20178

Health Net of California
CalViva Health

UTILIZATION MANAGEMENT/CASE MANAGEMENT

PROGRAM DESCRIPTION

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Section 1

Introduction and Background

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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 with health care operations throughout the United States. Health Net, Inc. is a subsidiary of Centene Corporation, a publicly traded company. 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
- Encounters
- Credentialing

- Provider
- Claims
- Billing
- Capitation
- Medical Management
- 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's, 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. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

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

Health Net has developed, implemented, and continuously updates and improves the UM Program to ensure appropriate processes are in place to review and approve the provision of medically necessary covered services. The plan has qualified staff who are responsible for the UM program. The plan separates its medical decisions 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.

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

Prior authorization is not required for emergency and sensitive services, family planning services, annual preventive care visits to an OB/GYN, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, basic obstetrical care, minor consent services, and immunizations at the Local Health Department (LHD). Utilization Management policies and procedures are available to members and providers upon request.

Health Net Utilization 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~~ continuity of care services. Pre-service decisions are required for elective inpatient admissions, referrals for selected ambulatory surgery, home health care, durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health

appropriateness that are based on sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

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

Inpatient Facility Concurrent Review

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

A goal of CCR is to support the Member and Member's healthcare team to optimize health outcomes 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 Managed Health Network, Inc. (MHN), case management, and community resources.

The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs

Health Net nurses and Medical Directors, delegated partners, and MHN conduct onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, or skilled nursing facilities. HN may monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status. The inpatient review process occurs within 1 business day from the day of hospital admission or within 1 business day of notification of admission and continues throughout the patient's hospital stay. The review process includes application of standardized nationally recognized criteria for medical appropriateness review, levels of care, discharge planning, and

transitional care management including assessment of medically appropriate alternatives to inpatient care.

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

Health Net non-clinical 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~~discharge needs, including but not limited to, home health care, durable medical equipment and/or transfers to a lower level of care (e.g., skilled nursing facility or acute rehabilitation).

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

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

- Assessment of continuity of care needs.
- Assessment of member's support system to determine necessary services and support needs.
- Development of a plan discharge 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 immediate 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 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) ~~c~~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) ~~r~~Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.

5) Follow-up calls with the member are conducted within 30 days post-discharge, with interventions focused on~~: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.

During the post discharge period, staff evaluates the member for Integrated Case Management, palliative care and other programs that may best support the member in managing their continued needs. A referral to these programs is conducted as applicable to ensure continuity of addressing outstanding member needs/goals. ~~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' medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization ~~payment~~ against documented medical record 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 Medi-Cal mental health services carved in to the Managed Care Plans.

MHN provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence based behavioral intervention services that develop or restore, to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD). 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 and received their services from MHN and not the Regional Center.

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

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). MHN and Health Net do not impose Quantitative(QTL), or Non-Quantitative Treatment Limitations(NQTL) more stringently on covered mental health and substance use disorder services than are imposed on

medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

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

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

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

- Treatment in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation to incorporate the unique perspectives and skills of behavioral health disciplines.
- A systems orientation which views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.

- The MHN utilization management program encompasses pre-service, concurrent, and post-service review for inpatient, alternative and some outpatient care of CalViva Health members. Licensed professionals and Customer Service Representatives coordinate these activities. The Care Managers and other treatment team members are located at MHN Service Centers in California.

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

Pharmacy

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

Integrated Carse Management (ICM) Program

The Plan makes case management services available to all members.

The goals of the ICM 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 self-management and 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 tools to empower the 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 Health Information Form and 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
- Transitional Care Management
- 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.

MemberConnections

MemberConnections is a special educational and outreach program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections Representatives (MCRs) extend the reach of member engagement and care management efforts by making home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan/providers and members.

More specifically, MCRs:

- Conduct non-clinical assessments to better understand members' needs such as the Health Risk Screening.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect members to case management and disease management to better manage their chronic and/or complex health conditions.
- Address social needs by linking members to county and community resources.
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.

Continuity and Coordination of Care ~~Members~~

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

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

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers. Care Managers are patient advocates

who ensure that these members receive timely and uninterrupted medical care during the transition process.

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

Primary Care Physician responsibility:

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

Health Net supports the medical home model of primary care~~,~~ and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

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

Population Based Programs/Be In Charge!℠ Programs

In 2016 Health Net began transitioning the *Be In Charge!℠* Programs. Complex Case Management transitioned in-house in September 2016 and was re-titled Integrated Case Management. The other programs will be transitioned to Envolve PeopleCare in 201~~7~~8.

Be In Charge! ℠ Programs

CalViva Health provides the *Be In Charge!℠* 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!* ℠ 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!*℠ Programs include:

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

Disease Management

The Disease Management – *Be In Charge!*℠ Program provides disease specific management for members with asthma, diabetes, and heart failure (HF) and will transition to . Upon transitioning to Envolve PeopleCare in 20178,. the program will expand to incorporate members with Chronic Obstructive Pulmonary Disease (COPD), and Coronary Artery Disease (CD). The goal of the *Be In Charge!*℠ 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 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 Integrated complex cCase mManagement pprogram if the member is identified as being at high risk for hospitalizations or poor outcomes.

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, 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.

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.

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:

- The Health Education Information Line – The Health Education Information Line (1-800-804-6074) allows members to request health education materials and find out about health education programs available.
- Weight Management Programs – Members have access to a comprehensive Fit Families for Life-*Be In Charge!*^{sm} suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Overweight children and adult can also access telephonic coaching through Raising Well and Adult Weight Management programs respectively.
- Disease Management Program – At risk members with asthma, diabetes, and chronic heart failure are offered enrollment into the *Be In Charge!*^{sm} Disease Management program to help them control their condition. Members receive educational resources and have unlimited 24-hour access to a nurse to address their medical concerns.

- Healthy Pregnancy Program – Pregnant members receive educational resources including telephonic case management for high-risk pregnancies to help them achieve a successful pregnancy and healthy baby.
- California Smokers' Helpline – The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego Moore's Cancer Center. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking.
- Nurse Advice Line – Members may speak to a nurse 24-hours a day, 7 days a week in the member's preferred language about any health-related concerns. Pre-recorded information about a variety of diseases and health issues is also available via the Nurse Advice Line as part of the Audio Health Library.
- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Electronic Health Education – Teens from 13 years old and adults may participate in electronic health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide participants in learning how to access credible health education information and seek preventive health care services.
- Community and Telephonic Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Member Newsletters – Newsletters are mailed to members on a quarterly basis and covers various health topics and the most up-to-date information on health education programs and services.
- ~~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 (MAC).

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.

Standards of Timeliness of UM Decision Making

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

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

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. He/she may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.
The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines

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

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

Appeals

A licensed physician reviews all member medical necessity appeals.

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

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

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

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

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

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

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

Evaluation of Medical Technology and Procedures

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

Health Net utilizes nationally recognized primary sources for evidence based information including the Hayes Medical Technology Directory, 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.
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.

Communication Services

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

- Toll-free member/provider services telephone number/fax or email.

- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CalViva Health members upon request.

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

Emergency Services

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

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

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

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

The Chief Medical Officer has decision-making responsibilities for Health Net medical matters. The Chief Medical Officer oversees, directs and coordinates all health services

functions in partnership with Senior Medical Directors, Medical Directors and other medical management leadership team members. Medical Management departments for which he/she has clinical oversight responsibility to include: Quality Improvement, Healthcare Services (UM/CM), Appeals and Grievances, Compliance, Program Accreditation and Disease Management.

The Chief Medical Officer's responsibilities include, but are not limited to: leading the health plan in national medical management initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization/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.

Chief Medical Director, State Health Programs

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

Medical Directors

The 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 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 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

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

Director, ~~Health Care Services~~Medical Management

The Director~~s is~~ are 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 and timely ~~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~~integrated 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 annually prepares the CalViva Health Utilization/Care Management Program Evaluation and presents the evaluation to CalViva Health for review.

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

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

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

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

UM/CM Program Work Plan

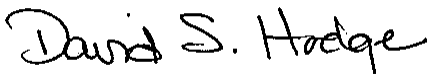
Health Net's SHP Senior Medical Director and Vice President Medical Management annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity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

Section 7

Approvals

Fresno-Kings-Madera Regional Health Authority Approval

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



~~December 19th, 2017~~

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

~~December 19th, 2017~~

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

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_____ Date _____
Farid Hassanpour, DO
Chief Medical Director

_____ Date _____
Jennifer Lloyd
Vice President of Medical Management

Committee Approval

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

_____ Date _____
Farid Hassanpour, DO
Chief Medical Director