoing monitoring in progress.	☒	02/21/2019 09/19/2019 12/31/2019	Continuing to monitor. Providing updates on Work Plan at mid-year and year-end. 2018 Year end was completed and brought to commission on 2/21/2019. 2019 Mid-Year was completed and brought to commission on 9/19/2019. 2019 Year-end has been completed.
CLINICAL DEPRESSION FOLLOW-UP					
1. Continue development and distribution of provider educational resources on screening for clinical depression and follow up (12 years and older)	CVH/HN	On track. In May, completed an online provider webinar on motivational interviewing for behavioral health screenings and referrals, including the Patient Health Questionnaire (PHQ) for depression.	☒	05/15/2019	Completed. The online provider webinar was completed on May 15th, 2019.

Item #10

Attachment 10.B

2019 Annual Utilization Management
Case Management
Year End Evaluation

CalViva Health
2019
Utilization Management (UM)/ Case Management (CM)
Annual Work Plan
End of Year Evaluation

Created: January 25, 2019
Last updated: February 12, 2020

TABLE OF CONTENTS

Created: January 25, 2019
Last updated: February 12, 2020

1. Compliance with Regulatory & Accreditation Requirements

Created: January 25, 2019
Last updated: February 12, 2020

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (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. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' 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. Verification of Continuing Medical Education (CME) standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Monthly As needed Ongoing Ongoing Ongoing

Created: January 25, 2019
Last updated: February 12, 2020

Health Net

CalViva HEALTH

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in the first half of 2019 • Pathways to Safer Pain Management • Work up and Management of COPD • End of Life • Updates on Evidence-based Statin Re-challenge Guidelines • HIV Part II Prevention and Management • Clinical Effectiveness & Scalability of the Diabetes Prevention Program • Motivational Interviewing New hire overview training is offered monthly for all new hires. Medical management onboarding classes are offered and completion is monitored through our online learning management system. Ongoing process of verification of CME standing and certification is in place.	None identified	None	Ongoing

Created: January 25, 2019
Last updated: February 12, 2020

CalViva Health
2019 UM/CM Plan

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in 2019 • Pathways to Safer Pain Management • Work up and Management of COPD • End of Life • Updates on Evidence-based Statin Re-challenge Guidelines • HIV Part II Prevention and Management • Clinical Effectiveness & Scalability of the Diabetes Prevention Program • Motivational Interviewing • Cultural presentation • The Importance of the Fourth Trimester of Pregnancy • Supporting members Living in Poverty • HEDIS 2020 Update and Best Practices • Clinical Trials • Eliminating Cervical Cancer • Cystic Fibrosis New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Ongoing process for verification of CME standing and certification is in place. Training materials were reviewed and revised including development standardized end-to-end processes. IRR training and testing was completed.	Different process had not been standardized so were reviewed, aligned and full end to end (E2E) processed created. IRR testing needed to align with corporate testing.	Each area has completed E2E process improvement. Training has been updated based on new processes including a more liberal training schedule for staff.	Ongoing

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM 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

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	Continue to assess implications of changes in regulation and update our policies and procedures as needed.	Ongoing Ongoing Ongoing

Created: January 25, 2019
Last updated: February 12, 2020

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers 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 acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire and annually thereafter through Cornerstone (online learning platform). Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter through Cornerstone. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Employees making UM decisions were required to sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. Staff review and acknowledge this statement through the Plan's online learning platform upon hire and annually thereafter. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None	None	Ongoing

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
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 staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing April 2019, July 2019, October 2019, January 2020

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
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.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	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.	None identified	None	Ongoing

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to CVH MD and CMO participation: ▪ Demonstrates CVH interest in DHCS activity and Medi-Cal Program. ▪ Provides CVH with in-depth information regarding contractual programs. ▪ Provides CVH 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 2019. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Created: January 25, 2019
Last updated: February 12, 2020

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
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	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	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 all four quarters in the year.	None identified	None	Ongoing Ongoing

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 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.	☒ Medi-Cal	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 Chief Medical Director (CMD), Regional Medical Directors, Director of Medical Management and Medical Management Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2019 UMCM Program Description. Write and receive CalViva approval of 2018 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2019 UMCM Work Plan. Write and receive CalViva approval of 2019 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 2019 Q 1 2019 Q 1 2019 Q 3 2019 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**	The 2018 Year End UM/CM Work Plan Evaluation, 2019 UMCM Work Plan, 2019 UM Program Description and the 2019 CM Program Description were submitted and approved in Q1 2019. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	The 2019 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3. CalViva continues to monitor and revise policies and procedures based on DHCS, DMHC and other regulatory requirements.	None identified	None	Ongoing

2. Monitoring the UM Process

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
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

Health Net

CalViva HEALTH

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2019 UM/CM Plan

<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 leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

Monthly Key Indicator (KIR) and Staffing reports are reviewed to track trends, results, opportunities and are discussed in the Medical Management Leadership Meetings. Action plans are developed/implemented as needed based on results/trends to mitigate risks with meeting requirements.
<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Modified</th><th>Denied</th></tr>
<tr><td>January</td><td>6,120</td><td>34</td><td>1,191</td></tr>
<tr><td>February</td><td>5,936</td><td>34</td><td>1,220</td></tr>
<tr><td>March</td><td>6,223</td><td>34</td><td>1,362</td></tr>
<tr><td>April</td><td>5,793</td><td>37</td><td>1,327</td></tr>
<tr><td>May</td><td>6,795</td><td>45</td><td>1,578</td></tr>
<tr><td>June</td><td>5,926</td><td>51</td><td>1,331</td></tr>
<tr><td>Totals</td><td>36,793</td><td>235</td><td>8,009</td></tr>
</table></td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
</table>

Created: January 25, 2019
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CalViva Health
2019 UM/CM Plan

<table>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2020</td>
<td>The Management team reviewed monthly reports to discuss and review 2019 expectations. Trends and results were discussed in the Medical Management Department KPI meeting.

Staffing needs based on authorization process and volumes were accounted for in the annual budget review.

2019 Authorization volumes:
<table>
<tr><th>Months</th><th>Approved</th><th>Modified</th><th>Denied</th></tr>
<tr><td>Jan</td><td>6119</td><td>37</td><td>1187</td></tr>
<tr><td>Feb</td><td>5943</td><td>35</td><td>1210</td></tr>
<tr><td>Mar</td><td>6228</td><td>35</td><td>1358</td></tr>
<tr><td>Apr</td><td>5808</td><td>42</td><td>1308</td></tr>
<tr><td>May</td><td>6816</td><td>55</td><td>1533</td></tr>
<tr><td>Jun</td><td>5972</td><td>61</td><td>1276</td></tr>
<tr><td>Jul</td><td>6414</td><td>64</td><td>1252</td></tr>
<tr><td>Aug</td><td>6468</td><td>49</td><td>1228</td></tr>
<tr><td>Sep</td><td>5971</td><td>30</td><td>1368</td></tr>
<tr><td>Oct</td><td>7241</td><td>46</td><td>1338</td></tr>
<tr><td>Nov</td><td>6265</td><td>21</td><td>995</td></tr>
<tr><td>Dec</td><td>6228</td><td>31</td><td>1020</td></tr>
<tr><td>TOTAL</td><td>75473</td><td>506</td><td>15073</td></tr>
</table>
</td>
<td>The Plan saw an influx preservice authorization requests for services that did not require authorization, were inappropriate requests, incorrect urgency, and extreme in volume in Q2 and Q3 from one provider. Education was provided to the provider and staff and volumes returned to anticipated totals in subsequent periods.

There are no ongoing issues impacting authorization volumes.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =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 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 monthly

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Activities were on target in Q1 of 2019, however barriers listed have adversely impacted TAT. TAT: Q1-2019: 98.9% Q2-2019: 65.6%	1. New hiring process rolled out in Q1 resulted in delays in onboarding staff. This contributed to a backlog in May and June and missed TAT 2. Central Valley provider inundated authorization request volumes, sending 100-600 requests daily in May, June. This caused a backlog throughout May and June.	1. Weekly meetings being held with Human Resources and Recruiting for status on open positions and ensure a timely candidate pool. Job Fairs being held in July to fill remaining vacancies. 2. Involved Medical Directors and Provider Relations to educate provider on appropriate level of services being requested. Authorization requests continue to be received from this provider in July, however volumes have greatly reduced.	9/15/19

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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>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2020</td>
<td>The Plan monitored TAT as planned in 2019. The benchmark of 100% TAT was not met in all months. A formal CAP for TAT was established and is ongoing.

<table>
<tr><th>Services</th><th>Q1 2019</th><th>Q2 2019</th><th>Q3 2019</th><th>Q4 2019</th></tr>
<tr><td>Preservice Routine</td><td>98.90%</td><td>65.60%</td><td>87.30%</td><td>88.67%</td></tr>
<tr><td>Preservice Urgent</td><td>98.90%</td><td>90.00%</td><td>91.80%</td><td>89.33%</td></tr>
<tr><td>Postservice</td><td>100.00%</td><td>98.90%</td><td>92.90%</td><td>94.00%</td></tr>
<tr><td>Concurrent (inpatient only)</td><td>92.20%</td><td>96.70%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>Deferrals - Routine</td><td>100.00%</td><td>92.40%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>Deferrals - Urgent</td><td>100.00%</td><td>100.00%</td><td>100.00%</td><td>100.00%</td></tr>
</table>
</td>
<td>HN Medical Management Team identified three root causes for the delay in decision making:
1. Resource Allocation: During the Second Quarter of 2019, HN Medical Management was short-staffed due to a higher than normal turnover in staff. This was compounded by a new centralized hiring program implemented by Human Resources which prolonged the recruitment process.
2. Increase in volume: A Pain management provider was noted as submitting upwards of 600-1000 referrals daily for drug testing over the course of one month. Our analysis show that the provider submitted duplicate requests, inappropriate requests for services that did not require prior authorization, and insufficient information to make a determination.
3. Misalignment of authorization procedures: Health Net MM discovered policies and procedures that were misaligned. The current procedures built in duplicate processes and ambiguous steps in the process which led to delays in reviews.</td>
<td>• Weekly requisition meetings with human resources and recruiting to track all open position requests and progress to candidate selection.
• Engaged Provider network management to work with pain management provider to cancel inappropriate authorizations.
• Overtime authorized.
• Daily meetings to review current pend and open referrals between clinical and non-clinical
• Hourly monitoring of PEGA system to monitor cases close to missing TAT
• Bi -Weekly Audits to validate weekly results between clinical leaders and auditing team. Deep Dive into failed cases
• Staff Productivity monitored daily
• Monitoring referrals for outlier provider referrals pattern/volume</td>
<td>Ongoing</td>
</tr>
</table>

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
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.	Health Net 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 2019. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2019.	Q3-4 2019 Q3-4 2019

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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**	IRR training and retesting courses were offered in May/June 2019 for those who did not pass the 2018 test. Trainers we will be attending train the trainer in July/August for IRR updates. Updates will be trained and retested Oct-Dec 2019.	None identified	None	12/31/2019

Annual Evaluation
 	
☒ **MET OBJECTIVES**
 	
☒ **CONTINUE ACTIVITY IN 2020**
	Minimum testing scores were not achieved in 2018. An action plan was implemented in 2019 to re-educate and retest.
	
	Following InterQual refresher training, the Change Health (formerly McKesson) InterQual IRR modules were administered to the Physician Reviewers and the non-physician clinical staff requiring a minimum score of 90% to pass.
	
	Overall pass score was 98%
		None identified	• 2019 Tests were administered via links directly sent from Change Health
			• Reports were generated by corporate training.
			  • New Summary of Changes modules were introduced in the 2019 version
			  • Refresher Trainings were provided by the plan training team
				Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.4 UM Process Improvement Initiative	☒ Medi-Cal	Increase Medical Director collaboration with the UM teams to ensure members are receiving appropriate services timely	5% Increase in number of inpatient and preservice referrals for Medical Director review	Managers will huddle with clinical staff daily to review cases. Medical Directors will be attending daily huddles/rounds to identify cases for further consultation and direction. Institute nurse cross training and training regarding appropriate use of policies related to MD referrals, Monitoring productivity report and quality audits by volume and by staff member to ensure referrals are appropriate. MD referral rates will be incorporated into existing reports.	Ongoing Ongoing Jan 2019 and Ongoing Ongoing Q1 2019 and 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**	We are continuing to work with the MD's and the nursing teams. We have implemented different processes to ensure reviews/referrals are being sent appropriately. We are working with an outside consultant to ensure correct referrals and education is department wide and consistent. We are still in process of adding additional measures to the teams.	Inconsistent review process and workflows in the teams. End to End processes were formalized and trained to each department/team.	Working with outside consultant to ensure reviews are consistent and appropriate.	12/31/2019
Annual Evaluation ☒ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2020**	In 2019 multiple approaches were taken increase Medical Director collaboration with the UM teams including: • End to End processes were formalized and additional training was provided to nurses regarding appropriate use of policies related to MD referrals. • Managers huddled with clinical staff daily to review cases, • Medical Directors attended huddles/rounds to identify cases for consultation and direction • Manual quality checks on referrals going/not going to the Medical Directors were implemented. As a result of the activities, the Medical Director reviews have increased from 5% of total authorizations to an average of 8% of total authorizations.	Inconsistent review process and workflows identified.	Worked with outside consultant to ensure reviews are consistent and appropriate.	12/31/2019

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.5 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 Turnaround 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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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Appeals data is a consistent component of UM/QI and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met. Turnaround Time Compliance for resolved expedited and standard appeals = 99.71% or 341 out of 342. 2019 Semi-Anneal Appeals January -June 2019 Appeal Type / Case Count / Percentage Overturn / 153 / 44.74% Partial Uphold / 6 / 1.75% Uphold / 180 / 52.63% Withdrawal / 3 / 0.88% Total Cases / 342	None identified	None	Ongoing

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<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2020</td>
<td>Appeals data is a consistent component of UM/QI and tracked on a routine and ongoing basis. Activity was ongoing in 2019 and will continue in 2020 to ensure quality outcomes are met.

Appeals of UM Appeal determinations for time frame January – December 2019. Turnaround Time Compliance for Appeals = 99.66% or 884 out of 887 cases.

<table>
<tr><th colspan="3">2019 Annual Count of Appeal Type</th></tr>
<tr><td>Appeal Type</td><td>Case Count</td><td>Percentage</td></tr>
<tr><td>Overturn</td><td>399</td><td>44.98%</td></tr>
<tr><td>Partial Uphold</td><td>19</td><td>2.14%</td></tr>
<tr><td>Uphold</td><td>463</td><td>52.20%</td></tr>
<tr><td>Withdrawal</td><td>6</td><td>0.68%</td></tr>
<tr><td>Case Total</td><td colspan="2">887</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

3. Monitoring Utilization Metrics

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and Medical Management 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 2019 Goals: • 10% reduction in admissions over prior year • 5% increase in discharge to recuperative and alternative care	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. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. Focus on the top 10 admitting diagnosis, and long length of stay admissions will also continue in 2019; adding a focus on 0-2 day stay admissions for appropriateness of admission. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement.	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**	Completed end to end processes and continue to work towards consistent processes. Working with an outside consultant for LOC, review consistency and training to ensure consistent and accurate reviews are completed within regulated TAT.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	2019 interventions to improve inpatient performance included strengthening the discharge navigator program, established on site reviews in high volume hospitals. Implemented collaborative huddles with key providers. Engaged medical directors and care management daily. Comparison of Fee For Service Q1-Q3 2018 versus Q1-Q3 2019 Admissions shows a 13.5% reduction.	Reestablishing relationships with key providers Hiring staff for key positions such as discharge navigator. The Plan does not have the ability to monitor discharges to recuperative and alternative care.	None	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net 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 for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. % 0-2 day admits In addition PPG metrics will include: 7. Specialty referrals for target specialties 8. C-section rates. PPG profile reports are made available quarterly 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 2019 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Specialties and PPG's 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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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The CVH PPG specific data Dashboard Reports are produced quarterly. A narrative summary portion has been added to the reports. The data is presented at the CalViva Management Oversight meeting. The reports are derived from claims data and have a time lag of approximately four to five months.	None identified	Access: Updated UM metrics reported are Bed Days/K, Admits/K, ALOS, ER Visits/K, and 30-day all-cause readmission rates. Reports are presented by aid type (SPD, Non-SPD, and MCE) and compared to established benchmarks. The analysis of the data includes: 1) Current status compared with benchmarks; 2) Changes and trends with causal analysis; and 3) Action plan including performance improvement plans o CVH and HN working together on Report. HN working with PPG to improve identified areas of concern (i.e. AHP, First Choice) and will provide quarterly updates	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (IP/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis. Milliman thresholds were used for evaluation. - Dignity ended the year with a favorable readmission rate. - LaSalle showed overall improvement in utilization metrics - Sante had an improvement in Admits per K and ER/K	Demographics of Central Valley skewing to an SPD population. Lack of Skilled nursing beds in Fresno drive up utilization. Most PPGs did not have data their ER visit cross referenced with MWOV breakdown. FCMG Data submission needed improvement. IMG acquisition by Dignity had initial encounter data submission delays.	Best practices to decrease inappropriate utilization and ER/K distributed to all PPGs in their 2019 JOMs. New dashboard of MWOV cross referenced with ER utilization given to each PPG. FCMG contracted Q Metrics vendor to improve data submissions. HN and FCMG meet bimonthly to improve utilization. HN had Meetings with Dignity to address and correct data submissions.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Claims timeliness 2. Provider dispute volume & timeliness 3. Prior authorization volume & timeliness 4. Specialty referral volume for in network/out of network 5. Specialty referral access timeliness 6. Credentialing volume The DO Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score etc.	CalViva PPG profile dashboard includes metrics for claims, utilization management processing and timeliness and credentialing for delegated providers CalViva delegated PPGs reports are evaluated on a quarterly basis for variance and compliance rates Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Claims timeliness • Provider dispute timeliness • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. CAPs identified during an annual audit by the HN delegation Oversight is monitored and followed-up by HN Delegation Oversight.	Ongoing

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Last updated: February 12, 2020

Health Net

CalViva HEALTH

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1 2019 PPG Profile and Narrative was provided 5/31/2019 and was reviewed at MOM at 6/11. CalViva PPG profile reports are made available quarterly. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	None identified	Enhancements to PPG profile dashboard data sources and ownership were completed in the first half of 2019.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Dashboard reports are in place. DO dashboard and Narrative report was presented quarterly in 2019. The narrative reports were edited to a PPG format by CalViva for 2020. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	None identified	None identified	Ongoing Ongoing Ongoing

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4. Monitoring Coordination with Other Programs and Vendor Oversight

Health Net

CalViva HEALTH

CalViva Health
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.1 Case Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving 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 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, LCSWs, Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities. Continue use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	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**	Number of HIFs completed in January -June by member and returned or EPC outreach was 2,429. 180 members subsequently referred to CM through June. Total members managed through Q2 across physical, behavioral health and TCM programs was 421. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Q1 results include members with active or closed case on or between 1/1/2019 & 3/31/2019 & remained eligible 90 days after case open date. 134 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 27% difference • Volume of ED claims/1000/year decreased by 328 • Total health care costs reduction related to reduction in inpatient costs, slight increase in outpatient services and pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 42 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life Section 72.7% improvement in ability to care for self/family post CM (46.3%) vs pre CM (26.8%); 97.5% (39/40) of respondents reported CM exceed their expectations	None	Continue existing interventions. Behavioral health cases included in CM utilization outcome measures. Evaluating opportunity to utilize member contact data from Health Information Exchange to increase successful outreach.	Ongoing Ongoing Q3

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Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Number of HIFs completed in 2019 by member and returned or EPC outreach was 4,547. 390 members subsequently referred to CM through December. Total members managed through Q4 across physical, behavioral health and TCM programs was 992 (preliminary data). Outcome measures include: readmission rates, ED utilization, overall health care costs, & member satisfaction. Utilization measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Q1-Q2 results include members with active or closed case on or between 1/1/2019 & 6/30/2019 & remained eligible 90 days after case open date. 259 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 19.9% lower readmission rate • Volume of ED claims/1000/year decreased by 324 • Total health care costs reduction related to reduction in inpatient costs and slight decrease in outpatient services. Pharmacy costs increased. • Member Satisfaction Survey results include PH, BH, TCM and Perinatal. The survey is comprised of two sections; Care Team Satisfaction and Quality of Life 68 members were successfully contacted through Q3 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life Section 100% improvement in ability to care for self/family post CM (39.4%) vs pre CM (19.7%); 96.9% (63/65) of respondents reported CM exceed their expectations	None	None	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
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. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Implement use of Pregnancy Program materials to increase outreach to moderate and high risk member through education packets, text reminders, etc. Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Q1 Ongoing Quarterly

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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**	Referrals increased from 135 in Q1 to 514 in Q2. Through Q2 221 members managed in PCM program, exceeding number managed in 2018. Quarterly average engagement rate remained constant at 25% across Q1 and Q2.			Ongoing
	Distribution of materials began late Q4. Texting portion of program on hold while texting policy under review by DHCS.	Issue identified with pregnancy and post-delivery mailings for CalViva Pregnancy Program	Continue collaboration with Corporate team to address issue impacting mailings for pregnancy program	Q3
	Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. Q1 results demonstrated greater compliance in managed members for both measures. • 30 members met the outcome inclusion criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 7.6% greater compliance in completing the first prenatal visit within their first trimester o 12.5% greater compliance in completing their post-partum visit	Texting portion of program delayed due to new DHCS texting requirements,	Upon approval of DHCS texting policy collaborate with Health Education and Corporate team to implement program.	Q3

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Preliminary data: Referrals increased from 135 in Q1 to a high of 514 in Q2 with a total of 1,526 referrals in 2019. Through Q4 496 members managed in PCM program, 140% increase in number managed in 2018 (206). Quarterly average engagement rate increased in Q4 to 37% with YTD average of 28%. Distribution of NOP and pregnancy materials continued. Texting portion of program on hold while texting policy under review by DHCS. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. A new outcome measure was added comparing the rate of pre-term delivery of high risk members managed to high risk members not managed Results through Q2 demonstrated: • 75 members met the outcome inclusion criteria for visits and 31 members met the inclusion criteria for the pre-term delivery measure • Members enrolled in the High Risk Pregnancy Program demonstrated: o 8.6% greater compliance in completing the first prenatal visit within their first trimester o 9.0% greater compliance in completing their post-partum visit o 7% less pre-term deliveries in high risk members	Issue identified with post-delivery mailings for CalViva Pregnancy Program Texting portion of program delayed due to new DHCS texting requirements,	Continue collaboration with Corporate team to address issue impacting post-delivery mailings. In Q4 implemented work around to mail post-delivery packets from CM department while Corporate works on solution. Upon approval of DHCS texting policy and with CalViva approval will collaborate with Health Education and Corporate team to implement program.	Q1 2019 Q1 2019

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health 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 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 LCSWs, LMFT, and Care Coordinators to perform BH CM activities. Use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	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**	Referrals to behavioral health program through Q2 was 183. Total members managed through Q2 was 84. CY engagement rate 42%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Q1 results include members with active or closed case on or between 1/1/2019 & 3/31/2019 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Referrals to behavioral health program through Q4 was 390. Total members managed through Q4 was 180. CY engagement rate 41.5%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results through Q2 include members with active or closed case on or between 1/1/2019 & 6/30/2019 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	None	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.4 Disease Management (DM)	☒ 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	Continue transition to insourced disease management programs for: asthma, diabetes, and heart failure. Transition process began Q4 2018. Ongoing program monitoring to assure that reporting needs are met including enrollment statistics.	April 2019 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**	Complete: Successful transition to insource disease management programs for asthma, diabetes, and heart failure to Envolve People Care (EPC). Transition process began Q4 2018 and concluded end of March 2019. Ongoing: Insourced DM program will continue to send educational materials and information about the program to enrolled CVH members. Additionally, insourced program will continue to conduct outbound telephonic interventions and make referrals to case management for CVH members identified as being at high risk for hospitalizations or poor outcomes, or in need of assistance with behavioral health issues. Ongoing program monitoring is taking place to assure that reporting needs are met including enrollment statistics.	None identified	None	Complete Ongoing Ongoing

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Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Complete: Successful transition to insource disease management programs for asthma, diabetes, and heart failure to Envolve People Care (EPC). Transition process concluded end of March 2019.	None	None	March 2019
	Ongoing: Insourced DM program will continue to send educational materials and information about the program to enrolled CVH members. Additionally, insourced program will continue to conduct outbound telephonic interventions and make referrals to case management for CVH members identified as being at high risk for hospitalizations or poor outcomes, or in need of assistance with behavioral health issues.	None	None	Ongoing
	Ongoing program monitoring continues.	None	None	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2019 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. State Health Program (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 prevent fraud and abuse, and prevent adverse selection to the CalViva Medi-Cal plan.	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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Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly PA statistics are tracked and reported quarterly in the UM/QI meeting. Active engagement with Pharmacy and existing narcotic prior authorization requirements continue as planned. New opioid edits on track for September/October implementation pending Provider Notification 30-45 days prior to go live and regulatory approval of Formulary Front Matter.	None	Removed "Monthly check write review." from Methodology.	Ongoing Ongoing 10/1/2019 (pending approval/ notification)
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Monthly PA statistics are tracked and reported quarterly in the UM/QI meeting. Large update to formulary 5/1/2019 to align formulary decisions with key changes for consistency. Pharmacy Network updated 5/15/2019. Opioid PA, Quantity Limits, updated PA Policy were implemented 10/15/2019 to meet federal and state regulations regarding opioid management. Quarterly Pharmacy Meeting with CalViva and HNET re-established in June 2019 to review issues, trends and oversight tasks not reviewed in the QI meeting.	None Identified	Re-established Quarterly RX meeting with CalViva Health and HNET pharmacy team.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.6 Manage care of CalViva members for Behavioral Health (BH)	☒ Medi-Cal	CalViva collaborates with BH 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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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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. During the period January through June, 2019, MHN received 308 referrals from Fresno, Kings and Madera counties. MHN referred 2 members to the county for Specialty Mental Health Services.	None Identified	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care Continue Behavioral health complex case management through the HN CM department.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	The bidirectional referral process with Fresno, Kings and Madera counties continued in the second half of 2019. During the period of July, 2019 through December, 2019, MHN received 430 referrals from those counties. During the same time period MHN made 5 referrals to County behavioral health services. In addition, 3 members were referred to BH complex case management through the HN Case Management department. During Q3 and Q4 a total of 436 members called MHN for referrals and linkage. In 2019 a total of 245 CalViva members who called MHN stated that they were referred by their PCP/medical provider.	None Identified	Continue bidirectional referral process, as well as monitoring, tracking, and revising metrics to ensure coordination, continuity and integration of care Continue Behavioral health complex case management through the HN CM department. Effective January, 2020, all members transitioning between MHN and County services will be referred to plan behavioral health case managers for outreach.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.7 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Performance measures monitored. Participated in cross functional team to improve the quality of behavioral health care. • **Provider Appointment Availability Survey (PAAS):** For MY 2018 all reporting populations and Psychiatrist & NPMH provider types fell below the 90% target for access to urgent appointments, measuring against both the DMHC 96-hour standard and the CDI 48-hour standard. For non-urgent appointments (for either new or existing patients-the DMHC metric), Medi-Cal NPMH providers met the 90% standard but all other results are below standard. However, routine appointment access results came in at or above 80 % for both provider types and all reporting populations. MY 2018 showed excellent results among autism providers across all applicable reporting populations. Compliance results for routine appointment availability ranged between 90% and 100%. The DHMC tool does not adequately apply to autism providers and the autism model of care. DMHC has instructed plans to exclude autism providers from PAAS in measurement year 2019	• Provider data accuracy and response rate to the survey continue to be a challenge.		
Mid-Year Report Continued	• **Timeliness:** Performance was below target for Q1 2019 Authorization Decisions Timeliness. The overall rate for MHN is 93%, which is 2% below the target. In Q2 the Authorization Decisions Timeliness was 100% for non-ABA requests and 96% for ABA requests.	• Timeliness numbers were artificially low because MHN's medical management system has historically been incapable of capturing when an extension is applied to a particular case. Therefore, many cases with extensions were reported as not having met timeliness when they actually did. • Post Service Review received a high volume of Medi-Cal ABA cases due to poor provider compliance with prior authorization	• Developed method to record a request for extension in UNITY case management system as well as enhanced reporting capabilities. • Provider communication regarding PA requirements. • Claims staffing changes and changes to process for requesting clinical information when claim is received.	8/1/19 4/1/19 9/1/19

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.7 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
	• **PQI:** There were 3 cases submitted in Q1 • **Provider disputes**: In Q1 26 provider disputes were received and all were upheld. In Q2, 3	requirements, resulting in slower turnaround times for case review. • Some PSR cases were late as a result of claims backlogs-cases received through Claims Dept. Some cases were not received by PSR until close to or after the due date for decision. • N/A			

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.7 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
	provider disputes were received and one resolved in favor of the provider. • **Network Availability and Adequacy:** All availability and adequacy metrics met standard in Q1. • **Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.** For MY 2018, 83% compliance with 10 day first appointment standard was achieved.		• For MY 2019, DMHC has instructed the industry to exclude autism providers from PAAS. MHN will be developing and administering its own survey. It will be called the ABA Provider Accessibility Survey.	Development of the new ABA Provider Accessibility Survey.	Q4-2019

Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Performance measures monitored. Participated in cross functional team to improve the quality of behavioral health care. • **Provider Appointment Availability Survey (PAAS)** The MY 2019 PAAS survey results will be available in May 2020. Results from the new ABA Provider Accessibility Survey will be available in June 2020. • **Timeliness:** Performance was below target for Q1 2019 Authorization Decisions Timeliness. The overall rate for MHN is 93%, which is below the target. In Q2 the Authorization Decisions Timeliness was 100% for non-ABA requests and 96% for ABA requests. In Q3 the Authorization Decision Timeliness for ABA was 99%, and for non-ABA it was 80%. The standard for timeliness is 95%. The non-ABA timeliness failure to meet standard was due to a low total number of cases (n=5) and a miss on one case due to care manager error. This employee has since received re-training. Q4 timeliness performance data is not yet available. • **PQI:** There were a total of 8 cases submitted in MY 2019. All were resolved within the 30-day standard. • **Provider disputes**: In Q1 26 provider disputes were received and all were upheld. In Q2, 3 provider disputes were received and one resolved in favor of the provider. In Q3, there were 196 provider disputes, and 97% of those were resolved timely, which is above target by 2%. ABA claims continue to be the largest category of dispute type. Q4 provider dispute data is not yet available. • **Network Availability and Adequacy:** All availability and adequacy metrics met standards in Q1-Q3, with the exception of BHP Open Practice, which measures the percentage of providers who are taking new patients. This metric		**Timeliness**: Authorization decision timeliness reporting ability improved greatly in 2019, and MHN is now able to account for authorization extensions in calculating due dates. Because of the low number of non-ABA authorizations MHN will remain at risk of not meeting standard in that category, as even one missed case will result in a fail. **Network Availability and Adequacy:** MHN Provider Relations staff are actively recruiting providers of all types in Fresno, Kings and Madera counties. The addition of providers to the network	

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.7 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
	was below the 85% standard at 72% in Q3. All availability and adequacy metrics met standard in Q1. Q4 data is not yet available. • **Timeliness to first appointment for members diagnosed with Autism Spectrum Disorder.** For MY 2019 this metric has been replaced by the ABA Provider Accessibility Survey results. Those results will be available in June, 2020.			should result in an increase in providers taking new patients.	

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5. Monitoring Activities for Special Populations

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
5.1 Monitor of California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) 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: Health Net identifies 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus for SHP. Work in CY 2018 to further develop internal systems and handoffs are expected to yield improvements in 2019. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine 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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<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>End to end process completed. This team is in process of cross training to ensure all staff are able to cross cover. Continue current process and poly. Continue to identify CCS members and eligibility.

<u>Q1-2019 % identified as CCS eligible:</u>
Fresno 8.36%
Kings 6.73%
Madera 6.79%

<u>Q2-2019 % identified as CCS eligible:</u>
Fresno 8.39%
Kings 7.02%
Madera 6.87%</td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2020</td><td>% of CCS Eligible by County in 2019:
<table><tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th></tr><tr><td>Fresno</td><td>8.37%</td><td>8.38%</td><td>8.35%</td><td>8.37%</td><td>8.43%</td><td>8.38%</td></tr><tr><td>Kings</td><td>6.89%</td><td>6.92%</td><td>6.95%</td><td>6.92%</td><td>7.04%</td><td>7.12%</td></tr><tr><td>Madera</td><td>6.80%</td><td>6.75%</td><td>6.83%</td><td>6.82%</td><td>6.92%</td><td>6.87%</td></tr></table>
<table><tr><th></th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th></tr><tr><td>Fresno</td><td>8.41%</td><td>8.43%</td><td>8.58%</td><td>8.52%</td><td>8.56%</td><td>8.59%</td></tr><tr><td>Kings</td><td>7.15%</td><td>7.09%</td><td>7.15%</td><td>7.16%</td><td>7.19%</td><td>7.17%</td></tr><tr><td>Madera</td><td>6.92%</td><td>6.97%</td><td>7.15%</td><td>7.16%</td><td>7.24%</td><td>7.21%</td></tr></table></td><td>Multiple Excel trackers are currently used by Public Programs team to track CCS processes. This includes tracking CCS referral submissions and outcomes for FFS IP and PA, pharmacy, and Aging Out CCS member calls.

Timeliness delays with dependent CCS County determinations impact the Plan and staff due to time required for weekly follow up on all pending SAR. Dependent County pending determinations can take many months before they are approved or denied.

On-going CCS training is needed for PPGs and providers.</td><td>TruCare assessments are being built to replace Excel tracking, starting with automated tracking of front-end FFS IP and PA PPS queue work.

The Plan has reached out to the new DHCS CCS Chief Medical Director to address aged casework. Public Programs is helping escalate CCS awareness of aged cases.

Public Programs is developing a tool to evaluate member CCS on-boarding at the Satellite PPG level, identifying key training opportunities for those PPG with lower conversion numbers.</td><td>Q4 2020

Ongoing

Q3 2020</td></tr>
</table>

Created: January 25, 2019
Last updated: February 12, 2020

CalViva Health
2019 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2019 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 UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as 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 CM, Disease Management and Care Coordination.	Ongoing

CalViva Health
2019 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 199 SPD members have been managed 2019 through Q2. This includes PH CM, BH CM, & OB CM, as well as, both Care Coordination & Complex CM. Timely HRA outreach reported for CalViva SPD members as of June 2019: 100%	None identified	Continue monthly stratification/referrals to ICM.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2020**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 397 SPD (nondual SSI) members were managed in 2019. This includes PH CM, BH CM, PCM & TCM (both noncomplex and complex cases) Timely HRA outreach reported for CalViva SPD members in 2019 was 100%	None identified	Continue monthly stratification/referrals to ICM.	Ongoing

Created: January 25, 2019
Last updated: February 12, 2020

Item #10

Attachment 10.C

2020 Utilization Management
Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Marianne Armstrong Utilization Management

COMMITTEE DATE: February 20, 2020

SUBJECT: Utilization Management Program Description Change Summary

UM Redline Page #	**Section/Paragraph name**	**Description of change**
Throughout	Multiple	Updated year from 2019 to 2020
ii-iii	Table of Contents	Page numbering updated
11, 21	• Inpatient Facility Concurrent Review • Health Education Programs and Services Flyer	Spacing corrections
22-23	Utilization Decision Criteria	• Updated resources and criteria used • Removed Preferred drug list as a benefit determinant • Added reference to availability of criteria
23, 31	• Separation of Medical Decisions from Fiscal and Administrative Management • Medical Management Resources	Chief Medical Director title changed to Vice President Medical Director
32	Medical Management Resources	Added description of Senior Vice President of Medical Management
41	Program Approval	Approver title updated from Chief Medical Director to Chief Medical Officer.

~~2019~~2020

Health Net Community Solutions, Inc.
CalViva Health
Utilization Management (UM) Program Description

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The CalViva Health Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)

- Practitioners and providers contracted directly with Health Net or CalViva Health.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN staff via the corporate intranet website, “Cornerstone Learning”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Medical Management
- Customer Service
- Appeals and Grievance
- Case Management

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, National Medical Advisory Council, Customer Services and Claims. Additional sources of information include member and provider feedback.

Section 2

Mission

Centene Corporation

"Transforming the health of the community one person at a time by offering unique, cost-effective coverage solutions for low-income populations through locally based health plans and a wide range of specialty services."

Health Net Mission

The mission of Health Net is:

"To help people be healthy, secure and comfortable."

State Health Programs UM Vision

The mission of Health Net's State Health Programs Utilization Management Program is to design and implement programs that facilitate the highest level of the member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Health Net Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address access and timeliness of care
- Initiate documentation to support investigation of potential quality of care issues
- Identify and resolve problems that result in excessive resource utilization and inefficient delivery of health care services
- Identify and resolve problems that result in under or over utilization
- Assess the effects of cost containment activities on the quality of care delivered
- Promote the role of the primary care physician in the management of patient care

- Identify opportunities to improve the health of members through coordination with Case Management and Public Health Programs
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Monitor consistency in application of all UM functions for members
- Review and evaluate health care services for quality, medical necessity and appropriate levels of care
- Identify actual and potential quality issues through this review process and refer to the appropriate quality management personnel
- Evaluate the need for case management and discharge planning in coordination with the PCP
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Case Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Provider Oversight to determine delegation status for UM activities
- Evaluate the UM Program on a regular basis to respond to changes in the health care environment
- Collaborate with county Public Health-Linked Programs

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed for all State Health Program members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program is under the clinical supervision of the Health Net Chief Medical Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, preauthorization's, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continuously updates and improves the UM Program to ensure appropriate processes are in place to review and approve the provision of medically necessary covered services. The plan has qualified staff who are responsible for the UM Program. The plan separates its medical decisions from fiscal and administrative management to assure the medical decisions are not unduly influenced by fiscal and administrative management. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 17, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) Policy Letters. Additionally, Health Net's State Health Programs Utilization Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and MRMIB for Utilization Management and Care Coordination activities.

The Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq.

Prior authorization is not required for emergency and sensitive services, family planning services, annual preventive care visits to an OB/GYN, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective

pregnancy termination, basic obstetrical care, minor consent services, and immunizations at the Local Health Department (LHD). Utilization Management policies and procedures are available to members and providers upon request.

Health Net Utilization Management nurses provide decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources to support the plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Health Net and its delegated PPGs do not require prior authorization for emergency and sensitive services as outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals enhance the member's ability to directly access specialists such as dermatologists, podiatrists, ophthalmologists and OB/GYNs.

Preauthorization / Prior Authorization

Health Net requires delegated PPGs to create and maintain programs, policies and procedures, which at a minimum, meet Health Net's established standards. Health Net Utilization Management staff determines pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for elective inpatient admissions, referrals for selected ambulatory surgery, home health care, durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

Health Net has established a referral tracking process to track and monitor referrals requiring prior authorization. Health Net's referral tracking system includes authorized, denied, deferred and/or modified referrals. Finally, the process of referral tracking includes monitoring of timeliness.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for hospitalized patients. Any review for continued benefit coverage and provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

A goal of CCR is to support the Member and Member's healthcare team to optimize health outcomes in the event the Member experiences a health status change. This is done through CCR work and advocacy with the PPG, Member and the Interdisciplinary Care Team to:

1) Ensure services are accessed timely,
2) Educate the Member's healthcare team on the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to appropriate Member resources, such as Managed Health Network, Inc. (MHN), case management, and community resources.

The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs. Health Net nurses and Medical Directors, delegated partners, and MHN conduct onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, or skilled nursing facilities. HN may monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status. The inpatient review process occurs within 1 business day from the day of hospital admission or within 1 business day of notification of admission and continues throughout the patient's hospital stay. The review process includes application of standardized nationally recognized criteria for medical appropriateness review, levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses use nationally recognized criteria, which includes InterQual® criteria, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical staff supports pre-service and concurrent review with data entry, receipt and documentation of notification, and receipt and attachment of clinical content.

Reviews of requests that do not meet guidelines or criteria for certification are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess for member specific case management and disease management needs and refer such cases to case management for evaluation. Concurrent Review Nurses collaborate with Case Managers on all members identified in active case management.

CCR goals include supporting the member and member's healthcare team to optimize health outcomes in the event the member experiences a health status change. This is done through work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are accessed timely, 2) educate to the member's healthcare team on the member's benefit structure and resources, 3) facilitate expeditious authorization of services when appropriate, and 4) facilitate referrals to appropriate member resources, where appropriate, such as MHN, case management, and community resources. The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and member care management support programs.

Discharge Planning

HN, MHN and/ or delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in conjunction with the practitioner, member, and member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the member's admission, whenever possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to, home health care, durable medical equipment and/or transfers to a lower level of care (e.g., skilled nursing facility or acute rehabilitation).

HN Concurrent Review nurses identify potential case management cases and refer such cases to Case Management and other outpatient programs for post discharge evaluation and/or services

The criteria used for evaluating and guiding timely discharge planning is nationally recognized criteria including InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care needs.
- Assessment of member's support system to determine necessary services and support needs.

- Development of a discharge plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

Retrospective Review

Delegated PPGs conduct retrospective review activities in compliance with Health Net standards. Conversely, Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service review of medical records when services rendered have not been authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the member received the services and that services meet the criteria for medical necessity. Post-service review determinations are processed within the timeframes specific to the product line after obtaining all necessary information required to review the request.

Second Opinion

A member, member's authorized representative or provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned members who request a second opinion to a participating physician within their medical group. If a member requests a second opinion about specialty care from a participating specialist physician who practices outside of the member's PCP's medical group, the request will be forwarded to Health Net medical management for review. Health Net does not routinely require prior authorization for such services given that the second opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. There is no cost to the member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the member to obtain a second opinion out-of-network at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical management information.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. Selection of a Primary Care Physician (PCP) and establishment of a relationship with that physician is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access / Availability to Health Care Services

An ongoing review of the Health Plan's network is conducted to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of member records are met. Recruitment will take place in areas where unmet needs are identified.

Coordination with Quality Improvement Programs

The Health Net State Health Programs Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the appropriate committees. Corrective actions, as appropriate, are required to continually improve care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate members for Public Health and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.

- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits
- Offers Disease Management (DM) Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. DM activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

MHN Services is the behavioral health subsidiary of HNCS and HNCA that administers the Medi-Cal mild to moderate mental health services carved in to the Managed Care Plans.

MHN provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD) as well as other disorders that result in behavioral disturbances.

MHN will manage specified mental health benefits to adults and children who are diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as members seeking other services not provided by MHN, will be referred to the County Specialty MHP.

MHN's utilization management decisions are based on Change Healthcare's InterQual Level of Care Criteria; MHN's evidence-based internal criteria; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). MHN's evidence-based internal criteria guidelines are based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). MHN and Health Net do not impose Quantitative(QTL), or Non-Quantitative Treatment Limitations(NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a

network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered a Non-Quantitative Treatment Limitation (NQTL) under the definitions of the federal rules. MHN may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by MHN and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process will be supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at MHN is to manage available behavioral health care benefits to achieve the best possible clinical outcomes for members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, MHN has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The MHN utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by MHN do not require authorization. All MHN staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors. MHN staff providing services to CalViva members are located at MHN offices in California.

MHN coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, LLC Health Net Pharmaceutical Services, administers and manages the prescription drug benefit including select

injectable for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Pharmacy Prior Authorization, Recommended Drug List/formulary management, Education programs for physicians, pharmacies and members, and Pharmaceutical Safety.

The basic Medi-Cal "formulary" is prescribed by the state; however managed care organizations have latitude within each drug class for equivalent substitution. A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications for placement on the formulary, as well as approve all criteria guiding prior authorization decisions.

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers. Care Managers are patient advocates who ensure that these members receive timely and uninterrupted medical care during the transition process.

- Implementation of specific population-based, disease management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal case management, asthma or diabetes.

Primary Care Physician responsibility:

The Primary Care Physician is responsible for the management and coordination of a member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours

per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides Nurse Advice and Triage line 24 x 7. Health Net strives continually to meet the access and availability standards through our network relationships, member and provider education and Triage services.

Health Promotion Programs

Be In Charge! ℠ Programs

CalViva Health provides the *Be In Charge!*℠ Programs for Medi-Cal members to help manage their health. These programs provide specific interventions to facilitate the member's individual goals. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The goal of the *Be In Charge!*℠ *Programs is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventative wellness, and chronic care* disease management in accordance with national peer-reviewed published guidelines. Preventative medicine services, achieved through proactive education and active engagement of the members, promotes optimal health.

The *Be In Charge!*℠ Programs include:

- Disease Management
- Nurse Advice Line
- Weight Management Programs
- Health education classes and programs are offered in specific counties to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health, hypertension and healthy pregnancy.

Disease Management

Members with asthma, diabetes, and chronic heart failure are enrolled into *Be In Charge!*℠ Disease Management programs to help them control their condition. Members receive educational resources and have unlimited 24 hour access to a nurse

to address their medical concerns. High-risk members also receive nurse initiated outbound calls to help members manage their conditions.

Nurse Advice Line

The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines, patented, algorithm based tools with high-touch call center services. The NAL provides immediate symptom assessment, and member education services. In addition to educating members how to better manage their own health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is offered 24 hours a day, seven days a week, all year long, in English and Spanish with interpreter services available for other languages. Only California-licensed nurses assess, evaluate, triage or advise regarding the condition of an enrollee.

Using clinical decision algorithms, the NAL registered nurse listens to each member's chief complaint, identifies member symptoms, and selects the most appropriate algorithm to be used for a thorough assessment. A combination of member input and clinical judgement allow the nurses to answer clinical questions and determine timeliness of care. The NAL is URAQ accredited and has also received the Health Information Line NCQA Certification.

Weight Management Programs

Members have access to a comprehensive Fit Families for Life-*Be In Charge!℠* suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. The Healthy Habits for Healthy People weight management educational resource is designed specifically for adults and seniors. Other nutrition and weight control education resources are also available upon request. Fit Families for Life community classes teaching basic nutrition and physical activity information are offered at community resource center, community based organizations and provider clinics located in areas where CalViva Health members reside. The community classes are free to all CalViva Health members and the community. Providers should complete and fax a copy of the Fit Families for Life - *Be In Charge!℠* Program Referral Form to the CalViva Health's Health Education Department to refer members to the Home Edition program.

Health Education Programs, Services and Resources

Health Net State Health Programs provides health education programs, materials, and services to Medi-Cal members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle

behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. Health education services may include individual, group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors. Health Education programs, services and materials vary by membership type but generally include:

- Pregnancy Program – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- California Smokers' Helpline - The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking. Helpline services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available to teens, pregnant women, and tobacco chewers. Members are offered a 90 day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.
- Diabetes Prevention Program – Eligible members 18 years old and older with prediabetes can participate in a yearlong evidence-based, lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- Healthy Hearts Healthy Lives Program - Members have access to a health heart prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Digital Health Education - Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and encourage members in accessing timely preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, substance use, pain management, and insomnia.
- Health Promotion Incentive Programs - The Health Education Department (HED) partners with Quality Improvement Department to offer incentive programs to encourage members to access HEDIS related preventive health care services.
- Know Your Numbers Community Class and Screening Events - The HED conducts health screening on Body Mass Index (BMI), diabetes, hypertension and/or cholesterol to help participants understand their current health status. At the same event, participants are provided the appropriate preventive health education to help

them adopt healthy behaviors and connect them to health care providers to control their health conditions.

- Community Health Education Classes - Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

The following educational resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental health, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form – Members complete a pre-stamped form to request free health education materials available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on a regular basis and covers various health topics and the most up-to-date information on health education programs and services.

Over and Under Utilization

All providers are required to submit to Health Net claim/encounter data for all services. Multiple methodologies are utilized to monitor under and over utilization, referral timeliness, provider appeals, denials and member appeals and grievances. The types of methods include:

- Annual on-site evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacology data
- Evaluation of individual direct contract physician practice patterns

Also through these monitoring efforts, Health Net's Utilization Management Department regularly tracks its performance.

Through these comprehensive monitors, Health Net's Utilization Management Department:

- Measures compliance to guidelines
- Tracks performance against established goals
- Educates and addresses variances from agreed upon clinical criteria
- Conducts provider outreach programs to modify performance

Finally, Health Net completes the Quality Management education process with its contracted providers through local interaction with the regional Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's State Health Programs Utilization Management Program use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

A. State law/guidelines (Title 22 CCR, Title 17 CCR, Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters, and California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v))

B. Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria);

C. Centene clinical policy (including Centene clinical policies in InterQual as custom content);

~~C.~~D. If no Plan~~-~~, or Centene specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;

~~D.~~E. In the case of no guidance from A-~~E~~D, additional information that the applicable Health Plan Medical Director will consider, when available, includes:

1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
4. Medical association publications;
5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and

Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
6. Published expert opinions;
7. Opinion of health professionals in the area of specialty involved;
8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
~~D. Preferred Drug List (PDL)~~

When state Medicaid coverage provisions conflict with the coverage provisions in Plan- or Centene-specific clinical policy, state Medicaid coverage provisions take precedence. Refer to the state Medicaid manual for any coverage provisions. Clinical policies, benefit provision, guideline, protocol or criteria are available upon request per Federal and State regulatory guidelines.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

- Utilization management decisions are based on medical necessity and medical appropriateness
- Health Net does not compensate physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and attention is paid to the risk of under-utilization
- Health Net and its delegates distribute to all practitioners, providers,
- and employees a statement describing Health Net's policies and restrictions on financial incentives
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service
- Health Net Regional Medi-Cal Medical Directors and the ~~Chief~~ Vice President Medical Director for State Health Programs do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net's Regional Medical Director, Care Managers and CalViva Health Chief Medical Officer participate in biweekly regional Utilization Management rounds. At these

meetings, a selection of appropriate inpatient admissions and outpatient services are reviewed and summarized. Problematic cases are discussed in detail to promote staff education and appropriate utilization. Potential PPG management issues are identified and referred to the Provider Oversight Department.

Inter-rater Reliability Review Process:

Health Net's Medical Directors and Registered Nurses who perform UM and CM activities all participate annually in the InterQual® Products Group Interrater Reliability (IRR) Program. The Acute, Home Care, Imaging, and Procedures modules may all be required, in adult and pediatric versions, depending upon the reviewer's job description. A passing score must be achieved, or corrective action plans are developed. IRR results are reported annually at the Health Net State Health Programs UMQI Committee Meeting.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight audit, which requires a file audit of denial files using Health Net Provider Delegation Audit Tool with Medi-Cal Addendum
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

Health Net follows established time frames for internal and delegated PPG decision making to minimize any disruption in the provision of health care. The established time frames regarding medical necessity and authorization depend on the urgency of the clinical situation. Turnaround Time (TAT) Standards for requests are based on current DHCS, DMHC, and/or State regulatory guidelines, whichever guideline maintains the most stringent standard, is applied.

Health Net's delegated providers are informed of the decision timeliness standards in the Provider Operations Manual. A Health Net Medical Programs Manager, assessing the compliance of each medical group, performs an annual evaluation including review of timeliness. All requests for determination are communicated back to the member and the provider within the timeframes and methods dictated by the DHCS, DMHC, and/or State regulatory guidelines, whichever is the most stringent requirement.

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. He/she may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into "threshold languages" in collaboration with Industry Collaboration Effort (ICE).

Rationale contained in denial letters includes a *summary denial reason/rationale* that is easily understandable for the member. In addition, a *detailed denial reason/rationale* is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Appeals

A licensed physician reviews all member medical necessity appeals.

CalViva Health does not delegate the appeals process. CalViva Health has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CalViva Health, CalViva Health is responsible for appeals for their members. However, Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net State Health Programs Medical Director. The case is forwarded to the CalViva Health CMO for review and final determination.

CalViva Health maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CalViva Health, MHN or its delegates.

Each denial letter that is sent to the member includes the member's right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member's right of appeal is communicated to the practitioners in the Provider Operations Manual and to the members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member

Services representative then forwards requests for member appeals to the Appeals and Grievances Department.

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net performs technology assessment through formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages. Health Net's Medical Policy Department provides support in the development of technology statements in response to specific requests and for proactively assessing current medical literature for new technology that may be sought by members.

Health Net utilizes nationally recognized primary sources for evidence based information including the Hayes Medical Technology Directory, Change Healthcare's InterQual criteria and information from nationally recognized evidence-based medical journals, colleges and academies. Health Net may also perform a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness, as reported in peer–reviewed journals, seek opinions and assessments by relevant specialists, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations and use reports and publications of government agencies (for example, the Food and Drug Administration [FDA], Centers for Disease Control [CDC], National Institutes of Health [NIH]).

Health Net Medical Policies are developed to guide utilization management decision making when there is no InterQual criterion or the InterQual criteria need to be revised to meet the needs of the population. These policies are developed through the review of the peer reviewed evidence based medical literature.
Once approved, it becomes established Health Net medical management policy, and providers and members have access to the information on Health Net's website. The clinical criteria are reviewed at least annually by the policy committees or more frequently as dictated by current medical literature. Satisfaction with the Utilization Management Process

At least annually, Health Net surveys members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the Health Net UMQI Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the Health Net UMQI Committee.

Communication Services

The Plan, MHN and the delegated partners provide access to Utilization Management staff for members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, MHN and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal members have 24/7 access to the Nurse Advice and Triage Line. Inbound and outbound communication regarding utilization management issues are accomplished through the following:

- Toll-free member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CalViva Health members upon request

The Plan will notify contracting health care providers, as well as, members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Evaluation of the Health Net State Health Programs UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CalViva Health UM Program Description is forwarded to CalViva Health for review and approval.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Health Net's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Health Net Organizational Structure and Resources

MHN Medical Management Resources

The MHN Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. They participate in UM activities such as the MHN UM/QI Committee and the HN CA Utilization Management Committee (UMC), as well as quality improvement committee activities.

MHN Medical Staff have duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery and ensuring that adequate and timely BH services are available to all HN members. The MHN Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the MHN UM/QI Committee, and to the Health Net Quality Improvement Committee (HNQIC). MHN Medical Staff sits on the following committees: HN Quality Improvement Committee, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the MHN Quality Improvement Committee, the MHN Utilization Management Committee and the MHN Clinical Leadership Committee (CLC). Additionally, Health Net Medical Directors and UM/QI staff sits on MHN's QI and UM Committees.

Medical Management Resources

Health Net Chief Medical Officer

The Chief Medical Officer's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations. This position makes recommendations to the Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

The Chief Medical Officer has decision-making responsibilities for Health Net medical matters. The Chief Medical Officer oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other medical management leadership team members. Medical Management departments for which he/she has clinical oversight responsibility to include: Quality Improvement,

Utilization Management, Case Management, Appeals and Grievances, Compliance, Program Accreditation and Disease Management.

The Chief Medical Officer's responsibilities include, but are not limited to: leading the health plan in national medical management initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

~~Chief~~ Vice President Medical Director, State Health Programs

The ~~Chief~~ Vice President Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Case Management activities for Medi-Cal. In addition, the ~~Chief~~ Vice President Medical Director is responsible for QI activities for these programs. The ~~Chief~~ Vice President Medical Director is the chair of the Health Net Community Solutions Committee and is actively involved in implementing the SHP UM Program. The State Health Programs ~~Chief~~ Vice President Medical Director reports to HN's Chief Medical Officer.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and case management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Senior Vice President of Medical Management (VPMM)

The Senior VPMM is a registered nurse with experience in utilization management and case management activities. The Senior VPMM is responsible for overseeing the activities of the Plan's Utilization Management and Case Management Programs. The Senior VPMM reports to the Plan Chief Operating Officer. The Senior VPMM, in collaboration with the Vice President Medical Director (SHP), assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Healthcare Services (UM/CM) Resources

Vice President, Medical Management

The Vice Presidents are responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and case/disease management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Director, Medical Management

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the member's benefit structure.
- Emphasizes continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e. Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Case/Disease Management when appropriate,
- Management of out-of-area cases, and
- Monitoring effectiveness of delegated entities and contracted providers.

Additionally for State Health Plan Members in California

- Referral of members to County CCS offices when eligible
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health

All UM LVN, LCSW and RN staff is under the direct supervision of a Manager, HCS or UM, who is an RN.

Additional licensed and clerical staff supports UM activities for all product lines.

MHN Medical Director and MHN Medical Staff

The MHN Medical Director, Western Region, is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of MHN behavioral health program and clinical policies, the MHN Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The MHN Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN members. The MHN Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the MHN QI Committee and to the Health Net Quality Improvement Committees. The MHN Medical Staff sits on the following committees: HN Quality Improvement Committee, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the HN Medical Advisory Council, the MHN Quality

Improvement Committee, and the MHN Utilization Management Committee. Additionally, Health Net's Medical Directors and UM/QI staff sits on MHN's QI and UM Committees.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions Committee

The Health Net Community Solutions Committee reports directly to the Health Net Board of Directors. The committee is charged with the monitoring of the medical management and quality of care and services rendered to members within State Health Programs including identification and selection of opportunities for improvements, monitoring interventions and addressing UM and QI activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the Health Net Community Solutions Committee biannually reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI for this program. The Committee membership also includes practicing network physician representatives. The Health Net Community Solutions Committee is chaired by the Senior Medical Director for SHP and meets quarterly. The SHP Dental UM/QI Committee reports to the Health Net Community Solutions Committee.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs) and strategic partners (delegated partners).

Health Net has a thorough process in place to assess a potential delegate's readiness for delegation and to systematically monitor the performance. Health Net has designated Clinical Care Administrators (CCA) who are registered nurses specially trained to perform this evaluation. CCAs evaluate and monitor delegated partners annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities. Additionally, CCAs are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, CCAs, in conjunction with the Regional Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. CCAs evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC).

Delegated partners are required to submit quarterly reports (for Medi-Cal) to Health Net. Reports are reviewed and assessed for content and feedback is given for reports submitted.

Responsibility of Delegation Oversight includes, but is not limited to:

A. Assessing and determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Performing ongoing monitoring of any open CAP items as requested by the Delegation Oversight Workgroup (DOW)/Delegation Oversight Committee (DOC). This may include additional file reviews, policy and procedure reviews, and educational sessions, on site meetings to ensure the delegated partner is meeting compliance.
C. Performing any additional delegation oversight activities as requested by the DOC.

Delegation Oversight Committee

A. Reviews Delegation Oversight activities and recommendations of the DOW and, as needed identifies corrective actions specific to delegated partner(s) that are not meeting compliance. The DOC will review the results of annual or focused audits, the corrective actions recommended and already undertaken by the delegate, minutes from the follow-up meetings or correspondence with the delegate, and results of follow-up audits, as appropriate.

B. As needed, initiates remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing monitoring/oversight
- Freezing membership
- Revoking delegation
- Terminating the organization's contract with Health Net.
- Imposing financial penalties as allowed per contract.
- Removes sanctions, if appropriate.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate's program.

Onsite review of the contracted delegates shall be performed annually. More frequent assessments shall be performed, as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

Section 6

Utilization and Case Management (UM/CM) Program Evaluation

UM/CM Program Evaluation/Work Plan

UM/CM Program Evaluation

Health Net's Vice President of Medical Management annually prepares the CalViva Health Utilization/Care Management Program Evaluation and presents the evaluation to CalViva Health for review.

The annual evaluation of the CalViva Health Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and members on CalViva Health Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net's SHP Senior Medical Director and Vice President Medical Management annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan

process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description.

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

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

Health Net Community Solutions UM/QI Committee
Medi-Cal Utilization Management Program Approval

The Health Net Chief Medical ~~Director~~ Officer and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Jennifer Lloyd
Vice President of Medical Management

Committee Approval

The Health Net Community Solutions UM/QI Committee has reviewed and approved this Utilization Management Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

Item #10

Attachment 10.D

2020 Case Management
Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Paula Ackerman, Case Management

COMMITTEE DATE: February 20, 2020

SUBJECT: Case Management Program Description Change Summary

CM Redline Page #	Section/Paragraph name	Description of change	New Page #
2	Table of Contents; Organization Structure	• Changed Chief Medical Director to Vice President Medical Affairs • Changed Vice President of Case Management to Sr. Vice President Medical Management.	
2	Table of Contents; Care Team Staffing Model	Changed title Member Connections Representative to Connection Representative.	
5	Scope; Definition of Case management	Paragraph 2, last sentence changed ensure member compliance to promote member compliance.	
7	Goals of Case Management Program	• Pre and post-partum measures for OB program clarified goal >5% difference in members managed compared to non-managed. • Added new measure for OB program related to pre-term delivery.	
9	Organizational Structure; Chief Medical Director	Changed title and reference to Chief Medical Director to Vice President Medical Affairs throughout the section.	
10	Organizational Structure; Vice President of Case Management	Changed title and reference to Vice President of Case Management to Sr. Vice President Medical Management throughout the section.	
10	Organizational Structure; Case Management Director/ Manager	Changed reference to Vice President of Case Management to Sr. Vice President Medical Management.	
11	Care Team Staffing Model	• Changed average caseload 40-50 to average active caseload of 62 cases. • Spelled out ICT to Integrated Care Team. • Changed Member Connection Representatives to Connection Representatives.	

12	Care Team Staffing Model; Member Connections Representative	Changed title and reference to Member Connections Representative to Connection Representative.	
14	Health Plan Staff	Changed reference to Member Connections Representative to Connection Representative and MCR to CR.	
15	Screening and Assessment	• Paragraph 1, changed within 30 days to 7 calendar days. • Paragraph 5, changed outreach based on stratification to outreach is initiated within 7 calendar days and completed within 14 calendar days of identification/referral.	
17	Screening and Assessment	Paragraph 1, sentence 2, changed the initial assessment and care plan are completed no later than 60 days after member agreement to CM to no later than 60 days the after identification/referral of the member to CM.	
21	Discharge from Case Management	Paragraph 1, bullet 4 deleted WIC.	
23	Outcomes	Paragraph 2: • Bullets 3 and 4 changed from rate of pregnant to rate of pregnant members. • Added bullet 5 to address rate of pre-term delivery as an outcome measure.	
24	Condition Specific CM and DM Programs	• Paragraph 1, changed from Disease Management (DM) being managed with in the Plan to DM is delegated to Envolve PeopleCare and the Plan CM coordinates with DM to prevent duplication of contacts and services. • Paragraph 2, changed Post Hospitalization Follow-up to Transitional Care Management.	
30	Health Net UMQI Committee Approvals	• Changed reference to Alex Chen to Ramiro Zuniga and title Chief Medical Officer to Vice President Medical Affairs. • Changed reference to Barbara Swartos to Annette Graham and title Vice President of Medical Management to Sr. Vice President Medical Management.	

2020~~19~~

Health Net Community Solutions, Inc.
CalViva Health
Case Management
Program Description

Table of Contents

PURPOSE

The purpose of the Case Management (CM) Program Description is to define case management, identify case management functions, determine methods and processes for member identification and assessment, manage member care and measure outcomes.

Delegated Participating Provider Groups (PPGs) conduct basic case management activities in compliance with the Plan's standards.

In both delegated and non-delegated situations, the Case Management Program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses and members who are out-of-area. The focus is on early identification of high-risk members, applying a systematic approach to coordinating care and developing treatment plans that will increase satisfaction, and improve health and functional status. In addition, certain Case Management responsibilities are an integral part of Carve-Out and Public Health Programs, for example, CCS or Regional Center Programs.

The Plan makes available a comprehensive, high-risk perinatal Case Management Program to members regardless of delegation status. Care Managers work with Primary Care Physicians and other providers to develop individualized plans for appropriate members.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net or CalViva Health.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the CM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN staff via the corporate intranet website, "Cornerstone Learning".

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

SCOPE

Definition of Case Management

Case Management is a key vehicle for managing the health of the population. The Plan adheres to the Case Management Society of America's (CMSA) definition of case management which was updated in 2016: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost effective outcomes".
The Plan also abides by the principles of case management practice, as described in CMSA's most recent version of the Standards of Practice for Case Management, revised in 2016.

The Case Management Program and the tools utilized to manage care were developed based on evidence based clinical practice guidelines and preventive health guidelines adopted by the Plan. The assessments utilize the CMSA Standards of Practice for Case Management and other evidence based tools including the PHQ2/9. Disease specific assessments include research of latest scientific sources, articles and publications from national organizations, such as the American Diabetes Association. The program also includes adherence to HEDIS® effectiveness of care measures and the associated technical specifications to ~~ensure~~ promote member compliance.

The Plan trains and utilizes motivational interviewing techniques to guide member goal identification and actions.

Levels of case management include:

- **Care Coordination** – appropriate for members with primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of case management is used for continuity of care transitions and supplemental support for members managed by the county.
- **Case Management** – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a complex condition or multiple co-morbidities that are generally well managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services included at this level of case management include the level of care coordination along with identification of member agreed upon goals and progress towards meeting those goals.
- **Complex Case Management** – a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex case management is performed by CalViva for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex case management include all coordination and case management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence.

Goals and Objectives

The Mission of Plan's Case Management Program is to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

The Goals of the Case Management Program are:

Measure	Goal	Frequency
Member experience survey – each question and overall	> 90%	Annual
Member complaints/grievances	< 1/10,000 members	Annual
Reduce Non-Emergent ER Visits from 90 days pre CM	> 3%	Annual
Reduce Readmissions from 90 days pre CM	> 3%	Annual
Members managed in high risk OB program have greater % of members completing the 1st pre-natal visit with in the 1st trimester or 42 days of enrollment than pregnant members not managed.	> 5% ~~of non- managed members~~difference	Pregnancy
Members managed in high risk OB program have greater % of members completing the post-natal visit between 21-56 days post-delivery than pregnant members not managed.	> 5% ~~of non- managed members~~difference	Pregnancy
Members managed in high risk OB program have a lower rate of pre-term delivery than high risk members not managed.	> 2% difference	Pregnancy

Case Management Functions:

Case Management functions include:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an individualized plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers.
- Identification of barriers to meeting goals included in the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/case management activities.
- Addressing the member's right to decline participation in the case management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all case management procedures in compliance with HIPAA and state law.

Program Segments

The Plan has defined a set of case management population criteria for use with all CalViva members (children, adults and seniors, children with special needs (CSHCN), developmentally

disabled (DD), seniors and persons with disabilities (SPD) etc.). This creates efficiencies and a consistent measurement process of case management program effectiveness across the CalViva membership. The criteria below is not all inclusive; clinical judgment should be used to determine a member's appropriateness for each level of case management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

The Plan also offers a case management program specific to our pregnant moms and new babies, called CalViva Pregnancy Program. The program is focused on helping prospective moms to have a healthy happy pregnancy and wellness of the fetus and newborn. The program goals are quality of care in prenatal visits acknowledgement of and American College of Obstetricians and Gynecologists (ACOG) standards. The quality measures include HEDIS® rates for timelines of prenatal care and timeliness of postpartum care.

Complex Case Management Criteria
The Plan uses Impact Pro a predictive modeling and care management analytic tool with a built in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. Members are stratified into one of ten Population Health Categories: Level 01: Healthy, 02: Acute Episodic, 03: Healthy, At Risk Level and 04A: Chronic Big 5 Stable, 04B: Chronic Other Condition Stable, 04C: BH Primary Stable, Level 05A: Health Coaching, Level 05B: Physical Health CM, Level 05C Behavioral Health CM, Level 06: Rare High Cost Condition, Level 07A: Catastrophic: Dialysis, Level 07B: Catastrophic: Active Cancer, Level 07C: Catastrophic: Transplant Level 08A: Dementia, Level 08B: Institutional (custodial care)_ Level 09A: LTSS and MMP - Service Coordination, Level 09B: LTSS and MMP - High Needs Care Management or Level 10: End of Life. Members stratified into levels 05B and 5C are identified as high risk and impactable and are referred to case management as described below. Members stratified in Impact Pro into Level 5B: Physical Health CM and Level 05C Behavioral Health CM AND have other designated parameters such as: • CM engagement score ≥ 80 • ORCA (opioid risk classification) score of medium or high • Priority Flag = Yes • Annual ER designated cost shall be referred to the case management program. Additionally, any member, regardless of the risk stratification, who reach a designated score based on responses to the Screening HRA shall be referred to Case Management.
Case Management Criteria
Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to: • HIV/AIDS • Cancer • Sickle cell

• Asthma/COPD • Diabetes • Congestive Heart Failure • Children with special health care needs • Other State-mandated criteria
Care Coordination Criteria
• Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing health care services related to continuity of care • Participation in county program requiring supplemental Plan support

INFRASTRUCTURE AND TOOLS

Organizational Structure

~~Chief Medical Director~~Vice President Medical Affairs

The ~~Chief Medical Director~~Vice President Medical Affairs has operational responsibility for and provides support to the Plan's Case Management Program. The Plan ~~Chief Medical Director~~Vice President Medical Affairs (VPMA~~CMD~~), Sr. Vice President of Medical Management (VPMM), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the Case Management Program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to case management. A behavioral health practitioner is involved in the implementation, monitoring, and directing of behavioral health aspects of the Case Management Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the ~~CMD~~VPMA, the Plan may have one or more Medical Director and/or Associate Medical Directors.

The ~~CMD's~~ VPMA's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations.
- Monitors compliance with the Case Management Program.
- Provides clinical support to the case management staff in the performance of their case management responsibilities.
- Provides a point of contact for practitioners with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.
- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed.
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees.

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of the Plan's Case Management Program. A behavioral health practitioner may participate in case management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a Plan network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

Sr. Vice President of ~~Case~~ Medical Management (VPM~~C~~M)

The Sr. VPM~~C~~M is a registered nurse with experience in utilization management and case management activities. The Sr. VPM~~C~~M is responsible for overseeing the activities of the Plan's ~~day-to-day operational activities of the Plan's~~ Utilization Management and Case Management Programs. The Sr. VP~~C~~MM reports to the Plan- Chief Operating Officer.~~Senior Vice President of Medical Management.~~ The Sr. VP~~C~~MM, in collaboration with the ~~CMD~~VPMA, assists with the development of the Case Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Case Management Director/ Manager

The Director/Manager of Case Management is a registered nurse or other appropriately licensed healthcare professional with case management experience. The Case Management Director/Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists and Program Coordinators. The Case Management Director reports to the Sr. Vice President of ~~Case~~ Medical Management. The Case Management Manager reports to the Director of Case Management. The Case Management Director/Manager work in conjunction with the Utilization Management Director to execute the strategic vision of Health Plan objectives and attendant policies and procedures and state contractual responsibilities.

Supervisor, Program Coordinator (PC)

The Supervisor PC is highly skilled high school graduates or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience preferably in a managed care setting. The Supervisor PC oversees day to day operations and supervision of the Program Coordinators in CM and performs collaborative duties related to coordinated care programs. The Supervisor PC provides support to the Program Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.

Care Team (CT) Staffing Model

Care Coordination/Case Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the Concurrent Review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a

common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average active case load would be ~~40 –~~ ~~50~~ 62 cases. The Integrated Care Team ~~ICT~~ roles and responsibilities include: care managers, social workers, other licensed clinical staff, program specialists, program coordinators, care coordinators, and ~~Member~~ Connection Representatives.

Medical Director

- Physician who holds an unrestricted license to practice medicine in the Plan's state and is board-certified with experience in direct patient care if required.
- Serves as a clinical resource for care managers and members' treating providers.
- Participates in multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases.
- Provides a point of contact for providers with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.

Care Manager

- Licensed RN, Licensed Clinical Social Worker, or Licensed Marriage and Family Therapist.
- CM certification preferred.
- Responsible for oversight of non-clinical members of the CC/CM team.
- Responsible for working with the member and their physician to identify needs and create a care plan to help the members achieve their goals.
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers.
- Communicates and coordinates with the member and their caregivers, physicians, behavioral health providers, Disease Management staff, and other members of the CT to ensure that member's needs are addressed.

Social Workers/Program Specialists (SW/PS)

- Non-licensed Social Worker or licensed vocational nurse.
- Considered a care manager with an assigned caseload and responsible for following all standards of case management practice.

Program Coordinator (PC) II /Service Coordinator (SC)

- Can be either an LPN or a highly trained non-clinical staff person working under the direction and oversight of a CM.
- Provides support for moderate or low risk members.
- Collects data for Health Risk Screening.
- Provides information to CM/PS for care plan.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager/Program Specialist.

Program Coordinator (PC) I

- Non-clinical staff person working under the direction and oversight of a PC II or CM.
- Provides administrative support to CC/CM team.
- Collects data for Health Risk Screening.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager.

~~Member~~ Connection~~s~~ Representative (~~M~~CR)

- Health outreach workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.
- Works both in the office and in the community, sometimes with face to face member interaction.
- Performs member outreach, education, and home safety assessments.
- May assist with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- ~~Member~~ Connection~~s~~ Representatives report to the Manager of Member Connections.

Integrated Care Team meetings are held at least bi-weekly. The participants are comprised of plan behavioral health and physical health care managers, social workers, non-clinical associates, medical directors, and a pharmacy coordinator. Other participants may include: PCPs or specialists, behavioral health providers and/or County Mental Health Plan staff and/or MCR depending on the case.

Information System

Assessments, care plans, and all case management activities are documented in a clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the care team to generate reminder/task prompts for follow-up according to the timelines established in the care plan. Reminders/tasks can be sent to any team member, e.g. allowing Care Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of case management interventions.

MEMBER IDENTIFICATION AND ACCESS TO CASE MANAGEMENT

A key objective of Plan's Case Management Program is early identification of members who have the greatest need for care coordination and case management services. This includes, but is not limited to, those classified as children or adults with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Data Sources

Members are identified as potential candidates for case management through several data sources as available to the Plan, including, but not limited to:

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency department utilization reports
- Laboratory data
- Readmission reports
- State/CMS enrollment process and other State/CMS supplied data
- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD/SSI)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments, Member Evaluation Tool (MET)
- Information provided by practitioners, such as Notification of Pregnancy

Reports identifying members for case management are run on at least a monthly basis and forwarded to the care team for outreach and further appraisal for case management.

Referral Sources

Additionally, direct referrals for case management may come from resources such as:

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Case Management Program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Envolve PeopleCare Nurse Advice Line staff –has policies and procedures in place for referring members to the Health Plan for case management screening. This may be accomplished via a "triage summary report" that is sent to the Plan electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at the Plan.
- Envolve PeopleCare Disease Management (DM) Program staff –work closely with the case management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as case management rounds, are held between the care team and DM staff.

- Hospital staff, e.g. hospital discharge planning and emergency department staff - facility staff is notified of the Plan's Case Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform Plan UM staff if they feel a member may benefit from case management services; UM staff then facilitate the referral.
- Health Plan Staff - UM staff work closely with case management staff on a daily basis and can initiate a referral for case management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - Health Plan MemberConnections® Program ~~Member~~ Connection~~s~~ Representatives (M~~M~~CRs) are trained in all departments within the Health Plan and have a full understanding of all staff functions. M~~M~~CRs work closely with the care team, referring members who may benefit from case management services.
    - Health Plan Member Services - Member Services staff is also trained in all departments within the Plan and have a full understanding of all staff functions, including the role and function of the care team.
    - Other intradepartmental referrals e.g., Provider Specialists, Plan Advocates, and QI Department.
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about case management services in the Member Handbook, received upon enrollment and available on the Plan website, member newsletters, and through contact with Member Services and/or other Plan staff.
- Community/social service agencies – community agency staff are informed of the Case Management Program during interactions with the Plan care team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential case management needs to Plan staff (California Childrens Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.)
- Delegated entity staff (e.g. vision, dental, DME/home health, etc.~~,~~ as applicable) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for case management. The Plan also regularly communicates with delegates through oversight meetings, case management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center.

The specific means which a member was identified as a potential candidate for case management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to case management. Multiple referral avenues help to minimize the time between need for and initiation of case management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

SCREENING AND ASSESSMENT

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within ~~30~~ 7 calendar days of identification as potential candidates for case management. Care team staff obtain consent to complete the case management screening and/or initial assessment once member contact is made. Case Management staff also explains the care manager role and function and benefits of the Case Management Program to the member and/or their authorized representative or guardian.

General standardized assessments have been developed internally to address the specific issues of the Plan's unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for case management. All assessments are documented in the clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Case Management Program, and are informed they are entitled to decline participation in, or disenroll from case management at any time, if allowed per state regulations. The member/guardian is notified of the potential need for the care team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in the Case Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the care team. Member Connection Representatives may also be utilized when necessary, to assist in outreach for members who are difficult to contact. Member Connection Representatives go the member's physical address and attempt to initiate contact. They may also outreach to local community agencies and provider offices in an effort to locate a member. If a MCR is successful in locating the member, they may perform a general screening in person, including observation of the member in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outreach to members is initiated within ~~stratified as high is made within~~ 7 calendar days and completed within ~~, moderate priority within~~ 14 calendar days ~~and for those at low priority, within 30 calendar days of screening completion and identification~~of identification/referral.

A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management may be revised at this time, or following further assessment.

The Care Manager then attempts outreach to the member and/or authorized representative or guardian telephonically within one week for members identified as high priority and thus appropriate for Complex Case Management, to perform an in-depth assessment to more closely identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's condition(s). These condition-specific assessments, such as the Diabetes and Asthma assessment, are derived from evidence-based clinical guidelines. During the in-depth case management assessment, the Care Manager evaluates the full scope of the member's situation, including:

- Evaluation of communication barriers; cultural, linguistic, hearing, and visual, preferences or limitations.
- The member's health status, including condition–specific issues and likely co-morbidities.
- Assessment of behavioral health status (e.g. presence of depression and/or anxiety) and cognitive functioning.
- Assessment of social determinants of health issues such as alcohol or drug dependency, smoking, significant life stressors, etc.
- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring.
- Assessment of activities and instrumental activities of daily living.
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of caregiver resources and potential involvement in care plan implementation.
- Assessment of personal resources, limitations, and presence of social determinants
- Evaluation of available benefits and other financial resources.
- Evaluation of need for, and availability of, community resources.
- Assessment of educational and vocational factors.

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital case managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Care Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The care team reviews the gathered information and begins to build a plan of care. The initial assessment and plan of care are completed no later than 60 days after the identification/referral of the member to Case Management, but in most cases is completed earlier. ~~a member or caregiver acting on member's behalf, agrees to participate in Complex Case Management, but in most cases is completed earlier.~~ A member is considered eligible for case management services upon their consent to participate unless otherwise defined by individual state laws. Care teams may include Nurse Care Managers, Program Coordinators, Social Workers, Behavioral Health Specialists, and Member Connection Representatives. Each contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member
- Member authorized representative or guardian
- PCP and specialty providers
- Plan Medical Directors
- Hospital discharge planners
- Ancillary providers (e.g.. home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g. United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)
- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

Behavioral Health Services

The Plan is responsible to provide mild to moderate mental health services to all members, including Applied Behavioral Analysis (ABA) when medically necessary. The Plan strongly supports the integration of both physical and behavioral health services through screening and strengthening prevention and early intervention, Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan will ensure that Members who need Specialty Mental Health Services are referred to and are provided these services by an appropriate Medi-Cal FFS mental health provider or the local mental health plan in accordance with contract requirements. The Plan will assist members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care. The Plan shall also assist individuals requesting Voluntary Inpatient Detoxification (VID) services and provide care coordination to assist the member in locating a general acute care hospital (may not be a chemical dependency treatment facility or Institution for mental disease).

Continuity and Coordination of Care between Medical and Behavioral Health Care

When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager of the member. If the member's primary diagnosis is a behavioral health condition, the case is referred to a Behavioral Health Care manager, who serves as the lead Case Manager, working in tandem with the medical care team. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Case Manager will serve as the lead Case Manager. The medical and

behavioral health Case/Care Managers confer with each other to confirm which Case/Care Manager will serve as the lead or secondary Case/Care Manager. If the Case/Care Managers cannot agree, a supervisor is consulted for a decision.

When assigned to a physical health Care Manager, he/she reviews the member's clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult.
- Assists the member, or coordinates with the behavioral health Case Manager, to make arrangements for the behavioral health consult.
- Follows up to make sure a behavioral health consult was conducted.

When appropriate (including but not limited to when the primary Care Manager is revising the plan of care or evaluating a member for discharge from case management), the medical and behavioral Case/Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide members' care. The primary Care Manager, is responsible for assuring appropriate physical and behavioral health follow-up in case management discharge planning.

Coordination with External Programs

The Plan will refer identified members to external agencies offering appropriate services and programs to complement those provided by the Plan. Programs and services may include, but are not limited to: Public Health Departments, Severe Mental Health Services, California Children's Services (CCS), Transplant services with the exception of kidney, Regional Center for the developmentally disabled, Home and Community-Based Services (HCBS) Waiver program administered by the State Department of Developmental Services (DDS), Regional Center or local governmental health program as appropriate for the provision of Targeted Case Management services. The Plan shall continue to provide all Medically Necessary Covered Services per the Memorandum of Understanding for all eligible members that are not authorized or covered by external agencies. The Plan shall ensure the coordination of services and joint case management between its Primary Care Providers, specialty providers, and the local programs or agencies.

ONGOING MANAGEMENT

Plan of Care Development

The initial assessment serves as the foundation for the member's care plan. The care team identifies issues and needs, and utilizing input from team participants, develops a proposed care plan. The care plan is developed in conjunction with the member; the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting goals or complying with the plan of care are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care plan.

The proposed plan of care is discussed with the member and/or member authorized representative or guardian, the PCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's ability and willingness to participate. The Care Manager assures all parties are in agreement with the care plan to ensure successful implementation.

Members assigned to Care Coordination, or members identified as moderate/medium priority assigned to Case Management have an abbreviated care plan. The care plan for members in Complex Case Management includes, at a minimum:

- Prioritized goals – goals are specific, realistic, and measurable and are associated with a timeframe for completion. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible.
- Identification of barriers to meeting the goals and recommended solutions for each barrier.
- Resources to be utilized, including the appropriate level of care.
- Interventions to reach those goals, including development of member self-management plans. The care manager assures the member has a full understanding of their responsibilities per the self-management plan.
- Planning for continuity of care.
- Collaboration with and involvement of family and significant others, health care providers, etc.(as applicable).
- The schedule for on-going communication with the member and other involved parties, based on individual needs and member preference.
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

The care plan is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes and asthma management, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Monitoring and Evaluation

Once the plan of care is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are reached, etc. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may assign tasks to other members of the care team, such as a Program Specialist to manage or assist with social determinants of health issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the care team when follow-up contacts are needed. Follow-up reminders can be set

for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and time lines in the care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers' or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in the Case Management Program (agreement may be oral or written; if oral, the Care Manager documents the discussion with the member/caretaker).
- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's case.
- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.
- The case management care plan, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers.
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan.
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

The Care Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical status.
- Change in the member's social stability.
- Change in the member's functional capability and mobility.
- Progress made in reaching the defined goals.
- The member's adherence to the established care plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels, etc.
- Changes in the member or family's satisfaction with the Case Management Program and other services addressed in the care plan.
- The member's quality of life.
- Benefit limits and financial liability.

The Care Manager completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year if the member remains active in case management. If the member loses eligibility for more than 30 days then a new assessment is performed upon enrollment back into the complex case management program to ensure the member is being assessed for current case management needs. The plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the care team care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The care team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes to the care plan to ensure ongoing success. The care team also monitors the case on an ongoing basis for sentinel events and quality indicators and, if present, makes the appropriate referral to the Quality Improvement Department.

Discharge from Case Management

The Care Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's plan of care to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from case management should occur:

- Member terminates with the Health Plan.
- Member/family requests to disenroll from the Case Management Program.
- The member/family refuses to participate in case management despite efforts to explain how it can benefit the member.
- Plan is unable to reach member despite at least three (3) different types of attempts (phone attempts at different times during day, visit to home, letter submission with address correction request, and/or contacting PCP/ ~~WIC/~~Specialists/Programs) to locate and engage the member.
- The member reaches maximum medical improvement or reaches established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources.
- Insurance benefits are exhausted and community resources are in place.
- Member expires.

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Coordinates care with the new medical entity and community resources as required, allowing for a smooth transition for the member.
- If Complex Case Management has been refused by the member/family, the Care Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system.
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from case management.
- Discusses the impending discharge from case management with the member/family.
- Presents community resources and assists in making arrangements with those relevant at the time of discharge.

A letter noting the member is discharged from case management is generated and sent to the PCP and the member. The letter documents the reason for discharge and includes, if the member has

not terminated with the Plan, a reminder to contact the care team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented. A member satisfaction survey may be included with the discharge letter, as described below.

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

Population Health Assessment

At least annually, the Plan assesses the entire member population and any relevant subpopulations (e.g. Children with Special Needs, Seniors and Persons with Disabilities Foster Care) to determine if the Plan's programs meet the needs of members. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age (especially children/adolescents and elderly), gender, ethnicity, race, and/or primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g. overall claims received, inpatient admissions and ED visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with mild to moderate mental illness.

Results of the population assessment are analyzed and subsequent enhancements made to the Case Management Program if opportunities for improvement or gaps in case management services are identified. Potential revisions to the Case Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of case management activities assigned to specific members of the care team (e.g., clinical versus non-clinical staff responsibilities).
- Implementation of targeted training, e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff.
- Improvement in identification of appropriate community or other resources provided to members and the resources available to staff and the process for assisting members in accessing resources.

The annual population assessment may be a separate document or included as part of the Utilization Management/Case Management program evaluation and will be presented to appropriate committees, such as the Quality Improvement Committee, for review and feedback.

Member Experience with Case Management

Member experience with the Case Management Program is assessed no less than annually. Member experience surveys, specific to case management services, are completed at least annually for members enrolled in case management. Surveys are completed via mail or telephonically for members who have been enrolled in case management for ≥ 45 days. The results of the surveys are aggregated and evaluated annually and are included in the overall evaluation of the Case Management Program, which may be part of the annual Quality Improvement and/or Utilization Management program evaluation as described below.

Member complaints and grievances regarding the Case Management Program are monitored no less than quarterly. Results of the analysis of member experience surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and

determine which opportunities to pursue regarding changes to the Case Management Program, as needed.

Outcomes

Case Management Program outcomes are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Health Plan specific state requirements/expectations.

The Plan measures effectiveness of Complex Case Management no less than annually using at least three (3) measures that assess the process or outcomes of care for members in Complex Case Management. Additional details regarding these measures are identified in the Utilization Management/Quality Improvement (UM/QI) work plan. Measures of effectiveness may include indicators such as:

- Readmission rates.
- ED utilization.
- Rate of pregnant members with an appropriate prenatal visit.
- Rate of pregnant members with an appropriate post-partum discharge visit.
- Rate of high risk pregnant members who have a pre-term delivery.

Measurement and analysis of the Case Management Program is documented as part of the annual Quality Improvement and/or Utilization Management program evaluation. The Case Management Program is evaluated at least annually and modifications to the program are made as necessary. The Plan evaluates the impact of the Case Management Program by using:

- Results of the population assessment.
- The results of member experience surveys (i.e. members in case management).
- Member complaint and grievance data regarding the Case Management Program.
- Practitioner complaints and practitioner satisfaction surveys regarding the Case Management Program.
- Other relevant data as described above.

The evaluation covers all aspects of the Case Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Quality Improvement/Utilization Management Committee for review, action and follow-up. The final document is then submitted to the RHA Commission through the Quality Improvement/Utilization Management Committee for approval.

Condition Specific CM and DM Programs

Members in condition specific Case/Disease Management Programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The case management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination

with behavioral health, and discharge from case management when not specifically addressed in the program. Disease Management has been delegated to Envolve PeopleCare and the Plan Care Manager coordinates care and member interaction to prevent duplication of contacts and services.~~Disease Management is managed within the Plan and the Plan Care Managers coordinate care and member interactions to prevent duplication of contacts and services.~~

Plan Case Management Programs may include, but are not limited to:

- Children and Adults with Special Health Care Needs
- Sickle Cell
- Transitional Care Management (post hospitalization follow-up)
- ~~Post Hospitalization Follow-up~~
- High Risk Pregnancy

Plan Disease Management Programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure

Transitional Care Management Program

The purpose of the Transitional Care Management Program (TCM) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The TCM Program is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

Health Net's TCM conceptualizes the Coleman model within its foundation. The focus of this model is based on a coaching intervention rather than a case management intervention. Under this model, the Care Transition nurse helps patients/members and/or their primary caregiver, learn transition specific self-management skills by:

1. Introducing the CTI to the member at the time of hospitalization,

2. Use of role playing and other tools to transfer skills to patients and family members on how to communicate care needs effectively during direct encounters with their health care team,

3. Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation- how to respond to medication discrepancies, how to utilize a personal health record (PHR), and

4. Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.

5. Follow-up calls with the member are conducted within 30 days of post-discharge, which focuses interventions on:

- Reviewing the progress toward established goals
- Discussing encounters with other health care professionals
- Reinforcement of the importance of maintaining and sharing the PHR
- Supporting the patient's self-management role
- Medication reconciliation with access to Health Net pharmacist.
- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge.

During the post discharge period, staff evaluates the member for Case Management, palliative care and other programs that may best support the member in managing their continued needs. A referral to these programs is conducted as applicable to ensure continuity of addressing outstanding member needs/goals.

Member Impact

- Better ability to manage member care through coaching interventions. Increasing member engagement will reduce risk of adverse post discharge outcomes and/or readmissions.
- Positive experience with the Transition Care Management Program increases member satisfaction further strengthening Health Net's brand and market standing.
- Coaching interventions encourage active participation of the member/member's representative in the health care continuum. Member becomes more apt to take an assertive role in his/her own care.
- Problem-solving skills, proactive thinking and ability to anticipate issues,
- Ability to collaborate with clinical staff to address ongoing needs of members
- Ability to understand psychosocial barriers and members' needs
- Good understanding of contracted network/resources for assigned medical group including PCP, specialist physicians, radiology, laboratory services, urgent care, etc.
- Organizational and time management skills

Health Net's TCM staff are located throughout California. They are linked through common management teams and systems. Health Net's Medical Directors participate in all aspects of Care Transition/Transition Care Management operations.

Palliative Care Program

The Palliative Care Program is a no-cost service that CalViva offers to its members. Palliative Care is a free program that CalViva offers to members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care is able to provide nurses, medical directors, and social workers in a home setting to members at no additional cost. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle

The Palliative Care Program may be appropriate if there is a chronic or serious illness that is significantly impacting the quality of life or daily activities of the member. The Palliative Care team works in accordance with the member's current primary physician and specialists to provide pain management, symptom management and disease management to enhance the member's quality of life. Palliative Care services are in addition to other current benefits, and existing curative medical treatment and social services may continue as before.

Diagnoses that may qualify a member for Palliative Care include but are not limited to:

- Advanced Cancer
- COPD
- CAD/CHF
- Liver Disease
- AIDS

Other indicators that may qualify the member for Palliative Care include but are not limited to:

- Multiple Hospitalizations or ER Visits
- Limited Social Support and a Serious Illness
- Declining ability to complete activities of daily living
- Member previously enrolled in hospice program that may have revoked due to wanting to seek curative treatment
- Long term planning needs

Palliative care services

- Advance Care Planning- Discussions and counseling of Advance Directives, Physician Orders for Life-Sustaining Treatment (POLST) forms and alike between qualified healthcare professional and the member, family member, or legally-recognized decision-maker.

- Palliative Care Assessment and Consultation- This service aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to: treatment plans, including palliative care and curative care, pain and medicine side effects, emotional side effects, spiritual concerns, member goals, advance directives, including POLST forms, legally recognized decision maker.

- Individualized Plan of Care- The plan of care may include, but not limited to pain and symptom and curative care, and all other palliative care services. This is developed with the member, decision-maker, and the Palliative Care team. This will reflect any changes from any ongoing care and discussion. The plan of care does not include services already received through another Medi-Cal funded benefit program.

- Palliative Care Team- This team consists of Palliative Care Vendors that employ qualified health care professionals such as Primary Care Providers (MD or DO), Registered Nurse, Licensed Vocational Nurse, Nurse Practitioners, Social Workers, Chaplain, and Coordinators. The team also includes Health Plan Palliative Care Coordinators/Liaisons and Medical Directors who works together with the Palliative Care Vendors to provide the Palliative Care Services.

- Care Coordination- Palliative Care Team provides care coordination continuously that reflects the member's needs and plans of care.

- Pain and Symptom Management- Pain and symptom management is part of the member's plan of care. Prescription drugs, physical therapy and other medically necessary services may be coordinated as authorized.

- Mental Health and Medical Social Services- Psychotherapy, bereavement counseling, medical social services, and discharge planning are some of the ways Mental and Social Services are provided by the Palliative Care Team.

- Chaplain Services- Chaplain Services are provided to members if the need is indicated in the care plan and/or requested by member.

- 24/7 Telephonic Palliative Care Support

- May authorize additional palliative care services medically necessary or reasonable for eligible members (e.g. expressive therapy for the pediatric population)

Palliative Care Services may be provided in inpatient, outpatient, home-based, community-based and other variety of settings. The setting may be based on what is medically necessary for the member's needs.

A. *Fresno-Kings-Madera Regional Health Authority Commission Approval*

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description

David Hodge, MD, Fresno County Regional Health Authority Commission Chairperson	Date
Patrick Marabella, MD, Chief Medical Officer Chair, CalViva Health QI/UM Committee	Date

Health Net Community Solutions UM/QI Committee
Medi-Cal Utilization Management Program Approval

The Health Net Chief Medical Director and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
~~Alex Chen~~Ramiro Zuniga, MD
~~Chief Medical Officer~~Vice President of Medical Affairs

_____ Date _____
~~Barbara Swartos~~Annette Graham
Sr. Vice President of Medical Management

Committee Approval
The Health Net Community Solutions UM/QI Committee has reviewed and approved this Case Management Program Description.

_____ Date _____
Ramiro Zuniga, MD
Vice President of Medical Affairs~~Alex Chen, MD~~
~~Chief Medical Officer~~