Item #8

Attachment 8.A

Annual Utilization Management Program Review 2016 Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO: CalViva Health QI/UM Committee
Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Sharon Almany, Vice President Medical Management

COMMITTEE DATE: February 16th, 2017

SUBJECT: CalViva Health Utilization Management/Case Management 2016 Annual Evaluation Executive Summary

Summary:

Utilization Management (UM) processes have been consistent and evaluation/monitoring of UM metrics continue to be a priority. Both Case Management and Disease Management continue to monitor the effectiveness of programs in order to better serve our members.

Purpose of Activity:

CalViva Health has delegated responsibilities for utilization management and case management (UM/CM) activities to Health Net Community Solutions. CalViva Health's UM/CM activities are handled by qualified staff in Health Net's State Health Program (SHP) division.

The Utilization and Case Management Program is designed for all CalViva Health members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely and effective manner.

CalViva Medical Management staff maintains clinical oversight of services provided through review/discussion of routine reports and regular oversight audits.

The Year End Evaluation of the UMCM Work Plan encompasses a review of medical management activities through the documentation of current and future strategic initiatives and goals. The Work Plan tracks key performance metrics, regulatory compliance, provides for an assessment of our progress and identifies critical barriers.

This plan requires involvement from many areas such as Appeals & Grievances, Compliance, Information Technology, Medical Informatics, Member Services, Pharmacy, Provider Oversight, Provider Network Management, Provider Operations, Quality Improvement and Medical Management.

Data/Results (include applicable benchmarks/thresholds):

This metric is identified as Not Met for the Annual Evaluation Reporting:

- Timeliness of processing the Authorization Request

Key data metrics to note:

- Turnaround Time (TAT) for processing authorization requests within regulatory timeframes had an overall score that averaged 95.0% for January – December 2016 with a goal of 100%.

Month	All TAT Overall Score
January 2016	85.6%
February 2016	87.1%
March 2016	100%
April 2016	100%
May 2016	97.5%
June 2016	87.7%
July 2016	93.2%
August 2016	95.4%
September 2016	98.7%
October 2016	96.8.%
November 2016	96.7%
December 2016	99.4%

- Appeals of UM Appeal determinations for time frame January – December 2016
  Turnaround Time Compliance for Appeals = 100%

2016 Annual Count of Appeal Type		
	Outcome	Case Count
CalViva	Overturn	47
	Partial Uphold	4
	Uphold	133
CalViva Total	Cases	188

Annual Appeal Percentage	
Decision Overturn	25%
Partial Upholds	2%
Upholds	71%
Withdrawals	2%
Turnaround time Compliance	100%

- Target UM Admit per thousand (AD/K), Bed days per thousand (BD/K) and average length of stay (ALOS) goals have been established for the SPD and Non-SPD populations. The UM targets for AD/K, BD/K and ALOS MCE population are under review.

Data time frame January – December 2016.

Non- SPD (TANF)

Counties	Days/1000	Goal
Fresno	89.3	216.6
Kings	86.9	216.6
Madera	130.1	216.6

SPD

Counties	Days/1000	Goal
Fresno	1122.2	1129.7
Kings	616.4	1129.7
Madera	751.2	1129.7

MCE

Counties	Days/1000	Goal
Fresno	346.9	TBD
Kings	269.1	TBD
Madera	309.5	TBD

- The Public Programs Department began enhanced reporting for 2016 for CCS Identification Rates by County. CVH Benchmark is 5% per county. Yearly comparison data will be available in 2017.

2016 CCS Identification Rate

	Fresno	Kings	Madera
Jan 16	7.98%	6.03%	5.94%
Feb 16	7.50%	5.69%	5.71%
Mar 16	7.54%	5.93%	5.98%
Apr 16	7.48%	5.99%	5.89%
May 16	7.59%	6.06%	5.94%
June 16	7.66%	6.05%	5.96%
Jul 16	7.72%	6.17%	6.09%
Aug 16	7.66%	6.07%	6.04%
Sept 16	7.55%	5.57%	5.93%
Oct 16	7.53%	6.06%	5.96%
Nov 16	7.55%	6.00%	5.90%
Dec 16	7.57%	6.04%	5.98%

Analysis/Findings/Outcomes:

Key findings to note:

1. Compliance with Regulatory & Accreditation Requirements

- Medical Management reviewed and incorporated into practice new Federal and State legislation and regulations specific to Medi-Cal Managed Care to ensure compliance with current policies and procedures.
- Health Net Medical Directors and the CalViva Chief Medical Officer attended all DHCS Medi-Cal Managed Care Division's Medical Directors quarterly meetings in 2016.

2. Monitoring the UM Process

- Inter-rater Reliability Testing (IRR) was completed in Sept/Oct 2016 with a required passage of 90% an increase from 80% for clinical and 85% for Physicians. All staff completed IRR testing with an average passing score of 96% collectively.
- Achieved 100% compliance in appeal process turnaround time which was an improvement from 98.70 in 2015.

3. Monitoring Utilization Metrics

- Continued initiative to identify high risk members and enroll them into the Transition Care Management (TCM) program. TCM staff collaborates with the On-site Concurrent Review (CCR) nurses to engage members with the highest risk of readmission based on advanced analytics model.
- Continue to monitor IP case management initiatives for adults including early intervention to establish medical home and care coordination for carve out services/community resources, behavioral health screening and referral.
- PPG Profiles and Over/Under Metrics: Quarterly UM/QI reports have been generated by PPG and most recently for the FFS network dating back to Q1 2016. Parameters include Admission rates, maternity admission rates, ER utilization, and readmission rates. Further drill down into several AID categories has also

been undertaken, including SPD, Expansion and non-expansion /SPD. These were shared and reviewed with CVH upon their completion.

- Continue MRU review and MD collaboration for review of cases for potential CCS diagnosis, IP trauma level review, ER trauma claims for documentation of trauma team activation, and making sure that denials are correct based on coding edits, although this is no longer a formalized process, review continues.

4. Monitoring Coordination with Other Program and Vendor Oversight

- In September 2016, the Case Management Program Model changed to Integrated Care Management (ICM) with the transition to TruCare. 2017 Data will include all cases under the category of ICM.
- Perinatal Case Management saw an increase in participation in 2016 with 179 members, an increase from 77 in 2015.
- Continuation of monthly meetings with CalViva and Case Management to review Key Indicator Report and other program monitoring issues and opportunities for improvement.
- Continued active engagement with pharmacy. Medical Directors meet with pharmacy on a quarterly basis to review prior authorization trend reports, discuss utilization of medications, review overturns on appeal trends, and discuss formulary and prior authorization guideline changes.
- MHN participates in weekly rounds with HN case managers and MD to integrate and coordinate care between medical and behavioral health.
- MHN tracks network availability (timeliness) which was 100% for the first three quarters of 2016. with the exceptions of 1 BCBA within 60 miles: rural, which was 99% and 2 BCBA within 60 miles: rural, which was 99%. Fourth quarter information not yet available.

5. Monitoring Activities for Special Populations

- The Prior Auth and CCR teams screen requests for service and/or every inpatient admission, under their review, for CCS eligibility. Any person under the age of 21 with a complex medical condition is screened for potential CCS eligibility. Cases identified as potentially eligible or confirmed eligible for CCS services are referred to the local CCS office.
- The CCRNs collaborate directly with the local CCS office to ensure coordinated services and expedited access to care through CCS paneled providers and/or Specialty Care Centers.

Actions Taken:

Ongoing monitoring of interventions will be essential for all areas to ensure appropriate actions are being taken to meet goals.

Next Steps:

Continue progress towards completion of all activities.

Item #8

Attachment 8.B

Annual Utilization Management Program Review 2016 Work Plan Evaluation

CalViva Health

2016

Utilization Management/ Case Management Annual Work Plan Evaluation

Created: January 14, 2016
Updated: February 8, 2017

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1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support UM decisions.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Qualified licensed and trained professionals make UM decisions.	HN has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. HN HCS (for nurses) National Credentialing (for physicians) and Pharmacy (for pharmacists) maintain records of health professionals' licensure and credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for RNs	Monthly As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Clinical credentials tracked monthly with copies of licenses for all clinical staff on file. InterQual associate training sessions for all Physician Reviewers and non-physician clinical reviewers is scheduled for September/October 2016. The following continuing education sessions were offered in the first half of 2016: January 2016: Palliative Care February 2016: SNP Model of Care March 2016:Treatment of Primary Immunodeficiency including HYQVIA March 2016: Asthma April 2016 Osteoporosis May 2016 Diabetes May 2016 Homelessness June 2016 Cardiac Health	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Clinical credentials tracked monthly with copies of licenses for all clinical staff on file. InterQual Refresher courses were conducted in October 2016 with clinical reviewers and physicians. The following continuing education sessions were offered to the medical management staff in 2016: ●Palliative Care (2 sessions) ●SNP Model of Care ●Improving Asthma ●Osteoporosis: Fracture Liaison Services ●Primary Immunodeficiency Treatment - HYQVIA ●Diabetes ●Homelessness (2 sessions)	None	None	Ongoing

	●Exercise and its physiological effects on health ●Innovative ways to incorporate flu vaccination and colorectal cancer screening ●MHN/County behavioral health for SHP members: Services and Challenges ●HEDIS Update – ICD-10 Best Practices ●Hepatitis C ● Quality Outcomes			

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.2 Review and coordinate UM compliance with California legislative and regulatory requirements	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	All processes are on track. Medical Management's Business Compliance Consultant (BCC) attends all relevant EPCO (implementation) meetings, specific to Medi-Cal impacted processes. Pertinent issues related to compliance have been communicated to CalViva Health.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	During calendar year 2016, Medical Management actively participated in discussions regarding proposed legislation and regulations, as well as strategized and then implemented newly vetted requirements. The process of monitoring, recognizing and acting on signed and enacted legislation is an on-going process, which includes the assessment of each new law, rule or regulation's impact on patient benefits, patient services, medical management functions and healthcare reporting requirements, to name a few. Medical Management's 2016 endeavors achieving compliance with this deliverable, and will proceed on the same course for 2017.	None	None	Completed for 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	DHS, DMHC, and CMS, at a minimum, require that Medical Decisions made by MDs and RNs are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with distribution of affirmative statement about financial incentives to members, practitioners, providers and employees.	Circulate to all MDs and RNs an attestation that states: ▪ Utilization Management decisions are based on medical necessity and medical appropriateness. ▪ Health Net and CalViva do not compensate physicians or nurse reviewers for denials. ▪ Health Net and CalViva do not offer incentives to encourage denials of coverage or service. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or RNs based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Attestations are on file for all staff. Activities on target for 2016.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	The Affirmative Statement was sent to all UM staff on 12/5/16. In addition, the Affirmative statement is included on the UM audit tool in the annual audit of delegates.	None	None	Completed for 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with HNCS staff on issues revealed during the file review process.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Combined audit from the California Department of Managed Health Care (DMHC) and Department of Healthcare Services (DHCS) was conducted in April. Awaiting audit results.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	No DMHC/DHCS findings for UM Denial Files were reported. Continued education and training continues for best practice and compliance with regulatory standards Audit Monitoring database is utilized for tracking of audits conducted monthly. Results are then shared with management to review findings and collect corrective action plans when needed	None	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS).	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN State Health Programs MDs interact with the MMCD Division of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program ▪ Provides HN with in-depth information regarding contractual programs ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings Ensures participation by RMDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each RMD. HN and CalViva remain a strong voice in this body with participation on key workgroups	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2016. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Health Net Medical Directors and the CalViva Chief Medical Officer attended the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters one and two this year.	None	Communication continues to center on the following areas: 1. CCS Redesign Stakeholder Advisory Board 2. CCS Care Coordination Workgroup 3. Palliative Care Workgroup 4. Health Homes Workgroup 5. All Plan Letters 6. Duals Workgroup 7. Mental Health Workgroup	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Health Net Medical Directors and the CalViva Chief Medical Officer attended the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for all quarters in 2016.	None	Communication continues to center on the following areas: 1. CCS Redesign Stakeholder Advisory Board 2. CCS Care Coordination Workgroup 3. Palliative Care Workgroup 4. Health Homes Workgroup 5. All Plan Letters 6. Duals Workgroup 7. Mental Health Workgroup	Completed for 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	State Health Programs Health Services reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs CMD, Regional Medical Directors, Director of Health Services and Health Services Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2016 UMCM Program Description Write and receive CalViva approval of 2015 UMCM Work Plan Year-End Evaluation Write and receive CalViva approval of 2016 UMCM Work Plan. Write and receive CalViva approval of 2016 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 2016 Q 1 2016 Q 1 2016 Q 3 2016 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva Policies and Procedures were reviewed during 2016 and submitted to the appropriate regulatory agencies. During the 1st quarter 2016, the 2016 CalViva UM/CM Program Description, 2016 CalViva UM/CM Work Plan and the 2015 Year End Evaluation were presented and Approved in March 2016.	None	Revised Policies and Procedures are reviewed by CalViva Health medical management staff and edits to CalViva Health Policy and Procedures are considered/made as appropriate.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	CalViva Policies and Procedures were reviewed during 2016 and submitted to the appropriate regulatory agencies. During the 1st quarter 2016, • The 2016 CalViva UM/CM Program Description, • The 2016 CalViva UM/CM Work Plan and • The 2015 Year End Evaluation were presented and approved.	None	Revised Policies and Procedures are reviewed by CalViva Health medical management staff and edits to CalViva Health Policy and Procedures are considered/made as appropriate.	Completed for 2016

2. Monitoring the UM Process

Created: January 14, 2016
Updated: February 8, 2017

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and Trend authorization requests month to month. Tracking includes number of prior authorization requests submitted, approved, deferred, denied, or modified. Turnaround times (TAT) Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The Management team reviews monthly reports to ensure expectations are met in 2016, trends and results discussed during Monthly Medical Management Department KPI meeting. Activities are all on target for 2016.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	The Management team reviewed monthly reports to ensure expectations are met in 2016, trends and results discussed during Monthly Medical Management Department meeting.	None	None	Completed for 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request. (Turn Around Times =TAT)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and Trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of turnaround times (TATs). Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining	Ongoing

<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>Currently below target at 93%. Continue interventions and monitoring.

<table>
<tr><th>Month</th><th>All TAT Overall Score</th></tr>
<tr><td>January 2016</td><td>85.6%</td></tr>
<tr><td>February 2016</td><td>87.1%</td></tr>
<tr><td>March 2016</td><td>100%</td></tr>
<tr><td>April 2016</td><td>100%</td></tr>
<tr><td>May 2016</td><td>97.5%</td></tr>
<tr><td>June 2016</td><td>87.7%</td></tr>
</table>
</td>
<td>• Staff Error

• Process Error

• Global system outage</td>
<td>Education and reinforcement of root cause with the staff members who made errors. Coaching on how to avoid future failures and review of correct process.

Education reviewed with the clinical team and non-clinical teams to review root causes of errors and reinforce correct process.

Continue to monitor weekly turnaround time reports to identify trends.

Monitor clinical and non-clinical meetings to review monthly failures.

Staff resources increased for weekend coverage for non-clinical team.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2017</td>
<td>Turnaround Time (TAT) for processing authorization requests within regulatory timeframes had an overall score that averaged 95% for YTD 2016.

<table>
<tr><th>Month</th><th>All TAT Overall Score</th></tr>
<tr><td>July 2016</td><td>93.2%</td></tr>
<tr><td>August 2016</td><td>95.4%</td></tr>
<tr><td>September 2016</td><td>98.7%</td></tr>
<tr><td>October 2016</td><td>96.8.%</td></tr>
<tr><td>November 2016</td><td>96.7%</td></tr>
<tr><td>December 2016</td><td>99.4%</td></tr>
</table>
</td>
<td>• Staffing Resources</td>
<td>Education reviewed with the clinical team and non-clinical teams to review root causes of errors and reinforce correct process.

Continue to monitor weekly turnaround time reports to identify trends.

Monitor clinical and non-clinical meetings to review monthly failures.

Process improvement evaluation ongoing with management staff</td>
<td>Completed for 2016</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	HN administers 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 for physicians and 90% for non-physician staff.	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2016 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson's InterQual® IRR tool in Q3-4 2016	Q3-4 2016 Q3-4 2016

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Annual InterQual updates to be scheduled September/October. IRR testing for both non-clinical and MD scheduled for completion in September/October.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Following InterQual refresher training on InterQual, the McKesson InterQual IRR modules were administered. In addition for clinical staff, IRR was administered on the application of the Hierarchy of Medical Resources which was updated this year to include both Medicare and Commercial Lines of Business. IRR was administered to the Physician Reviewers and the non-physician clinical staff requiring a minimum score of 90% to pass. Non-Physician Outcomes: All staff completed and passed the IQ IRR tests with an average passage rate for all modules of 98% Medical Director Outcomes: The Medical Directors completed and passed the IQ IRR tests with an average passage rate for all modules of 95% .	None	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turn Around Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2016 Planned Interventions	Target Completion Date

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	**Mid-Year Count of Appeal Type** CalViva: Overturn 16; Partial Uphold 0; Uphold 57; CalViva Total Cases 74 **Mid-Year Appeal Percentage** Decision Overturn 22% Partial Upholds 0% Upholds 77% Withdrawals 1% Turnaround time Compliance 100%	None	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	**2016 Annual Count of Appeal Type** CalViva: Overturn 47; Partial Uphold 4; Uphold 133; CalViva Total Cases 188 **Annual Appeal Percentage** Decision Overturn 25% Partial Upholds 2% Upholds 71% Withdrawals 2% Turnaround time Compliance 100%	None	None	Completed 2016 and ongoing for 2017

Created: January 14, 2016
Updated: February 8, 2017

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Health Net Central Medical Directors and Health Care Services manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting 2016 Goals are based on 2015 Milliman Loosely managed targets for Commercial and Medicare respectively, area adjusted to CA Non SPD: 216.6 SPD 1129.7	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services and community resource needs and Transition Care Management and Discharge Programs. Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Complex Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development.	

<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>Days/1000 are YTD through June 2016. Initially D/K includes pended CCS days at the time of this report and could be either paid/denied based final determination by CCS

Note: Goals were set for a blend of SPD and TANF. TANF Only Goals were not established except in CV Counties (Fresno, Kings, Madera)

Currently above targets in two of three counties for both SPD and Non-SPD. Continue interventions and monitoring.

Currently trending and monitoring MCE data. The current MCE goals are under the umbrella of the TANF goals, but specific MCE goals are under review with new goals to be identified. Continue interventions and monitoring.
Non- SPD (TANF)
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>88.9</td><td>216.6</td></tr>
<tr><td>Kings</td><td>80.2</td><td>216.6</td></tr>
<tr><td>Madera</td><td>134.8</td><td>216.6</td></tr>
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SPD
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>1240.5</td><td>1129.7</td></tr>
<tr><td>Kings</td><td>754.2</td><td>1129.7</td></tr>
<tr><td>Madera</td><td>862.6</td><td>1129.7</td></tr>
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MCE
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>336.7</td><td>TBD</td></tr>
<tr><td>Kings</td><td>259.2</td><td>TBD</td></tr>
<tr><td>Madera</td><td>361.2</td><td>TBD</td></tr>
</table>
</td>
<td>Complex psycho-social barriers.</td>
<td>Continue TCM outreach for high risk CV members with a greater than 55% engagement rate.

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

Institute 1:1 communication with high risk members in the acute setting during on-site process to identify gaps in care and development of post-acute care plan in collaboration with member's IDT.

Continue to track the effectiveness of various case management initiatives on readmissions, hospital utilization, and pharmacy and disease management.</td>
<td>Completed</td>
</tr>
</table>

<table>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2017</td>
<td>Days/1000 are YTD through December 2016 BD/K statistics include pended CCS days that are restated at 30/60/90/120/180 days.

YTD 2016: Meeting benchmark targets in all 3 counties of Fresno, Kings and Madera. Continue interventions and monitoring through 2017.

Currently trending and monitoring MCE data. The current MCE goals are under the umbrella of the TANF goals, but specific MCE goals are under review with new goals to be identified. Continue interventions and monitoring.

Non- SPD (TANF)
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>89.3</td><td>216.6</td></tr>
<tr><td>Kings</td><td>86.9</td><td>216.6</td></tr>
<tr><td>Madera</td><td>130.1</td><td>216.6</td></tr>
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SPD
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>1122.2</td><td>1129.7</td></tr>
<tr><td>Kings</td><td>616.4</td><td>1129.7</td></tr>
<tr><td>Madera</td><td>751.2</td><td>1129.7</td></tr>
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MCE
<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>346.9</td><td>TBD</td></tr>
<tr><td>Kings</td><td>269.1</td><td>TBD</td></tr>
<tr><td>Madera</td><td>309.5</td><td>TBD</td></tr>
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</td>
<td></td>
<td>Continue TCM outreach for high risk CV members with a greater than 55% engagement rate.

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

Institute 1:1 communication with high risk members and their inpatient case manager and/or treating physician in the acute setting during the on-site process to identify gaps in care and development of post-acute care plan in collaboration with member's IDT.

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

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non SPD >1000 and SPD greater than 500 members	The UM metrics are claimed based with IBNR and will be reported quarterly. Metrics include: 1. Acute bed days/K 2. Average length of acute care stays 3. ER visits/ 4. All Cause Readmission rates within 30 days 5. Outpatient visits per member per year PPG profile reports are made available quarterly and one metric for over utilization (ER/K), and one metric for underutilization, (readmissions in 30 days, are assessed on a biannually basis Results are compared to HN internal thresholds to identify potential outliers RMD's perform further analysis and discuss with Clinical Team to determine if CAP is needed.	Continue to enhance provider profile to with Medi-Cal expansion data. Identify PPG PIP, outcome results and barriers on a bi-annual basis and present aggregated and PPG specific results to CalViva. Identify possible fraud, waste and abuse issues. Report any issues to the Compliance Department	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Development of data thresholds based on authorization data for this population.	Membership growth and changing regulations.	Development of PPG specific data Dashboard Reports. These reports are produced quarterly and presented to the CalViva Health. The reports are derived from claim data and accordingly are produced after the claim time lag is no longer an issue. (Approximately 4 -5 months).	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Quarterly UM/QI reports have been generated by PPG and most recently for the FFS network dating back to Q1 2016. Parameters include Admission rates, maternity admission rates, ER utilization, and readmission rates. Further drill down into several AID categories has also been undertaken, including SPD, Expansion and non-expansion /SPD. These are shared and reviewed with CVH upon their completion.	Membership growth and changing regulations.	When there are issues identified such as over or underutilization the RMD's are outreaching to the PPG's to identify opportunities for improvement and whether a CAP is indicated.	Will continue in 2017

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
3.3 HN SHP Medical Director MRU and Provider Dispute Unit review of ER, ambulance high dollar, coding edits and potential CCS claims	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Emergency Room visits often are not for valid emergency conditions and do not meet Title 22, Section 53855 parameters Inpatient LOC may be inappropriate Hospital charges may include unbundling and non-benefit items Claims for both inpatient and ER visits may be CCS carve-out program responsibility Codes not allowed by Medi-Cal may be submitted, as well as unbundling of codes in excess of CMS and CCI rules.	Medi-Cal claims units are sending high-cost and questionably inappropriate claims to respective State Health Programs Medical Directors for timely line-item review to monitor quality of care provided, to identify inappropriate utilization patterns and to ensure that members are connected to other public programs such as CCS. Claim review remains an important activity for HN medical directors to control cost, prevent fraud, and direct provider to the correct payer for the carve out programs. MRU areas of importance are: CCS identification. Trauma reviews. ER visits for ambulatory care sensitive conditions.	Review potential CCS responsibility Review of non-approved inpatient care for medical necessity. Review claims denied for bundling edits, other inconsistent billing patterns according to Claims policy, and industry standard payment rules Review for quality of care issues and inappropriate utilization Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Medical necessity and appropriateness of billings continue to be appropriately monitored and adjudicated.	Staffing allocation.	MRU and Claims teams continue to meet on a regular basis to review CCS claims.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2017**	This is no longer a formal process with an assigned medical director however MRU and Provider Dispute Units continue to review cases for potential CCS diagnosis, IP trauma level review, ER trauma claims for documentation of trauma team activation, and making sure that denials are correct for coding edits.		MRU Cases processed within Claims TAT and recoupment process initiated as applicable once county field office determination is received.	Completed for 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
3.4 PPG Profile	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva data and peer group comparative performance data are evaluated to help measure to improve their UM and QI performance for SPD and Non SPD's. HN ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non SPD members. 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	The UM metrics are claimed based with IBNR and will be reported quarterly. Metrics include: 6. Acute bed days/K 7. Average length of acute care stays 8. ER visits/ 9. All Cause Readmission rates within 30 days 10. Outpatient visits per member per year PPG profile reports are made available quarterly and one metric for over utilization (ER/K), and one metric for underutilization, (readmissions in 30 days, are assessed on a biannually basis Results are compared to HN internal thresholds to identify potential outliers RMD's perform further analysis and discuss with Clinical Team to determine if CAP is needed	Monitor current utilization and quality metrics from the Key Indicator Report (KIR). Monitor current metrics the UM/QI PPG Profiles report as well as data for MCE population. The Regional Medical Director will work with Internal Reporting & Data Strategy to explore developing CalViva PPG specific metrics and adding 0-2 day LOS within the UM/QI PPG Profiles report.	Q2 and Q4 2016 Q2 and Q4 2016 Q1 2016

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva Health specific PPG specific data Dashboard Reports have been developed.	Membership growth and changing regulations.	The PPG specific data reports are produced quarterly and presented to CalViva Health. The reports are derived from claims data and accordingly are produced after the claims time lag is no longer an issue. (Approximately 4 -5 months).	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Quarterly UM/QI reports have been generated by PPG and most recently for the FFS network dating back to Q1 2016. Parameters include Admission rates, maternity admission rates, ER utilization, and readmission rates. Further drill down into several AID categories has also been undertaken, including SPD, Expansion and non-expansion /SPD. These are shared and reviewed with CVH upon their completion.		When there are concerns identified MD's are outreaching to the PPG's requesting outreach to members for follow up.	

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
4.1 Ambulatory Case Management Program (ACM)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner optimizes physical and emotional health and well-being and improves quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Report referrals to appropriate internal and external programs. Enhance Key Indicator reporting to report, track and trend Ambulatory Case Management Activities monthly	Dedicated staff of RNs, CM Assistants, and LCSWs to perform ACM Further reinforcement of predictive modeling to increase engagement of members.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Volume of members who accepted ACM for 2016 year to date is 313. 2015 had a total of 575 members who accepted ACM. We are well on our way to meeting or exceeding our total number of accepted members from previous year.	Primary reason for decline into our ACM program is due to members who are screened and decline services and those we are unable to reach.	We have increased the number of outbound attempts to reach members, especially the post hospitalized members. We will also revisit extending our call process for other referrals, and we have also extended our process to research additional contact information for the members by investigating claims data, UM history, contacting PPG in addition to contacting the PCP.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Volume of members increased from 469 in 2015 to 753 in 2016. Monthly meetings including CVH, CM & CCM to review KIR and other program monitoring to identify opportunities for improvement.	Unable to Reach - Difficult to locate some members due to homelessness, financial resources and inaccurate contact information for members.	Monitor open case volume and identify opportunities for greater engagement rate. Continue refinement of stratification methodology. Program Model changed to Integrated Care Management (ICM) including complex cases 9/1/16. 2017 data will include all cases under category of ICM.	Completed 2016 Goals and will continue per new interventions in 2017

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Ensure that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services. Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program Monitor inpatient and NICU utilization for this population, to tailor interventions going forward.	Assess member's level of Social Support and refer to appropriate community resources, as needed. PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Refine case finding strategies and key indicators for program	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	New members engaged in program for 2016 year to date is 40 and our acceptance rate is currently at 21%. We have seen an increase in referrals into our HROB program. Total outreached members year to date for 2016 is 160 members. 2015 had a total of 180 members outreached. Continue with current interventions, reassess and continue to monitor and report.	Primary reason for members decrease in acceptance rate is due to members who are screened for HROB program but decline participation and members who are unable to reach. This information is tracked and trended monthly.	We are collaborating with our Perinatal Initiative Committee to assist our QI department with outreach to high risk members identified from the PNIP forms received. Our HROB CM's outreach members identified by their providers as having a high risk pregnancy, and to those whose risk status is unknown due to incomplete forms. We will visit member engagement strategies to help improve our engagement rate.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	New members engaged in program were 179 for 2016, an increase from 77 in 2015.	Receiving all applicable referrals from providers.	Using Inpatient reports to identify potential members for this program. Continue with Perinatal Initiative Committee Collaboration. Continue to perform outreach upon receipt of PNIP forms.	Completed 2016 Goals and will continue per new interventions in 2017

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
4.3 Complex Case Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	The identification of high-risk members and early intervention on the population will facilitate members being able to access the health care resources that are indicated at times that are appropriate. Focus is: high cost, high risk, multiple co-morbidities, members with frequent hospitalizations, frequent ER visits, on greater than 8 medications, multiple specialists involved in the case.	Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs	Monthly risk stratification and identification per contract. Direct referrals into Complex Case Management continue by the PCP, concurrent review nurses, or member/caregiver self-referrals. Enhanced education about the program to the Provider/Providers Groups through Lunch and Learns and Provider *Updates* about the program, criteria, expected outcomes and referral process. Ongoing program monitoring to assure that reporting needs are met. Continue to ensure that newly enrolled members meet monthly enrollment targets. Continue to notify PCPs of their patients enrolled in complex case management (post assessment mailing and care plan is sent to the PCP to notify them of the members enrollment in the Complex Case Management program).	Ongoing Ongoing February and August Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	1. Monthly risk stratification and identification continue to ensure that newly enrolled members and others receive case management services as needed. 2. Direct referrals into the Complex Case management program are received from: Provider/Provider Group's, member/caregiver, internal programs, claims and file data loading. An increased number of real time referrals have occurred since January, 2016. 3. Provider Relations Team members are meeting with the Provider/Provider Groups at Lunch and Learns and Coffees with Health Net events and providing education and referral information on the Complex Case Management program and other available case management services. (64 encounters completed.) 4. New Provider *Update* sent in February, 2016 and to be sent in August, 2016 (biannually) describing the Complex Case Management program and referral process. 5. Updated Operations Manual on Complex Case Management program occurred in January, 2016. 6. Weekly Issues and Oversight meeting with the vendor. Vendor team meetings with the medical director to review members who have been in the program over 90 days. 7. Annual Vendor Delegation Oversight Audit to be started in July, 2016. 8. Monthly meetings with CalViva and Case Management to review Key Indicator Report and other program monitoring issues and opportunities for improvement.	None	1. Complex Case Management services targeted to be transitioned from the vendor to in-house. 2. Continued tracking and trending of referral sources. 3. Continued Provider Relations Team trainings to Providers/Provider Groups, Information about the Complex Case Management and other case management services to be added to future CalViva 'Rainbow' provider guides. 4. Provider Update on Complex Case Management to be sent to Provider/Provider Groups in August 2016. 6. Ongoing program monitoring to ensure that reporting needs are met. Monthly reports from the vendor are reviewed in the Issues and Oversight meetings. 7. Completion of Delegation Oversight Audit report and appropriate follow up as needed.	September, 2016 Ongoing December, 2016 August, 2016 Ongoing August and ongoing

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	1. Transition of program from vendor to in-house Integrated Case Management program. As of 9/1/16: all new referrals/cases were sent and managed in-house and CCM cases open before 9/1/16 were managed by the vendor to closure. New unique cases for the year were 444. 2. Direct referrals into the Complex Case management program are received from: Provider/Provider Group's, member/caregiver, internal programs, claims and file data loading. An increased number of real time referrals have occurred since January, 2016. 3. New Provider *Update* was sent in August, 2016 (biannually) describing the Complex Case Management program and referral process. 4. Weekly Issues and Oversight meeting with the vendor. Vendor team meetings with the medical director to review members who have been in the program over 90 days. 5. Annual Vendor Delegation Oversight Audit was completed in August, 2016 with no corrective actions identified. 6. Monthly meetings with CalViva and Case Management to review Key Indicator Report and other program monitoring issues and opportunities for improvement.	None	1. Collaborating with the Case Management team and the vendor on the transition. Monitoring of cases to assure appropriate actions were taken at the time of closure (i.e. referrals to other programs, notification to PCPs…) 2. Continued tracking and trending of referral sources. 3. Provider *Update* to be sent in February, 2017 describing the Integrated Case Management program. 4. Ongoing program monitoring to ensure that reporting needs are met. Monthly reports from the vendor are reviewed in the Issues and Oversight meetings. 5. Continue annual program oversight audits. 6. Continue meetings between CVH and Case Management to review reports discuss program monitoring issues, and collaborate on the transition.	1. December 31, 2016 2. In-house: ongoing Vendor: 9/1/16 3. Ongoing 4. Ongoing 5. Completed August, 2016 6. Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
4.4 Disease Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program **Asthma Age Groups** All members age 5 –56 with 1-4 year olds under evaluation for inclusion. ☐ Other _____	The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes. The Disease Management program includes 3 gateway conditions (Asthma, Diabetes, and Heart Failure).	Eligibility data from pharmacy and hospital claims. PPG encounter and PM 160 data. Evaluation data from HEDIS® specification using hybrid data collection method and Clinical metrics from DSM database. Review/analyze AxisPoint Health annual report Continue to work with ITG regarding data transfers to create a more robust program	Monthly risk stratification and identification per contract. Continue to notify PCPs of their patients enrolled in the Asthma, Diabetes, and Heart Failure program; include risk stratification (post assessment mailing to notify PCPs of their patients enrolled in Disease Management is sent with care plan attached). Continued focus on streamlining hand-off between Ambulatory Case Management, Disease Management and Complex Case Management (Modification of the referral form and member referral process is in process.) Review of member materials and scripts by Health Officer, Pharmacy, Quality Improvement, Compliance, Cultural &Linguistics departments before going to press. Ongoing program monitoring to assure that reporting needs are met. Monthly reports from AxisPoint to Health Net via Client Data Acquisition Tool. Continue to ensure that newly enrolled members meet monthly enrollment targets.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Bi-Annual mailings are sent to the Providers to notify them of their patients who are enrolled in DM. Annual Vendor Delegation Oversight Audit to be started in July, 2016. Ongoing program monitoring to ensure reporting needs are met.	None	Review of collaterals by appropriate departments (Health Officer, Pharmacy, and QI, Compliance and Cultural and Linguistics departments) before mailing. Completion of Delegation Oversight Audit report and appropriate follow up as needed. Continued weekly Issues and Oversight meetings	July, 2016 and ongoing August, 2016 and ongoing Weekly and ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	1. Continue to monitor the program closely to ensure that optimal program benefits are achieved. 2. Review of collaterals 3. Annual Vendor Delegation Oversight Audit completed with no corrective action items identified. 4. Disease management transition from the current vendor (AxisPoint Health) to Envolve People Care is in process and will include once transitioned the 5 Disease, CAD, COPD, Diabetes, Asthma and Heart Failure.	None	1. Continued weekly Issues and Oversight meetings with the vendor. 2. All collaterals to be reviewed by appropriate departments Pharmacy, Quality Improvement, Compliance and Cultural and Linguistics departments) before mailing. 3.Delegation Oversight Audit completed 4. Collaborating with CVH at the monthly case management meetings. Collaterals are being rebranded, going through the C&L process, and being shared and reviewed with CVH	1. Ongoing 2. Ongoing 3.Completed August, 2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2016 Planned Interventions	Target Completion Date
4.5 MD interactions with HNPS	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. SHP MDs and the CalViva Health Chief Medical Officer work with HNPS to refine RDL 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 HNPS to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with HNPS to improve CCS ID using pharmacy data SHP MD's and HNPS have a new narcotic intervention, to adopt DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the HN Medi-Cal plan.	Monthly check write review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Continued active engagement with pharmacy. Medical Directors meet with pharmacy on a quarterly basis to review reports, discuss utilization of medications and discuss proposed formulary and prior authorization guideline changes	None	Continue with quarterly meetings	Ongoing
	Continue narcotic prior authorization requirements. A review of prior authorizations is reviewed at the quarterly Medical Director/pharmacy meeting for changes in trends; current guidelines have been working well.	None	Continue with quarterly meetings and review of prior authorization statistics and trends	
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Continued active engagement with pharmacy. Medical Directors meet with pharmacy on a quarterly basis to review prior authorizations trend reports, discuss utilization of medications, review overturns on appeal trends, and discuss formulary and prior authorization guideline changes.	None	Continue with quarterly meetings	Ongoing
	Continue restrictive narcotic prior authorization requirements. A review of prior authorization trends is reviewed at the quarterly Medical Director/pharmacy meeting for changes in trends; current guidelines have been working well.	None	Continue with quarterly meetings and review of prior authorization statistics and trends	Ongoing
	CCS reporting has been increased in frequency to allow for more timely referrals to the CCS program.	None	Continue current CCS reporting	Ongoing
	Focus on Hepatitis C treatment following new treatment options released to the market. Monitoring for use of preferred treatments was conducted.	Different restrictions/requirements were presented by the state at separate meetings for pharmacy and to the medical directors. Final guidance was required.	No further action required.	12/31/2016

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2016 Planned Interventions	Target Completion Date
4.6 Manage care of CalViva members for Behavioral Health	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to monitor and improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Participate in cross functional team to improve coordination of care. Review data that indicates when a member was referred to the County for services. Review data that indicates when a PCP has referred a member to a BH provider.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	731 calls from members 1/1/16 to 6/30/16. 44 of 731 were referred from PCP/PPG. 355 of 731 calls were sent to clinical care managers for assessment; of these 5 of 355 were referred to the County for services.	None identified	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	1427 calls from members 1/1/16 to 12/31/16. 80 of 1427 were referred from PCP/PPG. 717 of 1427 calls were sent to clinical care managers for assessment; of these 56 of 717 were referred to counties for services. MHN and Fresno. Kings, Madera Counties continue to refer members bi-directionally based on symptoms acuity and need for routine mild-mod vs specialty mod-severe behavioral health services. MHN also participates in weekly rounds with HN case managers and MD to integrate and coordinate care between medical and behavioral health. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions.	None identified	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2016 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to 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
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Appointment Accessibility by Risk Rating: all cases risk rated other than routine met DMHC/DHCS TAT standards for Q1 and Q2 2016. Authorization Decision Timelines: All adverse determinations for outpatient cases met a 5 business day TAT standard. Two PQI's were filed for the CalViva account for Q1 and Q2 2016. Both were resolved within PQI timeliness standards of 30 days. Provider Disputes: Cases received 1st Quarter 2016. Q2 2016 100% of provider disputes were resolved within 45 days. Network Availability: 100% compliant with a target of 95% or above for Q1 and Q2 2016. Network Adequacy: Met target goal for All Behavioral Health Providers with a rate of 1: 1920 for Q1 and 1:1994 for Q2 2016, exceeding target of 1:5000. Timeliness to first appointment offered through ASG for members with ASD: For the first quarter 2016 ASG offered by 75% of members a first appointment within 10 days of 80%.For Q2 2016 50% of members received a timely referral.	None None None None None		Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	Appointment Accessibility by Risk Rating: all cases risk rated other than routine met DMHC/DHCS TAT standards for Q1, Q2 and Q3 2016. Q4 results not available at the time of this report. Authorization Decision Timelines: All adverse determinations for non-ABA outpatient cases met a 5 business day TAT standard for the first 3 quarters of 2016. Q4 data not yet available. Potential Quality Issues: Seven PQIs were filed for the CalViva account during calendar year 2016. All were resolved within PQI timeliness standards.	None None None	N/A	Ongoing

	Provider Disputes: 16 provider disputes were filed for CalViva in 2016.100% of those were resolved within timeliness standards. MHN determines provider availability (timeliness) through the standard measures below: Network availability was 100% for first three quarters 2016, with the exceptions of 1 BCBA within 60 miles: rural, which was 99% and 2 BCBA within 60 miles: rural, which was 99%. Fourth quarter information not yet available. Network Adequacy Member Ratio: All Behavioral Health Providers Target 1: 5000, was 1: 1834 for the first three quarters 2016. Fourth quarter data is not yet available.			

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2016 Planned Interventions	Target Completion Date
5.1 Monitor of CCS identification rate.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CASHP will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Department and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Medi-Cal utilizes a 70% factor to account for CCS age band.	CCS identification and reporting continues to be a major area of focus for SHP. Continue current CCS policies and procedures. Identification through claims review, concurrent review, prior authorization, case management, pharmacy, and member services (welcome calls and CAMHI screening tool) Improve coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans.	Ongoing

<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>Continue to monitor the rate of CCS identification and follow the current planned interventions.

The CCR team screens every inpatient admission, under their review, for CCS eligibility. Any person under the age of 21 with a complex medical condition is screened for potential CCS eligibility. Cases identified as potentially eligible or confirmed eligible for CCS services are referred to the local CCS office.

The CCRNs collaborate directly with the local CCS office to ensure coordinated services and expedited access to care through CCS paneled providers and/or Specialty Care Centers.</td><td>None</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2017</td><td>The Public Program Department began enhanced reporting for 2016 for CCS Identification Rates by County. HN benchmark is 5% per county. Yearly comparison data to be available in 2017

<table><tr><td></td><td>Fresno</td><td>Kings</td><td>Madera</td></tr><tr><td>Jan 16</td><td>7.98%</td><td>6.03%</td><td>5.94%</td></tr><tr><td>Feb 16</td><td>7.50%</td><td>5.69%</td><td>5.71%</td></tr><tr><td>Mar 16</td><td>7.54%</td><td>5.93%</td><td>5.98%</td></tr><tr><td>Apr 16</td><td>7.48%</td><td>5.99%</td><td>5.89%</td></tr><tr><td>May 16</td><td>7.59%</td><td>6.06%</td><td>5.94%</td></tr><tr><td>June 16</td><td>7.66%</td><td>6.05%</td><td>5.96%</td></tr><tr><td>Jul 16</td><td>7.72%</td><td>6.17%</td><td>6.09%</td></tr><tr><td>Aug 16</td><td>7.66%</td><td>6.07%</td><td>6.04%</td></tr><tr><td>Sept 16</td><td>7.55%</td><td>5.57%</td><td>5.93%</td></tr><tr><td>Oct 16</td><td>7.53%</td><td>6.06%</td><td>5.96%</td></tr><tr><td>Nov 16</td><td>7.55%</td><td>6.00%</td><td>5.90%</td></tr><tr><td>Dec 16</td><td>7.57%</td><td>6.04%</td><td>5.98%</td></tr></table></td><td>None</td><td>Prior Authorization enhanced the process of CCS Prior Auth review alleviating any potential delay of services for members by ensuring that the request is processed within TAT and not inhibited by delay of notification by county field office of their determination.
Once a determination is received from the county field office notification of the determination is made to the provider and a recoupment process is initiated as applicable.</td><td>Completed for 2016</td></tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2016 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements .	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UMCM program. Monitor HRA completions	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into multiple programs, including Complex Case Management, Pharmacy program to prevent hospital readmission, Ambulatory Case Management, and 5 Disease Management gateway conditions. Continue to meet all requirements for SPDs and utilize all programs to support them, including ACM, CCM, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The identification, risk stratification and assessments performed during member enrollment into the DM, CCM or ACM program addresses the HRA reassessment requirement. This activity is monitored the through McKesson Assessment Report.	None	Continue to track the effectiveness of various case management initiatives on readmissions, hospital utilization, and pharmacy and disease management.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2017**	The identification, risk stratification and assessments performed during member enrollment into the DM, CCM or ACM program addresses the HRA reassessment requirement. This activity is monitored the through McKesson Assessment Report.	None	Policies continue to be updated/revised based on regulatory and process changes and submitted to DHCS as applicable. Continue to track the effectiveness of various case management initiatives on readmissions, hospital utilization, and pharmacy and disease management. SPD HRA activities ongoing.	Completed for 2016

Item #8

Attachment 8.C

Annual Utilization Management
Program Review
2017 Utilization Management
Program Description

2017

Health Net of California
CalViva Health

UTILIZATION MANAGEMENT/CARE MANAGEMENT

PROGRAM DESCRIPTION

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The CalViva Health Utilization and Care Management (UM/CM) Program Description summarizes the policies, processes and standards that govern Health Net's UM/CM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization / Care 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 of Health Net management or concerns for the plan's fiscal performance. The Utilization/Case 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

Health Net of California, Inc., is a wholly owned subsidiary of Health Net, Inc., a managed care organization~~publicly traded company~~ with health care operations throughout the United States. Health Net~~ of California~~, Inc. is a subsidiary of Centene Corporation, a publicly traded company.~~, maintains centralized operations in Woodland Hills, CA.~~

CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, Inc.

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/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 associates via the corporate intranet website, "Learning Management System".

The Health Net, Inc. 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/CM. The major sources of data utilized for UM/CM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Encounters
- Credentialing
- Medical Management

- Claims
- Billing
- Capitation
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net of California 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, Inc. Mission

The mission of Health Net, Inc. is:

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

State Health Programs UM/CM Vision

The mission of Health Net's State Health Programs Utilization Management and Care 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 and Care Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM/CM 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
- Access 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 disease management activities, focused population interventions, preventive care services and coordination with 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/CM 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
- Analyze the effectiveness of outcomes achieved from case management
- 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 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 and Care 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/Case Management Program is under the clinical supervision of the Health Net Medical and Health Care Services Operations Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization and Care Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, preauthorization'spreauthorizations, concurrent review, discharge planning, care management and/or long term catastrophic case management, disease management, Palliative Care Referrals and care coordination with Public Health-Linked Programs.

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 form 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 and Care Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and MRMIB for Utilization Management and Care Coordination activities.

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).

Health Net Utilization and Care 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. Care Managers may include registered nurses, social workers and other health professionals with significant clinical experience. Care managers work collaboratively with members and/or family and the member's care team to manage care and resources across the continuum. The member's care team may include the member's physician(s), care providers, hospital and/or skilled facility utilization management and discharge planning staff, social workers, and members of the hospice or palliative care team.

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 and Care Management section of the UM/CM 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 continuation of 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 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 during 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 access timely,
2) Education to the Member's healthcare team on the Member's benefit structure and resources,
3) Facilitation of expeditious authorizations of services when appropriate, and
4) Facilitation of 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

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 admission appropriateness, appropriate level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the requirements 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 associates support pre-service and concurrent review by data entry, receipt, 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 during the event the member experiences a health status change. This is done through our work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are access timely, 2) education to the member's healthcare team on the member's benefit structure and resources, 3) facilitation of expeditious authorizations of services when appropriate, and 4) facilitation of 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 post-acute services 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.
- Development of a plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

Transition Care Management Program

The purpose of the Transition Care Management Program 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 post discharge period (until day 7) 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~~are~~ essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The Transition Care Management Program (TCM) is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. The TCM 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 24-72 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.

A minimum of two follow-up calls are made to the member within 7 days of discharge which focus 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.

After the post discharge period, the staff performs a warm hand off for continued case management needs is performed. All assessment documents are transferred to the assuming case manager along with outstanding and/or in process issues that need additional case management intervention.

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.

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'~~partners~~ medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for payment against documented evidence that the member received the services and that services meet the criteria for medical necessity and were provided within the context of the member's contract. 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 and case 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/Care 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. DM activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

MHN Services is a behavioral health TPA contracted with HNCS and HNCA to administer the ~~new~~ Medi-Cal mental health services carved in to the Managed Care Plans.

~~Effective September 15, 2014,~~ 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). Prior to February 1, 2016, members may have received these services either from MHN or the Regional Center. Beginning February 1, 2016, members who were receiving their services at the Regional Center transitioned~~will transition~~ and received~~receive~~ their services from MHN and not the Regional Center. ~~The transition will occur from February 1, 2016 until July 1, 2016.~~

These preparations include ensuring continuity of care by initiating single case agreements for non-panel providers, interfacing with Regional Centers to facilitate a seamless handoff, streamlining utilization management procedures to accommodate the increase in volume, and adding additional staff as needed.

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 services not provided by MHN, will be referred to the County Specialty MHP.

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

Pharmacy

The corporate pharmacy division of Health Net, Inc. Health Net Pharmaceutical Services, administers and manages the prescription drug benefit including select injectable~~injectables~~ for Health Net of California'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.

Care Management

Delegated PPGs conduct basic care management activities in compliance with Health Net's standards.

In both delegated and non-delegated situations, the Care 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 Care Management responsibilities are an integral part of Carve-Out and Public Health Programs, for example, CCS or Regional Center Programs.

The Care Management Program of Health Net's State Health Programs uses actively licensed nurses, social workers, and Medical Directors to provide an integrated network of programs and services for the management of high-risk, chronic, and catastrophically ill or injured individuals.

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

Health Net

Integrated Care
~~Complex Case~~ Management (ICM) Program

Health Net makes available ~~and its delegated partner make complex~~ case management services ~~available~~ to all members.

The goals~~goal~~ of the ICM~~complex case management~~ program ~~is to ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services. Members are initially identified for participation in the program using data stratification that includes:~~

~~Claims and encounter data~~

~~Hospital discharge data~~

~~Pharmacy data~~

- ~~Information gathered as part of the concurrent review process.~~

~~Once members are identified for potential inclusion in the complex case management program by either data stratification or direct referral from sources, which may include:~~

~~Health information lines~~

- ~~Any of the Health Net Disease management programs~~

~~The concurrent review and discharge planning process~~

- ~~A member request for case management~~
- ~~A practitioner request for case Management~~

~~Members are screened telephonically by a registered nurse and invited to participate in complex case management if they meet established screening criteria. Members are also afforded the opportunity to decline participation in the program.~~

~~The Health Net complex case management program includes an initial assessment (usually face to face), the use of evidence based care plans and algorithms, documentation of member resources, barriers, goals, progress and ongoing evaluation of members needs with adjustments of interventions as needed.~~

~~Each year the program is evaluated for it effectiveness using both established metrics and documented measures of member satisfaction.~~

~~Ambulatory Case Management~~

~~Members are referred or identified for case management by utilizing a proprietary advance analytics model accompanied by the provision of operational, performance and outcome metrics.~~
~~primary components of the program are:~~

- ~~Triage and Evaluation~~
- ~~Active Case Management~~
- ~~Outcomes Monitoring~~

~~This program seeks to identify and intervene with members:~~

- ~~1 - Who are at risk of re-admission to hospitals~~
- ~~2 - With declining health status~~
- ~~3 - Whose profiles resemble other members with prior poor outcomes~~
- ~~4 - Who are most likely to engage with case manager (demographics)~~
- ~~5 - With extensive coordination of care needs, such as members receiving transgender services~~

~~The goals of this program~~ are:

- Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.
- Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.
- Accomplish the goals in the individual member's care plan.
- Provide members and their families with the information and education that promotes self-care management.
- Assist in optimizing use of available benefits.
- Improve member and provider satisfaction.

- Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the member.
- Provide member with tools to empower member to achieve optimal health, independence and functioning in the most proactive and effective way.

  - Ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services.

This program seeks to identify and intervene with members:

- 1 - Who are at risk of re-admission to hospitals
- 2 - With declining health status
- 3 - Whose profiles resemble other members with prior poor outcomes
- 4 - Who are most likely to engage with case manager (demographics)
- 5 – With extensive coordination of care needs, such as members receiving transgender services.

Members are initially identified for participation in the program using data stratification that includes:

- Claims and encounter data
- Hospital discharge data
- Pharmacy data
- Information gathered as part of the concurrent review process, as applicable.

Members may also be identified for case management programs by direct referral from sources, which may include:

- Health information lines
- Any of the Disease management programs
- The concurrent review and discharge planning process
- A member/caregiver request for case management

- A practitioner request for case management

Once members are identified for potential inclusion in the case management program, outreach to the member is completed to assess the care need and the member is invited to participate in case management if they meet established screening criteria. If the member agrees, the member is assigned to the appropriate program and acuity level to address their care needs. Acuity levels vary from complex to low. Members are also afforded the opportunity to decline participation in the program.

The Case Management Program includes an initial assessment, the use of evidence based care plans and algorithms, documentation of member preferences, resources, barriers, goals, progress and ongoing evaluation of members needs with adjustments of interventions as needed. In addition, an in home assessment is preferred for the highest risk complex members.

Each year the program is evaluated for its effectiveness using both established metrics and documented measures of member satisfaction.

Continuity and Coordination of Care Members

SeveralHealth Net implements 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.

- CoordinatingHealth Net coordinates 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.

Population Based Programs/*Be In Charge!* SM Programs

In 2016 Health Net began transitioning the *Be In Charge!* SM Programs. -Complex Case Management transitioned in-house in September 2016. The other programs will transition to Envolve PeopleCare in 2017.

~~*Disease Management*~~

~~Health Net's State Health Programs Disease Management programs are population-based. The Programs were created in partnership with Health Net's Disease Management vendor. Actual member interventions are delegated to this NCQA-Accredited Disease Management vendor and are delineated in a comprehensive Delegation Agreement.~~

Be In Charge! SM Programs

CalViva Health provides the *Be In Charge!* SM Programs for the State Health Plan 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!* SM 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 management evaluations and treatments performed in accordance with national peer-reviewed published guidelines. Preventative medicine, achieved through proactive education and active engagement of the members, promotes optimal health.

The *Be In Charge!* SM Programs include:

• Disease Management

~~• Complex Case Management~~

• Nurse Advice Line

• ~~Fit Families for Life~~Adult Weight Management

• ~~Breastfeeding and Nutrition Support Line~~Raising Well-Pediatric Weight Management

• Audio Library

• Health Education classes and programs are offered in specific counties to target issues identified for the Medi-Cal population, such as ~~health~~ asthma, diabetes, nutrition, heart health, hypertension and healthy pregnancy. ~~and nutrition classes, diabetes classes and health promotion.~~

Disease Management

The Disease Management – *Be In Charge!* SM Program provides disease specific management for members with asthma, diabetes, and heart failure (HF). Upon transitioning to Envolve PeopleCare in 2017, the program will expand to incorporate members with Chronic Obstructive Pulmonary Disease (COPD), and Coronary Artery Disease (CD). ~~will be).~~ The goal of the *Be In Charge!* SM Program is to improve member knowledge and self-management of these diseases leading to improved quality of life, better functional status and decreased absenteeism. Additionally, the program aim is~~s~~ to empower members to manage their diseases in accordance with national peer-reviewed published guidelines and to ensure that members receive necessary screenings and monitoring services.

Enrolled members in the program are mailed educational materials with action plans, information about the program, and contact numbers for the Nurse Advice Line. Program members receive outbound telephonic interventions and referrals are made to the complex case management program if the member is identified as being at high risk for hospitalizations or poor outcomes. ~~Twice each year, following identification and~~

~~stratification activities, the program sends the providers lists of their members enrolled in the Disease Management program and each members risk category.~~

Nurse Advice Line

The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines high-tech, patented, algorithm based tools with high-touch call center services. The NAL provides immediate symptom assessment, ~~referral services~~ 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 translation services available for other languages.

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 Nurse Advice Program have physicians there to provide support to the nurses as they interact directly with the member. The NAL is URAQ accredited.

~~On-call physicians are accessible in person or by telephone 24 hours a day, seven days a week to provide nursing support, respond to provider or member concerns, and to serve as a consultant for any clinical issues that may develop. The NAL is NCQA and URAQ certified.~~

Adult Weight Management

Members ages 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered dietitians and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, tips for eating out, and more. Members are offered unlimited inbound calls and appropriate educational resources.

Raising Well-Pediatric Weight Management

Raising Well is a new telephonic weight management program for children and adolescents. Members ages 2–17 with a body mass index (BMI) at or above the 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight

management. Coaches include registered dietitians, exercise physiologists and nutritionists.

Developed from nationally recognized, evidence-based practices, program components include:

- Behavioral counseling and coping skills.
- Dietary counseling and physical activity education.
- Parent training and modeling.
- Physician visit promotion and tracking.
- Printed educational materials.
- Private social media/Facebook peer support group.
- Readiness to change assessment.
- Unlimited inbound calls.

~~Fit Families for Life~~

~~The Fit Families for Life is a five week, home-based family intervention program that is available as a home-based or telephonic program that promotes healthier lifestyles. Through goal setting strategies, participants receive guidance on making better food choices and increased physical activity. A program workbook covers topics such as how to read a nutritional facts label, tips for adding fruits and vegetables to everyday meals, family involvement in the kitchen, tips for eating out, and aerobic exercise options. A healthy recipes cookbook and DVD accompany the workbook – each offering visual references to healthier meals and nutrition concepts. The DVD provides multiple easy to follow exercise segments designed to accommodate various levels of physical ability.~~

~~Program materials are available in English and Spanish, which providers can request for CalViva members (regardless of weight status) by contacting the Health Education Department, or by using the referral form. The program is also available to members and the community through a three week community classroom format, whereby trained classroom facilitators educate participants about how to incorporate healthy eating and active living strategies into their family lifestyle.~~

~~Members ages six through 20, who have a body mass index (BMI) at or above the 95th percentile, are eligible for the Fit Families for Life telephonic coaching program. This program provides eligible members with personalized telephonic coaching support from a nutrition support nurse or registered dietitian to address nutritional concerns and help members recognize and change negative behaviors and triggers.~~

~~Breastfeeding and Nutrition Support~~

~~The Breastfeeding and Nutrition Support Line provide telephone access to personalized counseling on breastfeeding, nutrition and weight management topics. A registered nurse is on call to answer nutrition-related questions. Members have the option to speak~~

~~with a registered dietician upon request. Members interested in the Breastfeeding and Nutrition Support Line can contact the CalViva Member Medi-Cal line.~~

Audio Library

Members can choose from over 1000 health-related topics in the Audio Health Library for a concise overview of any subject of interest. Topics are available in English and Spanish.

Health Education

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:

- Weight Management Programs – Members have access to adult and pediatric weight management programs and suite of Fit Families for Life community classes and print educational resources to help members achieve healthy eating and active living.
- Pregnancy Matters® – Pregnancy members receive educational resources including Text4baby text messaging program to help them achieve a successful pregnancy and healthy baby.
- California Smokers' Helpline - The service provides personalized telephonic counseling and educational resources.
- Healthy Hearts Healthy Lives Program - Members can access preventive and disease management resources to maintain a healthy heart.
- myStrength™, an online wellness program that addresses depression, anxiety, and substance abuse. This program is available at www.mystrength.com or through the myStrength mobile app.
- Community Health Education Classes - Members can participate in health promotion classes covering topics such as diabetes, nutrition, exercise, asthma, hypertension, dental, pregnancy, parenting and more.
- T2X – Members can participate in electronic health education campaigns and programs through the web, mobile applications, and text messaging. Current campaigns and programs include asthma, immunizations, nutrition, smoking cessation, anti-bullying, sexually transmitted diseases (STDs), adolescent well care visits, talking to their doctor, teen pregnancy, and depression. More topics will be added in the future.

- Health Education incentive programs- Members may participate in various incentive programs to encourage them to receive prenatal and postpartum visits, get certain preventive health screenings, and attend community health education classes.
- Lifeline Program and Health Promotion Text Messaging Programs-Medi-Cal members can enroll in a federal Lifeline Program to receive a free cell phone with unlimited minutes and text, and a data plan. These members may also participate in various health promotion text messaging program to get educational messages and health reminders to stay healthy.
- Health Education Materials - Members have access to culturally appropriate health education brochures, flyers, newsletter, and screening guidelines on 25 health topics and up to 3 threshold languages.

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 utilizes recognized guideline and criteria sets for utilization decision making, such as Title 22, DHCS Manual of Criteria for Medi-Cal Authorization (MOC) and Medi-Cal Provider Manuals.

Health Net also follows the National Policy - Hierarchy Medical Resources for Utilization Management criteria which includes the use of InterQual® Clinical Decision Support Criteria along with other company-wide evidence-based medical policies and technical assessment tools which are approved by the Health Net Inc. Medical Advisory Council.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net of California's Medi-Cal UM/CM 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, members, 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 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.

Communication Services

Health Net and its delegates 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 and its delegates, are available at least eight hours a day, Monday through Friday, to receive and respond to inbound inquiries. In addition, members have 24/7 access to the Nurse Advice and

Triage Line; a telephonic nurse advice/triage line operated by Health Net's vendor. Inbound and outbound communication regarding utilization management issues are accomplished through the following:

- Toll-free member/provider services telephone number
- Voicemail message capability is available during and after business hours at Health Net's Health Care Services, and at the delegated PPGs. Message retrieval and response for messages left after hours is performed on the next business day.
- Fax
- E-mail

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. TurnaroundTurn Around 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, McKesson'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. ~~and are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Health Net may also develop clinical policies that are plan specific based on specific business needs.~~

~~The National Medical Advisory Council (MAC) is responsible for approving the assessment, identifying and reviewing existing research and establishing positions on medical policy where decision support is not addressed by Health Net's primary sources or if primary source decisions are challenged. The MAC membership includes medical directors from all Health Net regions with a variety of specialties represented, one legal representative, one pharmacy representative, and clinical experts in defined specialties selected to attend on an ad hoc basis, depending on the technology being evaluated.~~

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 Community Solutions Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the Health Net Community Solutions Committee.

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/CM Program Description and the UM/CM Policies and Procedures

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

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Health Net's Medical and Health Care Services Operations Officer has direct responsibility for the Utilization/Care 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 ~~and Health Care Services Operations~~ Officer

The Chief Medical Officer's~~and HCS Operations Officers'~~ 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 ~~and HCS Operations~~ Officer has decision-making responsibilities for Health Net medical matters. The Chief Medical ~~and HCS Operations~~ 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, Healthcare Services (UM/CM), Appeals and Grievances, Compliance, Program Accreditation and Disease Management.

The Chief Medical Officer's~~and HCS Operations Officers'~~ 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/Case 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.

~~Senior~~ Chief Medical Director, State Health Programs

~~Health Net's Senior~~The Chief Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Case Management activities for Medi-Cal. In addition, the ~~Senior~~ Chief Medical Director is responsible for QI activities for these programs. The ~~Senior~~ Chief 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 ~~Sr.~~Chief Medical Director reports to HN's ~~Medical and Health Care Services Operations Officer~~Chief Medical Officer.

~~Senior~~ Medical Directors~~, Western Region~~

The ~~Senior~~ Medical Directors administer and coordinate the overall development of medical policies, utilization/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 ~~Senior~~ 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/Case Management Program for all product lines.

The Medical Directors interface with ~~Preferred~~ 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/Case Management staff and other Health Net associates

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.

Healthcare Services (UM/CM) Resources

Vice President, Medical Management and Case Management ~~Clinical Services~~

The Vice Presidents are ~~President, Clinical Services is~~ 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, Health Care Services

The Director is responsible for statewide oversight of the UM/CM Program and:

- Oversees 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 is placed on continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination of CCS referrals.

Health Net UM/CM Clinical Staff

HN UM/CM clinical nursing staff (i.e. Care Managers and Case Managers) 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/CM LVN, LCSW and RN staff is under the direct supervision of a Manager, HCS or UM/CM, who is a RN.

Additional licensed and clerical staff supports UM/CM 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 Medical Program Managers (MPMs) who are registered nurses specially trained to perform this evaluation. MPMs 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, MPMs are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, MPMs, in conjunction with the Regional Medical Directors, focus efforts on delegated partners whose metrics indicate potential problems in the UM process to implement improvement strategies. MPMs 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 semi-annual reports (for Commercial HMO and Medicare) or 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. Assesses and determines the appropriateness of delegation for each component of the delegated responsibilities: utilization management, complex case management (for select number of delegated partners), Special Needs Population Model of Care (for select number of delegated partners) administrative services, credentialing and recredentialing, claims processing and payment and disease management. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Performs 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 the previous activities and recommendations of the DOW/DOC and 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. 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

UM/CM Program Evaluation

UM/CM Program Evaluation/Work Plan

UM/CM Program Evaluation

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

The annual evaluation of the ~~CalViva~~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 ~~Health Net's~~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 ~~of Clinical Services~~Medical Management annually develop the ~~CalViva~~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 / Care Management Program Approval

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

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_____ Date _____
Farid Hassanpour~~Patricia Buss~~, MD
Chief Medical Director~~and Health Care Services Operations Officer~~

_____ Date _____
Sharon Almany
~~Christopher Hill, RN~~
Vice President of Medical Management~~Clinical Services~~

Committee Approval

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

_____ Date _____
Farid Hassanpour~~James Gerson~~, MD
Chief~~Senior~~ Medical Director~~ and Committee Chair~~

Item #9

Attachment 9.A

2016 Annual Quality Improvement Work Plan Evaluation Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Quality Improvement Department
COMMITTEE DATE:	February 16, 2017
SUBJECT:	CalViva Health 2016 Quality Improvement Work Plan Annual Evaluation Executive Summary

Summary:
CalViva Health's 2016 Quality Improvement (QI) Program monitors improvement in clinical care and service using a range of indicators. These key performance indicators are found in service, clinical, and utilization reports from QI and various other departments. Based on these reports, areas of improvement are identified, and interventions implemented and monitored. In 2016, quality improvement initiatives were focused on (but not limited to) improving preventative care, disease management outcomes, continuity and coordination of patient care, patient safety metrics, member access to care, and supporting provider initiatives.

Purpose of Activity:
The QI Work Plan Evaluation Executive Report provides evidence of monitoring of the overall effectiveness of the QI activities and processes, and identifies barriers and opportunities for improvement.

Work Plan Initiatives:
Details for the end of year outcomes are included in the 2016 QI Work Plan Evaluation. Key end-of-year highlights include:

1. Access, Availability, and Service
   - MY2015 CAP packets mailed on 9/9/16 to 14 PPGs and 20 direct providers.
   - MY2016 CVH Access and After Hours surveys conducted in Q4 2016
   - The DMHC Timely Access Reporting (TAR) was completed and submitted by the end of March with all required reports and provider network lists.

2. Quality and Safety of Care
   - **HEDIS® Minimum Performance Level (MPL) Default Measures**

Childhood Immunization Combo 3	Fresno and Madera Counties exceeded DHCS MPL of 66.19 for RY2016. Although Kings County increased by over 5 percentage points, it remained below the MPL at 63.03 and CalViva submitted required PDSAs timely and completely.
Well Child Visits 3-6 years	All three counties exceeded DHCS MPL of 65.54

Timeliness of Prenatal Care	All three counties exceeded DHCS MPL of 77.44
Comprehensive Diabetes Care HbA1c Testing	Madera county exceeded DHCS MPL of 83.19 this year. This MPL increased by 3 percentage points. For Kings (rate of 76.64, a decrease from RY 2015) and Fresno Counties (rate of 80.29), improvement will be addressed via the Performance Improvement Project.
Controlling High Blood Pressure	Fresno County is below the MPL at 47.96, a decrease of nearly 14 percentage points. Madera and Kings Counties exceeded DHCS MPL of 49.88. Prior to RY 2016, this measure exceeded the MPL across all three counties. PDSA Plan initiated.
Cervical Cancer Screening	Fresno County remained above the MPL of 54.33 this year. In Kings County, the RY 2016 rate improved above the MPL at 54.99. Madera County dropped below the MPL at 52.87. CalViva submitted all the required PDSAs timely and completely.

- **Non-Default HEDIS® Minimum Performance Level (MPL) Measures – Additional measures Below the MPL in RY 2017**

Timeliness of Postpartum Care	In RY 2016, CVH was below the MPL of 56.18% in Kings County (50.24%), and above the MPL in Madera (58.76%) and Fresno (67.59%) Counties. Improvement is being addressed via the Performance Improvement Project (PIP).
Medication Management for people with Asthma (MMA)	This metric was modified by DHCS mid-year to a more accurate measure the Asthma Medication Ratio (AMR). CVH met the new measure in all three counties.
Annual Lab Monitoring for Patients on Persistent Medications (MPM)	Fresno and Madera Counties exceeded DHCS MPL for ACE/ARB of 84.87% Kings County was below the MPL at 83.07% Fresno and Kings Counties exceeded the MPL for Diuretics of 84.66 % Kings County was below the MPL at 83.57%. PDSAs were submitted timely and completely.
Avoidance of Antibiotic Treatment for Bronchitis (Adults) (AAB)	Fresno County was above the MPL of 22.00 at 37.62. Kings and Madera Counties were below the MPL at 21.38 and 19.69 respectively. Summaries of Activities to improve performance have been submitted timely and completely.

3. Performance Improvement Projects

DHCS requires **two** Performance Improvement Projects (PIPs) for each health plan. CalViva Health's PIPs for 2016 were:

#1 Comprehensive Diabetes Care: HbA1c Testing:
In Kings County, a targeted provider group has been collaborating with the CVH Medical Management team to improve the HbA1c rates for members within their clinics.

- The outcome being measured is the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a HbA1c test during the measurement year.
- The initial focus of the project was to improve the ability to contact members to schedule an appointment, however this was unsuccessful. A new intervention has been submitted and approved by HSAG. The project has been expanded to include the Fresno and Kings County clinics of the targeted provider. Results are pending.
- HSAG and DHCS have been consulted throughout the project as needed and all required documentation has been submitted.

#2 Timeliness of Postpartum Care:

- The goal for this improvement project is to improve the health of new mothers by ensuring that women attend a postpartum visit at a targeted OB clinic in Kings County.
- Throughout 2016, revisions and improvements were made to the project documentation Modules per HSAG recommendations. Activities to help determine interventions included: process mapping, FMEA documentation and analysis of the scheduling and postpartum visit processes. The PIP opportunities include:
    1) Notifying members of the importance of postpartum care
    2) Obtaining accurate contact information
    3) Scheduling visits at the time of discharge from the hospital
    4) Implementing a point of service $25 member incentive for completing a timely postpartum visit to address the "no show" rate.

Item #9

Attachment 9.B

2016 Annual Quality Improvement Work Plan Evaluation

CalViva Health
2016
Quality Improvement
Annual Evaluation

2/10/17/17

CalViva Health 2016 Quality Improvement Work Plan

TABLE OF CONTENTS

Submitted by:

Patrick Marabella, MD, MS	Chief Medical Officer
Amy Schneider, RN, BSN, PHN	Director Medical Management

CalViva Health 2016 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 2016. The development of this document requires resources of multiple departments.

CalViva Health 2016 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances	**HPL:**	High Performance Level
A&I:	Audits and Investigation	**HN:**	Health Net
AH:	After Hours	**HSAG:**	Health Services Advisory Group
AWC:	Adolescent Well-Care	**IHA:**	Initial Health Assessment
BH:	Behavioral Health	**ICE:**	Industry Collaborative Effort
C&L:	Cultural and Linguistic	**IP:**	Improvement Plan
CAHPS:	Consumer Assessment of Healthcare Providers and Systems	**IVR:**	Interactive Voice Response
		MCL:	Medi-Cal
CAP:	Corrective Action Plan	**MH:**	Mental Health
CDC:	Comprehensive Diabetes Care	**MMCD:**	Medi-Cal Managed Care Division
CM:	Case Management	**MPL:**	Minimum Performance Level
CP:	Clinical Pharmacist	**PCP:**	Primary Care Physician
CVH:	CalViva Health	**PIP**:	Performance Improvement Project
DHCS:	Department of Health Care Services	**PMPM:**	Per Member Per Month
DM:	Disease Management	**PMPY:**	Per Member Per Year
DMHC:	Department of Managed Health Care	**PNM:**	Provider Network Management
DN:	Direct Network	**PRR:**	Provider Relations Representative
FFS:	Fee-for-Service	**PTMPY:**	Per Thousand Members Per Year
HE:	Health Education	**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 seven 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 ICE-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 QI-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 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	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q2 and Q3	CVH/HN
Update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q2	CVH/HN
Communicate monitoring requirements through Provider Update and distribute collection tool (sign in template) and report findings quarterly.	P	Ongoing	CVH
Complete all Provider Updates for informing CalViva Health providers of AH Survey results, with educational information for improvement (no later than 3 months after survey is conducted).	P	Q1-Q2 (for 2015 results)	CVH/HN
Promote and distribute After-Hours Scripts to providers to improve after-hours results	P	Q2-Q3	CVH/HN
Send Provider Update informing providers of upcoming After Hours survey	P	Q3	CVH/HN
Process and conduct the CalViva Health AH Survey	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	CVH/HN
Distribute and promote the Patient Experience Toolkit and appointment Access Tip sheet	P	Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• MY2015 CVH After-Hours Survey completed May 2016 – 71 CAPS to be issued by mid-August 2016. Targeted completion date mid-October 2016. • MY2015 PAAS Survey completed & data to be finalized July 2016. CAPs to be issued by late August 2016. Target completion date is early November 2016. • CVH Provider Update distributed June 2016 regarding MY2015 PAAS & After-Hours Survey results. • Patient Experience Toolkit – Appointment Scheduling Tip Sheet to be updated July 2016. In approval routing process. Will be distributed as part of the CVH After-Hours CAP packet. • QI 007-008 Policies updated as needed.	• MY2015 CAP packets mailed on 9/9/16 – 14 PPGs and 20 direct providers • Conducted onsite CAP training for PR staff in Fresno office on 9/12/16 • Provider Relations staff in Fresno completed site visits on 10/21/16 for all 255 non-compliant providers • MY2015 CAP packets delivered included educational pieces on: CVH Guidelines Compliance & Monitoring, After Hours Script samples, Patient Experience Toolkit (updated), Appointment Scheduling Tip Sheet (updated) • Alltran conducting MY2016 CVH Access and After Hours surveys Q4 2016

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 2017)

Measure(s)	Specific Goal	Rate RY 2016	Rate RY 2017	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall= 83.4% Fresno=82.3% Kings=93.1% Madera=82.9%	TBD	CVH Performance Ry2015	Overall= 92% Fresno=97% King=100% Madera=92%
Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall= 76.1% Fresno=87.6% Kings=80.9% Madera=60%	TBD	CVH Performance RY2015	Overall=91% Fresno=100% Kings=n/a Madera=50%
Access to Urgent Care Services that do not require prior authorization – Wait time not to exceed 48 hours	80%	Overall= 72.5% Fresno=71.3% Kings=67.7% Madera=81.6%	TBD	CVH Performance RY2015	Overall= 88% Fresno=100% Kings=n/a Madera=0%
Access to Urgent Care Services that require prior authorization – Wait time not to exceed 96 hours	80%	Overall= 55.5% Fresno=50% Kings=44.4% Madera=73%	TBD	CVH Performance RY2015	Overall= 84% Fresno=100% Kings=n/a Madera=100%
Access to First Prenatal Visit – Within 10 business days of request	80%	Overall= 84.2% Fresno=80.2% Kings=100% Madera=100%	TBD	CVH Performance RY2015	Overall=01% Fresno=92% Kings=92% Madera=84%
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall= 77.3% Fresno=73.6% Kings=92.8% Madera=88%	TBD	CVH Performance Ry2015	Overall=81% Fresno=78% Kings=100% Madera=92%
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall= 90.4% Fresno=88.3% Kings=92.8% Madera=100%	TBD	CVH Performance RY2015	Over all= 96% Fresno=93% Kings=90% Madera=96%
Access to Urgent Ancillary services that require prior authorization for any urgent MRI/Mammogram/Physical Therapy – Appointment within 48 hours of request	80%	Overall= 50% Fresno=50% Kings=N/A	TBD	CVH Performance RY2015	N/A

		Madera=N/A			
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall= 90.9% Fresno=90.9% Kings=N/A Madera=N/A	TBD	CVH Performance RY2015	N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall= 92.3% Fresno=94.6% Kings=79.4% Madera=83.3%	TBD	CVH Performance RY2015	Overall:93% Fresno:93% Kings: 95% Madera: 91%
Member informed to expect a call-back from a qualified health professional within the standard (Per P&P)	90%	Overall= 86.5% Fresno=87.1% Kings=90.9% Madera=80%	TBD	CVH Performance RY2015	Overall:61% Fresno: 62% Kings: 35% Madera:77%

Analysis: Intervention Effectiveness w Barrier Analysis

- **ANALYSIS:**
- Overall 6 of the 11 measures surveyed for MY2015 Appointment Access & After-Hours did not meet the compliance goals.
- Fresno County did not meet the goals for 5 of the 11 metrics and Madera followed closely with 4 of the 11 metrics not being met.
- Specialists in all three counties (Fresno, Kings and Madera) did not meet the metric for Urgent Appointment within 96 hours (prior auth required). An analysis of shortage of specialists is being addressed through the Access Workgroup and will be monitored on a monthly basis with reports being presented quarterly.
- On After-Hours access 1 of the 2 measures surveyed did not meet the compliance goal of 90%. After-Hours member call back within 30 minutes' compliance rate was reported at 87% overall. Through the Provider Relations (PR) staff visits to providers it was discovered that there was some confusion surrounding the use of the Nurse Advice Line in lieu of providers returning calls to members. Additionally, there are many solo practices in the area. Through the PR staff visits providers were educated on the metrics and clarification on the use of the Nurse Advice Line was addressed.
- MY2016 surveys have been recently completed and the data is pending analysis. Tentative completion date of the analysis is March/April 2017. CAPs will be issued to PPGs/direct network CVH providers not meeting one or more of the metrics, as outlined above, during May/June 2017.
- **BARRIERS:**
- MY2015 surveys were conducted between June 2015 and July 2016 with Fresno PR staff visits beginning in mid-September 2016. Due to the length of time between the survey dates and the actual visits, PR staff were coming across discrepancies in the data (i.e., office closed, provider no longer practicing at the group, etc.). A further analysis is being conducted and a cross reference tracking log has been created to analyze against the MY2016 data.
- **LESSONS LEARNED:**
- Provider education is key to improving compliance. More frequent education reminders and provider visits regarding Access & Availability guidelines throughout the year are needed to help improve scores (i.e., Provider Updates, Lunch & Learns, etc.).
- Data integrity issues are being tracked and addressed for MY2016 survey

Initiative Continuation Status ☐ **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 Satisfaction by DHCS was last evaluated in RY 2014 and results were aligned close to the Medicaid State Average. Member perception of quality of care and care coordination is multifaceted and affected by the provider, the plan, member demographics and individual health status and experience so evaluation and intervention are directed towards touchpoints by the member.

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

The following CAHPS Metrics will be used to evaluate the effectiveness of the interventions:

1. Getting Needed Care (Ease to get appointment with specialist, and ease to get care, tests, and treatment);
2. Getting Care Quickly (Getting care right away (urgent), getting appointment as soon as needed (routine) and see doctor within 30 minutes of apt. time
3. Rating of all health care
4. Rating of personal doctor
5. How well do doctors communicate (did your doctor explain things in a way that was easy to understand and did the doctor listen to the patient)

The goal for member satisfaction is to reach the Quality Compass 50th percentile.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Distribute and promote the 2016 Patient Experience(PE) Toolkit	P	Q3	CHN/HN
Update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q2	CVH/HN
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	CVH/HN
Remind providers of the availability of interpreter services 24/7 and how to access these services through distribution and education on the Rainbow Guide	P	Q2	CVH/HN
Update and enhance materials on the Nurse Advice Line to encourage use of this service by members	P/M	Ongoing	CVH/HN
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3	CVH/HN

Section B: Mid-Year Update on Intervention Implementation (due Q3)

- Patient Experience Toolkit – Appointment Scheduling Tip Sheet to be updated July 2016. In approval routing process. Will be distributed as part of the CVH After-Hours CAP packet.
- Talking with my Doctor – part of the Patient Experience Toolkit that will be distributed as part of the CVH After-Hours CAP packet.
- Rainbow Guide distribution completed in Q1 and Q2 during Provider Relations visits to offices.

Section B: Analysis of Intervention Implementation (due end of Q4)

- Provider Relations staff in Fresno completed site visits on 10/21/16 for all 255 non-compliant providers for MY2015 CAP.
- MY2015 CAP packet delivered included educational pieces on: CVH Guidelines Compliance & Monitoring, After Hours Script samples, Patient Experience Toolkit (updated), Appointment Scheduling Tip Sheet (updated)
- Patient Experience Toolkit was updated and included educational pieces on: Talking with My Doctor, Availability of Interpreter Services, Nurse Advice Line, Appointment Scheduling Tip Sheet
- Rainbow Guide was not distributed formally this year as the information contained within it was captured in the updated Patient Experience Toolkit.

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 2017)

Measure(s)	Specific Goal	RY Rate 2016	Ry Rate 2017	Baseline Source	Baseline Value
CAHPS metric: Getting Needed Care	Exceed RY2016 All Plans Medicaid Average	65%	66%	RY 2014 CVH results	67%
CAHPS metric: Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average	77%	79%	RY 2014 CVH results	79%
CAHPS metric: Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average	TBD	TBD	RY 2014 CVH results	52.3%
CAHPS metric: Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average	TBD	TBD	RY 2014 CVH results	63.1%
CAHPS metric: How well doctors communicate	Exceed RY2016 All Plans Medicaid Average	TBD	TBD	RY 2014 CVH results	82.6%

Analysis: Intervention Effectiveness w Barrier Analysis	Getting Needed Care and Getting Care Quickly - More frequent provider and member education reminders on Access & Availability guidelines throughout the year via Provider Updates/Member Newsletters. Corrective Action Plans (CAPs) were issued for MY 2015 PAAS results, which included information to providers regarding compliance and monitoring standards, improving the patient experience. We expect that educating the providers and provider feedback on the improvement plans will have an impact on member experience.
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: Meet or Exceed HEDIS® Minimum Performance Levels for Cervical Cancer Screening

☐ **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

Pap testing is an effective method for early detection of cervical cancer. According to the American Cancer Society an estimated 12,990 cases of invasive cervical cancer are expected to be diagnosed in 2016 and project 4,120 deaths to occur from cervical cancer. RY 2015 rates for CVH counties, Fresno (64.74), Kings (51.12) and Madera (58.68) were within wide ranges away from the Minimum Performance Level (MPL) or the 25th national percentile. Kings county rate was below the MPL (54.5%). All three counties declined when compared to RY 2014.

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

Cervical Cancer Screening HEDIS measure: Goal – meet HEDIS RY 2016 MPL or exceed

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with high volume, low compliance providers in Kings County to distribute provider profiles to targeted clinics that include lists of members due for Pap test to facilitate scheduling of screening	P	Q1, Q2, Q3, Q4	CVH/HN
Newsletter article: Cervical Cancer Screening	M	Q4	CVH/HN
Complete “Call to Action” Mailing-Pap test reminder mailing	M	Q1	CVH/HN
Interactive Voice Response (IVR) outreach	M	Q1	CVH/HN

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

- Targeted high volume, low compliance provider group for noncompliant CCS member appointment scheduling outreach. Received provider profile 1/12/16. The final result is 42 patients scheduled of the denominator of 101 or 41.6%. The goal of 30% was exceeded.
- Follow up on scheduled appointments performed in Q2. The 30% target was reached and exceeded. Eighteen (18) of the 44 scheduled CCS appointments were completed resulting in a rate of 41%.
- Newsletter article in planning stages for Q4.
- Call to Action Mailings distributed in both Q1 (3/11/16 26,878) and Q2 (6/8/16 24,639).
- IVR outreach was completed for members between 3/17/16 and 4/4/16. Reach rate was 37.2% (N=7,559).

Section B: Analysis of Intervention Implementation (due end of Q4)

- Targeted high volume, low compliance provider group for noncompliant CCS member appointment scheduling outreach in Kings County. Provider profiles distributed to facilitate scheduling of screenings for members coming due.
- Working with female Nurse Practitioner at the targeted clinic to establish one day per week to focus on Pap tests. Members indicate preference for female provider. Initiated “Pap Fridays” with member education and onsite distribution of incentive ($25 gift card)
- “Call to Action” mailers distributed to all CVH counties in Q4 (10/16 36,944).
- The member newsletter article on cervical cancer screenings was mailed to 150,435 households in November 2016. The article was titled, “Which Health Screenings Do You Need?”
- An educational CCS interactive voice-response (IVR) including member barrier questions was launched timely in Q1 for 24,849 members in need of CCS in CVH counties. Of the attempts to contact members, 81.7% (20,306) of members were reachable. Of the reachable members, 10,508 messages were left either with a machine (7,857), or another individual who answered the call and accepted the message (2,651)..

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 2017)

Measure(s)	Specific Goal	Rate 2016	Rate 2017	Baseline Source	Baseline Value
Cervical Cancer Screening (CCS)	Meet or Exceed DHCS MPL 54.33%	Fresno: 61.05% Kings:54.99% Madera: 52.87%	TBD	RY 2015 CVH results	Fresno= 64.74 Kings=51.12 Madera=58.68

Analysis: Intervention Effectiveness w Barrier Analysis

Based on the overall HEDIS rates for RY 2016, the CCS goals were reached for Kings County (54.99%),

Summary

- Working with a high volume low compliance clinic In Kings County, we were able to schedule 42 patients of the denominator of 101 (41.6%) in Q1 2016 by distributing a Provider Profile (list of patients needing their exam) to the clinic. The goal of 30% was exceeded. At the end of Q2 2016, 18 of the 44 scheduled CCS appointments in Kings County were completed resulting in a rate of 41%. The goal of 30% was exceeded. However, a high "no show" rate was identified.
- In an effort to address the high "no show rate" as well as evidence that members prefer female provider for Pap tests the CVH CCS Improvement team worked with a female nurse practitioner at the clinic to establish "Pap Test Fridays", one day per week focused on Women's Health. Working with Health Ed brief educational sessions were offered to members and a $25 gift card for completing their Pap test. This multi-pronged approach was successful in getting women to complete their Pap tests at a rural clinic in Kings County. In Q4 efforts were focused on how to sustain the improvement and support the clinic to continue these efforts.

Barriers:

- Reasons for incomplete appointments included: patient cancellations, appointments rescheduled outside of the audit timeframe and a large number of patients failing to attend their CCS appointment (No Show).
- It is noted that the vast majority (81%) of the patients that did not attend their appointment simply did not show up. Further discussion with the clinic manager revealed that many patients have expressed a preference for a female provider to complete the Pap test.
- Results of IVR calls were limited due to many members did not answer the phone or declined the call. Findings from those who did respond included concerns about: Cost of the test (66/215), Discomfort (66/227), and Fear of results (52/236) Indicating a need for continued educational support for our members.

Lessons Learned:

- Providing a concrete list of actionable opportunities and a specific timeframe including a deadline serves as a call to action for providers to balance conflicting priorities.
- Having a Clinician at the clinic as a point of contact and champion for quality initiatives improves implementation.
- It is important to many members to have a female clinician to perform the exam.
- Providing education and offering a member incentive ($25 gift card) may improve "no show" and test completion rates..

Initiative Continuation Status ☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-2: Meet or Exceed HEDIS® Minimum Performance Levels for Measures Well Child Visits and Childhood Immunizations

☐ **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

Goal: Improve child health by ensuring CVH children receive timely age-appropriate vaccinations and well-child visits.

Rationale: Bringing children in for their regular visits helps keep children healthy, especially during a time when they experience substantial growth and developmental changes. Additionally, regular visits ensure that children are up-to-date on their immunizations and protected against preventable diseases.

Childhood Immunizations: Evidence suggests that appropriate vaccination coverage is linked to improved health outcomes and cost savings. A study examining completion of the childhood vaccination schedule in a 2009 United States (US) birth cohort indicated prevention of approximately 42,000 early deaths and 20 million cases of disease in their lifetime. Moreover, the analyses showed that routine vaccination may lead to an offset of approximately $69 billion in total societal costs. Additionally, the Healthy People 2020 Immunization and Infectious Disease goals targets 90% of children to receive all doses of individual vaccines (i.e., DTaP, IPV, MMR, Hib, HepB, and varicella), 80% to receive all doses of rotavirus vaccine, and 80% to receive all doses in the 4:3:1:3:3:1:4 series by age 19 to 35 months.[1] In RY2015, Kings County demonstrated a considerable drop in performance from the prior year (57.75% for RY2015 compared to 70.06% in RY2014), highlighting the opportunity for improvement.

Well-Child Visits: Well-care visits provide an opportunity for providers to influence health and development. A well-care visit is a critical opportunity for screening and counseling. Assessing changes in physical and social circumstances can help lessen the risk of serious and long-term health effects. However, the 2011/2012 National Survey of Children's Health showed that an estimated 11 million children 0 to 17 years of age did not have any preventive medical care visits in the past year. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.[2] Kings County performance rates for well-child visits in the third, fourth, fifth, and sixth years of life (W34) have been below the minimum performance level (MPL) in RY2014 and RY2015. While the performance rate increased in RY2015, there is still an opportunity for improvement to reach the MPL.

1. Kurosky, S.K. (2016). Completion and compliance of childhood vaccinations in the United States. *Vaccine. 34*(3). 387-394.
2. National Quality Measures Clearinghouse | Well-child Visits in the third, fourth, fifth, and sixth years of life." National Quality Measures Clearinghouse | Well-child Visits in the third, fourth, fifth and sixth years of life: percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year. Agency for Healthcare Research and Quality. Web. 03 March. 2016.
3. Since routine immunizations and well-child visits are linked activities CalViva Health decided to combine these two measures into one improvement project in Kings County.

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

Childhood Immunization Combo 3 HEDIS measure: Goal – meet HEDIS RY 2016 MPL or exceed

Well-Child Visits 3-6 Years HEDIS measure: Goal – meet HEDIS RY 2016 MPL or exceed			
Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Continue to work with high volume, low compliance providers in Kings County to distribute provider profiles to 5 targeted clinics to facilitate scheduling appointments for immunization/well-child visits for children turning 2 years and 13 years.	P	Q1, Q2, Q3 and Q4	CVH/HN
Member newsletter article: Childhood IZ including pertussis	M	Q3 2015	CVH/HN
Member newsletter article: Well-Child visits	M	Q3 2015	CVH/HN
Kids and Teens Challenge (valid for AWC and Well-Child 3-6 visits)	M	Ongoing weekly	CVH/HN
Provider profiles listing members turning 18 months who will need additional vaccines before age 2 and listing adolescents aged 12.5 years in need of IMA Combo 1 vaccines	P	Quarterly	CVH/HN
Targeted member mailing to children 18 months old emphasizing importance of childhood immunizations and attending well-child visits and promoting the direct member incentive	M	Quarterly	CVH/HN
Targeted member mailing to adolescents 12 years old, missing one or more immunization and promoting the direct member incentive	M	Quarterly	CVH/HN
Pilot direct member incentive among children 18 months and adolescents 12.5 years to increase childhood and adolescent immunizations	M	Q2 2016-Q4 2016	CVH/HN

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

- The work with high-volume, low compliance providers in Kings County has been completed in each quarter. Small, rapid tests continue to be implemented. Profiles were distributed to the 5 targeted clinics, testing different age groups for outreach, to assess the best time to effectively close immunization gaps before children turn 2 or 13 years old.
- Additional provider letter was completed in Q1 and Q2. In Q1, the letters were distributed in March, mailed to 252 providers. The Q2 provider letters were distributed in June, mailed to 190 providers.
- The member newsletter article on well-child visits and childhood immunizations has been combined into one article for the Fall 2016 newsletter. The article is on-track to print in the member newsletter and will be mailed in Q3 2016
- The CVH Kids and Teens Challenge campaign continued throughout Q1 and Q2.
- The member mailings have been postponed due to the effectiveness of member mailings as many are returned mail. Instead, they will be replaced with a direct member incentive. Automated calls will begin along with the mailing and is intended to launch in Q3 2016, targeting children and adolescents turning 2 or 13 in Q4 2016.

Section B: Analysis of Intervention Implementation (due end of Q4)

- Targeted a high volume, low compliance provider in Kings County to distribute Provider Profiles to facilitate scheduling of immunization appointments. In Q4, profiles were distributed to 5 targeted clinics testing if the provider directly outreaches the member will completion rates improve.
- In an effort to reduce “no show“ rates and improve immunization completion rates a member incentive at the point of service was added to our interventions ($25 gift card) Additionally, the provider initiated special clinic days at alternate times (Saturdays and evenings) to facilitate immunization appointment attendance for working families. They called these “HEDIS clinics”
- Provider letters were discontinued after Q2.
- The member newsletter article on well-child visits and childhood immunizations was mailed to 141,444 households in August 2016. The article was titled, “Check-ups and Vaccines are Key.”
- The CVH Kids and Teens Challenge campaign continue through 2016, and was discontinued at the end of the year.
- The Medical Outreach Team (MOT) completed two rounds of live outreach calls with members in Kings County that are turning 2 between October – December 2016. There were a total of 124 members in Kings County that met the criteria. On the first attempt 26.6% of members were reached (124), and on the second attempt 13.3% of members were reached (90).
- From June – December 2016, we partnered with CVS to pilot a health tag campaign. Parents or guardians of targeted members (turning 1 year old in 2016) received a health education message on the prescription bag. Among childhood immunization and well child-visits, out of the 704 eligible members, only 110 messages were identified as opportunities. Of the opportunities identified, 53.64% of the members received the message.

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 2017)					
Measure(s)	**Specific Goal**	**Rate 2016**	**Rate 2017**	**Baseline Source**	**Baseline Value**
Childhood Immunization Combo 3	Meet or Exceed DHCS MPL 66.19%	Fresno= 68.19 Kings=63.03 Madera=71.19	TBD	RY 2015 CVH results	Fresno= 66.96 Kings=57.76 Madera=69.54
Well-Child Visits 3-6 Years	Meet or Exceed DHCS MPL 65.54%	Fresno=76.39 Kings=66.32 Madera= 87.08	TBD	RY 2015 CVH results	Fresno=76.80 Kings=64.82 Madera= 83.16

Analysis: Intervention Effectiveness w Barrier Analysis

Based on RY2016 HEDIS rates for CIS-3 Fresno and Madera Counties met the MPL. While Kings County fell below the MPL, the county demonstrated substantial improvement from the prior year. For W34 all counties met the RY2016 MPL, which is significant for Kings County given the MPL was not met in the prior year.

Successes:

- In Q1 2016, we exceeded our target of 30% of patients with scheduled appointments or voicemails completing their appointments in Kings County. Eighteen (18) out of 26 patients completed their appointment with a final rate of 69%.
- Despite other factors, we exceeded our objective with 35 out of 46 members (76%) with scheduled immunization appointments in Q2 2016. The prior study cycle demonstrated that scheduled appointments increase the likelihood the member will complete the appointment and become compliant with the immunization schedule.
- A point of service member incentive and special clinic days (Saturdays and evenings) called HEDIS Clinics may have also improved “no show” and immunization completion rates.

Barriers:

- In Q1, members were lost to follow up because they were unable to contact the members, due to disconnected phones or lack of phone numbers on file.
- Claims lag can be a barrier to obtaining a current list of children due for immunizations. During the Q4 2016 study cycle, the Provider conducted a similar activity on a larger scale to accomplish compliance with multiple HEDIS measures. For this larger scale activity, the Provider used a different set of data to identify patients that are CIS-3 non-compliant and turning 2 years in Q4 2016.
- The low IVR reach rate may be due to calling during business hours when parents or guardians of members are working or are attending to competing tasks. Among member reached, only one member requested scheduling assistance; other parents/guardians indicated they would schedule their own appointments, or already had an appointment scheduled.
- The CVS Health Tag interventions did not work as expected. Although CVS was able to match members to their Pharmacy database, only a fraction of members were considered active with the pharmacy (within the past 2 years), yielding only a fraction of members identified as opportunities to receive messages. This discrepancy may be due to age, as younger members would not have been active within the past couple years. Additionally, younger members may not often be prescribed medications, rendering no opportunity to visit the pharmacy and receive the immunization messages.

Lessons Learned:

- While we exceeded our target of 30% in Q1 2016, we learned that a greater lead time to schedule appointments can help to account for missed or rescheduled appointments to ensure immunizations are timely.
- Patients with scheduled appointments were more likely to complete their appointment compared to patients that were reached via voicemail.
- CVH Medical Management staff distributed a survey to obtain feedback from each clinic on the effectiveness of the activity and to solicit any suggestions to improve the activity in the future. All the clinics reported the patient lists were helpful and that they would like to have the lists forwarded at intervals from weekly to monthly.
- Providing a specific list of actionable opportunities allows providers to develop a targeted strategy when reviewing patient records and identifying true care gaps versus data issues with claims lags.
- A provider assigned point of contact for quality initiatives improves implementation, by serving as a liaison between the provider group and the health plan.
- In the future, we will collaboratively establish the type of data presented to the Provider, the information to be gathered by the Provider and the frequency of check-in calls or meetings throughout the study cycle to effectively monitor data collection.
- We learned from the larger Provider activity that in order to accommodate families that could not attend appointments during regular business hours, the Provider scheduled additional clinic times outside of usual business hours. The Provider referred to the additional clinic hours as HEDIS Clinics. In addition, during the HEDIS Clinics, twenty-four (24) $25 gift cards were administered. These activities although effective interfered with our data collection and analysis for our planned project.

Initiative Continuation Status	☐ Closed	☐ Continue Initiative Unchanged	☒ Continue Initiative with Modification

Section A: Description of Intervention (due Q1)

2-3: Medication Management for People with Asthma (MMA)

☐ 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

2014RY was the first year that CVH did not meet the MMA HEDIS MPL rate in Fresno and Madera counties for the percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. Both counties did exceed the MPL for the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period. For RY2016, CVH did not meet the MMA HEDIS MPL rate for 50% and 75% in Fresno and Madera.

The following issues have been identified, and numbered by highest priority as barriers to performance based on literature review, data analyses, and HEDIS® process evaluation:

1) Providers may not be aware of their member's non-adherence to their medication management regimen.
   a. Patients with asthma also often display a series of behaviors that are not compliant with their asthma treatment including receiving prescriptions but not filling them, stopping the treatment too soon, delay in seeking medical care, and failing to follow the provider's instructions.[1] Thorough patient and provider education, more frequent patient contact, and "the development of a patient-clinician partnership dedicated to the effective treatment of asthma" are recommendations made to help improve patient adherence to medication and treatment regimens and improve the health outcomes for those with asthma.[2] The National Heart, Lung, and Blood Institute guidelines[3] and National Institute of Allergy and Infectious Diseases emphasizes that "people with asthma can prevent asthma attacks if they are taught to use … daily long-term control medicines correctly and to avoid asthma triggers."[4] It supports the

creation of a personal asthma action plan to help doctors and patients better manage asthma.

b. Additionally, providers may also be unaware of this HEDIS® measure as it was implemented relatively recently (in 2012) nor may they be aware of the changes in its specifications as that just occurred this year.

2) The MMA rates for specific sub-populations in Fresno and Madera counties show a disproportion, specifically by age (data tables are on the following page). The rate differences are statistically significant and can be addressed through a targeted intervention.

3) The MMA rates for specific sub-populations in Fresno and Madera counties show a disproportion, specifically by ethnicity (data tables are on the following page). The rate differences are statistically significant and can be addressed through a targeted intervention.

a. Many studies have shown results of how limited English proficiency in groups such as Hispanics leads to worse asthma control.[5,6,7,8] Wisnivesky wrote that "patients with limited English had worse understanding of the disease, poorer self-management, and lower [medication] adherence.[7]

[1] Jin J, Sklar GE, Min Sen Oh V, Chuen Li S. Factors affecting therapeutic compliance: A review from the patient's perspective. *Ther Clin Risk Manag*. 2008;4(1):269-286
[2] Bender, B (2002). Overcoming Barriers to Nonadherence in Asthma Treatment. Journal of Allergy and Clinical Immunology, Volume 109, Issue 6, Supplement 2002, pages S554-S559.
[3] Cabana, M.D. et al. Racial and Ethnic Disparities in the Quality of Asthma Care. CHEST Journal, November 2007, Vol. 132, No. 5_Supplement.
[4] National Institute of Allergy and Infectious Disease web site http://www.niaid.nih.gov/topics/asthma/understanding/Pages/usAsthma.aspx. Accessed on November 20, 2014.
[5] Krueger, K.P. et al. Medication Adherence and Persistence: A Comprehensive Review. Advances in Therapy, Volume 22, No. 4, July/August 2005.
[6] Federman, A.D. et al. Inadequate Health Literacy is Associated with Suboptimal Health Beliefs in Older Asthmatics. Journal of Asthma. August 2010, Volume 47, No. 6, pages 62-626.
[7] Wisnivesky, J.P. et al. Language Barriers May Interfere with the Care of Asthma Patients. Medical Care, February 2009, Volume 47, Issue 2, pages 243-249.
[8] Wisnivesky, J.P. el al, The Association Between Language Proficiency and Outcomes of Elderly Patients with Asthma. Annals of Allergy, Asthma & Immunology, Volume 109, Issue 3, September

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

The specific HEDIS metric, MMA, will be the outcome measure to evaluate the effectiveness of interventions.

MMA: The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Distribute New Provider Letter: Identifying Members with a Low Rate of Asthma Medication Dispensing	P	Q2, Q3, Q4	CVH/HN
Work directly with a targeted high volume, low compliance clinic in Madera County to distribute provider profiles to facilitate scheduling appointments to review asthma medication regimens for patients that showed up as non-compliant (numerator negative).	P	Q1, Q2 Q3 Q4	CVH/HN
Asthma Action Plan Mailing to address member medication modifications based upon current breathing status	M	Q2	CVH/HN
Teen Social Media Asthma Campaign on T2X	M	Q2, Q3, Q4	CVH/HN
Health education message ("Health Tag") printed on PBM pharmacy bag label	M	Q3,Q4	CVH/HN

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

- The work with the targeted high volume, low compliance clinic in Madera has continued from Q1-Q2. The PDSAs (activities with the clinic) were submitted on time. The group will be invited to the asthma project meetings in Q3. The initiatives that were evaluated included scheduling visits and confirming completion of the visit. The clinic profiles were distributed in Q2 and resulted in the clinic exceeding the target goal.
- The activity to distribute new Provider Profiles/Letters was deferred to Q3.
- The member mailing was changed to focus on the new member incentive program administered by Health Ed. The asthma action plan and asthma basics class flyer will be

Section B: Analysis of Intervention Implementation (due end of Q4)

- The work with the targeted high volume, low compliance clinic in Madera continued from Q1-Q3. The PDSAs (activities with the clinic) were submitted on time. The group was invited to and joined the asthma project meetings starting in Q3. The initiatives that were evaluated included scheduling visits and confirming completion of the visit. The clinic profiles were distributed in Q2 and Q3 and resulted in the clinic exceeding the target goal. Given the change in the asthma measure from MMA to AMR that showed all three counties are now above the MPL the PDSA projects for MMA have been ended.
- The activity to distribute new Provider Profiles/Letters was postponed indefinitely in Q3

included in the mailing in Q4. • The Teen Social Media Asthma Campaign on T2X continues and is available to members.	given the change in the asthma measure from MMA to AMR. This change showed that all three counties were now above the MPL. • The member mailing was changed to focus on the new member incentive program administered by Health Ed. There were delays in the intervention due to barriers encountered in the development and printing of the marketing materials. Campaign launched at the end of 2016 and is currently being evaluated for 2017. • The Teen Social Media Asthma Campaign on T2X continues to be available to members. • The Health Tag messaging option through our Pharmacy Benefits Manager is new and was rolled out August 2016 through December 2016 for all three CVH counties. Over 3,300 members were identified for this intervention. The reach rate and initial care gap closure evaluation will be determined in Q1 2017.

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 2017)

Measure(s)	Specific Goal	Rate 2016	Rate 2017	Baseline Source	Baseline Value
HEDIS: Medication Management for People with Asthma: 50% Compliance	Meet or Exceed DHCS MPL 47.41%	Fresno=35.14 Kings=46.69 Madera=39.91	TBD	RY 2015 CVH results	Fresno=38.30 Kings=56.63 Madera=41.01
HEDIS: Medication Management for People with Asthma: 75% Compliance	Meet or Exceed DHCS MPL RY 2016 MPL 23.72%	Fresno=15.27 Kings=23.90 Madera=18.16	TBD	RY 2015 CVH results	Fresno=17.59 Kings=29.59 Madera=21.63

Analysis: Intervention Effectiveness w Barrier Analysis

Whether the overall goal for the asthma activities was reached or not will be determined in Q3 2017 when the HEDIS RY2017 rates are released. During 2016, there were three PDSA cycles completed per DHCS requirements. All of the PDSA were successfully submitted to DHCS without technical assistance being required.

Lessons Learned

Throughout the PDSA cycles process several lessons were learned included:

- Having a direct clinic point of contact for quality initiatives improves implementation;
- Providing a concrete list of actionable opportunities allows providers to develop a strategy when reviewing patient records and help identify actual care gaps versus data issues such as time lag for claims.
- Providing a concrete list of actionable opportunities and a specific timeframe including a deadline serves as a call to action for providers that balance conflicting priorities.

Other activities:

- The Teen Social Media Asthma Campaign on T2X continues to be available to members. Aggregate numbers for 2016 show that 158 Medi-Cal members including those from CVH visited the program with 129 enrolling in the educational program. There were 854 learning materials viewed and 856 educational text messages sent.

	• The Health Tag messaging option through our PBM is new and was rolled out August 2016 through December 2016 for all three CVH counties. Over 3,300 members were identified for this intervention. The reach rate and initial care gap closure evaluation will be determined in Q1 2017. This project is being closed since DHCS is no longer using MMA and is transitioning to AMR as an indicator. Under AMR (Asthma Medication Ratio), CalViva Health counties are above the MPL.

Initiative Continuation Status	☒ Closed	☐ Continue Initiative Unchanged	☐ Continue Initiative with Modification

Section A: Description of Intervention (due Q1)

2-4: Monitoring 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

Rationale and Aim(s) of Initiative

Adverse drug events cause more than 700,000 visits to the ER each year. The more medications people take, the higher their risk of having an adverse drug event.[1]

- Approximately 1.5 million preventable adverse drug events occur in the United States each year, resulting in $3.5 billion in medical costs. [1]
- Severe adverse drug events can result in hospitalization. From 2007–2009, there were an estimated 99,628 emergency hospitalizations for adverse drug events in adults 65 years of age or older. [2]

In addition, a study showed nearly one-third of patients dispensed an ACEI/ARB, did not have an annual laboratory monitoring event. Though patients are at increased risk of hyperkalemia were more likely to be monitored, many remained unmonitored. [3]

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for member on diuretics

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1. Centers for Disease Control and Prevention. 2012. "Adults and Older Adult Adverse Drug Events." http://www.cdc.gov/MedicationSafety/Adult_AdverseDrugEvents.html (June 19, 2014)
2. Institute of Medicine. 2007. "Preventing Medication Errors: Quality Chasm Series." Washington, DC: The National Academies Press.
3. Raebel, M. A., Lyons, E. E., Andrade, S. E., Chan, K. A., Chester, E. A., Davis, R. L., Ellis, J. L., Feldstein, A., Gunter, M. J., Lafata, J. E., Long, C. L., Magid, D. J., Selby, J. V., Simon, S. R. and Platt, R. (2005), Laboratory Monitoring of Drugs at Initiation of Therapy in Ambulatory Care. Journal of General Internal Medicine, 20: 1120–1126. doi: 10.1111/j.1525-1497.2005.0257.x

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

Reporting Year (RY) 2015 HEDIS® results for Annual Monitoring for Patients on Persistent Medications (MPM) fell below the Minimum Performance Level (MPL) in Fresno, Madera, and Kings counties for the following two sub-measures. RY2015 rates for ACE/ARBs were below the MPL in Fresno and Kings counties and for Diuretics rates are below the MPL in all three counties.

Planned Activities

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

Engage high volume, low compliance provider in Fresno County to distribute provider profiles to targeted clinics to facilitate ordering and/or scheduling appointments to order required annual laboratory test monitoring.	P	Q2	CVH/HN
Monthly IVR to members who are non-complaint for all counties	M	Monthly beginning February 2016	CVH/HN
Implement quarterly email campaign to members who have provided their email address captured from the monthly IVR.	M	Quarterly 2016 - May, August, November	CVH/HN
Launch CVS Health Tags to members in Fresno county for lab-monitoring test reminders. When a member fills a prescription at a CVS pharmacy, the member will receive a specific message reminding them to have a lab-monitoring test.	M	Q2 2016	CVH/HN
Distribute Quarterly Provider profiles s for members who are missing their annual lab-monitoring test.	P	Q2 2016	CVH/HN
Mail Provider Education materials to provide best practice information on which lab test members need to be compliant with the MPM measure	P	Q3 2016	CVH/HN
Healthy Heart, Healthy Lives education materials were mailed to all members in the MPM denominator for Fresno, Kings, and Madera Counties.	M	Q2 2016	CVH/HN

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

- CalViva is working with a high volume low compliance clinic in Fresno County. The clinic profiles were distributed in Q2 and resulted in the clinic exceeding the target goal. The Profiles support the clinic in writing the orders for the test for patients who needed their lab test and engaging the member to complete office visits.
- PCP/Clinic letters for all three CVH counties were hand delivered by Provider Relations in June to a total of 243 PCP/Clinic letters representing 2,990 members. Targeted PPG profiles were also generated in Q2.
- Monthly member IVR calls continue with average reach rates of 34% for Q1 and Q2.
- The first of three emails was deployed in June with distribution of the remaining emails slated for Q3 and Q4.
- The CVS Health Tags campaign was launched in June and will continue through September in Madera, Kings, and Fresno counties.
- An annual mailing containing 10 Heart Health tips, along with a call to action to obtain an annual blood test for MPM was distributed in June in both English and Spanish.
- The Provider Education mailing was launched in June and included best practices for MPM. The mailing targeted 210 PCPs/Clinics covering Madera, Fresno, and Kings County.

Section B: Analysis of Intervention Implementation (due end of Q4)

- **PCP/Clinic Provider Profiles:** CalViva worked with a high volume low compliance provider in Fresno County to improve compliance with annual testing for patients on certain medications**. Provider** Profiles were distributed to the clinic to schedule patients/write orders for annual testing. Targets were met for completion of testing.
- The provider profile letters were sent in May.
- **Member IVR:** The monthly IVR calls targeted 7,735 members and the reach rates varied from 22.4% to 40.9%.
- **Member Mailings**: Non-compliant MPM members in all three counties received an education mailer (n=11.446 members).
- **E-mail Campaign:** The quarterly e-mail campaign had a 95% delivery rate, with 18-20% of the members opening their e-mail.
- **CVS Health Tags:** The percentage of members who were matched with CVS as having an "active" CVS Pharmacy Client ID was 92%. Of those members, 79% received a Health Tag message.

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 2017)

Measure(s)	Specific Goal	Rate 2016	Rate 2017	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL 84.87%	Fresno: 84.94% Kings: 83.07% Madera: 83.98%	TBD	RY 2015 CVH results	Fresno: 84.88% Kings: 80.17% Madera: 86.14%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL 84.66%	Fresno: 85.07% Kings: 84.26%	TBD	RY 2015 CVH results	Fresno: 84.82% Kings: 82.83%

		Madera: 83.57%			Madera: 82.97%

Analysis: Intervention Effectiveness w Barrier Analysis

Reporting Year (RY) 2016 HEDIS® results for Annual Monitoring for Patients on Persistent Medications (MPM) for ACE/ARBs was above the MPL for Fresno County but fell below the Minimum Performance Level (MPL) for Kings and Madera Counties. RY2016 rates for Diuretics were above the MPL for Fresno County but below the MPL for Madera and Kings Counties. **Two of the six goals were met for ACE/ARBs and diuretics.**

Successes:

- Upon delivery of the Provider Profile to the clinic, 47.3% (35 of the 122 targeted members) had their annual monitoring laboratory test ordered. This rate exceeded the specific aim of 30% (22 of the 74 targeted members) who would have had the correct laboratory test ordered.
- In the next phase, 80% (28 of the 35 members) completed their laboratory testing and with documentation in the member's chart. This rate exceeded the specific aim of at least 30% (11 of the 35 targeted members) who would have completed their annual laboratory testing.

Barriers:

- Provider Profiles may contain the names of members who have already completed their tests due to claims lag.
- Although emails were successfully sent only 18-20% of members opened them.
- Some mailings were unsuccessful due to member change of address

Lessons Learned:

- A direct clinic point of contact for quality initiatives improves implementation.
- Providing a concrete list of actionable opportunities allows providers to develop a strategy when reviewing patient records and help identify actual care gaps versus data issues such as time lag for claims.
- Providing a concrete list of actionable opportunities and a specific timeframe including a deadline serves as a call to action for providers that balance conflicting priorities.
- The Provider Profile process when used in conjunction with direct clinic communication is an effective method to improve lab test completion.

Initiative Continuation Status	☐ **Closed**	☐ **Continue Initiative Unchanged**	☒ **Continue Initiative with Modification**

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)

3-1: Comprehensive Diabetes Care – PIP

☐ **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

Comprehensive Diabetes Care is below the MPL for HbA1c testing in Kings County. For 2015 the rate was 79.08 and the RY 2015 MPL target was 80.18. While we met the MPL for Madera and Fresno, Kings County has room for improvement in particular when compared to RY 2016 MPL (83.19). Fresno and Madera county HbA1c rates, 84.67 and 88.32 respectively, have room for improvement to achieve the HPL (91.94). We have potential to have a favorable impact for health outcomes for a growing population in our membership. A bundled approach has the potential for improving both morbidity and mortality for the diabetic patient

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

HEDIS measure – Comprehensive Care (CDC) HbA1c Testing: The percentage of members 18-75 of age (as of December 31 of the measurement year) with diabetes (type 1, type 2) who had Hemoglobin A1c testing.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Establish Diabetic Team/Metrics (Module 1&2)	P	Q2	CVH/HN
Perform Process Mapping and FMEA (Module3)	P	Q2	CVH/HN
Initiate interventions/PDSA	P/M	Q3&Q4	CVH/HN

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

- CalViva has partnered with a medical clinic in Kings County to implement a diabetes performance improvement project (PIP). A diabetes workgroup comprised of CalViva and medical clinic staff has been established. Over the course of several in-person meetings and conference calls, we reviewed the clinic workflow and developed a process map to identify failure points and improvement opportunities.
- These opportunities were identified: 1) collect current patient contact information and 2) initiate a new process to text appointment reminders to diabetic patients due for an HbA1c test.
- The clinic developed a new patient information survey to collect current contact information for new patients, including the best time to reach them. This information is entered into the EMR, and later used to call the patient with appointment reminders. While the reminder calls have just begun, and analysis is yet to be completed, initial results show a high rate of success in contacting the patient.
- By June, Modules 1-3 were submitted. Module 4 is on track.

Section B: Analysis of Intervention Implementation (due end of Q4)

- Continuing our efforts with a high volume low compliance clinic in Kings County Module 4 Intervention Determination was completed and submitted to HSAG and approved.
- A new patient survey was used to gather updated patient contact information for patient follow up and appointment scheduling.
- By asking the patient the best time to call, it was expected to improve the likelihood of reaching the patient at a time when they are available to answer the phone to schedule an appointment.
- The survey was implemented for 2 months, June/July, and was extremely successful (94%-100% successful) in contacting patients within 24 hours after their initial appointment.
- However, too few CalViva members with diabetes were being reached and identified through this process. Module 4 was submitted to HSAG/DHCS 8-12-16. Data was collected through August, with similar results.
- On 9-16-16, it was determined that a Technical Assistance call with HSAG was needed to discuss a change in our intervention. The survey was not capturing CalViva members who are diabetic and a new approach using a Provider Profile was recommended.

	• The CVH Diabetic Improvement team met with HSAG and DHCS on 11-7-16, reviewed the intervention status and findings, and suggested expanding the intervention to Fresno County with a modified outreach. The plan was approved. Closing documents for Intervention #1 were submitted to HSAG on 12-12-16. • A new Module 4 and revised Module 3 were submitted the HSAG on 12-12-16 outlining the new process with the Provider Profile.

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 2017)

Measure(s)	Specific Goal	Rate 2016	Rate 2017	Baseline Source	Baseline Value
Comprehensive Diabetes Care - HbA1c Testing	Meet or exceed DHCS MPL 83.195	Fresno=80.29 Kings=76.64 Madera=87.10	TBD	RY 2015 CVH results MPL	Fresno=84.67 Kings=79.08 Madera=88.32

Analysis: Intervention Effectiveness w Barrier Analysis

Lessons Learned:

- The new patient survey process was able to effectively gather accurate contact information in order to call and speak to patients within 24 hours, however, initial data showed that there were too few CalViva patients that were new to the clinic and even a smaller number that were diabetic. Therefore, we were not reaching our target population through the use of the survey tool.

Next Steps:

Our plan for 2017 is to initiate a modified intervention that will utilize a Provider Profile to identify CalViva diabetic patients at the targeted clinics in Fresno and Kings Counties to complete needed HbA1c testing. The clinics have an internal process for identifying patients that need preventive services and our first step will be to determine whether the patients identified on the CVH list are on the clinic's internal list. Additional steps will be initiated based upon the initial findings.

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Initiative Continuation Status ☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

3-2 Postpartum Care - PIP

☐ **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

Goal: Improve the health of new mothers by ensuring that women attend a postpartum visit.

Rationale: The American Congress of Obstetricians and Gynecologists (ACOG) and National Committee for Quality Assurance (NCQA) recommend women have postpartum visits between three and eight weeks after delivery. This is an important visit during which healthcare providers can address with patients any complications that may have occurred during pregnancy, any underlying medical conditions, health of the infant, breastfeeding and breast health, maternal/infant bonding, and family planning.

In reporting year 2015, CVH was below the MPL (56.18) in 1 of 3 counties. Kings county rate was 52.82. CVH is working with Adventist in Kings County on the Postpartum PIP. Established team /defined metrics submitted modules 1&2 on 12/4/15.

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

CVH will be tracking an Adventist specific postpartum HEDIS rate based on the exchange of delivery information and postpartum appointments kept. The SMART AIM for the Postpartum PIP is: By June 30, 2017, increase the postpartum visit rate among CalViva Health members who belong to Adventist from 55% to 65%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Perform Process Mapping and FMEA (Module 3)	P	Q1	CVH/HN
Test Interventions using the PDSA methodology	P/M	Q2, Q3 & Q4	CVH/HN
Implement member postpartum incentive by mailing the incentive brochure to all identified members.	M	Ongoing	CVH
Implement Eliza IVR calls to all pregnant and postpartum members with reminders for postpartum care and live assistance to schedule appointments.	M	Ongoing	CVH/HN QI
Implement Baby Showers with members with education about the importance of postpartum visit.	M	Ongoing	CVH

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

- CalViva has partnered with a medical clinic in Kings County to implement a postpartum Performance Improvement Project (PIP). A workgroup collaborated to complete Modules 1-4 and those were submitted prior to the end of Q2. This included Process Mapping and FMEA documenting and analyzing the process for scheduling and completing postpartum visits. The PIP opportunities were identified including:
  - 1) Notifying members of the importance of postpartum care
  - 2) Obtaining accurate contact information
  - 3) Scheduling visits at the time of discharge from the hospital.
- In addition, CalViva submitted a Plan section for the PDSA that was pre-validated by DHCS and HSAG. This plan includes a process for obtaining accurate member information and engaging the hospital to do the scheduling of visits.
- 755 Postpartum Member Incentive Forms were mailed to members. Thirteen members received the $25 Visa gift card.
- Eliza calls started in April 2016 and will continue through 2016.
- No baby showers conducted with the targeted medical clinic. There are challenges in

Section B: Analysis of Intervention Implementation (due end of Q4)

- CalViva Medical Management team has continued its efforts to work with a high volume low compliance provider in Kings County to improve postpartum visit completion rates.
- **(Intervention #1)** The Director of the OB Unit of the only Acute Care Hospital in Kings County joined the CVH Postpartum Improvement team in order to initiate a new process for gathering patient contact information in order to schedule and provide reminders for the postpartum visit. The L & D Admitting Clerks request information on "What is the best way to reach you during the next 2 months while you are recovering from having the baby?" and this information is placed in the RCI Software system used by the clinic staff to contact and schedule members.
- The Admitting Clerks were educated and laminated reminder cards were

scheduling baby showers and promoting them in the Clinic.	placed at the computer stations (in English and Spanish) as a visual reminder to use the specified terminology. • This intervention was found to be very successful in improving contact information. Further study revealed that the main issue associated with not completing the postpartum visit was patient "no show" • **(Intervention #2)** In an effort to reduce the patient "no show" rates, the CVH Postpartum Improvement team initiated a point of service $25, member incentive for completing the 3-8 week postpartum visit. • Members are educated about the incentive during prenatal visits and when appointments are scheduled by the front office staff at the clinic. • Initial data is demonstrating a positive trend and final results will be reported to the state in June 2017 with the submission of a completed Module 4 & 5. • **(Intervention #3)** OB Unit staff have been trained and have the ability to schedule Postpartum visits 24/7 prior to discharge from the hospital in the RCI software used by the clinic to schedule patients. • The postpartum member incentive mailings continued through December 2016. Two hundred and ninety-eight (298) members that were mailed postpartum brochures returned the forms (9.7% of brochures mailed). One hundred and eight (108) completed brochures/forms were received through provider offices (26.6% of all of the returned forms). A total of 406 members returned brochures/forms; 381 members out of the total 406 (93.8%) completed the requirements to earn the incentive. • The Interactive Voice Response-ELIZA (IVR) calls started in April 2016 and continued through 2016 for 3,448 members in need of PPC in CVH counties. Of the attempts to contact members, 83.4% (2,875) of members were reachable. Of the reachable members, 1,175 of the members were reached on the phone, and 1,367 messages were left with a machine. 55.1% (385) members, who were reached, finished the survey, 51 members responded "yes" to transfer and 126 members responded "yes" to email. • Two baby showers took place in Q4 in October (1) and November (4) with a total of 5 attendees. During the showers, health educators discussed the importance of prenatal care, breastfeeding, and the importance of postpartum care visits through engaging activities and interactive group discussions.

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 2017)

Measure(s)	Specific Goal	Rate 2016	Rate 2017	Baseline Source	Baseline Value

Postpartum HEDIS rates for Kings County and Adventist as calculated for the Postpartum PIP.	Kings: MPL of 56.18 Adventist = 65%	Kings 50.24		RY 2015 CVH results	52.82%

Analysis: Intervention Effectiveness w Barrier Analysis

In RY 2016, CVH was below the MPL of 56.18% in Kings County (50.24%), and above the MPL in Madera (58.76%) and Fresno (67.59%) Counties. Based on RY2016 HEDIS rates for postpartum care visits, Kings County will continue the interventions for the PIP through June 2017.

Successes:

- A total of 381 members completed the requirements for the member incentive and received their gift cards.
- A positive trend is noted for postpartum visit completion since the implementation of the point-of-service member incentive.

Barriers:

- Patients do not always understand the importance of the information covered during the postpartum visit. Provider feedback indicated that language and cultural barriers can make it difficult to communicate the importance of the visit to their patients. Cultural beliefs may also require that the member remain in the home for an extended period of time (past the timely postpartum visit timeframe).
- Patients forget their appointment due to overwhelming responsibilities at home (e.g. taking care of baby, caring for additional children, etc.) and may or may not contact the clinic to reschedule.
- Transportation may not be available in some cases making it difficult to attend the appointment. The clinic may be too far to walk in rural areas, or it may be too hot and uncomfortable to walk during the summer months.
- Postpartum visit may be occurring with PCP and may or may not be coded or documented as such (low volume).
- Each mailing cycle was affected by outdated member addresses resulting in 10% of the incentive mailers being returned to the health plan.

Lessons Learned:

- When requesting secondary contact information, a standardized tool is needed to facilitate consistent use of terminology. Laminated cards were created and placed at each computer station that the admitting clerks use in the OB Unit of the hospital to support use of consistent wording when requesting secondary contact information.
- When collaborating with providers, it is critical to ensure a structured relationship exists with consistent communication regarding the data to be used and the processes to be implemented for each HEDIS measure. Establishing a consistent schedule for check-ins regarding the improvement project provides more opportunities to address feedback from the clinic, provide feedback on data collection, and validate data during the review cycle. During the review cycle, updates were made to the tracking log in order to ensure all data was collected appropriately (e.g. due date), and to work with the clinic staff to ensure all information was collected appropriately.

Initiative 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?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN	PSG is distributed in the new member packet and is available upon member request to the Health Education department	☒	08/2016	Preventive screening Guidelines in the following languages were updated in August 2016 Hmong, English and Spanish
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Approved by QIUM Committee and distributed via Provider Updates	☒		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor disease management program and ensure vendor conducts member and provider enrollment mailers and outbound calls.	AxisPoint Health CVH/HN	Weekly meetings are held with the vendor for program oversight. Weekly review of the enrollment counts and monitoring of a sample of the Disease Management charts is done quarterly for engagement activities, program monitoring and opportunities for improvement.	☒	Ongoing	**Weekly oversight meetings continue.** **Members:** receive a pre-enrollment letter. Letters with educational materials and action plans are sent following the completed assessments. IVR's and educational materials are sent twice a year. In June, 2016 campaign information was sent out targeting members with Diabetes and Asthma. In the Fall, 2016 campaign educational pieces were on Flu Prevention. **Providers:** An introductory letter was sent with the engaged member roster and program overview brochure. In April and September, 2016 Provider Updates were sent describing the Disease Management program, criteria and referral process. Quarterly chart reviews are done by the Medical Management Accounts Team to monitor for compliance.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Reports: Analyze and submit Cultural and Linguistics (C&L) related reports.	CVH/HN	Reports were submitted and approved in May	☒		All reports submitted to the QIUM as required.
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s)	CVH/HN	MY2015 PAAS Survey completed & data finalized July 2016. CAPS to be issued by late August 2016. Target completion date is early November 2016.	☒		CVH CAPs sent out September 2016 Improvement Plans due no later than 11/24/16 Escalated missing Improvement Plans due 1/31/17 - currently 1 PPG and 3 direct network providers are outstanding Sante granted extension to return IP by 2/10/17

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
					3 direct providers - will follow up today to see if I can get the IP
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date	CVH/ HN	TAR filing completed by due date – reported at the CVH Access meeting in March & July 2016.	☒		
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN	A&G workgroup continues to meet to improve A&G reporting.	☒		Quarterly reports submitted to Qi-UM
5. Group Needs Assessment– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistic Health Education, services and Quality Improvement (QI) programs and resources	CVH/HN	In Progress, to be completed by October 2016.	☒	10/2016	Completed in October 2016 submitted to CVH compliance for filing with DHCS
6. 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. (bi-annual: next report 2017)	CVH/HN	Report due in 2017	☒		Bi-Annual Report is due Sep 2017
7. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	Report was presented and approved on 5/17/16	☒		Report was presented and approved at the 11/17/16 QI/UM meeting.
QUALITY AND SAFETY OF CARE					
1. Complex Case Management – Utilize Stratified Data to Identify High Risk Members and Engage them in Case Management Programs: Evaluate clinical outcomes for members enrolled in Complex Case Management	AxisPoint Health CVH/HN	Information is presented in the Key Indicator Report and also in the quarterly Case Management reports presented to the QI workgroup.	☒	12/31/2016	Reports that have been completed: monthly KIR, quarterly CCM Reports, and the annual report of clinical outcomes. Starting September 1, 2016 all new CCM cases were referred in house to the Integrated Case Management program. All cases that were open prior to September 1, 2016 remained with the legacy CCM program and were managed to closure (i.e. goals met, referred to another program, unable to contact). The legacy CCM program was completed on December 31, 2016.
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN	Monthly credentialing and re-credentialing reports are presented at the QI workgroup meetings.	☒		Monthly and Quarterly Reports
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH (may include member	CVH/HN	Quarterly reports being submitted and reported to the QI/UM Committee.	☒		Quarterly Reports

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
satisfaction surveys, provider surveys, etc.)					
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 Survey per MMCD Policy Letter 12-006 & 15-023	CVH/HN	Ongoing monitoring conducted. Bi-annual report of quarterly monitoring of FSR/MRR and PARS to QI	☒	12/31/2016	Required FSR/MMR Audis for 2016 completed. Required PARS for PCP's and identified high volume providers for 2016 completed.
2. Evaluation of the QI program: Complete QI Work Plan evauation annually.	CVH/HN	Ongoing monitoring conducted.	☒	Feb 2017	