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SPECIAL NEEDS PLANS

MODEL OF CARE

Health Net of Arizona H0351 C-SNP 2018

Allwell CHF/Diabetes (HMO SNP)

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Special Needs Plans

2018 MODEL OF CARE DESCRIPTION

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

MOC 1.A DESCRIPTION OF OVERALL SNP POPULATION

MOC 1.A.1 Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

Health Net follows the Centers for Medicare and Medicaid Services (CMS) requirements contained in Chapter 2 of the Medicare Managed Care Manual (MMCM) and in the applicable regulations in reviewing each enrollment election to ensure that the enrollee meets Special Needs Plans (SNPs) eligibility requirements as applicable, prior to submitting the enrollment to CMS for approval. Upon receipt of the application, Health Net (HN) verifies the enrollee's applicable chronic condition for the Allwell CHF/Diabetes Medicare (HMO SNP), based on the plan selected, through one of the following methods:

If the provider verification of condition is included with the application, HN will continue with the eligibility process outlined in "Processing the Enrollment Request", including sending the acknowledgement of enrollment notice.

When a CMS approved prequalification assessment tool is received with an application HN will continue with the Eligibility process outlined in "Processing the Enrollment Request", including sending the acknowledgement of enrollment notice.

Additionally, HN will conduct follow up calls to the provider as needed to request verification of the qualifying condition.

If confirmation is received either verbally or in writing, documentation is completed and updated to reflect this confirmation. HN will document the appropriate system with all outreach attempts and outcomes and will retain a copy of any communication received in writing in the enrollee's file.

If by the end of the first month of enrollment, no confirmation has been received, HN will send the member a notice of his/her disenrollment for not having a qualifying condition. The disenrollment is effective at the end of the second month of enrollment, the disenrollment transaction is sent to CMS within 3 business days of the expiration of the deeming time frame; however, HN must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of the enrollment.

If HN is unable to obtain provider verification of condition (and/or CMS approved prequalification assessment tool) HN will follow the pend process outlined in “Processing the Enrollment Request”, including sending the enrollment pending notice to the enrollee.

Notice Requirements:

Request for Additional Information: To obtain information to complete the enrollment request, HN must contact the individual to request the information within **ten calendar days** of receipt of the enrollment request. The request may be written or verbal but in either case the request must be made within ten calendar days

Acknowledgement of Receipt: A notice acknowledging receipt of the completed enrollment request and showing the effective date of coverage must be provided to enrollee/member. This notice must be sent no later than **ten calendar days** after receipt of the completed enrollment request.

Enrollment Confirmation or Rejection: HN must notify the enrollee/member in writing of CMS’ acceptance or rejection of the enrollment within **ten calendar days** of the availability of the daily *Transaction reply report (TRR)*, whichever contains the earliest notification of the acceptance or rejection.

Provider Verification Form: A form to be completed by the provider to verify the enrollee’s chronic condition.

CMS Approved Prequalification Assessment Tool: A notice that must be completed by the enrollee, which allows HN to contact the provider to verify the enrollee’s chronic condition on a post-enrollment basis.

MOC 1.A.2 Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP Population.

Health Net’s (HN) chronic disease Allwell CHF/Diabetes Medicare (HMO SNP) for chronic heart failure (CHF) and diabetes provides healthcare services for residents of Maricopa and Pinal counties in the state of Arizona. Arizona is located in a hot arid region of the southwest United States where temperatures can frequently exceed 100 F. The specific targeted population resides in Arizona’s south central region that encompasses the larger cities of Phoenix, Mesa, Glendale, Scottsdale and Chandler. Maricopa County is the largest population-dense county in Arizona with over 4 million residents, accounting for more than half of the entire state population.¹ Pinal County is the third-most populous county in Arizona with an estimated population of over 400,000 residents as of July 1, 2015.² As of 2015, the diversity of residents in

¹ United States Census Bureau. Quickfacts: Maricopa County, Arizona. Retrieved January 17, 2017, from <http://www.census.gov/quickfacts/>

² United States Census Bureau. Quickfacts: Pinal County, Arizona. Retrieved January 17, 2017, from <http://www.census.gov/quickfacts/>

the State of Arizona consisted of 55.8% non-Hispanic white, 30.7% Hispanic or Latino, 5.3% American Indian or Alaskan Native, 4.8% African American and 3.4% Asian.³

Noteworthy is that in addition to Hispanics, Maricopa and Pinal counties have a large population of American Indian residents. The majority of American Indians in Arizona participate in the National Indian Health Services. Services are comprehensive and range from primary care (inpatient and outpatient) to tertiary care and specialty services. In addition, dental services; behavioral health; public health nursing; health education; and environmental health services are provided. The services are provided through ten service units located throughout the tri-state area. The Phoenix Area works closely with over forty tribes within the tri-state area in providing health care services.⁴

Results from the 2012 Maricopa REACH (Racial and Ethnic Approaches to Community Health) Survey indicated that on average, 88% of residents responded always (40%), or sometimes (48%) to the question “On a monthly basis, do you have enough money to pay for essentials such as food, clothing, housing and medicine?” A higher percentage of African American (21%) and American Indian (12%) residents were, however, more likely to respond “never” to this question, meaning that these subpopulations are more often unable to afford these essentials compared with the other race/ethnic groups. Among Hispanic residents, 9% could never afford these essentials; and similarly for 5% of Asian Americans.⁵ About 16.3% of Maricopa residents were below the federal poverty level as of 2015.⁶

In comparison, the 2015 HN Health Risk Assessment (HRA) data showed that 32% of Allwell CHF/Diabetes Medicare (HMO SNP) members reported they cannot shop for their own food and 34% of members reported that they cannot cook their food. Transportation is an economical factor that contributes to members being able to get to doctor appointments, pick-up prescriptions, and attend social events. About 22% of SNP members depended on friends for transportation. As a result, 47% of members reported that they are unable to participate in social activities on a regular basis. Allwell CHF/Diabetes Medicare (HMO SNP) members that cannot afford the essentials or perform tasks on their own, such as food shopping and cooking, buying clothes, dressing themselves and securing housing, experience a social deficit that can impact their physical and mental health.

Health Net SNP-specific demographic information according to Health Net of Arizona (HNAZ) Epidemiological and Demographical Analysis – Medicare SNP, reported that the member

³ United States Census Bureau. Quickfacts: Arizona. Retrieved January 17, 2017, from <http://www.census.gov/quickfacts/>

⁴ Indian Health Service. Phoenix area. Retrieved January 17, 2017, from <http://www.ihs.gov/phoenix/>

⁵ Maricopa County Department of Public Health (2012). Maricopa County Community Health Status Assessment. Phoenix, AZ. Author. Retrieved January 17, 2017, from http://www.arizonahealthmatters.org/content/sites/arizona/maricopa/Health_Status_Report_Assessment_2012.pdf

⁶ United States Census Bureau. Quickfacts: Maricopa County, Arizona. Retrieved January 17, 2017, from <http://www.census.gov/quickfacts/>

average age as of December 31, 2015 was 70.6 years, which was almost the same as the 2014 average of 70.8 years. However, the SNP population was younger on the average than the Non-SNP Medicare population by 2.1 years. The Allwell CHF/Diabetes Medicare (HMO SNP) population was comprised of 48% males and 52% females based on the 2015 HN HRA data.

Self-reported ethnicity information gathered from the 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁷ for HNAZ Medicare, inclusive of the SNP population, revealed that respondents were 93% white and 5% African American. The response counts for other ethnicities (American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islanders) were suppressed for 2016 reporting year CAHPS results. Of the aforementioned ethnicities, 23% of members designated themselves as Hispanic or Latino. About 55% reported a high school or less education and 45% had some college education or higher.

Responses gathered from the 2015 HN HRA revealed that English was the primary language for 91.1% of Arizona Allwell CHF/Diabetes Medicare (HMO SNP) members, followed by Spanish (7.8%), and Other (0.9%). In order to address any health literacy issues among SNP members, Health Net provides culturally acceptable and readable materials for all federally required threshold languages in Arizona. Member informing materials are available in English and Spanish and upon request, in additional languages. Health Net customer service representatives who speak Spanish or other languages are also available and required interpreter and language services are provided. Health Net Allwell CHF/Diabetes Medicare (HMO SNP) HRA data indicated that 96% of members can read in their own language, although literacy may still be an issue. In 2016, Health Net received the Multicultural Health Care Distinction by the National Committee for Quality Assurance (NCQA) for the third time since 2012. Health Net has earned the two-year distinction and remains the only health plan in the nation to earn the distinction simultaneously for all three lines of business (Commercial, Medicaid, and Medicare).

Please see MOC 1.A.3 for cognitive factors and co-morbidities of the Arizona Allwell CHF/Diabetes Medicare (HMO SNP) population.

MOC 1.A.3 Identify and describe the medical and health conditions impacting SNP beneficiaries.

In 2014, heart disease and stroke were the second and sixth leading causes of death respectively in Arizona.⁸ Increasing age is a major risk factor for cardiovascular disease. In fact, nearly 83% of the deaths for individuals over the age of 65 were from heart disease and stroke. American Indians (69.6 years) and African Americans (72.1 years) had lower median ages for cardiovascular deaths than Hispanics (75.8 years) and Asians (79.1 years). The premature death

⁷ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

⁸ American Heart Association. Arizona State Fact Sheet. Retrieved January 17, 2017, from http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_466773.pdf

rates from cardiovascular disease were higher among racial and ethnic minorities than the white population. About 68% of American Indians and about 64% of African Americans died prematurely compared to only 37% for whites.⁹ Most premature deaths from cardiovascular disease can be prevented by adopting lifestyle changes, such as eating a healthy diet, exercising regularly, and avoiding tobacco use.

Additionally, heart disease was noted on 68% of diabetes-related death certificates among people ages 65 years old or older. The diabetes death rate was higher in African Americans (62.4%) and Hispanics (36.1%) than in the white (14.6%) and Asian/Pacific Islander (12.0%) populations in Arizona. It should be noted that African American and Hispanics may be culturally less likely to seek routine medical care. Stroke was also noted on 16% of diabetes-related death certificates among people ages 65 years old or older in Arizona. Diabetes is a leading cause of Cardiovascular Disease. People with diabetes ages 60 years old or older were 2-3 times more likely to report an inability to walk one-quarter of a mile, climb stairs, or do housework compared to people without diabetes in the same age group.¹⁰

According to the Recommendations for Maricopa County Health Assessment, combined results from the REACH Community Survey and the Maricopa County Dept. of Public Health (MCDPH) Survey indicated that chronic diseases are important health problems for Maricopa County communities. Chronic diseases/issues that were ranked highly include: overweight / obesity, diabetes, heart disease and stroke, cancers, and high blood pressure. In focus groups conducted with three subgroups, LGBT, low socio-economic status, and senior populations, obesity also emerged as an important health problem. In the REACH Community Survey, “lack of exercise” and “poor eating habits” ranked as the third and fourth most important “risky behaviors” for the community as a whole.¹¹

As expected, the Health Net Allwell CHF/Diabetes Medicare (HMO SNP) varies from the general state population because members must have CHF or diabetes to enroll. Allwell CHF/Diabetes Medicare (HMO SNP) 2015 HRA data identified the following incidence of diseases and co-morbidities self-reported by members included but are not limited to:

- 91% have diabetes
- 13% have experienced heart failure
- 19% have atrial fibrillation
- 71% have hypertension
- 31% are obese

⁹ Arizona Department of Health Services. The Burden of Cardiovascular Disease in Arizona. Retrieved January 17, 2017, from <http://www.azdhs.gov/documents/prevention/tobacco-chronic-disease/az-heart-disease-stroke/az-burden-of-cardiovascular-disease.pdf>

¹⁰ Arizona Department of Health Services Bureau of Tobacco and Chronic Disease. Arizona Diabetes Burden Report: 2011. Retrieved January 17, 2017, from <http://azdhs.gov/documents/prevention/tobacco-chronic-disease/diabetes/reports-data/AZ-Diabetes-Burden-Report-2011.pdf>

¹¹ Recommendations for Maricopa County Health Assessment. St. Luke's Health Initiatives 2012. Retrieved January 17, 2017, from <https://www.maricopa.gov/PublicHealth/programs/OPI/pdf/CHA-Recommendations.pdf>

- 12% have a history of stroke
- 15% have osteoporosis
- 23% have impaired vision
- 18% have memory problems
- 9% have mental health problems

An epidemiological and demographic analysis is conducted annually to assess the clinical needs of HNAZ Medicare SNP members (Allwell CHF/Diabetes SNP, Allwell Cardio SNP and Allwell Dual SNP). The SNP population is a subset of the Medicare population, and has an additional set of care requirements mandated by CMS. Another purpose of this activity is to identify trends in the SNP sub-categories and age groups. Top 10 primary medical diagnoses and Top 20 prescriptions in combination with member demographic information, are presented to assess the characteristics of this population.

There is a more noticeable difference in the Top 10 primary diagnosis categories between the SNP and the Non-SNP populations than in previous years. However, standardized Per Thousand Members Per Year (PTMPY) rates continued to be much higher for the SNP population compared to the Non-SNP population.

Among all SNP age groups and the Non-SNP Medicare population, members tended to be admitted to a hospital for: Acute and Unspecified Renal Failure, Respiratory Failure Insufficiency Arrest and Cardiac Dysrhythmias. Less common though still prevalent in the Inpatient setting are Chronic Renal Failure and Other Lower Respiratory Disease. SNP members, rather than Non-SNP Medicare members, tended to be admitted for Chronic Renal Failure, Coronary Atherosclerosis and Other Heart Disease and Skin and Subcutaneous Tissue Infections. The type of diabetes that is with complications tended to appear more in hospitalized SNP members than in non-SNP members.

The Outpatient setting was where the most similarities were found. Five of the Top 10 disease categories in the Outpatient setting were common among all SNP age groups and the Non-SNP Medicare population. They were: Spondylosis, Diabetes Mellitus with Complications, Diabetes Mellitus without Complication, Essential Hypertension and Other Non-traumatic Joint Disorders. Other Nutritional Endocrine and Metabolic Disorders were more likely to be prevalent in SNP, rather than in non-SNP members.

In the Emergency setting, three of the Top 10 disease categories were common among all SNP age groups and Non-SNP Medicare. Members in all groups tended to go to the emergency room for Diabetes Mellitus (both with and without Complications), Spondylosis and Other Connective Tissue Disease.

Differences were more pronounced when the SNP population was stratified by age group. Cardiac Dysrhythmias and Acute Cerebrovascular Disease were more likely to be found in SNP members 65 and older. In contrast, Chronic Ulcer of Skin, Open Wounds of Head, Neck and

Trunk, Diabetes Mellitus with Complications and Cardiac Arrest and Ventricular Fibrillation appeared more in members 49 and younger than in older members.

In the Outpatient setting, Cardiac Dysrhythmias were more likely to be found in SNP members 65 and above. Coronary Atherosclerosis and Chronic Renal Failure were also prevalent, albeit more in members 50 and older. Complications with Diabetes Mellitus were prevalent with both SNP and non-SNP members. Other Nervous System Disorders were more likely to be found in SNP members under 65 years of age.

Members aged 50 and older were more likely to seek emergency treatment for Essential Hypertension and Disorders of Lipid Metabolism. Cardiac Dysrhythmias, Cataract and Chronic Renal Failure were more likely to be found in SNP members 65 and older. Members younger than 65 were more likely to go to the emergency room for Other Connective Tissue Disease, Other Non-traumatic Joint Disorders, Abdominal Pain and Osteoarthritis. Headache Including Migraine, Chronic Ulcer of Skin, Other Nervous System Disorders and Skin and Subcutaneous Tissue Infections were more common reasons for members aged 49 years old and younger to seek treatment in the Emergency Room.

There was a greater correlation between the Non-SNP Medicare population and the 65-and-over SNP group than with the younger SNP age ranges in all settings. For example, in the Inpatient and Emergency settings, these two groups had eight of the top ten diagnoses in common while the age groups under 65 had less.

The Top 10 SNP inpatient and outpatient behavioral health diagnoses fell under the broad categories of Schizoaffective Disorders, Bipolar Disorders, Major Depressive Disorders, Psychosis, and Alcohol Dependence.

From January 1 through December 31, 2015, roughly 39.3% of the SNP population (3,008 / 7,652) had a mental health diagnosis present in Health Net medical claims and encounters, and of these, 12.7% (382 / 3,008) had corresponding claims in Managed Health Network (MHN) databases. Note that these were oftentimes not the primary diagnoses in the medical claims/encounter data.

Fourteen of the Top 20 drugs utilized by the SNP population regardless of age were also in the Top 20 most utilized drugs in the Non-SNP Medicare population. However, utilization was much higher in the SNP population than in the rest of the Medicare population. A review of the Average Days' Supply of the Top 20 drugs revealed that the medication duration for both SNP and Non-SNP Medicare members appeared longest for Diabetic Therapy, Antihypertensive Therapy Agents and Antihyperlipidemics. The shortest duration was for Analgesic, Anti-inflammatory or Antipyretic – Non-Narcotic.

The utilization pattern of the SNP 65-and-over age group most closely resembled that of the Non-SNP Medicare population, with 18 out of the Top 20 drugs being the same for both. The patterns started to diverge in the 50-to-64 age range, but the most noticeable differences were

found in the under-50 group. The utilization pattern of the 50-to-64 age group more closely paralleled that of the under-50 group more than any other group, having 16 of the Top 20 most utilized drugs in common.

Antipsychotics, one of the Top 20 most-utilized drugs in members under 64, were not prominent in the Non-SNP Medicare population. Antipsychotic medication had a particularly high per capita utilization in the 49-and-under age range. It is ranked 17th in the 50-to-64 range (42.9 dose days per member) but rose to 5th in the under-50 group (104.4 dose days per member).

Drugs with greater utilization for members aged 65 and over but whose utilization was not as pronounced in members under 65 were Platelet Aggregation Inhibitors and Combinations, Anticoagulants, Prostatic Hypertrophy Agents, Ophthalmic – Intraocular Pressure Reducing, Minerals and Electrolytes, Calcium and Bone Metabolism Regulators and Hyperuricemia Therapy.

Calcium Channel Blockers/Combinations were drugs used more by members aged 50 and older. The dose days per member tended to increase for these drugs as members get older. The 50 and over age groups, both in the SNP and the Non-SNP Medicare populations tended to have Diabetic Therapy, Antihypertensive Therapy Agents and Antihyperlipidemics in the Top 5 most-utilized drug categories.

Drug with greater utilization for members aged 49 and under but have lower utilization in members older than 49 were Antivirals, Antiparkinson Therapy, Nasal Preparations and Antibacterial Agents.

As for the similarities, the most utilized drug categories in all SNP and Non-SNP Medicare groups were Diabetic Therapy, Antihypertensive Therapy Agents, Antihyperlipidemics, Beta Adrenergic Blockers, Diuretics, Antidepressants, peptic Ulcer Therapy, Thyroid Therapy, Analgesics-Narcotic, Anticonvulsants and Asthma/COPD Therapy Agents.

MOC 1.A.4 Define the unique characteristics of the SNP population served.

The specific SNP type will be: Severe and Disabling Chronic Disease SNP for CHF and diabetes in Maricopa and Pinal counties. Please see MOC 1.A.3 for disease incidence and prevalence including behavioral health disorders.

The purpose of targeting these populations is to demonstrate that an improved Model of Care emphasizing coordination of services can improve outcomes and balance utilization for members with CHF and diabetes. SNP members with CHF are at risk for complications such as impaired kidney function, pulmonary congestion, weakness, arrhythmias, angina, pedal edema and heart attacks. SNP members with diabetes are at risk for complications such as cardiovascular disease, lower limb amputations, infections, kidney failure, non-healing wounds, hypertension, neuropathies and eyesight loss. In addition, members with one or more of these

chronic conditions and accompanying side-effects may require complex medication regimens to treat symptoms and avoid complications. The SNP population may also incur a loss of independence and cognitive decline especially when CHF and diabetes are not well-managed. Many have co-morbid conditions that further complicate the clinical course of their illness. They see multiple specialists and may have frequent emergency and inpatient stays which further contribute to coordination of care issues. Members identified at risk for chronic co-morbid diseases including coronary artery disease, heart failure, diabetes, asthma and COPD are referred to a Disease Management program for additional support. Based on clinical trends, tailored quality improvement interventions and services are designed to address limitations and barriers and respond to complex health care needs of these at-risk members.

According to the 2015 HN HRA, 48% of Allwell CHF/Diabetes Medicare (HMO SNP) members reported that pain regularly interfered with performing daily activities with an average pain score rating of 6.3 out of 10. However, only about 53% of members reported effective pain control. Also, 23% of Allwell CHF/Diabetes Medicare (HMO SNP) members indicated that they were bothered by emotional problems (such as feeling anxious, depressed, or irritable) in the past month.

Overall, problems and co-morbidities identified through the HRA suggest that Allwell CHF/Diabetes Medicare (HMO SNP) members are less mobile or independent with 32% having difficulty walking and 26% reporting a fall in the past 12 months. The majority appear to have the resources they need to buy food, although 30% reporting difficulty affording food.

1.B SUBPOPULATION-MOST VULNERABLE BENEFICIARIES

MOC 1.B.1 Define and identify the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries.

Vulnerable populations are identified in order to direct resources towards the members with the greatest need for case management services. Multiple methods are used to identify these vulnerable groups including initial stratification, HRA data, self-referral and Advanced Analytic models. Examples of these populations include but are not limited to:

Frail – may include the super elderly (> 85 years) and/or with diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty

Disabled – members who are unable to perform key functional activities independently such as ambulation, eating or toileting, or who have suffered an amputation and/or blindness due to their diabetes or circulatory impairment

Dementia – members at risk due to moderate/severe memory loss or forgetfulness

ESRD post-enrollment – members with complex medical treatment plan for kidney failure

End-of-Life – members with terminal diagnosis such as end-stage cancers, heart or lung disease

Complex and multiple chronic conditions – members with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems

To identify the most vulnerable population within the SNP, the member's initial stratification is automated for members and based on criteria combining the Risk Adjustment Factor and Hierarchical Condition Categories (RAF/HCC) when available. The stratification level assignment process allows members to move between stratification levels to meet changing levels of need across the care continuum. The goal of automated stratification is to initially categorize members in the correct level of acuity. Definitive categorization occurs when the clinical assessment is conducted by Case Managers. Upon member status changes and at least annually, stratification could be revised based on the determination of the Case Manager.

The initial stratification occurs within 30 days after member enrollment. If enrollment is retro-active, initial stratification will occur within 30 days after enrollment notification is received. The member can be stratified with only one data source if others are not available. The initial automated stratification is done once and members are assigned to the responsible case management group.

Once member stratification is received, the Health Net Case Manager conducts a telephonic clinical assessment and validates the assigned level. The stratification is determined across three dimensions: medical, psychosocial, and cognitive/functional. If stratification levels are revised based on the assessment, it is documented in the medical management system.

In addition, authorizations, claims, encounter and pharmacy data for non-delegated members who are not already categorized as high risk are assessed on a weekly basis using the Advanced Analytic Models to identify cases where reassessment is warranted based on a change in the member's health status. The models use sophisticated algorithms and modeling approaches to identify members who have had a change in health status putting them at increased risk. The scores and ranking of members who meet these criteria are communicated to the case management department to perform outreach and assessment and provide interventions designed to mitigate risk factors and improve health.

Specialty Services and Benefits

In addition to a coordinated care model, Health Net offers SNP members a number of specialty services and benefits designed to meet their additional and unique healthcare needs. These benefits vary by region and SNP plan and the specific Explanation of Coverage should be referenced each year for exact details.

- **Transportation Services:** Health Net provides transportation services to Allwell CHF/Diabetes Medicare (HMO SNP) members as part of their core supplemental benefits. The transportation benefit includes 8 one-way trips per year, limited to the 30 mile radius. Transportation requests over the 30 mile radius will be authorized on a case

by case basis. Members are provided with the benefit and contact information for transportation services upon enrollment so they can access services directly. The member can bring a caretaker or family member for no charge. Transportation vehicle will be based on the location and nature of the appointment, when the request for transport was requested, and the availability of transportation resources. Members may ask the driver to stop at a pharmacy for prescription pick-up after a physician visit, and the stop will not count as an additional trip. Moreover, convenient curb-to-curb or door-to-door assistance is offered depending upon the member's need. The expected outcome is that provision of transportation services will promote member access to medical services and compliance with the medical goals of the Care Plan.

- **Vision/Dental Services:** Where applicable, members are provided with vision and dental benefits, provider directories and contact information for dental and vision services upon enrollment so they can access these services directly. The member's Case Manager will also educate members about these benefits and encourage them to obtain regular dental and vision care. The expected outcome is that members will have improved oral health, prevention or early detection of dental and visual complications and access to eyewear as needed. Good oral care has been linked to general medical health.
 - **Vision Benefit:** Allwell CHF/Diabetes SNP members have core supplemental vision benefits. The vision benefit includes an annual routine eye exam and eyewear allowance for frames and lenses or contact lenses every two years. This is especially important for diabetics who are at greater risk of infection and vision loss.
 - **Dental Benefit:** Allwell CHF/Diabetes SNP members have dental benefits included as part of their medical benefit. Additional preventive/comprehensive dental benefits are available to members for purchase as an optional supplemental benefit. Dental can range from diagnostic x-rays, preventive cleaning and services, restorative amalgam dental treatments and discounts for other services to a comprehensive dental benefit.
- **Medication Therapy Management (MTM):** All SNP members are enrolled in the MTM program with quarterly medication reviews by a pharmacist. The review looks for evidence of noncompliance, gaps in care, duplication or potential for adverse reactions and the member, physician and HN Case Manager receive the results of the review when problems are identified in addition to information on how to speak with a pharmacist directly. This communication among the team members facilitates follow-up with the member regarding medication issues. The pharmacy reviews will be provided automatically and the member is provided with the contact information for the pharmacist to access additional medication information, if desired. The expected outcome is increased knowledge of their medication profile, improved compliance, and decreases in gaps in care, duplication of medications and adverse reactions.

- **Disease Management:** Allwell CHF/Diabetes SNP members have access to a health care professional for education and counseling regarding health concerns and biometric monitoring when indicated. The focus is on members with chronic disease such as diabetes, chronic heart failure, COPD and asthma to improve disease management and decrease unplanned admissions. In addition to providing educational materials and educating the member how to manage their disease process, there is access to interactive programs on the member portal regarding smoking cessation, increasing physical activity and weight management and a comprehensive library of health information. Care gap reminders are also distributed for gaps in care such as preventive screening and medication adherence. Members are provided with education and contact information about how to access disease management services upon enrollment. The member's Case Manager and providers can also refer members to disease management as indicated. The expected outcome is for members to have improved knowledge and management of their disease process resulting in a decrease in complications and utilization and improved quality of life. In-home biometric monitoring is available to qualified members. In-home biometric monitoring is available to qualified members.
- **Chronic Disease specific:** Depending on the region and specific SNP plan, members in Chronic Disease SNPs may have access to such benefits as zero or lower costs for diabetic monitoring supplies, diabetes self-management training, Medicare covered routine or intensive cardiac rehab, supplemental podiatry visits, oxygen or covered pulmonary rehab services. Additionally, select cardiovascular and diabetic drugs are made available to SNP members for zero dollars out-of-pocket. Add-on benefits are re-evaluated annually to meet member needs.
- **Case Management for Special Needs:** All SNP members are enrolled in case management. In addition, for a small subset of members with conditions such as ESRD, catastrophic or end-of-life situations, members may be enrolled in more specialized case management programs which include home visits. The member's Case Manager or provider will refer the member for the services.
- **Social Workers and/or Case Managers:** County-specific research is conducted to identify and connect members with additional resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps, financial assistance, support groups, home delivered groceries and meals, in-home supportive services, transportation, etc.
- In addition, SNP members may receive the following interventions as indicated by their individualized Care Plan:
 - HRA and initial assessment done at least annually

- Condition specific assessment and condition detail may be performed at least quarterly for members with any applicable HCC condition (all conditions assessed) depending on member's acuity.
- Chronic care guidelines utilized for condition specific care plan and interventions, as appropriate
- If available, utilize internally developed evidence based conditions specific to case management process guidelines, such as Diabetes, COPD, CHF, and CAD
- Coordination of multiple services, such as home health, PT, OT, wound care, DME, specialty visits, etc. (5+)
- Coordination of care with multiple external entities (i.e. Department of Social Services, Medicaid, etc.)
- Referral for disease management
- Surveillance for potential status changes such as ER visits, hospitalizations, claim data

MOC 1.B.2 Explain how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries.

Age – As of December 31, 2015, the HNAZ SNP average age was 71 years. The older a member is, the more likely they are to have degenerative diseases such as failing vision, hearing, impaired cognition, changes in kidney and liver function and loss of mobility. All of these can impact their ability to understand and manage their disease process, follow a healthy exercise routine and metabolize medications and puts them at greater risk of adverse drug reactions and falls and injuries.

Gender – As of 2015, the Allwell CHF/Diabetes Medicare (HMO SNP) population was comprised of 48% males and 52% females. In addition to routine screening for chronic diseases such as hypertension, coronary artery disease and diabetes, men require regular screening for disorders of the prostate. It is important to women's health that they receive regular screening for breast and cervical cancer and osteoporosis in particular. Research has also identified that women are less likely to obtain the necessary screening for cardiovascular disease than men.

Ethnicity – Self-reported ethnicity information gathered from the 2016 CAHPS® for HN Arizona Medicare, inclusive of the Allwell CHF/Diabetes Medicare (HMO SNP) population, revealed that respondents were 93% white and 5% African American. The response counts for other ethnicities (American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islanders) were suppressed for 2016 reporting year CAHPS results. Of the aforementioned ethnicities, 23% of members designated themselves as Hispanic or Latino. Arizona has a large immigrant population of Hispanics. From the "Racial and Ethnic Disparities in Health Care in Medicare Advantage" report released in 2016 by the CMS Office of Minority Health, some health disparities exist for Black and Hispanic populations. Utilizing CAHPS/HEDIS data collected in

2014, the Office identified that Black and Hispanic populations had significantly lower results compared to Whites for some access, preventive care and health outcomes. For access to care, these included getting needed care, including from specialists, getting appointments and care quickly and getting prescription drugs. Significantly lower rates for preventive care were observed for annual flu vaccine and colorectal cancer screening. Important health outcome rates such as control of blood sugar and blood pressure were also lower, especially for the Black population.

Language barriers – For non-English speakers, language can be a communication road block and have a negative impact on quality care and health outcomes. Responses gathered from the 2015 HN HRA revealed that English was the primary language for 91.1% of Arizona Allwell CHF/Diabetes Medicare (HMO SNP) members, followed by Spanish (7.8%), and Other (0.9%). Language barriers are addressed with ongoing action plans that include distribution and utilization of a cultural and linguistic provider toolkit and continued provision of a comprehensive Language Assistance Program. Health Net provides required language and interpreter services to meet member needs.

Health Literacy – Self-reported member information gathered from the 2016 HNAZ Medicare CAHPS®, inclusive of the SNP population, revealed that 55% reported a high school education or less and 45% had some college education or higher. The 2015 HN Allwell CHF/Diabetes Medicare (HMO SNP) HRA data indicated that only 96% of members can read in their own language. However, research has shown that even college educated persons can have very low health literacy. Low health literacy can impact the ability of members to understand and follow the instructions provided to manage their conditions. Easy to understand language and communication is promoted in Health Net documents.

Socioeconomic status – Not being able to afford the essentials, such as food, clothing, transportation, and housing creates a social deficit and can lead to behavioral health problems such as depression. Not being able to purchase fresh fruits and vegetables due to price or mobility issues and buying high caloric and high sodium processed foods instead can result in poor control of CHF and diabetes. Low income members with concerns about additional costs for healthcare visits, medications or testing supplies may miss medical appointments or preventive care.

Other – The 2015 HN Allwell CHF/Diabetes SNP HRA data indicated that 32% of SNP members reported that they cannot shop for their own food and 34% of members reported that they cannot cook their food. About 22% relied on friends as the main mode of transportation; 1% used the services of a medical specialty van, and 2% used public transportation. As a result, 47% of members reported that they were unable to participate in social activities on a regular basis. These factors can have an impact on member's physical and emotional health and ability to follow their doctor's treatment plan. Members who live alone may require assistance with additional long-term care supports and services such as delivered meals, help with household chores and identification of social supports in the community. Members without transportation may have difficulty making doctor's appointments for preventive and routine care.

MOC 1.B.3 Illustrate a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.

The focus of Health Net's Arizona Allwell CHF/Diabetes Medicare (HMO SNP) for CHF and diabetes will be on coordinated care, treatment and condition-specific education to improve disease management and prevent readmissions and transitions of care. The fundamental structure of the SNP Model of Care such as Case Management for all members (especially the most vulnerable SNP population), Health Risk Assessments, Individualized Care Plans, management of Transitions of Care, Interdisciplinary Care Teams and add-on benefits like Disease Management and Medication Therapy Management will assist high-risk members with CHF and diabetes to navigate complex healthcare systems and promote improved self-management of their chronic conditions.

The special services and supports provided to address the demographic characteristics described in MOC 1.B.2 will include:

Age – Case Managers are provided with additional training and regular inservices that improve their skills at working with the elderly, disabled and chronic diseases of the elderly including those with sensory and cognitive impairment such as dementia, diabetes, heart disease and bariatric surgery. They also assess members for safety issues such as fall risk, medication safety risk and ability to manage their care needs. Specialized services for older and disabled members include making core documents and other materials available in alternative formats to meet the needs of members with visual impairment. A 711 relay number, office interpretation services, and Speech-to-Text interpreting meet the needs of members with hearing impairment.

Gender – Case Managers promote preventive screening for male and female members. There are also quality improvement programs to identify elderly women with fractures so appropriate treatment for osteoporosis can be provided if indicated. HN also monitors if members have obtained preventive care or screenings for breast, colorectal and flu vaccine and provides reminders when care gaps are identified.

Ethnicity – To address health disparities for some populations, the Disease Management and Health Education programs develop educational material and interactive programs available in English and Spanish on chronic diseases and conditions such as fall prevention, osteoporosis, diabetes, depression, high blood pressure, weight management, preventive screening and smoking cessation. HN Case Managers and if indicated Disease Management reach out to members, including Hispanics and African Americans identified with care gaps to encourage regular follow-up care with their doctors. Bi-lingual Case Managers and educational materials in English and Spanish are made available as much as possible. The HN Disease Management program also has educational material on chronic disease and interactive programs in English and Spanish to help members attain their ideal weight. Members can also be referred for bariatric surgery if it is indicated.

Language barriers – Health Net has an active language assistance program that is available to members and/or caregivers and Health Net associates and contracted providers when the member needs assistance. Core documents and other materials are available in English and Spanish and can be translated upon request. Core materials are also available in alternative formats. Interpreter services and oral translation services to communicate with the plan are offered to all limited English proficient (LEP) members. Interpreter services including sign language services will be available at all medical points of contact at no cost to the provider for all Health Net LEP members. In addition, population assessments are conducted to monitor language needs, quality standards for timely delivery, and quality of services and oversight to ensure effective service.

Health Literacy – Although the majority of HN Allwell CHF/Diabetes SNP members report they can read in their own language, they may still have health literacy issues. They may not have the skills to correctly follow directions on prescription bottles, understand medication and disease literature or read other health materials that may be at a high grade level. Health Net launched the Clear and Simple initiative in 2010 in an effort to address health literacy issues by promoting the use of plain language. At its most basic, *health literacy* is our ability to gather, process and understand health information in order to make sound health care decisions. Using plain language in communication with members improves health literacy and an 8th grade reading level or lower is promoted.

Socioeconomic status – HN has designed special benefits for the Allwell CHF/Diabetes SNP plan to meet the needs of seniors who are on a fixed income. These can include zero cost or lower costs for select cardiovascular and diabetic drugs, diabetic testing supplies, additional routine podiatry visits, and free medical transportation.

Other – To meet the needs of members with CHF and diabetes, Health Net has additional disease management services as described in SNP MOC 1.B.1 under specialty services.

MOC 1.B.4 Identify and describe established relationships with partners in the community to provide needed resources.

HN Case Managers and Social Worker's maintain a good working knowledge of community resources in the member's geographic location and provide the member with coordination of services to assist them with their needs. This includes establishing relationships with the providers of services. Social Workers and/or Case Managers conduct county-specific research to identify and connect members with the resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps to financial assistance, support groups and in-home supportive services.

Health Net collaborates with its participating provider groups in order to enhance member care. Actionable data is shared on a regular basis with providers on care gaps, member pharmacy issues, results of member surveys and other data for providers to follow-up and

perform outreach with members. Health Net also provides clinical practice guidelines and member educational tools around CHF and diabetes to provider partners for optimum disease management. The online provider portal provides access to member level data on the HRA, authorizations, claims and other information.

The Disease Management (DM) program provides a health management solution that improves the health and quality of life of members, while controlling health-related costs. Through personalized interventions, bio-metric monitoring, and contemporary behavior change methodologies, experienced clinical staff assist individuals at-risk and those diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Health Net's Disease Management programs include: Heart Failure, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, and Asthma. The programs are designed to reduce health risks, increase member compliance with the plan of care and prescribed medications, and ensure appropriate testing in accordance with national clinical standards.

Health Net partnered with the Alzheimer's Association in 2014 to provide training for Case Managers working with members diagnosed with dementia and other related disorders. Health Net Case Managers received an eight-hour training in June and 25 case managers from HN delegated medical groups or participating provider groups (PPGs) in Los Angeles received the same training in December. A case consultant is available to care managers for up to 6 months after training has been completed to provide consultation and to participate in care conferences. The first year of the training is a pilot with modifications occurring in the 2nd and 3rd years. There is also a Caregiver Education component for families caring for relatives with dementia. In September 2016, the Alzheimer's Association collaborated with Health Net and its delegate case managers to implement the Dementia Specialist Program.

Health Net's partnership with the American Cancer Society (ACS) is aimed at improving the health of our members and activating our communities to join the fight against cancer. Health Net leverages ACS education materials, branding, and best practices for member outreach to increase preventive care including breast cancer and colon cancer screenings. In addition, Health Net has joined an initiative sponsored by the National Colorectal Cancer Round Table and American Cancer Society to improve colorectal cancer screening rates to 80% by 2018. With over 400 collaborating organizations, the initiative builds momentum and awareness in the healthcare community to implement programs that allow for easier screening.

Health Net supports the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients' efforts to improve quality, safety and affordability of health care. The Partnership for Patients focuses on making hospital care safer, more reliable and less costly through the achievement of (1) reducing hospital-acquired conditions (HACs) by 20% and (2) reducing 30-day hospital readmissions by 12%. In order to achieve these goals, the Partnership for Patients has replaced and expanded the Hospital Engagement Networks (HENs) with a new similar initiative called Hospital Improvement and Innovation Networks (HIINs), which includes hospital

associations and health systems. Health Net has pledged to work towards attaining the goals of this initiative and most Health Net contracting hospitals and respective providers are already collaborating with HENs to share best practices, report and share quality data, and identify effective strategies to reduce HACs and readmissions.

MOC 2: CARE COORDINATION

MOC 2.A SNP STAFF STRUCTURE

MOC 2.A.1 Describe the administrative staff's roles and responsibilities, including oversight functions.

Health Net of Arizona, Inc. is a wholly owned subsidiary of Health Net, Inc. Centene Corporation is the parent company of Health Net, Inc.; within the corporate structure, the Corporate Executive Vice President oversees the Corporate Medicare CEO. The Medicare CEO oversees the Corporate Director of Compliance and Regulatory Affairs and at the Plan level, the Health Net Medicare Product Lead, the Senior Vice President of Government Relations and Compliance. Health Net has a dedicated Medicare Sales Team, as well as dedicated Enrollment and Marketing staff. The Medicare Medical Management staff is a separate multidisciplinary team receiving support from other plan departments such as Quality Improvement/Management, Pharmacy, Member Services, Provider Services and Claims.

Centene Corporation provides executive and operational support to Health Net and offers specialty affiliates and contracted vendors that serve the Health Net of Arizona (HNAZ) Allwell CHF/Diabetes SNP C-SNP plan. These include affiliates who may participate in the care of Medicare members such as: *Envolve – Nurtur* for Disease Management services; *Envolve – US Script* for Pharmacy Benefit Management; *Envolve – NurseWise*, a 24 hour Nurse help-line; and *Managed Health Network, Inc. (MHN)*, a part of *Envolve People Care*.

To ensure a seamless operational integration of services, Health Net utilizes existing employed and contracted staff to manage the administrative services noted throughout the Model of Care, in addition to hiring staff as needed to supplement any additional functions.

Currently, the Health Net Quality Improvement Committee (HNQIC) has oversight of the QI Program including SNP and has delegated authority from the Health Net Boards of Directors. Please see complete information in SNP MOC 4.A.3. In addition, the administrative functions and the corresponding staff structure to implement the SNP program is summarized in Table 2.1. See the job description summaries in MOC 2.A.3 and organizational charts at end of this document for more details.

Administrative Functions

Table 2.1

Role/Responsibilities	Personnel
Process enrollment	Eligibility Representatives
Verify eligibility for special needs plan	Eligibility Representatives
Complete Pre-Screening tool for C-SNP	Eligibility Representatives
Process Claims	Claims Adjusters
Process and facilitate resolution of grievances and provider complaints	Grievance and Appeals, Member Service Associates
Communicate plan information	Sales and Marketing, Brokers, Member Service Associates
Collect, analyze, report, and act on performance and health outcomes data	HEDIS® Program Managers and Analysts, Quality Improvement Specialists
Conduct Quality Improvement Program	Quality Improvement Specialists and Managers
Review and analyze utilization data	Medical Management, Quality Improvement, Research and Analysis Specialists
Survey members and providers	Quality Improvement, MHN
Report to CMS and state regulators (as requested)	Quality Improvement, Compliance, Product Development

The administrative staff functions including oversight and the corresponding staff structure to implement the SNP program is summarized in Table 2.2. See the job description summaries in MOC 2.A.3 and organizational charts at end of this document for more details.

Administrative Oversight

Table 2.2

Role/Responsibilities	Personnel
Monitor care management implementation	Director Care Management, Providers
Assure licensure and competency	Director Credentialing
Assure statutory/regulatory compliance	Director Compliance
Monitor contractual services	Director Provider Network
Review pharmacy claims for appropriateness	Director Pharmacy Services
Maintenance and sharing of healthcare records	Director Care Management, Providers
Assure HIPAA Compliance	Privacy Official, All
Maintenance of paper based and/or electronic information systems	Director Information Management
Evaluate effectiveness of Model of Care	Director/ Manager Quality Improvement
Implement and comply with required claims procedures for SNP	Director Claims, VP Claims Operations

Ensure compliance with QI program for the SNP Model of Care	Director /VP Quality Improvement Program
Compliance with HEDIS®, CAHPS® and HOS requirements	Director HEDIS® Management
Compliance with network adequacy	VP Medical and Network Management, Chief Provider Contracting Officer
Compliance with SNP eligibility requirements	VP Membership Accounting and Eligibility
Maintain integrated communication systems for the SNP program	VP Customer Contact Center, Chief Customer Services Officer, Chief Information Officer
Ensure compliance with all CMS Requirements including SNP	VP and Chief Operating Officer, CEO and President

MOC 2.A.2 Describe the clinical staff's roles and responsibilities, including oversight functions.

Health Net has an internal integrated care team comprised of clinical and non-clinical staff with knowledge of and experience working with SNP members. The team consists of employed and contracted staff responsible for performing clinical functions. Clinical leadership has oversight of the Medical Management (CM, UM, DM). Our internal integrated care team includes licensed physicians, registered nurses, licensed social workers, pharmacists and other healthcare professionals. Members of these disciplines may also be on the Interdisciplinary Care Team (ICT), which is involved in the planning, provision and monitoring of the member's care and services.

The clinical staff roles and responsibilities and the corresponding staff structure to implement the SNP program is summarized in Tables 2.3. See the job description summaries in MOC 2.A.3 and organizational charts at end of this document for more details.

Clinical Functions

Table 2.3

Role/Responsibilities	Personnel
Coordinate care management	Medical/Behavioral Case Managers, Providers
Advocate, inform, and educate beneficiaries on services and benefits	Medical/Behavioral Case Managers, Customer Services Representatives, Providers
Identify and facilitate access to community resources	Medical/Behavioral Case Managers, Providers
Triage care needs	Medical/Behavioral Case Managers, Providers
Facilitate Health Risk Assessment (HRA)	Medical/Behavioral Case Managers, Customer Services Representatives, Survey

	vendor
Evaluate and analyze responses to HRA and assign members according to risk level	Data Analysis, Medical/Behavioral Case Managers
Facilitate implementation of Care Plan	Medical/Behavioral Case Managers, Providers
Educate members in disease and behavioral health self-management	Medical/Behavioral Case Managers, Disease Management, Providers
Conduct review of members admitted to inpatient, manage transition and facilitate discharge planning	Medical/Behavioral Case Managers, Concurrent Review, Providers
Consult on pharmacy issues	Pharmacists
Authorize or facilitate access to services	Providers, Pre-authorization, Concurrent Review, Medical/Behavioral Case Managers
Obtain consultation and diagnostic reports	Case Managers, Pre-authorization, Concurrent review, Medical/Behavioral Case Managers, Providers
Facilitate translation services	Cultural and Linguistics, Customer Services Representatives, Medical/Behavioral Case Managers, Providers
Facilitate additional benefits such as transportation, dental, vision	Medical/Behavioral Case Managers, Providers, Managers Product Development
Provide Medical and Mental Health Care	Medical/Behavioral Providers
Counsel on Substance Abuse and rehab strategies	Behavioral Providers, Behavioral Case Managers, Social Workers
Coordinate Social Services	Medical/Behavioral Case Managers, Social Workers, Providers
Conduct medication reviews	Pharmacists, Providers

The clinical staff roles and responsibilities including oversight functions and the corresponding staff structure to implement the SNP program is summarized in Tables 2.4. See the job description summaries in MOC 2.A.3 and organizational charts at end of this document for more details.

Clinical Oversight

Table 2.4

Role/Responsibilities	Personnel
Monitor interdisciplinary care team	Director Care Management, Providers, MHN Director of Clinical Services, Director of Delegation Oversight
Assure timely and appropriate delivery of services	Director Care Management, Providers, Director of Delegation Oversight, MHN

	Director of Clinical Services
Monitors providers for use of clinical practice guidelines	Director Quality Improvement, Director Delegation Oversight
Coordinate and monitor care for seamless transitions across settings and providers	Director Health Care Services, Director Care Management, Providers, MHN Director of Clinical Services
Implementation of SNP Model of Care	VP Clinical Services
Implementation SNP Medication Therapy Management Program	VP Pharmacy
Monitor network providers compliance with SNP Model of Care	Medical Directors, Director of Delegation Oversight
Monitor compliance SNP Model of Care requirements	Director of Compliance, Clinical Operations Officer, VP and Chief Medical Director, Chief Medical Officer
Ensure compliance with all CMS Requirements including SNP	Healthcare Services Officer and President Pharmacy, VP and Chief Operating Officer, CEO and President, VP and Compliance Officer

MOC 2.A.3 Describe how staff responsibilities coordinate with the job title.

Health Net develops, reviews, approves and maintains role based job descriptions for every employee. These job descriptions create the foundation for all training, supervision, monitoring and feedback regarding employee performance.

Please see the summaries of the specific job descriptions below for a full description of the administrative and clinical staff roles and how their responsibilities coordinate with their job title including licensing requirements. Changes in staff are made when it is required to accommodate operational changes. For example, there is a ratio of 1 Case Manager per 150 members and new staff are hired to accommodate increase in SNP membership. Organization charts are also provided.

Job Description Responsibilities/Qualifications of Medical Director:

The Medical Director works actively to implement and administer medical policies, disease and medical care management programs, integrate physician services, quality assurance, appeals and grievances, and regulatory compliance programs with medical service and delivery systems to ensure the best possible quality health care for Health Net members. Assists by providing input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. Participates actively on quality improvement committees and programs to obtain and ensure continued accreditation with regulatory agencies.

Responsibilities: Leads the effective operational management of assigned departments or functions with an emphasis on execution, outcomes, continual improvement and performance enhancement. As a representative of the Health Net Plan, assists in maintaining relationships with key employer groups, physician groups, individual physicians, managed care organizations, and state medical associations and societies. Participates in quality improvement programs to assure that members receive timely, appropriate, and accessible health care. Provides ongoing compliance with standardized Health Net, Inc. systems, policies, programs, procedures, and workflows. Participates and supports communication, education, and maintenance of partnerships with contracted providers, provider physician groups and IPA's and may serve as the interface between Plan and providers. Responsible for recommending changes and enhancements to current managed care, prior authorization, concurrent review, case management, disability review guidelines and clinical criteria based on extensive knowledge of health care delivery systems, utilization methods, reimbursement methods and treatment protocols. May participate in business development, program development, and development of care integration models for increased care delivery efficiency and effectiveness. Participates in the administration of medical management programs to assure that network providers deliver and Plan members receive appropriate, high quality, cost effective care. Assures compliance with all regulatory, accreditation, and internal requirements and audits. Articulates Plan policies and procedures to providers and organizations and works to ensure effective implementation of policies and programs. May serve as a member on quality and/or care management programs and committees as directed. Investigates selected cases reported as deviating from accepted standards and takes appropriate actions. Actively interfaces with providers (hospitals, PPG's, IPA's) to improve health care outcomes, health care service utilization and costs. Analyzes member and population data to guide and manage program direction such as ensuring that members enroll in clinical programs indicated by their clinical need. Leads and/or supports resolution of member or provider grievances and appeals. Optimizes utilization of medical resources to maximize benefits for the member while supporting Health Net Plans and Health Net corporate initiatives. Actively supports Quality and Compliance to ensure that Health Net meets and exceeds medical management, regulatory, agency, and quality standards. Provides effective and active medical management leadership. Serves on quality and care management teams and committees. Performs all other duties as assigned.

Education: Graduate of an accredited medical school; Doctorate degree in Medicine. Board certification in an ABMS recognized specialty. Unrestricted active MD license in the State of practicing and credentialed by the health plan of employment.

Experience: Minimum five years medical practice after completing residency-training requirements for board eligibility. Minimum three years medical management experience in a managed care environment

Job Responsibilities/Qualifications of Director of Compliance:

The Director of Compliance is responsible for ensuring compliance with state and federal statutes and regulations for a state's health plans.

Responsibilities: Maintains compliance with state and federal statutes and regulations for health plans and insurers. Acts as liaison with appropriate governmental agencies. Monitors proposed legislation to assess potential financial and/or administrative impact. Serves as a resource to associates, government affairs, communications, corporate legal and actuarial departments regarding interpretation of laws and regulations. Coordinates the collection of information necessary to meet state and federal filing regulations applicable to health plans and insurers. Evaluates the company's operations and recommends changes where required to maintain compliance. Analyzes, researches and responds to complaints made to and inquiries from regulatory agencies. Leads the response to external audits, manages compliance department audits and coordinates with internal audit by other departments. Reviews documentation from other departments, to ensure accuracy and consistency with applicable statutes and regulations and contractual requirements of specified government purchasers. Monitors or creates training for new associates on regulatory and compliance issues. Manages and directs compliance department associates

Education: Bachelor's degree in health care, law, or business administration, or an equivalent degree in a related field required; Master's degree preferred

Experience: Demonstrated ability to interpret, analyze, apply and communicate policies, procedures, and regulations effectively. Excellent verbal and written communication skills. Strong analytical and problem solving skills. Capable of taking initiative. Project management and interpersonal skills. Ability to work with minimal supervision to accomplish multidisciplinary assignments. Ability to identify problems/issues and develop processes to rectify them.

Job Responsibilities/Qualifications of Senior Research Analyst:

The Senior Research Analyst defines, develops, processes and analyzes reports intended to meet regulatory needs. This position is responsible for population measurement, stratification, data analysis and reporting to support quality improvement initiatives. Using defined national standards, the Senior Research Analyst creates methods, processes, algorithms and programming required to extract data used to stratify populations and prepares reports using centralized and regional data sources as required.

Responsibilities: Develops baseline measurements and populations, and stratifies populations based on defined criteria using centralized and regional as well as internal and external data sources; supports standardized and ad hoc reporting. Reviews data set integrity and creates normative and comparative validation and control criteria and standards for key databases and data sets. Identifies issues related to data systems, data inputs and integrity. Implements short and long-term approach to data and/or reporting capability deficiencies. Validates and verifies accuracy of reports and other outputs. Develops standards and processes for analyzing data to identify clinical issues that may represent opportunities for improvement. Defines and develops methods for baseline measurements and works with staff to establish quantitative baseline goals. Develops measurement methods to assess initiative results and isolates the impact of interventions versus other variables. Compares goals to measured results and identifies reasons for variance. Documents data collection, manipulation methods, measures, results, data sources and other information needed for NCQA or regulatory agencies. Acts as a member of

national teams to define, continually review, and refine national standards in support of various initiatives for population identification and stratification, and data presentation and reporting. Monitors changes in industry standards for clinical analysis and integrates into Health Net processes. Acts as project lead to ensure planning, implementing, reporting, and presenting on various analytic projects related to health outcomes

Education: Bachelor's degree required. Master's degree in biostatistics, biometry, epidemiology or related field preferred

Experience: Minimum 4+ years healthcare experience or related experience in statistical analysis. Experience developing and presenting reports and presentations to the Medical Director, Executive- and Sr. VP-level audiences required. Experience with theoretical or applied healthcare research in program measurements. Demonstrated experience in applied statistics and population-based measurements. Knowledge of HEDIS®, NCQA, and other regulatory/industry reporting standards and methodologies is desired. Advanced skills using Microsoft Excel, Access, Word and analytic software. Strong working knowledge of SAS and SAS programming with a focus in generating statistics, populations, and reporting, and experience in applied programming in SAS, SQL or equivalent. Thorough understanding of major health care systems (claims, pharmacy, authorizations, membership) and issues; medical terminology and managed care. Strong presentation skills with ability to present analytic findings at professional workgroups and committee meetings. Ability to work collaboratively within a team environment and with internal and external customer groups, and act as team lead for specific assigned projects and responsibility areas. Demonstrated ability to manage multiple projects with minimal supervision and exceptional attention to detail.

Job Description Responsibilities/Qualifications of Case Managers:

The Case Manager/Care Coordinator is responsible for the coordination of services and cost effective management of health care resources to meet individual members' health care needs and promote positive health outcomes. Acts as a member advocate and a liaison between providers, members and HN to seamlessly integrate complex services. Case Management services are generally focused on members who fall into one or more high risk or high cost groups and require significant clinical judgment, independent analysis, critical-thinking, detailed knowledge of departmental procedures, clinical guidelines, community resources, contracting and community standards of care. Case Management includes assessment, coordination, planning, monitoring and evaluation of multiple environments. Acts as a resource for training, policy and regulatory and accreditation interpretation.

Education: One of the following required: Valid Registered Nurse, Licensed Practical/Vocational Nurse, Clinical Psychologist, Licensed Marriage & Family Therapist (LMFT), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker license. Case Management certification (CCM) preferred.

Experience: Minimum two years clinical experience preferred. Three to five years Case Management experience and/or Health Plan experience preferred.

Job Description Responsibilities/Qualifications of Concurrent Review Nurses:

The Concurrent Review/Care Manager performs advanced and complicated case review and first level determination approvals for members receiving care in an inpatient setting determining the appropriateness and medical necessity of continuing inpatient confinement including appropriate level of care, intensity of service, length of stay and place of service. Case reviews and determinations require considerable clinical judgment, independent analysis, critical-thinking skills, detailed knowledge of departmental procedures and clinical guidelines, and interaction with Medical Directors.

Reviews may be completed on-site at the facility and/or telephonically, and may be assigned based on geography, facility, provider group, product or other designation as determined appropriate. Performs discharge planning, care coordination, and authorization activities to assure appropriate post-hospital support and care. Acts as liaison between the beneficiary and the network provider and HN to utilize appropriate and cost effective medical resources. Acts as a resource for training, policy and regulatory/accreditation interpretation.

Education: Graduate of an accredited nursing program. Bachelor's degree preferred. Valid state RN license. UM/CM certification preferred.

Experience: Minimum two years acute inpatient clinical experience preferred. Three to five years managed care experience, including discharge planning, Case Management, Utilization Management, transplant or related experience and/or Health Plan experience preferred.

Job Description Responsibilities/Qualifications of Enrollment and Eligibility Associates:

The eligibility associate processes and maintains eligibility information for specialized and/or large group accounts. Acts as liaison for assigned groups/members and reconciles enrollment and processing. Provides mentoring and training to less experienced representatives. Reviews and processes enrollment documents submitted by employer groups. Troubleshoots escalated and/or complex eligibility issues for immediate resolution. Responds to all written and telephone eligibility inquiries from internal (e.g. Member Services, Sales, Underwriting, Appeals and Grievance, Compliance) and external (e.g. employer groups, members CMS, DHS) customers. Identifies membership discrepancies, eligibility issues, and group contract issues for resolution by Service Representatives. Provides and documents continuous follow-up on open issues. Tracks, reviews and manually processes submitted enrollment transactions. Reviews eligibility reports and identifies all changes to eligibility (additions, terminations, and/or contract changes) and processes all resulting transactions. Compiles data and prepares reports reflecting daily statistics on new incoming forms and pending forms for distribution within department and to management. Provides project support, new hire training and coordination of open enrollment processing as needed.

Education: High School Diploma required; Post high school course work in Business or Accounting helpful.

Experience: Three to four years membership eligibility experience preferred within HMO/Health care industry.

Job Description Responsibilities/Qualifications of Appeals and Grievances Specialists:

The Senior Appeals and Grievance Clinical Specialist performs advanced and complicated case review of the appropriateness of medical care and service provided to members requiring considerable clinical judgment, independent analysis, and detailed knowledge of managed health care, departmental procedures and clinical guidelines. Activities include case preparation, research and overturn determinations within established guidelines. The position identifies and communicates system issues that result in failure to provide appropriate care to members or failure to meet service expectations, and coordinates activities with quality management staff. Acts as a resource for training, policy and regulatory/accreditation interpretation.

Education: Graduate of an accredited nursing program. Bachelor's degree required. Master's degree preferred. Current Licensed Registered Nurse.

Experience: Minimum five years clinical experience required. Three to five years utilization management or quality management experience required. 2 years previous experience in appeals and grievance case work required.

Job Description Responsibilities/Qualifications of Member Service Associates:

The role of the Customer Service Representative is to respond to routine and escalated telephone inquiries with careful attention, courtesy and respect for our members, providers and employer groups to provide excellent customer service while providing information and clarification on multiple products. Always trying to achieve first call resolution, and document all inquiries in the system of record. Works to enhance relationships with Health Net's cross-functional business partners. Coordinates, processes, and documents PCP/PPG transfers utilizing appropriate protocols. Utilizes multiple internal and external systems for accessing member information. Processes material requests such as: provider directories, mail-order pharmacy information, and promotional items. Updates members' addresses and phone numbers in the system of record. Orders member identification cards, as needed. Facilitates the filing of Appeals and Grievances through accurate and timely collection of information.

Education: High School Diploma or equivalent

Experience: 1+ years of call center customer service experience required or 2+ years of customer service experience in health care or insurance environment. Bi-lingual is preferred. Good oral and interpersonal communication skills. Positive attitude. Ability to interact professionally with both internal and external contacts. Basic computer skills and familiarity with Windows PC applications. Established good listening and problem solving skills. Ability to multi-task in a face paced environment.

Job Description Responsibilities/Qualifications of Data Analysts Performing Initial Stratification:

The Health Economist is responsible for the development, testing, analysis, implementation and management of the technical interface of all systems and reports for provider profiling and disease management. The Health Economist will develop and coordinate the case management reporting initiatives in support of the medical management team, employer groups and vendors.

Responsibilities: Assists in the building of analytical/statistical models, develops databases, analyses costs and tracks utilization trends. Performs advanced statistical analysis, prepares action plans and recommendations. Prepares data for presentation to management. Acts as a technical resource. Provides analytical and statistical expertise focusing on provider profiling activities and case management programs. Oversees case management enrollment verification and medical cost reconciliation with vendors and auditors. Designs and develops standard, custom and ad hoc reports for business owners which require data modeling and programming in data base query tools. Provides support regarding statistical information and data to requesting departments, agencies and corporate subsidiaries. Develops graphic, narrative and other visual presentations to clarify and substantiate data specific to the case management programs. Analyzes and proposes system changes or enhancements to improve trending analysis for case management programs, health care cost reporting and medical management. Provides population based analysis to determine needs for future case management programs. Coordinates the exchange of information between profiling data and case management to identify opportunities for member health management. Reviews and verifies utilization and cost reports to ensure their accuracy and confirm that the correct controls and procedures for collecting and analyzing data are being followed. Assures report validity through analysis and ongoing audits as well as periodic review of Health Services systems configuration.

Education: Undergraduate degree required, Master's prepared candidate preferred.

Experience: Minimum five years' experience in an HMO or related business, preferably working with utilization reporting required. Experience with database query tools, database management and various PC based software applications.

MOC 2.A.4 Describe contingency plans used to address ongoing continuity of critical staff functions.

Health Net recognizes in the event of an "natural disaster", declared emergency or disaster, war, riot, civil insurrection, or any other similar event not within the control of Health Net, Health Net has responsibility to continue to directly provide services, or otherwise arrange for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met. This is detailed in *Policy/Procedure #FS617-213557 – Health Net Federal Disaster or Public Health Emergency*.

Health Net is also required to cover urgently needed services within the service area when, due to unusual and extraordinary circumstances such as complete or partial destruction of facilities, atomic explosion, or other release of nuclear energy, disability of significant Medical Group personnel, or other similar events, not within the control of Health Net, results in the facilities, or personnel of Health Net not being available to provide or arrange for services or benefits. Fire drills and emergency planning drills are conducted regularly and at least annually for Health Net facilities.

If administrative or executive staff is unable to fulfill their roles, resources are diverted among corporate or regional offices within the Health Net network.

In the event of an absent employee, clinical employees are cross-trained to ensure continuity of operations, which equates to staff members having one successor. Additionally, remote access is available to Health Net's applications for clinical staff if they cannot commute to the office due to a natural disaster or other impediments. Remote access consists of a web-based program on a secure network. Ultimately, remote access allows staff to continue services securely despite their physical location.

Regulatory Information:

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Health Plans are expected to:

- Cover benefits furnished at non-contracted facilities (note, Medicare Part A/B benefits must, be furnished at Medicare certified facilities per 42 CFR 422.204(b)(3))
- Waive in full, requirements for gatekeeper referrals where applicable
- Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility
- Make changes that benefit the enrollee effective immediately without the 30-day notification requirement per § 422.111(d)(3).

Health Net plans will resume normal operations no later than when the emergency or disaster is over as clarified by the agency or source that declared the disaster. If the disaster or emergency timeframe has not been closed 30 days from the initial declaration, and if CMS and or regulatory agency have not indicated an end date to the disaster or emergency, plans should resume normal operations 30 days from the initial declaration. If Health Net is not able to resume normal operations CMS and or regulatory agency reserves the right to assess each disaster or emergency on a case-by-case basis and issue further guidance supplementing or modifying the requirements in this policy.

During emergencies or disasters in which the Secretary has invoked his/her authority under Section 1135, Health Net plans must review information about the waiver posted on the

- a. Department of Health and Human Services (DHHS) website (<http://www.hhs.gov/>);
- b. Disaster Federal Register Notice Section on FEMA's website (<http://www.fema.gov/news/disasters.fema>);
- c. CMS web site (<http://www.cms.hhs.gov>)

MOC 2.A.5 Describe how the organization conducts initial and annual MOC training for its employed and contract staff.

Health Net requires that all employed and contracted staff undergo SNP MOC training within 90 days of hire, annually, and on an ad hoc basis when circumstances warrant (e.g., policy change, need for improvement, coaching). The Health Net Compliance Officer, in conjunction with the

VP Medical Management, are responsible for the oversight of the delivery of initial and annual web-based MOC training.

Additional mandatory training modules include information on:

- Compliance Program
- Fraud, Waste and Abuse
- Code of Conduct
- HIPAA
- Cultural Competency
- Conducting administrative activities necessary for the operation of the Part D benefit
- Medicare Marketing
- Marketing the prescription drug benefit to Medicare beneficiaries
- Medicare Member Eligibility
- Medicare Medical Management Training:
 - Medicare Overview Medical Management Operations
 - Medicare Utilization Management Process
 - Medicare Model Of Care
 - Medicare Guidance on Coverage Policy
 - Medicare Jimmo v. Sebelius
 - TruCare Training
 - InterQual Training
- Customer Service and Call Center Operations Standards
- Appeals and Grievance Process
- Administering the compliance program and operations, i.e., the Part D Officer and his/her staff
- Business Ethics and Conduct policy and other compliance related policies, procedures, standards

Case Management and Case Management Assistants Training

Case Management and Case Management Assistants receive, at time of hire and annually Medicare Boot Camp Training including, but not limited to the following:

- Case Management and Case Management Assistants policies and procedures and regulatory requirements
- Member-Centered Care Planning
- Case Managers/Case Management Assistants roles and responsibilities
- Motivational interviewing and readiness to change techniques
- Medicare Assessments
- Member Outreach
- Documentation
- ICP and ICT Processes
- Care Transitions
- Provider Relations
- Member Outcomes

- Case Management and Case Management Assistants (including appropriate documentation of tasks in TruCare)
- Utilization of Home and Community Based Services (HCBS) to support transitions back into the community, independent living and recovery
- Behavior management strategies
- Behavioral health 101
- De-escalation techniques
- Accessibility and accommodations for persons with disabilities

Training to Ensure Alignment of D-SNP and C-SNP Models of Care

CMs receive Medicare and Medicaid specific training that describes how the programs intertwine and their specific roles and responsibilities when a Member is enrolled in the SNP:

- Coordination and management of dual Members
- Specific characteristics of the population
- Services to meet specialized needs
- Engagement techniques such as motivational interviewing

In addition, training may be conducted to cover regional variances and/or specific indicators and/or needs of different areas of the state. Health Net measures effectiveness of education/training provided through audits and individual assessments. Trainers update materials as soon as new information and updated components become available.

Continuing education is provided to CM staff to support clinical competency as well as communication skills. The Cornerstone web learning is available for both required and optional topics, and lunch and learn opportunities are provided for CM staff.

Methods for Delivering Training

Training is provided using one or more of the following methods:

- Face-to-face training via a preceptor
- Peer shadowing
- Web-based interactive training
- Group led training
- Telephonically
- Self-study through the use of print materials and electronic media (i.e., Centene's/Health Net Cornerstone library of training classes)

Coordination of Benefits and Appeals and Grievance Training

The Manager of Medical Management provides additional training specific for integrated care team staff regarding coordination of Medicare and Medicaid, Members rights and responsibilities, appeal and grievance policies, procedures and processes.

MOC 2.A.6 Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.

Employees and contracted staff completion of class room trainings, group led training, and on-line MOC training is documented and maintained via Cornerstone, an internal web-based educational database that efficiently tracks training completion. Through Cornerstone, the Compliance Officer, VP Medical Management and Director of Medical Management are able to track and review completion of training.

MOC 2.A.7 Describe actions the organization takes if staff do not complete the required MOC training.

If it is identified that an employee failed to complete MOC training, the employee and the employee's supervisor are notified and the employee is instructed to complete the course immediately. For those who fail to complete required MOC training after the first attempt of remediation, disciplinary actions are administered in accordance with Health Net Human Resources discipline policy.

Challenges with employed and contracted staff completing the SNP MOC training include the time taken away from the regular workday to complete the training, repetitiveness of annual training and time for managers to monitor that training is completed. To address these issues, the training is updated regularly, is interactive and informative and can be completed in a reasonable amount of time.

MOC 2.B HEALTH RISK ASSESSMENT TOOL (HRAT)

MOC 2.B.1 How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary.

The Health Risk Assessment (HRA) for SNP members includes a comprehensive set of questions designed to assess their medical and mental health history, psychosocial, functional and cognitive needs and identify risks.

The Health Net Case Manager or designee conducts the member HRA with the member at a mutually agreed date and time that is within 90 days of the member's effective date. Once the HRA is completed, the Case Manager reviews, analyzes and stratifies the member's HRA and completes the individualized care plan (ICP). Every attempt is made to complete the initial HRA within 90 days for new members and within a year of the last HRA for ongoing members enrolled in the Health Net SNP program.

MOC 2.B.2 How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information.

The member's HRA responses and risks are communicated by Case Managers during ICT meetings, rounds, and communications with members and through documentation in the electronic medical record system. The Case Manager contacts members telephonically as they

are enrolled in case management to perform a complete assessment, validate the initial risk level and follow-up on HRA identified risks as indicated. The Case Manager, in collaboration with the ICT, uses these guidelines to evaluate members for development of the ICP:

- Evaluation of clinical and psychosocial information through review of HRA results, risk assessment scores, interviews with the member or family/caregiver, review of medical information, and communication with the member's Primary Care Physician and other clinical practitioners.
- Identification of current and potential problems and care needs based on the initial assessment
- Development of an individual plan of action, which includes the physician's treatment plan and appropriate community-based services and care facilities.
- Determination of the need for social and community services and benefits and incorporation into the ICP.

Documentation of ICP, interventions, implementation notes and ongoing evaluation is documented in the electronic medical management system.

MOC 2.B.3 How the organization conducts the initial HRAT and annual reassessment for each beneficiary.

For the initial screening, the assigned Case Manager or vendor contacts the member to conduct the HRA and risk stratification within 90 days of the member's effective date. Multiple phone attempts are made to engage the member. All outreach attempts (successful or unsuccessful) are documented in the electronic medical record. When Case Management calls members for other purposes and notices the HRA has not been completed, the Case Manager attempts to complete the assessment. Members unable to be contacted via telephone are mailed the HRA. Outreach will continue to complete assessments of those members with an incomplete HRA.

Follow up assessments are conducted if there is a change in the member's condition or health status, such as a recent hospitalization to determine if adjustments to the care plan are needed. Annual health risk assessments are also done within 12 months of the last assessment in order to evaluate the effectiveness of the ICP and collect data to measure outcomes. In order to assist in timely reassessments, the vendor is provided in advance with a list of continuing members due for a reassessment HRA so it can be completed within one year of the initial or previous HRA. To ensure timely annual reassessments, Health Net monitors and tracks the date through the use of the Health Net SNP Audit Report.

MOC 2.B.4 The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

All HRA assessments are documented in electronic medical record system with date/time stamps for each activity, including documentation of the staff member completing the activity. The HRA is scored according to member's response to weighted questions. The total number

scored at the end of the HRA will place the member in a stratification category: Low or High. The HRA score is then reviewed with the member to develop the care plan problems, interventions, and goals and associated time frames for completion.

Also, based on the HRA score and any available claims, pharmacy, lab or encounter data and medical records that are available, the member maybe re-stratified as high or lower acuity. A referral to MHN, Health Net's Behavioral Health subsidiary, is completed if the member has needs related to a mental health or substance abuse condition.

Health Risk Assessment – Each newly enrolled Medicare SNP member is asked to complete a Health Risk Assessment (HRA). The HRA is comprised of questions that include:

1. Demographics (Languages Spoken, Insurance Status, Contact Info)
2. Functional Status (Well Being, Activities of Daily Living, Home Safety, Psychosocial)
3. Health Status (Medical and Mental Health Conditions)
4. Cognitive (Member's ability to process information and apply knowledge)

The Functional and Health Status questions are used to provide an overall assessment of the member's condition in relation to other SNP members on a self-reported basis. At a minimum, assignment of risk and subsequent stratification for a new Medicare SNP member will occur within the first 90 days of member enrollment, even if data is incomplete. Members will only be stratified once using this model with the intent of providing timely information to non-delegated Case Managers. Subsequent stratification may occur when any (or a combination) of the following criteria is met:

1. Case Management outreach determines that a members should be re-categorized based on their findings
2. Claims, pharmacy, lab, or encounter data, if available, indicate that the member may have a new condition or an exacerbation of an existing condition and the Case Management team feels it appropriate to re-categorize the member

In addition to the HRA process for stratifying members enrolled into SNP, Health Net uses additional data sources to assist with the early categorization of the membership and assignment of a risk. When no data is available, a member may be stratified into the lowest risk category until additional information is available. The sources of data may include (but are not limited to):

Risk Adjustment Factors – Data is collected by the Centers for Medicare and Medicaid Services (CMS) for payment purposes. The Risk Adjustment Factor (RAF) data includes demographic information (Age, Sex, and Geography) and any clinical conditions that CMS has historically reimbursed for a Medicare member in the last 12 months. These clinical conditions are represented by groupings of related ICD codes called Hierarchical Condition Categories (HCCs). While it is possible for a SNP member not to have any historical HCCs, every member will have demographic information and therefore a RAF score after they are enrolled into the program and CMS begins payment.

Risk stratification results are used for early identification of current and potential problems along with the initial HRA assessment. The results are used to improve the care coordination of the member ensuring that they receive specialized medical, psychosocial care, and health education through their interdisciplinary team.

MOC 2.C INDIVIDUALIZED CARE PLAN (ICP)

MOC 2.C.1 Essential components of the ICP

Person-Centered Care Planning – Health Net’s person-centered approach focuses on the member’s strengths, needs, preferences and develops individual goals and interventions in collaboration with the member and caregivers. To support the member safely, in the least restrictive setting of choice, CMs work with the member to develop an ICP that identifies barriers preventing the member from managing their current conditions and determines interventions to promote and maintain self-sufficiency.

Once the problems, goals and interventions are established, agreement is reached with the member or the member’s authorized representative and the care team to implement the ICP. The ICP and its approval are documented in the member’s electronic medical record system. Medical and behavioral health care needs are integrated into the ICP.

The essential elements of the Individualized Care Plan include, but are not limited to the following:

CASE MANAGEMENT ASSESSMENT

During the assessment phase, the Case Manager collects information about the member’s situation and functioning to identify their needs and develop an ICP. In addition to this assessment, supplemental information is gathered from other relevant sources (i.e. claims, pharmacy, lab and encounter data, primary care provider, professional caregivers, non-professional caregivers, health records, and educational institutions/records). Re-assessment occurs on an ongoing basis while the member is active in case management.

After identifying the member’s problems and concerns using information obtained from the HRA, ICT members, caregivers; the Care/Case Manager collaborates with the member and the ICT to establish measurable short-term and long-term goals to meet the member’s needs and develop interventions required to meet the goals. Goals should be measurable, aligned and directly linked to the identified problems. The identified problems will drive goal statements and facilitate the direction in which the member/caregiver participates in the ICP.

IDENTIFICATION OF PROBLEMS

The Case Manager asks both open and closed ended questions in order to obtain key information. He/she practices active listening to appropriately identify the member’s problems. In order to achieve the best possible health outcome, the Case Manager collaborates with the

member, his or her support person, and the PCP to identify true problems and barriers to meeting goals.

To overcome barriers and issues, the Case Manager includes a set of tailored interventions for each member, which includes preventive health services, preferences for care, chronic disease education, and other accommodations. The ICP is intended to increase self-management, independence, and improved health status of each member.

ESTABLISHING GOALS

The Case Manager collaborates with the member, caregiver, provider, and ICT members when establishing the ICP goals and member agreed upon self-management plan. The ICP includes the member's healthcare preference and a description of the services tailored to the member's needs. The goals are realistic, individualized, and measurable. They are developed using the following criterion:

- Long Term Goals
- Short Term Goals
- Consult with attending physician, other health care providers, client, family members, guardians etc.
- Obtain member buy-in for effective behavior modification and superior outcomes
- Determine how goals will be achieved and revise goals if necessary
- Be flexible
- Be creative
- Need for authorization

The Case Manager will include a recommendation for services that are not covered by the member's benefits. The Case Manager reviews the member's benefits and additional resources, including community-based, to determine how to best support the ICP. Alternative funding avenues such as secondary coverage, third party liability, and community-based resources are evaluated.

INTERVENTIONS

During the implementation phase, the Case Manager executes specific case management activities and/or interventions that lead to accomplishing the goals set forth in the ICP. Selected interventions are usually inclusive of member's willingness to participate, time sensitive and measurable. For example, the case manager:

- Implements a self-management plan which demonstrates:
 - Documentation of the action the member will take to improve the care
 - Documentation of member agreement to perform the action

- Documentation which support the case manager monitoring of plan to ensure the action is completed
- Identifies/contracts with providers needing to be involved
- Determines if services or equipment which are not covered benefits may be a cost effective intervention
- Provides education based on health education needs
- Educates on medication administration
- Reinforces and explains member need to be adherent to treatment plan
- Anticipates any obstacle to meeting treatment goals (e.g. transportation, ability to schedule appointments)
- Establishes effective date for start of services
- Contacts member and/or caregiver and initiates education and other activities

EVALUATION

The Case Manager performs ongoing assessments in order to evaluate the member's progress toward the goals or identify barriers impeding the achievement of goals. The Case Manager completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year if the member remains active in case management. This often leads to a modification or change in the case management plan in its entirety or in any of its component parts, as follows:

- Determine if treatment plan goals have been attained
- Measure member/family/significant other's satisfaction with services
- Discharge of from case management services

When goals are not met, the Case Manager reassesses the member's situation and functioning, as described above. The Case Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. Based on the findings, the Case Manager provides supplemental resources or modifies the goals. The case manager communicates any changes in the ICP to the member, other members of the ICT, and providers as needed via phone, email, mail, and fax and documents this in the clinical documentation system.

CARE COORDINATION

The Case Manager is responsible for ensuring that the member has access to resources necessary to accomplish the goals set forth in the case management plan. This is accomplished by:

- Monitoring of care and/or services received from all providers
- Serving as a liaison between the member, provider and ancillary case management team members to ensure that established care/service goals are met

MOC 2.C.2 Process to develop the ICP including how often ICP is modified as beneficiaries' healthcare needs change.

The Case Manager is responsible for ongoing monitoring of the ICP. He/she continuously gathers information from all relevant sources about the member and his/her progress toward meeting the established goals. He/she accomplishes this by:

- Monitoring activities to ensure that needed services are provided
- Verifying that the treatment plan is executed effectively and determine the extent of progress compared to goals of treatment
- Providing regular reporting to PCP and/or attending physician as defined in treatment plan
- Revising treatment plan as indicated in conjunction with PCP and patient/caregiver

The ICT works with the member (or member's designated representative), the member's primary care physician, and other key specialists when feasible to develop the ICP specific to the needs of the member and designed to mitigate any risks identified. The ICP includes a set of attainable goals and measurable outcomes including, preventive health services delivered to the member, preferences for care, chronic conditions and special needs of the member. The ICP is intended to increase self-management, improve mobility and functional status, reduce any pain and create an improved satisfaction with health status and health care services that result in improved quality of life perception. The ICT, specifically the Case Manager, communicates any changes in the ICP to the member, other members of the ICT, and providers as needed via phone, email, mail, and fax and documents this in the electronic medical record system. The ICP is reviewed and revised annually or more often if the member has changes in condition such as a new diagnosis, hospitalization or ER visits.

Working with the member and/or caregivers and the multidisciplinary care team, the Case Manager implements the activities and interventions in the ICP. The Case Manager ensures that the ICP contains services and interventions that are consistent with the member's health care needs, Health Net's medical policies and the member's benefits or, if no benefits are available, accessible through alternative funding or community resources.

MOC 2.C.3 Personnel responsible for development of the ICP including how beneficiaries and/or caregivers are involved

Health Net's Case Management program utilizes a collaborative multidisciplinary approach that is member-focused, interactive, and goal-directed in the development, implementation and monitoring of the case management plan of care. The Case Manager works collaboratively with the Interdisciplinary Care Team (ICT), member/caregiver and the member's provider(s) to develop an individualized care plan (ICP) incorporating information from the HRA, member assessment and other sources such as pharmacy, labs and claims data.

Our goal is for the individual care plan to be a “living document” that provides a framework for managing the member’s care and services. As a member’s needs and preferences evolve over time, the care plan, along with the composition of the ICT, also evolves and changes.

The member and/or their caregiver are included in the development of their ICP whenever feasible and the Case Manager communicates with the member telephonically to discuss revisions as they occur. A hard copy of the ICP is sent to the PCP to discuss and share with the member and integrate into the medical record. The member can be provided with a hard copy of the ICP upon request. Internal members of the ICT have access to the ICP through the electronic medical record system.

Job Description Responsibilities/Qualifications of Case Managers:

The Case Manager/Care Coordinator is responsible for the coordination of services and cost effective management of health care resources to meet individual members’ health care needs and promote positive health outcomes. Acts as a member advocate and a liaison between providers, members and HN to seamlessly integrate complex services. Case Management services are generally focused on members who fall into one or more high risk or high cost groups and require significant clinical judgment, independent analysis, critical-thinking, detailed knowledge of departmental procedures, clinical guidelines, community resources, contracting and community standards of care. Case Management includes assessment, coordination, planning, monitoring and evaluation of multiple environments. Acts as a resource for training, policy and regulatory and accreditation interpretation.

Education: One of the following required: Valid Registered Nurse, Licensed Practical/Vocational Nurse, Clinical Psychologist, Licensed Marriage & Family Therapist (LMFT), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker license. Case Management certification (CCM) preferred.

Experience: Minimum two years clinical experience preferred. Three to five years Case Management experience required and/or Health Plan experience preferred.

MOC 2.C 4 Documentation, updating and maintenance of the ICP.

Through ongoing assessment using system assessment tools and risk profiles the Case Manager determines whether the goals continue to be appropriate and realistic, and what interventions may be implemented to achieve positive outcomes. As part of the monitoring process, the Case Manager contacts the member or authorized representative and provider(s) at established timeframes based on specific interventions and/or the Case Manager’s clinical judgment.

Contacts should be at the minimum frequency as defined by the member’s acuity level. The ICP is reviewed and modified by the Case Manager for any significant life/health event as needed, but no less than annually after the initial assessment. Modifications involve the entire ICT, including the member and/or their caregiver. The Case Manager or a member of the ICT team completes the ICP changes after the review and with the assistance of the full ICT, and with the involvement of the member or member’s caregiver. The PCP’s input is critical as well.

Life/health events may include recent new diagnoses or complications of prior diagnoses, recent hospital stays, caregiver changes, living arrangement changes, or even financial changes.

Revisions need to be reasonable, understood and accepted by the member and/or their caregiver to encourage full and active participation with the ICP.

As the Case Manager monitors the ICP and the progress towards meeting the goals, he/she evaluates the need for modification. The Case Manager may base the assessment of progress on information obtained from the member or member's representative, family members, attending physician, professional and non-professional caregivers, multidisciplinary care team members and risk profiles. It is the responsibility of the Case Manager, as a member of the ICT, to inform other team members about any changes in the member's health status so that the team is able to track the progress of the ICP and make any modifications needed to improve outcomes or support a member during a significant health event or transition in care.

The ICP is documented and maintained in the electronic medical record system. It is accessible to the internal ICT members electronically. ICT members that do not have access to the electronic medical record system are provided with hard copies as appropriate. Health Net's state, national, and professional confidentiality regulations and guidelines govern all communications between the care manager, the participant and members of the participant's treatment team as necessary to implement the care management plan. All HIPAA and document security policies are followed to ensure privacy and confidentiality; no voluntary disclosure of participant-specific information will be made, except to persons authorized to receive such information. Health Net staff must follow release of information procedures and record retention policies that comply with all applicable rules and regulations.

MOC 2.C.5 Communication of updates and modification of the ICP to the beneficiary and stakeholders.

All documentation of assessments, ICP, and related follow up communications are documented and updated in the electronic medical record system. Member records are maintained in accordance with HIPAA, state and federal privacy laws, and professional standards of health information management.

The Case Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers, or other involved parties. ICP goals are monitored and changed according to a change in the member's condition or transition in care as necessary and communicated to the provider in writing or member if requested.

As a Special Needs Plan, Health Net is dedicated to gaining participation from all potential eligible members. All potential eligible members are encouraged to participate in the program however; they have the right to opt out. The ICP developed by the Case Manager with the ICT incorporates results of the risk assessment, specific outcome goals, the plan benefits and other specialized needs of a member.

A hard copy of the ICP is sent to external members such as the primary doctor to discuss and share with the member and integrate into the medical record. The member can be provided

with a hard copy of the ICP upon request. Internal team members have access to the ICP through the electronic medical record system.

MOC 2.D INTERDISCIPLINARY CARE TEAM (ICT)

MOC 2.D.1 How organization determines composition of the ICT membership.

Health Net has an integrated interdisciplinary Care Team (ICT) model with members of the team who are selected based on their knowledge and experience with working with Special Needs Plan members.

Care is coordinated for SNP members through an ICT to address medical and mental health history, psychosocial, functional and cognitive needs. The ICT is responsible for overseeing, coordinating, and evaluating the care delivered to members. Each SNP member is assigned to an interdisciplinary care team appropriate for the member. The ICT is composed of primary, ancillary, and specialty care providers. The ICT monitors the individual member's progress towards goals and health outcomes to modify interventions as indicated. The composition of the ICT and how it is determined is described below.

At minimum, ICT members include:

- Medical Expert (e.g. Primary Care Physician (PCP), Specialist, or Nurse Case Manager) The member's PCP and the Case Manager assigned to the member is always included on the team, the Medical Director and specialists may be included when needed for specific disease management
- Social Services Expert (e.g. Social Worker, or Community Resource Specialist) Social workers or Community Resource Specialists are included on the ICT as SNP members often have psychosocial or economic issues requiring social services intervention
- Behavioral and/or mental health specialist e.g. psychiatrist, psychologist, licensed marriage & family therapist (LMFT), licensed professional counselor (LPC) or drug or alcohol therapist) when indicated. Behavioral health specialists from Health Net's Behavioral Health Division, (MHN) attend the ICT meetings upon request to assist when the member has behavioral health issues such as mental illness or substance abuse

Additional ICT members may be included as determined by the member's individual needs and special requests based upon the member's HRAT and ICP. Examples of how the member's unique needs are met are provided under each specialist:

- Pharmacist – may be included when the member has medication issues such as complex medication regimes, adverse reactions and side-effects, noncompliance, care gaps or other issues requiring pharmaceutical expertise
- Restorative Health Specialist (e.g. physical, occupational, speech, or recreational therapist) – may be included when the member requires restorative services to improve mobility, home safety, therapeutic exercises, ambulatory aides/equipment or

treatment of musculoskeletal disorders such as arthritis, multiple sclerosis, Parkinson's, stroke, paralysis, or major joint surgery

- Nutrition Specialist (e.g. Dietician or Nutritionist) – may be included for members with nutritional issues such as weight loss, obesity, or therapeutic diets requiring the assistance of a dietician such as enteral feedings or complex diabetic, cardiac, renal or other specialized diets
- Disease Management Specialist (e.g. Preventive Health or Health Promotion Specialist) or Health Educator (Nurse Educator) - The disease management or nurse educator may be included on the ICT when the member has been referred to Disease Management and their input would improve care coordination by sharing the specific educational plans, goals, barriers and member's response to the program with the ICT
- Caregiver/Family – may be included (when consent is obtained from the member and/or they are the legal guardian of the member) and it is determined that participation of the caregiver/family will improve the coordination of the member's care

MOC 2.D.2 How roles and responsibilities of the ICT members contribute to the development and implementation of an effective ICT process.

Each of the required and optional members of the ICT contributes to the effectiveness of the ICT process through their specialized knowledge as described in MOC 2.D.1 according to their field of expertise:

- Medical Expert – provide guidance on appropriate disease management
- Social Services Expert – assists with psychosocial or economic issues requiring social services intervention
- Behavioral and/or mental health specialist – can assist when the member has behavioral health issues such as mental illness or substance abuse
- Pharmacist – contributes knowledge around medication issues such as complex medication regimes, adverse reactions and side-effects, noncompliance, care gaps or other issues requiring pharmaceutical expertise
- Restorative Health Specialist – can assist to improve mobility, home safety, therapeutic exercises, ambulatory aides/equipment or treatment of musculoskeletal disorders such as arthritis, multiple sclerosis, Parkinson's, stroke, paralysis, or major joint surgery
- Nutrition Specialist – expertise on weight loss, obesity, or therapeutic diets requiring the assistance of a dietician such as enteral feedings or complex diabetic, cardiac, renal or other specialized diets
- Disease Management Specialist- improve care coordination by sharing the specific educational plans, goals, barriers and member's response to the program with the ICT

- Caregiver/Family –when consent is obtained from the member and/or they are the legal guardian of the member) and it is determined that participation of the caregiver/family will improve the coordination of the member’s care

The member and/or caregivers are encouraged to participate on the ICT. The new SNP member is sent a Case Management introduction letter which advises the member if they wish to be part of the ICT conferences to notify their Case Manager. In addition, the Case Manager encourages member participation verbally by informing the member of the meeting time and providing contact information when appropriate. Ad-hoc team meetings are also arranged by the Case Manager when initiated by the member or caregiver to assist with care issues or specific problems they may be experiencing such as communication with the PCP or need for additional services. The Case Manager will facilitate participation by communicating with the member prior to and after the team meeting and sharing the member’s input with the team when the member does not wish or is unable to attend the ICT.

Any complaints or grievances addressed to the ICT by the member, caregiver, or the provider are carefully recorded and forwarded immediately to the grievances and appeal department for resolution and tracking.

MOC 2.D.3 How ICT members contribute to improving the health status of SNP beneficiaries.

Members are provided with a single point of contact through their assigned Case Manager. They are provided with this information in writing and verbally when contacted by the Case Manager. The Case Manager facilitates contact with the other members of the ICT as indicated. SNP members are also provided with contact information for the pharmacist when issues are identified through the quarterly review of their medications. ICT members contribute to improving the health status of the member by:

- Analyzing and incorporating the results of the initial and annual health risk assessments including agreed upon goals and interventions into the ICP
- Teach the member how to optimally manage their disease process using motivational interviewing techniques
- Communicating and intervening with the member and/or provider when health outcomes are not improving as expected or put the member at risk
- Providing social service interventions and community resources when the member has psychosocial problems that are interfering with the goals of the ICP
- Providing pharmacy interventions when there are issues with duplication, drug interactions, care gaps or adherence issues
- Communicate with team members and providers of care to coordinate the member’s ICP
- Monitor health outcomes of the member and make recommendations to revise the plan of care based on the clinical outcomes

MOC 2.D.4 How the SNP's communication plan to exchange beneficiary information occurs regularly within ICT including ongoing information exchange.

The Case Manager determines the membership of the ICT based on the member's medical, psychosocial, cognitive and functional needs identified through the HRA and initial assessment. Representatives for HN non-delegated SNP members are informed of the plan of care, their involvement on the ICT and the meeting schedule through the electronic medical record system, letter, e-mail or fax. Team members are documented in the member's electronic medical record system. Attendance sheets and the outcomes of the team meeting are documented, retained according to the document retention policy and the ICP is updated as indicated to communicate the results to the team. Regular ICT meetings are scheduled for non-delegated managed members to ensure that the ICP is updated appropriately addressing member's needs. All communication with the member is conducted in a culturally competent manner according to the members' needs. This includes addressing language barriers, hearing impairments, and cognitive deficiencies.

The Provider Directory is provided in English and Spanish, and HN also provides members with information regarding languages other than English that are spoken in the provider offices. The customer service center employs associates who speak multiple languages and in addition, a telephone interpreter service is available to associates and providers to provide verbal and written translation.

Additional services include:

- The national toll free 711 relay is utilized to communicate with members with hearing impairment
- Health Net's Language Assistance Program services are available to all members 24 hours a day through Health Net's Customer Contact Center
- Health literacy materials and in-person training available to provider offices
- In-person interpretation and sign language services available to provider offices with 3 day advance notice.
- For members with hearing impairment who cannot communicate through sign language, an interpreter trained in the use of closed captioning is available for medical appointments
- Care plans are translated upon request in threshold languages
- Cultural sensitivity training materials for providers
- Case Manager training to provide care to members with cognitive deficits such as Alzheimer's

To overcome communication barriers, and support member's engagement in care and service planning, the following strategies for Case Managers to enhance communication with members who have hearing impairment, language barriers and/or cognitive deficiencies:

- Hearing impaired: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
 - Speech reading (lip reading)
 - Written and visual aids
 - Visual language systems (telecommunications device for the deaf TDD)
 - Interpreters
- Language barrier:
 - Health Net utilizes translation services when no staff is available to provide translation services.
 - Members may request to have printed materials translated into another language free of charge
- Cognitive deficiencies: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
 - Repeat information
 - Write important elements; use pictures
 - Choose best time of day to communicate
 - Keep the environment calm
 - Keep the environment quiet
 - Keep the communication simple and/or going slowly

MOC 2.E CARE TRANSITION PROTOCOLS

MOC 2.E.1_ How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.

Health Net recognizes that the SNP member populations moving between different health care settings are highly susceptible to receiving fragmented and unsafe care. It is Health Net's responsibility to coordinate care for members transitioning between care settings. This service ensures quality of care and safety.

During care transitions, the Case Manager and Concurrent Review Nurses, in collaboration with the ICT, ensure facilitation of the discharge and transfer process to make sure that continuity of care is maintained for SNP members during the care transition process. Once Health Net has received confirmation that the member has been admitted to an acute or sub-acute setting, the implementation of the concurrent review/case management activities to manage the inpatient stay is initiated. Facilities are required to notify Health Net and the Participating Provider Group of inpatient acute and sub-acute admissions within 24 hours. Coordination occurs prior to the

transition when the transition is identified through the pre-authorization process, during the inpatient stay and during the post-discharge period.

MOC 2.E.2 Personnel responsible for coordinating the care transition process.

The Case Manager and the Concurrent Review Nurses are responsible for Transition of Care.

The Case Manager works with the hospital Case Managers to arrange discharge needs. Assessments are initiated to determine member needs and coordinate referrals as necessary. Members are educated and encouraged to maintain relationships with their Primary Care Physician and/or specialty providers. Upon discharge, the Case Manager will discuss discharge orders with the member, such as medications, follow-up appointments, and signs/ symptoms that require medical attention.

The Case Manager will determine an appropriate follow up schedule to support the member through the entire transition process to ensure that the member and caregiver has the support and follow up that they need to recover successfully.

From the hospital to the next level of care, prior to the transition, the Concurrent Review Nurse will document that the transition from the hospital to the next level of care was identified. The Concurrent Review Nurse will document a request for the hospital to share the care treatment plan with the next care setting. The Concurrent Review Nurse will document that the care plan, discharge summary, or discharge instructions were provided to the next provider and PCP. This information is faxed to the provider and this serves as evidence of notification of transition. The ICT member documents this communication in a note in the electronic medical record system. The ICT will continue to communicate with the member/caregiver after the member is transitioned through a series of post discharge calls.

Once a member reached their former level of care, post discharge calls are completed within two business days of notification of discharge, and as needed. The purposes of these calls is to ensure that there is continuity of care, medications are taken as directed, follow-up visits are scheduled and attended, questions answered regarding care, and verify adequate supports are in place (e.g. home care available).

MOC 2.E.3 How organization transfers elements of the beneficiary's ICP between health care settings when the beneficiary experiences a transition in care.

For admissions, the Case Manager provides information to the facility regarding the member's ICP, authorized services and providers to support assessment and discharge planning. The concurrent review nurse alerts the PCP of any transition in care setting. The concurrent review nurse or the Case Manager collaborates with the facility treating physicians and Behavioral Health providers, as appropriate, to facilitate discharge planning and follow up as needed. The concurrent review nurse or the Case Manager coordinates and facilitates provider communication, and ensures that the PCP and all treating providers, including formal and informal community supports, as appropriate, are involved in the planning for the anticipated

transition. The concurrent review nurse or the Case Manager sends the discharge plan to the PCP (and, for discharges from inpatient psychiatric facilities, to the Behavioral Health Provider as well). The discharge plan is incorporated by the Case Manager into the ICP.

Transfer of the Individual Care Plan

- For care transitions, the Care/Case Manager, in collaboration with the Interdisciplinary Care Team, will ensure facilitation of the discharge and transfer process.
 - Arrangements for a receiving practitioner/provider will be made
 - Availability of a required bed and/or service(s) in receiving the setting will be arranged
- Health Net will monitor that a discharge plan was implemented and psychosocial and health needs are met.

Care Transitions

- When the SNP Case Manager becomes aware of a planned transition, the Case Manager will work with the member to assist with educating the member and/or caregiver(s) regarding the planned transition, such as: making sure the member's ICP is transferred between health care settings, plan of action of how to proceed if the member's condition worsens or improves, and assist with determining plans post discharge.
- The discussion and related activities related to the planned transition is documented in the electronic record system
- The member's ICP is updated in the electronic record system, as appropriate
- For inpatient transitions, the Concurrent Review Nurse may reference the ICP as he/she develops the discharge plan. For complex cases, the Concurrent Review Nurse may contact the Case Manager for input.
- Upon member's discharge from an inpatient transition, Case Manager will review Concurrent Review Nurse activity notes; post discharge assessment completed in electronic medical record system by the Concurrent Review Nurse and will conduct post discharge call.

Post Hospital Discharge Member Call

- Upon member's discharge, Case Manager will review post discharge assessment completed in the electronic record system by Concurrent Review Nurse and will conduct post discharge call.

- Case Manager calls the member upon discharge from the inpatient setting to confirm a solid discharge plan, educate and screen the Member for additional gaps in care that may benefit or require assistance from Case Management intervention.
- Medication review ensuring Member has appropriate medication
- Address with the member the importance of follow up with their primary care provider and/or specialist and to ensure that the member knows when to call their provider and how to seek assistance in the event of worsening of their condition.

MOC 2.E.4 How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.

HN provides members with an online Personal Health Record (PHR). The PHR is a tailored online record that is integrated with HN's clinical application. The PHR provides an individual with auto-populated content from several sources of data and an interactive, personalized knowledge base to help the individual better manage his/her health. Members can enter their personal information and print reports from their PHR to keep doctors updated by simply checking the boxes next to the information they want in the report, click "Print Preview", and see all health record entries displayed in one place. They are provided with a set of routine and preventive comprehensive guidelines for the types of information to enter.

For members who do not want to use their online PHR, HN also sends annual pocket size health planner calendar with room to record health information such as doctor visits, lab values and preventive screenings and be taken to doctor appointments to share information with their primary doctor, record notes and provide information to doctors they may encounter in other settings such as emergency departments and hospitals. Members can also print a medication schedule from the member portal.

Members may obtain their own medical records on request. Adult members also have the right to provide a written addendum to the medical record if the member believes that the record is incomplete or inaccurate. Members may also request that their personal health information be limited or restricted from disclosure to outside parties or may request the confidential communication of their PHI to an alternate address. The member can also be provided with a hard copy of their ICP upon request to share with providers in other healthcare settings.

MOC 2.E.5 How beneficiaries are educated about their health status to foster appropriate self-management activities.

Post-Discharge Outreach, Education, and Assessment

A Case Manager conducts post-discharge follow-up with the member within 24-48 hours to verify that they have been able to get prescriptions, equipment, and supplies if home and community based services have been initiated. They review with the member/caregiver the discharge plan to ensure they understand the importance of accessing recommended follow-up care, address barriers to accessing follow-up care, and review "red flags" and the process for

contacting the PCP or other providers when complications arise. The Case Manager educates the member/caregiver about how to use Nurse Advice Line, the after-hours nurse advice line.

The goal of post-discharge follow up is to assist members in closing identified healthcare gaps and barriers during transitions from an inpatient hospital to home. We focus on care coordination, health education, medication adherence, and follow-up appointments in order to promote healthy behaviors and reduce the risk of readmission, and ensure that the member can remain in a least restrictive setting of their choice.

Medication Reconciliation

Medication reconciliation is a critical element of care transitions and preventing readmission due to medication error or adverse event when a member has poly-pharmacy, low health literacy, or communication barriers. The Case Manager ensures that the member is able to safely use medications in accordance with their discharge plan and confirms that the member has picked up his/her medications. Medication reconciliation may be done during the outreach phone call with member, or by a home health agency RN. This includes checking the accuracy of medication lists; identifying changes in medication regimen, duplication of therapy and/or potential interactions with medications in the home; and assuring that the member/caregivers understands changes and side effects that should be reported to his/her PCP. It also includes communicating the discharge medication regimen to the PCP, if he/she was not the treating physician during the inpatient admission.

The Case Managers use information from the facility, treating providers, and the members to identify members' at risk for readmission. This includes but is not limited to members with complex medical and social needs, co-existing medical and behavioral health conditions, and members with a history of non-compliance or poor community supports. Case Managers support concurrent review nurses as follows:

- Participate in interdisciplinary rounds when possible
- Identify and attempt to resolve barriers to care
- Coordinate initiation of services such as home health and DME
- Encourage medication adherence and follow-up care
- Assist with scheduling follow-up appointments
- Assist with scheduling transportation to scheduled appointments
- Complete referrals to appropriate community agencies
- Discuss "red flags", and when to contact the PCP, the use of the Emergency Room and Urgent Care Centers and what is considered a true emergency

Collaborating with the Member/Family

The Case Managers, when additional support might be needed, outreach to at-risk members, their provider(s), and family/supports as appropriate, to the following:

- Assess health status, care plan changes, any needs such as unmet education or psychosocial needs, reasons for unplanned admissions and ED visits, and potential risks

and barriers in their environment which potentially will, or in the case of readmission, have interfered, with a successful recovery. Assessment also includes the evaluation of the member's functional status, health literacy, self-management skills, social and community supports and culture and language needs

- Provide education about the member's condition, red flags, and other topics (as described above)
- Conduct medication reconciliation
- Involve the member in discharge/service planning
- Assist the member as needed with choosing providers of post-discharge services
- Educate the member and their caregivers about available Health Net support to help connect caregivers to support groups and other community resources

Collaborating with Community Resources

The Case Managers address barriers related to physical, behavioral, socioeconomic, functional status, and other needs such as food, housing, or other assistance utilizing available community resources as applicable.

In addition, during the course of Case Management activities, Health Net provides SNP members and or their caregivers when appropriate, with individualized disease specific educational information regarding how to maintain health and remain in the least restrictive setting, reduce their risk of hospitalizations and unplanned transitions. Education includes both telephonic and written mailed communication as applicable to individual Members' needs.

Members also have access to a broad range of educational material on the member portal about how to manage chronic health conditions. Educational material is also available about steps to prepare for an admission and the discharge process.

The Disease Management suite of online programs and resources guides an individual to change unhealthy behaviors and adopt positive lifestyle changes in order to promote the life-long practice of good health behavior, prevent costly chronic conditions and reduce healthcare costs. Health Net's program focuses on the whole person and supports the individual to change health behaviors that they are willing and ready to change. This whole-person approach reduces the risk of preventable diseases, such as coronary artery disease and diabetes, and promotes key health behaviors, including, but not limited to:

- Healthy weight (BMI) maintenance
- Smoking/tobacco cessation
- Physical activity
- Healthy eating/nutrition
- Managing stress
- Type 2 Diabetes

Case Managers employ the “teach back” method to ensure members understand the information that is provided. This involves having the member repeat back their understanding of how to manage their disease and medications. This allows the Case Manager to address any health literacy issues or knowledge deficits promptly.

MOC 2.E.6 How the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

SNP members and/or caregivers are notified by letter with follow-up phone contact upon enrollment and notified of their assigned Case Manager and contact information within 30 days of enrollment. This introduction letter also advises the member that if they wish to attend the ICT to notify the Case Manager. The Case Manager is the member’s single point of contact and provides coordination of care along with the concurrent review team when there is a transition including reaching out to members in advance of a transition for pre-authorized care. The Case Manager is responsible for coordinating the needs of the member to promote a healthy outcome and is the point of contact to support them during transitions.

The Case Manager of non-delegated members is notified of SNP member discharges to home through a post-hospital discharge call program created in the electronic medical management system and reaches out to members as needed to ensure transition needs are met. The performance standard is for Case Managers to call members within 2 business days of notification of discharge to review changes to the ICP, medications and promote follow-up care.

MOC 3: PROVIDER NETWORK

MOC 3.A SPECIALIZED EXPERTISE

MOC 3.A.1 How providers with specialized expertise correspond to the target population identified in MOC 1.

Health Net maintains a comprehensive network of Primary Care Providers, facilities, specialists and ancillary services to meet the needs of SNP members with chronic disease such as diabetes, cardiac, respiratory, musculoskeletal and neurological disease and behavioral health disorders. Contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, outpatient pharmacies, and hospices allow SNP members to obtain the services they need at a convenient location. The Health Net website also has a user friendly search function for members to locate providers and specialists in their area. Please see HSD tables for complete details on primary and specialist providers.

The specialized expertise of the provider network meets the unique healthcare needs of SNP members as described in MOC 1. Following is a partial listing of how the providers in the network can address the healthcare needs of Allwell CHF/Diabetes SNP members:

- Primary Care Providers such as family care practitioners and internists provide chronic disease management such as diabetic and cardiovascular care and coordination with the ICT, and referrals to specialists and ancillary services such as home care and restorative therapists
- Behavioral health practitioners meet the counseling and psychoactive medication needs of members with mental health disorders such as depression, substance abuse, schizophrenia and paranoid disorders
- Cardiologists provide cardiac medication and disease management as needed for members with CHF, hypertension, cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders
- Endocrinologists provide medication and disease management expertise as needed for diabetics, hypothyroidism, hyperthyroidism and other endocrine disorders
- Neurologists are available as needed to treat members with cerebrovascular disease, stroke, Alzheimer's and dementias, peripheral neuropathies and other nerve tissue disorders
- Nephrologists provide treatment members with disorders of the kidneys such as chronic renal failure, electrolyte disorders, kidney stones and infections
- Dermatologists provide medication and treatment for members with skin cancers, wound care, skin infections and other skin disorders

MOC 3.A.2 How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.

Health Net operates as both a delegated and traditional model for managed health care delivery. In the delegated model, Health Net may delegate responsibility for activities associated with utilization management, credentialing and/or case management to select medical groups. Groups with the infrastructure to provide the SNP Model of Care can also be contracted and responsible for the team-based Model of Care requirements. Members that are not part of a group delegated for the SNP Model of Care receive the team-based care through Health Net. As part of the delegation oversight process, HN conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files and an on-site review of the SNP delegated group's operations. The evaluation results are compiled and a written summary of the findings and recommendations are presented to the Delegation Oversight Committee. This type of audit is also performed annually, at a minimum, to determine the continuation of the delegated relationship. Delegated groups that do not meet the SNP program requirements as determined by the delegation oversight committee are issued a Corrective Action Plan, closely monitored until compliance is met. If they continue to be noncompliant and/or fail to fully implement the Corrective Action Plan, this can lead to de-delegation.

The Health Net Credentialing Department obtains and reviews information on credentialing or re-credentialing applications and verifies the information is in accordance with Health Net's primary source verification practices. Health Net requires groups to which credentialing has been delegated to obtain primary source information in accordance with Health Net standards of participation, state and federal regulatory requirements and accrediting entity standards.

Prior to providing health care services to Health Net members, all practitioners seeking admission to the Health Net network undergo a comprehensive review and verification of professional credentials, qualifications and other background checks. This review is conducted in accordance with Health Net standards for participation requirements, state and federal regulatory requirements and accrediting entity standards. All initial applicants are notified of the Credentialing Committee's decision within 90 days of Health Net's receipt of a completed application.

Following initial approval into the network by the Credentialing Committee, practitioners are re-credentialed within 36 months. Practitioner re-credentialing includes reviewing Health Net captured performance data that provide an assessment of indicators representing professional competence and conduct. Practitioners identified in the initial or re-credentialing processes with adverse actions will be investigated in accordance with *Policy/Procedure #RE429-15914: Adverse Action*. In addition, Health Net conducts ongoing monitoring of sanctions and complaints in accordance with the guidelines established by the credentialing policy.

The credentialing process is also administered by Health Net approved delegated entities that qualify and agree to credential practitioners in accordance with Health Net's credentialing standards, state and federal regulatory requirements and accrediting entity standards. Oversight of delegated credentialing and re-credentialing activities is administered under the direction of the Health Net Delegation Oversight Committee and in accordance with process described in *Policy/Procedure #WB106-125123 Delegated Entity Evaluation and Delegation Determination – Credentialing*.

Health Net retains the right to approve, deny, suspend or terminate any and all practitioners participating in the Health Net network. All records, electronic or hard-copy, are maintained in accordance with Health Net corporate retention policies and procedures.

Health Net Incorporated (HNI), Behavioral Health Division, Managed Health Network (MHN) is responsible for the credentialing/re-credentialing of the Health Net behavioral health care network. MHN credentials and re-credentials practitioners in accordance with state and federal regulatory requirements and accrediting entity standards prior to providing health care services to Health Net members. Health Net credentials those behavioral health care practitioners not credentialed by MHN. Please see the Health Net Credentialing and Re-credentialing Policy for complete information:

The practitioner must complete all items on a Health Net approved application and submit all requested supporting documentation. The verification time limit for a Health Net approved

application is 180 days. The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely, including but not limited to:

Present illegal drug use

History of loss of license or certification

History of criminal/felony convictions

History of loss or limitation of privileges or disciplinary actions with any health care entity

Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance

Current malpractice insurance coverage

The practitioner will attest to the completeness and truthfulness of all elements of the application. Information submitted on the application by the practitioner must be supported by verifiable sources.

The practitioner must provide continuous work history for the previous five years. The verification time limit is 180 days. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. All verbal communication will be documented in the file. Any gap(s) in work history that exceeds one year must be clarified in writing.

The practitioner must possess a current, valid license or certificate issued by the state in which the practitioner is applying to practice. The verification time limit is 180 days. Licenses that are limited, suspended or restricted will be subject to investigation, administrative termination or denial, as outlined in *Policy/Procedure #RE429-15914: Adverse Action, Attachment A: "Adverse Action Classification Guidelines for Practitioners."*

The practitioner must possess adequate and appropriate education and training as stated in *Policy/Procedure #RE429-14334: Credentialing/Recredentialing, Attachment C: "Board Certification/Education Table."* The board certification verification time limit is 180 days; verification of medical school/residency completion is valid indefinitely.

The practitioner for whom hospital care is an essential component of their practice must possess admitting privileges with at least one Health Net participating hospital or freestanding surgery center. A documented coverage arrangement with a Health Net credentialed practitioner of a like specialty is a requirement in lieu of admitting privileges. Hospital privileges that have been impacted for quality of care reasons will be acted upon as outlined in *Policy/Procedure #RE429-15914: Adverse Action, Attachment A, "Adverse Action Classification Guidelines for Practitioners."*

The practitioner must possess a valid, current drug enforcement administration (DEA) and/or controlled dangerous substances (CDS) certificate, if applicable. The document must be current at the time of the credentialing committee decision. Health Net verifies a DEA or CDS certificate in each state in which the practitioner is contracted to provide care to its members. If a practitioner does not have a DEA or CDS certificate, Health Net obtains an explanation that includes arrangements for the practitioner's patients who need prescriptions requiring DEA certification.

The practitioner will possess malpractice insurance coverage that meets Health Net standards. This information must be documented on the application or submitted as a face sheet. The document must be current at the time of credentialing committee decision. Exceptions may be granted for post-dated insurance coverage as indicated in the “policy statement” section of this policy. The practitioner will assist Health Net in investigating professional liability claims history for the previous five years.

The practitioner must be absent from the Medicare/Medicaid cumulative sanction report if treating members under the Medicare or a Medicaid line of business. The verification time limit is 180 days. Practitioners with identified sanctions will be investigated according to the leveling guidelines established by *Policy/Procedure #RE429-15914: Adverse Action Attachment A: “Adverse Action Classification Guidelines for Practitioners.”* The practitioner must be absent from the Medicare opt-out report if treating members under the Medicare line of business. The verification time limit is 180 days. The practitioner must be absent from the federal employee health benefits program debarment report if treating federal members. The verification time limit is 180 days.

The Health Net contracting department is responsible to determine that the facilities it contracts with are actively licensed and/or accredited. Health Net also encourages transparency by providing Health Net’s Hospital Comparison Report on the member website. The Hospital Comparison Report has easy to understand details about hospital treatment outcomes, the number of patients treated for a particular illness or procedure, and the average number of days needed to treat that illness or procedure. Health Net also encourages the hospitals in its network to participate in the Leapfrog Hospital Quality and Safety Survey, a national rating system that gives consumers reliable information about a hospital’s quality and safety based on computer physician order entry, intensive care physician staffing and experience with high-risk and complex medical procedures.

MOC 3.A.3 How the SNP documents, updates, and maintains accurate provider information.

The Credentialing Department has established a recredentialing cycle through which each non-delegated practitioner’s recredentialing materials are processed at least every 36 months. The Credentialing Department forwards a recredentialing package/notification to the practitioner and/or IPA/medical group eight (8) months in advance of the scheduled reappointment date. Practitioners with current Council for Affordable Quality Healthcare (CAQH) on-line credentialing/recredentialing applications do not receive recredentialing notices.

By completing and signing the recredentialing application, the practitioner:

- a. affirms the completeness and truthfulness of representations made in the application;
- b. indicates a willingness to provide additional information for the credentials process;
- c. authorizes Health Net to obtain information regarding the applicant’s

qualifications, competence or other information relevant to the credentialing review, and

d. releases Health Net and its independent contractors, agents and employees from any liability connected with the credentialing review.

The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely. The Credentialing Department completes a review of the practitioner's recredentialing file and conducts primary source verification as outlined in the Primary Source Verification Tables specified for recredentialing. Practitioner performance data include, but are not limited to, member complaints and quality improvement activities. These data are incorporated into each recredentialing file to be reviewed by the Credentialing Committee for a decision.

A roster of practitioners who are administratively noncompliant with Health Net recredentialing criteria is presented to the Credentialing Committee for consideration and decision-making. A list of terminated practitioners is forwarded to Provider Network Management and/or Provider Data Management staff for deletion from the Health Net network where all provider information is housed and updated.

MOC 3.A.4 How providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services.

The member's Primary Care Provider (PCP) in conjunction with the ICT determines which specialized services the member requires to meet the goals of the Care Plan. The PCP refers the member to services, specialists or providers within the network through the pre-authorization process. Services are authorized following CMS and clinical practice guidelines and the member is notified in a timely manner within set timeframes. The PCP, Customer Call Center Representative, Case Manager and/or Social Services expert assists the member to connect to the appropriate service provider as necessary, for example specialists, medical transportation services, disease management, behavioral health, durable medical equipment, home health care, pharmacies, wound care, podiatrists, community services, etc. Please see MOC 2.D for complete information on how providers collaborate with the ICT.

MOC 3.B.USE OF CLINICAL PRACTICE GUIDELINES AND CARE TRANSITION PROTOCOLS

MOC 3.B.1 Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP's target population.

Clinical practice guidelines (CPGs) are developed and/or adopted to reduce variation in practice and improve the health status of members. Health Net adopts nationally recognized, evidence-based clinical practice guidelines for medical and behavioral health conditions through Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Specialty input on guidelines is obtained when indicated. Guidelines are evaluated for consistency with Health Net's benefits, utilization management criteria, and member education

materials. New technologies (medical and behavioral health), and devices are evaluated for safety and effectiveness. The CPGs are reviewed at least every two years or more frequently when there is new scientific evidence or new national standards are published.

Approved clinical/medical policies and clinical practice guidelines are published and made available to the network providers through the provider portal of the Health Net web site and through provider updates. Physicians are informed about current preventive care guidelines through regularly updated provider operations manual and as indicated through provider updates. The preventive guidelines Health Net endorses are published by, but not limited to, USPSTF, ACOG, AAP, CDC, AAFP and ACS. Provider groups are required to participate in the collection of HEDIS® data to monitor and ensure clinical care is consistent with evidence based clinical guidelines. In addition, the processes for appeals, grievance and potential quality issues identify deviations from accepted clinical practice and action is taken as indicated.

Physician compliance with CPGs is monitored through the HEDIS® outcomes for SNP members. Health Net has a process to inform provider groups in a timely manner of their performance on select HEDIS® and Part D pharmacy measures so they can improve practices. Providers are also educated about the SNP program outcomes for HEDIS® and preventive measures during Provider webinars and through quarterly newsletters and provider updates and encouraged to provide input on barriers and how to improve rates.

MOC 3.B.2 Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries.

The member's primary doctor, in consultation with the member/caregiver as appropriate, has the ultimate responsibility and decision-making for the member's individualized treatment plan. Individuals with multiple complex conditions may present challenges when a CPG for one condition can cause complications with another disease that is present. Specific vulnerable populations such as bedbound members may not be appropriate for the CPG that would be

appropriate for an ambulatory member. CPGs around pharmaceutical interventions may need to be adjusted due to allergies, adverse reactions and therapy tolerance of the member. The HN SNP Model of Care is member-centric to account for individualized problems and needs.

MOC 3.B.3 Provide details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICP and acted upon by the ICP.

If a PCP or Specialist is experiencing challenges pertaining to the individualized needs of the member and has a special request that is not part of the Clinical Practice Guidelines and nationally recognized protocols then the Provider must provide the details in writing of what is being requested for the medical necessity of the specific SNP beneficiary. HN Medical Directors will then review and will speak with the PCP and/or Specialist if necessary and it would be incorporated into the ICT and chart documentation when it is approved as medically necessary

or denied. This information would all go into the member's ICP and communicated to the ICT so it could be acted on as indicated.

MOC 3.B.4 Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

The PCP is a member of the ICT and works with the team and Case Manager to ensure that the member receives the specialized services they require in a timely manner. The services provided, implementation and follow-up are documented in the member's record and communicated to the members of the ICT. Each member is assigned a Case Manager who reaches out to the member and serves as their primary point of contact upon enrollment. According to the member's risk, the Case Manager contacts the member or responsible party to determine if services such as home care or durable medical equipment are needed to reduce risk of hospitalization. The Case Manager makes referrals to other programs such as disease management, pharmacy, and behavioral health as indicated. The Case Manager follows up with the member to verify that services have been provided and to the member's satisfaction. In addition, members are informed of their rights in their health plan materials to file appeals and grievance if services are not delivered in a timely and quality manner.

Health Net makes a special effort to coordinate care for members enrolled in Special Needs Plans when members move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions can result in poor quality care and risks to patient safety. Case Managers are informed of planned admissions through the pre-authorization process and members are prepared for the admission according to the admitting physician's protocol. Review of inpatient management for non-delegated members by the concurrent review nurse occurs within one business day of notification of admission. Upon completion of an inpatient authorization and/or notification of concurrent admission process, an assessment for discharge planning begins. The Case Manager contacts the ICT to assist with the completion of the assessment for appropriate discharge planning and updates to the Care Plan. The Case Manager ensures timely and sufficient communication between the ICT team.

- The physician, physician office, facility or other assigned staff contact members prior to planned hospital admissions and discuss expectations, assess the member's condition and ability to follow the treatment plan, advise members of probable length of stay and help anticipate and arrange for services such as home health, durable medical equipment, transportation, etc. at discharge.
- The Case Manager works collaboratively with the ICT to identify fragmented care, clarify diagnosis, prognosis, therapies, daily living activities, obtain reports on services delivered and ensure changes are documented in the Care Plan
- The Case Manager conducts and facilitates discharge planning upon notification of an admission to a facility. Discharge planning needs are assessed and continuity of care is facilitated through coordination between the facility, ICT and Health Net as needed to ensure a timely and safe discharge.

- When the attending physician has determined the member no longer requires inpatient stay and authorizes discharge, the discharge and/or care transition process is communicated and a written discharge plan is provided at the time of discharge that is understandable to the member and/or responsible party by the facility representative.
- When an admission is elective/planned, the member is notified verbally and/or in writing as well as the member's usual practitioner at the time the admission is prior authorized. This ensures that the practitioner and member are aware of the planned transition.
- When a member transfers from inpatient setting to an outpatient setting the case manager ensures discharge notification is communicated to the member's usual practitioner by following current procedures.
- The Case Manager conducts post hospital discharge member calls when notified of member discharge home from the inpatient setting to confirm discharge plan, complete medication review, ensure follow-up appointments, educate and screen the member for additional gaps in care that may benefit or require assistance from Case Management and communicate information related to community services available to assist with ongoing care and services.

3.C MOC TRAINING FOR THE PROVIDER NETWORK

MOC 3.C.1 Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.

Providers responsible for the administration or delivery of the SNP Model of Care are provided initial and annual training. Training is offered through multiple learning environments to meet individual learning needs. Methodology may be lecture format, interactive (web-based, webinar) or self-study (printed materials, electronic media). Comprehensive MOC training includes topics of: Goals of the MOC, SNP Population Characteristics and Vulnerable Subpopulations, specialized benefits, Case Management, HRA, ICP, ICT Care transitions, Clinical Practice Guidelines and a description of the Quality Improvement Program.

The SNP MOC training is updated annually and presented as a provider webinar. Registration at these webinars is not limited to in-network providers. The updated training is then posted on the provider web portal so it is accessible to providers at any time. This training is also available to delegated groups to use with their staff. Additional provider webinars on topics that are relevant to the Model of Care such as chronic disease management and best practices are offered throughout the year. These topics vary each year and new topics are selected based on provider interest and initiatives to improve outcomes.

Online, providers also have access to information and policies on the SNP program through the electronic Provider Manual. Providers are notified of changes and regulatory revisions through ongoing online articles, quarterly newsletters and faxed provider updates.

MOC 3.C.2 Documenting evidence that the organization makes available and offers training on the MOC to network providers.

Training materials including attendance record records for SNP MOC provider training are documented, retained and retrievable upon request. Provider webinar training records including attendee name, company and phone number for the MOC training are provided by the webinar company, dated and maintained. As stated earlier, Health Net posts the MOC presentation on the provider web portal for medical groups to share with providers who are unable to attend, providing 24 hour access to MOC training to providers.

In addition, Delegation Oversight completes annual audits of SNP delegated groups. One of the elements of this audit is confirming that there is documented evidence of SNP MOC training.

MOC 3.C.3 Explaining challenges associated with the completion of MOC training for network providers.

Health Net has had good success with attendance at the annual provider teleconference on the MOC with almost 500 participants in 2016 and continuing education hours are provided. The majority of these participants are Case Managers and other personnel involved in the SNP MOC. Health Net sends the training notice/presentation electronically to almost 1400 recipients. Attendees are provided with a toll-free number for easy access to the live portion of the training and to accommodate a variety of medical offices. Each session also provides opportunity for questions and answers and provider feedback. Training is an hour long and start and stop times are adhered to avoid undue interruption in the work day. The training is promoted through multiple channels and departments - online articles, newsletter, quality improvement, delegation oversight team and the provider network staff. Doctors are often challenged with time constraints when it comes to attending educational seminars and therefore the training is offered over the lunch hour and slides are available online for viewing at a time that is convenient for them such as after office hours.

MOC 3.C.4 Taking action when the required MOC training is deficient or has not been completed.

The Delegation Oversight team conducts a pre-delegation audit and an annual audit to ensure contracted providers delegated for SNP have complied with requirements. If the delegate does not have documentation of annual MOC staff training, a corrective action plan for noncompliance is required and monitored until the issue has been resolved in a timely manner.

MOC4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

4.A MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

MOC 4.A.1 Describe the overall quality improvement plan and how the organization delivers or provides appropriate services to SNP beneficiaries based on their unique needs.

At the member level, the SNP MOC provides case management for all members to meet their unique needs. A comprehensive assessment is completed to assist in the development of a person-centric Care Plan incorporating the member's individualized needs and goals. The program provides care coordination and complex case management including decision support, member advocacy, identification and recommendation of alternative plans of care and community resources to support the plan of care. Overall, the goal of Case Management is to promote the member's desire to self-direct care and help members regain optimum health or improved functional capability in the right setting and most cost effective manner. Individual goals determined with the member are measurable, within a certain timeframe and are monitored for completion to meet the member's unique needs.

The overall Quality Improvement Program evaluates that appropriate services are delivered to SNP members by looking at a comprehensive set of utilization, access, satisfaction and clinical measures to measure improvement and effectiveness of the Model of Care and to identify areas for improvement. Appropriate clinical measures such as cardiovascular and diabetic measures are collected to evaluate a chronic disease SNP. Controlling Blood Pressure, Beta Blockers after a Heart Attack, Annual Monitoring of Medications (digoxin, diuretics, ACE/ARBs) and the administrative HEDIS Comprehensive Diabetic Care measure (CDC) is collected at the plan benefit package to measure that the appropriate clinical services are delivered. The Medicare provider network, inclusive of SNP, is monitored for availability of primary care providers, behavioral health providers and high volume specialists including nephrologists, ophthalmologists, gastroenterologists and surgeons important to members with chronic disease.

MOC 4.A.2 Specific data sources and performance measures used to continuously analyze, evaluate and report MOC quality performance.

The data sources and performance measures are described here. Please see Table 4.1 for the specific measures, goals and timeframes and plan for re-measurement. Evaluation of the effectiveness of the SNP Model of Care occurs annually as part of the overall Health Net Quality Improvement Program. Metrics may be reported monthly, quarterly or annually depending on the established procedure for the specific metric. Standard processes for evaluating health outcomes, access, availability, member satisfaction, providers, utilization, etc. are followed along with new processes developed to allow for the analysis of unique SNP outcomes.

The following sources will be utilized to collect and analyze data as part of the annual evaluation of the SNP Model of Care to evaluate outcomes in each of the domains as specified in 422.152(g)(2)(i)-(x) of the Code of Federal Regulations (CFR):

- **Health Outcomes And Use Of Evidence Based Practices** – Health Care Effectiveness Data and Information Set (HEDIS®) measures, including utilization metrics for inpatient, emergency and readmission
- **Access to Care** – member medical and behavioral health surveys, appeals and grievances re: access, monitoring of provider network, utilization metrics, HEDIS® preventive care metrics
- **Improvement in Health Status** – related HEDIS® measures, responses to HRA questions re: health status, pain, functional status, self-management
- **Implementation of Model of Care** – process reports from medical and behavioral health case management and delegation oversight
- **Health Risk Assessment** – initial and annual completion rates
- **Implementation of Care Plan** – audits of case management records and Care of Older Adults (COA) HEDIS® measure
- **Specialized Provider Network** – delegation oversight audits, availability of providers and facilities including behavioral health providers and specialists, member surveys, HEDIS® clinical measures
- **Continuum of Care** – related HEDIS® measures such as Medication Reconciliation, Plan All Cause Readmissions and Follow up after Hospitalization for Mental Illness and response to HRA question regarding transitions
- **Delivery of Extra Services** – utilization for transportation, Decision Power, Complex Case Management, Medication Therapy Management program, dental and vision benefits
- **Integrated Communications** – Customer Call Center (service level, abandonment rate), satisfaction survey

MOC.4.A.3 How leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.

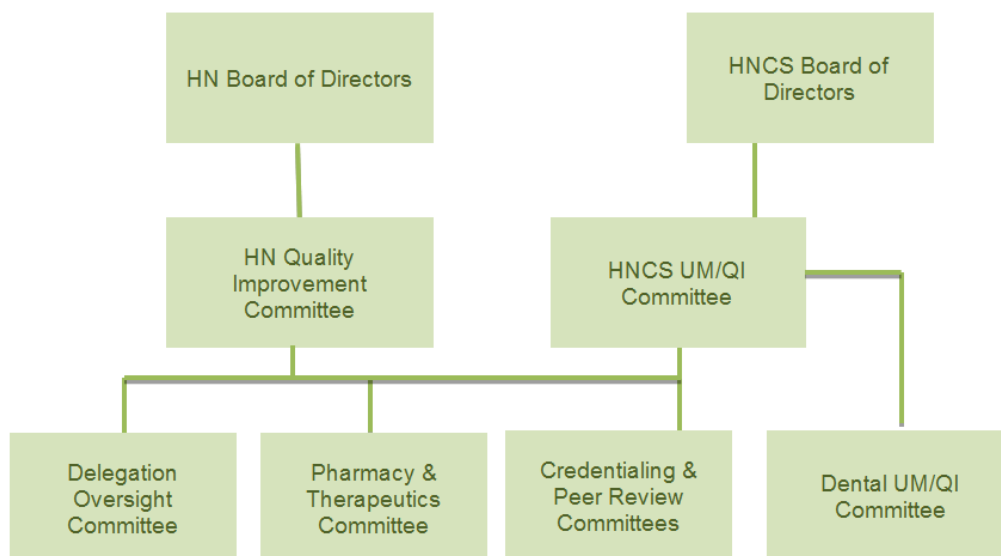
The Board of Directors are the governing bodies for the oversight of the Health Net QI Program, and have delegated the authority and responsibility for the development and implementation of the QI Program to the HNQIC and the HNCS UM/QI Committee.

Functions:

- Establish strategic direction for the QI Program

- Review reports from QI Committees delineating actions taken and performance improvements
- Ensure the QI Program and Work Plan are implemented effectively and result in improvements in care and service
- Assess and recommend, as needed, resources to implement quality improvement activities

Health Net Quality Improvement Committee Organizational Charts



QI Committee Structure

Health Net has established a committee structure to foster quality improvement discussions and activities from multi-disciplinary areas to ensure compliance with regulatory and accreditation requirements across all regions. The structure of the Health Net committee promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities.

The Quality Improvement Committee structure includes HNQIC, HNCS UM/QI Committee, and various sub-committees and workgroups. HNQIC and HNCS UM/QI Committees meet at least quarterly. Committees review and approve the QI Program Description, QI Workplan, and QI Annual Workplan Evaluation annually. Subcommittees meet regularly usually quarterly, and workgroups are convened as needed at which time an appropriate meeting schedule is created. Quality Committee and sub-committee minutes are recorded at each meeting. Minutes include the topics and key discussion points, and planned actions/follow-up if needed.

1. Health Net Quality Improvement Committee

HNQIC has responsibility for oversight of the QI Program and is responsible for monitoring the quality and safety of care and services rendered to Commercial and

Medicare Health Net members. The Committee is chaired by a Sr. Medical Director identified by the Chief Medical Officer and meets at least quarterly.

The HNQIC structure ensures practitioners participate in the planning, design, implementation, and review of the QI Program. External network practitioners participate on HNQIC along with representatives from MHN, Health Net Pharmacy Department, Network Management, Regional Medical Directors, Customer Service Operations, and Medical Management including Credentialing, Peer Review, and Utilization Management.

HNQIC Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Board of Directors or Executive Management Team at least annually
- Recommends policy decisions
- Ensure external practitioner participation in the QI program through planning, design, implementation or review
- Maintain meeting minutes
- Review behavioral health care initiatives and outcomes
- Monitors activities and evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement
- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement
- Oversees the CMS QI Program, receiving periodic reports on CMS-required QI activities
- Provides support and guidance to health plan associates on quality improvement priorities and projects
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service
- Addresses UM and QI activities which affect implementation and effectiveness of the QI Program and interventions

2. Health Net Community Solutions UM/QI Committee

The Health Net Community Solutions (HNCS) UM/QI Committee encompasses Health Net's Medi-Cal line of business and includes the Cal MediConnect demonstration program. The committee is charged with monitoring the medical management and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The HNCS UM/QI Committee is chaired by a Sr. Medical Director identified by the Chief Medical and meets at least quarterly. External practitioners

participate on this Committee along with representatives from MHN, the Health Net of California Pharmacy Department, HN's Dental Department, Network Management, Regional Medical Directors, Customer Service Operations, and Medical Management including Credentialing, Peer Review, and Utilization Management. The Dental UM/QI Committee reports to the HNCS UM/QI Committee and the HNCA Board of Directors. The Public Policy Committee includes Health Net members and provides regular reports to the HNCS UM/QI Committee.

HNCS UM/QI Committee Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Board of Directors or Executive Management Team at least annually
- Recommends policy decisions
- Ensures external practitioner participation in the QI program through planning, design, implementation or review
- Maintains meeting minutes
- Reviews behavioral health care initiatives and outcomes
- Monitors activities and evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement
- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement
- Provides support and guidance to health plan associates on quality improvement priorities and projects
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service
- Addresses UM and QI activities which affect implementation and effectiveness of the QI Program and interventions
- Reviews, approves, evaluates and make recommendations for Physical Accessibility of the providers offices

3. QI Sub-Committees & Workgroups

The following subcommittees and workgroups provide ongoing updates to HNQIC and/or HNCS UM/QI Committee to ensure consistent decision making, share information and provide a mechanism for escalating issues.

Pharmacy & Therapeutics Committees (P & T)

The Health Net Pharmacy and Therapeutics (P&T) Committees are decision-making bodies that meet quarterly to develop and update the company's drug formulary, or drug list. The P&T Committees' primary goal is to assure continuous member access to

quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a national strategy to optimize pharmacotherapy that is cost-effective for members.

The Committee membership includes Health Net pharmacists and associates, and practicing pharmacists and physicians from the provider network. A Health Net Medical Director chairs each state P&T Committee. Responsibilities include:

- Reviewing and approving policies that outline pharmaceutical restrictions, preferences, management procedures, delineation of recommended drug list exceptions, substitution/interchange, step-therapy protocols and adoption of pharmaceutical patient safety procedures
- Reviewing of pharmaceutical utilization and prescribing practice patterns
- Reviewing, revising and adopting of the Formulary on an annual basis
- Reporting to Health Net Quality Committees at least annually

Credentialing & Peer Review Committees

The Health Net Credentialing Committees (CC) oversees the credentialing and re-credentialing process for delegated and non-delegated practitioners and providers. This process ensures that the networks of health care practitioners providing professional services to Health Net members are trained, licensed, qualified and meet criteria for participation in accordance with regulatory requirements and accreditation standards. The Committees review performance data and have final decision-making authority. The Credentialing Committees have representation from primary and specialty care participating practitioners. The committees are chaired by a Health Net Medical Director and meet at least quarterly.

Health Net's Peer Review Committees (PRC) are responsible for decisions relating to quality of care and provide a forum for instituting corrective action when needed. The Peer Review Committees also assess the effectiveness of interventions through systematic follow-up. A Health Net Medical Director chairs each Peer Review Committee and meetings take place at least quarterly, or as deemed necessary by the Peer Review Committee Chairperson, to assure business is conducted timely. The members include representation from primary and specialty care practitioners and credentialing. Behavioral health representation is included on an ad hoc basis.

Delegation Oversight Committee (DOC)

The Delegation Oversight Committee (DOC) is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net. The overall goal is to ensure that Health Net members receive comparable quality of care and service. The Delegation Oversight Committee meet at a minimum of monthly with additional meetings added as needed to meet the business requirements. Responsibilities include:

- Ensuring there is a contractual agreement between Health Net and the delegate, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies
- Monitoring and evaluating a delegate's performance through routine reporting and an annual evaluation of the delegate's processes in compliance with all regulatory and accreditation standards
- Taking action if the monitoring reveals deficiencies in the delegate's processes
- Monitoring and evaluating a delegate's performance through due diligence prior to granting delegation

Medical Advisory Council (MAC)

Health Net's National Medical Advisory Council (MAC) is responsible for oversight of the formal process for the development and approval of medical policies, technology assessment, medical necessity criteria, clinical practice guidelines and preventive health guidelines. The MAC uses the principles of evidence based medicine to provide fair and impartial assessment of current medical and scientific literature of the effectiveness and appropriateness of procedures, devices, select drugs and biologicals. The MAC membership includes medical directors from all Health Net regions with a variety of specialties represented and other ancillary department representatives including medical management, legal and pharmacy and input is sought from physician experts as necessary. The MAC is chaired by the Senior Medical Director and meets at least 10 times per year.

Dental UM/QI Committee

The Dental UM/QI Committee monitors utilization management and care coordination activities, and the quality of care and services rendered to Medi-Cal dental members. The committee identifies and selects opportunities for improvement and monitors interventions.

The Dental UM/QI Committee is chaired by the Dental Medical Director and meets at least quarterly, independently of the HNCS UM/QI Committee. The findings and action of the Dental UM/QI Committee's Quality Improvement Program are presented at the quarterly meetings of the HNCS UM/QI Committee and the HNCA Board of Directors. Annually the Dental Medical Director presents the written report on the status of dental QI activities. The HNCS Committee approves the overall dental Quality Improvement System Manual (QIS) and the annual dental QIS report, directs the operational dental QIS to be modified on an ongoing basis.

Other:

QI Clinical & Service Workgroup

The QI Clinical and Service Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The workgroup also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, access, services and member and provider satisfaction. The workgroup consists of a core group of QI associates, a consulting physician and ad-hoc members pertinent to the report topic. At each meeting, there is focused discussion on report findings, barriers, and interventions for the purpose of making and implementing decisions regarding QI activities. The QI Clinical and Service Workgroup meets at least four times per year and reports significant findings to the HNQIC and/or HNCS UM/QI Committee.

Other Committees and Workgroups:

Committees and workgroups are convened at Health Net to address specific products or requirements and may not report directly to the Quality Improvement Committee. Current examples include the Medi-Cal Governance Committee, the Medicare STARS Governance Committee, the Commercial Governance Committee, and Cal MediConnect Governance Committee.

Key Associate Resources & Accountability

1. Chief Medical Officer

This position has responsibility for the QI and UM Programs and must assure that the Programs are compatible and interface appropriately with the provider network; oversee compliance with regulatory standards and reporting requirements; and achieve consistency in leading QI/UM operations. This individual has direct authority over Medical Management, Quality Improvement, Medical Directors and Behavioral Health.

2. Medical Director QI

The Chief Medical Officer designates a Medical Director to provide clinical and administrative physician leadership to the QI Program, including:

- Oversight of the development, implementation and evaluation of QI projects and population based care programs.
- Physician leadership for NCQA and regulatory agency surveys/audits.
- Represents Health Net as the physician QI liaison to external organizations, as needed.
- Chair Health Net Quality Committees

3. Vice President Quality Management

The VP of Quality Management reports directly to the Chief Medical Officer and is responsible for the overall direction and management of the QI Program, including:

- Organization wide QI outcomes and compliance with regulatory and accreditation bodies.
- Successful accreditation outcomes for all applicable regions and product lines
- Oversight of delegation to ensure performance meets established standards for quality and cost-effective delivery of healthcare services
- Overall HEDIS® operations and performance
- Credentialing and Peer Review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.
- Wellness, Health Education and Cultural & Linguistic program and services are developed and implemented for all members

4. Behavioral Health Medical Director

The MHN Medical Director is involved with the behavioral health care aspects of the QI program, including participation on the MHN QI/UM Committee, HNQIC, HNCS UM/QI and evaluating continuity and coordination of care between behavioral and medical health, triage and referral process and access/availability performance to ensure that a close, coordinated approach to provision of behavioral health services and coordination of care with medical services is in place.

5. Medical Directors

The Medical Directors are licensed physicians responsible and accountable for assuring appropriate clinical relevance and focus of the Utilization and Care Management and QI Programs for all lines of business. The Medical Directors interface with providers and individual practitioners and facilities to ensure the performance of the provider community meets established Health Net standards. The Medical Directors participate in HNQIC, HNCS UM/QI Committee and other QI activities.

6. Director of Quality Improvement

The Director of Quality Improvement reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Overall management of the QI Program including the behavioral health QI program
- Resolves barriers that prevent appropriate monitoring of quality of care and quality of services
- Assures implementation of quality improvement activities
- Reviews reports, identifying issues, formulating policies and procedures and makes recommendations to the QI committees
- Provides consultation to Quality Management associates
- Maintains accreditation and QI compliance

- Directs and leads a cross functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships and leading to affect appropriate and substantive interventions among leaders.
- Continuously assesses the data and information available on Medicare STAR performance, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Leads reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manages vendor relationships as necessary to support the processes to improve STARS performance.

7. Quality Improvement Managers

Health Net Quality Improvement Managers report to the Director of Quality Improvement. Responsibilities related to the QI Program include:

- Implements the structural components of the QI Program
- Maintains accreditation and compliance to QI requirements
- Organizes and directs activities designed to illustrate process improvement
- Oversees Facility Site Review and identifies issues regarding PCP and High Volume Specialty providers (including BH, Ancillary and CBAS) facility's physical accessibility

8. Quality Improvement Research & Analysis Manager

The Quality Improvement Research & Analysis Manager reports to the Director of Quality Improvement. Responsibilities related to the QI Program include:

- Assures implementation of quality improvement metrics and outcome measures
- Conducts an in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement
- Identifies data to be collected for selected studies and review format and methodology for appropriateness. Evaluates and analyzes relevant findings

9. Quality Improvement (QI) Associates

QI Associates have RN licenses or are Masters / PhD educated associates who implement quality improvement initiatives and studies for Health Net through multi-disciplinary workgroups designed to address clinical and service issues to meet all regulatory and accreditation requirements. Responsibilities are:

- Conduct the evaluation and review of the effectiveness of the QI Program and prepares documents for submission to the QI Committees, Executive Management Team and the Board of Directors

- Provide support, guidance and collaboration to Health Net departments to assure implementation, analysis and follow-up of activities per the QI Work Plan
- Review and/or revises policies and procedures on an annual basis, or as necessary
- Identify data to be collected for selected studies and reviews format and methodology for appropriateness. Reviews and analyzes the findings and recommends corrective actions and re-measurement as applicable
- Establish and implement programs and initiatives to meet NCQA requirements
- Maintain regulatory compliance
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

10. Director of Health Education/Wellness/Cultural and Linguistic Services

The Director of Health Education/Wellness/Cultural and Linguistic Services reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Overall management of the health education, wellness and cultural and linguistic related programs including health disparities reduction efforts.
- Directs and oversees department-led interventions and programs that address HEDIS measures and identifies and ensures action is taken on priorities.
- Reviews reports, identifies issues, formulates policies and procedures and makes recommendations to the QI committees.
- Provides consultation to Quality Management associates.

MOC 4.A.4 How SNP specific measureable goals and health outcomes are integrated into the overall performance improvement plan.

The SNP QI Program is part of the overall Health Net QI Program. The QI Program establishes standards for the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and member and provider satisfaction. Quality improvement activities are selected based on areas identified for improvement through data collection and monitoring and the following program goals:

- Support Health Net's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.

- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving/maintaining performance of target measures and takes action, as needed, to improve performance.
- Support a partnership among members, practitioners, providers, regulators and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and disease management programs.
- Monitor and improve Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of practitioner and member satisfaction surveys, focused studies, and analysis of administrative data; emphasizing administrative, primary care, high-volume specialists/specialty services, and behavioral health/chemical dependency services.
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolutions of perceived failure by practitioner/providers or Health Net personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate

Established quality improvement activities implemented to improve health outcomes, access and member satisfaction are inclusive of SNP members and new activities are developed as a result of analysis of SNP specific data and guidance from the HNQIC. SNP specific measureable goals and outcomes are integrated into the QI Workplan. Some examples of activities integrated into the overall performance improvement plan to meet SNP specific goals and health outcome objectives include:

- Quality Improvement Project to Improve Management of Osteoporosis
- Chronic Care Improvement Program to promote appropriate management of chronic disease as directed by CMS

- Medication Therapy Management program with quarterly medication reviews, appropriate provider and member interventions including access to a pharmacist
- High Risk Drugs to Avoid in the Elderly Program
- Decrease the use of Multiple Narcotics and High Dose Tylenol
- Promote Preventive Care: initiatives such as flyers, newsletters, on-hold messages, IVR calls to improve flu/pneumonia vaccine, breast cancer screening, colorectal cancer screening, diabetic retinal exam
- Activities to Improve Diabetic Care measures

Data collected from HEDIS®, CAPHS®, surveys, HRA, audits, appeals and grievance, utilization, customer service and other sources will be used to evaluate if the Allwell CHF/Diabetes SNP Cardiovascular SNP met the specific and measureable goals within a certain timeframe as described in Table 4.1 (please see MOC 4.B.2). These measurable goals are identified based on the overarching healthcare domains of the overall quality performance improvement plan (as detailed in MOC 4.A.2) and the aforementioned program objectives that are relevant to the SNP population. The current Star cut-points and CMS National Part C Average are utilized as goals when applicable. Outcomes are compared to applicable and available benchmarks from internal and external sources such as NCQA, CMS, Medicare Advantage and SNP member data. Each goal as stated in Table 4.1 will be compared to the previous year's performance and to the measurable specific goal and designated as "met" or "unmet" as part of the annual SNP MOC evaluation.

The results of the annual SNP MOC evaluation are reported to stakeholders and HNQC and their recommendations are considered in determining quality improvement activities, projects and specialized services and benefits to improve performance. Actions taken when program goals are not met will vary according to specific metrics, goals and affected departments. Please see MOC 4.B.5 for more details regarding plan for remeasurement of goals. Additional areas for potential improvement are prioritized based on compliance with regulatory guidelines, NCQA standards, performance as compared to the reference value and the ability to effectively address identified barriers.

MOC 4.B MEASURABLE GOALS AND HEALTH OUTCOMES

MOC 4.B.1 Identify and define the measurable goals and health outcomes used to improve the healthcare needs of SNP beneficiaries.

Overall the goals for the SNP Model of Care as stated by the Center for Medicare and Medicaid Services are to improve health outcomes through:

- Improved access to essential services such as medical, mental health and social services

- Improving access to affordable care
- Improved coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

MOC 4.B.2 Identify specific member health outcomes measures used to measure overall SNP population health outcomes at the plan level.

As part of the annual SNP evaluation, data is collected from HEDIS®, CAPHS®, surveys, HRA, audits, appeals and grievance, utilization, customer service and other sources for a comprehensive set of metrics in each healthcare domain (as detailed in MOC 4.A.2) and to meet requirements in 422.152(g)(2)(i)-(x) of the Code of Federal Regulations (CFR). Outcomes are compared to applicable and available benchmarks from internal and external sources such as NCQA, CMS, Medicare Advantage and SNP member data. A subset of metrics is identified for each of the program objectives that are relevant to the SNP population and re-evaluated each year. Measureable goals are determined on baseline performance and reference values within a certain timeframe (Table 4.1). The current Star cut-points and CMS National Part C Average are utilized as goals when applicable. Results will be compared year to year and to measure specific benchmarks that are available.

Table 4.1

DATA SOURCE	MEASURABLE GOALS AND TIMEFRAME
Improved Access to Essential Services: Medical, Mental Health and Social Services	
SNP Satisfaction Survey	"How often did you get appointment as soon as you thought you needed" Always/Usually will improve by 1% or achieve 84% Q12
HEDIS®	Percent of members with access to preventive or ambulatory health services (AAP) will achieve 95% in measurement year
Improved Access to Affordable Care	
SNP Satisfaction Survey	Rate for "How often did your case manager give you phone numbers or names of other groups to help you meet your health needs? will improve by 2% or achieve 70% Q6
Improved Coordination of Care Through an Identified Point of Contact	
SNP Part C Report	Overall completion of HRA (initial and reassessment) will improve by 3% or meet National Part C Average of 59% in measurement year
SNP	Rate for "Did you get the help you needed from your personal doctor's office

Satisfaction Survey	to manage your care among different providers and services?" will achieve 85% in measurement year
Improving Seamless Transitions of Care Across Health Care Settings, Providers and Health Services	
HRA	Continuing members with transition responding "Yes" to "Did you have the information you needed upon discharge regarding medications and follow-up care?" will improve by 3% or meet 85% in measurement year
HEDIS®	Members with Medication Reconciliation documented post-discharge will improve by 2% in measurement year
Improved Access To Preventive Health Services	
HRA	Continuing members reporting obtaining Flu Vaccine will improve by 1% or meet National Part C Average of 72% in measurement year
HEDIS®	Rate for Comprehensive Diabetes Care - Diabetic Retinal Exam will improve by 1% or meet National Part C Average of 70% in measurement year
Assuring Appropriate Utilization of Services	
HEDIS®	Rate for Emergency Department Utilization (AMB ED) will decrease from previous year
HEDIS®	All Cause Readmission rate in 30 days (>65 years) will decrease by 0.5% or meet National Part C Average of 10% in measurement year
Improving Beneficiary Health Outcomes	
HEDIS®	Rate for High Risk Drugs in the Elderly (1 drug) will improve by 1% or meet NCQA 50 th percentile of 17% in measurement year
HEDIS®	Rate for Osteoporosis Management will improve by 1% or meet National Part C Average of 35% in the measurement year*
HEDIS®	Rate for Controlling Blood Pressure will improve by 1% or meet National Part C Average of 71% in the measurement year.

*C-SNP Allwell CHF/Diabetes SNP plans will be combined to obtain sufficient denominators

MOC 4.B.3 How methods are established to assess and track the MOC's impact on SNP beneficiaries' health outcomes.

As a Medicare Advantage Organization, Health Net is required to collect and report annual Health Care Effectiveness Data and Information Set (HEDIS®), including the SNP specific HEDIS® metrics as directed in Chapter 5 of the Medicare Managed Care Manual. Health Net contracts with a NCQA-certified software vendor to produce the HEDIS® measures. The vendor follows the NCQA Technical Specifications and applicable Technical Update to define the eligible population/denominator and numerator compliance through proprietary software certified annually by NCQA. The HEDIS® reporting process is audited by an NCQA-licensed audit firm.

For HEDIS® reporting, Health Net obtains and provides pharmacy, claims, encounter, membership, provider and other supplemental data to the software vendor through a secure FTP transmission process. The submission of data is reconciled from Health Net to the software vendor through an access database called the Data Tracking Tool which ensures data has been transmitted correctly and completely to the software vendor. The data is then loaded into the certified software product. The specifics of the loads are documented on the Check Figure Report which contains a listing of all data received. The report is reviewed by Health Net for accuracy and completeness.

As required by CMS and state agencies, Health Net's HEDIS reporting activities must undergo an audit by an NCQA-certified HEDIS Compliance Audit Firm. Health Net contracts with an NCQA-licensed audit firm to conduct the audit. The HEDIS audit program verifies that Health Net's HEDIS production conforms to the Technical Specifications.

Health Net is also required to contract with an NCQA-certified vendor to conduct the Medicare Consumer Assessment of Health Care Providers and Systems (CAHPS®) Survey for Medicare members as outlined in the CMS Chapter 5 of the Medicare and Managed Care Manual. CAHPS® is an annual nationwide survey that is used to report information on Medicare beneficiaries' experience with managed care plans. Health Net receives written notification from CMS of the timeline in which the surveys are conducted, the number of surveys and the expected number of Medicare, inclusive of SNP members, who will receive a survey. CAHPS® data are made available to all stakeholders. The results are shared with Medicare members and the public by CMS.

As described in MOC 4.B.2, relevant measures are selected that will have an impact on the health outcomes of SNP members, such as improvement in cardiovascular and diabetic health outcomes, preventive care and coordination of care. Health Net has established processes and contracts with vendors when appropriate to collect SNP health outcome data through HEDIS® and annual HRAs, member experience and access to care through CAHPS® and internal surveys, and data from provider network, delegation oversight, utilization of services, customer service, communication systems and transitions of care through internal information systems and audits of case management and concurrent review files. Data is collected according to the established process for the individual metric and could be monthly, quarterly or annually as with HEDIS® and CAHPS®. Medicare rates, of which SNP is a subset, for select HEDIS® measures are also reported to providers monthly for more current monitoring of performance.

The SNP member health outcomes from each of these measures are compared year to year and with available benchmarks and/or goals as part of the annual evaluation of the SNP MOC. Annual data and progress towards goals is collected, analyzed and reported to the HNQC and stakeholders. Electronic and print copies of the evaluation of the SNP Model of Care are prepared annually, reported to the HNQC and as requested, to regulatory and accreditation organizations and preserved as an official record. The complete document includes quantifiable measures, quantitative and qualitative analysis, barrier and opportunity analysis, actions taken to address barriers, goals met/unmet and data definitions.

MOC 4.B.4 Describe the processes and procedures the SNP will use to determine if health outcomes goals are met.

The SNP member health outcomes from each of these measures are documented in the CMS Plan Performance Monitoring and Evaluation tool (PPME) and compared year to year and with available benchmarks and/or goals as part of the annual evaluation of the SNP MOC. Annual data and progress towards goals is collected, analyzed and reported to the HNQC and stakeholders. Established processes to collect outcomes are described in MOC.4.B.3. In the annual MOC evaluation, each goal as stated in Table 4.1 is compared to the previous year's performance and to the measurable specific goal and designated as "met" or "unmet".

MOC 4.B.5 Describe steps taken if goals not met in expected time frame.

As stated in MOC 4.A.3, Health Net has established a committee structure to foster quality improvement discussions and activities from multi-disciplinary areas to ensure compliance with regulatory and accreditation requirements across all regions. One of the functions of the committee structure is to provide input and recommendations for corrective actions and monitoring previously identified opportunities for improvement. The structure of the Health Net committees promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities. The results of the annual SNP MOC evaluation including "met" and "unmet" goals are reported to stakeholders and HNQC and their recommendations are considered in determining quality improvement activities, projects and specialized services and benefits to improve performance. Actions taken when program goals are not met will vary according to specific metrics, goals and affected departments.

Outcomes from the HEDIS®, CAHPS®, HRA, Medication Therapy Management (MTMP), utilization, communication systems and other program indices are analyzed at least annually. Action taken for metrics that do not meet goals can include Quality Improvement Projects or activities such as member outreach, provider education, benefit restructuring or system and process changes designed to impact the outcomes and improve care or service. Interventions can include automated calls, newsletters, health calendars, emails, and educational materials designed to improve Flu/Pneumonia Vaccination, diabetes care, colorectal cancer and glaucoma screening, cardiac health and member satisfaction. Providers are also given access to actionable care gap lists to provide follow up with members to close gaps.

Health Net also investigates and requests corrective actions when timely access to care, as required by Health Net's Access and Availability policies, is not met. Health Net has provided doctor's offices with educational materials, after-hours provider scripts in multiple languages, and a patient experience materials in multiple languages for improving access to care. Results of access monitoring through surveys and appeals and grievance data and applicable actions for improvement are reported to the HNQC for review and approval.

Health Net also conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files and an on-site review of the SNP delegated group's

operations. The evaluation results are compiled and a written summary of the findings and recommendations are presented to the Delegation Oversight Committee for final determination. This type of audit is also performed annually, at a minimum, to determine the continuation of the delegated relationship. Delegated groups that do not meet the SNP program requirements are issued a Corrective Action Plan, closely monitored until compliance is met. If they continue to be noncompliant and/or fail to fully implement the Corrective Action Plan, this can lead to de-delegation.

Performance is also evaluated at the provider level for select clinical measures and monthly “report cards” are provided with year to date rates. Groups that are low performing and consistently below the goal of 4 Stars are asked to document and provide a corrective action plan (CAP) and monitored for improvement. Plans that do not meet performance goals can be excluded from the Medicare network.

MOC 4.C. MEASURING PATIENT EXPERIENCE OF CARE (SNP MEMBER SATISFACTION)

MOC 4.C.1 Describe the specific SNP survey used.

Health Net has collaborated with a CAHPS® certified vendor to develop and conduct a survey to assess the experience of the SNP population with the Case Management program. This SNP satisfaction survey asks members to rate their experience with: their Case Manager, care coordination between case manager and provider, access, and ease of obtaining appointments. A random sample of eligible SNP members per applicable region (AZ, CA, and OR) is selected to participate in this SNP Satisfaction survey annually. The administered survey should take no longer than ten minutes to complete. The goal is to complete 400 member surveys per region. The response rate is monitored to collect an adequate sample size. The questionnaire is programmed in English and Spanish into the Computer Assisted Telephone Interview (CATI) system, and bilingual interviewers will conduct the survey via the telephone. At least three call attempts will be made to reach respondents. The survey results are produced for each region and stratified by SNP type (C-SNP vs. D-SNP).

Table 4.2 details survey questions asked of SNP members regarding member satisfaction.

Table 4.2

QUESTIONS
Q1. Have you received help from a case manager or health team member in the past 12 months? This help could be from someone in your doctor office or from Health Net.
Q2. How often did the case manager or health team help you get the doctor visits or services you needed?
Q3a. How often was the help from your case manager to meet your health needs easy to understand and follow?

QUESTIONS
Q3b. How often did your case manager or health team treat you with courtesy and respect?
Q3c. How often did your case manager or health team give you the help you needed for your health needs?
Q4. How often did you make changes that improved your health because of help from your case manager or health team?
Q5. How often was any written health information from your case manager or health team useful and easy to follow?
Q6. How often did your case manager give you phone numbers or names of other groups to help you meet your health needs?
Q7. What is your overall satisfaction with the case management program?
Q8. How likely are you to get a flu shot or test for cancer because the case manager or health team asked you to?
Q9. How likely are you to take your medications regularly because of help from the case manager or health team?
Q10a. How would you describe your ability to understand what your doctor tells you?
Q10b. How would you describe your ability to follow what your doctor tells you?
Q11. In the last 12 months, not counting the times you needed emergency care, did you make any appointments for your health care at a doctor's office or clinic?
Q12. In the last 12 months, not counting the times you needed emergency care, how often did you get that appointment as soon as you thought you needed?
Q13a. In the last 12 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?
Q13b. In the last 12 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?
Q14. In the last 12 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
Q15. Specialists are doctors like surgeons, heart doctors, allergy doctors, psychiatrists, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make appointments to see a specialist?
Q16. In the last 12 months, how often was it easy to get appointments with specialists?

MOC 4.C.2 Explain the rationale for the selection of a specific tool.

The tool as described in the previous section was developed because it allowed Health Net to have input into the design of the questions and survey methodology. Questions were framed to evaluate the case management program and impact on member health. Additional questions were added to obtain data specific to SNP access to care. The survey measures if specific program goals are being met to identify processes for improvement.

MOC 4.C.3 Describe how results of patient experience surveys are integrated into the overall MOC performance improvement plan

The vendor for the patient experience survey completes a quantitative and qualitative analysis and report of barriers and opportunities based on member's survey responses and compared to the previous year. Outcomes are communicated to case management, delegation oversight, providers and additional departments. Health Net evaluates the report, identifies barriers and opportunities and plans interventions to address barriers and improve outcomes. The survey outcomes are integrated into the annual evaluation of the SNP Model of Care and measurable goals are developed for the Plan Performance Monitoring and Evaluation document (PPME). Please see MOC 4.C.4 for more details regarding next steps.

MOC 4.C.4 Describe steps taken by the SNP to address issues identified on survey response

The vendor completing the SNP program satisfaction survey provides an annual report designed to determine strengths, weaknesses, and priorities for improvement as well as to monitor the results of improvement efforts over time. After the barrier analysis is conducted, low scoring areas will be incorporated into action plans to improve member experience with case management such as educational programs to improve communication, coordination of care, knowledge of community resources, and use of motivational interviewing to change health behaviors.

4D. ONGOING PERFORMANCE IMPROVEMENT OF THE MOC

MOC 4.D.1 How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

The vendor completing the SNP program satisfaction survey provides an annual report designed to determine strengths, weaknesses, and priorities for improvement as well as to monitor the results of improvement efforts over time. After the barrier analysis is conducted, low scoring areas will be incorporated into action plans to improve member experience with case management such as educational programs to improve communication, coordination of care, knowledge of community resources, and use of motivational interviewing to change health behaviors.

MOC.4.D.2 How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.

The analyzed results of the effectiveness of the SNP MOC are collected and reported annually. Individual interventions that are implemented to improve select measures are re-evaluated for effectiveness when goals are not met and new interventions may be developed based on best practices. Additionally, new metrics may be identified for potential improvement as part of the annual evaluation of the SNP MOC when they decline or are below the available reference value. The potential areas for improvement identified through data collection are prioritized based on compliance with regulatory guidelines, NCQA standards, performance as compared to the reference value and the ability to effectively address identified barriers. Potential new measures to be targeted for improvement based on the annual evaluation of the SNP MOC is included in the annual report. New and revised goals to continuously improve the MOC are based on the data analysis and documented in the annual SNP MOC evaluation.

MOC.4.D.3 The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

Multiple data sources are utilized to evaluate the SNP MOC that are collected and acted upon by various departments. Data is collected at intervals that allow timely intervention by the affected department. For example, the customer service department evaluates their ability to answer calls in a timely manner and has a back-up system in place to make immediate adjustments when performance goals are not being met such as adjusting staffing and call systems during unplanned and known periods of high call volume. The pharmacy department monitors performance for medication adherence and drugs to avoid in the elderly monthly and provides proactive interventions with member or providers when care gaps are identified.

Health Net also produces year to date performance reports on HEDIS measures for provider groups to obtain continuous, instead of annual, performance results for HEDIS metrics. This supports timely evaluation of the effectiveness of health plan and provider interventions and taking action for performance that is not meeting the expected targets and goals.

MOC.4.D.4 How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders

The annual SNP MOC evaluation and progress towards goals is reported to the Health Net Quality Improvement Committee (HNQIC) which includes internal and external stakeholders such as providers and leadership from key departments. HNQIC and the Director of QI provides a summary report to the Board of Directors (BOD). HNQIC is composed of internal and external providers, management and leadership of key departments responsible for implementation of the SNP Program such as program accreditation, delegation oversight, contracting, case management, disease management, cultural and linguistics, appeals and grievances, research and analysis, and credentialing.

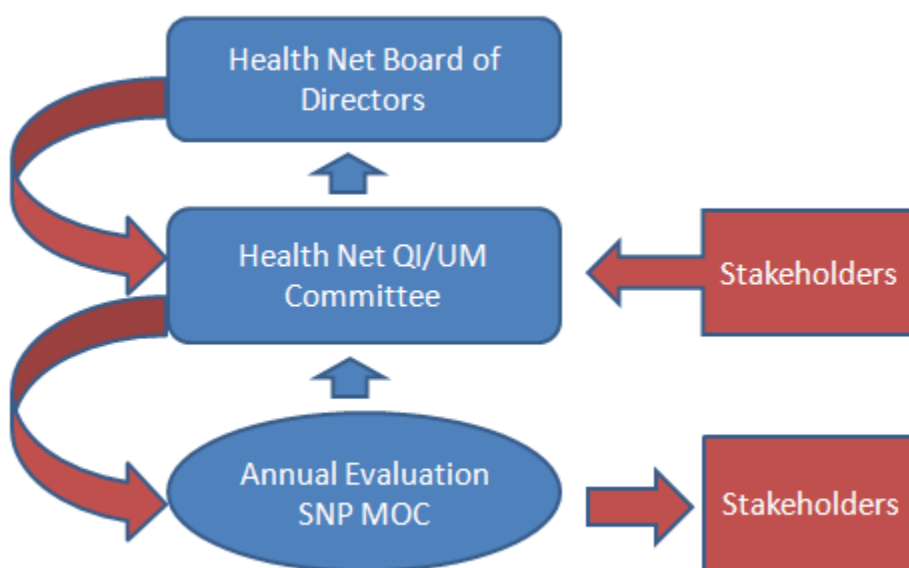
Results of the data analysis and recommendations of HNQIC is considered in determining quality improvement activities, projects and specialized services and benefits. In addition, a provider webinar on program outcomes is conducted annually with opportunity for feedback and recommendations. Providers also represent and communicate member issues at HNQIC and during webinars. Electronic and print copies of the evaluation of the SNP Model of Care are prepared annually, reported to the HNQIC and as requested, to regulatory and accreditation organizations and is recorded in the minutes and preserved as an official record.

MOC 4.E. DISSEMINATION OF SNP QUALITY PERFORMANCE OF THE MOC

MOC 4.E.1 Describe how performance results are shared with multiple stakeholders

Providers and members are informed of outcomes through educational programs, meetings, provider updates, newsletters, and provider and member portal online articles. The Medicare Newsletter includes, “Health Net’s Commitment to Quality” informing members of Health Net’s progress towards goals for key HEDIS® and Customer Satisfaction metrics including improvement from the previous year and comparison to national benchmarks. The SNP specific HEDIS® Care of Older Adults metrics are included.

Quarterly provider newsletters report similar information according to product line. Provider updates throughout the year inform providers of the outcomes of the quality improvement program and projects. A provider webinar on quality outcomes and progress towards goals for measures regarding preventive care, chronic disease management, care transitions and member satisfaction is conducted annually. Provider meetings are scheduled throughout the year with the Regional Medical Team and “Report Cards” are reviewed with the provider group including best practices and resources available to improve performance.



The annual SNP MOC evaluation and progress towards goals is reported to the HNQIC which includes internal and external stakeholders such as providers and leadership from key departments. HNQIC is composed of internal and external providers, management and leadership of key departments responsible for implementation of the SNP Program such as program accreditation, delegation oversight, contracting, case management, disease management, appeals and grievance, cultural and linguistics, research and analysis, and credentialing. Member advisory committees for public programs solicit member feedback.

MOC 4.E.2 State the scheduled frequency of communication with stakeholders.

- Annual webinars are conducted with Provider Groups on program outcomes and progress towards goals. Results from quality measures related to preventive care, chronic disease management, care transitions and member satisfaction is reviewed and followed by a discussion of how to improve results.
- Annual SNP Program evaluation is reported to the HNQIC committee. In addition to the outcomes, the report includes a barrier analysis, opportunities and summary of interventions to address low performance.
- An online article, “Quality Improvement Outcomes and Progress” is published annually for providers and includes key outcomes compared to the previous year and to national standards for multiple lines of business. Examples of the measures of clinical care included in the online article are: Advance Care Planning, Functional Assessment, Medication Review, and Pain Assessment.
- The Medicare newsletter article, “Health Net’s Commitment to Quality” informs members of Health Net’s progress towards the goal of improving care and outcomes and is produced annually. Categories include: Measures of Clinical Care, Service, and Health Outcomes.

MOC 4.E.3 Describe the methods for ad hoc communication with stakeholders.

In addition to the annual provider teleconference on quality outcomes, additional teleconferences (6 per year) are scheduled on the SNP MOC, chronic disease management, preventive care and other relevant topics. Topics for the teleconferences change each year according to the initiatives targeted for improvement as a result of ongoing data collection and monitoring. At each teleconference providers are encouraged and given the opportunity to ask questions or share observations or best practices with each other. Ad hoc online, provider email alerts and faxed communications are produced periodically throughout the year to provide updates to providers on a variety of quality initiatives including those by Health Net Pharmacy Services.

MOC 4.E.4 Identify the individuals responsible for communicating performance updates in a timely manner

Health Net has provided extensive resources to the SNP program to meet the comprehensive data collection, analysis, evaluation and communication requirements. The Medicare QI Manager, BSN, CPHQ leads a team of 6 Senior QI Specialists with nursing, master's or doctoral prepared backgrounds in public health fields. SNP members are incorporated into the initiatives to improve healthcare outcomes for all Medicare members including improving diabetic and cardiovascular measures, the Chronic Care Improvement Program (CCIP) and the Quality Improvement Programs (QIP) to decrease readmissions and management of Osteoporosis. The Medicare QI Manager or delegate annually reports SNP progress towards goals, CCIP and QIP outcomes to the HNQIC and to stakeholders through the Provider webinar. Senior QI Specialists develop the online article and Medicare newsletter article annually reporting clinical outcomes.

The QI Research and Analysis (QIRA) team includes Doctoral, Master or Bachelor prepared Research Analysts in Public Health, Biostatistics, Epidemiology and Business Economics. The QIRA team also participates in the data collection, analysis and SNP program evaluation and the QIRA Manager or designee presents reports to the HNQIC on integrated member satisfaction, access and availability and epidemiological reports.

The QI Director holds a Masters in Exercise Studies and a Bachelor of Science in Physical and Health Education. She has multiple years of experience with the Medicare, Stars and SNP programs and provides resources and guidance for the QI Medicare Manager and communicates updates on the SNP MOC evaluation to the Board of Directors.

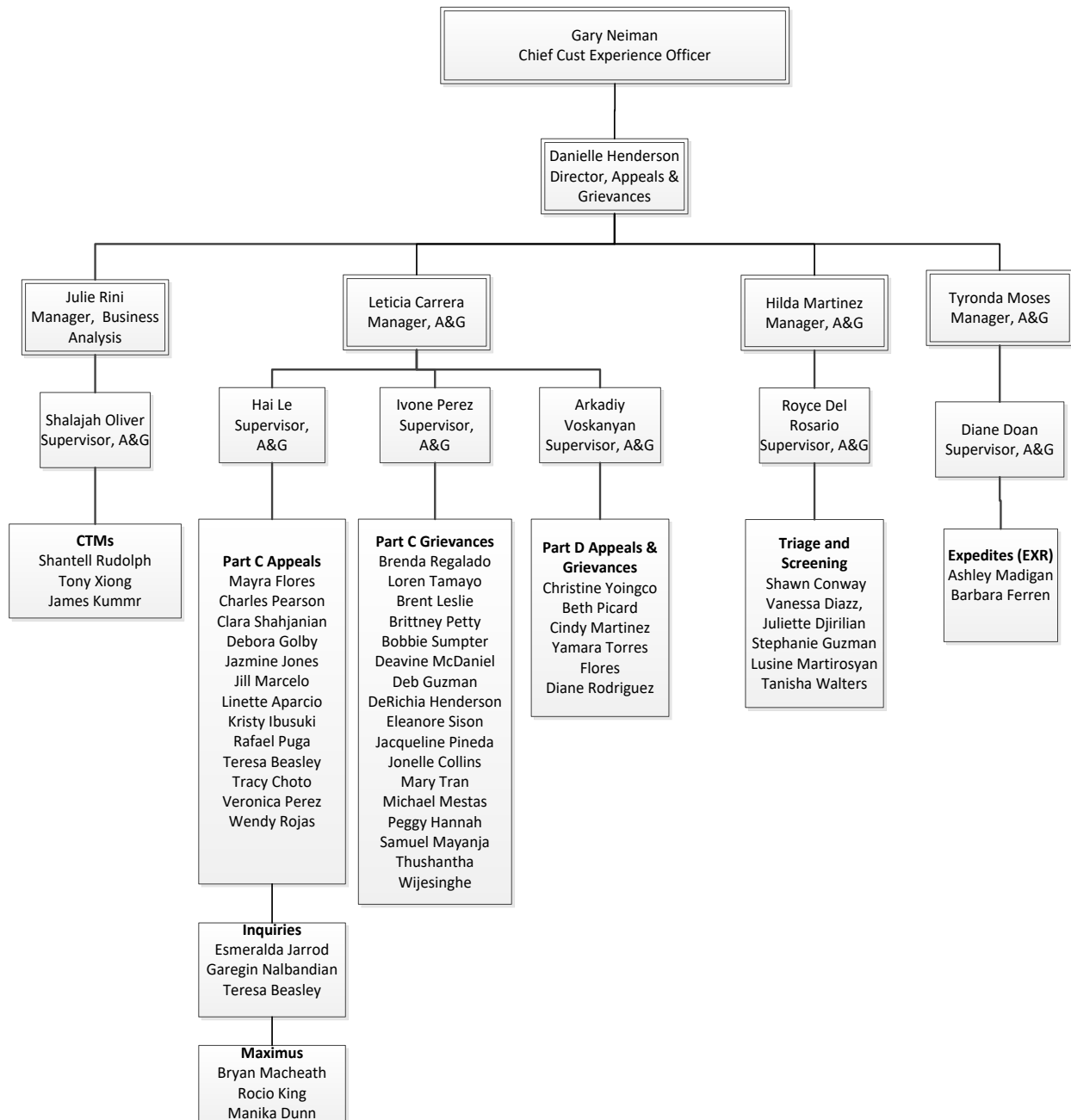


Organizational Charts

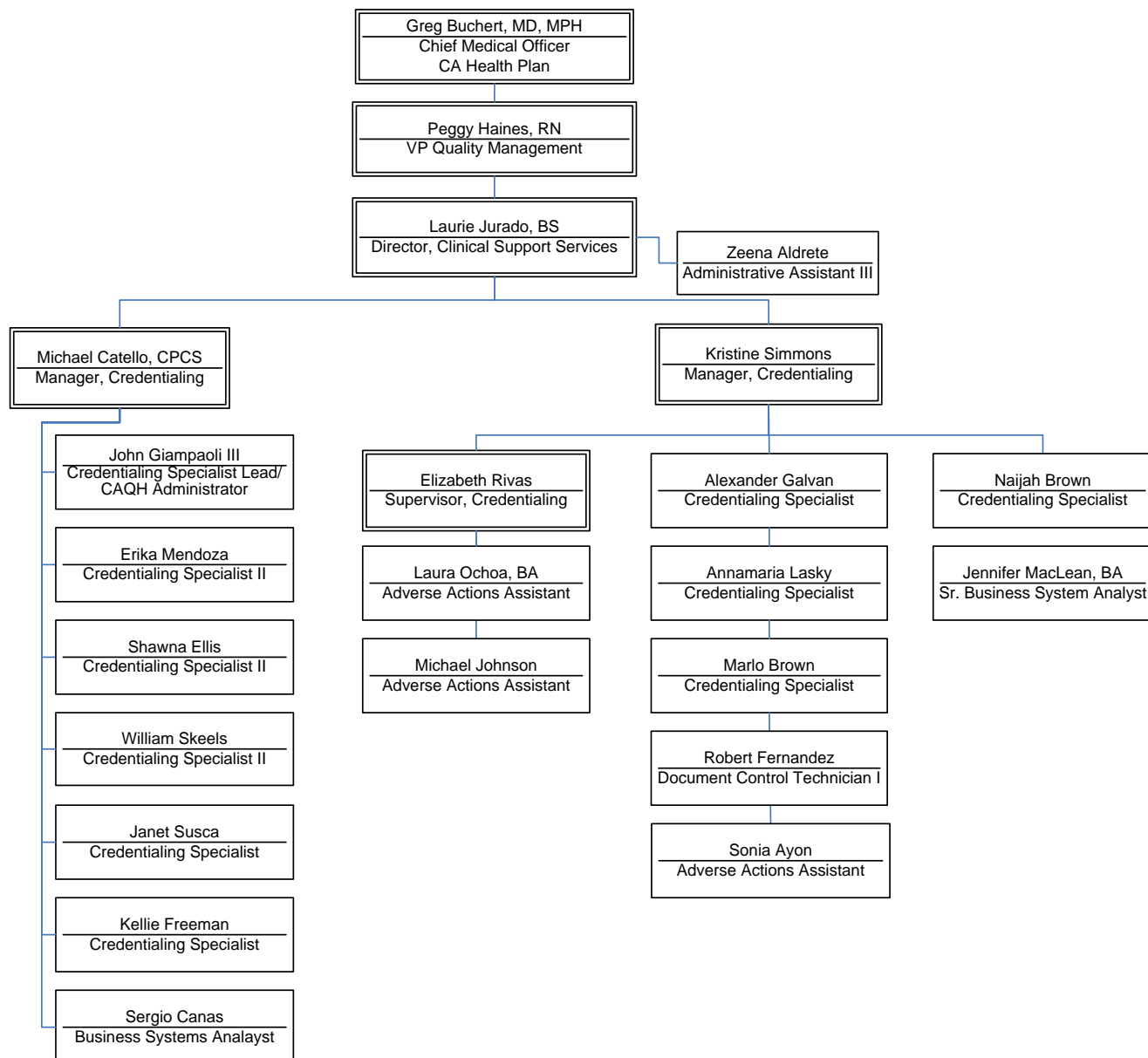
These organizational charts represent the complete departments and not the SNP line of business only.

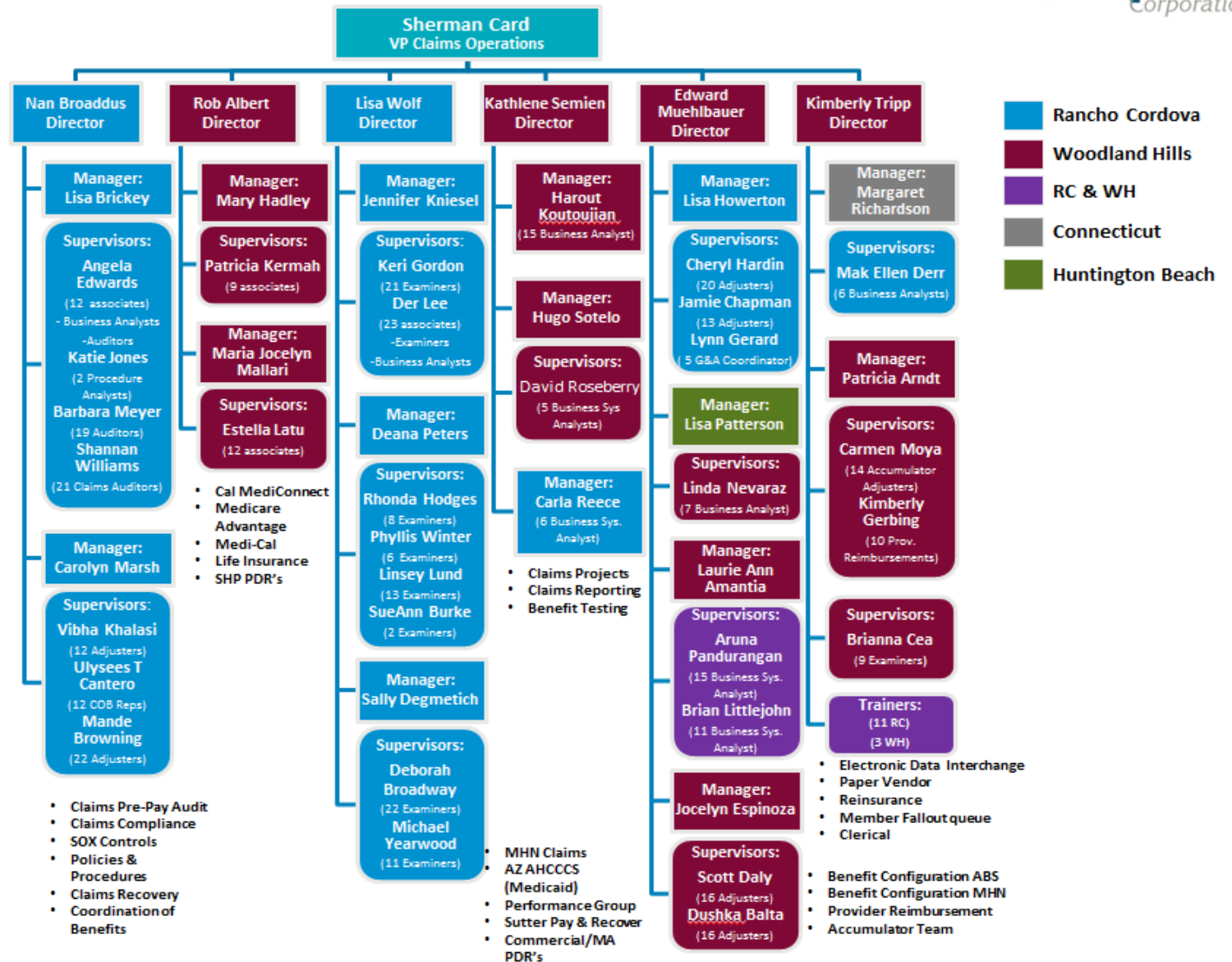
February 2017

Member Appeals & Grievances

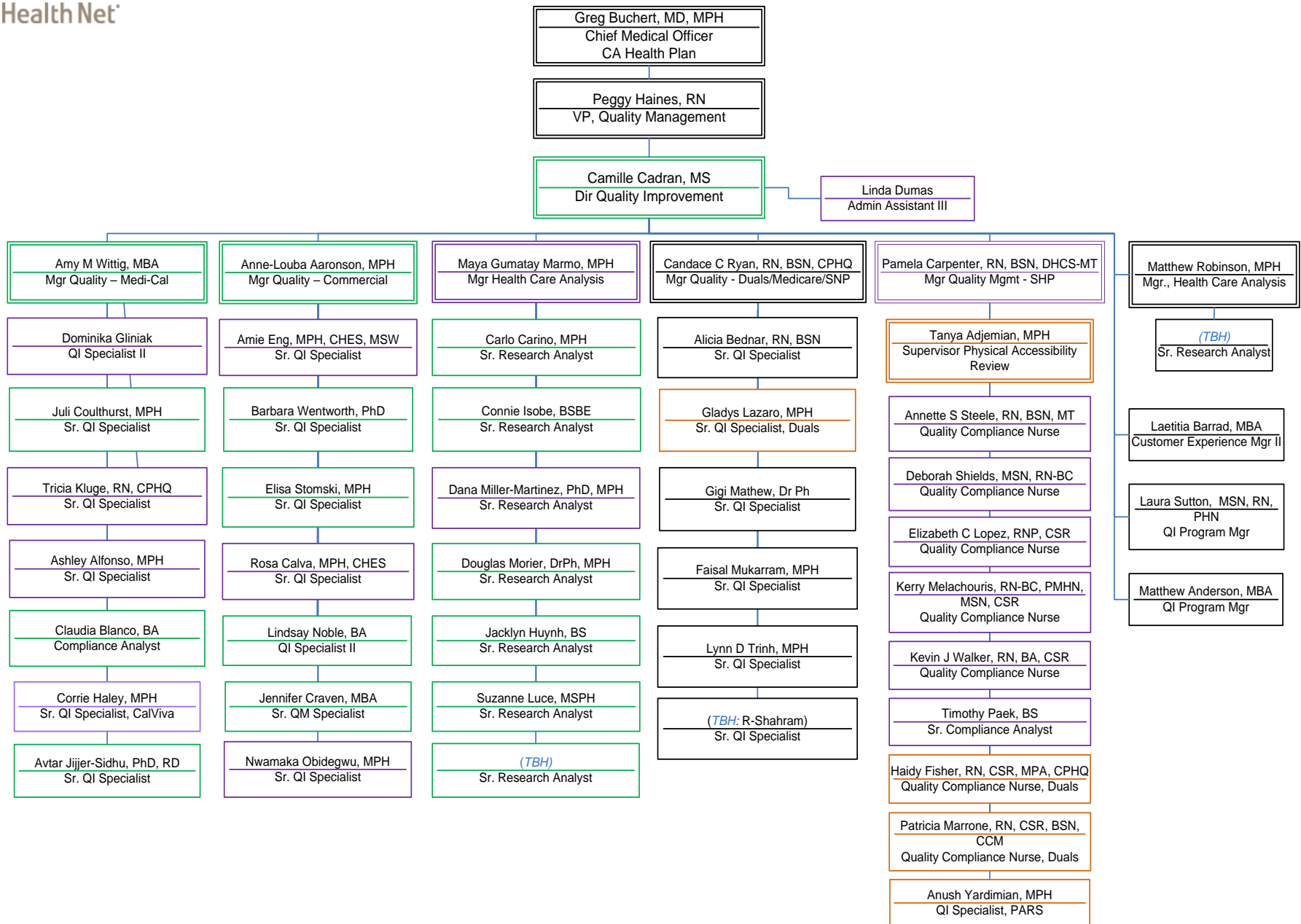


Credentialing Adminstrative

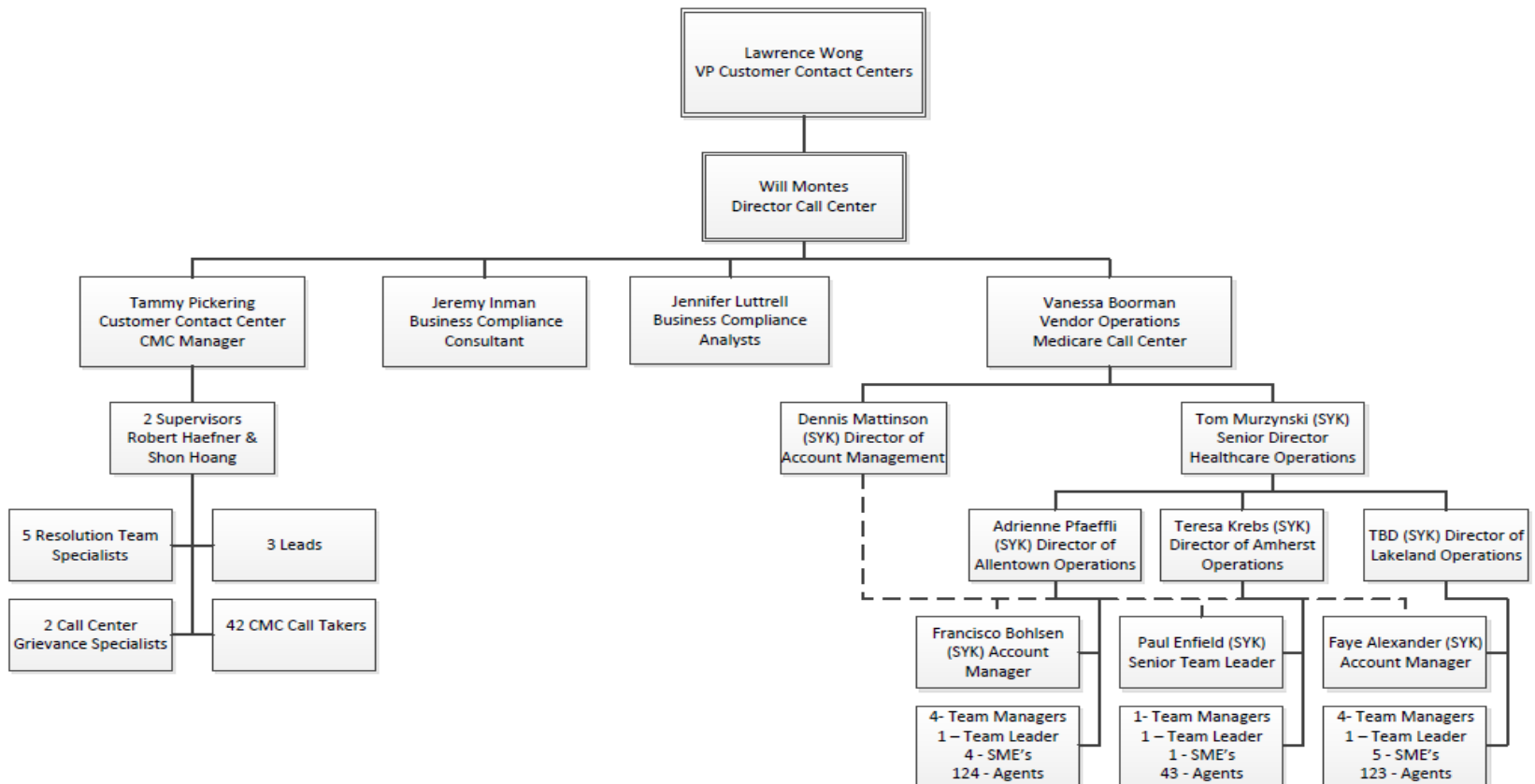


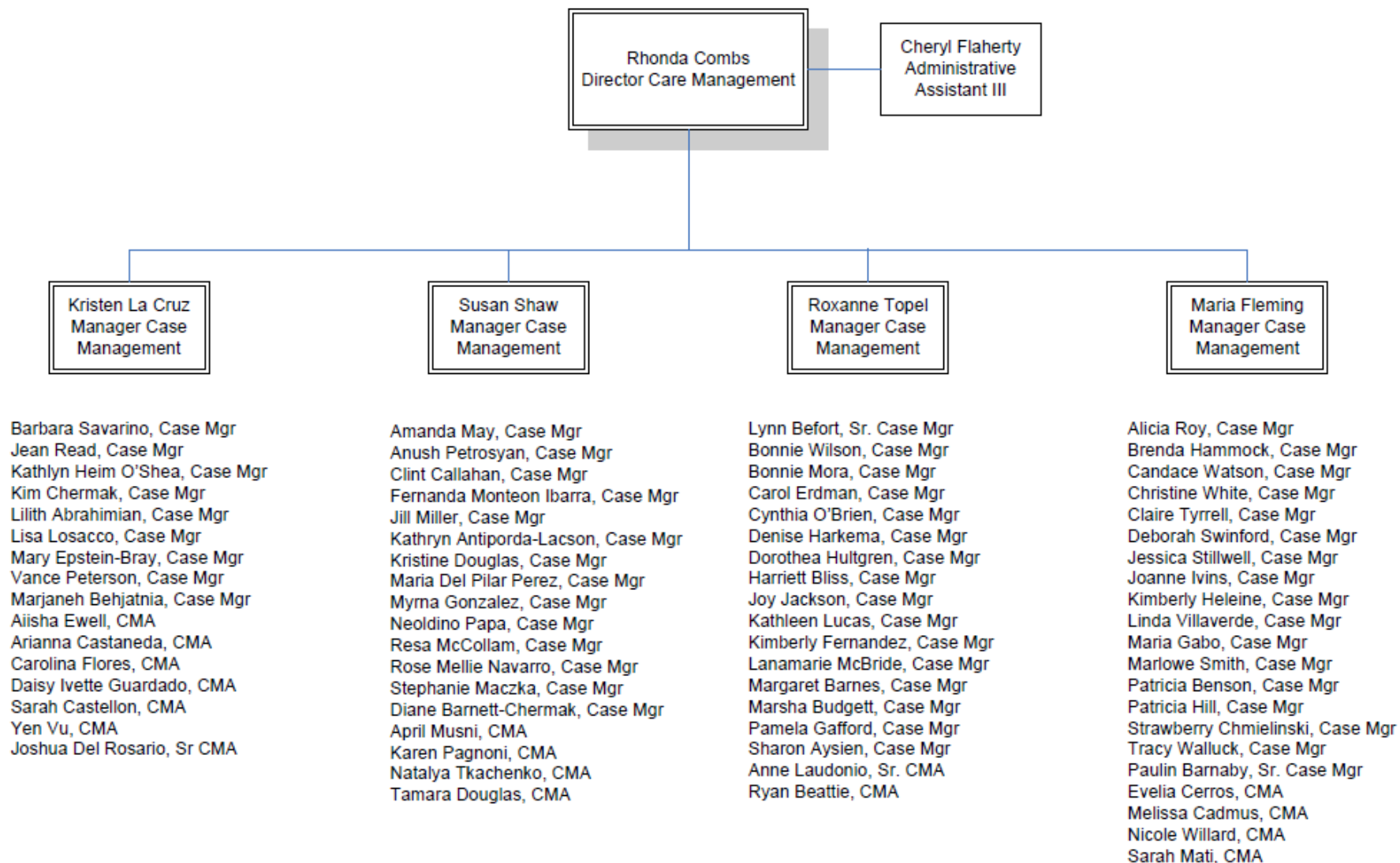


Quality Improvement

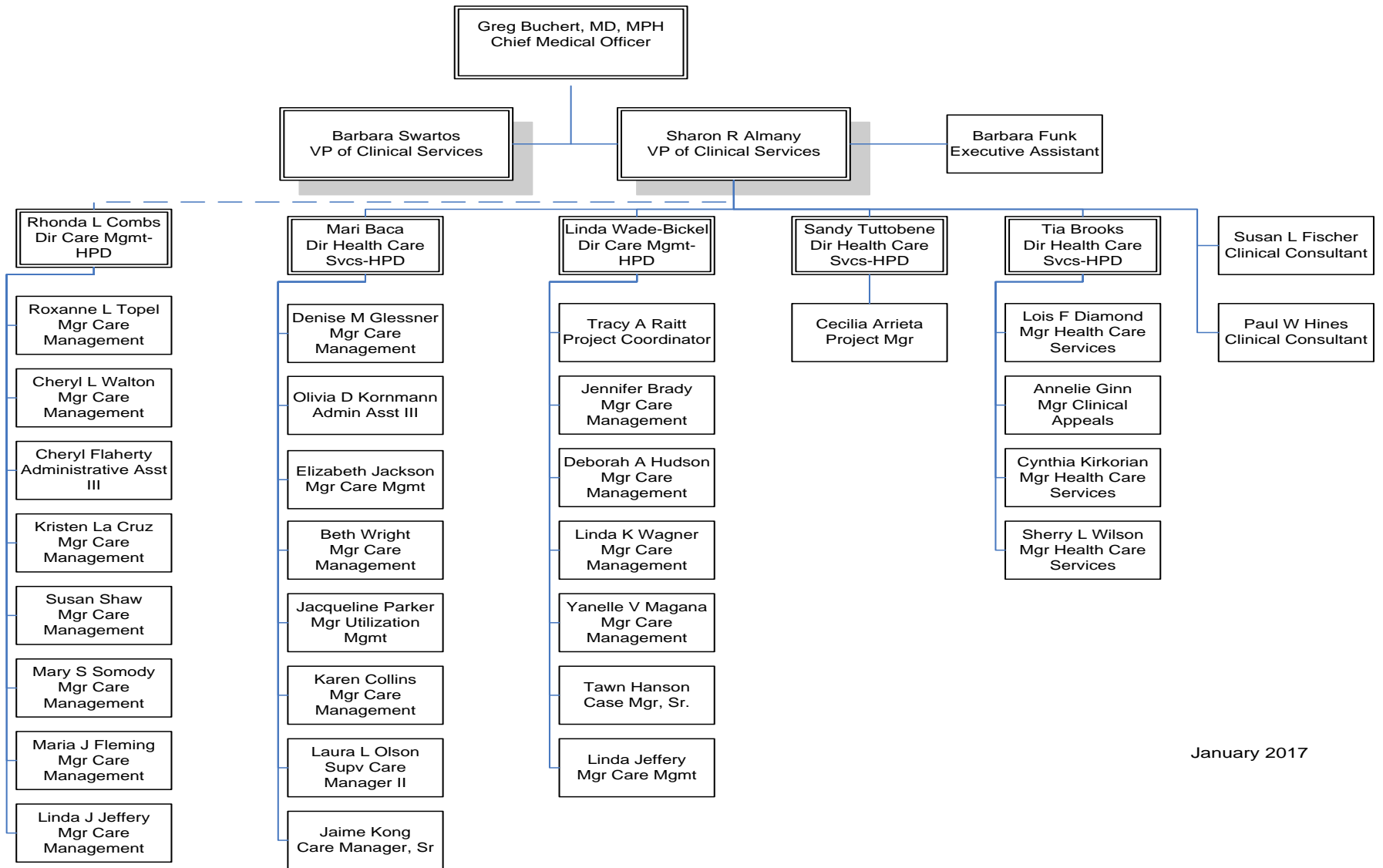


Customer Call Center Oversight



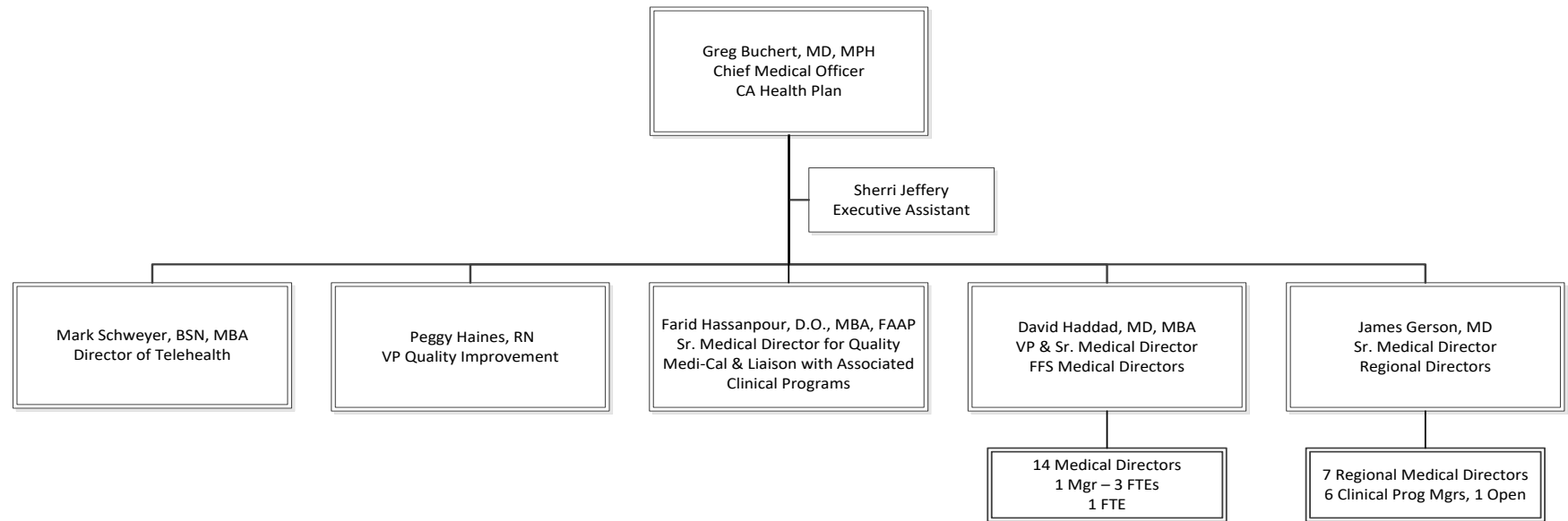


Clinical Services VP / Director Level Oversight

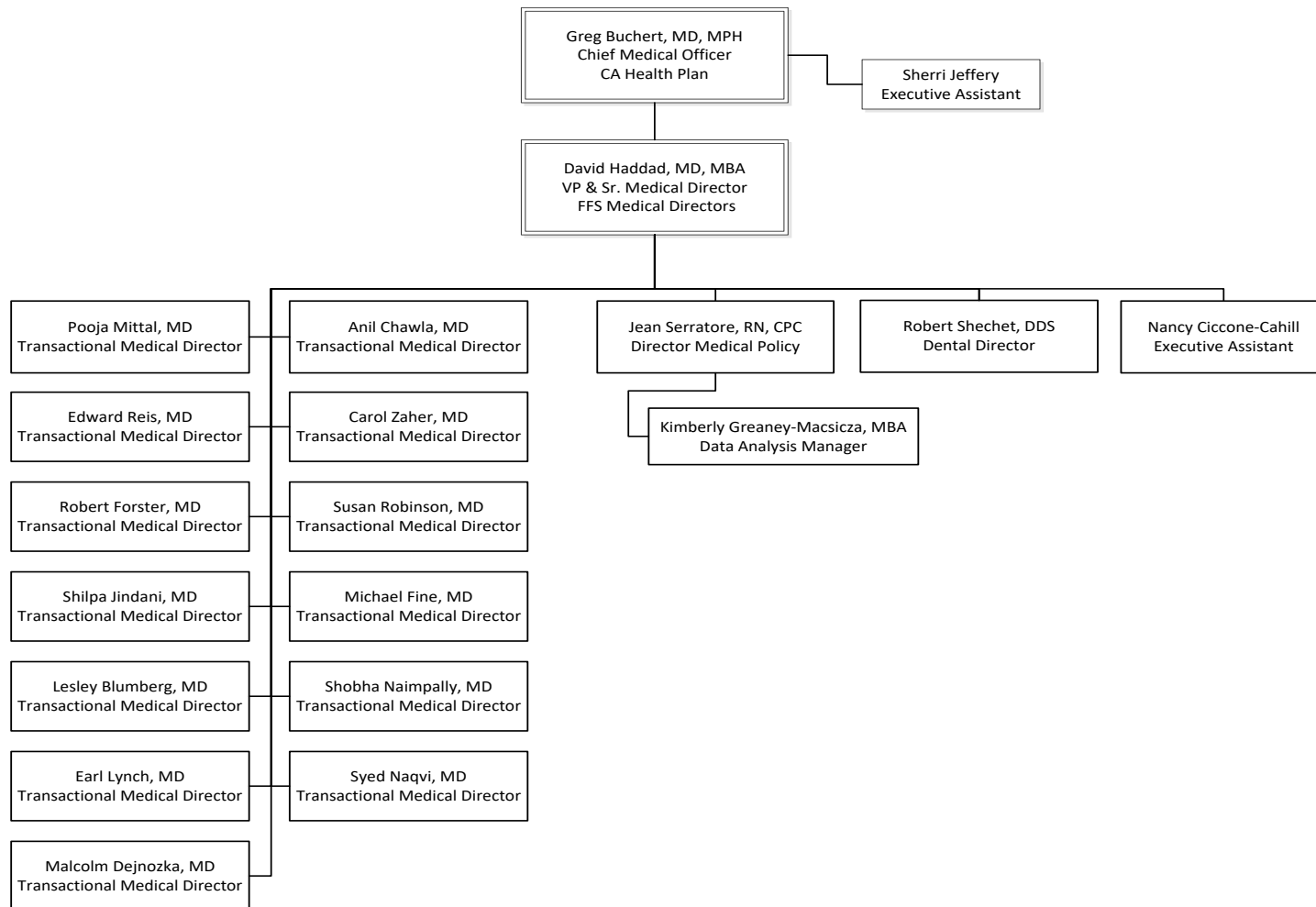


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Medical Management Oversight

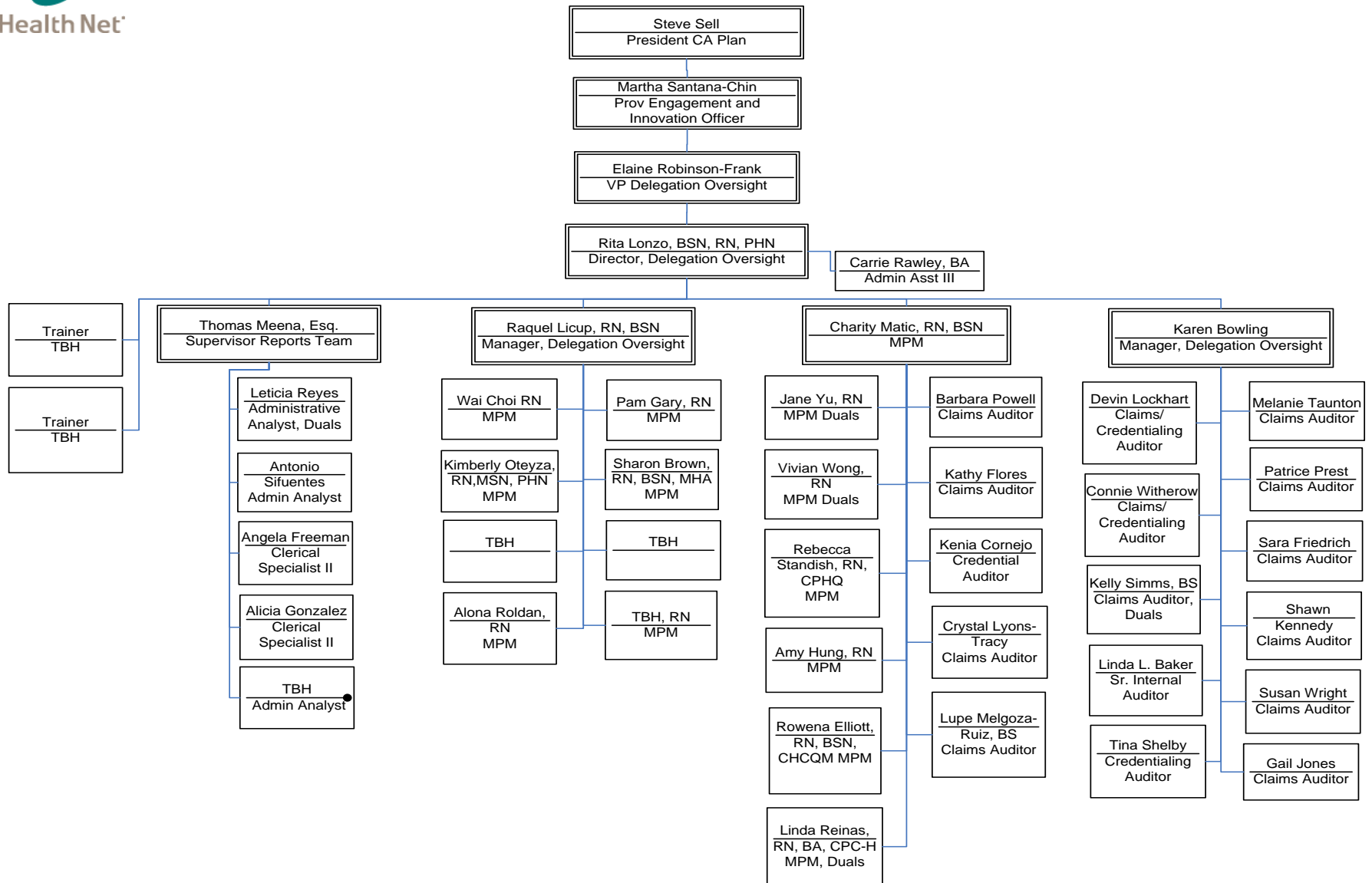


Transactional Medical Directors Clinical

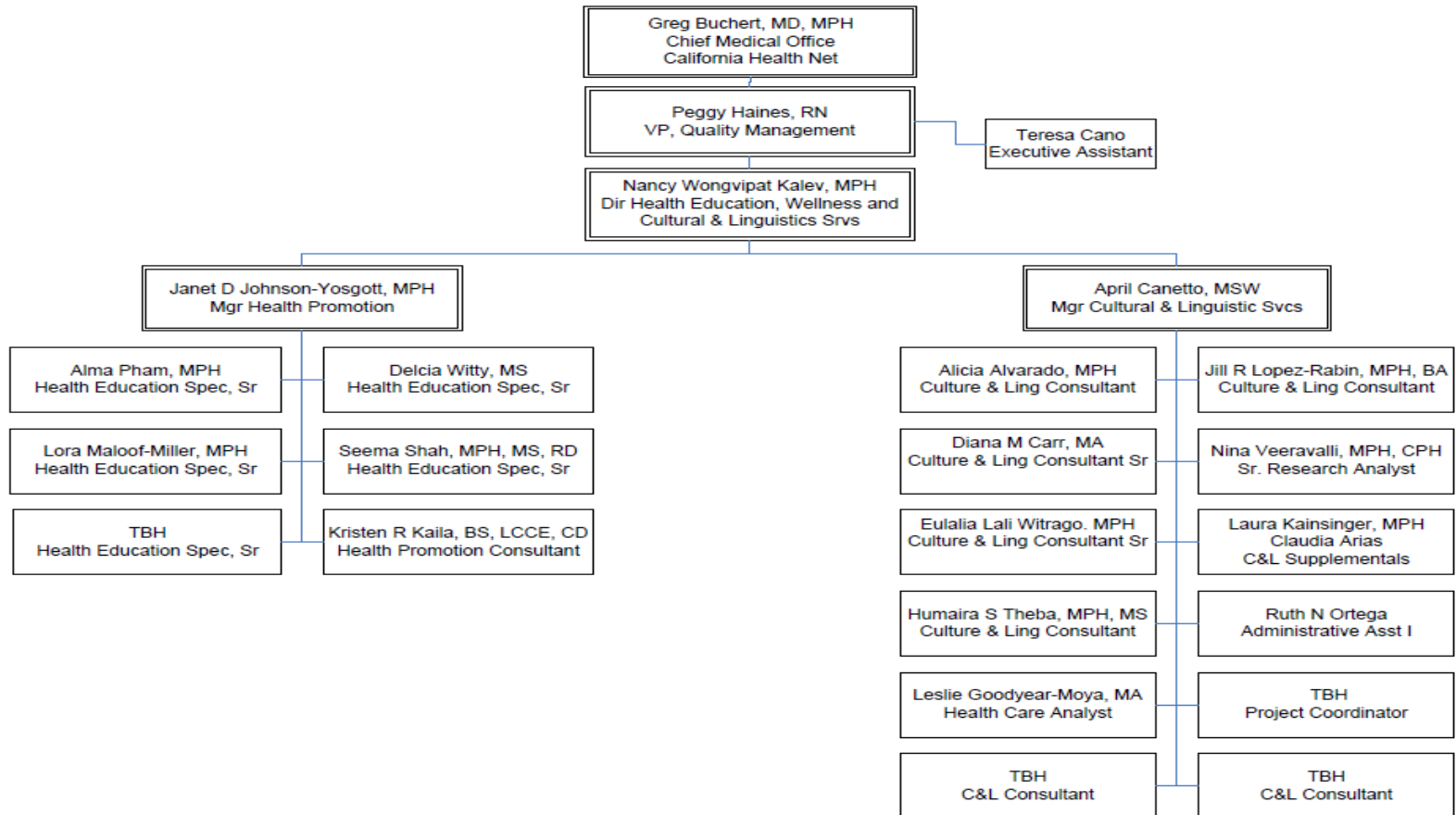


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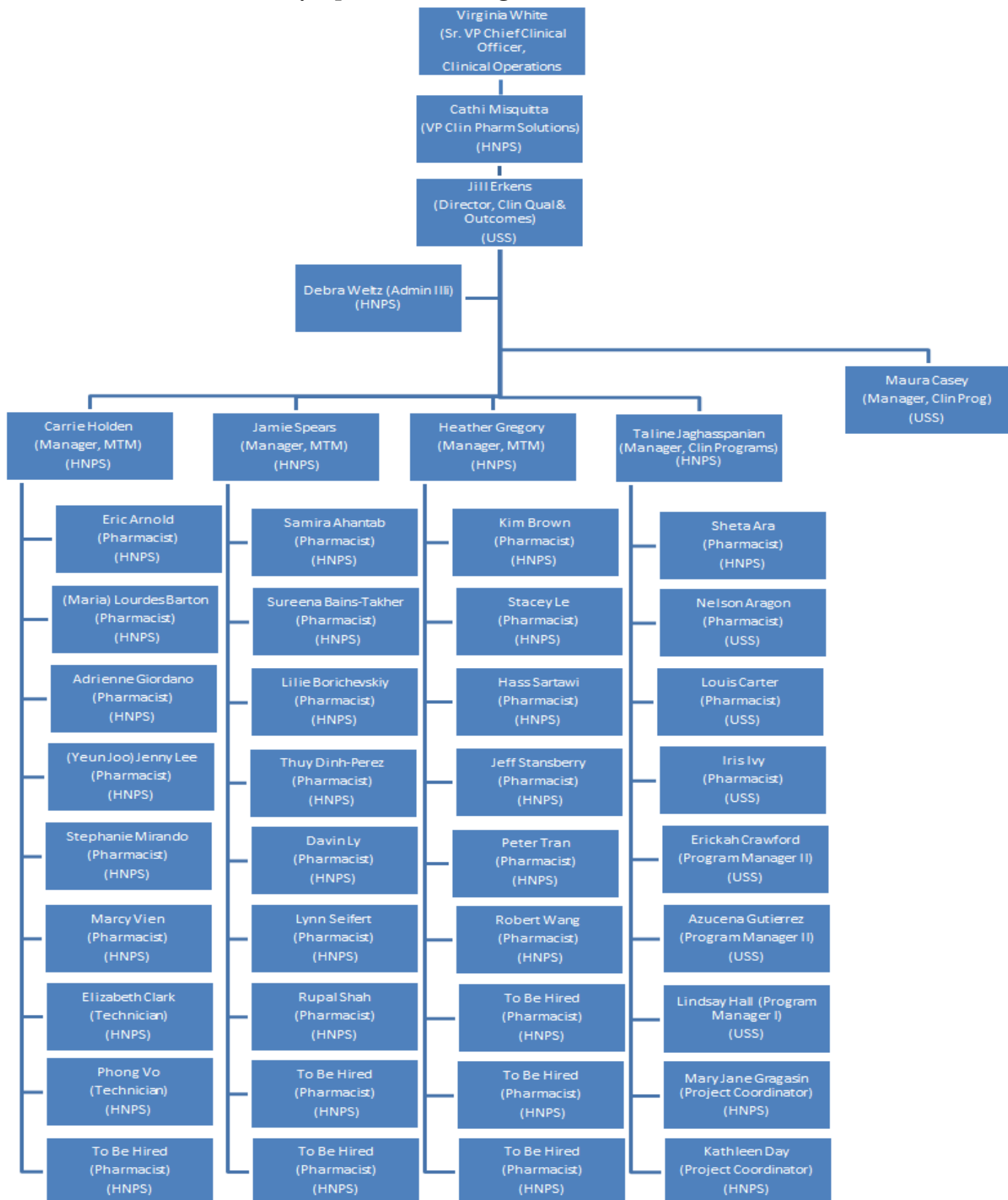
Delegation Oversight



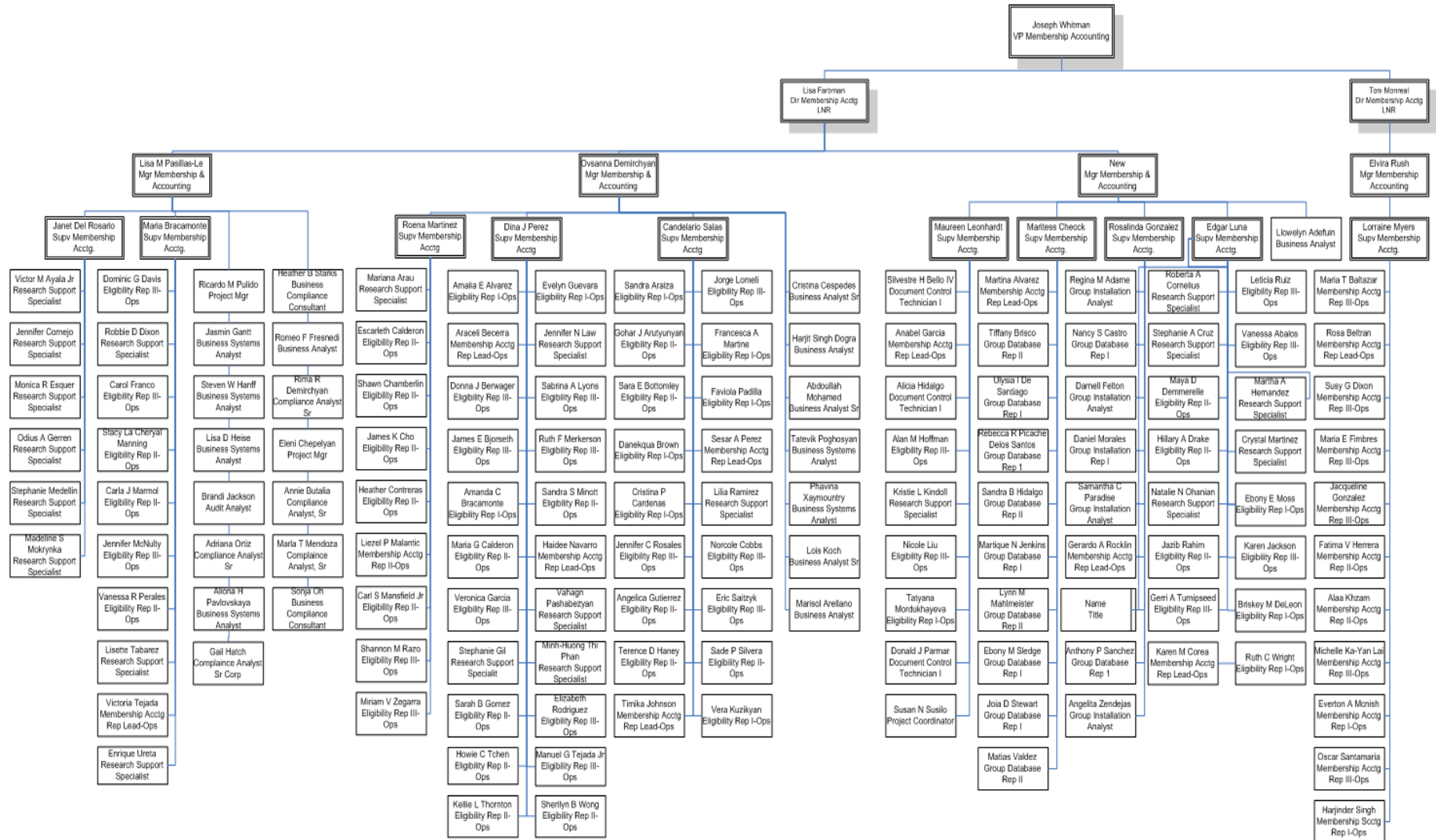
Cultural & Linguistics and Wellness Oversight



Pharmacy Operations Oversight and Clinical



Enrollment & Eligibility – Administrative



Clinical Operations Organization

