Health Net®
COMMUNITY SOLUTIONS

Health Net Community Solutions, Inc.
11971 Foundation Place
Rancho Cordova, CA 95670

February 24, 2012

Toby Douglas
Director
California Department of Health Care Services
1501 Capitol Ave., 6th Floor, MS 0002
Sacramento, CA 95814

Dear Mr. Douglas:

Health Net Community Solutions (Health Net) is pleased to submit its Application in response to California's Dual Eligible Demonstration (Demonstration) Request for Solutions. We have more than two decades of experience serving Medi-Cal and Medicare beneficiaries in San Diego County. Our experience uniquely qualifies us to enhance the County's Dual Eligible beneficiaries' ability to self-direct their care, improve their satisfaction with care provided as well as the coordination of their care. This Demonstration will strengthen our existing partnership with Healthy San Diego, the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) as we collectively strive to achieve the goals of the pilot.

The selection of San Diego County for inclusion in the Demonstration will offer the State and CMS the opportunity to implement the full spectrum of managed care support across physical and behavioral health, as well as home and community based services using the Geographic Managed Care Model. The demographics of San Diego County provide the Demonstration with a diverse population comprised of approximately 76,000 eligible beneficiaries. Additionally, the provider community is extensive and is capable of delivering optimally integrated and coordinated medical, behavioral, home and community based care.

Our Application is submitted knowing that many of the considerations that provide the financial underpinnings for the Demonstration are yet to be finalized. Rates need to be established to responsibly provide compensation for the array of support and care that is to be provided under the Demonstration. Final decisions regarding certain policies and the transition of specific care components (e.g., Long Term Care) to the health plans, and inclusion of beneficiaries currently under D-SNPs without a Medi-Cal contract need to be made to ensure coordination of care occurs throughout San Diego County. We look forward to the opportunity to collaborate with DHCS and CMS in finalizing these critical financial arrangements and program decisions.

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Our corporate mission is to help members be healthy, secure and comfortable. We are confident that the goals of this Demonstration can be achieved and the quality of life for Dual Eligible beneficiaries in San Diego County be improved.

Sincerely,

David J. Friedman
Vice President
Health Net Community Solutions, Inc.

Martha J. Smith
Chief Program Officer
Dual Eligible Demonstration

Project Narrative and Supporting Attachments

California's Dual Eligible Demonstration Request for Solutions

San Diego County Application

February 24, 2012

Submitted by:

Health Net® COMMUNITY SOLUTIONS

Health Net Community Solutions, Inc.
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Rancho Cordova, CA 95670

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Section Executive Summary

With over two decades of managed care experience ensuring coverage to both the underserved and senior populations, Health Net Community Solutions (Health Net) is pleased to present its application to the Department of Health Care Services' (DHCS) Request for Solutions (RFS) for the Dual Eligible Demonstration Project (Demonstration) in San Diego County – home to approximately 75,000 Dual Eligible beneficiaries. Health Net's commitment to serving San Diego's Medi-Cal beneficiaries began in 1985. Since that time Health Net has evolved in tandem with the San Diego health community to work collaboratively in Healthy San Diego and in the Long Term Care Integration Project (LTCIP).

In 1998, Health Net joined the San Diego Geographic Managed Care model. Since that time, Health Net has added a Medicare Dual Eligible Special Needs Plan (D-SNP) in the county, and we are accredited by the National Committee for Quality Assurance (NCQA) for both our Medicare and Medi-Cal plans. Health Net has worked on San Diego's LTCIP since its inception in 1998 to create an integrated system of care for members who are Seniors and Persons with Disabilities (SPD). The Demonstration combines and enhances Medicare and Medi-Cal benefits and furthers the LTCIP stakeholders' recommendations to expand the Healthy San Diego delivery system model to integrate health care services in a single health home approach.

The Healthy San Diego program is unprecedented in terms of its leadership that includes county health programs, managed care plans, a range of community advocates, and professional partners. Health Net has worked collaboratively with Community Health Group, Molina Health Plan, Care First, and Kaiser Health Plan on the entire range of Healthy San Diego committees, workgroups, and task forces to improve the health care delivery system for Med-

Cal and Medicare beneficiaries. Health Net serves on a variety of workgroups including Behavioral Health, SPD members, and Regional Center; chairs the Health Plan Work Group; and co-chairs the Quality Improvement Sub-Committee.

Health Net's response illustrates our understanding of the Demonstration goals established by Senate Bill 208 and DHCS and is based on the Centers for Medicare and Medicaid Services (CMS) guidance and stakeholder input, as outlined in the RFS. The Demonstration's benefits include a focus on maximizing beneficiaries' abilities to self-direct their care by placing them at the center of the integrated health home, with sound protections; minimizing provider disruption; and rationalizing and simplifying the points of contact and care coordination for beneficiaries, providers, and home and community-based support services programs. Ongoing, substantive stakeholder and beneficiary input will help guide Health Net's activities during the Demonstration as it evolves over its three-year course.

The Demonstration is enhanced by the collaborative effort with Healthy San Diego to provide beneficiaries access to coordinated and integrated health care. Health Net is able to enroll as many as one third of the Dual Eligible beneficiaries (25,000) in the county. Our provider commitments include Sharp Rees Stealy Medical Group, Sharp Community Medical Group, Vantage, UCSD, Multicultural Medical Group, Arch Health Partners, and Mercy Physicians Medical Group. Upon contract award, a dedicated team of Health Net staff will be focused on contract implementation. We are committed to delivering the right care at the right time in the right place and to continuing to provide expanded access to quality health care services.

Section 1. Program Design

Section 1.1 Program Vision and Goals

Health Net offers a programmatic and operational solution for an integrated care model for San Diego County Dual Eligible beneficiaries. Health Net brings significant experience creating solutions and implementing large-scale programs and has been working collaboratively with Healthy San Diego to develop an effective and efficient county-wide solution. A San Diego County Demonstration offers the DHCS and CMS the following advantages:

- Familiar existing choices for beneficiaries, who know and trust the combined efforts of Health Net, Healthy San Diego, and our large networks of partnering plans and providers
- Sufficient scale to secure results for the Dual Eligible population as a whole, as well as for sub-populations
- Experienced, culturally-competent, NCQA-accredited health care plan that has demonstrated the ability to both compete and collaborate in the best interest of beneficiaries
- Existing operational infrastructure using the Geographic Managed Care (GMC) Model to ensure efficient and timely implementation
- Availability of existing special initiatives, such as the Program of All-inclusive Care for the Elderly (PACE), to ensure health continuity of care delivery
- Ability to secure near and long-term quality of care improvements
- Identified means to generate cost savings for the State and Federal governments

Health Net and Healthy San Diego, as collaborative partners, recognize the need to include strong consumer protections when tailoring the benefits to meet the needs of beneficiaries and their advocates. We are collaboratively engaged with the beneficiary and advocacy

communities, and plan to ensure extensive engagement with these important representatives to secure valuable input into the design, implementation, and ongoing operation of the Demonstration.

We also recognize that high quality care at a lower cost can be delivered to beneficiaries within the managed care environment. Therefore, our solution offers all of the managed care elements and embraces passive enrollment, with the opportunity for beneficiaries to opt out. We expect to offer enhanced benefits and services so that beneficiaries can meet their health care goals while remaining within the organized care delivery systems of the Healthy San Diego plans.

Question 1.1.1 Describe the experience serving dually eligible beneficiaries, both under Medi-Cal and through Medicare Advantage Special Needs Plan contracts, if any.

Health Net and its predecessor companies (Foundation Health and Amerimed) have maintained continuous Medi-Cal operations for 28 years. Starting operations as a PHP in 1984 in three Southern California counties, Health Net has expanded our service area to include nine other counties and enhanced our capabilities to provide services to meet the evolving needs of the DHCS and our members. Over the years, many Dual Eligible and SPD beneficiaries have chosen Health Net as their managed care program. Since June 2011, Health Net has successfully transitioned approximately 65,000 SPD members into mandatory Medi-Cal Managed Care. Health Net currently arranges health care services for over 882,000 Medi-Cal beneficiaries in 12 California counties, with over 35,000 in San Diego County.

Health Net has offered Medicare HMO products since 1992 and has provided comprehensive benefits with a long-standing commitment to the health home model. Health Net has entered its fifth year offering Dual Eligible Special Needs Plans (D-SNP) in San Diego County. Due to our

experience providing high-quality, NCQA-accredited care and services to eligible populations, Health Net has been selected to offer Chronic-SNPs and D-SNPs. **Figure 1** illustrates Health Net's existing Medicare Advantage and D-SNP membership.

Figure 1. Health Net's Medicare Advantage and D-SNP Membership

	California	San Diego County
Medicare Advantage Members	140,000	10,000
D-SNP Members	15,000	2,000

Health Net's current Medicare coverage includes valuable benefits, such as prescription drugs, dental care, and eyeglasses, as well as transportation and wellness programs designed especially for the unique needs of older adults. Additionally, Health Net has a long history of rewarding practitioners for delivering high-quality, person-centered care through the capitated Participating Physician Group (PPG) health home model (See **Section 7.2**).

Question 1.1.2 Explain why this program is a strategic match for the Applicant's overall mission.

At Health Net, our mission is to help our members be healthy, secure, and comfortable. We embrace strategies that allow us to deliver high-quality health plan services and focus on our relationships with our members, providers, and government customers. Health Net's extensive Medicare and Medi-Cal experience, combined with our knowledge, infrastructure, and abilities, make us uniquely qualified to fulfill our mission in addressing the challenges posed by the diverse ethnic, cultural, health, and social support needs of Dual Eligible beneficiaries.

Health Net has been a GMC plan since the inception of the Healthy San Diego Model. This model offers an established platform upon which to build an integrated managed care program for Dual Eligible beneficiaries. Health Net is positioned to provide a comprehensive and fully

integrated San Diego County-specific solution that leverages our experience with existing programs, structures, and systems of care.

While Health Net and the other Healthy San Diego plan are submitting separate RFS applications (as required by the RFS), we are collaborating in a manner that will enhance the beneficiary experience, both at the outset of the Demonstration and as the spectrum of services expands to include the full integration of long-term supportive services (LTSS), inclusive of In-Home Supportive Services (IHSS), long-term care (LTC), and community-based services. These efforts aim to simplify navigation for both beneficiaries and providers while enhancing coordination of services throughout the entire continuum of care. At the heart of Health Net's mission is developing robust solutions that improve the quality and cost-effective delivery of care to beneficiaries.

Question 1.1.3 Explain how the program meets the goals of the Duals Demonstration.

Health Net supports the Demonstration goals: generating greater value for California by rebalancing the health care delivery system to provide coordinated and person-centered care and improving beneficiary health outcomes achieved for each dollar invested. **Figure 2** illustrates how Health Net will deliver a program to meet the State's goals and objectives.

Figure 2. Health Net Meeting Demonstration Goals

SB 208 Demonstration Goal	Evidence of How Health Net Program Meets Goal
1. Coordinating benefits and access to care, improving continuity of care and services.	▪ Streamlined continuum of care, care coordination, evidence-based interventions, and use of intensive case management, as demonstrated in our SNP Model of Care (MOC) for the Dual Eligible Demonstration in San Diego County (**Attachment 4**) ▪ With the primary care provider (PCP) as a key provider of care in the health home model, Health Net will increase access to primary care services and ensure high standards of quality of care across the care continuum through its quality standards ▪ Experience managing care for Dual Eligible beneficiaries with both D-SNP and Medi-Cal Managed Care programs, and SPD Medi-Cal-only beneficiaries, who have a similar incidence of co-morbidity within similar clinical conditions ▪ Experience transitioning D-SNP and SPD populations to managed care ▪ Transition care experience with D-SNP and SPD populations and member assistance post acute care to return home
2. Maximizing the ability of Dual Eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.	Health Net will: ▪ Seek to enable beneficiaries to remain in their homes for as long as possible and assist them to return to their homes after an acute episode of care. Health Net will collaborate with Healthy San Diego to: – Expand contractual relationships with the County to include IHSS integration – Develop processes to allow for the sharing of care needs information ▪ Explore contracts with existing Multi-Purposes Senior Services Programs (MSSP) contractors in San Diego for the provision of MSSP services ▪ Employ Interdisciplinary Care Team (IDCT) staff to refer Demonstration enrollees to existing HCBS services ▪ Collaborate with Healthy San Diego during the 2012 planning phase and Year 1 of the Demonstration (2013) to develop uniform HCBS care collaboration agreements that: – Develop a mechanism for in-home LTSS assessments, working with existing San Diego County Aging and Independence Services (AIS) social workers who currently perform IHSS assessments to include expanded health-related needs – Refine the implementation of a uniform LTSS assessment tool – Work with San Diego County AIS and member stakeholders to develop a phased plan to improve the overall member/caregiver experience in the IHSS program ▪ Build on transitions of care experience with D-SNP and SPD populations to develop best practice models for returning home
3. Increasing availability and access to home- and community-based alternatives.	▪ Develop an HCBS funding plan to increase the availability of services to the Demonstration population by redirecting savings from delayed and avoided institutional stays
DHCS Demonstration Goal	**Evidence of How Health Net Program Meets Goal**
1. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.	▪ The existing Healthy San Diego/GMC Model has the advantage of providing both a familiar choice for beneficiaries who know and trust Health Net and our large network of providers (See **Section 7**) ▪ Collaborating with existing HCBS and LTSS programs to ensure the preservation of beneficiary self-directed care standards

DHCS Demonstration Goal	Evidence of How Health Net Program Meets Goal
2. Improve health processes and satisfaction with care.	▪ The managed care model, as demonstrated in other mandated Medi-Cal populations, has proven it can achieve actual savings through efficiencies and better coordinated care ▪ Cultural competence, as demonstrated with NCQA Distinction Status for Multicultural Health Care
3. Improve coordination of and timely access to care.	▪ The managed care model has demonstrated it can achieve actual savings through efficiencies and better coordinated care. ▪ Streamlined access to the continuum of care, care coordination, evidence-based interventions, and use of intensive case management, as demonstrated in our MOC (**Attachment 4**) ▪ 24/7/365 access to Member Services Center that can assist members with removing barriers to accessing care in real time
4. Optimize the use of Medicare, Medi-Cal and other State/County resources.	▪ Experience serving vulnerable and at-risk populations through an organized, comprehensive, and accountable care delivery system ▪ Lessons learned in the transition of SPD members into Medi-Cal Managed Care ▪ Variety of reimbursement models ▪ Use of intensive case management/other coordinated services

Section 1.2 Comprehensive Program Description

Question 1.2.1 Describe the overall design of the proposed program, including the number of enrollees, proposed partners, geographic coverage area and how you will provide the integrated benefit package described above along with any supplemental benefits you intend to offer. (You may mention items briefly here and reference later sections where you provide more detailed descriptions.)

Health Net and Healthy San Diego are proposing a collaborative, comprehensive, managed care model that includes all 75,000 Dual Eligible beneficiaries in San Diego County. Health Net is prepared to enroll in excess of 25,000 new Dual Eligible beneficiaries in the Demonstration. Health Net is committed to developing its provider network to accommodate additional enrollment as needed (See **Section 7.1**).

Organized Care Delivery System: Dual Eligible beneficiaries would have a choice of five organized, accountable, and comprehensive care delivery system: Health Net, Care 1st Health Plan, Community Health Group, Kaiser Permanente, and Molina Healthcare, which includes their respective provider groups. Health Net has received letters of commitment from several health care providers interested in participating in the Demonstration, including, but not

limited to, Sharp Rees-Stealy Medical Group, Sharp Community Medical Group, Vantage Medical Group, UCSD, Multicultural Medical Group, Arch Health Partners, and Mercy Physicians Medical Group. Together, we offer a Demonstration program that assures all partners' interests are aligned with delivering organized, person-centered, and cost-efficient care to Dual Eligible beneficiaries, resulting in measurably improved outcomes. We will do this in a fashion that is inclusive of the key stakeholders in San Diego County that share a common interest in delivering high-quality care at a reasonable cost, while adhering to the rules, regulations, and oversight imperative to ensure Demonstration success.

A combined Medicare/Medi-Cal benefit package, enhanced with additional value-added benefits and services, will be offered as a means of helping beneficiaries meet their health care goals. Health Net and Healthy San Diego propose that the covered benefits across participating plans be standardized in order to reduce selection bias and integrate HCBS, behavioral health, and IHSS. Health Net supports DHCS' and CMS' goals of ensuring beneficiary retention in the Demonstration and will explore the possibility of including additional value-added benefits and services that align with that objective to the extent they are supported by actuarially-sound fiscal rates. Other possible benefits we will consider include:

- Dental coverage
- Vision coverage
- Emergency Response Service
- Enhanced substance use services
- Non-emergency medical appointment transportation
- Gym membership
- Nutrition counseling

In order to assure consumer choice and competition consistent with the current GMC Model, Health Net intends to continue to compete with the other Healthy San Diego plans for Dual

Eligible membership in the manner we do today. This healthy competition has preserved consumer choice, improved quality, and helped contain costs for the Medi-Cal program, and we believe that the same positive impact will occur in the Demonstration.

Health Net/Healthy San Diego Collaboration

To enhance the care delivery model and improve beneficiaries' health care outcomes, Health Net intends to work together with providers to develop an on-site care management model in high-volume hospitals, clinics, and physician practices contracted with both health plans to share care management resources. These on-site care managers will facilitate care transitions and work with mental health providers to reduce the high level of recurrent admissions for Dual Eligible beneficiaries related to severe and persistent mental illness (SPMI). The care managers will have greater opportunity to establish a rapport and expertise with providers and their patients since they will be involved with larger numbers of the providers' patients and will reduce the burden providers could otherwise experience in trying to effectively manage a complex case load. It also helps ensure continuity of care and integration of physical and behavioral health to address the needs of the whole person. This innovative approach is different from similar models in which care managers work for just one plan—they will be a resource for the benefit of all Dual Eligible beneficiaries in the practice or hospital. This joint effort will enhance our ability to provide high-quality medical services to our respective beneficiaries.

Services

The San Diego Demonstration will test the efficacy of delivering a comprehensive and seamless set of all Medicare services (Parts A, B, and D) and all Medi-Cal services, including

LTSS. Medi-Cal-funded behavioral health services will be added to the single blended rate in the second year of the Demonstration, and coordination and contracting with providers of those services is underway.

LTSS: LTSS will be an integral part of the Demonstration. California has made progress toward LTSS system integration into managed care with the inclusion of CBAS in the array of health plan-offered benefits; however, opportunities remain for diverting Dual Eligible beneficiaries from institutional settings and expanding HCBS over time (See **Section 2.1**).

HCBS: HCBS programs are an essential part of the lives of many Dual Eligible beneficiaries and an important alternative to institutional care. Health Net and Healthy San Diego propose building upon the existing infrastructure of the San Diego County Aging and Independence Services (AIS) programs and working with AIS to explore enhancing the care coordination plan developed by the health plans.

IHSS: Health Net and Healthy San Diego will work with the AIS and United Domestic Workers (UDW) to develop an integrated program that preserves this pivotal program for beneficiaries in California. The program has been a key element in California's efforts to balance its delivery system and will be an integral partner in any successful Demonstration (See **Section 2.2**).

Behavioral Health: We expect that the Medicare and Medi-Cal mental health benefits would be immediately integrated in the first year of the Demonstration. Health Net and Healthy San Diego will coordinate closely with the County Medi-Cal behavioral health system to improve the connections between providers for both physical and mental health while planning for full integration. (See **Section 3.1**)

Person-Centered Care: Health Net proposes to create one point of accountability for the delivery, coordination, and management of benefits and services to members that meets regulatory requirements and assures accountability for this program.

Our interdisciplinary care teams (IDCTs) employ a person-centered care model, working with the member, caregivers, primary care providers (PCPs), specialists, LTSS providers, community organizations, and others to plan and coordinate a holistic package of services and support. Care managers will be actively engaged with members and PCPs, calling on the expertise of IDCT members to plan and deliver care plans.

We envision multiple care management delivery models. We will encourage large practices and hospitals to embed shared care managers in high-volume facilities to ensure frequent face-to-face contact with providers and members. When co-location is not feasible, we will assign care managers from our own IDCTs with the expertise to help Dual Eligible beneficiaries meet their care goals. (See **Section 4.1**)

Quality of Care Delivery: Health Net's existing NCQA-accredited Quality Improvement (QI) programs for both our Medicare and Medi-Cal programs are dedicated to rigorous monitoring and quality improvements. We are fully committed to a QI process that includes implementation of special initiatives across Health Net and our contracting provider systems (see **Section 7** and **Attachment 14**).

Health Information Technology (HIT): It is commonly understood that widespread use of HIT will improve quality, reduce health care costs, and improve efficiencies. As this Demonstration will introduce Dual Eligible beneficiaries into coordinated care settings, Health Net understands that the systems used must be nimble enough to facilitate cost-effective strategies, provide

appropriate reporting to DHCS and CMS on the Demonstration effectiveness, and ensure compliance and data integrity. We strive to ensure system stability and also foster CMS systems "meaningful use" expectations (See **Section 8**).

Consumer Protections and Outreach: We will build upon our recent experience enrolling SPD members to ensure a strong system of consumer protections and outreach. Health Net acknowledges and understands the need for engaging, embracing, and interacting with the advocacy constituents in San Diego County during planning, transition, and on an ongoing basis, and propose provisions in the Demonstration to satisfy those requirements. (See **Section 5**)

Network Composition and Participation Standards: In a county as large and diverse as San Diego, one size will not fit all. With our extensive experience in delegated health plan and provider group oversight, we plan to validate different care delivery models in the Demonstration. Health Net proposes that minimum participation standards for subcontracting health plans or provider groups be developed in cooperation with CMS, DHCS, and Healthy San Diego, ensuring appropriate service levels for health care services and the delivery of quality care. Health Net is taking an inclusive approach, insofar as providers, physicians, and hospitals that meet the criteria, standards, and requirements consistent with program expectations, will be included in our network. (See **Section 7**)

Question 1.2.2 Describe how you will manage the program within an integrated financing model, (i.e. services are not treated as "Medicare" or "Medicaid" paid services)

Health Net has a dedicated senior management team that will oversee this Demonstration and validate the new capitated payment model using a three-way contract among DHCS, CMS, and Health Net. Health Net plans to deliver a seamlessly integrated program to Dual Eligible

beneficiaries that includes a combined benefit package for which Health Net would receive a blended capitated rate for the full continuum of care.

Health Net will employ different contracting methodologies such as capitation and fee-for-service (FFS) reimbursement, along with shared risk and quality incentives, to reimburse PPGs, hospitals, and ancillary providers that contract with Health Net for the Demonstration. The methodology Health Net will employ is further elaborated in **Section 7.2**.

Once enrolled in Health Net, beneficiaries will receive one ID card and a comprehensive and integrated Explanation of Coverage (EOC) booklet, and may select a PCP. Those who do not select a PCP will have one selected for them based on prior claims history (if supplied), or location, specialty, or gender. One ID card will allow the member and the provider to avoid having to coordinate benefits between Medicare and Medi-Cal and should enhance the patient experience.

Health Net supports the need to evaluate the Demonstration's success and its ability to improve quality while reducing costs, as required by DHCS and CMS. Health Net's computer systems function on an integrated system-wide basis and have the capabilities to administer multiple provider payment methodologies and can effectively process financial, membership, provider, encounter, claims, utilization, and quality data, delivering advanced reporting options.

Question 1.2.3 Describe how the program is evidence-based.

In addition to being NCQA-accredited, Health Net has existing quality management systems for our current Medicare and Medi-Cal products. An example is clinical practice guidelines (CPGs) that have been developed and adopted in order to reduce practice variation and improve the health status of our members. Health Net adopts nationally recognized evidence-

based CPGs for medical and behavioral health conditions through our National Medical Advisory Council (MAC) of Health Net medical directors and network practitioners. This group works with the Health Net Quality Improvement Committee (QIC) to review and update CPGs every two years (or more frequently when new scientific evidence or new national standards are published) and obtains input on guidelines from recognized specialists in their field of medicine. Guidelines are evaluated for consistency with Health Net benefits, utilization management criteria, and member education materials. In addition, MAC evaluates new technologies (medical and behavioral health) and devices for safety and effectiveness.

Approved national medical policies and CPGs are published and available to network providers through the provider portal of Health Net's website and through provider communications. PPGs are required to participate in the collection of Healthcare Effectiveness Data and Information Set (HEDIS®) data to monitor and ensure clinical care is consistent with evidence-based clinical guidelines.

For the Demonstration, Health Net will build from current quality management systems and guidelines to evaluate and implement the appropriate initiatives and incentives across our subcontracted plan(s) and provider systems. The Demonstration is expected to follow the standards and expectations as currently managed and outlined above, ensuring that care is delivered following evidence-based practices and addressing our members' needs in a holistic manner.

Question 1.2.4 Explain how the program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify risk factors.

Health Net understands that the Dual Eligible population has a greater incidence of chronic disease and utilization of Medicare and Medi-Cal resources and that Dual Eligible beneficiaries

present with co-morbid mental health conditions at a higher incidence than that of the Medicare-only population.

Health Net uses a person-centered care model and IDCTs to improve health care outcomes by enhancing care delivery and emphasizing the coordination of services. We recognize the need to address health disparities for vulnerable populations as may be defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, and risk status. In the Demonstration, all members will have a health risk assessment (HRA) to identify at-risk individuals, as outlined in Element 7 of the D-SNP Model of Care (MOC) (**Attachment 4**). Care plans that seek to reduce risk factors will be developed with the direct participation of the member and caregiver and will reflect each member's unique needs, preferences, values, and priorities. Further elaboration is provided in Element 8 of the D-SNP MOC (**Attachment 4**).

In the Demonstration, IDCTs will be key agents in care integration, working with the member, caregivers, PCPs, specialists, LTSS providers, and HCBS programs to plan and coordinate person-centric health care services and supports.

Health Net and its predecessor companies have been meeting the health care needs of an increasingly culturally diverse population in California for the past 28 years. Recently, Health Net was recognized with the NCQA Distinction Status for Multicultural Health Care. One of its five core standards, "Reducing Health Care Disparities", requires organizations to use data to assess the presence of disparities, undertake QI efforts to decrease or eliminate them, and improve culturally and linguistically appropriate care. To meet this standard, Health Net has demonstrated that we undertake QI projects to address disparities or other opportunities to

improve culturally and linguistically appropriate services. Health Net intends to build off this solid foundation, incorporating the same standards to serve the Dual Eligible beneficiaries.

Additionally, Health Net's health education programs combine advanced analytics to find at-risk members and bring to them sophisticated engagement methods and techniques to enable positive behavioral change. We use a comprehensive tool, including wellness risk scoring, to understand the magnitude of the wellness opportunity; assess with the member his or her needs, goals, and expectations; and design a solution that can result in improved health. We will offer Dual Eligible beneficiaries a comprehensive suite of programs and other health education services that can impact health risk factors, especially those prevalent in underserved populations. For example:

- **Disease Management Programs:** Health Net's Disease Management Programs provide severity-specific interventions to members with diabetes, asthma, congestive heart failure, coronary heart disease, and chronic obstructive pulmonary disease. The programs adhere to a whole-person approach with a focus on removing barriers to care and providing guidance for members' co-morbidities. The interventions are tailored to the diverse clinical, cultural, and linguistic needs of our members. Members receive 24/7/365 access to educational resources, reminder calls, and health coaches.
- **Heart Health/Cardio Metabolic Risk Management:** Our cardio metabolic risk management program supports individuals who have more than one of the following risk factors: a diagnosis of metabolic syndrome, high BMI, high blood sugar/insulin resistance, high blood pressure, high triglycerides, tobacco utilization, and abnormal cholesterol levels. Health coaches are trained to support and educate individuals about critical aspects of care

associated with cardio metabolic risk management, and risks that could lead to diabetes and/or cardiovascular disease. Participants who are identified as being obese or using tobacco can also be transferred into the weight management and/or tobacco cessation structured behavior programs.

- **Tobacco Cessation:** Our tobacco cessation program incorporates the latest evidence about effective tobacco cessation. Members receive four outbound coaching calls, unlimited inbound calls to a quit coach, a quit aid workbook, and nicotine replacement therapy.

Question 1.2.5 Explain whether/how the program could include a component that qualifies under the federal Health Home Plans SPA.

Health Net has worked with DHCS to develop a survey of our network in conjunction with the other managed care plans, and plans to proceed with administering this survey of our primary care network and provider groups to determine which provider offices are functioning as health homes and which offices are capable of and interested in becoming full health homes.

Health Net provides IDCTs to enhance the health home: case management is available to all members. Additional support includes 24/7/365 access to Nurse Advice Line and Member Services Center. Health Net's 24/7/365 Member Services Center assists with access to interpreter services, appeals, grievances, hospitalizations, in-network transfers, coordination with PCPs, benefit explanations, assistance with medical appointments, non-emergent medical transportation, and assistance with public programs access.

Question 1.2.6 Identify the primary challenges to successful implementation of the program and explain how these anticipated risks will be mitigated.

Figure 3 outlines the primary challenges to implement a successful Demonstration.

Figure 3. Demonstration Implementation Challenges and Recommended Mitigation

Challenge	Recommended Mitigation
Significant additional data needed by the health plans to help ensure an adequate program design and a comprehensive, yet sustainable, benefit package. This data is needed to develop reasonable capitation payment structures and ensure continuity of care with established providers. This data includes, but is not limited to: ▪ Current funding sources and amounts for each of the programs being brought under the umbrella of care ▪ Historical claims and/or utilization data, including beneficiary location and prior medical providers, consistent with the benefits expected to be covered under the integrated plan ▪ Proposed rates and risk adjustment	Propose working closely with representatives from CMS and DHCS to assist the plans with the timely removal of obstacles and barriers to success. With the direct involvement of DHCS, CMS, plans, and the county in the implementation process, the risk of not receiving needed information to adequately design a sustainable program and benefit package will be mitigated.
When program change is proposed, there is a risk that the enrollment figures may fall short of expectations if stakeholder concerns are not addressed	Collaborate with Healthy San Diego to build upon our recent experience enrolling SPD members to ensure a strong system of consumer protections and outreach including: ▪ An advisory group comprised of beneficiaries and key constituent representatives during the Demonstration planning and implementation ▪ A process to ensure effective and timely transition of services ▪ Clear and understandable education/communication regarding the enrollment and disenrollment process and the ability to opt out ▪ Integrated member material to include: single ID card, enrollment and disenrollment information, Evidence of Coverage (EOC), Summary of Benefits, etc. ▪ Accessible and understandable member materials for members with limited English proficiency or visual or cognitive impairments ▪ Comprehensive Member Services with a single point of contact for Medicare and Medicaid ▪ Web-based services for beneficiaries and their caregivers ▪ Robust plan choice counseling, including translation of member materials and access to alternate modes of information for beneficiaries with diverse communication needs ▪ Appointment assistance for members who face challenges finding an appropriate provider within a reasonable distance in a timely fashion

Challenge	Recommended Mitigation
Offer a more seamless experience for beneficiaries	Possible coordination across all five plans in San Diego County, in collaboration with Healthy San Diego
As the delivery of mental health has historically not included the effective and timely integration with medical health services for persons with SPMI, the development of a comprehensive and collaborative approach that includes health plans, consumers, providers, the County and other stakeholders is required.	Please refer to **Section 3.1** for Health Net's proposed solution to mitigate this risk.
HCBS waiver programs that currently serve Dual Eligible beneficiaries are undergoing significant financial strain. The current demand for these services exceeds the capacity of most agencies to provide them. Therefore, a challenge and risk to integrating these services in the Demonstration is the viability of the infrastructure in some San Diego communities.	Health Net asks that DHCS consider this concern in the rate development, and reinvest some projected cost savings into strengthening and building HCBS.
The success of the Demonstration and the ability of the State to meet the expectations outlined in the Governor's budget proposal are dependent on Dual Eligible beneficiaries remaining in the Demonstration and that the project incurs a low opt out rate.	To achieve high retention rates in the Demonstration, it is imperative that DHCS pay adequate rates that enable plans to offer an enhanced suite of value-added benefits that help beneficiaries meet their health goals. It is also imperative that the State establish a level playing field between the Demonstration plans and any existing D-SNPs in San Diego County.

Section 2. Coordination and Integration of LTSS

Health Net and all of the plans that make up the Healthy San Diego GMC Model are committed to ensuring that LTSS remain an integral part of the suite of services available to support the independence of our members. We are prepared to take on the challenge of coordinating and integrating LTSS because of our experience effectively coordinating services for SPD members, coupled with our experience managing the Medicare D-SNP MOC that integrates physical and mental health. The Demonstration furthers our goal of integrating services in a way that maximizes beneficiaries' ability to remain as independent as possible and an integral part of the communities in which they live. Our goals are simple: to improve access, to integrate case management functions, and to develop care coordination plans in conjunction

with both the members and their health home provider, all while minimizing confusion. To reduce duplicative services and their fragmented delivery and improve on all aspects of our members' care and health outcomes, Health Net is committed to working with the LTSS programs that best know the beneficiary and have trusted relationships with those newly enrolled in managed care.

In San Diego County, Health Net contracts with fully delegated medical groups to provide the full array of basic case management services, while Health Net case managers provide complex case management for our shared members. Medical groups that are delegated to coordinate HCBS for our members have demonstrated that they can meet the rigorous delegation standards developed by Health Net's QI Program. These groups are continually monitored to ensure that care coordination includes the provision of appropriate resources to members and that care coordination and case management services are provided by appropriately credentialed staff. Health Net care managers will facilitate and communicate all referrals and care coordination for Dual Eligible beneficiaries that need complex case management.

Health Net has combined the best practices of our D-SNP and Medi-Cal SPD programs, in conjunction with the San Diego County HCBS programs, so that our members have optimal access to support services on a continuum that ensures they receive the right care, at the right time, in the right setting.

Section 2.1 LTSS Capacity

Question 2.1.1 Describe how you would propose to provide seamless coordination between medical care and LTSS to keep people living in their homes and communities for as long as possible.

By blending and enhancing the Medicare and Medi-Cal benefits covered under the Demonstration, Health Net will provide a seamless coordination of services to keep people in their homes and in the communities in which they live to the greatest extent possible. Working with Healthy San Diego, Health Net will develop a "no wrong door" approach, assisting members with all their HCBS program needs. Health Net's PCPs, case managers, and social workers will work in collaboration to develop an integrated care management plan that minimizes redundancies and duplication. Health Net's public programs administrators are working with their Healthy San Diego partners and HCBS providers to develop coordination of care procedures based on the Memoranda of Understanding (MOUs) that have been executed between the health plans and HCBS providers.

An example of this work is our partnership with AIS programs. This San Diego-based, federally designated Agency on Aging is a unique multi-services resource that combines over 30 programs for seniors and adults with disabilities. These programs are essential to helping beneficiaries remain in their homes and the communities they live in and are an alternative to institutional care. In San Diego, Health Net is working to complete our Memoranda of Agreement (MOA) with the AIS programs (see **Attachment 18**).

Building on Health Net's success integrating SPD members into Medi-Cal Managed Care, Health Net will continue to engage physicians and other providers in an education program to raise their competency and awareness to use programs that are an alternative to institutional

care. Over the first two years of the Demonstration, Health Net will work with Healthy San Diego and the AIS program to create a designation that identifies providers with advanced knowledge of, and working relationships with, HCBS providers.

Question 2.1.2 Describe potential contracting relationships with current LTSS providers and how you would develop a reimbursement arrangement.

Working with Healthy San Diego, Health Net has met with numerous LTSS providers over the past months to gain insight and to begin the dialogue to explore developing reimbursement methodologies for these vital services. With assistance from AIS, we have participated in meetings with San Diego stakeholders representing IHSS, CBAS, MSSP, and AIDS Waiver programs. We have gained valuable insight and received commitments from each of these programs to first pursue an integrated approach to improve the care delivery of our shared Dual Eligible beneficiaries and, second, to identify areas of benefit duplication. As a result of recent legislation and the expansion of Medi-Cal Managed Care to include SPD beneficiaries, our contractual relationship with CBAS will be in place before the Demonstration is launched. Health Net is working with California Association of Adult Day Services (CAADS) to develop a CBAS health home concept in San Diego that can be adopted by other health plans (see **Attachment 21**)

Taking this same innovative approach and building on our experience working with the MSSP and AIDS Waiver programs, we have begun laying the groundwork to pursue full integration and seek to establish a reimbursement methodology that would expand the availability of MSSP and AIDS Waiver slots for Dual Eligible beneficiaries.

If San Diego is selected as one of the Demonstration counties, Health Net will work with the State In-Home Operations (IHO) program to identify opportunities to develop person-centered,

integrated care delivery programs for our shared Dual Eligible beneficiaries. Health Net realizes that it is critical that these Dual Eligible beneficiaries with very complex conditions maintain their established provider relationships so that they can achieve their own goals to remain independent. Health Net looks forward to working with the State and IHO consumers to explore future reimbursement methodologies.

Health Net contracts with skilled nursing facilities (SNFs) on a per-diem basis to provide services to our Medi-Cal and Medicare members. Currently reimbursement for these services is limited to the terms of the Medicare benefit model and the Two-Plan contract provisions. We will conduct a thorough evaluation of all of the long-term care facilities being utilized by our Dual Eligible beneficiaries to develop rate methodology and reimbursement models that build on the current State methodology but are enhanced by the IDCT development of person-centered care planning.

Question 2.1.3 Describe how you would use your Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS.

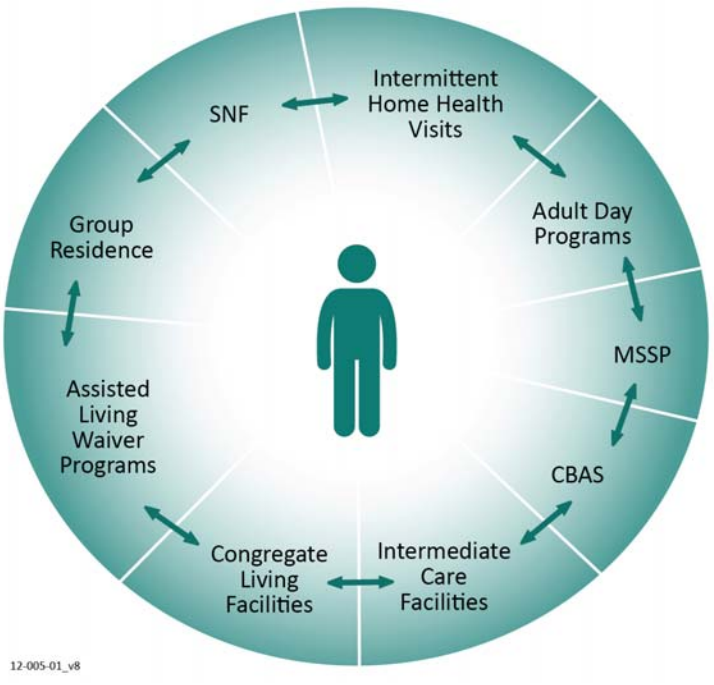
Health Net's case managers evaluate and risk stratify all Dual Eligible beneficiaries to assess a member's needs and identify appropriate support services in conjunction with the member, caregivers, and treating physicians. This is especially true for activities of daily living, self-health care management ability, and available support systems. Health Net employs an IDCT approach to identify community services that are available to new members. Health Net case managers meet with new members and their caregivers to discuss the continuum of support services that may be beneficial in supporting independence.

Health Net's IDCT will synthesize and consolidate existing health risk assessments (HRAs) and care plans completed by providers such as the AIS for IHSS determination, Regional Centers (Individual Family Service Plans), CBAS, mental health, and MSSP in order to avoid duplication and increase beneficiary satisfaction. With member permission, the consolidated case management plan signed off by the PCP will be distributed to the appropriate LTSS programs.

Question 2.1.4 Describe any experience working with the broad network of LTSS providers, ranging from home-and community-based service providers to institutional settings.

Health Net's MOC is built around an IDCT that has extensive experience working with D-SNP members to refer them to LTSS programs. Building on this MOC, Health Net has incorporated lessons learned from the SPD expansion to include a more comprehensive approach to integrating the entire continuum of available services in the care management planning process. Health Net and Healthy San Diego will work with the LTSS programs to formalize a consistent person-centered approach to accessing needed services (see **Figure 4**).

Figure 4. LTSS Care Continuum



Health Net recently partnered with CAADS and Independent Living Centers (ILCs) to develop an integrated care program with each of their respective providers to explore transition of care

paradigms to and from a variety of institutional settings. Abstracts from the two grants are included in **Attachment 21**.

Question 2.1.5 Describe your plans for delivering integrated care to individuals living in institutional settings. Institutional settings are appropriate setting for some individuals, but for those able and wanting to leave, how might you transition them into the community? What processes, assurances do you have in place to ensure proper care?

Health Net recognizes that many Dual Eligible beneficiaries may desire to transition from State long term care institutions and private SNFs to homes in their local community. Health Net case mangers have extensive experience working to transition members from SNFs to home. Health Net is part of the Healthy San Diego Regional Center Workgroup that has been working with DHCS to transition consumers from Lanterman Developmental Center to community group homes. Health Net has completed the successful transition of the first group of Lanterman residents into community homes. These care plans include physician-delivered services at home; IDCT evaluations; and an integrated, person-centered care plan developed by the Lanterman staff, Regional Center case managers, and Health Net's case managers. Health Net's dedicated, on-site Regional Center liaisons played an integral role in orchestrating this very complex transition.

Health Net has adopted the comprehensive service plan of the California Community Transitions (CCT) program, which was implemented under a federal Money Follows the Person Rebalancing Demonstration beginning in 2007. Through the CCT program, consumers in inpatient facilities are provided an opportunity to be informed about, and discuss the feasibility of, receiving HCBS alternatives. The CCT comprehensive service plan is used to assess both preferences and needs to allow the development of a support system that will help ensure the member's health and welfare immediately after transition and for the long term. The

comprehensive service plan is made up of seven service areas that create the foundation for a successful transition: health care, supportive, social, environmental, education/training, financial and other services. Health Net will work with the ILCs throughout San Diego County to explore the entire suite of services, including housing, that can be used to support a member's goal to transition from a custodial facility to an independent home environment.

Health Net acknowledges that many people may have gone from acute care settings to nursing homes without adequate, appropriate community-based services being offered. Upon enrollment, Health Net's IDCT will work with each Dual Eligible beneficiary living in a nursing home to determine if other living environments are wanted or feasible. For those beneficiaries who remain in nursing homes, Health Net will work with the nursing home administration to ensure that services are coordinated and integrated to meet the member's health care needs.

Section 2.2 IHSS

Health Net and Healthy San Diego understand the critical role that IHSS performs in the lives of many Dual Eligible beneficiaries. We are committed to maintaining the core tenet of this program: that caregiver services are and will remain member-directed. We also recognize that the success of the Demonstration for members with the most complex needs relies upon our ability to improve upon the IHSS system, while ensuring we do not fracture the system and disrupt members' abilities to receive needed IHSS services.

Health Net recognizes that without the successful coordination of IHSS, many Dual Eligible beneficiaries face institutionalization. During the first year of the Demonstration, Health Net and Healthy San Diego will continue to work with AIS and UDW to evaluate opportunities for IHSS program enhancement. Based on feedback received from the Healthy San Diego AIS

discussion group, Health Net and Healthy San Diego anticipate working with the IHSS program in three specific areas:

- Explore contracting with the Public Authority for the enhanced provision of IHSS care providers in tandem with home health care providers
- Work with UDW and other LTSS providers to develop an HCBS training and credentialing model that promotes worker development
- Collaborate with AIS to formalize our relationship with San Diego County DSS, including developing managed care education programs for DSS social workers and integrating their client evaluation in the member's case management plan to reduce redundancies and ensure effective coordination

Health Net's IDCT recognizes the complexity of the IHSS program and has experience working with IHSS through AIS for both our D-SNP and SPD members. Health Net's case managers routinely reach out to the AIS program on behalf of our members to initiate evaluations and request changes in their hour allotment at critical transition of care junctures. This is especially true when members are discharged from acute facilities and during the creation of the initial care plan when members are first enrolled.

Question 2.2.1 Certify the intent to develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1. The contract shall stipulate that: - IHSS consumers retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select who else participates in their care planning. - County IHSS social workers will perform assessments using the Uniform Assessment and guided by the Hourly Task Guidelines, authorize IHSS services, and participate actively in local care coordination teams. - Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers. - County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Duals Demonstration. - IHSS providers will continue to be paid through State Controller's CMIPS program. - A process for working with the County

IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive to the extent the site has determined additional hours will avoid unnecessary institutionalization.

Health Net certifies the intent to develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1. This contract shall stipulate that IHSS consumers will continue to retain the ability to select, hire, fire, schedule, and supervise their IHSS care provider. In addition, IHSS consumers would participate in the development of their care plan, and select who else participates in their care planning. Health Net, Healthy San Diego, and AIS will work in collaboration to coordinate IHSS benefit administration. The contract agreement will include that:

- County IHSS workers will perform assessments using the Uniform Assessment—guided by the Hourly Task Guidelines and authorized IHSS services—and participate actively in local care coordination teams. Health Net will develop a process with the county to allow information sharing on the care needs of the consumers.
- Wages and benefits will continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.
- County IHSS programs will continue to utilize procedures according to established federal and state laws and regulations under the Demonstration.
- IHSS care providers will continue to be paid through State Controller's CMIPS program.
- We will develop a process for working with the county IHSS agency to increase hours of support above what is authorized under current statute that beneficiaries receive, to the extent the site has determined additional hours will avoid unnecessary institutionalization.

Question 2.2.2 With consideration of the LTSS Framework in Appendix E, that emphasizes customer choice, and in consideration of the approach taken in Year 1 as described above, please describe the interaction with the IHSS program through the evolution of the Demonstration in Years 2 and 3. Specifically address:

During the implementation period prior to the start of the Demonstration, Health Net will work with Healthy San Diego and AIS to expand the MOA to include coordination of services with DSS (See **Attachment 18**). In Year 1, Health Net intends to collaborate with Healthy San Diego and AIS to train Health Net and other Healthy San Diego plan case managers and social workers about the IHSS program, including the IHSS Uniform Assessment tool and the Hourly Task Guidelines. Working with IHSS, an integrated case management plan will be developed with IHSS input that will include the IHSS Uniform Assessment. Case managers will update the plans quarterly and forward changes to the AIS social workers. Health Net will assign a liaison to work with AIS to conduct quarterly reviews of members who require intensive case coordination to avoid possible institutionalization and to address concerns and barriers to the successful implementation of member-caregiver relationships.

Based on lessons learned in Year 1 of the Demonstration, starting in Year 2 and continuing in Year 3, Health Net and Healthy San Diego will work towards developing a reimbursement methodology for IHSS hours provided to Health Net members.

In collaboration with UDW, Health Net, AIS, and Healthy San Diego will jointly develop an HCBS training and credentialing model. Findings from numerous surveys and focus groups of paraprofessional direct care workers consistently identify lack of adequate training as both a concern and a factor influencing workers decisions to stay in the field. Health Net's Health Education and Provider Communication teams will work with Healthy San Diego, AIS, and UDW to organize an ongoing schedule of trainings for formal and informal caregivers addressing core

competencies in geriatrics; soft skills (e.g., listening, communication, empathy, decision-making, personal time management, etc.); cultural competency; and an understanding of complex chronic conditions, multi co-morbidity complications, and the unique needs of individuals with dementia and Alzheimer's disease. Health Net, in collaboration with Healthy San Diego, will work with AIS and local agencies, including the Alzheimer's Association, the San Diego County Department of Mental Health, and the CBAS programs to develop a curriculum that includes:

- Essentials of caregiving and caregiver support
- Community resources
- Managing hygiene and the activities of daily living
- Transfers and the body mechanics of caregiving
- Challenges of Alzheimer's and dementia care
- Advanced care planning and end-of-life needs
- Nutrition training for caregivers
- Caregiving as a successful career
- Recognizing behavioral health concerns and de-escalation techniques
- Recognizing and reporting elder abuse and neglect
- Emergency preparedness

Health Net has a commitment from a CBAS program in San Diego County to provide these trainings collaboratively at their sites (the CAADS grant abstract is included as **Attachment 21**). Health Net will coordinate with AIS to triage the need for personal attendant coverage with our members to identify alternative caregiver resources to ensure member safety. This emergency system plan will include short-term CBAS access, if needed. In extreme cases this may include facility-based services. We believe that these kinds of short-term arrangements will ultimately contribute to the overall welfare and independence of our members.

Section 2.3 Social Support Coordination

Health Net and Healthy San Diego will continue to work with the stakeholders of the LTCIP to develop MOUs with LTSS programs that support an integrated MOC. These MOUs will include a service coordination model, along with a provision for ongoing case management training, to ensure that the health plan case managers have a working knowledge of available resources. This is critical in order to adapt to the ever-changing landscape of the provision of LTSS.

Question 2.3.1 Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.

Health Net certifies that it will provide an operational plan for connecting beneficiaries to social supports that include clear evaluation metrics. HCBS eligibility criteria will be used when making recommendations to members and their caregivers about services available to them that support both health and independence. This is especially true for CBAS services and services provided by AIS and other social support programs. These evaluation tools and metrics will be an integral part of the overall case management plan and will be made available to the PCP and the HCBS program(s). An example of this is a referral to a CBAS program for a member who needs continuous cueing to self-feed.

Question 2.3.2 Describe how you will assess and assist beneficiaries in connecting to community social support programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community.

Health Net recognizes that the MSSP program model developed in the communities where our members live is one of the most efficient ways to orchestrate available resources.

Health Net will adopt the MSSP methodology and standards in our IDCT reviews of institutionalized members and members at risk of institutional care. This very successful program currently has limited access. Health Net and the Healthy San Diego plan will work with

AIS and local MSSPs to explore options to increase capacity. Where available and appropriate, Health Net will contract with local existing MSSPs to assess and assist beneficiaries in connecting to community social support programs.

Question 2.3.3 Describe how you would partner with the local Area Agency on Aging (AAA), Aging and Disability Resource Connection (ADRC), and/or Independent Living Center (ILC).

Health Net and Healthy San Diego share a common understanding of the challenges that seniors encounter in striving to remain active and independent in their communities. This is especially true when it comes to managing the health care conditions related to aging (e.g., dementia, impaired mobility, falls, nutrition, etc.). We also recognize that not all communities in San Diego County have access to the same scope of services. It is our intent to use assigned public program liaisons to participate at the local level to help resolve chronic access to care issues.

Health Net has been a member of the California Area Agency on Aging Association (C4A) Corporate Advisory Board for five years. During this time we have worked with the Area Agency on Aging (AAA) programs to enhance our understanding of their programs that are available to our members. Health Net will create culturally relevant caregiver materials and provide health education programs in senior centers and AAA-sponsored events using a promotoras/mentoring model. Health Plan education materials will be made available to their Aging and Disability Resource Connection (ADRC), along with nutrition support programs like Meals on Wheels.

Representatives from Health Net also are members of the boards of two ILCs. In January 2012, Health Net worked with five ILCs—Westside Center for Independent Living (WCIL), Community Rehabilitation Services (CRS), Disabled Resource Center, Inc. (DRC), Southern

California Rehabilitation Services (SCRS), and Independent Living Center of Southern California (ILCSC)—on a CMS Innovations grant proposal, "Bridging Health Navigation and ILC Program Coordination." Health navigators at ILCs would help consumers with a variety of disabilities navigate the health care delivery system with the aim of promoting wellness and improving health outcomes. The program would integrate and coordinate health and ILC program services – including medical services, health education, health care self-management, mental health, transition services, daily living activities, job development, housing resources, peer support and assistive technology – in a person-centered setting that bridges health and ILC program coordination.

Question 2.3.4 Describe how you would partner with housing providers, such as senior housing, residential care facilities, assisted living facilities, and continuing care retirement communities, to arrange for housing or to provide services in the housing facilities for beneficiaries.

Health Net will work with Healthy San Diego to develop a collaborative approach to working with the spectrum of housing providers to coordinate services in the housing facilities. Health Net will assign a liaison to facilitate partnerships with residential care facilities, assisted living facilities, and continuing care retirement communities. Based on data from member assessments and stratification of member needs, Health Net will work with AIS and these housing providers to deliver health care services, such as physician visits, in these settings. We currently have members who participate in the Assisted Living Waiver program who would benefit from health promotion programs delivered in these communities. Over the next two years with the help of the AIS and HCBS programs, we will develop a directory of the senior housing programs by zip code that partner with Health Net. This will facilitate a beneficiary's ability to identify health care programs that are made available through Health Net at each site.

We will also develop policies, procedures, and training for case managers, the IDCT, and contracted PPGs regarding housing services and home modification programs available to members.

Section 3. Coordination and Integration of Mental Health and Substance Use Services

Question 3.1 Describe how you will provide seamless and coordinated access to the full array of mental health and substance use benefits covered by Medicare and Medi-Cal, including how you will:- Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for substance use.- Incorporate screening, warm hand-offs and follow-up for identifying and coordinating treatment for mental illness.

Health Net will achieve full integration of behavioral health services in a combined Medicare and Medi-Cal benefit by January 1, 2015 resulting from our extensive experience working with traditional Medicare and Medi-Cal members. Health Net, through its sister company MHN, Inc., (hereinafter referred to as Health Net) currently provides behavioral health services through an extensive practitioner network to our Medicare members. The delivery of behavioral health services to our Medi-Cal members is provided through an existing partnership with San Diego County Department of Mental Health. Through the combined efforts of these two delivery models, we intend to provide comprehensive behavioral health services for the Dual Eligible beneficiaries to ensure integration of all elements of individualized care.

Through Health Net's experience coordinating care for Medicare patients with mental illness and substance use disorders, regardless of whether the member's impairment is profound, severe, and persistent with complex psychosocial needs; of intermittent or moderate acuity; or mild to moderate focusing on co-management with PCPs. Health Net screens all members requesting services at the time of first contact to identify needs and resources available to the member. We have designed care management systems for these members to:

- Improve access to care by evaluating provider network adequacy, appointment availability statistics, and member satisfaction.
- Improve continuity of care and services by coordinating with medical providers, county behavioral health resources, and the full range of providers throughout our system of care. We share accountability for successful treatment outcomes with these partners and the member who is receiving services. This coordination leverages home and community-based alternatives to promote member directed treatment in the least restrictive setting possible.

Health Net's IDCT has been managing D-SNP members with complex medical, social, and psychiatric needs since 2009. Our clinical care managers have experience working with the County mental health providers to coordinate services for members with psychiatric and substance abuse issues. We coordinate services for our members who attend Medi-Cal-funded day programs, in conjunction with their Medicare-funded mental health services. We have also interacted with county mobile crisis intervention teams for many years and rely upon their psychiatric and social expertise available to our members during times of crises.

Health Net's provider network is comprised of licensed professionals with expertise in providing specialized, evidence-based services to Medicare Advantage and SNP members. We will work to expand our network to include the County behavioral health network of service providers, as appropriate, to ensure:

- Continuity of care for members currently receiving services within the County mental health system of care
- Access to the clinical expertise and experience of these providers

- Continued access to services that are available through the San Diego County Mental Health system of care, including crisis intervention and day programs

As members move through this integrated system of care, our focus will be on coordinating transitions of care, particularly for members with complex and persistent medical and behavioral health needs. Health Net's IDCT behavioral health clinicians will work to ensure timely referral, coordination, and warm transfers to help our members direct their care and access HCBS programs in their communities.

Working with Healthy San Diego and the County Department of Mental Health, we will fully integrate the Medicare and Medi-Cal benefits into one comprehensive system of care to achieve optimal health outcomes.

- We currently have specialized case management programs that work with the IDCT to coordinate, monitor, evaluate, and use a variety of collaborative service providers to meet specific complex needs of members affected by mental illness and chronic substance use.
- We coordinate, facilitate, and manage the development and ongoing support of collaborative partnerships among consumers, providers, County agencies, community-based organizations (CBOs), and individual medical and behavioral health practitioners to ensure effective comprehensive mental health and substance use services are designed to strengthen recovery and resiliency.
- Our direct interactions with members include assistance in accessing and navigating service systems.

We identify members in need of services by reviewing the HRAs performed on each new member, pro-actively identifying members for outreach who would benefit from the IDCT's

coordinated physical and behavioral health approach to care. Our dedicated Member Services Center representatives also respond to calls from members concerning referrals, appointments, and assistance with other health care concerns.

Health Net publishes and recommends use of standardized screening tools and standardized, evidence-based practice guidelines in behavioral health treatment to our network providers. These are tools that can be used by both behavioral health and medical practitioners.

Question 3.2 Explain how your program would work with a dedicated Mental Health Director, and/or psychiatrist quality assurance (preferably with training in geriatric psychiatry)

We will commit to a dedicated Mental Health Director to manage the Demonstration who will have experience working in both the private and public sectors serving Dual Eligible beneficiaries. The Mental Health Director will be a California licensed behavioral health professional—preferably with training in geriatric psychiatry—with experience in the following:

- Clinical and administrative experience working with Dual Eligible beneficiaries
- Demonstrated expertise in the design, development, implementation, and management of Behavioral Health Recovery Model programs
- Extensive knowledge of the Mental Health Services Act (MHSA) and its requirements and evidence-based behavioral health treatment
- Behavioral health care management, including experience with Quality Improvement/Quality Assurance

We will develop a collaborative working relationship with the experienced San Diego County behavioral health practitioners to enhance coordination of services.

Question 3.3 Explain how your program supports co-location of services and/or multidisciplinary, team-based care coordination.

Health Net currently works with PPGs and clinics within San Diego County that co-locate behavioral health practitioners in medical settings in order to appropriately assess behavioral health needs of medical patients and facilitate transitions in care. We will work to identify opportunities to increase the number of settings providing co-located services. Staffing primary care clinics with licensed behavioral health clinicians allows:

- Seamless continuity of the member's assessment/evaluation process
- The behavioral health clinician to initiate coordination of care and appropriate mental health/substance use referrals, including crisis intervention, medication support, and case management when initial screening identifies risk for a member
- Warm hand-offs for members transitioning between practitioners, treatment settings, and levels of care in order to support member engagement and continuity of care
- On-site case coordination to ensure that quality measures are met, providing care in the least restrictive setting, member engagement in care, continuity of care, and facilitate transitions of care

Health Net supports the concept of the recovery model and delivery of a person-centered, family focused system of mental health and substance use disorder services to promote wellness, eliminate stigma, and remove barriers to recovery with the belief that members with mental health and substance use disorders can lead productive lives.

In our co-location service settings we will encourage Integrated Screening, recommended by Substance Abuse & Mental Health Services Administration (SAMHSA) to address both mental health and substance use problems.

Behavioral health professionals and other health and social professionals working together on an IDCT as treatment partners to our members are able to leverage their expertise to develop effective treatment plans and strategic interventions to improve patient care. This coordinated approach will be critical to meeting the goals of this Demonstration by delivering the best patient care with seamless coordination of needed services.

Question 3.4 Describe how you will include consumers and advocates on local advisory committees to oversee the care coordination partnership and progress toward integration.

Our initial plan will be to engage with existing structures and forums, drawing on the expertise of the Healthy San Diego, San Diego County Mental Health Commission, AIS, local California Alliance for the Mentally Ill (CAMI), and consumer stakeholder groups, to engage consumers and advocates on the design, development, and implementation of a consumer-driven Demonstration Mental Health Advisory Committee. Working with Healthy San Diego, we fully expect, will allow us to accomplish consumer and advocate partnerships. We will develop additional opportunities for feedback and engagement if we believe that this will improve the quality of our services. Greater consensus on what constitutes appropriate care delivery, appropriate continuity of care for members, and compliance with recommended treatment plans would all be enhanced by the support of these stakeholders, leading to better outcomes for members in this person-centered, recovery model. Health Net is committed to developing, partnering with, and promoting educational and advocacy programs run by a partnership of consumers and professionals with the goals of empowerment, stigma reduction, wellness, advocacy, and education regarding mental health and substance use disorders.

Section 3.2 County Partnership

Health Net and the Healthy San Diego plans collaborated with the San Diego County Department of Mental Health to develop a comprehensive agreement for services for our Medi-Cal Managed Care beneficiaries over 14 years ago. The San Diego County Demonstration will advance our continuing collaboration to focus on building a person-centered, fully integrated, recovery-focused MOC.

Question 3.2.1 Describe in detail how your model will support integrated benefits for individuals severely affected by mental illness and chronic substance use disorders. In preparing the response, keep in mind that your system of care may evolve over time, relying more heavily on the County in Year 1 of the Demonstration. (See Appendix G for technical assistance on coordinating and integrating mental health and substance use services for the seriously affected.)

Health Net, Healthy San Diego plans, and the San Diego County Department of Mental Health recognize the unique challenges that persons with SPMI encounter accessing health care services. A key to our MOC is the early identification of members in need of services using the HRA and subsequent development of an individualized care plan. Health Net behavioral/mental health specialists and drug/alcohol therapists are an integral part of the IDCT for members who have behavioral health conditions, chronic substance use disorders, and SPMI. Developing a framework for integrating the County Department of Mental Health delivery system providers with the ICDT for members who are receiving services from County providers is a Year 1 priority for Health Net. Our Mental Health Director and case managers will work with the County Department of Mental Health to develop an integrated care management plan to be approved by the member's designated health home provider.

The following approach outlines how Health Net will work with Healthy San Diego to develop an integrated benefit for individuals severely affected by mental illness and chronic substance

use disorders. The three key elements are: 1) an integrated administration strategy that builds on our existing MOU with the San Diego County Department of Mental Health (in collaboration with the Healthy San Diego plans) to assign dedicated mental health case managers at the County mental health hubs to coordinate a "no-wrong door" approach to accessing behavioral health services, 2) develop an integrated care delivery system supported by a web-based, easily accessible, joint health plan behavioral provider directory, and 3) by Year 3, develop an integrated payment approach that combines both County Department of Mental Health and Medicare benefit structures in a seamless delivery and reimbursement system.

1) **Integrated Administration Strategy:** Integrated administration of the dual Medicare/Medi-Cal benefit will require a close partnership among multiple entities – Health Net, Healthy San Diego, and San Diego County Department of Mental Health. Health Net, in collaboration with Healthy San Diego, will consult consumer and advocacy groups, along with state and federal agencies, that have broad experience developing and delivering programs and services for individuals with SPMI and chronic substance use disorders to gain insight into which elements of the current system of care are working and which elements need to be improved. With stakeholder input, Health Net will evaluate existing program resources, both in and out of our network, to identify gaps in the current system of care. We will work with Healthy San Diego to further refine the role of Health Net and the other Healthy San Diego plans' liaisons to focus on streamlining member communications to ensure that members do not experience interruptions in care and that provider continuity is maintained. We will also evaluate the existing system controls, including quality management and utilization management processes, for services currently being received by members. We will

objectively and systematically monitor and evaluate the quality and safety of clinical care provided to members, as well as the accessibility and appropriateness of patient care and the performance of practitioners.

2) **Integrated Care Delivery System:** Having developed productive partnerships with the consumer community; the San Diego County Department of Mental Health; and its contracted administrator, Optum Health (which provides services through a network of mental health contracted providers), Health Net will administer an integrated care delivery system. Health Net care management will include utilization review, quality improvement, intensive case management, and disease management. In an integrated care delivery system, the IDCT uses a collaborative, multidisciplinary approach that is client-focused, interactive, and goal-directed in the development, implementation, and monitoring of the plan of care. This ensures members are receiving the correct level and intensity of care linked to their clinical status at the appropriate level on the continuum of services. This ranges from acute inpatient, intermediate levels of care such as Partial Hospital (Day Treatment), to intensive outpatient structured programs, as well as traditional outpatient office based care to address both mental health and substance use disorders. Health Net also endorses the recovery model and recognizes that comprehensive services focused on the goal of ongoing recovery are imperative. The goal is to move service delivery away from the acute hospital setting to community based services, resulting in better health outcomes, better quality of life, and the lowering of health care costs.

3) **Integrated Payment Approach:** The challenge and opportunity of this Demonstration is to combine the various funding streams and benefits that are available to our members. Health

Net has extensive experience contracting with a variety of mental health providers who offer a wide array of services, including facilities (inpatient psychiatry, inpatient substance abuse detox and rehabilitation, partial hospital programs, and intensive outpatient programs). After thorough evaluation of our current behavioral health network, Health Net will contract with existing County program resources that may not already be in our network. This will include outpatient structured programs, as well as outpatient office-based care for both mental health and substance use disorders. We will also formalize clinical practice guidelines and best practices regarding these services using evidence based practice and the robust experience of those currently providing services. Health Net will also explore incentive payments for meeting outcome and performance measures for successful integration and care coordination.

Question 3.2.2 Provide evidence of existing local partnerships and/or describe a plan for a partnership with the County for provision of mental health and substance use services to the seriously and persistently ill that includes measures for shared accountability and progress toward integration in the capitated payment by 2015. Describe how you will work with County partners to establish standardized criteria for identifying beneficiaries to target for care coordination. Describe how you will overcome barriers to exchange information across systems for purposes of care coordination and monitoring.

Health Net has worked collaboratively with Healthy San Diego for the last 14 years to develop agreements with public health programs, Regional Centers, and the San Diego County Department of Mental Health to adopt coordination of care policies and procedures to ensure access to these programs. Health Net will collaborate with Healthy San Diego and expand upon our existing MOUs with the County Department of Mental Health to include an integrated case management and care coordination program that spells out how we will jointly arrange and provide services to the Demonstration members. This MOU will also include measures for

shared accountability and progress toward full payment and service delivery integration by 2015. A copy of the current MOU is included in **Attachment 19**.

Health Net's mental health clinicians will collaborate with the County Department of Mental Health clinicians and other Healthy San Diego plan clinicians to establish standardized criteria for identifying beneficiaries in need of care coordination. These criteria will be based on information from:

- Claims data, including pharmacy data, that includes the member's past history of diagnosis and treatment
- Results from the current screening and evaluation tools used to determine SPMI and chronic substance use status
- Applied InterQual criteria from utilization data
- Available County Department of Mental Health provider treatment data

Evaluation of this data will determine which beneficiaries will be prioritized for a full assessment of their current symptoms, functioning, social supports, treatment, substance use, medications, and co-existing medical conditions in the expedited development of care coordination plans.

Health Net will work with Healthy San Diego and the County Department of Mental Health to overcome barriers to exchanging information for purposes of care coordination and establish a system that informs Health Net and the other Healthy San Diego plans of Demonstration members who are receiving mental health services. This will allow Health Net to assign case managers with specialized skill and experience with SPMI to these members. Health Net will work with Healthy San Diego and the Department of Mental Health to expand this data sharing

by building an on-line presence that would allow physical and behavioral health care providers, health plans and County administration, as well as consumers of services, to access and share relevant information with one another. This undertaking would require the establishment of clear data sharing/privacy guidelines to facilitate information exchange and protect personal health information as well as consensus on sharing of all data including pharmacy data with stakeholder buy-in and collaboration. Health Net, Healthy San Diego, and the San Diego County Department of Mental Health will engage with advisory and consumer groups to develop a task force to develop information sharing safeguards that will facilitate integration and development of case management services for members.

Section 4. Person-Centered Care Coordination

Health Net's care coordination and case management programs have been developed over the last 27 years to meet and surpass the expectations of the Medi-Cal Managed Care Division (MMCD), as well as those of the members we serve. Our D-SNP MOC offers a person-centered care coordination approach. In 2011, Health Net's SNP MOC was granted the maximum three-year approval. We have developed a culturally diverse and dedicated case management and other clinical staff who live and work in the same communities as our members. Through this local presence, we are able to effectively respond to our members' needs as they are identified. This model has contributed to the successful transition of over 65,000 SPD members to our Medi-Cal Managed Care program. The IDCT described below builds on our current experience managing and coordinating care for our SPD members and on our D-NSP MOC.

Question 4.1 Describe how care coordination would provide a person-centered approach for the wide range of medical conditions, disabilities, functional limitations, intellectual and cognitive abilities among Dual Eligibles, including those who can self-direct care and also those with dementia and Alzheimer's disease.

The Dual Eligible population is culturally diverse, and it will include members with a wide range of medical conditions, disabilities, functional limitations, and intellectual and cognitive abilities, including members with dementia and Alzheimer's. We also recognize the importance of providing care coordination across the full continuum of a member's needs to avoid duplication of services and to enhance the member's health home. To this end, our integrated person-centered care management system of ambulatory case management, complex case management, disease management, and home and community-based care coordination will be directed by the members and/or their caregivers to the greatest extent possible with the resources of Health Net's IDCT. Health Net's IDCTs are linked to our PPGs and are geographically based throughout San Diego County based on our membership distribution.

Based on the results of the initial HRA, members are connected to the appropriate IDCT. Key to the success of any care management program is the member's understanding, knowledge, and trust of the available health care and HCBS programs. Equally important is our members' ability to access these services. Therefore, a central goal of our care management model is to help our members meet their health care goals to enable them to attain their highest level of independence and stay in their homes as long as possible. To achieve this result in San Diego County, our IDCT of medical directors, nurses, social workers, mental health clinicians, pharmacists, and case management assistants live and work in San Diego.

To ensure that our Dual Eligible beneficiaries have ready access to IDCTs, in targeted areas they will be comprised of locally recruited, culturally diverse clinical and clinical support staff

co-located in high-volume clinics, hospitals, and medical offices. Their goal is to help our Dual Eligible beneficiaries navigate the health care system and collaborate with the other HCBS programs to meet their health goals. Individuals on the IDCT will be assigned to serve as a personal point of contact to help our most frail and vulnerable members navigate the myriad of health care services and programs. These assignments are made with member input and permission and are based on the results of HRAs and IDCT care conference recommendations.

IDCTs work with the member and the member's providers to develop a care management plan that includes ongoing treatment and focuses on removing barriers to attaining health goals and reducing the need for institutional care. They collaborate with HCBS programs to identify gaps in social service needs, including assessing environmental situations that could put the member at risk for injury, including abuse or neglect. The services provided by the IDCTs will include:

- Serving as the key point of contact to the member or the member's caregiver to help them understand benefits and how to access them
- Facilitating comprehensive medical evaluations by assisting with making provider appointments
- Conducting HRAs to screen for complex case management, disease management, and ambulatory case management
- Coordinating with LTSS, IHSS, HCBS, CBAS, and other county agencies
- Coordinating supplemental benefits
- Assessing members in nursing facilities for their ability to return to a home setting
- Reviewing medication regimens and recommending improvements to drug therapy

- Identifying members with mental health needs and ensuring linkages to behavioral health services are facilitated

As our attached MOC points out, it is estimated that over 43 percent of Dual Eligible beneficiaries have at least one mental/cognitive condition. This critical strength of our case management/care coordination team is vital to the development of an integrated care management plan that maximizes our members' ability to attain their health goals. When appropriate, mental health clinicians are assigned as the member's IDCT point of contact to assist with all of his or her health care navigation challenges. Health Net's mental health clinicians will be working with their San Diego County Department of Mental Health counterparts to coordinate member-specific services and work collaboratively to ensure that barriers to receiving mental health services are mitigated in real time.

Question 4.2 Attach the model of care coordination for Dual Eligibles as outlined in Appendix C. This will not account against any page limit.

The MOC is attached as **Attachment 4**.

Question 4.3 Describe the extent to which providers in your network currently participate in care coordination and what steps you will take to train/incentivize/monitor providers who are not experienced in participating in care teams and care coordination.

Our goal is to preserve beneficiary choice while contracting with PPGs that meet the qualification requirements outlined in **Section 7**. By building on our current experience, we are able to choose from a wide range of PPGs. It is our expectation that our PPGs will be experienced in both Medicare and Medi-Cal and will meet care coordination and case management requirements. We currently contract with 27 PPGs in San Diego County (970 PCPs; 550 behavioral health providers; and 3,950 specialists). We will be conducting readiness reviews on all of the PPGs and selecting for the Demonstration PPGs that best fit the needs of

the Duals Eligible beneficiaries. Provider training on different aspects of the Dual Eligible MOC will be offered online through the provider portal, in-person, and via teleconferences. Trainings will emphasize, among other topics, care coordination and case management, medication therapy, transition of care management, care plan development, and implementation.

We will be providing a combination of grants, incentives, and project management support to move PPGs to the health home model, which follows the whole-person approach to care by integrating medical, behavioral, and social supports, and by linking members to available community-based resources (see **Section 7.2**).

Monitoring will be done annually using the same NCQA criteria and CMS guidelines currently used to monitor our D-SNP program. The Delegation Oversight team will review the Dual Eligible MOC functions during the annual on-site audit, including MOC training. Health Net will ensure that PPGs complete necessary training.

Section 5. Consumer Protections

Health Net will ensure the consumer protections described in this Section. In particular, at the initiation of the Demonstration, Health Net will offer significantly expanded provider choice by collaborating with Healthy San Diego plan partners. Health Net will also leverage its experience managing a person-centered MOC for both the D-SNP population (using individualized care planning and IDCTs) and the SPD population to ensure that self-directed, well coordinated care is the central concept in the Demonstration.

Question 5.1 Certify that your organization will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.

Health Net certifies that we will be compliant with all consumer protections described in the RFS and Federal and State MOUs and we will prove compliance during the Readiness Review process.

Section 5.1 Consumer Choice

By leveraging the Healthy San Diego Model, using the current infrastructure, and expanding the beneficiaries' choice and access, they are provided with a wide range of provider choices through the health plans.

In the Demonstration, beneficiaries are connected with the appropriate PCPs and specialists of their choice to ensure they have access to medications, durable medical equipment (DME) and treatments without delay or disruption. There are key touch points for our members in the enrollment process, including the on-boarding process through our Member Services Center, the HRA outreach process, enrollment in disease management and case management where Health Net will ensure members have the information to make appropriate provider choices. Our Member Service Center staff and case managers will assist members with provider assignment and authorization for ongoing specialty care.

In addition to written and telephonic information on benefits and member rights, Health Net anticipates that Healthy San Diego and the Healthy San Diego plan will collaborate to hold periodic town hall meetings at locations throughout the county. Town hall meetings will provide beneficiaries and their caregivers with the opportunity to engage with health plan, consumer, and Healthy San Diego representatives who can answer questions about the

Demonstration, provider choice, service integration, care coordination, benefits, and access to care. These town hall meetings will be offered in different venues reflective of member diversity, including physical accessibility, cultural, cognitive, and linguistic needs.

Question 5.1.1 Describe how beneficiaries will be able to choose their primary provider, specialists and participants on their care team, as needed.

Members will continue to access their current primary and specialist physicians. Our goal is to facilitate smooth transitions with as little care disruption as possible. We will provide Dual Eligible beneficiaries with the same continuation of care benefits offered to SPD members, who may be treated by a non-participating provider for medically necessary services for up to 12 months from the date of their enrollment. During this time, the medical group or case manager works with the member to ensure a coordinated transfer to an in-network provider. Health Net requires all subcontracting health plans and PPGs to adhere to the SPD continuation of care policy and arranges for medically necessary services for members to be provided by non-participating providers as appropriate. Members choose from over 970 PCPs, 550 behavioral health providers, and 3,950 specialists in our San Diego County network. Network expansion is ongoing to improve physician choice, enhance continuity of care, and meet provider availability standards.

For members who do not have a PCP, or want health plan guidance, our provider directory is available in hard copy and online in threshold languages; the directory also includes physical accessibility symbols to allow members to select provider offices that can accommodate their physical needs. Additionally, our Member Services Center can link members to a provider that meets their cultural, linguistic, and physical accessibility needs.

Dual Eligible beneficiaries and/or their caregivers are contacted by case managers to assist in the identification of the IDCT participants. The IDCT is a core component of our member centric approach to care. Case managers also invite members and/or their caregivers to participate in any ongoing IDCT meetings.

Question 5.1.2 Describe how beneficiaries will be able to self-direct their care and will be provided the necessary support to do so in an effective manner, including whether to participate in care coordination services.

Self-directed care is a key feature of the Health Net person-centered model of care. During the HRA process, members are informed that participating in any of our case/care programs is their choice. If a member does not choose to participate in case management, assistance is still available through the Member Services Center, chronic disease management programs, educational and quality improvement programs, and the 24/7/365 Nurse Advice Line. Members may request case management services through their providers, HCBS plan partners, or our Member Services Center at any time.

This all-encompassing program of care for Dual Eligible beneficiaries cannot be designed and implemented in a vacuum. We seek the input and guidance from our external Duals Advisory Committee to create a meaningful program of person-centered care, linking primary and specialty care, HCBS, and mental health services through the IDCT case management program of health navigation.

Section 5.2 Access

Question 5.2.1 Certify that during the readiness review process you will demonstrate compliance with rigorous standards for accessibility established by DHCS.

Health Net certifies that it will demonstrate compliance with rigorous standards for accessibility established by DHCS during the Readiness Review process.

Question 5.2.2 Discuss how your program will be accessible, while considering: physical accessibility, community accessibility, document/information accessibility, and doctor/provider accessibility.

Physical access is assured by Health Net's site assessment process. During the mandatory transition of SPD members to managed care, Health Net established a system of facility site reviews (FSRs) in collaboration with other Medi-Cal Managed Care plans and the Harris Family Center for Disability Issues and Health Policy to ensure physical access to provider sites for all members including aging members and members with disabilities. The collaborative review process developed for the SPD implementation will continue to be used for the Demonstration. The Physical Accessibility Review Survey (PARS) tool is used to assess contracted providers' sites for accessibility. Accessibility to medical offices generally includes designated parking spaces, exterior building access, such as ramps, and interior building access, such as elevators, restrooms, exam rooms, and specialized equipment. During Health Net's FSR and PARS process, a finding of any obvious physical barrier to accessibility for members with disabilities is noted and discussed with the provider or PPG administrator. Sites are designated either Basic (all elements are present) or Limited (one or more element is missing).

Community access is promoted through Health Net's work with local CBOs to ensure coordinated member access to local programs and resources to meet the member's medical, behavioral, and social needs. Many of the following services and programs are administered by the local AAA. At a minimum, Health Net will collaborate with organizations, including:

- **CBAS (Adult Day Health Care)** provides health, therapeutic, and social services to the frail elderly and functionally impaired adults at risk of institutionalization

- **Alzheimer's Day Care Resource Centers** provide care for persons with Alzheimer's disease and other related dementias who are often unable to be served by other programs. The Centers provide respite, training, and support for families and professional caregivers
- **Local Brown Bag Volunteer Programs, Congregate Meals and Home Delivered Meals** provide food services
- **Information & Assistance** provides trained staff to provide information as well as assistance and follow-up to link older persons and their families to specific community services
- **In-Home Services, Respite Purchase of Service, Respite Registry Transportation Services** provide in-home supportive services and respite care for caregivers

Access to documents and information such as enrollment rights and options, plan benefits and rules, and care plan elements is ensured by the use of a variety of formats and languages accessible to enrollees. Health Net translates key documents and information material into threshold languages in San Diego County and has the capacity to provide information in a variety of formats described in this Section under Education. To make information exchange easier and to meet the unique needs of members and providers, Health Net operates a Member Services Center with dedicated associates for Dual Eligible beneficiaries. These dedicated associates are trained on the D-SNP MOC, including benefits and the provider network to effectively assist members and providers. The Member Services Center contact information is included on the member's ID card. In addition, Health Net providers and members have access to telephone interpreter support in over 100 languages for immediate access to interpretation. Educational material is also highly accessible.

Provider access is ensured by a comprehensive network of providers, complemented by Health Net's organization, which includes dedicated associates who are knowledgeable about, and experienced in, meeting both Medicare and Medi-Cal access and network adequacy needs. Health Net has established access to care policies and standards for health care services, including requirements that providers offer office hours at least equal to those offered to other lines of business and provide medically necessary services 24/7/365. Access standards include primary and specialty care appointment access, after-hours access and instruction, and telephone customer service and triage or screening service access. Additionally, Health Net has standards for availability of practitioners, providers, and health care facilities including distance to care and ratios of providers to members. Health Net regularly surveys members and providers to evaluate access to care and reviews this information alongside member grievances to assess overall satisfaction. Health Net is currently in compliance with DHCS standards and Department of Managed Health Care (DMHC) Timely Access regulations and meets access standards for CMS and NCQA with an accreditation rating of Excellent for Medicare and Commendable for Medi-Cal.

Question 5.2.3 Describe how you communicate information about the accessibility levels of providers in your network to beneficiaries.

Access standards, the availability of triage and screening services and the Nurse Advice Line and how to obtain these services is disclosed annually to Health Net's members via the EOC or member newsletters. Health Net identifies which providers have been assessed and evaluated as meeting access requirements for disabled members in the hard copy and online provider directory. Health Net's website also provides Demonstration information. Members who call the Member Services Center receive information on the providers in the network and are

offered assistance with making appointments or provided with assistance on securing out-of-area services.

Section 5.3 Education and Outreach

Question 5.3.1 Describe how you will ensure effective communication in a range of formats with beneficiaries.

Health Net provides alternative format materials consisting of: large print, Braille, Analog and Digital audio, computer disk digital audio (CDDA), and Accessible PDF. New technology has made it possible to overlay Braille translations on large font documents to assure that vision impaired members can receive support from their family and providers as well as understand their materials directly. Accessible PDFs contain voice recognition programming so that member devices such as iPads and smart phones can read the document aloud to the member. Health Net has contracted a consultant company to advise us on new and developing technologies to improve communication with disabled populations. In addition, Health Net's Cultural and Linguistic (C&L) Services department incorporates ADA-compliant guidelines into the contracting for, and provision of, language services and member communications. The C&L Services department provides in-service training to departments that routinely send member communications, such as Appeals and Grievance and Member Services Centers, to keep them informed of ADA-compliant communication guidelines.

Health Net routinely promotes the use of sign language services to contracted providers. Contracted providers are encouraged to use a qualified sign language interpreter for all informed consent and discouraged from using minors, family, or friends as interpreters. Health Net arranges and pays for sign language interpreters at the member or physician request for all

Dual Eligible beneficiaries. Health Net has a network of sign language vendors for San Diego County to assure all Dual Eligible beneficiaries will have access to in-person interpreter support.

Question 5.3.2 Explain how your organization currently meets the linguistic and cultural needs to communicate with consumers/beneficiaries in their own language, and any pending improvements in that capability.

Health Net has over 14 years of experience in producing quality translations, including alternate formats. Health Net translates member informing materials, member outreach materials, and our website content. Health Net has a thorough and comprehensive translation process that includes quality standards for translations, quality standards for translators, a translation and alternate format style guides to promote consistent translation quality, and a glossary of common terms in threshold languages. English documents are examined to guarantee that all phrases and concepts can be clearly translated and a quality monitoring process ensures vendors meet the quality standards established by Health Net. We have developed a style guide for use by translators that details our translation preferences to assure that all of the DHCS and CMS translation requirements are met each time. We are also developing language glossaries in threshold languages that standardize the terms used by translators.

Health Net translates a wide range of member informing materials including: Member EOCs, applications, disclosure forms, provider directories, marketing materials, letters (e.g., emergency room follow-up), Health Net-generated preventive health reminders, member surveys, and Member Newsletters. To assure that all members are aware that they can request translated materials, Health Net promotes translation services and interpreter assistance in the member newsletters and the EOC.

The C&L Services department produces member informing materials that are culturally and linguistically appropriate. The development and translation of health education materials is guided by policies approved by the QIC. Health Net has adopted plain language guidelines. This initiative addresses the issue of low health literacy that disproportionately impacts populations such as those enrolled in Medi-Cal. The C&L Services department oversees the translation process and is staffed with personnel trained in linguistics who are experienced in exploring and evaluating new technologies to provide language services. All translated member informing material is tracked. When members call our Member Services Center, the multi-lingual Member Service Center representatives are able to quickly locate a specific document through the document numbering system and provide an oral translation or send out the translated document to the member. Health Net recently received NCQA's Multicultural Health Care Distinction award for our Medi-Cal line of business. NCQA's distinction recognizes Health Net's Medi-Cal program as delivering quality multicultural health care, addressing health care disparities and providing culturally and linguistically appropriate services. Health Net has implemented processes to assure that we will maintain this distinction.

Question 5.3.3 Certify that you will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review: - A detailed operational plan for beneficiary outreach and communication. - An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. - An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.

Health Net certifies it will comply with the above referenced DHCS requirements in Question 5.3.3. **Figure 5** provides an outline of Health Net's operational outreach and communication plan for beneficiaries, providers and counselors.

Figure 5. Health Net's Operational Outreach and Communication Plan Outline

Communication	Distribution Method/Frequency	Details of Contents	Additional Formats
Enrollment Kit	Upon beneficiary request or distributed via enrollment meetings or educational events.	▪ Introduction Letter ▪ Plan Overview ▪ Summary of Benefits ▪ How to Enroll ▪ Enrollment Forms	▪ Threshold languages ▪ Large print ▪ Braille ▪ Audio CD ▪ Accessible PDF
Network Directories	Sent upon enrollment and annually thereafter. Provided to beneficiaries for reference in enrollment meetings, or upon request.	▪ Directories specific to the plan county updated twice annually if required ▪ Clarification on providers that speak secondary languages ▪ Physical accessibility information for provider offices	▪ Threshold languages ▪ Large print ▪ Braille ▪ Audio CD ▪ Website
Educational Materials (Counselors and Provider)	Available for training of counselors and providers around plan.	▪ Brochures, flyers, leave-behinds and/or training materials ▪ DVD training that outlines the plan structure, method of enrollment, benefit outline and claims process	N/A
Educational and Wellness Mailings	Disease Management to high risk members	▪ Living Tobacco Free Toolkit ▪ Weight Loss Toolkit ▪ Medication adherence, diabetes Control, heart health, breast and cervical cancer screenings	Threshold languages
Dedicated Member Services Center	Inbound calls	▪ Member Services Center with dedicated representatives for inbound calls from beneficiaries/members	Bilingual staff in six languages, telephone interpreter in over 100 languages

Section 5.4 Stakeholder Input

The San Diego Board of Supervisors has developed an organized system to include stakeholder involvement in the delivery of both Medi-Cal and Medicare programs over the past 20 years. In keeping with the model developed in San Diego County, stakeholder engagement for the Demonstration will be driven by Healthy San Diego, the LTCIP, and AIS. Health Net is an integral part of each of these programs and worked directly with CBAS programs, SNFs, hospitals, and other providers to prepare our response to this RFS.

Question 5.4.1 Discuss the local stakeholder engagement plan and timeline during 2012 project development/implementation phase, including any stakeholder meetings that have been held during development of the Application.

Health Net has worked with the LTCIP for 13 years to explore integrating health services for San Diego's Dual Eligible beneficiaries. In 2009 at the direction of the County Board of Supervisors, AIS was established to administer the county programs related to aging and independence services. AIS includes over 30 programs that provide services to older adults, people with disabilities, and their family members, to help keep clients safely in their homes, promote healthy and vital living, and publicize positive contributions made by older adults and persons with disabilities. After completing the MOU with the health plans that was developed for the SPD expansion, in October 2011 AIS began convening Dual Eligible discussion group meetings with the health plans, IHSS, and the County Department of Mental Health. AIS has also convened meetings of the LTCIP stakeholders regarding the Demonstration. **Figure 6** shows a list of the meeting dates, stakeholders and topics discussed. This discussion group will continue to meet after site selection in March.

Figure 6. Local Stakeholder Engagement Activities 2011-2012

Date	Stakeholders Represented	Topic Discussed
November 10, 2011	AIS, IHSS, County Department of Mental Health, health plans	▪ DHCS presentation of the demonstration program ▪ Overview of draft proposal by AIS ▪ Need for formal letter of interest from health plans
December 2, 2011	AIS, IHSS, County Department of Mental Health, health plans	▪ IHSS 101 ▪ Review of waiver programs ▪ Proposal development regarding eligibility and enrollment; long term care; mental health and substance abuse; and integration program administration, oversight and monitoring
January 19, 2012	AIS, IHSS, County Department of Mental Health, health plans	▪ Governor's proposed budget review and impact on IHSS and LTSS ▪ Proposal design strategy and creation of subgroup

Date	Stakeholders Represented	Topic Discussed
January 27, 2012	AIS, IHSS, County Department of Mental Health, health plans	▪ Actuarial analysis update ▪ Letters of agreement ▪ Process for development of application
January 31, 2012	AIS, IHSS, County Department of Mental Health, health plans	▪ Behavioral health key issues, including access to psychiatric medication and SNFs ▪ Integration of IHSS with health plans ▪ Schedule for ongoing meetings
February 14, 2012	Long Term Care Integration Program Stakeholders: AIS, IHSS, PACE, ADHC/CBAS, Senior Alliance, hospital association, community clinic association, health plans, SNFs, regional center, Access to Independence	▪ Impact of proposed changes ▪ Presentation from each health plan to share their vision and receive feedback on the Demonstration ▪ Proposal for the representation of the Advisory Committee
February 21, 2012	AIS, IHSS, County Department of Mental Health, health plans	▪ Discussion of RFS Appendix G – technical assistance regarding coordinating and integrating mental health and substance use services

Health Net anticipates that through these meetings we will gain critical insight into the current health care delivery system in San Diego County to identify areas that are working well and areas where there is opportunity for improvement. Health Net has also had a long-term and ongoing relationship with the C4A), the CAADS, and the California Association of Independent Living Centers and has partnered with all three organizations to promote common goals. We also sit on many of their local and statewide advisory groups.

Question 5.4.2 Discuss the stakeholder engagement plan throughout the three-year Demonstration.

Based on feedback received from stakeholders during the implementation period, Health Net, Healthy San Diego, and AIS will continue to hold regular stakeholder meetings to guide the development of standing stakeholder advisory groups in Years 2 and 3 of the Demonstration. The purpose of these meetings will be to gather and incorporate ongoing feedback from stakeholders on program operations, benefits, access to services, adequacy of grievance

processes, and other consumer protections. Summaries from the meetings will be posted on Health Net's dedicated Dual Eligible website, and members and other stakeholders will be invited to provide feedback through this website as well. Health Net seeks to obtain feedback from members and stakeholders through as many avenues as possible, paying special attention to members and caregivers who prefer providing feedback through alternative methods or who need assistance providing feedback.

Question 5.4.3 Identify and describe the method for meaningfully involving external stakeholders in the development and ongoing operations of the program. Meaningfully means that integrating entities, at a minimum, should develop a process for gathering and incorporating ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

Health Net and Healthy San Diego value all of the information received from stakeholders and members, and we are committed to incorporating their feedback to improve ongoing program operations, enhance benefits, ensure access to services, and maintain a grievance process that ensures consumer protections. All stakeholders' input will be presented to the relevant Health Net standing operations department meetings to identify areas for improvement and implement needed changes. This feedback will also be presented to Health Net's QIC. To ensure that stakeholders remain engaged in Health Net and Healthy San Diego's collaborative stakeholder involvement process, Health Net will develop a stakeholder feedback loop, including posting responses on our website, to keep stakeholders informed about actions taken and to respond to their concerns and suggestions.

Section 5.5 Enrollment Process

Question 5.5.1 Explain how you envision enrollment starting in 2013 and being phased in over the course of the year.

Health Net will support the intention of DHCS to enroll beneficiaries into the Demonstration during 2013 through a phased-in approach whereby beneficiaries are enrolled based on month of birth, or other strategy as determined by DHCS.

Question 5.5.2 Describe how your organization will apply lessons learned from the enrollment of SPDs into Medi-Cal managed care.

Our experience over the last year serving SPD members has prepared us to anticipate and plan for the needs of Dual Eligible beneficiaries. Similarly, SPD members have complex needs, are very diverse, and require creative approaches – whether it is in the way we conduct HRAs, or the way we handle their continuation of care needs, or simply the way we communicate benefit information. Based on our lessons learned during the SPD members' transition to managed care, we will be implementing the following strategies:

- Create member welcome materials specific to Dual Eligible beneficiaries that is reflective of the cultural, linguistic, and cognitive diversity within this membership and disseminate this information in creative modalities
- Build on our dedicated team of public programs coordinators in our Member Services Center to address complex questions, including continuation of care
- Match members to the PCP and PPG that best fits their needs using available utilization, treatment authorization, or member-reported data
- Collaborate with Healthy San Diego, the Healthy San Diego plans, and other partners to: develop a standard continuation of care form and distribute it widely so members and

providers are not confused; develop a process for identifying and communicating with the member's legal guardian or conservator so that delays or disruptions in care are avoided; set up town hall meetings to give enrolled members an overview of the program, their benefits, the continuation of care process, and to give them an opportunity to ask questions; develop care coordination strategies around communications and referrals to LTSS, county and community based programs, and other social services.

Question 5.5.3 Describe what your organization needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot programs begin enrollment.

Health Net is prepared to work closely with DHCS and CMS to make the Demonstration enrollment process successful. Health Net's enrollment process related questions are as follows:

1) We need DHCS to confirm that enrollment in the Demonstration will only be initiated by eligibility files received from DHCS and that Health Net will follow established CMS Medicare Advantage guidelines to submit Demonstration enrollment transactions to CMS.
2) What will be the file layout and frequency of the DHCS eligibility files? Will DHCS submit the Demonstration beneficiaries on the same files as the existing Medi-Cal members or will they come on separate files?
3) Will CMS be establishing any new transaction reply codes to support the Demonstration?
4) What mechanism will the health plans have to resolve any reconciliation discrepancies between CMS and DHCS?
5) Will the DHCS eligibility files utilize the "pending" eligibility status in the Demonstration as it does for the Medi-Cal Managed Care eligibility file process today? If so, Health Net needs to

know how to handle the "pending" status relative to beneficiary access to benefits and communication with CMS.

6) Will the existing member communications listed in Chapter 2 of the CMS Medicare Managed Care Manual be the template letters Health Net should implement or will new model letters specific to the Demonstration be created by DHCS/CMS?

7) We need confirmation from the State on the methodology to phase in beneficiary enrollment into the Demonstration.

Health Net's Enrollment and IT management teams are available to meet and discuss these questions at DHCS' earliest convenience. We welcome the opportunity to assist DHCS and CMS in resolving any administrative issues.

Section 5.6 Appeals and Grievances

Question 5.6.1 Certify that your organization will be in compliance with the appeals and grievances processes for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

Health Net certifies that we will be in compliance with the appeals and grievance process for both beneficiaries and providers described in the forthcoming Demonstration Proposal and Federal-State MOU.

Section 6. Organizational Capacity

Question 6.1 Describe the guiding principles of the organization and record of performance in delivery services to Dual Eligibles that demonstrate an understanding of the needs of the community or population.

Health Net's corporate principles of honesty, integrity, transparency, accountability, and commitment to compliance with applicable laws, regulations and company policies guide our daily work; our relationships with customers, members, and providers; and, ultimately, result in

the high-quality health plan services we provide. Our understanding of the needs of the community and Dual Eligible population is described in **Section 1**.

These guiding principles are evident in our long-standing and demonstrated success serving both the California Medicare and Medi-Cal populations. Health Net has successfully maintained continuous Medicare Advantage operations for over 17 years and Medi-Cal operations for the last 27 years. We have also successfully operated D-SNP programs for the past six years. We recognize and understand the unique challenges and needs faced by Dual Eligible beneficiaries such as greater incidences of chronic disease or co-morbid mental illnesses or substance use. As a result of our extensive experience, we have the knowledge, infrastructure, and competence to serve these needs.

Question 6.2 Provide a current organizational chart with names of key leaders

Health Net is committed to the success of the Demonstration and recognizes the importance of having dedicated individuals with the relevant skills and leadership abilities to effectively implement and manage this endeavor. **Figure 7** provides the current organizational chart with names of key leaders within Health Net, Inc.'s Government Services business segment that oversees Health Net Community Solutions. Also included is our functional organizational structure specific to the oversight and management of the Demonstration, which is depicted in **Figure 8**.

Figure 7. Current Organizational Chart with Names of Key Leaders

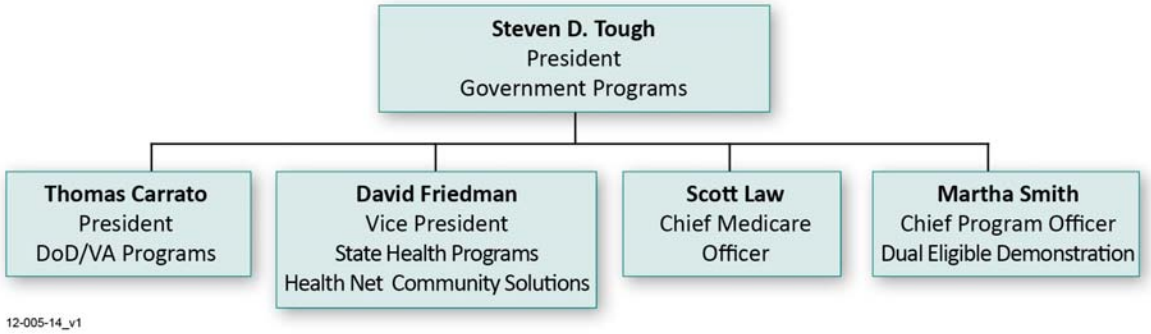
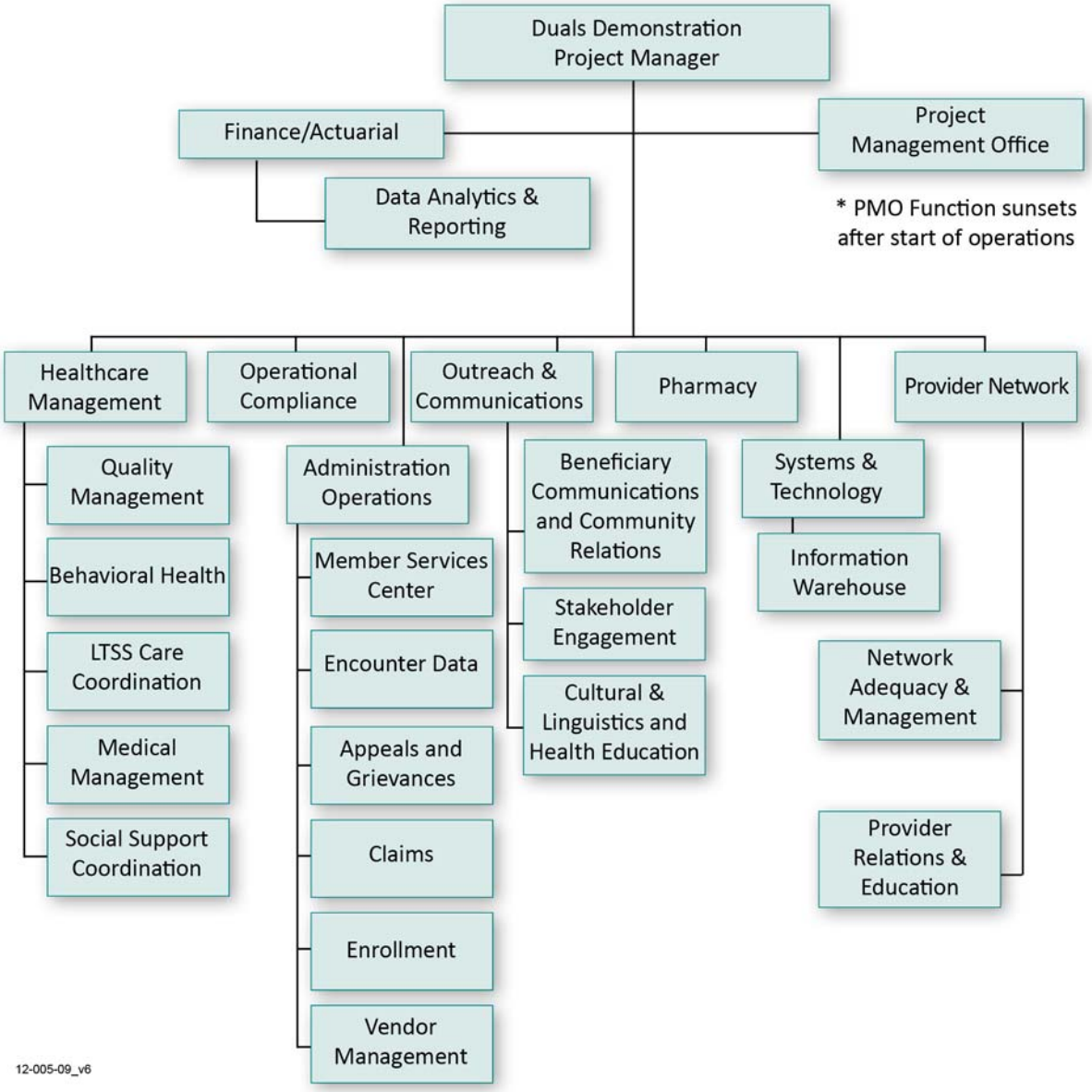


Figure 8. Health Net Functional Organizational Chart



Question 6.3 Describe how the proposed key staff members have relevant skills and leadership ability to successfully carry out the project.

In creating our team for the Demonstration, we leveraged in-place team members from our current Medicare Advantage, Medi-Cal Managed Care, and D-SNP contracts with proven leadership skills and demonstrated success to fill the key roles noted in our Demonstration organizational structure. The result is a highly experienced and seasoned team capable of delivering the right combination technical, programmatic, and experiential know-how to ensure a successful implementation and ongoing operations.

Question 6.4 Provide a resume of the Duals Demonstration Project Manager.

Ms. Martha Smith is responsible for guiding the operations and evolution of Health Net's Demonstration. A copy of Ms. Smith's resume is provided in **Attachment 23**.

Question 6.5 Describe the governance, organizational and structural functions that will be in place to implement, monitor, and operate the Demonstration

Demonstration Governance

Health Net recognizes the significance of this Demonstration in terms of its potential to increase the quality of care and health outcomes of California's Dual Eligible beneficiaries while lowering the overall cost of care for this population of health care service users. To realize the benefits envisioned, it will be critical to establish a framework that governs from the highest levels of authority, incorporates consumer and stakeholder input, and effectively partners with our DHCS and CMS customers in order to effectively implement, monitor, and operate the Demonstration. **Figure 9** reflects Health Net's Demonstration Governance Model that provides governance over Health Net's activities across the full life span of the Demonstration—planning, implementation, operations, and ongoing monitoring. Roles and responsibilities

related to Health Net's internal Demonstration Governance Model are described in **Figure 10**. To that end, Health Net envisions a governance model with the following key attributes:

- A Demonstration Executive Management Team comprised of Health Net senior executives and key business and functional area leaders
- An external Duals Advisory Committee (responding to the RFS request for an advisory board) with the ability to influence Demonstration health plan policies and the establishment of health plan programs
- Direct interface between a proposed Government Oversight Committee, the Demonstration Executive Management Team, and our Project Management Office (PMO)

Figure 9. Health Net's Demonstration Governance Model

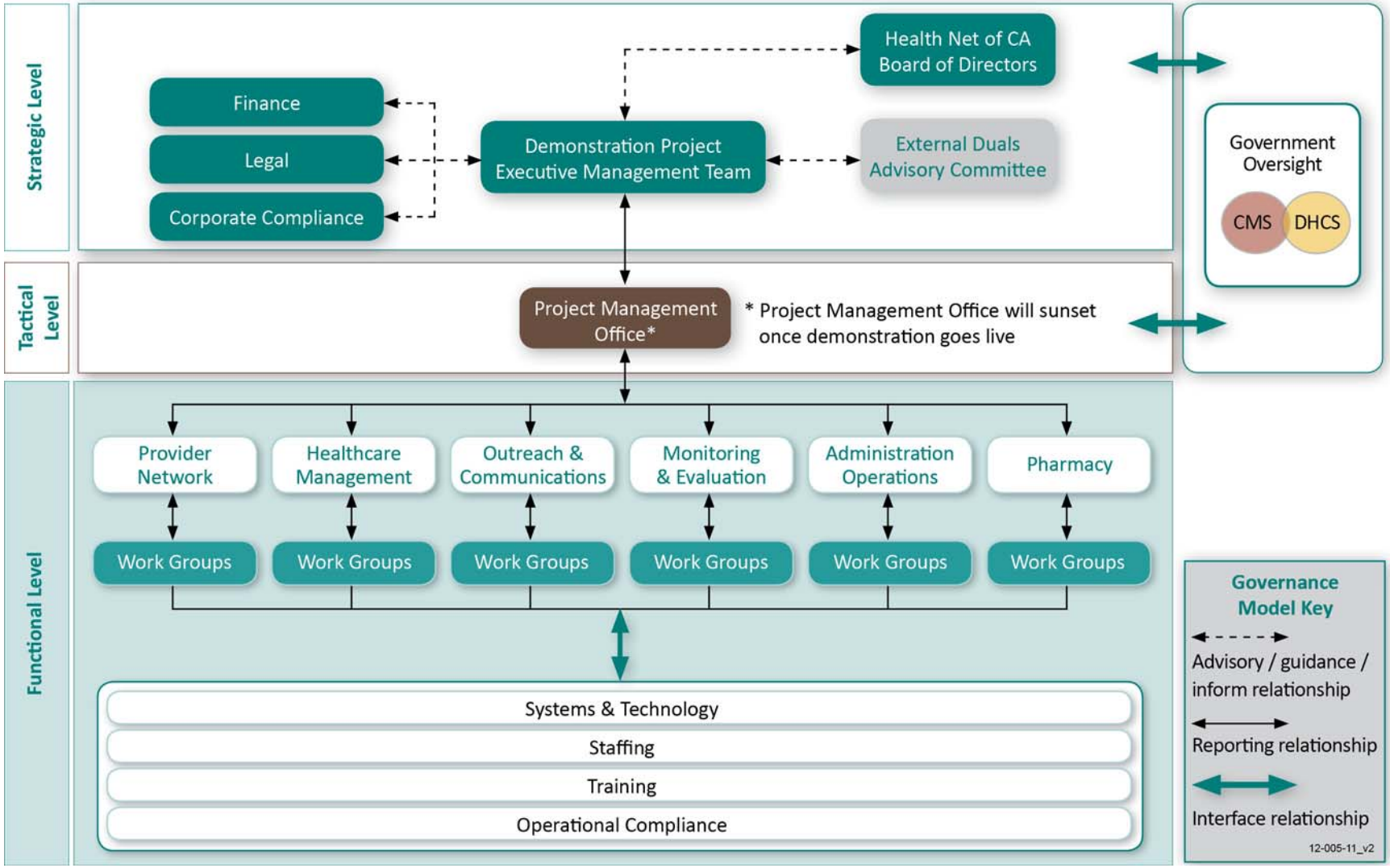


Figure 10. Health Net Demonstration Governance Model Roles and Responsibilities

Governance Role	Responsibility	Membership	Meeting Frequency
Executive Management Team	▪ Overall responsibility and accountability for Demonstration success ▪ Support functional teams and business areas with removal of obstacles and barriers to success ▪ Commit business resources and staffing for the Demonstration ▪ Inform/update Health Net Strategy Execution Team and Health Net of CA Board of Directors on Program progress and performance	▪ Steve Tough: Executive Sponsor/Co-Chair ▪ Martha Smith: Duals Demonstration Project Manager ▪ Other Executive Business Leaders	Weekly
External Duals Advisory Committee	▪ Provide external input regarding beneficiary needs	▪ Dual Eligible beneficiaries ▪ Community stakeholder representatives	Quarterly
Government Oversight	▪ Provide Federal and State level oversight and monitoring of solution development, program implementation and on-going operations of the Demonstration ▪ Support Health Net with removal of government obstacles and barriers to success ▪ Provide policy interpretation and clarification	▪ CMS representatives ▪ DHCS representatives	Weekly during implementation
Project Management Office	▪ Manage the implementation and project management team ▪ Report progress to the Demonstration Executive Management Team and to the CMS/DHCS Oversight Committee	▪ Diane Sargent: Implementation Manager ▪ PMO Team Members	Weekly
Functional Teams	▪ Execute implementation and on-going operations activities ▪ Define readiness criteria and certify operational readiness ▪ Report performance to the PMO (implementation) and the Demonstration Executive Management Team (on-going operations)	▪ Function-specific business leaders ▪ Project managers, functional team members, relevant subject matter experts and vendor representatives, if applicable	Weekly

To complement our governance approach, Health Net will also seek external input and guidance from our Duals Advisory Committee, which is discussed in **Section 5.1**.

Implementation Management and Methodology: Health Net recognizes the importance implementation plays in establishing a solid foundation for overall Demonstration success. We

have a long and successful history of managing complex implementations including our D-SNP program, the GMC and Two-Plan Medi-Cal Managed Care Model, our Federal Government TRICARE contracts, and other commercial programs. Coupled with the governance model described above, we will leverage experienced resources and existing processes and tools to accelerate the implementation start-up and quickly reach a stable implementation cadence.

Implementation Schedule: Key to implementation success will be a comprehensive and integrated work plan that captures and appropriately sequences all of the necessary work to begin enrollment on October 15, 2012, and start operations on January 1, 2013. Our proven and time-tested implementation schedule design uses project management best practices to identify, document, and integrate all the required work. Most importantly, our schedule design enables visibility into critical internal and external dependencies, which is essential to effectively manage the complexities of such a highly integrated effort.

Implementation Reporting: Health Net is committed to providing transparent and collaborative implementation progress reporting. Our PMO will deliver formal implementation status reports to the Demonstration Executive Management Team and the Government Oversight Committee, which will include key progress metrics such as status by function, risks, issues, deliverables, and milestones. We will also incorporate any specific implementation reporting elements that may be required by DHCS and CMS.

Section 6.2 Operational Plan

Question 6.2.1 Provide a preliminary operational plan that includes a draft work plan showing how it plans to implement in 2013 and ramp up in the first year.

A draft work plan of major implementation activities is found in **Attachment 22**. This draft will serve as the basis for further implementation planning and will be the foundation to

manage and monitor implementation progress. The work plan will provide DHCS and CMS, our Demonstration Executive Management Team, and each functional team with a complete, end-to-end view of all work throughout the Demonstration implementation period and into operations.

Question 6.2.2 Provide roles and responsibilities of key partners.

Health Net is proposing a comprehensive, managed care model that will deliver organized, person-centered, and cost-efficient care to Dual Eligible beneficiaries, resulting in measurably improved outcomes. Critical to the delivery of this care model will be our close collaboration with Healthy San Diego. Working closely with Healthy San Diego throughout the Demonstration will enhance our ability to effectively reach, educate, and coordinate the delivery of high-quality, integrated services to San Diego's Dual Eligible population.

Question 6.2.3 Provide a timeline of major milestones and dates for successfully executing the operational plan.

Figure 11 shows a high level proposed timeline of our planned major implementation milestones. These milestones are also reflected in our Draft Implementation Schedule found in **Attachment 22** and can be identified as BLUE highlighted tasks.

Figure 11. Proposed High Level Timeline of Major Milestones

Execution Milestone	Date(s)
Program Mobilization	
Governance structure established	February 2012
Detailed implementation planning completed	March 2012
Implementation kick-off	April 2012
Provider Network	
Provider network gap analysis completed	April 2012
Provider network plan developed	May 2012
Execute provider contracts; certify Medicare standards are met	August 2012

Execution Milestone	Date(s)
Medical/Quality Management	
Quality monitoring process established	August 2012
Quality metrics established and validated	October 2012
Quality reporting process established	October 2012
Enrollment	
Begin recruiting enrollment staff	June 2012
Finalize and approve enrollment operating policies and procedures	August 2012
Develop enrollment training program and curriculum (with Healthy San Diego)	August 2012
Deliver enrollment staff training	September 2012–October 2012
Enrollment systems and applications go-live	October 2012
Begin receiving eligibility files from DHCS and CMS	October 2012
Enrollment begins	October 2012
Start mailing of ID cards, post-enrollment kits (within 10 days after receipt of eligibility files)	October 2012
Member Services Center	
Begin recruiting member contact services staff	June 2012
Finalize and approve member services center operating policies and procedures	July 2012
Develop member services center training program and curriculum	July 2012
Deliver member services center staff training	August 2012–September 2012
Establish toll free member service number	September 2012
Member Services Center go-live	September 2012
Appeals & Grievances	
A&G process established	July 2012
Monitoring & Reporting	
Finalize and approve performance metrics	July 2012
Information warehouse established	April 2013
Performance dashboard developed	April 2013
Performance reporting begins	April 2013
Outreach & Communications (Activities will be coordinated with Healthy San Diego)	
Develop outreach and communications plan	June 2012
Develop outreach and communication materials	September 2012
Begin outreach and communication activities	October 2012
Beneficiary Communications and Education (Activities will be coordinated with Healthy San Diego)	
Develop beneficiary communications and education plan	June 2012
Develop beneficiary communication materials	September 2012
Begin beneficiary communications	October 2012
Provider Communications and Education	
Develop provider communications and education plan	June 2012
Develop provider operations manual	September 2012
Begin provider communications	October 2012

Execution Milestone	Date(s)
Stakeholder Engagement (Activities will be coordinated with Healthy San Diego)	
Finalize stakeholder engagement plan	April 2012
Establish External Advisory Group	April 2012
Begin stakeholder "town hall" meetings	September 2012
Service Coordination (Activities will be coordinated with Healthy San Diego and AIS)	
Contracts with SD County mental health services executed	TBD based on further discussions with Healthy San Diego and AIS
Execute Department of Social Service MOU (Year 1)	
Execute contract with Public Authority	
Execute contracts with LTSS providers	
Establish partnerships with community social support services	
Operational Readiness	
Readiness review conducted	July 2012–September 2012
Start of coverage	January 2013

Question 6.2.4 Certify that the Applicant will report monthly on the progress made toward implementation of the timeline. These reports will be posted publicly.

Health Net is committed to providing transparent and collaborative implementation progress reporting and certifies that it will provide monthly implementation progress status reports. Based on our experience with complex implementations such as this, it would be our recommendation that DHCS and CMS consider more frequent reporting to provide more timely insight into overall implementation progress.

Section 7. Network Adequacy

Health Net's expansive Medicare and Medi-Cal provider network in San Diego County includes a number of premier medical groups, practitioners, and hospitals that have unique knowledge and experience in serving Dual Eligible beneficiaries. Health Net has secured Letters of Commitment from broadly based, well-established, quality physician groups expressing their intent to participate in the Demonstration. These providers recognize that this Demonstration will include new contractual, utilization, data sharing, and oversight requirements. These organizations include the following PPGs:

- Arch Health Partners*
- Encompass Medical Group*
- Greater Tri-Cities IPA*
- Mercy Physicians Medical Group*
- Multicultural Medical Group
- Primary Care Associates Medical Group*
- Sharp Community Medical Group*
- Sharp Healthcare*
- Sharp Rees Stealy Medical Group*
- UCSD Medical Group
- Vantage Medical Group

**Not in Health Net's Medi-Cal network, but expressed interest in participating in the Demonstration and will expand our Medi-Cal provider access*

Figure 12 demonstrates the breadth of Health Net's San Diego County network and reflects the number of providers participating in Health Net's existing Medicare and Medi-Cal networks.

Figure 12. Provider Network Count by Line of Business – San Diego County

Provider	# of Medi-Cal Network Providers	# of Medicare Network Providers	Totals *
Physician Groups	4	28	27
PCP	338	840	972
Specialist	2,043	3,561	3,968
Hospital(s)	10	18	18
* Duplicate providers are not included in the Totals.			

Question 7.1 Describe how your organization will ensure that your provider network is adequate for your specific enrollees.

Health Net has commenced an assessment of its existing Medicare and Medi-Cal networks and has built an inventory of the network throughout San Diego County. Health Net is building a comprehensive view of provider interest and commitment to participate in the Demonstration to ensure broad geographic coverage in San Diego County and to preserve provider choice for the Dual Eligible beneficiaries. Health Net will evaluate the composition of each PPG to determine an adequate ratio of internal medicine PCPs and ensure a complete

panel of specialists is available. Health Net uses an industry-leading software program to evaluate network adequacy and ensure Medicare time and distance requirements are met. Presently CMS has an access requirement that 90 percent of Medicare beneficiaries must be within the maximum time/distance access standards to providers, and the plan must have the minimum number of providers by specialty type. Health Net currently exceeds the CMS requirement of 90 percent of Medicare beneficiaries having access according to the "large metro" time and distance standards for San Diego County.

Health Net has a robust network development and monitoring process that the provider network team has established in conjunction with our QI, Health Care Services, Delegation Oversight, Provider Data Management, and FSR departments. Networks are developed based on members' cultural, linguistic, and access needs; established PCP, specialty, and hospital ratios; practice patterns; and market analysis. They are assessed through monitoring of PCP open and closed status; monthly demographic changes; and annual network capacity review of access and availability reports, CAHPS results, and GeoAccess maps to identify gaps and develop activities to address identified gaps. Health Net employs a variety of monitoring activities to ensure our provider network is adequate for our specific enrollees. Examples of such monitoring activities include:

- **PCP Monitoring:** Our system tracks the number of members assigned to each PCP and the available capacity of each PCP, including the PCP's extenders (family nurse practitioner, physician assistant, and geriatric nurse practitioner)

- **Member Services Call Tracking:** Member calls related to access are tracked and feedback is provided to the Provider Network Management (PNM) department for follow up with the provider to address and resolve member access issues
- **Quarterly Grievance Monitoring:** The QI department reviews data related to provider availability and distance-to-provider, tracks and trends these issues, and reports to relevant departments so that action can be taken to address provider access/network adequacy
- **Quarterly SPD Member Continuity of Care Requests:** The Member Services, PNM, and Health Care Services departments review continuity of care requests quarterly to identify potential gaps in the network and frequently requested traditional FFS providers who are not in our network
- **Annual QI and PNM Monitoring:** Extensive network capacity review of access and availability reports, CAHPS results, and GeoAccess maps are used to identify gaps and develop activities to address identified gaps. These activities are reported to the Health Net QIC for input by our physician leadership and participating network physicians.

Question 7.2 Describe the methodologies you plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers.

Our experience has provided us with the opportunity to build upon our Medicare and Medi-Cal participating provider relationships and develop unique provider reimbursement methodologies and incentives. We have found innovative ways to support traditional and safety net providers to ensure their continued participation in our networks. Health Net will employ different contracting methodologies such as capitation and fee-for-service reimbursement, along with shared risk and quality incentives to reimburse our PPGs, hospitals, and ancillary providers. A shared risk program is an incentive program for designated institutional and other

ancillary services in which the PPG is encouraged to coordinate and effectively manage the member's care. Health Net has a network capitation model in which PPGs and certain hospital providers are reimbursed on a prepaid, per member per month (PMPM) basis for the delivery, management, and coordination of medical services. The capitation model has proven to be effective in supporting a PCP health home model in which the members' care is coordinated and quality care is delivered.

Health Net will ensure the most effective methodology is employed in order to align financial incentives and improve the coordination of care for Dual Eligible beneficiaries. When services are reimbursed on an FFS basis, Health Net will preserve the current method used to coordinate benefits between Medicare and Medi-Cal coverage. In other words, provider reimbursement will be calculated as the greater of original Medicare covered amount and Medi-Cal's allowed amount. Additionally, in an effort to rebalance service delivery away from the hospital and EDs as well as ensure their appropriate use, Health Net may pay a PPG an additional PMPM payment for extending evening or weekend hours, reducing ED visits by its members, reducing readmission rates, or meeting the NCQA standards for a health home. These funds would be used by the PPG on programs that improve the quality of care to members, such as an after-hours clinic to improve access, care management, or other quality management programs.

Question 7.3 Describe how your organization would encourage providers who currently do not accept Medi-Cal to participate in the Demonstration project.

Our history and experience as a Medi-Cal and Medicare plan in San Diego County has allowed our local PNM team to develop a strong understanding of both programs and establish robust provider networks that address the needs of our Medi-Cal and Medicare members and

community providers. Health Net will encourage providers who do not accept Medi-Cal to participate in the Demonstration by offering these providers the necessary resources, training, and support to integrate Medi-Cal benefits into their existing managed care infrastructure. Health Net intends to coordinate certain functions with providers so that there are operational efficiencies and consistencies to reduce the administrative burden. Health Net will promote and encourage provider participation by working with key provider trade associations such as the California Association of Physician Groups and Hospital Association of Southern California to engage in discussions around the development and implementation of the Demonstration. Our local PNM team has fostered strong provider partnerships and will work collaboratively to establish relationships in a timely manner with potential new providers by engaging in early discussions and having an open dialogue about the best model for coordination of benefits and access to care.

As demonstrated by the attached Letters of Commitment, Health Net has already begun provider outreach and has obtained Letters of Commitment from a broad range of PPGs covering an expansive geography in San Diego County. Well-established, large physician group organizations, such as Sharp Community Medical Group, that have not traditionally participated in Medi-Cal, have expressed a strong interest in participating in the Demonstration because of their experience in serving Dual Eligible beneficiaries under D-SNPs and the effectiveness of their robust, integrated D-SNP MOC programs. Through the D-SNP they have proven their ability to improve quality of care and contain costs.

Health Net will develop a unique network to serve the Dual Eligible population and will contract with PPGs that have a strong track record of providing innovative and high value care

to Dual Eligible beneficiaries. PPGs participating in the Demonstration will need to meet participation criteria and demonstrate the following:

- Providers geographically located near Dual Eligible beneficiaries
- Linguistic and cultural competencies offered in providers' offices
- Proven track record of quality performance as demonstrated by HEDIS®, Initial Health Assessments, and low grievance rates
- Ambulatory case management, health home, and capabilities of providing team care
- Skill and experience with administering the Medicare program and the Medi-Cal program

Behavioral health practitioners who are preferred by the PPGs, but not contracted with Health Net, will be recruited in an effort to promote continuity of care and integration.

Question 7.4 Describe how you will work with providers to ensure accessibility for beneficiaries with various disabilities.

The FSR and PARS assessments are ways in which Health Net will work with providers to ensure accessibility for beneficiaries with various disabilities. As described in **Section 5.2.2**, the PARS tool allows Health Net to review contracted providers' sites for accessibility. FSR nurses in our QI department are responsible for conducting facility site, medical record, and PARS of providers to evaluate their effectiveness in fulfilling their required roles and responsibilities and ensure accessibility for our members. FSR nurses, as part of the QI department, work closely with the Health Education and Community Relations departments to develop training materials for providers and their staff specifically focused on improving physician accessibility. These nurses are certified FSR reviewers per DHCS standards and provide on-site education for providers and their staff to help them meet regulatory and contractual requirements.

Health Net contracted with the Harris Family Center for Disability and the Health Professions. Their founding director, Brenda Premo, and associate director, June Kailes, provided Health Net expertise and guidance in the development of policies, procedures, provider trainings, and staff trainings for accessibility to health care for SPD members. Together with DHCS and the Harris Family Center, Health Net helped to develop the revised 2011 version of the PARS. Results of the PARS assessment are made available to the Member Services Center to assist members in selecting a PCP that can best serve their health care needs. The accessibility status will be provided in the Health Net member web portal and provider directory.

As we have implemented the SPD care model, we have identified and implemented various mechanisms to ensure accessibility for beneficiaries with disabilities. For example, Health Net has ensured access to physicians that specialize in home care visits to serve the needs of our SPD members who require home visits.

Question 7.5 Describe your plan to engage with providers and encourage them to join your care network, to the extent those providers are working with the Demonstration population and are not in the network.

Health Net's local PNM team is responsible for engaging with providers and encouraging them to join the Demonstration provider network. The PNM team will use our established provider participation standards and will negotiate, manage and implement the contracts with Demonstration providers, including PPGs, hospitals, LTC facilities, and other ancillary providers. We will carefully monitor continuity of care requests and solicit contracts, either directly or through our sub-contracted PPGs, with non-contracted providers who have historically provided a high volume of care to Dual Eligible beneficiaries. Since member demographic and utilization data for the Demonstration population is not readily available at this time, Health

Net is assessing data for its existing pharmacy drug program (PDP) members that qualify for Low Income Subsidy to determine member demographic information and identify prescribing physicians. This will allow us to identify higher volume non-contracted providers that Health Net may need to pursue for participation in the Demonstration network. Also, the member demographic information will enable us to identify which areas in San Diego County have a dense population of Demonstration beneficiaries that may require additional provider contracting and network expansion.

Question 7.6 Describe proposed subcontract arrangements (e.g., contracted provider network, pharmacy benefits management, etc.) in support of the goal of integrated delivery.

Health Net is committed to contracting with qualified providers and health care plans (currently offering D-SNPs) that have a strong record of providing innovative and high quality care to Dual Eligible beneficiaries. Health Net's provider network consists of medical groups and IPAs that are experienced in working with high risk populations (e.g., SPD and ADHCs/CBAS members) and have a robust person-centric health home model.

Health Net's behavioral health network consists of multi-specialty groups and practitioners in individual practice. This network includes psychiatrists, clinical psychologists, clinical social workers, Master's level therapists, and behavioral health nurse practitioners.

Health Net intends to enter into a new, unique subcontract arrangement with providers under the Demonstration. This contractual arrangement will include the various requirements needed to support the goal of the integrated delivery model. PPGs will be required to integrate Medicare and Medi-Cal benefits and implement a care management program that includes the full integration of professional, facility, and ancillary services, along with available LTC and home- and community-based services. Health Net will work towards establishing a coordinated,

robust educational program for providers, and enhanced supplemental benefits for Dual Eligible beneficiaries to maximize their ability to remain in their homes and communities as long as possible.

Health Net will continue its longstanding subcontract arrangement for pharmacy benefits management and pharmacy network management, which provides integrated delivery of pharmaceutical services and a seamless care experience for enrollees. Health Net Pharmaceutical Services, a wholly owned subsidiary of Health Net, Inc., manages and oversees all aspects of pharmacy benefit management for all Health Net health plans, and contracts with an external vendor, CVS/Caremark, for pharmacy claims processing and pharmacy network contracting services. Keys to the success of the longstanding relationship with CVS/Caremark include the integration of extensive vendor oversight activities within operational processes and the frequent exchange of operational, benefit utilization, and performance data.

Question 7.7 Certify that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by sub-contractual relationships of the Applicant.

Health Net certifies that the goal of integrated delivery of benefits for enrolled beneficiaries will not be weakened by sub-contractual relationships.

Question 7.8 Certify that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Health Net certifies that the Plan will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Question 7.9 Certify that the Plan will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.

Health Net certifies that it will meet all Medicare Part D requirements for Dual Eligible beneficiaries in San Diego County, and submit formulary and prescription drug event data.

Section 7.2 Technology

Question 7.2.1 Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the federal "meaningful use" health information technology (HIT) standards.

Health Net uses technology to provide important and actionable information to our providers about their assigned members, their benefits, and our managed care program. This information is made available through the provider portal on Health Net's website. The website also allows access to a host of important information, such as the formulary, medical necessity criteria sets, provider operations manuals, member EOCs, provider updates about changes to the program, claims editing updates, issues of public health importance, forms needed for submitting authorizations, and other timely health care topics. Providers in our FFS networks may also submit authorizations through the online portal to avoid a wasteful paper process and facilitate communication and turn-around time for decisions. Member eligibility is posted for the providers on a monthly basis. A critical tool of the MOC is the ability for providers to sign onto the provider portal to view the care plans for their patients. These care plans are living documents—as the case management nurses address gaps in care and other barriers, the care plan is updated and always available to the provider for reference. In the future, we anticipate the ability to post the Nurse Advice services and summaries of coaching calls, to ensure the providers can maintain a complete picture of their patient's health interactions. Another planned intervention is posting an opportunity report for the providers, to quickly assess which

members are missing necessary preventive services and chronic disease monitoring tests or treatments. Currently, those reports are hand-delivered or delivered via secure email.

Members may access similar information through the website member portal. For example, our members can access the website to check whether a preferred provider is available in our network, to check the provider's physical accessibility, and also to access important health information. Monitoring tools for tracking chronic illnesses are available, as well as a host of health-related educational topics. Health Net members also have access to a wide range of online tools and information provided in partnership with WebMD. One of these offerings is a Personal Health Record (PHR) and a Health Risk Questionnaire (HRQ). When a member completes the HRQ, the results are imported into the PHR. Additionally, a member can elect to automatically populate the PHR with claims data directly from our systems. Because we have chosen to partner with WebMD, our PHR is portable, allowing members to export and share their information via WebMD.com.

Health Net is committed to helping our providers achieve the federal "meaningful use" health information standards. To this end, we will be working with all of our providers, including safety net providers in underserved communities, to assess their readiness to transition to an electronic medical record (EMR) and ensure they have an action plan to adopt an EMR within a reasonable period of time. During this assessment we will ensure support for this transition, including grants, project management, technology support, and networking. We also are fully aware that the EMR is only the first step; to truly advance to a health home model with a focus on quality, integration, prevention and reduction in errors, the meaningful use software and modules need to be adopted as well. For our providers who currently have an EMR, our

approach is to provide bonus incentives for adoption of meaningful use measures. We will particularly promote e-prescribing, tracking of chronic disease through registries, provider-to-provider communication, problem lists, medication lists, allergy, and drug-drug interactions as the EMR enhancements most likely to reduce errors, prevent waste, and promote true integration across the spectrum of care.

Question 7.2.2 Describe how your organization intends to utilize care technology in the duals Demonstration for the beneficiaries at very high-risk of nursing home admission (such as telehealth, remote health vitals and activity monitoring, care management technologies, medication compliance monitoring, etc.)

Health Net has met with a variety of vendors who promote or provide electronic monitoring devices to allow frail, chronically ill or aged individuals to remain safely in their homes. Much of this technology is new and promising, with limited research regarding efficacy. It is our intent to strategically use technology to help this population remain independent and enhance adherence, however, we are aware of privacy concerns, and plan to avoid member distrust and confusion by judiciously introducing technology to this population, some segments of which have likely had limited electronic experience.

Currently, we have several tools at our disposal that we provide selectively, including cell phones for our members with chronic illnesses, such as diabetes, congestive heart failure and asthma to allow connectivity to the provider and case manager. These phones also issue medication reminders, timely tips about their illness, and through interactive text messaging, assess the member's disease stability and compliance with diet, salt, fluids, and medication. Abnormal responses to the text question trigger alerts to the provider and case manager and provide concrete guidance to the member.

In the future, we plan to add the following for Dual Eligible beneficiaries: electronic scales for monitoring daily weight for members with heart conditions, medication bottles programmed with reminder alerts and triggers to the provider and case manager if the alert is ignored, and medical alert system monitoring to connect members to ambulance and local hospital first responders for aid following a fall or other in-home acute problem. We are considering offering an in-home video-monitoring service that allows case managers to personally observe and interact via video with cognitively impaired or physically frail members who live alone but are not yet ready for custodial placement. In addition to working with vendors, we are also exploring ways to leverage existing government programs such as the federal Lifeline program, which provides a free cell phone, with a limited number of minutes per month, to Medicaid (Medi-Cal) members.

Question 7.2.3 Describe how technologies will be utilized to meet information exchange and device protocol interoperability standards (if applicable).

Health Net demonstrates current technological capacity to receive and transmit data between DHCS and Health Net and between CMS and Health Net. We are able to transmit using the DHCS proprietary formats without difficulty. Additionally, we are currently 5150 compliant, and are conducting all our electronic transactions in this compliant format. We have demonstrated connectivity via file exchange with our disease management, Nurse Advice Line, health coaching, and complex case management vendors to ensure timely and accurate member information is available to all staff directly involved with members. We access and post member information on secure websites for use by providers and case managers. We also have the ability to provide on-line real-time data transfers, rather than waiting for scheduled weekly or monthly file transfer updates. All security and privacy measures are in place to ensure the

highest protection of patient information. Through these means, we maximize the ability of case management and providers to take action on immediate issues and share data freely. We also minimize the use of paper, fax, and voice mail. This also allows case management to remain in real-time contact with the other members of the IDCT.

Section 8. Monitoring and Evaluation

Question 8.1 Describe your organization's capacity for tracking and reporting on: Enrollee satisfaction, self-reported health status, and access to care, Uniform encounter data for all covered services, including HCBS and behavioral health services (Part D requirements for reporting PDE will continue to be applied) Condition-specific quality measures, and Risk-adjusted mortality rates.

Health Net has the ability to create an Information Warehouse to customize the tracking and reporting requirements on all of our Medi-Cal and Medicare contracts.

Health Net Information Warehouse: A key Health Net strength lies in our Information Warehouse, which consists of several components that together allow users to search the full scope of health care data and documentation that we collect in support of diverse federal and state government agencies. While the original data and documentation continue to reside in the native systems in which they were collected, the Information Warehouse integrates disparate data to provide users with powerful tools for locating and assembling information for multiple purposes such as performance review, analysis, and trending.

Health Net Information Warehouse for the Demonstration will be made available to DHCS and CMS via a web interface. Software will be provided for Data Warehouse queries and Health Net will provide initial training to DHCS and CMS users. Through years of refinement, our Information Warehouse ensures information is current, accurate, complete, accessible, transparent, truly useful, and easy to work with, and we have accompanied the Information

Warehouse with modular training and ongoing support for all user-ability levels. It will provide DHCS and CMS access to a host of current reports and an outstanding adhoc reporting capability. Below is a description of the integrated components of our Information Warehouse.

- **Data Warehouse** containing up-to-date data and information feeds from all our transactional systems. The categories of data include: Authorizations/Referrals, Claims and Encounters (including pharmacy), Member Services Center, Enrollee Demographic, and Provider Demographic Data. Users can access the Data Warehouse on a 24/7/365 basis, except for periods of scheduled maintenance for which we typically provide a minimum of 24 hours' notice
- **Data Summaries** consist of regularly updated, pre-defined reports that are commonly used. For example, the Health Care Management Review provides a series of claim/encounter reports summarized by provider, diagnosis, and procedure code
- **Performance Management Dashboard** is a set of interfaces that provide a transparent window into our performance, measured against key contract standards, including required metrics and approved enhancements. Performance measures are displayed using a traffic light format

Enrollee Satisfaction: The HEDIS® Measurement and Reporting Unit (MRU) manages vendor selection and oversight for the CAHPS survey.

Self Reported Health Status: Health Net currently uses several methods to collect Self Reported Health Status for Medicare and Medi-Cal members. The Medicare Health Outcomes Survey data is collected and reported to Health Net from a contracted external vendor. The member evaluation tool/health information form questionnaire is distributed to Medi-Cal

members to fill out at the time of enrollment. For SPD members, this information is used by Health Net to initiate case management outreach and risk stratification. The HRA for Medicare members is administered by our case management nurses. The HRA tool consists of 45 total questions and covers the key areas dictated by CMS to assess the member's medical, psychosocial, cognitive, and functional needs. If a member is unable to be reached or declines to complete the HRA over the phone, a hard copy is mailed to the member with return envelope. The hard copy HRA will also be included in new member packets in the near future. Results from completed HRAs are loaded into Health Net's Care Management system so the IDCT can review and update member care plan as appropriate.

Access to Care Reporting: Access to readily available health care services is critical in maintaining and improving positive health outcomes. Health Net maintains Medi-Cal and Medicare policies defining standards for both timely access to appointments and provider network availability that have been approved by DHCS and DMHC. Health Net monitors and tracks performance compared to these standards. Health Net annually uses multiple surveys and system data to track access. Network adequacy is monitored and tracked using GeoAccess software to assess distance to providers and ratio of primary care and specialist providers to members. Monitoring of the Member Services Center and tracking of telephonic access using wait times, abandonment rates, and use of the telephone triage line is conducted quarterly. Health Net reports these findings in an annual integrated access report and an annual integrated availability report. Findings are also reported to Health Net's QIC.

Uniform Encounter Data: Health Net will work in partnership with DHCS to provide complete claims/encounter data as specified by DHCS to support the monitoring and evaluation of the

Demonstration. This includes all covered services (including HCBS, Behavioral Health, and Part D Prescription Drug Event).

Condition-Specific Quality Measures: Health Net has a dedicated department, the HEDIS® MRU, that is responsible for all data collection (administrative and medical record data) and reporting. The HEDIS® MRU reports all required HEDIS® and mandated HEDIS®-like measures nationally for all lines of business including Medi-Cal, Commercial, Medicare, and CHIP (Healthy Families). For the 2011 Reporting Year, the HEDIS® MRU produced 24 HEDIS® submissions, including 17 full and 7 partial reports.

Health Net has participated in the NCQA HEDIS® Compliance Audit program since it was introduced in 1997. The HEDIS® MRU also participates in the CMS Data Validation Audit for two of the Part C measures, Procedure Frequency and Serious Reportable Adverse Events. Final audit reports submitted to NCQA and the regulatory agencies document Health Net's compliance with the audit standards and procedures and confirm our ability to produce reliable HEDIS® results. The HEDIS® MRU is also responsible for reporting the CMS Part C Procedure Frequency and Serious Reportable Events measures annually. HEDIS® measures are reported for all domains: Prevention and Screening, Respiratory, Cardiovascular and Musculoskeletal Conditions, Diabetes, Behavioral Health, Medication Management, Access/Availability of Care, and Utilization and Relative Resource Use. Measures have been reported for specific conditions or to support specific quality programs. HEDIS® reports will be stored in the Information Warehouse Data Summary section for ease of retrieval and enhanced information dissemination.

Health Net commits to providing comprehensive financial reporting (including Medical Loss Ratio) for the Demonstration on a quarterly basis. In addition, we will work in partnership with DHCS Demonstration sites in ongoing meetings to share challenges and best practices learned throughout the Demonstration.

Question 8.2 Describe your organization's capacity for reporting beneficiary outcomes by demographic characteristics (specifically age, English proficiency, disability, ethnicity, race, gender, and sexual identity)

Member information is stored in Health Net's Information Warehouse. Member disability is analyzed based on Medi-Cal Aid Code. In addition, analyses have been completed on an annual basis to assess multiple clinical outcomes by age, language, ethnicity, race, gender, and Medi-Cal Aid Code across all Health Net's Medi-Cal counties. Health Net's QI Research and Analytics team recently analyzed our membership to identify members with asthma and diabetes by language, ethnicity, and race, as part of our NCQA submission for the Distinction in Multicultural Health Care. Member demographic information will be stored in the Information Warehouse and joined to claim/encounter data to further enhance reporting capability.

Question 8.3 Certify that you will work to meet all DHCS evaluation and monitoring requirements, once made available.

Health Net certifies we will work to meet all DHCS evaluation and monitoring requirements, once made available.

Section 9. Budget

Question 9.1 Describe any infrastructure support that could help facilitate integration of LTSS and behavioral health services (i.e. information exchange, capital investments and training to increase accessibility of network providers, technical assistance, etc).

With over 10 years of managed care experience in San Diego County serving both the underserved and senior populations, Health Net understands how important the seamless

implementation of a new health program is for California and the Dual Eligible beneficiaries. Health Net offers several possible channels of additional financing, including federal funds, to support the Demonstration's implementation.

It is Health Net's goal to enhance the exchange of clinical information electronically with County programs. We view the development of this as supporting and enhancing both quality and efficiency. Working with mental health and LTSS providers, Health Net will partner with programs to seek out and apply for innovative technology grants.

Working with the IHSS program, Health Net will seek grant funding to explore the development of a training program for personal care workers. Health Net will host advisory group sub committees comprised of AIS, UDW, HCBS, and ILC programs to develop a comprehensive training and certification program. This would allow professional mobility and may result in higher wages for IHSS workers. This would facilitate beneficiaries to orchestrate the delivery of their own care. Health Net will work with both CMS and DHCS to build grant funding programs.

The MSSP program is currently experiencing greater demand than capacity available to serve beneficiaries, as indicated by the wait lists for the program. Health Net will work with MSSP programs to address that current demand and develop a standardized, objective, reliable assessment process and tool going forward. Many of the services arranged by the MSSP programs will need continued grant funded support; this is especially true for housing and nutrition support programs.

Finally, many Dual Eligible beneficiaries are socially isolated despite being surrounded by family and caregivers. This social isolation has a direct negative impact on health care.

Borrowing from the promotoras network model of social connection, Health Net will work with AAAs and HCBS programs to develop a pilot model, with grant support, to address this barrier to accessing and navigating the complex health care delivery systems. The success of this program has obvious implications for improving the member's ability to gain insight into chronic disease processes and benefit from plan-offered disease management programs.

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

California Dual Eligible Demonstration
Request for Solutions Proposal Checklist

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.	✓ Attachment 1	
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)	✓ Attachment 2	
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.	✓ Attachments 3 and 4	
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.	N/A	
4	Applicant has a current Medi-Cal contract with DHCS.	✓	
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	✓	
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	✓	
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.	✓ Attachment 5	
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.	✓ Attachment 5	
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.	✓	
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.	✓ Attachments 6, 7, 8 and 9	
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.	✓ Attachments 6, 10, 11, 12 and 13	

Signature: _____

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.	✓ Attachment 14	
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the Demonstration.	✓	
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.	✓ Attachment 15	
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.	✓ Attachment 16	
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.	✓	
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.	✓	
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.	N/A	
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.	N/A	
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.	✓	

Signature: _____

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.	✓	

Signature: _____

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?	4 years	
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?	[No]	See Attachment 5
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?	Yes	
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?	Yes	See Attachment 14
5	Has the Plan received NCQA certification for its D-SNP Product?	Yes	See Attachments 3 and 14
6	How long has the Plan had a Medi-Cal contract?	16 years	
7	Does the plan propose adding supplemental benefits? If so, which ones?	Yes	See our response in the Project Narrative, Section 1.2.1 for list of supplemental benefits.
8	Did the Plan submit letters from County officials describing their intent to work together in good faith on the Demonstration Project? From which agencies?	Yes	See Attachment 17
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?	Yes	See Attachment 18
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?	Yes	See Attachment 19
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligibles? Which groups?	Yes	See Attachment 20

Signature: _____

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
2.2.1	Applicant will develop a contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS administration in Year 1, which stipulates the criteria in the RFS.	Yes	
2.3.1	Applicant will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.	Yes	
5.1	Applicant will be in compliance with all consumer protections described in the forthcoming Demonstration Proposal and Federal-State MOU. Sites shall prove compliance during the Readiness Review.	Yes	
5.2.1	During the readiness review process the Applicant will demonstrate compliance with rigorous standards for accessibility established by DHCS.	Yes	
5.3.3	Applicant will comply with rigorous requirements established by DHCS and provide the following as part of the Readiness Review. o A detailed operational plan for beneficiary outreach and communication. o An explanation of the different modes of communication for beneficiaries' visual, audio, and linguistic needs. o An explanation of your approach to educate counselors and providers to explain the benefit package to beneficiaries in a way they can understand.	Yes	
5.6.1	Applicant will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU.	Yes	
6.2.4 ~~6.1.1~~	Applicant will report monthly on the progress made toward implementation of the timeline.	Yes	NOTE: This Certification is in Project Narrative Section 6.2.4, not Section 6.1.1.

Signature: _____

Applicant Name: Health Net Community Solutions, Inc. Date: February 24, 2012

(San Diego County)

#	Project Narrative Criteria	Check Box to certify YES	If no, explain
7.7	Applicants' sub-contractual relationships will not weaken the goal of integrated delivery of benefits for enrolled beneficiaries.	Yes	
7.8	Applicant will meet Medicare standards for medical services and prescription drugs and Medi-Cal standards for long-term care networks and during readiness review will demonstrate this network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	Yes	
7.9	Applicant will meet all Medicare Part D requirements (e.g., benefits, network adequacy), and submit formularies and prescription drug event data.	Yes	
8.3	Applicant will work to meet all DHCS evaluation and monitoring requirements, once made available.	Yes	

Signature: _____

Table of Attachments *(Bold Attachments are part of 100-page limit)*

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF MANAGED HEALTH CARE

NONTRANSFERABLE AND NONASSIGNABLE

LICENSE
HEALTH CARE SERVICE PLAN

File No.: 933-0426
Application No.: 2005-4207
S-05-1484

Licensee: HEALTH NET COMMUNITY SOLUTIONS, INC.
21281 Burbank Boulevard
Woodland Hills, CA 91367

IS HEREBY LICENSED AS A FULL SERVICE HEALTH PLAN PURSUANT TO THE PROVISIONS OF THE KNOX-KEENE HEALTH CARE SERVICES ACT OF 1975, AS AMENDED ("ACT"), AND IS AUTHORIZED TO ENGAGE IN BUSINESS AS A FULL SERVICE HEALTH CARE PLAN TO OFFER SERVICES TO MEDI-CAL BENEFICIARIES WITHIN THE STATE OF CALIFORNIA IN THE COUNTIES PREVIOUSLY APPROVED FOR MEDI-CAL OPERATIONS OF HEALTH NET OF CALIFORNIA, INC. (FILE NO.: 933-0300), SUBJECT TO THE PROVISIONS OF THE ACT AND THE IMPLEMENTING RULES OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE ADOPTED PURSUANT THERETO AND SUBJECT TO ANY CONDITIONS INCORPORATED HEREIN, AND SHALL REMAIN IN EFFECT UNTIL SUCH TIME AS THE LICENSE IS SUSPENDED OR REVOKED BY ORDER OF THE DIRECTOR OR IS SURRENDERED.

THE LICENSE IS ISSUED AND EFFECTIVE ON THE DATE APPEARING BELOW.

Dated: June 13, 2005
Sacramento, California

LUCINDA A. EHNES, J.D.
Director
Department of Managed Health Care

By: _____
WARREN BARNES
Assistant Deputy Director
Office of Legal Services
Department of Managed Health Care

DEPARTMENT OF
Managed Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Phone: 916-445-7401
Email: reuren@dmhc.ca.gov

February 17, 2012

VIA ELECTRONIC MAIL & U.S. MAIL

Marshall Bentley
Health Net of California
2370 Kerner Blvd.
San Rafael, CA 94901

Re: Letter of Standing – Health Net Community Solutions, Inc.

Dear Mr. Bentley:

On February 6, 2012, you requested a letter regarding Health Net Community Solutions, Inc.'s ("HNCS") standing as licensee under the Knox-Keene Health Care Service Plan Act.[1] HNCS makes this request to satisfy requirements for a Request for Solutions ("RFS") issued by the California Department of Health Care Services, for the Dual Eligibles Demonstration Project.

The Department of Managed Health Care ("DMHC") confirms that, as of today's date, HNCS is licensed, and permitted to operate in the State of California, as a Knox-Keene health care service plan.

A review of the Enforcement Action Database shows that there are currently 34 enforcement actions involving HNCS. Of those, 33 involve grievance system violations; zero regard compliance with the financial requirements of the Knox-Keene Act and related regulations; and 1 was complaints regarding health care standards. The plan is not currently under supervision, a corrective action plan or special monitoring by the Office of Enforcement. The Office of Enforcement does not comment on past, pending, or anticipated Enforcement actions against any plan that might potentially impact its licensing with the State. Enforcement does not differentiate between Health Net Community Solutions, Inc. and Health Net of California, Inc. violations.

The Division of Financial Oversight ("DFO") has reviewed HNCS and HNCS is currently in compliance with the Department's financial solvency requirements, including Tangible Net Equity ("TNE") and financial viability.

[1] California Health and Safety Code Sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at Title 28 California Code of Regulations.

The Division of Plan Surveys ("DPS") shows that the last Routine Medical Survey Report for HNCS was issued on May 18, 2010. All deficiencies identified during this Routine Medical Survey are corrected. The next Routine Medical Survey is due by May 17, 2013.

Please contact me with any questions or concerns.

Sincerely,

Richard Luren
Health Program Manager II, Licensing Division
Office of Health Plan Oversight

cc: Suzanne Goodwin-Stenberg, Division of Financial Oversight
Anthony Manzanetti, Division of Enforcement
Marcy Gallagher, Division of Plan Surveys
Gary Baldwin, Division of Licensing
Amy Krause, Division of Licensing
David Bae, Division of Licensing
Kathleen McKnight, Division of Licensing
Ted Zimmerman, Division of Financial Oversight

MQR #3a – Attachment 3

3.a Current Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

Health Net Community Solutions, Inc. ("Health Net") meets the requirement of operating a D-SNP in a Geographic Managed Care Model in San Diego County in the last three years where it has operated a D-SNP for the last four years, through its parent, Health Net of California, Inc.'s (HNCA) contract with CMS for D-SNP enrollees.

Health Net Medicare Advantage (H0562) has administered two Dual (D-SNPs) and one Chronic or Disabling Condition (C-SNP). In 2009, the SNP Governance Committee was formed to guide implementation of the comprehensive care management and quality improvement requirements for SNPs regulated under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. Health Net underwent an extensive process to implement team-based care for each SNP member including annual health risk assessments, stratification according to risk, assignment to a case manager and interdisciplinary care team, and member participation in the creation of an individualized care plan. The improved SNP Program went "live" in January of 2010 after months of planning and preparation. In 2011, Health Net's SNP Model of Care received the maximum 3 year approval. Attachment 4 contains the Health Net SNP Model of Care Elements and Standards, as modified by the Dual Demonstration Application. Health Net has also participated in annual evaluations of the SNP program by NCQA since first established in 2008.

Health Net

SNP MODEL OF CARE

MODIFIED FOR THE

DUAL ELIGIBLE DEMONSTRATION PROJECT

2013 MODEL OF CARE

San Diego County

TABLE OF CONTENTS

Dual Eligible Demonstration Project

2013 SNP MODEL OF CARE DESCRIPTION

ELEMENT 1. DESCRIPTION OF THE DUAL ELIGIBLE DEMONSTRATION PROJECT-SPECIFIC TARGET POPULATION

The population targeted for Health Net's Dual Eligible Demonstration Project Special Needs Population (SNP) Model of Care consists of Dual Eligibles in San Diego County. Historically, this group has greater incidence of chronic disease and disproportionate utilization and health care spending of Medicare and Medicaid resources than the Medicare-only population. Epidemiological and disease characteristics of the Dual Eligible population at the county, state and national levels are described in Table 1.

The key intent of the Demonstration is to deliver a patient-centered integrated Model of Care emphasizing coordination of benefits and services that can improve outcomes and quality. An additional challenge is that almost 2 out of 5 Duals have co-morbid mental health diseases or conditions, increasing the complexity of care and coordination. In all, 43.8% of Dual Eligible beneficiaries have at least one mental/cognitive condition compared to 18.5% of all other Medicare beneficiaries. [1] In San Diego County, there are 3,276 Duals in the Short Doyle Medi-Cal System, which identifies mental health visits for beneficiaries covered under Medi-Cal. Duals with behavioral health disorders and co-morbidities are at further risk of serious complications and fragmented care.

Table 1

Duals Population Description		
San Diego County (July/2011)		
Age/Number of Dual Eligibles,		77,841
	22 to 64 years	25,067
	Greater than 65 years	52,635
California (July/2011)		
Age/Number of Dual Eligibles,		1,164,404
	22 to 65 years	350,635
	Greater than 65 years	813,774
National *		
Gender		
	Female	62%
	Male	38%

[1] Kasper, Judy et al, "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service use and Spending", Kaiser Commission on Medicaid and Uninsured, July 2010

Duals Population Description	
Race/Ethnicity	
White Non-Hispanic	57%
Black Non-Hispanic	19%
Hispanic	15%
Other	9%
Disease Incidence	
Pulmonary	28%
Stroke	24%
Cardiovascular	20%
Diabetes	35%
Osteoporosis	11%
Osteo or Rheumatoid Arthritis	62%
Total with any Physical Condition	85%
Mental/Cognitive Conditions	
Alzheimer's or Other Dementia	16%
Depression	23%
Intellectual Disabilities	3%
Schizophrenia	6%
Affective and Other Serious Disorders	22%
Total	44%

EXAMPLES:

Case Studies- Details have been summarized to ensure privacy

Middle aged disabled member residing in a Board and Care for multiple years. Mental Health diagnosis in addition to Chronic Obstructive Pulmonary Disease (COPD), obesity, and hypertension. No family support. Member had not seen a primary doctor for over a year. Seeing Psychiatrist regularly. Member hospitalized twice for wound care with noncompliance. Residence at Board and Care at risk due to health problems.

The Case Manager provided assistance with establishing a new Primary Care Provider, coordinated appointments with doctors, coordinated transitions of care, transportation to appointments, home health for wound care, and in some instances had to work with the member to convince member to accept services. This involved finding alternate home health care when one service declined to see the member. After a year, the member's acute medical condition resolved and remains fairly stable in Board and Care residence.

- Example of Epidemiological Characteristics of Health Net's California SNP members: The average age of the SNP population for the six months ending June 30, 2010 was 68.99 years, which was lower than the 2009 average of 69.94 years. The SNP population was also younger than the non- SNP Medicare population by over six years. The SNP population is predominantly white (69.3%). Hispanic/Latino members constitute 34.3% of the population, followed by African American members (17.6%), Asian (11.5%), American

Indian or Alaskan native (5.7%) and Hawaiian/Pacific islander (0.8%). Most have a high school education or less. Only 10.2% reported having a college education or more. A large percentage of SNP members (38.6%) live alone.

- Example of Disease Incidence among Health Net's California SNP members: Diabetes, hypertension, cardiovascular disorders and psychiatric disorders lead the list of the most prevalent diseases in the SNP population. Majority of the top ten diseases are commonly associated with the elderly. For the most part, SNP members 65 and over comprise significantly greater portions of the disease totals, with few exceptions. Younger SNP members have more psychiatric disorder occurrences (almost 68%) than members 65 and older. Epilepsy and AIDS are likewise more likely to be found in SNP members under 65 than in those 65 and over.

ELEMENT 2. MEASURABLE GOALS

Health Net Case Management provides a patient-centric model designed to identify, acknowledge and incorporate the member's unique needs and goals into a cost effective, individualized plan. The program provides care coordination and intensive case management including decision support, member advocacy, identification and recommendation of alternative plans of care, alternative funding and community resources to support the plan of care. The Dual Eligible SNP Case Management program incorporates requirements from the National Committee for Quality Assurance (NCQA) standards, Chapt.16.b. of the Medicare Managed Care Manual and Center for Medicare and Medicaid Services (CMS) guidance documents.

2a. Specific Care Management Goals

Overall, the goal of Case Management is to support self directed care, promote self-management and help members regain optimum health or improved functional capability in the right setting and most cost effective manner. Specifically, the goals for the Dual Eligible SNP Model of Care as stated by the CMS are to improve health outcomes through:

- Improved access to essential services such as medical, mental health, Long Term Supportive Services (LTSS) and social services to enable dual eligibles to remain in their homes and communities
- Improving access to affordable care including use of Medicare, Medi-Cal and other State/County resources
- Improved benefit coordination and timely access to care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and Home and Community Based Services (HCBS)

- Improving access to preventive health services
- Improving access to HCBS
- Assuring appropriate utilization of services
- Improved beneficiary health outcomes and satisfaction
- Preserve and enhance the ability for consumers to self-direct their care and receive high quality care

EXAMPLES:

Multiple examples of the specific metrics to measure each goal in 2a are included in Table 2 below and in Table 10 under Element 11a. The interventions taken to achieve goals are included in Table 11 under Element 11c.

2b. Measurable Outcomes and How Goals Evaluated

Measurable outcomes to identify if the above goals have been met will be collected through Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Risk Assessment (HRA), audit, appeals and grievance, utilization and other metrics targeting the goals in Table 2. Health Net will evaluate if the goals have been met by collecting, analyzing and reporting data annually or more often to determine if the metric specific goals have been met or exceeded. Goals will be determined through available Medicare Advantage, SNP or internal benchmarks or performance goals. Comparisons with Medicare Advantage benchmarks should be viewed with caution due to demographic differences in the populations. Results will be compared year-to-year or to Dual Eligible SNP specific benchmarks that are available.

EXAMPLES:

Table 2

MEASURABLE GOALS
Improved Access to Essential Services: Medical, Mental Health, LTSS and Social Services to enable dual eligibles to remain in their homes and communities
Member satisfaction with "Getting Needed Care" will increase by 2% in 2012
Percent of members with 1 high volume Behavioral Health Provider within 15 miles or 30 minutes from residence will meet or exceed performance goal of 90% in 2012
Percent members with Cardiologist within 15 miles or 30 minutes from residence will meet or exceed performance goal of 90% in 2012
Members utilizing transportation services will increase by 1% in 2012
Member Survey CAHPS Measures
Composite result for "Getting Needed Care"
Provider Availability Measures
Percent members with 1 High volume BHP within 15 miles or 30 mins from residence
Percent members with Cardiologist within 15 miles or 30 mins from residence

MEASURABLE GOALS
Add-On Benefits
% Members Utilizing Transportation Benefit
Improved Access to Affordable Care including use of Medicare, Medi-Cal and other State/County resources
Members with access to Providers contracted for Medicare and Medicaid will meet or exceed performance goal of 90% in 2012
Percent Geo-Access Availability of Providers Contracted for Medicare and Medicaid
PCP
Specialists
Utilization rates State/County resources
Add-On Benefits
Improved Benefit Coordination And Timely Access To Care Through An Identified Point Of Contact
Member satisfaction with help received to coordinate care will increase by 1% in 2012
HEDIS® measure Follow-up after Hospitalization for Mental Illness will increase by 2% for 7 and 30 day follow-Up
Member Survey CAHPS Measures
Percent “very” or “somewhat satisfied” with help received to coordinate care
HEDIS®
Follow-up after Hospitalization for Mental Illness
30-day Follow-up
7-day Follow-up
Improving Seamless Transitions of Care Across Health Care Settings, Providers and HCBS
The average number of days for non-delegated members to receive Post- Hospital Discharge Calls will be equal to or less than 2 days in 2012
Members that have been hospitalized or in a nursing home will respond “Yes” to “Did you have the information you needed upon discharge regarding medications and follow-up care?" 85% of the time in 2012
Members with Medication Reconciliation documented post-discharge will increase by 2% in 2012
Transition of Care Measures
Average Number of Days Post- Hospital Discharge Call
% Dual Eligible SNP members that have been hospitalized or in a nursing home responding “Yes” “Did you have the information you needed upon discharge regarding medications and follow-up care?" (Yes/No)
HEDIS® Measures
Medication Reconciliation Post-Discharge
Improved Access To Preventive Health Services
Percent of members obtaining Flu Vaccine will increase by 2% in 2012

MEASURABLE GOALS
Percent of members obtaining Pneumonia Vaccine will increase by 2% in 2012
HEDIS® Measures
Members reporting Flu vaccine in past year on CAHPS survey
Members reporting Pneumonia vaccine in past year on CAHPS survey
Improving Access to HCBS
Percent of members satisfied with access to HCBS will reach performance goal of 85% in 2012
CAHPS Measure (2012 supplemental question)
Members reporting "satisfied" or "very satisfied" with access to HCBS on 2012 CAHPS survey
Assuring Appropriate Utilization of Services
Case Management support will decrease inappropriate emergency room visits lowering utilization by 5 ER visits per thousand members per year in 2012
All Cause Readmission rate in 30 days will decrease by 1% in 2012
Utilization Measures
Emergency Room utilization (PTMPY)
HEDIS® Measures
All Cause Readmission Hospital rate - 30 day
Improving Beneficiary Health Outcomes and Satisfaction
HEDIS® Care for Older Adult measure will improve by 5% over the 4 components in 2012
HEDIS® Use of High Risk Medications in the Elderly will improve 1% over the 2 components in 2012.
HEDIS® Measures
Use of High Risk Medications in the Elderly (lower rate is better)
1 Drug
2 or More Drugs
HEDIS® Care for Older Adults (COA)
Advance Care Planning
Medication Review
Functional Status Assessment
Pain Screening
Preserve And Enhance The Ability For Consumers To Self-Direct Their Care And Receive High Quality Care
HEDIS® Care for Older Adult measure will improve by 5% over the 4 components in 2012
HEDIS® Use of High Risk Medications in the Elderly will improve 1% over the 2 components in 2012.
HEDIS® Measures
Use of High Risk Medications in the Elderly (lower rate is better)
1 Drug
2 or More Drugs
HEDIS® Care for Older Adults (COA)
Advance Care Planning

MEASURABLE GOALS
Medication Review
Functional Status Assessment
Pain Screening

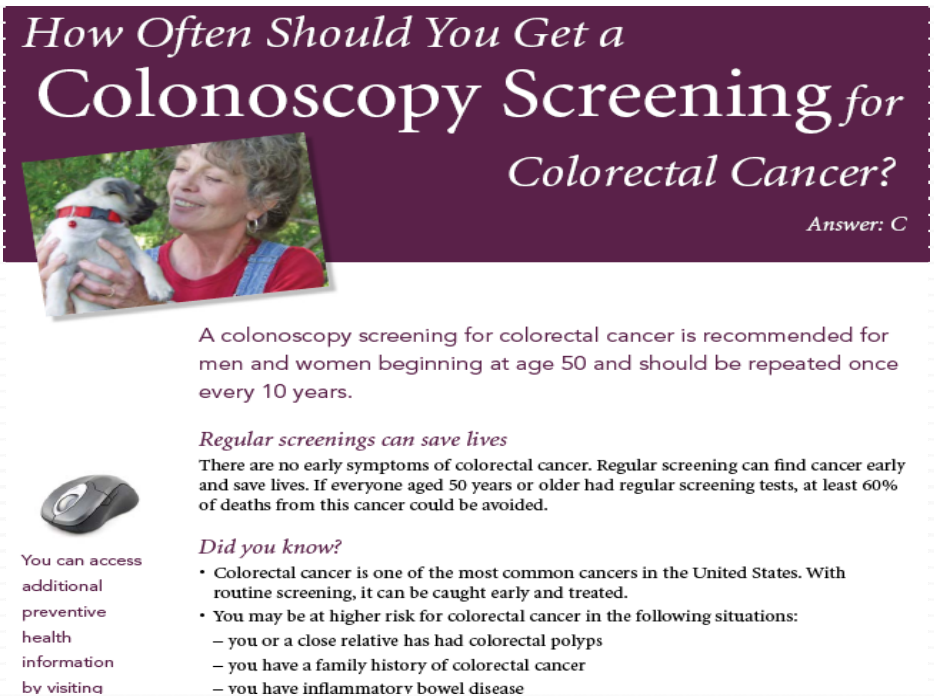
2c. Action Taken if Goals Not Met in Time Frame

Action taken when program goals are not met will vary according to specific metrics, goals and affected departments. 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. One of the functions of the committee structure is to provide input and recommendations for corrective actions and monitoring previously identified opportunities for improvement.

EXAMPLES:

- The Quality Improvement (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 Clinical QI Workgroup also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, access, services and member and provider satisfaction. The Clinical QI Workgroup consists of a small core of QI staff, 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 and actions to correct deficiencies. The Clinical QI Workgroup meets at least four times per year and reports significant findings to the Quality Improvement Committee.

- Outcomes from the HEDIS®, CAHPS, HRA, Medication Therapy Management (MTM), 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. In 2011, multiple interventions to Medicare and Dual Eligible SNP members and providers in the form of reminder calls, newsletters and educational materials were conducted after barrier analysis to improve below goal Flu/Pneumonia Vaccination, Colorectal Cancer and Glaucoma screening rates.



How Often Should You Get a

Colonoscopy Screening *for Colorectal Cancer?*

Answer: C

A colonoscopy screening for colorectal cancer is recommended for men and women beginning at age 50 and should be repeated once every 10 years.

Regular screenings can save lives

There are no early symptoms of colorectal cancer. Regular screening can find cancer early and save lives. If everyone aged 50 years or older had regular screening tests, at least 60% of deaths from this cancer could be avoided.

Did you know?

- Colorectal cancer is one of the most common cancers in the United States. With routine screening, it can be caught early and treated.
- You may be at higher risk for colorectal cancer in the following situations:
  - you or a close relative has had colorectal polyps
  - you have a family history of colorectal cancer
  - you have inflammatory bowel disease

You can access additional preventive health information by visiting

- Health Net conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files and an on-site review of the Dual Eligible SNP delegated group's operations. The evaluation results are compiled and a written summary of findings and recommendations are presented to the Delegation Oversight Committee for final determination. This type of audit is also performed annually to determine the continuation of the delegated relationship. Delegated groups that do not meet the Dual Eligible SNP program requirements are de-delegated. In 2011, 9 SNP groups were de-delegated. The role of delegated groups are elaborated on further in Element 5

Excerpt from Delegation Oversight Committee Report:

Interventions

1. MPM gave XXMG Medical Directors and Director of XX Managed Healthcare, sample SNP P&Ps, CM initial assessment and progress notes, & HN SNP PDAT and File Review Tools.

2. MPM met with and educated the XX Medical Group CM nurse regarding SNP CM documentation, and discussed the findings of the X/XX/XX SNP CM files review.

3. MPM contacted the CM nurse several times and discussed ways to streamline the SNP CM processes.

4. MPM discussed above at the X/XX/XX HN DOW.

Next Steps/Recommendations

1. De-delegate for SNP CM function.

2. Health Net Internal meeting for transition process.

3. Health Net and XX Medical Group meeting for transition process.

- 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 implements plan-level and Participating Provider Group (PPG) level corrective actions based on its accessibility assessments. Plan level results and applicable actions for improvement are communicated to the Health Net Quality Improvement Committee (HNQIC) for review and approval. In 2010, 108 provider groups were designated to complete Corrective Action plans as a result of the after-hours survey that evaluates member access to providers for urgent issues after routine business hours. Any group that did not achieve the 100% performance goal had to complete a Corrective Action Plan (CAP) with actions taken to become compliant.

ELEMENT 3. STAFF STRUCTURE AND CARE MANAGEMENT ROLES

The Dual Eligible SNP Governance Committee has oversight of the Dual Eligible SNP Program and reports to the Medicare Care Management Access and Clinical Quality Committee (CMACQC)**.** Membership on the Dual Eligible SNP Governance committee will include administrative representatives from departments such as: QI, Provider Network, Medical Management, Medicare Products, Case Management, State Health Programs, Delegation Oversight, Pharmacy Services, MHN (behavioral health) Compliance and Concurrent Review. The Dual Eligible SNP Governance committee oversees the implementation of the Dual Eligible SNP Model of Care, approves policies, procedures, materials and reviews the effectiveness of the Dual Eligible SNP Model of Care and the need for additional services and benefits.

In addition to the governance committee, the administrative, clinical and oversight functions and the corresponding staff structure to implement the Dual Eligible SNP program is represented in Tables 3-6:

EXAMPLES:

3a. Administrative Functions

Table 3

Role/Responsibilities	Personnel
Process enrollment	Eligibility Representatives
Verify eligibility for special needs plan	Eligibility Representatives
Annually complete Pre-Screening tool for Dual Eligible SNP	Eligibility Representatives
Process Claims	Claims Adjusters
Process and facilitate resolution of grievances	Appeals and Grievances, Member Service

Role/Responsibilities	Personnel
and provider complaints	Representatives
Communicate plan information	Sales and Marketing, Brokers, Member Service Representatives
Collect, analyze, report, and act on performance and health outcomes data	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

3b. Clinical Functions

Table 4

Role/Responsibilities	Personnel
Coordinate care management	Case Managers, Providers
Advocate, inform, and educate beneficiaries on services and benefits	Case Managers, Member Service Representatives, Providers, Care Coordinators and Patient Navigators
Identify and facilitate access to community resources	Case Managers, MHN Case Managers, Providers, Care Coordinators and Patient Navigators
Triage care needs	Case Managers, MHN Case Managers, Providers
Facilitate Health Risk Assessment (HRA)	Case Managers, Member Service Representatives, Survey vendor, Care Coordinators and Patient Navigators
Evaluate and analyze responses to HRA and assign members according to risk level	Data Analysis, Case Managers
Facilitate implementation of Care Plan	Case Managers , MHN Case Managers, Providers
Educate members in disease and behavioral health self-management	Case Managers, MHN Case Managers, Disease Management Licensed Health Coaches, Providers, Health Educators
Consult on pharmacy issues	Pharmacists
Authorize or facilitate access to services	Providers, Pre-authorization, Concurrent Review, Case Managers, MHN Case Managers, Care Coordinators and Patient Navigators

Role/Responsibilities	Personnel
Obtain consultation and diagnostic reports	Case Managers, Pre-authorization, Concurrent review, MHN Case Managers, Providers
Facilitate translation services	Cultural and Linguistics, Member Service Representatives, Case Managers, MHN Case Managers, Providers
Facilitate transportation services	Case Managers, MHN Case Managers, Providers, Care Coordinators and Patient Navigators
Provide Medical and Mental Health Care	Providers for Health Net and MHN
Counsel on Substance Abuse and rehab strategies	MHN Providers, MHN Case Managers, Social Workers
Coordinate Social Services	Case Managers, MHN Case Managers, Social Workers, Providers, Care Coordinators and Patient Navigators
Conduct medication reviews	Pharmacists, Providers

3C. Administrative and Clinical Oversight Functions

Table 5

Role/Responsibilities	Personnel
Monitor care management implementation	Director Case 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 Case 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 Dual Eligible SNP	Director Claims, VP Claims Operations
Ensure compliance QI program for the Dual Eligible SNP Model of Care	VP Quality Improvement Program
Compliance with HEDIS®, CAHPS, HOS requirements	VP HEDIS® Management
Compliance with network adequacy	VP Medical and Network Management, Chief Provider Contracting Officer

Role/Responsibilities	Personnel
Compliance with Dual Eligible SNP eligibility requirements	VP Membership Accounting and Eligibility
Compliance with requirements of the integrated communication systems for the Dual Eligible SNP program	VP Customer Contact Center, Chief Customer Services Officer
Ensure compliance with all CMS Requirements including Dual Eligible SNP	VP and Chief Operating Officer, CEO and President

Management Oversight- Clinical Functions

Table 6

Role/Responsibilities	Personnel
Monitor interdisciplinary care team	Director Case Management, Providers
Assure timely and appropriate delivery of services	Director Case Management, Providers
Monitor providers for use of clinical practice guidelines	Director Quality Improvement, Delegation Oversight
Coordinate and monitor care for seamless transitions across settings and providers	Director Health Care Services, Director Dual Eligible SNP Case Management, Providers
Implementation Dual Eligible SNP Model of Care	VP Clinical Services
Implementation Dual Eligible SNP Medication Therapy Management Program	Director Clinical Pharmacy
Monitor network providers compliance with Dual Eligible SNP Model of Care	Medical Directors, Director Delegation Oversight
Monitor compliance with Dual Eligible SNP Model of Care requirements	Clinical Operations Officer, VP and Chief Medical Director, Chief Medical Officer
Ensure compliance with all CMS Requirements including Dual Eligible SNP	Healthcare Services Officer and President Pharmacy, VP and Chief Operating Officer, CEO and President

EXAMPLES:

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 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, Independent Practice Associations (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 American Board of Medical Specialties (ABMS) recognized specialty. Unrestricted active Medical Doctor (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 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 Health Net 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: Registered Nurse (RN) License with Bachelor's degree; or Master's degree in related health field, such as Public Health; or Bachelor's degree with equivalent experience. Graduate of a clinical degree program preferred. Valid Registered Nurse, Clinical Psychologist, or Licensed Clinical Social Worker license. Case Management certification preferred.
Experience: Minimum three years clinical experience required. Three to five years Case Management experience required. 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 Health Net 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 three years acute inpatient clinical experience required. Three to five years managed care experience, including discharge planning, Case Management, Utilization Management, transplant or related experience required. 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 pended 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. Valid state RN license.

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 Member Service Associate is to respond to routine and escalated telephone inquiries from members, providers and employer groups to provide information and clarification on multiple products and provide customer service that eventually leads to resolution of the initial inquiry. Works to enhance relationship with Health Net business partners. Coordinates, processes, and documents PCP/PPG transfers utilizing appropriate protocols. Utilizes multiple company database programs for accessing member information. Sends out requested material such as: provider directories, mail-order pharmacy information, and travel kits. Updates members' addresses and phone numbers in the data system. 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: Experience with Health Net automated systems to access claims, eligibility, correspondence, and related information. Fluency in English and Spanish, Mandarin, Cantonese, Vietnamese, Korean, Cambodian or other language related to the position as required.

ELEMENT 4. INTERDISCIPLINARY CARE TEAM

Care is coordinated for Dual Eligible SNP members through an Interdisciplinary Care Team (IDCT) to address medical, cognitive, psychosocial, and functional needs. The IDCT is responsible for overseeing, coordinating, and evaluating the care delivered to members. Each Dual Eligible SNP member is assigned to an interdisciplinary care team appropriate for the member. The IDCT is composed of primary, ancillary, and specialty care providers. The composition of the IDCT and how it is determined is described below.

4a. Composition of the IDCT

At minimum, IDCT members include:

- Medical Expert (e.g. Primary Care Physician (PCP), Specialist, or Nurse Care/ 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 IDCT as Dual Eligible SNP members often have psychosocial or economic issues requiring social services intervention

- Behavioral and/or mental health specialist e.g. psychiatrist, psychologist, or drug or alcohol therapist) when indicated. Behavioral health specialists from Health Net's Behavioral Health Division, (MHN) attend the IDCT meetings upon request to assist when the member has behavioral health issues such as mental illness or substance abuse

Additional IDCT members may be included as determined by the member's individual needs according to the examples provided under each specialist:

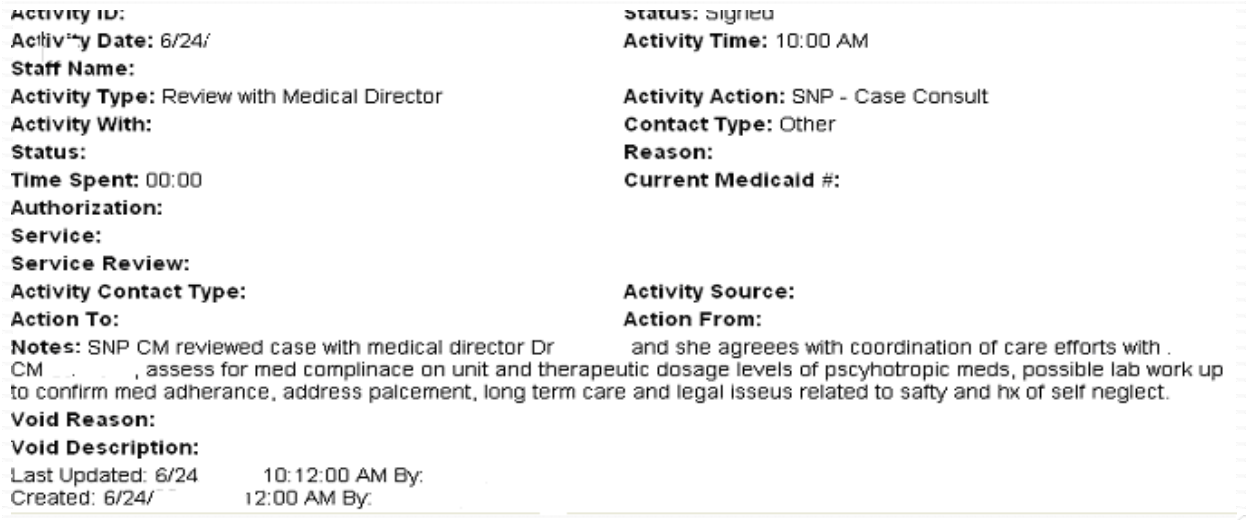
- Pharmacist – may be included when the member has medication issues such as complex medication regimes, adverse reactions and side-effects, noncompliance, care gaps or other issues requiring pharmaceutical expertise
- Restorative Health Specialist (e.g. physical, occupational, speech, or recreational 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, Parkinsons, 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 external 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 IDCT 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 IDCT
- Care Coordinators and Patient Navigators are unlicensed associates who extend the work of the Case Manager or Social Worker assisting the member to access services and coordinate care under the direction of the Case Manager or Social Worker
- 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
- Pastoral Specialist – may be included when the member requests that their personal spiritual advisor be included or a community Pastoral Specialist when the member has requested and consented to their involvement
- Promotoras – may be called upon to serve as liaisons between the Latino community and health professionals, human and social service organizations and provide culturally-sensitive basic health education

EXAMPLE:

Case Study – Details have been summarized to ensure privacy

This is an example of the members of the IDCT: Health Net's Behavioral Health division, MHN, identified this case during the inpatient psychiatric admit and requested co-management assistance from the Medical Group for discharge planning and coordination of care because of the member's medical conditions. MHN also contacted the Health Net (HN)--MHN Utilization Service Team to review the inpatient psych clinical assessment available in the medical management system for discharge coordination. The member's psychiatrist was also contacted and the member. Other IDCT Members Included:

- *The HN-MHN Case Manager – Coordination of Behavioral Health services*
- *Medical Group Case Manager – Coordination of Medical services and ICT*
- *Psychologist – Provider for psychological outpatient treatment*
- *The MHN Behavioral Health Utilization Team – Coordination of inpatient care*
- *The Medical and Psych MD's – Treatment for inpatient services*
- *Inpatient Case Manager – Coordination of care delivery & Transitions*
- *Social workers – Coordination of social services/discharge planning*
- *Primary care physician – Medical provider for outpatient services*
- *The home health care agency – In-home care and follow up for wound healing*



Activity ID: **Status:** Signed
Activity Date: 6/24/ **Activity Time:** 10:00 AM
Staff Name:
Activity Type: Review with Medical Director **Activity Action:** SNP - Case Consult
Activity With: **Contact Type:** Other
Status: **Reason:**
Time Spent: 00:00 **Current Medicaid #:**
Authorization:
Service:
Service Review:
Activity Contact Type: **Activity Source:**
Action To: **Action From:**
Notes: SNP CM reviewed case with medical director Dr and she agreees with coordination of care efforts with . CM , assess for med complinace on unit and therapeutic dosage levels of pscyhotropic meds, possible lab work up to confirm med adherance, address palcement, long term care and legal isseus related to safty and hx of self neglect.
Void Reason:
Void Description:
Last Updated: 6/24 10:12:00 AM By:
Created: 6/24/ 12:00 AM By:

4b. Beneficiary Participation

The member and/or caregivers are encouraged to participate on the IDCT. The Case Manager will encourage member participation verbally and/or in writing 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 IDCT.

EXAMPLES:

- *Case Study cont: Details have been summarized to ensure privacy.*

Middle aged member was initially admitted to hospital due to deterioration of mental health condition with diagnosis of dehydration and malnutrition. Discharge planning began early in this member's inpatient stay and included frequent communication between the acute medical, and the Psychiatric team at the facility for care transitions, MHN and Medical Group Case Managers, Outpatient Providers, the member and family to create an effective Care Plan for discharge and follow-up. Transition of care between acute medical to psych and back to medical was critical for continuity of care.

Activity ID: **Status:** Signed
Activity Date: 8/16/20 **Activity Time:** 11:29 AM
Staff Name:
Activity Type: Call Outbound - Mbr/WIC **Activity Action:** SNP - Case Consult
Activity With: **Contact Type:** Enrollee
Status: **Reason:**
Time Spent: 00:00 **Current Medicaid #:**
Authorization:
Service:
Service Review:
Activity Contact Type: **Activity Source:**
Action To: **Action From:**
Notes: SNP CM spoke with mbr at tel # . Mbr reports that has seen psychiatrist and adhering to regime. Mbr reports is also seeing outpt therapist Dr. in . Mbr requested additional information on tx options for ED programs. SNP CM warm transferred mbr to service team and spoke with CM to offer clinical hx.
Void Reason:
Void Description:
Last Updated: 8/16/20 11:32:00 AM By:
Created: 8/16/20 11:32:00 AM By:

4c. IDCT Operation and Communication

The Case Manager determines the membership of the IDCT based on the member's medical, psychosocial, cognitive and functional needs identified through the HRA and initial assessment. Representatives for Dual Eligible SNP non-delegated members are informed of the plan of care, their involvement on the IDCT and the meeting schedule by "scheduler" (electronic medical management system) letter, e-mail or fax. Members are consulted if possible during the development of the team. Team members are documented in the member's record. Attendance sheets and the outcomes of the team meeting are documented, retained according to the document retention policy and the Care Plan is updated as indicated to communicate the results to the team. Weekly team meetings are held for internally managed members to ensure all have an IDCT documented. Care Coordination Interdisciplinary Case Rounds are attended by

a minimum of Case Managers, medical staff, social workers and behavioral health and occur at least monthly for members stratified into high risk and managed by Health Net.

The role of the Interdisciplinary Care Team is to:

- Analyze and incorporate the results of the initial and annual health risk assessment into the Care Plan
- Collaborate to develop and annually update an individualized Care Plan for each Dual Eligible SNP member
- Manage the medical, cognitive, psychosocial, and functional needs of the members
- Communicate with team members and providers of care to coordinate the member Care Plan

EXAMPLE:

Case Study cont: Details have been summarized to ensure privacy.

A safe discharge plan to an appropriate setting with adequate caregivers was the goal of the interdisciplinary team including a reduction of psychosis so patient no longer put self at risk, appropriate medical equipment for wound healing, adequate member and caregiver education, supervision so patient could safely manage daily care and sufficient nutrition. Member and family contacts to provide education on member's condition, available resources, benefits and psychological resources were a priority. Family was very involved and desired help as much as possible and received information willingly. Follow-up was continuous with member/family and providers to evaluate status, Care Plan, and promote compliance. Ongoing care coordination with IDCT team included frequent follow-up by PCP, appointments to Psychiatrist and Psychologist. Member initially refused resources for socialization and health education materials related to treatment and disease management, but was later willing to have case management services. Member eventually agreed to go into an apartment where meals would be provided and would have daily contact with others.

Activity ID: **Status:** Signed
Activity Date: 6/ **Activity Time:** 1:31 PM
Staff Name:
Activity Type: Call Outbound - Other **Activity Action:** SNP - Case Consult
Activity With: **Contact Type:** Other
Status: **Reason:**
Time Spent: 00:00 **Current Medicaid #:**
Authorization:
Service:
Service Review:
Activity Contact Type: **Activity Source:**
Action To: **Action From:**
Notes: SNP CM spoke with PPG RN and gave RN tel # to medical unit SW for dc planning, mbr may be dc to house, RN will assist with order for in home health serivces with SW and possbile MD in home. RN reports that mbr was assessed by oon psychiatrist Dr on 6/ psychiatrist on medcial unit spoke with AP from psych bed Dr. Dr. assessment indicates that mbr is at baseline for weight and psychosis, cooperative on medical unit, hyper verbal and appropriate for dc. Psyciatrist did not select to request involuntary petition or trasfer back to psych bed. CM called outpt psychiatrist Dr. and there is not a scheduled follow up appointment. Cm left message for Dr. to request appointment and support med adherace stratiges or assess for need of conservtorship if indicated. Mbr also has option of PHP or IOP in area.
Void Reason:
Void Description:
Last Updated: 6/ . 1:39:00 PM By:
Created: 6/ 1:39:00 PM By:

ELEMENT 5. PROVIDER NETWORK HAVING SPECIALIZED EXPERTISE AND USE OF CLINCIAL PRACTICE GUIDELINES AND PROTOCOLS

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 case management to select medical groups. Groups with the infrastructure to provide the Dual Eligible SNP Model of Care can also be contracted and responsible for the team based care requirements. Advantages to centralizing these functions within the medical group include improved communication and coordination of care for members.

Coordination of Community Based Services, IHSS and LTSS remains a responsibility of the Plan. Health Net is responsible to audit delegated medical groups to ensure that the contracted services are provided in compliance with applicable rules and regulations. Members that are not part of a group delegated for the Dual Eligible SNP Model of Care receive the team based care through Health Net.

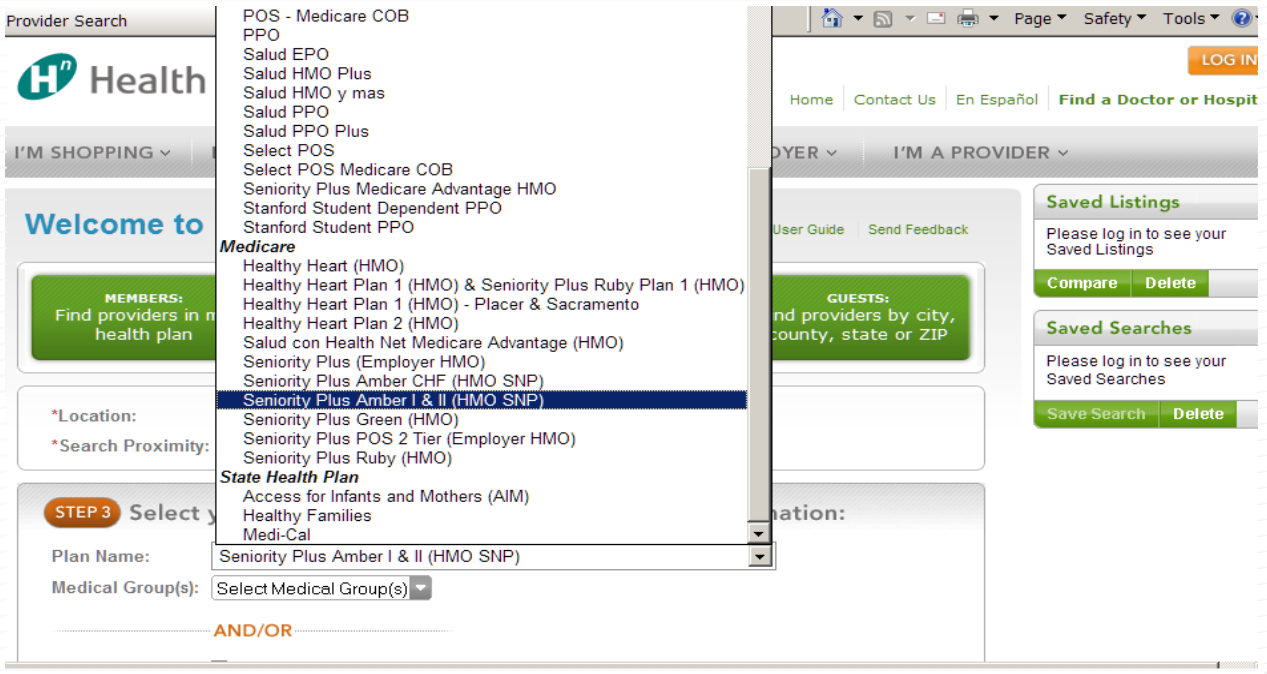
5a. Specialized Expertise

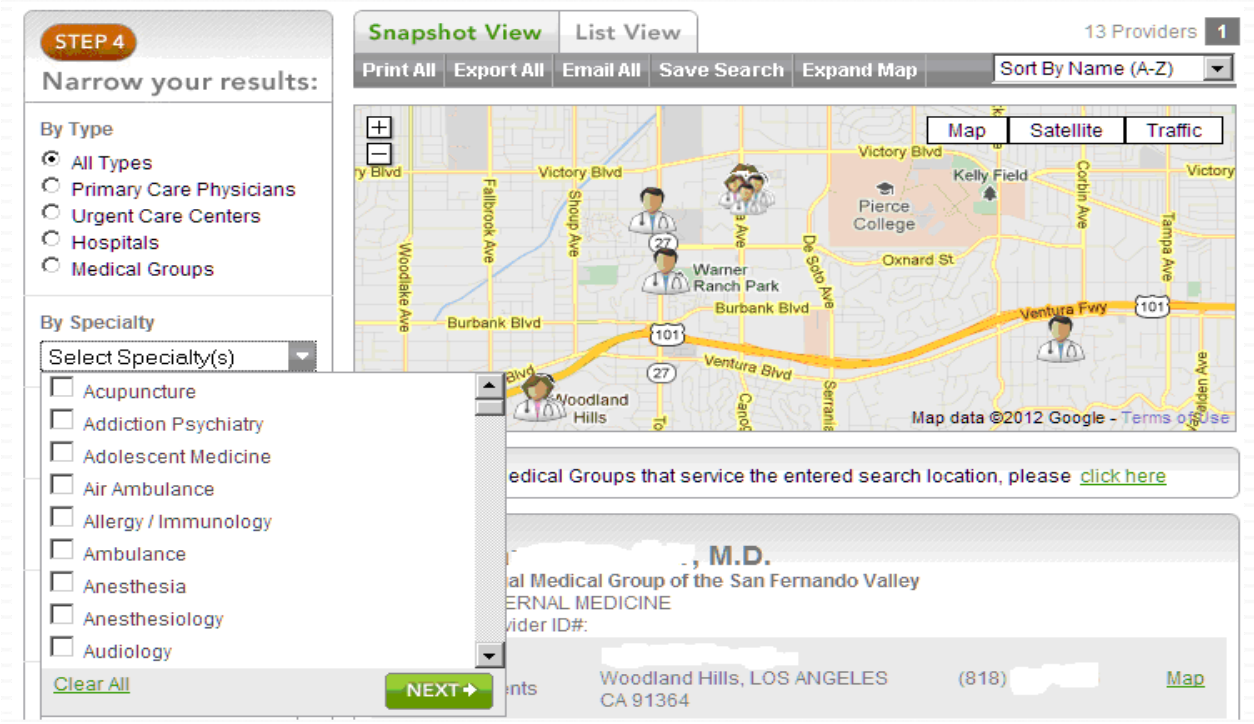
Health Net maintains a comprehensive network of Primary Care Providers, facilities, specialists, behavioral health care providers, social service providers, community agencies and ancillary services to meet the needs of Dual Eligible members with complex social and medical needs including chronic disease, 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 subacute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, outpatient pharmacies, and hospices allow Dual Eligible SNP members to obtain the services they need at a convenient location. An overview is described in Table 7. Availability of providers to members is monitored regularly per the example in Table 8. The Health Net website also has a secure and user friendly search function for members to locate providers and specialists in their area.

EXAMPLES:

The screenshots below illustrates the provider search function available to members on the member portal. In addition, members can contact the Member Services Contact Center or their Case Manager for assistance locating specialists and other providers.





- Table 7 below provides examples of key provider types and current number available in the network to *Dual Eligible SNP* members. Many of our Health Net providers who have earned Board certification in subspecialties, such as Geriatricians, but are identified based on their primary specialty. We are exploring opportunities to capture and report those subspecialties. Home and Community Based Services such as IHSS, County Mental Health services, and other Long-Term Support services will also be added to the network.

Table 7

Health Net Providers Available to SNP Members	San Diego County
Primary Care Providers	**446**
Behavioral Health Providers (total)	**557**
Psychiatrists	**176**
Psychologists	**267**
Substance Abuse Counselors	**184**
Specialists	
Cardiologists	**105**
Neurologists	**72**
Opthamologists	**105**
Gastroenterologists	**65**
Endocrinologist	**34**

Health Net Providers Available to SNP Members	San Diego County
Facilities	
Hospitals	**18**
Behavioral Health Facilities	**18**
Freestanding Hospital	**3**
Acute/General Hospital	**11**
Residential Treatment Center	**0**
Freestanding Partial Program	**0**
Freestanding IOP/SOP	**4**
Skilled Nursing Facilities	**40**
Outpatient Surgical Centers	**27**
Dialysis Centers	**31**
Laboratories	**54**
Pharmacies (retail)	**419**
Other Pharmacies (LTC, Home Infusion)	**43**
Radiology/Imaging Centers	**43**
Acute Rehab Facilities	**4**
Durable Medical Equipment	**22**
Nursing Professionals	
Nurse Case Managers	**18**
Social Workers	**5**
Concurrent Review Nurses	**29**
Nurse Health Coaches (Disease Management)	**550**
Allied Health Professionals	
Pharmacists (Health Net)	**9**
Physical Therapists	**71**
Occupational Therapists	**14**
Speech Pathologists	**0**
Radiologists	**223**

Table 8 presents an example of the availability monitoring of facilities and providers conducted to ensure the network adequacy for Dual Eligible SNP members.

Table 8

Availability of Network Providers 2010 CA	%
% 1 PCP within 15 miles or 30 mins from residence or workplace	**100**
% 1 High volume BHP within 15 miles or 30 mins from residence or workplace	**98**
% 1 Hospital within 15 miles or 30 mins from residence or workplace	**95**
% 1 ER within 15 miles or 30 mins from residence or workplace	**95**
% 1 Pharmacy within 15 miles or 30 mins from residence or workplace	**100**
% 2 Specialists within 15 miles or 30 mins from residence or workplace (for each high volume specialty type)	

Availability of Network Providers 2010 CA	%
Orthopedic Surg.	**97**
Gastroenterology	**97**
Cardiology	**98**
Neurology	**96**
Ophthalmology	**97**

5b. Determination of Licensure and Competence

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 recredentialed within 36 months. Practitioner recredentialing includes reviewing Health Net captured performance data that provide an assessment of indicators representing professional competence and conduct. Practitioners identified in the initial or recredentialing processes with adverse actions will be investigated in accordance with *Policy/Procedure #CR140: 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 recredentialing activities is administered under the direction of the Health Net Delegation Oversight Committee and in accordance with process described in *Policy/Procedure #CR180: IPA/Medical Group/Entity Evaluation & 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's Behavioral Health Division, MHN is responsible for the credentialing/ recredentialing of the Health Net behavioral health care network. HN credentials and recredentials 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 Recredentialing 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 #CR140: Adverse Action, attachment A: "Adverse Action Classification Guidelines."*

The practitioner must possess adequate and appropriate education and training as stated in *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 #CR140: Adverse Action, attachment A, "Adverse Action Classification Guidelines."*

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 #CR-140: Adverse Action, attachment A: "Adverse Action Classification Guidelines.*" 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.

EXAMPLES:

- Screenshots of Health Net's website Hospital Comparison report that allows members to locate the best hospital in their area for select procedures and conditions.

Hospital Advisor

We make it easy to find hospital facilities that match your location, your situation, and your preferences.
For additional information in California, you may wish to visit the California Hospitals Assessment and Reporting Task Force (CHART) website at www.calhospitalcompare.org

Secure Messages (1 new)

1 CHOOSE REPORT — 2 CHOOSE HOSPITALS — 3 RANK CRITERIA — 4 VIEW REPORT

Report on Mastectomy, Total/Simple

This report compares hospitals within 20 miles of Tarzana, CA. This is just one of several sources you should consult to select a hospital; always consult your physician about what decision is right for you.

Summary | Patients | Length of Stay | Cost | Safety | Patient Experience | Other Data

Related Reports

Name	Rank	Index	Patients/yr	LOS	Cost
Los Robles Regional Medical Center	1st	2.00	3rd	1st	3rd
St. John's Hospital And Health Center	2nd	2.50	2nd	3rd	2nd
Providence Holy Cross Medical Center	3rd	3.00	5th	1st	1st
Cedars Sinai Medical Center	3rd	3.00	1st	5th	5th
Providence Tarzana Medical Center	5th	4.00	4th	4th	4th

About the Data — Print report

- The following grid is an example of a tool the Credentialing Department uses to monitor the License/Accreditation status of facilities.

National Credentialing Organizational Providers Report

Facilty Name	Facility Type	Prior Validation Date/License Status	Current Validation Date/License Status	Prior Accreditation Validation Date/Body/Status
4th Street Laser & Surgery Center	Free Standing Surgery Center	8/9/07; ACTIVE	10/22/09; ACTIVE	08/09/07; Accreditation Association for Ambulatory Healthcare; ACTIVE
AccentCare Home Health - Burbank	Home Health	10/11/07; ACTIVE	10/22/09; ACTIVE	N/A
AccentCare Home Health - El Centro	Home Health	N/A	10/11/07; ACTIVE	N/A
AccentCare Home Health - Escondido	Home Health	N/A	10/11/07; ACTIVE	N/A
AccentCare Home Health - Lancaster	Home Health	N/A	10/11/07; ACTIVE	N/A
AccentCare Home Health - Sacramento	Home Health	10/11/07; ACTIVE	10/22/09; ACTIVE	10/11/07; The Joint Commision; ACTIVE
AccentCare Home Health - San Diego	Home Health	N/A	11/8/07; ACTIVE	N/A
Access IV	Home Infusion	7/13/06; ACTIVE	4/23/09; ACTIVE	7/13/06; The Joint Commision; ACTIVE
Admiral Home Health	Home Health	4/15/04; ACTIVE	4/12/07; ACTIVE	N/A
Advanced Ambulatory Surgery Center	Free Standing Surgery Center	10/11/07; ACTIVE	10/22/09; ACTIVE	10/11/07; Accreditation Association for Ambulatory Healthcare; ACTIVE
Advanced Diagnostic and Surgical Center	Free Standing Surgery Center	10/11/07; ACTIVE	10/22/09; ACTIVE	10/11/07; Accreditation Association for Ambulatory Healthcare; ACTIVE
Advanced Endoscopy Center	Free Standing Surgery Center	7/14/2005: ACTIVE	6/12/08; ACTIVE	7/14/05; Accreditation Association for Ambulatory Healthcare; ACTIVE
Advanced Medical Laboratory	Laboratory	8/19/04; ACTIVE	8/9/07; ACTIVE	8/19/04; Clinical Laboratory Improvement Ammendments; ACTIVE
Advanced Surgery Center	Free Standing Surgery Center	N/A	6/14/07; ACTIVE	N/A
Agape Home Care, Inc.	Home Health	7/14/05; ACTIVE	7/29/08; ACTIVE	N/A
AGMG Endoscopy Center	Free Standing Surgery Center	7/14/05; ACTIVE	7/10/08; ACTIVE	7/14/05; Accreditation Association for Ambulatory Healthcare; ACTIVE

Report Nat'l Credentialing Org Prov 1 01/14/2010

5c. Determination of Services Members Receive

The member's Primary Care Provider (PCP) in conjunction with the IDCT determines which specialized medical 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, Member Services 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, diabetic supplies, podiatrists, etc. The Case Manager with the IDCT refers members to receive IHSS to continue living in their homes and communities.

EXAMPLES:

- Case study- Details have been summarized to ensure privacy

Member is a young adult with a mental health disorder and kidney disease resulting in dialysis. History of medical and social problems present as a result of noncompliance to medical advice, lack of financial support, and lack of psychiatric care. Family support not present in the immediate area. Member requires in-home support for meals, housekeeping and errands.

Health Net Social Worker was involved in case to assist with financial resources. Case Manager worked with the Medical Group and DME company to coordinate equipment and supplies. Contacted the dialysis center frequently to assess member's needs and follow up with specialists. Mental Health issues required frequent interventions and coordination with other medical providers including referrals and scheduling member with Psychiatrist fluent in member's primary language. This resulted in a decrease in the psychiatric symptoms that were interfering with treatment goals. CM arranged transportation and coordinated with PCP and PPG when member had medical complications. Health Net Social Worker is also helping the member with housing assistance.

5d. Provider Coordination with IDCT

The PCP is a member of the IDCT 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 IDCT. Each member is assigned a Case Manager who serves as the member's primary point of contact upon enrollment. Upon identification of a member at risk, the Case Manager will contact the member or responsible party to determine if services, such as home care or DME to reduce risk of hospitalization are appropriate. 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 to file appeals and grievance if services are not delivered in a timely and quality manner in their health plan materials.

Special efforts to coordinate care for members enrolled in Dual Eligible SNPs are made to maintain member in their homes and communities and especially 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. Inpatient management review 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. Health Net's Care/Case Manager contacts the IDCT to assist with the completion of the assessment for appropriate discharge planning and updates to the Care Plan. The Health Net Case Manager ensures timely and sufficient communication between the IDCT team.

EXAMPLES:

- Case Study: Details have been summarized to ensure privacy

This case illustrates coordination with PCP and discharge planning. Middle aged member with mental illness, diabetes and complications from continued substance abuse. History of multiple admissions, homelessness and lack of effective treatment plan. The barriers included difficulty finding appropriate residence due to behavior issues and lack of follow-up with primary doctor. Goals set with and agreed to by the member included sobriety, address medical and mental health issues through follow up with providers and participation in behavioral health clinics. The Care Plan included discharge plan to address relapse issues.
Additional Interventions included conferences with Health Net Social Worker, hospital Social Worker, medical group outpatient Social Worker, in-patient Case Manager, MHN Case Manager, Regional Medical Director and Concurrent Review Team. Member agreed and assisted to placement in sober living facility. Case Manager facilitated change to primary doctor closer to member's current residence to improve follow-up care.

- 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 Care/Case Manager works collaboratively with the IDCT 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 Care/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, IDCT 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 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 Health Plan sends written notice to the member and the member's usual practitioner at the time the admission is prior authorized. The letter is issued within 5 days of the authorization. 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 concurrent review nurse ensures discharge notification is communicated to the member's usual practitioner within 5 business days of discharge by issuing the "PCP Notification Letter of Discharge".
- The Case Manager conducts "Post Hospital Discharge Member Calls" within 2 days of notification of discharge home from the inpatient setting to confirm discharge plan, complete medication review and educate and screen the member for additional gaps in care that may benefit or require assistance from Case Management and communicate information with family or responsible person related to community services available to assist with ongoing care and service.

5e. Ensuring Use of Evidence Based Clinical Practice Guidelines

Clinical practice guidelines (CPGs) are developed and/or adopted to reduce variation in practice and improve the health status of members. Health Net, Inc. adopts nationally recognized, evidence-based clinical practice guidelines for medical and behavioral health conditions through the national Medical Advisory Council (MAC). Health Net Medical Directors and network practitioners are involved in the review and update process for clinical practice guidelines through MAC and Health Net Quality Improvement Committee (HNQIC). 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. MAC evaluates new technologies (medical and behavioral health), and devices 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 national 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. 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.

EXAMPLES:

- Annual Provider Audit: Prior to participating with Health Net, and at least annually thereafter, the Delegation Oversight team conducts an on-site review of each delegated medical group. Health Net uses the Dual Eligible SNP addendum of the Provider Delegation Assessment Tool (PDAT), to evaluate the provider's ability to deliver high-quality health care consistently and perform the necessary functions of the Dual Eligible SNP Model of Care. In addition, Delegation Oversight periodically reviews medical group specific data including complaints, access audit performance, member satisfaction results, and quality-of-care information. A member of the regional team assigned to oversee the medical group's activities conducts the evaluation. Based on the audit scores and findings, if certain thresholds and criteria are met, the Health Net Delegation Oversight Committee (DOC) may delegate certain specific functions to the PPG to perform. In addition, Delegation Oversight functions as a liaison between the health plan and the medical groups, providing education and support. The Delegation Oversight team reviews the following Dual Eligible SNP MOC functions during the on-site audit:

Staff Structure and Roles: group has the appropriate care management and administrative staff to coordinate needs of Duals members

Interdisciplinary Care Team and assignment

Provider Network: performance requirements, coordinating delivery of services

Policies and Procedures: all functions

Care Transitions: identifying transitions, managing transitions, reducing transitions

Model of Care training: staff training requirements, staff training strategies

Individualized Care Plan: including member participation

Case Management Systems and process

Integrated Communication Systems

Performance and Health Outcomes Measures: system to collect and analyze data to evaluate the Duals Model of Care

File review: initial assessment, individualized Care Plan, case management

- Provider Agreement - Medical groups that have the potential to meet the Model of Care requirements and interested in participating receive initial information on the goals, requirements and expectations of the Dual Eligible SNP program. If approved for delegation, an extensive provider agreement listing the details of the delegated functions and Model of Care requirements is sent to the medical group for signature. The delegation agreement includes a grid that delineates the specific responsibilities delegated to, and accepted by, the group. The Delegation Oversight team is instrumental in determining which groups are appropriate for the program. Health Net may revoke partial or complete delegation at any time if the committee determines that the group is no longer capable of performing delegated functions. The screen shot below is the section related to use of clinical practice guidelines.

Health Net

Participating Physician Group / Provider
Delineation of Delegated SNP Care Management Responsibilities

es	PPG Status Delegated (Yes) or Not Delegated (No)	Delegated Participating Physician Group's (PPG) Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating PPG's Performance	Corrective PPG Fails Respons
	☒ Yes ☐ No	PPG assures its providers deliver evidence-based services in accordance with nationally recognized clinical protocols and guidelines when available (see the Agency for Healthcare Research and Quality's National Guideline Clearinghouse at http://www.guideline.gov)	Annually: UM/SNP Program Description or P&Ps UM/SNP Workplan Semi-annually: UM/SNP Program Evaluation	• Written contract with PPG stipulates that contracted providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available	• Review UM/SNP Workplan/reports with written evaluation provided to PPG. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews	• Reques Correct Plan(s) elemen compli • Potenti revocat Care Manag delegat objecti achieve • Contin noncon may lea breach

ELEMENT 6. MODEL OF CARE TRAINING

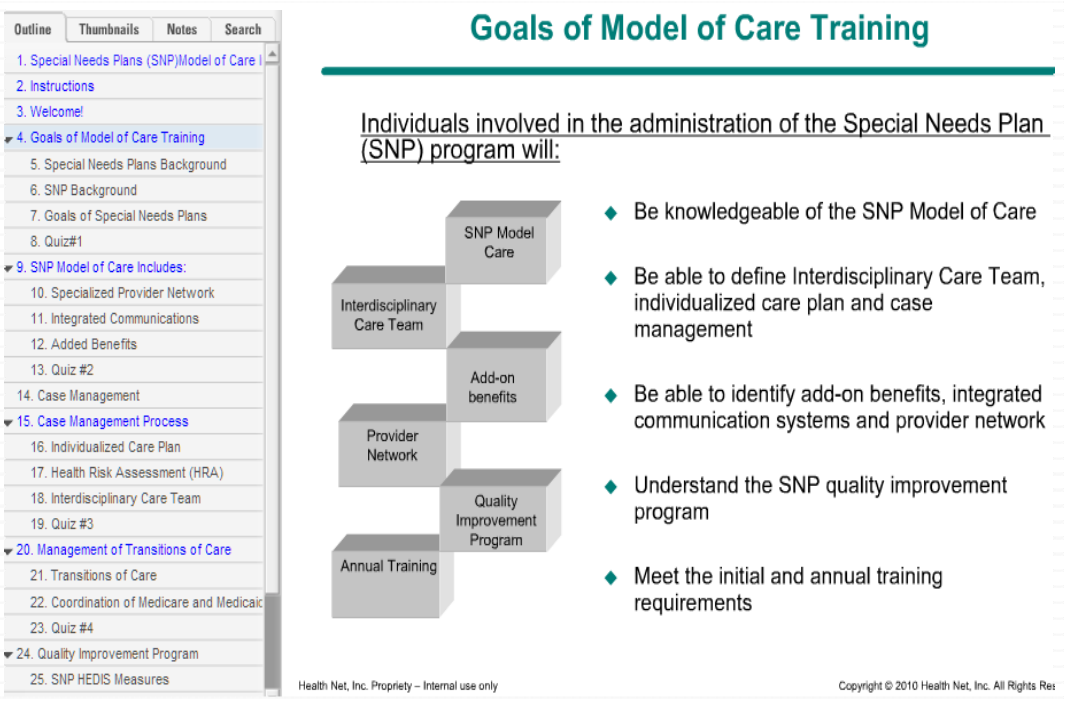
6a. Initial and Annual MOC Training

The goal of Health Net's training and education program is to equip employees with the knowledge they require to excel in their designated roles. Health Net maintains a sophisticated web-based tracking program for initial and annual staff training and orientation that can be customized to the level of the employee and the applicable regulations for their individual position. Optional modules such as enhancing computer skills are also available. Employees manage their requirements training online and receive reminders when annual or additional training is required.

Provider training on the Dual Eligible SNP Model of Care is offered through multiple learning environments. Online, providers have access to training, information and policies on the Dual Eligible SNP program through the Provider Manual and portal. Providers are notified of changes and regulatory revisions through ongoing online news articles and faxed provider updates. In-person presentations on the Dual Eligible SNP Model of Care can be conducted for medical groups interested in becoming delegated providers for the Dual Eligible SNP program. Health Net also provides a series of Dual Eligible SNP educational teleconferences for interested or delegated medical groups.

EXAMPLES:

Screenshot of Table of Contents and sample slide of Health Net associate LMS Dual Eligible SNP training.


Outline
Thumbnails
Notes
Search
1. Special Needs Plans (SNP)Model of Care
2. Instructions
3. Welcome!
4. Goals of Model of Care Training
5. Special Needs Plans Background
6. SNP Background
7. Goals of Special Needs Plans
8. Quiz#1
9. SNP Model of Care Includes:
10. Specialized Provider Network
11. Integrated Communications
12. Added Benefits
13. Quiz #2
14. Case Management
15. Case Management Process
16. Individualized Care Plan
17. Health Risk Assessment (HRA)
18. Interdisciplinary Care Team
19. Quiz #3
20. Management of Transitions of Care
21. Transitions of Care
22. Coordination of Medicare and Medicaid
23. Quiz #4
24. Quality Improvement Program
25. SNP HEDIS Measures
Goals of Model of Care Training
Individuals involved in the administration of the Special Needs Plan (SNP) program will:
SNP Model Care
Interdisciplinary Care Team
Add-on benefits
Provider Network
Quality Improvement Program
Annual Training
Be knowledgeable of the SNP Model of Care
Be able to define Interdisciplinary Care Team, individualized care plan and case management
Be able to identify add-on benefits, integrated communication systems and provider network
Understand the SNP quality improvement program
Meet the initial and annual training requirements
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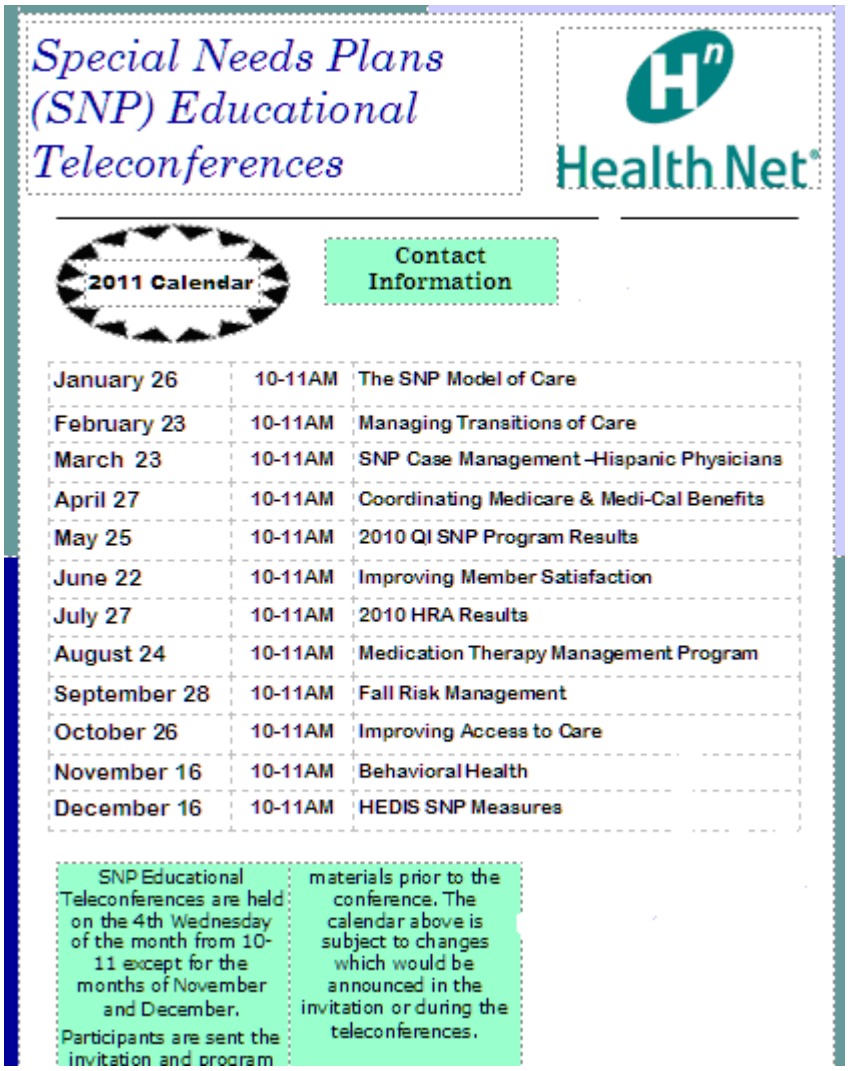
- 2011 Calendar for SNP Provider Teleconferences:



Special Needs Plans (SNP) Educational Teleconferences

Health Net®

2011 Calendar

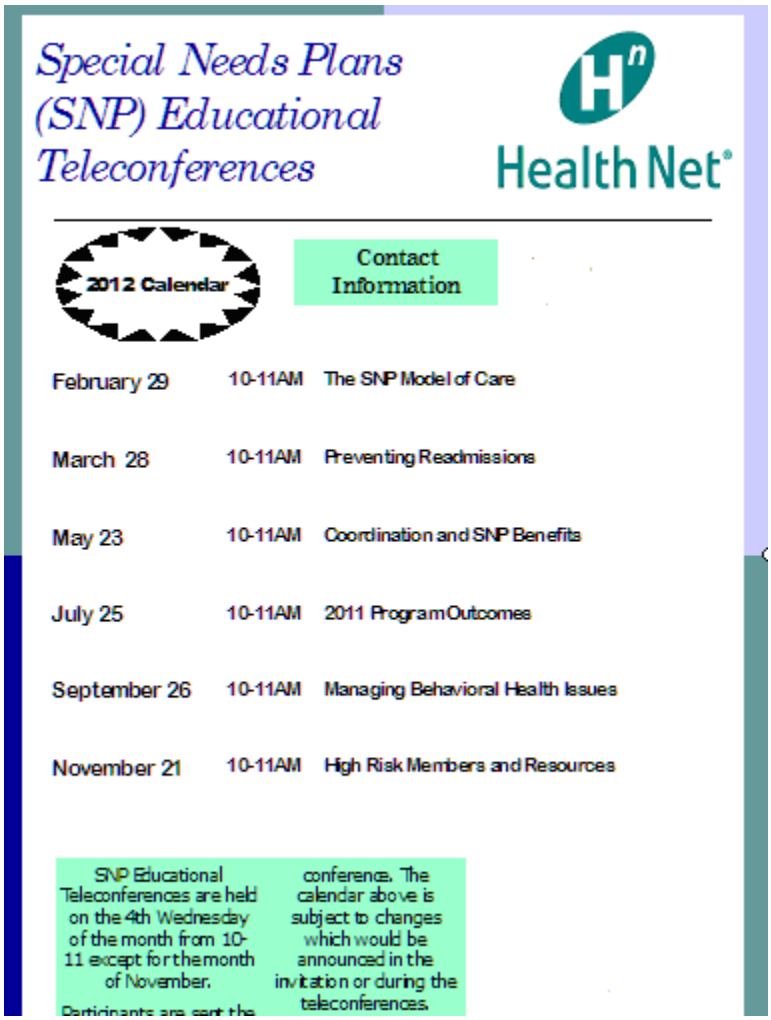
Contact Information

January 26	10-11AM	The SNP Model of Care
February 23	10-11AM	Managing Transitions of Care
March 23	10-11AM	SNP Case Management –Hispanic Physicians
April 27	10-11AM	Coordinating Medicare & Medi-Cal Benefits
May 25	10-11AM	2010 QI SNP Program Results
June 22	10-11AM	Improving Member Satisfaction
July 27	10-11AM	2010 HRA Results
August 24	10-11AM	Medication Therapy Management Program
September 28	10-11AM	Fall Risk Management
October 26	10-11AM	Improving Access to Care
November 16	10-11AM	Behavioral Health
December 16	10-11AM	HEDIS SNP Measures

SNP Educational Teleconferences are held on the 4th Wednesday of the month from 10-11 except for the months of November and December.

Participants are sent the invitation and program materials prior to the conference. The calendar above is subject to changes which would be announced in the invitation or during the teleconferences.

- 2012 Calendar for SNP Provider Teleconferences



Special Needs Plans (SNP) Educational Teleconferences

Health Net

2012 Calendar

Contact Information

February 29	10-11AM	The SNP Model of Care
March 28	10-11AM	Preventing Readmissions
May 23	10-11AM	Coordination and SNP Benefits
July 25	10-11AM	2011 Program Outcomes
September 26	10-11AM	Managing Behavioral Health Issues
November 21	10-11AM	High Risk Members and Resources

SNP Educational Teleconferences are held on the 4th Wednesday of the month from 10-11 except for the month of November.

Participants are sent the conference. The calendar above is subject to changes which would be announced in the invitation or during the teleconferences.

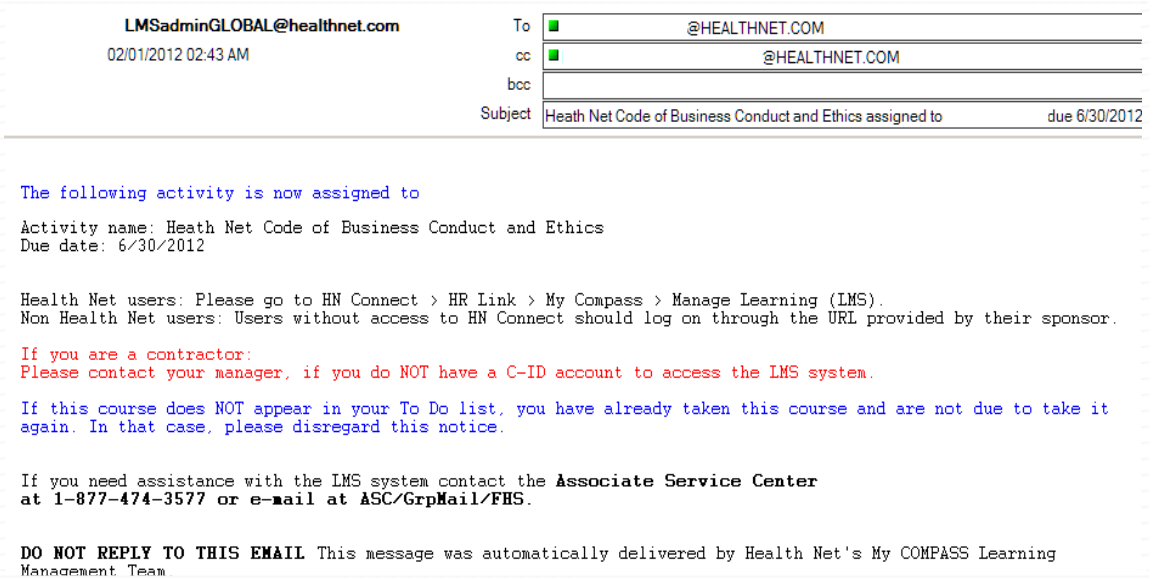
6b. Ensuring Completion of Training

Completion of required training modules is an annual compliance goal for every Health Net employee. It is a required element included in all employee's annual performance evaluations, including senior executive leadership. An amount earmarked in the Management Incentive Plan for Managers, Directors, Vice Presidents and Chief Officers is not earned if their direct reports do not complete required training. Disciplinary action may be initiated by a Manager if associates fail to complete required training.

The Delegation Oversight team reviews the MOC functions during the annual on-site audit including MOC training. Groups that have not completed the training receive a corrective action plan and are at risk of de-delegation if training standards are not met.

EXAMPLES:

- Screenshot of e-mail sent to remind associates of required training that is due.



LMSadminGLOBAL@healthnet.com
02/01/2012 02:43 AM

To @HEALTHNET.COM
cc @HEALTHNET.COM
bcc
Subject Heath Net Code of Business Conduct and Ethics assigned to due 6/30/2012

The following activity is now assigned to

Activity name: Heath Net Code of Business Conduct and Ethics
Due date: 6/30/2012

Health Net users: Please go to HN Connect > HR Link > My Compass > Manage Learning (LMS).
Non Health Net users: Users without access to HN Connect should log on through the URL provided by their sponsor.

If you are a contractor:
Please contact your manager, if you do NOT have a C-ID account to access the LMS system.

If this course does NOT appear in your To Do list, you have already taken this course and are not due to take it again. In that case, please disregard this notice.

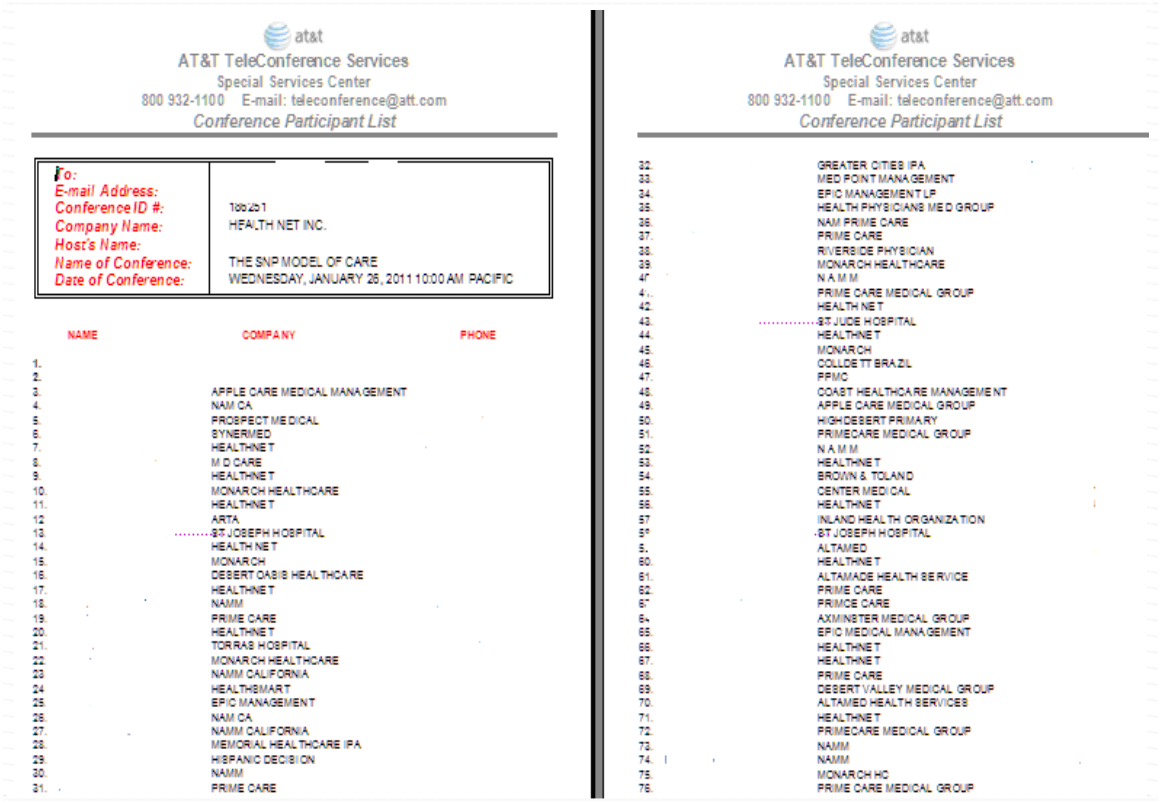
If you need assistance with the LMS system contact the **Associate Service Center at 1-877-474-3577 or e-mail at ASC/GrpMail/FHS.**

DO NOT REPLY TO THIS EMAIL This message was automatically delivered by Health Net's My COMPASS Learning Management Team

See bottom row of example below for training transcript for Special Needs Plans and expiration date.

Activity	Start Date	Completion Date	Expiration Date	Score
Course: Health Net Code of Business Conduct and Ethics	11/17/2011	11/17/2011	11/16/2012	92
Course: The Painful Price of Healthcare Fraud	11/10/2011	11/10/2011	11/9/2012	
Course: Cultural Competency-Heritage Day Training	8/31/2011	8/31/2011	8/30/2012	100
Course: Medicare Compliance Material Developer Training Overview	8/1/2011	8/1/2011	7/31/2012	100
Course: Ergonomics - Remedy Interactive	7/14/2011	7/14/2011		100
Course: HIPAA: An Overview	6/16/2011	6/16/2011		97.67
Course: Pharmaceutical Fraud, Waste and Abuse_Retired Course	5/26/2011	5/26/2011		100
Course: Records and Information Management Training Module	5/25/2011	5/25/2011	5/24/2012	100
Course: Medicare General Compliance Training	5/25/2011	5/25/2011	5/24/2012	91
Course: Escalation Process Training	5/20/2011	5/20/2011	5/19/2012	
Course: Special Needs Plans Training	1/24/2011	3/14/2011	3/13/2012	

▪ Attendee list for Provider teleconference on SNP Model of Care training on 1/26/11, for which there were 89 attendees.



at&t
AT&T TeleConference Services
Special Services Center
800 932-1100 E-mail: teleconference@att.com
Conference Participant List

To:	
E-mail Address:	
Conference ID #:	1662451
Company Name:	HEALTH NET INC.
Host's Name:	
Name of Conference:	THE SNP MODEL OF CARE
Date of Conference:	WEDNESDAY, JANUARY 26, 2011 10:00 AM PACIFIC

	NAME	COMPANY	PHONE
1.			
2.			
3.		APPLE CARE MEDICAL MANAGEMENT	
4.		NAM CA	
5.		PROSPECT MEDICAL	
6.		SYNERMED	
7.		HEALTHNET	
8.		M D CARE	
9.		HEALTHNET	
10.		MONARCH HEALTHCARE	
11.		HEALTHNET	
12.		ARTA	
13.		ST JOSEPH HOSPITAL	
14.		HEALTH NET	
15.		MONARCH	
16.		DESERT OASIS HEALTHCARE	
17.		HEALTHNET	
18.		NAMM	
19.		PRIME CARE	
20.		HEALTHNET	
21.		TORRAS HOSPITAL	
22.		MONARCH HEALTHCARE	
23		NAMM CALIFORNIA	
24		HEALTHMART	
25.		EPIC MANAGEMENT	
26.		NAM CA	
27.		NAMM CALIFORNIA	
28.		MEMORIAL HEALTHCARE IPA	
29.		HISPANIC DECISION	
30.		NAMM	
31.		PRIME CARE	

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Conference Participant List

32.	GREATER CITIES IPA
33.	MED POINT MANAGEMENT
34.	EPIC MANAGEMENT LP
35.	HEALTH PHYSICIANS MED GROUP
36.	NAM PRIME CARE
37.	PRIME CARE
38.	RIVERSIDE PHYSICIAN
39.	MONARCH HEALTHCARE
40	N A M M
41.	PRIME CARE MEDICAL GROUP
42.	HEALTH NET
43.	ST JUDE HOSPITAL
44.	HEALTHNET
45.	MONARCH
46.	COLLDETT BRAZIL
47.	PPMC
48.	COAST HEALTHCARE MANAGEMENT
49.	APPLE CARE MEDICAL GROUP
50.	HIGHDESERT PRIMARY
51.	PRIMECARE MEDICAL GROUP
52.	N A M M
53.	HEALTHNET
54.	BROWN & TOLAND
55.	CENTER MEDICAL
56.	HEALTHNET
57	INLAND HEALTH ORGANIZATION
58	ST JOSEPH HOSPITAL
59.	ALTAMED
60.	HEALTHNET
61.	ALTAMADE HEALTH SERVICE
62.	PRIME CARE
63	PRIMCE CARE
64.	AXMINSTER MEDICAL GROUP
65.	EPIC MEDICAL MANAGEMENT
66.	HEALTHNET
67.	HEALTHNET
68.	PRIME CARE
69.	DESERT VALLEY MEDICAL GROUP
70.	ALTAMED HEALTH SERVICES
71.	HEALTHNET
72.	PRIMECARE MEDICAL GROUP
73.	NAMM
74.	NAMM
75.	MONARCH HC
76.	PRIME CARE MEDICAL GROUP

6c. Personnel Responsible for Oversight of Training

The Dual Eligible SNP Governance Committee, Medicare Oversight Committee, Medicare Compliance and the appropriate department Directors, Managers, and Supervisors are responsible for oversight of the Dual Eligible SNP Model of Care training for their respective departments. In addition to monitoring employee completion of the initial and annual training requirements, they are responsible to provide training on individual responsibilities related to the implementation of department specific components of the Dual Eligible SNP Model of Care. This training may be offered in a classroom, teleconference, or self-study environment as appropriate.

The QI Manager of the Dual Eligible SNP Program along with key personnel from Case Management, Concurrent Review, Medicare Products, Human Resources, Provider Communications, Delegation Oversight, Appeals and Grievances, Claims, Member Services and others worked together to develop and/or conduct training. The QI Manager has 4 years of experience with the SNP Program and related CMS and NCQA regulations and standards. She has attended multiple SNP related NCQA and CMS conferences and teleconferences and also coordinates the Dual Eligible SNP Governance Committee meetings.

EXAMPLES:

- *Job Description Responsibilities/Qualifications of the Dual Eligible SNP QI Manager:*

The Quality Improvement Program Manager will evaluate program requirements and develop a quality program implementation strategy within Medical Management. This position oversees consistent program implementation among multiple Health Net departments, regions and delegated provider groups as needed to meet regulatory requirements, quality improvement accreditation standards and related government contractual obligations.

Duties: Designs and implements quality improvement projects to address government contract requirements. Works with appropriate business units such as case management, care transitions, delegation oversight and UM to define and lead ad-hoc teams necessary for implementing program(s). Designs and administers clinical program training across impacted regions and departments. Provides direction for the creation of new product lines (within clinical program) which require unique team-based care and assures that specific state and government regulations per the program are adhered to based on the those specificities. Manages program/project budget. Collaborates with data managers and systems managers to design and implement health outcome measurement, monitoring and reporting of program performance. Oversees the dissemination of member information reports to internal and external clients. Coordinates the collection of data as well as the maintenance and analysis of all program evaluation components. Participates in the development, implementation, and evaluation of an annual strategic plan. Manages vendor relationships. Performs other related duties as assigned.

Qualifications: Bachelor's Degree in Nursing or Master's Degree in health related field. RN preferred. *Experience:* Five years healthcare experience, including two to three years in a health plan role leading in the assessment, design and delivery of integrated health initiatives. Prior experience in technical or clinical writing, analysis and project management preferred.

6d. Actions Taken if Training Not Completed

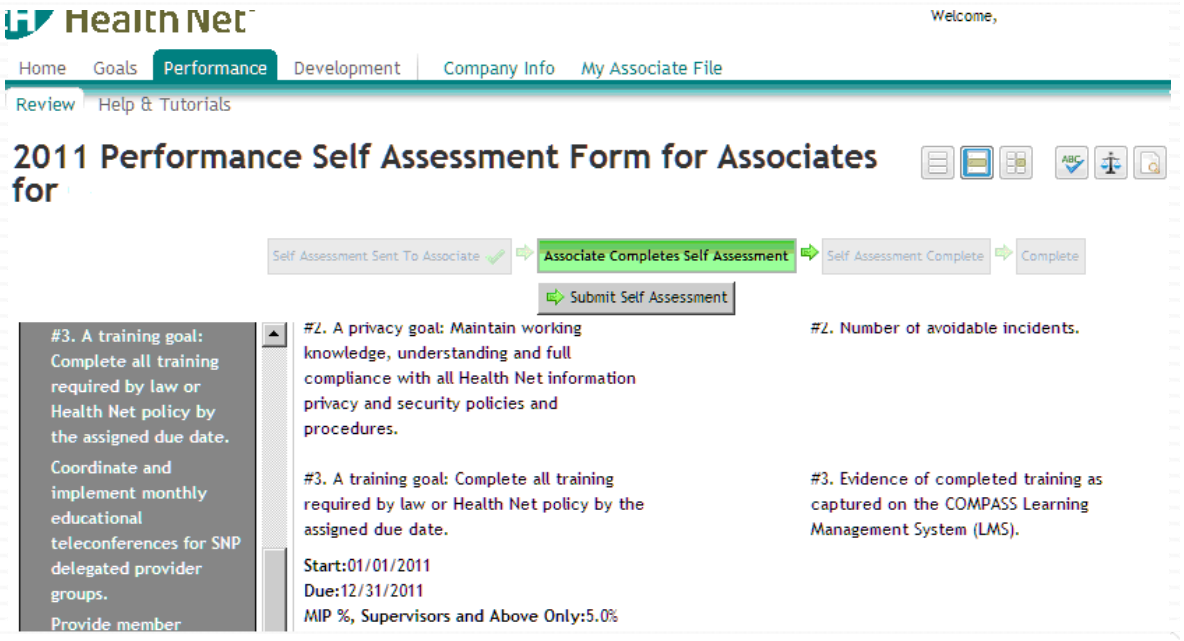
Associates will not receive annual increases if their required training is not completed. In addition, to further ensure compliance, the Management Incentive Plan for Managers, Directors, Vice Presidents and Chief Officers is affected if their direct reports do not complete required training. Disciplinary action up to and including termination can be initiated if associates fail to complete required training.

- Beginning in 2011, initial and annual training on the Dual Eligible SNP Model of Care has been incorporated into Health Net's web-based Learning Management System (LMS) for efficiency and tracking purposes. The human resource department manages the LMS system and maintains the list of associates as required by their managers to complete Dual Eligible SNP MOC training. The LMS system automatically creates an electronic training record documenting the associates who have completed the training and the date

completed. In addition to maintaining the associate's individual training record and providing a web-based attendance confirmation, the LMS system notifies the associate and their manager electronically when the training is due or overdue. The Dual Eligible SNP teleconferences and presentations are recorded and posted for medical groups to share with staff unable to attend.

EXAMPLES:

- Screenshot from Health Net Associate annual performance evaluation with section showing all required training to be completed. This is on all Health Net performance evaluations.



- Example of Annual Provider Audit showing section where SNP Training is evaluated and completed:

Element: SNP 2E LOB: Z	100% Score Type: Check Boxes	80%	50%	2
SNP 2E: Informing and Educating Staff/Providers The PPG has staff (employed, contracted, or non-contracted) trained on the SNP MODEL OF CARE to include instructions on how to use services and how the PPG works with a practitioner's patients in the program and process to take action if training is not completed. [_] All employees have initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations. [_] All network/contracted providers have initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations. [_] All temporary non-contracted staff has initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations. Source: CMS Model of Care and Quality Improvement Training 5/27/09, slide 36; NCQA 2011 SNP 1: Complex Case Management (eff 11/20/10)	3 There is evidence that all 3 staff categories have been trained	2 There is evidence that 2 staff categories have been trained	No Scoring Option	1 T e 1 c t

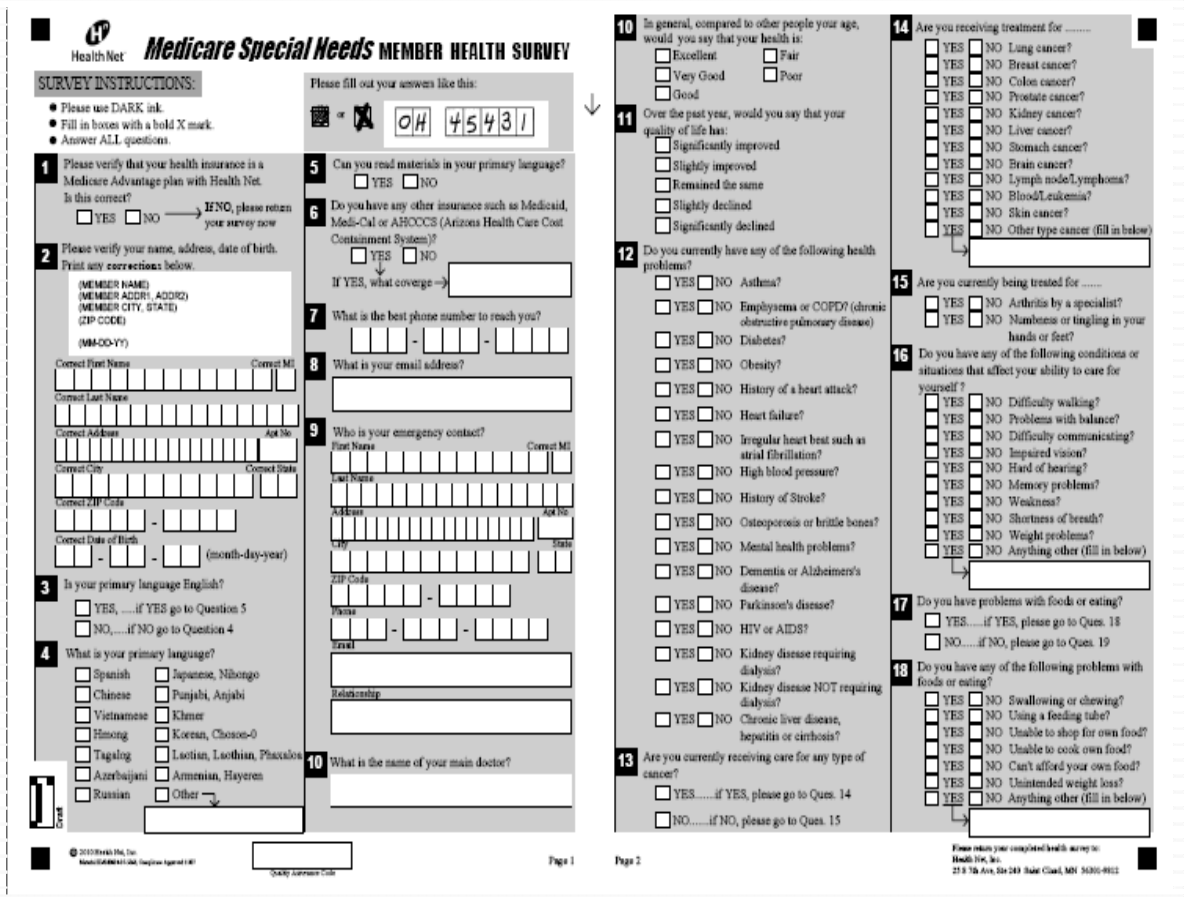
ELEMENT 7. HEALTH RISK ASSESSMENT

7a. HRA Tool

Health Net conducts an initial health assessment and annual reassessment of each Dual Eligible SNP member's medical and mental health history, psychosocial, functional and cognitive and LTSS needs. The results are evaluated by the Interdisciplinary Care Team to develop or update the member's individualized Care Plan. The assessment is primarily performed by telephone or mail and is available in threshold languages.

EXAMPLES:

Sample of HRA mailed to members if they are not reached by phone. Examples of questions from the HRA that identify risks or special needs of the population targeted by Health Net's Dual Eligible SNP program are: "What is your primary language, if not English". "Do you currently have any of the following health problems? (list of 18 common diseases such as diabetes, COPD, heart failure)" Do you have any of the following conditions or situations that affect your ability to care for yourself? (list of 9 functional disabilities such as problems with walking, balance, shortness of breath)" "During the past month, have you often been bothered by feeling down, depressed or hopeless?"



Health Net **Medicare Special Needs MEMBER HEALTH SURVEY**

SURVEY INSTRUCTIONS:
- Please use DARK ink.
- Fill in boxes with a bold X mark.
- Answer ALL questions.

Please fill out your answers like this: ■ or ☒ OH 45431

1 Please verify that your health insurance is a Medicare Advantage plan with Health Net. Is this correct? ☐ YES ☐ NO → IF NO, please return your survey now

2 Please verify your name, address, date of birth. Print any corrections below.
(MEMBER NAME)
(MEMBER ADDR1, ADDR2)
(MEMBER CITY, STATE)
(ZIP CODE)
(MM-DD-YY)
Correct First Name | Correct MI
Correct Last Name
Correct Address | Apt No
Correct City | Correct State
Correct ZIP Code
Correct Date of Birth (month-day-year)

3 Is your primary language English?
☐ YES, ...if YES go to Question 5
☐ NO,.....if NO go to Question 4

4 What is your primary language?
☐ Spanish ☐ Japanese, Nihongo
☐ Chinese ☐ Punjabi, Anjabi
☐ Vietnamese ☐ Khmer
☐ Hmong ☐ Korean, Chosoe-O
☐ Tagalog ☐ Laotian, Laothian, Phasalos
☐ Azerbaijani ☐ Armenian, Hayeren
☐ Russian ☐ Other →

5 Can you read materials in your primary language? ☐ YES ☐ NO

6 Do you have any other insurance such as Medicaid, Medi-Cal or AHCCCS (Arizona Health Care Cost Containment System)? ☐ YES ☐ NO
If YES, what coverage →

7 What is the best phone number to reach you? ( ) - -

8 What is your email address?

9 Who is your emergency contact?
First Name | Correct MI
Last Name
Address | Apt No
City | State
ZIP Code
Phone ( ) - -
Email
Relationship

10 What is the name of your main doctor?

Grant

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Page 1

Quality Assurance Code

10 In general, compared to other people your age, would you say that your health is:
☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

11 Over the past year, would you say that your quality of life has:
☐ Significantly improved
☐ Slightly improved
☐ Remained the same
☐ Slightly declined
☐ Significantly declined

12 Do you currently have any of the following health problems?
☐ YES ☐ NO Asthma?
☐ YES ☐ NO Emphysema or COPD? (chronic obstructive pulmonary disease)
☐ YES ☐ NO Diabetes?
☐ YES ☐ NO Obesity?
☐ YES ☐ NO History of a heart attack?
☐ YES ☐ NO Heart failure?
☐ YES ☐ NO Irregular heart beat such as atrial fibrillation?
☐ YES ☐ NO High blood pressure?
☐ YES ☐ NO History of Stroke?
☐ YES ☐ NO Osteoporosis or brittle bones?
☐ YES ☐ NO Mental health problems?
☐ YES ☐ NO Dementia or Alzheimer's disease?
☐ YES ☐ NO Parkinson's disease?
☐ YES ☐ NO HIV or AIDS?
☐ YES ☐ NO Kidney disease requiring dialysis?
☐ YES ☐ NO Kidney disease NOT requiring dialysis?
☐ YES ☐ NO Chronic liver disease, hepatitis or cirrhosis?

13 Are you currently receiving care for any type of cancer?
☐ YES.....if YES, please go to Ques. 14
☐ NO.....if NO, please go to Ques. 15

Page 2

14 Are you receiving treatment for .....
☐ YES ☐ NO Lung cancer?
☐ YES ☐ NO Breast cancer?
☐ YES ☐ NO Colon cancer?
☐ YES ☐ NO Prostate cancer?
☐ YES ☐ NO Kidney cancer?
☐ YES ☐ NO Liver cancer?
☐ YES ☐ NO Stomach cancer?
☐ YES ☐ NO Brain cancer?
☐ YES ☐ NO Lymph node/Lymphoma?
☐ YES ☐ NO Blood/Leukemia?
☐ YES ☐ NO Skin cancer?
☐ YES ☐ NO Other type cancer (fill in below)

15 Are you currently being treated for .....
☐ YES ☐ NO Arthritis by a specialist?
☐ YES ☐ NO Numbness or tingling in your hands or feet?

16 Do you have any of the following conditions or situations that affect your ability to care for yourself ?
☐ YES ☐ NO Difficulty walking?
☐ YES ☐ NO Problems with balance?
☐ YES ☐ NO Difficulty communicating?
☐ YES ☐ NO Impaired vision?
☐ YES ☐ NO Hard of hearing?
☐ YES ☐ NO Memory problems?
☐ YES ☐ NO Weakness?
☐ YES ☐ NO Shortness of breath?
☐ YES ☐ NO Weight problems?
☐ YES ☐ NO Anything other (fill in below)

17 Do you have problems with foods or eating?
☐ YES.....if YES, please go to Ques. 18
☐ NO.....if NO, please go to Ques. 19

18 Do you have any of the following problems with foods or eating?
☐ YES ☐ NO Swallowing or chewing?
☐ YES ☐ NO Using a feeding tube?
☐ YES ☐ NO Unable to shop for own food?
☐ YES ☐ NO Unable to cook own food?
☐ YES ☐ NO Can't afford your own food?
☐ YES ☐ NO Unintended weight loss?
☐ YES ☐ NO Anything other (fill in below)

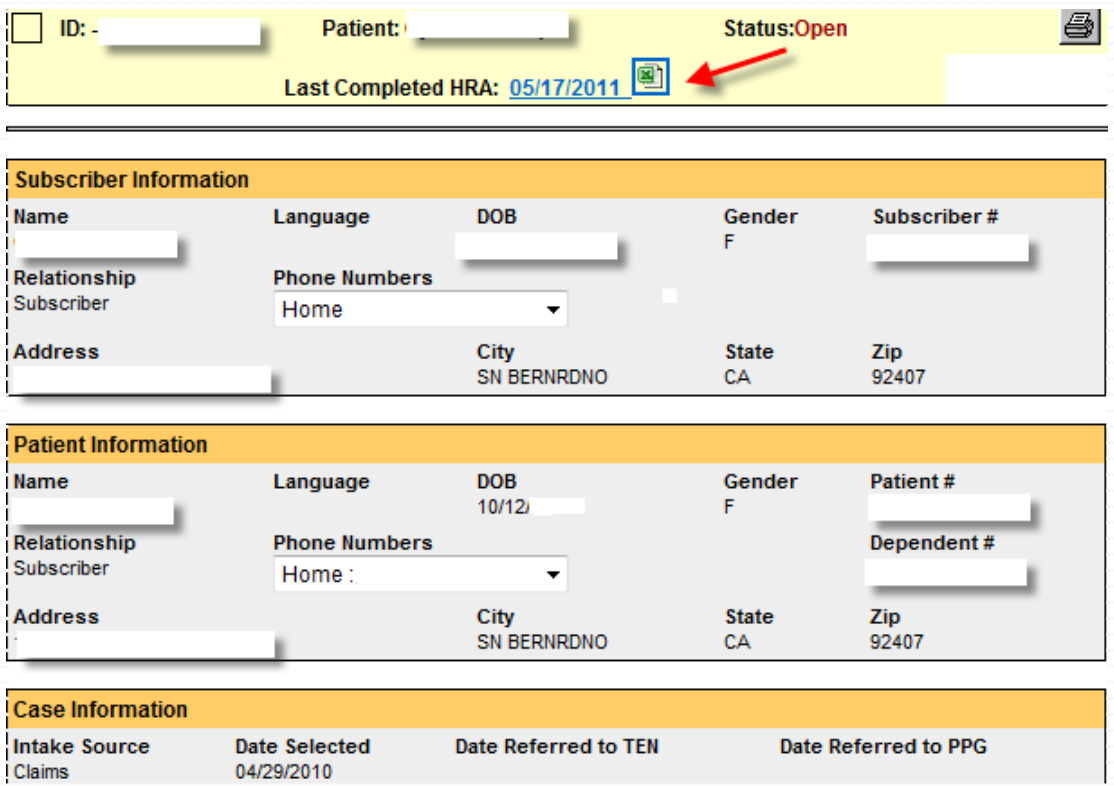
Please return your completed health survey to:
Health Net, Inc.
25 B Vly Ave, Ste 240 Saint Cloud, MN 56301-9012

7b. How HRA is Conducted:

Telephonic outreach to complete the Health Risk Assessment (HRA) with new Dual Eligible SNP members occurs within the required number of days of member enrollment. The department performing the outreach is staffed with multilingual associates and also has access to language line services. If the member was not reached after multiple attempts, the Health Risk Assessment is mailed. A postage paid return envelope is provided to assist with returning the information. The same process is followed for established Dual Eligible SNP members to complete the reassessment HRA within 12 months of the last risk assessment.
Health Net provides medical groups delegated for Dual Eligible SNP with member information and respective responses to the assessment via the designated and secure provider portal.

EXAMPLES:

Screenshot of provider portal showing icon for most recent member HRA



7c. Personnel Reviewing /Analyzing/Stratifying HRA

Information/data is collected from the Hierarchical Condition Codes (HCC), Risk Adjustment Factor (RAF) data and Health Risk Assessment, if available, to initially stratify members into appropriate risk level based on chronic conditions and inpatient utilization for members receiving internal case management. The initial stratification is performed by data analysts based on the numerical score derived from the member HCC, RAF and HRA responses if available. After the initial stratification, the personnel who review, analyze and assign the definitive stratification are registered and licensed nurses experienced in the principles of case management, the member's licensed Primary Care Providers, licensed clinical social workers and licensed behavioral health care providers.

EXAMPLES:

- *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 disease 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 disease management programs. Oversees disease 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 disease management programs. Analyzes and proposes system changes or enhancements to improve trending analysis for disease management programs, health care cost reporting and medical management. Provides population based analysis to determine needs for future disease management programs. Coordinates the exchange of information between profiling data and disease 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.

7d. Communication of the HRA

The member's HRA responses and risks are communicated by Case Managers during IDCT meetings and through documentation in the electronic medical management system for internally managed members. 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 IDCT, uses these guidelines to evaluate members for development of the individualized Care Plan:

- 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 add-on services and benefits and incorporation into the individualized Care Plan.

Documentation of Care Plan, interventions, implementation notes and ongoing evaluation is documented in the electronic medical management system. Health Net maintains a provider portal at www.healthnet.com. Use of the provider portal is optional but encouraged; however, delegated Dual Eligible SNP providers are required to register on the portal. An additional web tool on the portal for groups delegated for Dual Eligible SNP links providers to timely and secure information on Dual Eligible SNP members. Delegated groups receive training on this portal feature that allows them to receive the monthly demographic and medical information on new Dual Eligible SNP members and the results of initial and annual health risk assessment.

EXAMPLES:

Screenshot of Provider Portal feature showing member's HRA results:

Patient Name	DOB	SubscriberID
[redacted]	[redacted]	

Physician	HRA Completed Date
- [redacted]	5/17/2011

Question	Answer
1. Please verify that your health insurance is a Medicare Advantage plan with Health Net?	Y
2. Responder:	M
3. Primary language English?	Y
4. Primary lang:	-
5. Read materials:	Y
6. Other Coverage?	N
7. Name, address and date of birth?	Y
8. Phone:	Y
9. Email:	N
10. Emergency contact:	Y
11. Primary Phys:	Y
12. General health:	Fair
13. Quality of life:	Slightly declined
14. Asthma?	N
15. Emphysema or COPD?	N
16. Diabetes?	N
17. Obesity?	N
18. History of a heart attack?	N
19. Heart failure?	N
20. Irregular heart beat?	N
21. High blood pressure?	Y
22. History of stroke?	N
23. Osteoporosis?	N
24. Mental health problems?	Y

ELEMENT 8. INDIVIDUALIZED CARE PLAN

8a. Personnel Developing the Care Plan

Health Net's Case Management program utilizes a collaborative multidisciplinary approach that is client-focused, interactive, and goal-directed in the development, implementation and monitoring of the case management plan of care. The Care/Case Manager works collaboratively with the IDCT, member/caregiver and the member's provider(s) to develop an individual documented plan of care incorporating information from the HRA, member assessment and other sources.

The Care/Case Manager identifies specific individual problems or concerns, in collaboration with the IDCT, to establish a Care Plan that meets the member's needs. Each problem is documented with a problem statement in the medical management system and has at least one goal and one intervention.

After identifying the member/caregiver problems and concerns, the Care/Case Manager collaborates with the member and the IDCT care team to establish short and long-term goals. Short-term goals address acute and immediate clinical, psychosocial and financial needs. Long-term goals delineate activities to sustain health improvements and optimal health status, or provide optimal support at the end of life. Evidence-based clinical guidelines (i.e.: Milliman Chronic Care Guidelines) are utilized to achieve clinically appropriate goals. All care team members agree with the goal, understand their role and are committed to achieving it.

The identified problems drive interventions and goal statements and facilitate member/caregiver participation. Goals are directed to improve health status and prevent/reduce transitions of care through improved independence and self-management, mobility and functional status, pain and symptom management, quality of life perception and satisfaction with health status and healthcare services. Goals are **SMART**, measurable, aligned and directly linked to the problems:

- **S**pecific: clear with target result to be achieved
- **M**easurable: includes quantifiable criteria of how the result will be measured such as quantity, frequency, time period, etc
- **A**chievable: realistic, clinically appropriate, and credible (Care/Case Manager, Medical Director, member or provider is confident that he/she has the ability to attain the goal)
- **R**esults-oriented: stated in terms of an outcome that must be achieved and requires focused interventions and effort
- **T**ime-bound: includes specific deadline by which the goal must be achieved that focuses attention and effort on achieving the goal results

EXAMPLES:

- Case Study: Details have been summarized to ensure privacy

This is an elderly member with multiple chronic diseases such as coronary artery disease, pulmonary disease and diabetes. Member could not be reached by phone or mail and Case Manager finally located member through Social Worker. Inconsistent follow-up with primary provider and specialists as well as noncompliance with discharge instructions and medication regimen resulted in multiple hospitalizations and SNF admissions despite involvement of Home Health.
HN Case Manager collaborated with the Long Term Care Case Manager for appropriate discharge plan. Member wanted to go home to family but family unable to provide care. HN Case Manager arranged patient care conference with SNF Social Worker prior to discharge from SNF with Long Term Care Case Manager, Utilization Review Nurse, Health Net Social Worker, Health Net Case Manager, member and family. All attended IDCT except family. The member still preferred to return to home. A second care conference was coordinated with the same team members but discharge was delayed due to unstable medical condition.
Case Manager continued coordination with facility Social Worker and Long Term Care Case Manager. Member finally agreed discharge to assisted living situation was best where consistent assistance with ambulation, meals, medication, monitoring, socialization, and breathing treatments could be obtained. Result has been a dramatic decrease in emergency room use and hospitalizations.

8b. Elements Incorporated into the Care Plan

Once the problems, goals and interventions are established, agreement is reached with the member and the care team to implement the Care Plan. The Care Plan and its approval are documented in the member's record:

- Names of the multidisciplinary care team currently involved in the member's care, including specialty
- Physical care needs – what care the member is receiving and what else may be needed such as home health care, home infusion, specialty services, etc.
- Equipment and supplies – the services in place or being requested, appropriateness to the member's needs, are they being provided by a participating provider
- Caregivers and other sources of social support that provide physical, emotional, and spiritual assistance
- Alternative benefits or financial resources the member has access to or requires to meet his/her needs

- Available community resources including State, County and Community resources – what resources is the member accessing now, if any; what might he/she need for additional support such as meals assistance, transportation services, etc.
- Member's healthcare preferences and prioritization of goals.
- Intervention prioritization – defines long and short-term goals with target dates for completion

Each problem and goal(s) will have associated interventions required to achieve the goal. The Care/Case Manager will document the specific type of intervention, date established and the date completed. Interventions can be completed when established or scheduled for a follow-up date. Interventions are based on appropriateness, availability, and accessibility of medical, psychosocial and financial resources. The following will be documented:

- Interventions provided for the member to achieve specific goals
- Referrals to other programs (internal and external)
- Skills training interventions structured with incremental time frames as appropriate to achieve educational and self-management goals
- Discharge interventions established to target optimal health condition and prevent re-admissions
- Development and communication of self-management plan to the member, their caregiver and/or his family
- The priority of the interventions based on the urgency of the problem or issue, and what is important to the member and/or family/representative
- The schedule for follow up and communication with the member and/or representative based on the member's acuity level and clinical judgment of the Care/Case Manager.

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

When a member has multiple conditions and/or providers, the Care/Case Manager has a key role in coordinating the member's care and providing continuity. The Care/Case Manager's established relationship and rapport with the member and/or caregivers and provider(s) help facilitate care coordination and opportunities for the Care/Case Manager to identify, develop and recommend alternative treatment services.

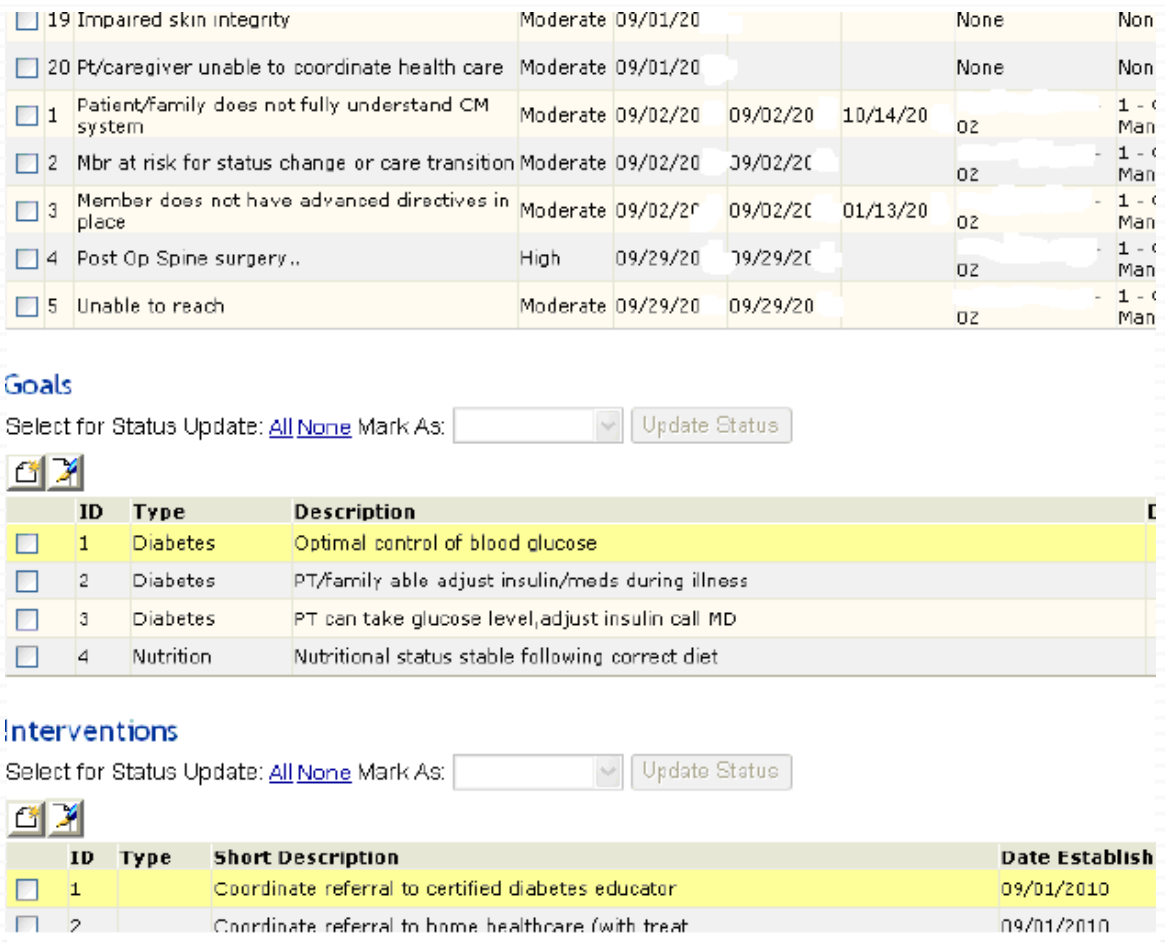
Working with the member and/or caregivers and the multidisciplinary care team, the Care/Case Manager implements the activities and interventions in the Care Plan. The Care/Case Manager ensures that the Care Plan contains services and interventions that are consistent with the

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. In addition:

- The Care Plan addresses the effectiveness of the treatment plan and includes interventions to address any specific treatment plan related issues
- Referrals are made to available contracted service providers, vendors, Health Net programs or resources, as appropriate. These may include a referral to disease management or Behavioral Health providers
- Referrals are made to any appropriate community resources such as disease specific or other support groups and resources, and when appropriate, programs that provide assistance with non-covered services
- If the member is on a benefit plan allowing the use of non-participating providers, the Care/Case Manager provides information to the member and provider on member out-of-pocket-costs when using a non-participating instead of a participating provider
- If the member is on an HMO plan and contracted providers are not available the Care/Case Manager works with the medical director to determine if non-contracted providers should be approved
- The Care Plan includes interventions, which support the functions of service coordination and monitoring

EXAMPLE:

Screenshot of member Care Plan with problems, goals, interventions



☐	19	Impaired skin integrity	Moderate	09/01/20			None	Non
☐	20	Pt/caregiver unable to coordinate health care	Moderate	09/01/20			None	Non
☐	1	Patient/family does not fully understand CM system	Moderate	09/02/20	09/02/20	10/14/20	02	1 - Man
☐	2	Mbr at risk for status change or care transition	Moderate	09/02/20	09/02/20		02	1 - Man
☐	3	Member does not have advanced directives in place	Moderate	09/02/20	09/02/20	01/13/20	02	1 - Man
☐	4	Post Op Spine surgery..	High	09/29/20	09/29/20		02	1 - Man
☐	5	Unable to reach	Moderate	09/29/20	09/29/20		02	1 - Man

Goals

Select for Status Update: All None Mark As: Update Status

	ID	Type	Description
☐	1	Diabetes	Optimal control of blood glucose
☐	2	Diabetes	PT/family able adjust insulin/meds during illness
☐	3	Diabetes	PT can take glucose level,adjust insulin call MD
☐	4	Nutrition	Nutritional status stable following correct diet

Interventions

Select for Status Update: All None Mark As: Update Status

	ID	Type	Short Description	Date Establish
☐	1		Coordinate referral to certified diabetes educator	09/01/2010
☐	2		Coordinate referral to home healthcare (with treat	09/01/2010

8c. Personnel Reviewing and Revising the Care Plan

Through ongoing assessment using system assessment tools and risk profiles the Care/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 Care/Case Manager contacts the member or authorized representative and provider(s) at established timeframes based on specific interventions and/or the Care/Case Manager's clinical judgment. Contacts should be at the minimum frequency as defined by the member's acuity level. At a minimum, the Care Plan is updated annually.

As the Care/Case Manager monitors the Care Plan and the progress towards meeting the goals, he/she evaluates the need for modification. The Care/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.

If progress is not being made toward meeting the goals, the Case Manager should reassess the case to identify barriers. Examples of these may include:

- Insufficient information for the Case Manager or provider(s) to fully understand the case due to missing information, family dynamics, and/or lack of care coordination
- Member or representative not willing to participate in case management.
- Resistance of member or representative to change
- Lack of communication between member and his/her family or providers or other psychosocial concerns.
- Lack of advance directives
- Lack of an effective strategy for managing home care
- Unidentified or un-manageable psychosocial issues with the member and/or family or caregivers.
- Lack of rapport between the member and the Case Manager or the attending provider(s) and the Case Manager.

A behavioral health team member should be consulted as indicated to address identified psychosocial barriers.

EXAMPLES:

- Case Study - Details have been summarized to ensure privacy

This case illustrates frequent updates to the Care Plan necessary when members have changes in medical condition. This is an elderly member with diagnosis of cancer and surgery complicated by swallowing problems and weight loss that resulted in a feeding tube. Primary support system was an involved family. Member had been living independently prior to surgery. Interventions included coordination with home health, primary doctor and family and addressing psychological needs of member. Case Manager updated Care Plan and communicated with family and member as member declined functionally and needed more assistance at home. Eventually member was not able to be maintained at home and relocated to Assisted Living facility. Primary doctor provided with updated Care Plans as member's condition changed. Case Manager coordinated care and eventually hospice services, updating Care Plan, interventions and goals as member's condition changed.

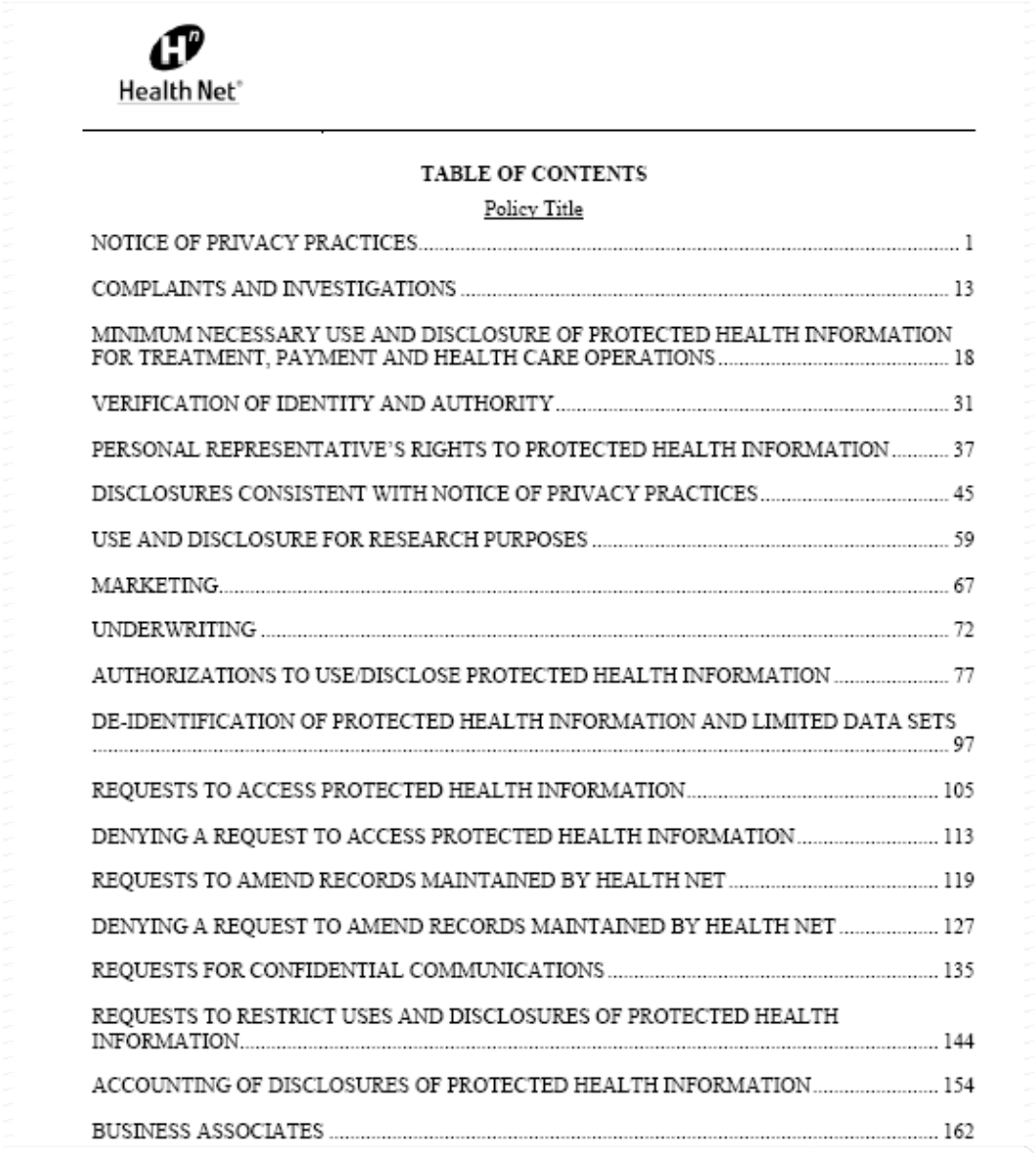
8d. Documentation of the Plan of Care

The Plan of Care is documented and maintained in the secure electronic medical management system. It is accessible to the internal IDCT members electronically. IDCT members that do not have access to the electronic medical management 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.

EXAMPLES:

- Table of Contents for Health Net's Privacy Program in compliance with HIPAA regulations



Health Net®

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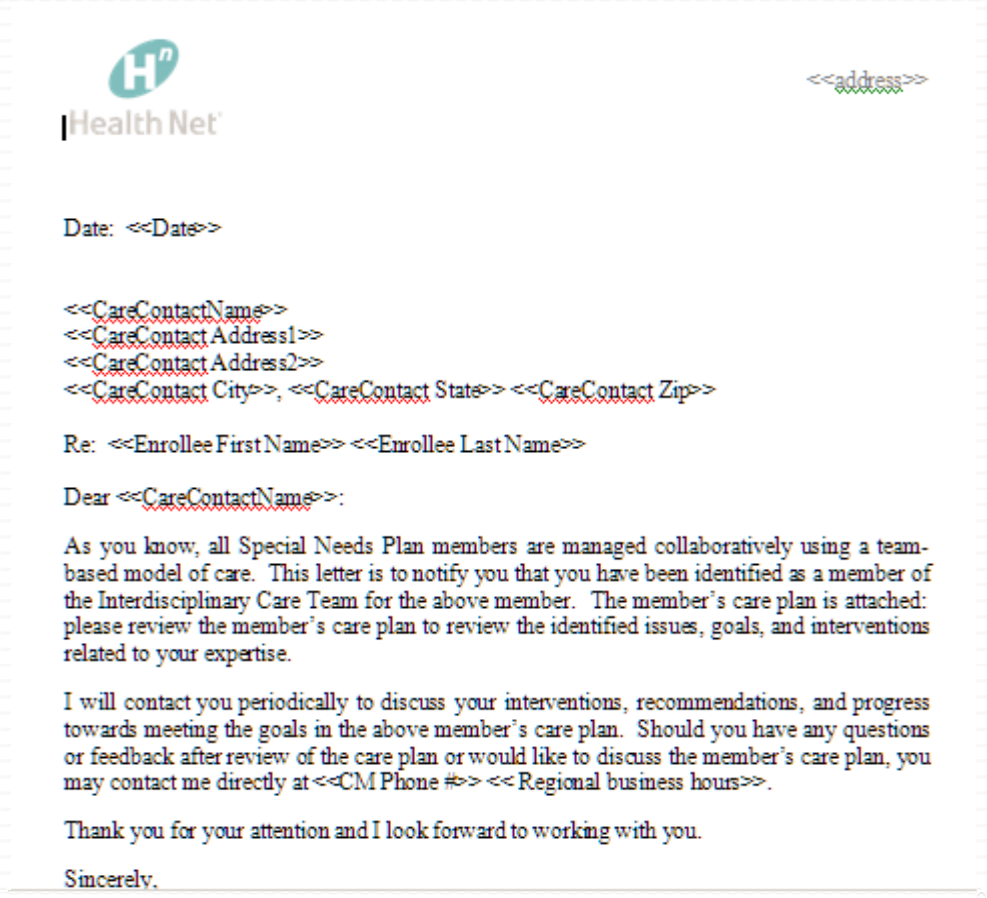
Policy Title

8e. Communication of the Care Plan and Revisions

The member is included in the development of their Care Plan whenever feasible and the Case Manager communicates with the member telephonically to discuss revisions as they occur. A hard copy of the Care Plan is sent to the PCP to discuss and share with the member. The member can be provided with a hard copy of the Care Plan upon request. Internal members have access to the Care Plan through the electronic medical management system. External IDCT members such as the PCP are sent a hard copy of the Care Plan.

EXAMPLES:

- Cover Letter to PCP sharing Care Plan:



Health Net

<<address>>

Date: <<Date>>

<<CareContactName>>
<<CareContact Address1>>
<<CareContact Address2>>
<<CareContact City>>, <<CareContact State>> <<CareContact Zip>>

Re: <<Enrollee First Name>> <<Enrollee Last Name>>

Dear <<CareContactName>>:

As you know, all Special Needs Plan members are managed collaboratively using a team-based model of care. This letter is to notify you that you have been identified as a member of the Interdisciplinary Care Team for the above member. The member's care plan is attached: please review the member's care plan to review the identified issues, goals, and interventions related to your expertise.

I will contact you periodically to discuss your interventions, recommendations, and progress towards meeting the goals in the above member's care plan. Should you have any questions or feedback after review of the care plan or would like to discuss the member's care plan, you may contact me directly at <<CM Phone #>> << Regional business hours>>.

Thank you for your attention and I look forward to working with you.

Sincerely,

ELEMENT 9. COMMUNICATION NETWORK

9a. Communication Network Structure

Health Net maintains a comprehensive medical management system and intranet for internal departments, a contact center and user friendly website for members and providers. The

communication systems are varied to meet the needs and abilities of the various groups and individuals that will be utilizing them and include member and provider newsletters and online articles. In addition to specific department monitoring activities for efficiency and effectiveness, the QI department monitors the quality of communication systems as part of the annual integrated member satisfaction report and provider satisfaction surveys.

EXAMPLES:

- **Medical Management System:** Health Net utilizes an electronic medical management system for member medical records and the review and authorization of services and claims. Membership and provider data from the claims systems are fed into the medical management system on a daily basis to synchronize and facilitate the processes of review and authorization. In addition to following HIPAA privacy regulations, validity and consistency edits are employed throughout to ensure data integrity.

  The internal electronic medical management system allows case management, concurrent review, and the hospital notification unit to document member information in the system so it is available to the complete Health Net team. This facilitates appropriate interventions and timely management for members in the Dual Eligible SNP model of care. A comprehensive set of evidence-based assessments and Care Planning programs are embedded in the documentation system for the Case Management process.

- **Member Services Contact Center:** to meet the unique needs of members and providers, health net operates a Medicare or dual eligible SNP member services center with dedicated associates. The associates staffing the center are trained on the dual eligible SNP model of care, including coordination of benefits and the provider network, to effectively assist members and providers. The member services center contact information is included on the member's ID card. In addition to access to language line services, they are also staffed with bi-lingual employees to better assist members.

- **Provider Portal:** Health Net maintains a provider portal at www.healthnet.com with easy and secure access to the provider manual, newsletters, medical policies, eligibility, claims, hospitalization notification, authorizations and pharmacy information. Providers can also validate if members are involved in health coaching or intensive case management. Use of the provider portal is optional but encouraged; however, delegated Dual Eligible SNP providers are required to register on the portal. An additional web tool on the portal for groups delegated for Dual Eligible SNP links providers to timely and secure information on Dual Eligible SNP members. Delegated groups receive training on this portal feature that allows them to receive the monthly demographic and medical information on new Dual Eligible SNP members and the results of initial and annual health risk assessment.

- **Member Website:** The member portal on the Health Net website provides a variety of convenient features and access to benefit and health information. Members are encouraged to create their own personal health record with appointment history, medical

information and medication list stored in an accessible and secure environment. An interactive program allows members to obtain comprehensive medication information including drug/drug interactions, purpose and precautions. Automatic reminders for preventive health such as seasonal influenza vaccines or recommended screenings can be personalized to the member's demographics.

In addition, the member website contains a large variety of health information. Decision Power utilizes Healthwise® Knowledgebase, a comprehensive online source of validated health information that provides detailed materials on over 6,000 health topics including chronic disease management and decision support. The content in the Knowledgebase is reviewed and updated quarterly. Web-based interactive toolkits for weight management and smoking cessation offer additional support and encourage self-management skills.

9b. Connection of Stakeholders

Stakeholders are connected via the specific communication network that will meet their business, personal, educational or health needs as established by Health Net. The member is central to all communications and is kept informed via phone calls and mail from the Case Manager. Members can also receive disease management information by mail or electronically from the member portal. The internal IDCT members are connected via the electronic medical management system for member information and the intranet for e-mail communications. The Member Services Contact Center for members and providers has access to the member information necessary to assist members to resolve any questions or issues and can also quickly connect to their Case Manager if additional follow-up is needed. Providers have access to member information on the provider portal in addition to phone and mail communications they receive from the Case Manager. External IDCT members other than the PCP receive communications by phone or mail and records of this communication are entered into the electronic medical record system by the Case Manager. Information from Health Net's network of communication systems is available to regulatory bodies following established privacy and information management policies.

EXAMPLES:

- Screenshot from the member portal at www.healthnet.com

9c. Preservation of Communication

All communication of the delivery of member services is preserved according to Health Net's established information management policies and procedures. The Case Manager records communication with members, providers and IDCT members in the Activity Notes of the electronic medical management system - examples of which are included in the IDCT section. Annual Medicare Newsletters are preserved and archived on the Marketing intranet site. Minutes and attendance from the Dual Eligible SNP Governance Committee are recorded, distributed and approved at the subsequent meeting.

EXAMPLES:

- Agenda from SNP Governance Meeting showing Agenda Item regarding approval of minutes.


Health Net
A Better Decision

2012 SNP Model of Care Governance DRAFT Agenda

Meeting Topic	2011 SNP Governance Meeting
Date/Time	Monday, January 9, 2012 / 1-2 pm PST / WH Conf. Rm. 335-B
Dial #	Call in: 818-347-1134; ID 7622

#	Description	Responsible Party	Time/ Mins.
1.	Review and Approve Minutes 11/14/2011	All	3
2.	*Monthly CM Metrics:* MHN – Metrics (pending) PPG – Metrics (under attachments) CA & AZ – Metrics (xx)		15
3.	Monthly SNP Report		15

9d. Oversight Responsibility

The Web Center of Excellence (WCOE) is the award winning department responsible for planning, design, development and maintenance of the member and provider portals. The Vice President of Information Systems and Chief Information Officer are responsible for oversight, system security and providing the information architecture to meet Health Net customer needs by leveraging technology, best practices, and standards to improve productivity and overall efficiency of associates and systems. The Vice President of the Contact Centers and Chief Customer Services are responsible for oversight of the Member Services Contact Center to ensure employees that interface with members are knowledgeable of benefits, services and processes to be able to handle member calls in a professional, efficient and timely manner.

The Vice President of the Quality Management Department and the Dual Eligible SNP Program Manager are responsible for the oversight of the company-wide Quality Improvement and Dual Eligible SNP Care Management Programs' overall effectiveness and communications. The oversight responsibility includes functioning as the Chairperson and facilitator of the Dual Eligible SNP Governance Committee and communication of the overall effectiveness of care to the membership of that committee. Written minutes are maintained for every meeting, including reports on utilization and outcome measures. Items communicated at the Dual Eligible SNP
Governance Committee include, but are not limited to:

- Monthly Case Management metrics: medical, behavioral, delegated
- Monthly and quarterly Dual Eligible SNP Reports
- Training and Regulatory Updates
- Discussion of progress towards goals and barriers
- Clinical care and service delivery (by provider) updates

EXAMPLES:

- *Job Description Responsibilities/Qualifications of IT Director:*

The IT Director ensures that established security practices and processes are followed at Health Net while using external vendors for service delivery, supports Health Net legal functions as

they pertain to IT services and functions at Health Net, conducts periodic review and audit of services and practices of Health Net and vendor delivered services. Manages the execution of the following:

Security Management: Response and incident management for major security events. Risk management, assessment and validation. Owns Information Security Policy. Owns ITG policy and review. Forensics and investigations. Manage and conduct periodic review and audit of security practices. Manage reporting activities as required. ITG representation for all security committees and processes. Single point of contact for IT related security matters. Company information security awareness and education program.
Compliance and Legal Support: Coordinates with other functions to define and perform audit functions as required to document and ensure vendor compliance (includes contract, service, security, architecture, etc.). Reporting functions related to audit activity. External audit management and tracking. Definition, management and review of the Data Control process; to include formal definition of business and system owners and processes to conform to SOX requirements. Audit and periodic review of the Data Control function. ITG aspects of business continuity. ITG representation for all legal needs and processes. ITG representation for all compliance committees and processes. Single point of contact for compliance, legal and business continuity matters.

Education and Experience: Bachelor's Degree in one of the following subject areas: Computer Science, Business Administration, or related field preferred or equivalent relevant work experience**.** CISSP certification is a plus. Five to eight years work experience in IT with direct experience in legal, compliance and security related operations are required**.** Additionally, minimum five years demonstrated budget management is required**.** Demonstrated understanding of the processes in use at Health Net as they relate to security, compliance and legal support is desired.

ELEMENT 10. CARE MANAGEMENT FOR HIGH RISK POPULATION

10a. Identification

The member's initial stratification is automated for non-delegated members and based on criteria combining the Risk Adjustment Factor/Hierarchical Condition Categories (RAF/HCC) and/or HRA scores when available. The stratification level assignment allows members to move between stratification levels to meet changing levels of need across the care continuum. The goal of automated stratification is to optimally 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 Case Manager determination.

The initial stratification occurs as part of the HRA, soon after member enrollment. The initial automated stratification is done once and members are assigned to the responsible case management group:

Health Net will provide case management for those members that do not belong to a Dual Eligible SNP delegated medical group

Medical Groups delegated for Dual Eligible SNP will provide team based services for their members

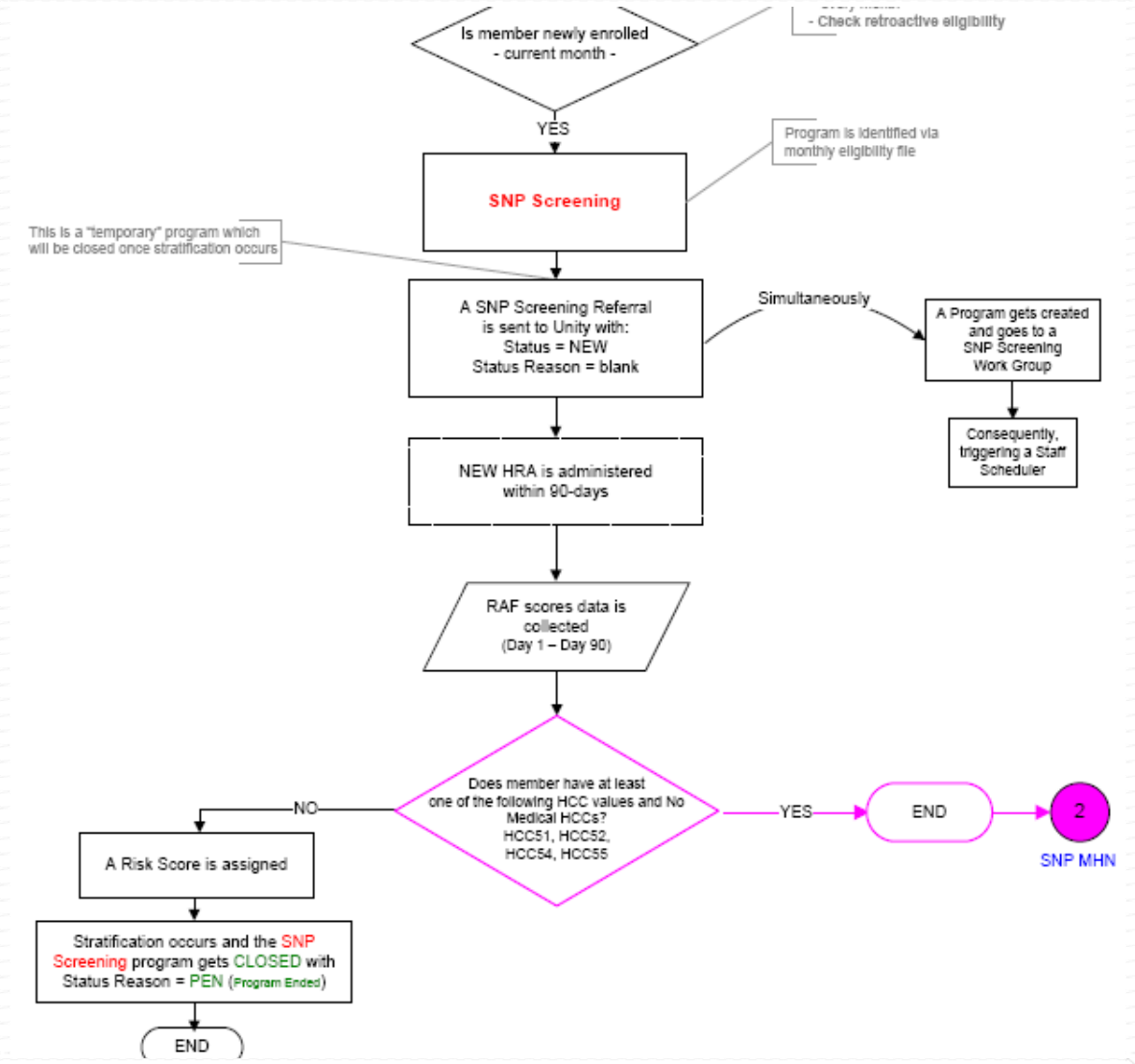
Managed Health Network (MHN), Health Net's behavioral health division will provide team based services for those members with mental health diagnosis only

A report of the members and respective HRA responses will be communicated to the appropriate delegated groups via the secure provider portal. 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, automated surveillance triggers (e.g. daily authorization/discharge data,) are utilized to provide early identification of members at risk that may require case management intervention.

EXAMPLES:

- Member screening, identification and risk stratification flow chart



10b. Add-on Services and Benefits

A combined Medicare/Medi-Cal benefit package, enhanced with additional value-added benefits and services, will be offered as a means of helping beneficiaries meet their health care needs. Health Net supports including additional value-added benefits and services to the extent they are supported by actuarially-sound fiscal rates.

EXAMPLES:

- Transportation Services: Health Net provides a variable number including unlimited medically related trips annually according to the individual Dual Eligible SNP plan. The

member can bring a caretaker or family member for no charge. This promotes member access to medical services and compliance with the medical goals of the Care Plan.

- Dental/Vision Benefit: The dental and vision benefits can be core or buy-up benefit depending on the individual Dual Eligible SNP plan. 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. The vision benefit includes an annual eye exam, eyeglasses.

- Dual Eligible SNP members that meet inclusion criteria are enrolled in the Medication Therapy Management (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, Doctor and Case Manager receive the results of the review when problems are identified in addition to contact information to speak with a pharmacist. This communication among the team members facilitates follow-up with the member regarding medication issues.

- Disease Management (DM) with access to a licensed health coach (RN, Respiratory Therapist, Dietician) 24 hours a day/7 days a week for education and counseling regarding health concerns. The focus is to identify and outreach to members with the five major chronic diseases of diabetes, hypertension, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure. In addition to mailed educational materials, videos, 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 education.

- Intensive Case Management: All Dual Eligible SNP members are enrolled in case management and stratified according to care needs. In addition, for a small subset of members with conditions such as ESRD, catastrophic or end-of-life situations, members can be enrolled in more specialized intense case management programs going beyond home visits, assessments and coordination of care to include stabilization of highly complex medical care plans. Care needs may include mental health services from County or Plan contractors and community based services or IHSS.

- In addition, Dual Eligible SNP members stratified as high risk by Health Net for internal case management 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 performed at least quarterly for members with any applicable HCC condition (all conditions assessed).

- Milliman CM 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 Renal Failure
- Coordination of multiple services, such as home health, PT, OT, wound care, DME, specialty visits, etc. (5+)
- Coordination of social services to manage activities of daily living and nutrition
- Coordination of care with multiple external entities (i.e. Department of Social Services, Medicaid, County Mental Health Services, Ombudsman Services, County Assessment Agencies and IHSS workers etc.)
- Referral for health coaching/disease management
- Surveillance for potential status changes such as ER visits, hospitalizations, claim data
- Case Manager in contact with member at least monthly and more frequently as indicated by member needs/Care Plan goals
- Case Management/IDCT follow-up and Care Plan update with member/caregiver is at least quarterly and when there are any status changes.

ELEMENT 11. PERFORMANCE AND HEALTH OUTCOMES MEASUREMENT

11a. Evaluation of the MOC

Evaluation of the effectiveness of the Dual Eligible SNP Model of Care occurs at least 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, member satisfaction, etc. are utilized along with new procedures developed to allow for the analysis of Dual Eligible SNP specific outcomes. Table 9 describes specific metrics according to the goals in Element 2a, data source of the metric and comparison outcomes or performance goals. Dual Eligible SNP outcomes are compared to the performance goal or available Dual Eligible SNP or Medicare value, although Medicare comparisons should be viewed with caution.

Table 9

Health Outcomes Measurement	
Improved Access to Essential Services: Medical, Mental Health, and Social Services	**Performance Goal or Available Comparison Value**
Member Survey CAHPS Measures	**National Medicare Avg**

Health Outcomes Measurement	
Composite result for “Getting Needed Care”	91.9
Composite result for “Getting Care Quickly”	79.0
Composite result for “Getting Needed Prescription Drugs”	95.0
Provider After Hours Survey	**Performance Goal**
Percent After-Hours Physician availability within 4 hours	90%
Percent After-hours Emergency Instructions	90%
Behavioral Health Access (Commercial/Medicare)	
Percent members reporting able to get routine appointment in 10 days	80%
Percent members able to get urgent care within 48 hours	90%
Percent members able to get non-life threatening emergent services within 6 hours	90%
Appeals and Grievance Access Issues	**HN Medicare**
Quality of Service Access Grievance Rate (PTMPY) (N)	1.14 (150)
Quality of Care Access Grievance Rate (PTMPY) (N)	0.03 (4)
HEDIS® Measure – Board Certification	
Family Medicine	66.15
Internal Medicine	75.28
Other Physician Specialists	78.69
	National SNP Mean
Geriatricians	54%
CAHPS Member Survey	**National Medicare Avg**
CAHPS Overall rating of Personal Doctor	92.5%
CAHPS Overall Rating of Specialists	90.8%
CAHPS Composite score for “Doctors who communicate well”	94.6%
Overall percent compliance with Dual Eligible SNP Model of Care criteria from Delegation Oversight audit tool for Dual Eligible SNP delegated groups (66)	80%
Availability	**Performance Goal**
Percent members with 1 PCP within 15 miles or 30 mins from residence	90%
Percent members with 1 High volume BHP within 15 miles or 30 mins from residence	90%
Percent members with 1 Hospital within 15 miles or 30 mins from residence	90%
Percent members with 1 ER within 15 miles or 30 mins from residence	90%
Percent members with 1 Pharmacy within 15 miles or 30 mins from residence	90%

Health Outcomes Measurement	
Percent members with 1 Specialist within 15 miles or 30 mins from residence (for each high volume specialty type)	
Orthopedic Surg.	90%
Gastroenterology	90%
Cardiology	90%
Neurology	90%
Ophthalmology	90%
Improved Access to Affordable Care	**HN Medicare**
Percent Geo-Access Availability of Providers Contracted for Medicare and Medicaid	**Performance Goal**
PCP	90%
Specialists	90%
Improved Coordination of Care Through an Identified Point of Contact	
Mean rate of compliance with criteria for audit of Dual Eligible SNP Case Management files (Non-delegated members)	90%
Percent overall compliance with criteria for audit of Dual Eligible SNP files (delegated members)	95%
Percent Non-delegated members with Care Plan established	100%
Percent Behavioral Health members with Care Plan established	100%
Percent Delegated members with Care Plan established	100%
Improving Seamless Transitions of Care Across Health Care Settings, Providers and Health Services	**Performance Goal**
% Documentation that Plan of Care communicated to Receiving Setting within 1 business day of notification of hospital admit or discharge to next setting (Behavioral Health)	95%
% PCP Notification of Hospital Discharge in 5 days (Behavioral Health)	95%
% of hospital discharges to home receiving post-hospital discharge calls in 5 business days (Behavioral Health)	95%
% Documentation that Plan of Care communicated 1 business day of admission notification (Non-Behavioral Health) (Dual Eligible SNP Non-delegated)	95%
% PCP Notification letter within 5 days of Hosp Discharge (Non-Behavioral Health) (Dual Eligible SNP Non-delegated)	95%
Average Number of Days Post- Hospital Discharge Call (Non-Behavioral Health) (Dual Eligible SNP Non-delegated)	2.0 Days
% Dual Eligible SNP members that have been hospitalized or in a nursing home responding “Yes” “Did you have the information you needed upon discharge regarding medications and follow-up care?" (Yes/No)	90%
HEDIS® Measures	

Health Outcomes Measurement	
Follow-up after Hospitalization for Mental Illness	**Medicare Avg**
30-day Follow-up	54.2%
7-day Follow-up	37.1%
All Cause Readmission	NA
	SNP Mean
Medication Reconciliation Post-Discharge	30%
Improved Access To Preventive Health Services	**Medicare Avg**
HEDIS® Measures	
Colorectal Cancer Screening Rate	54.5%
Glaucoma Screening in Older Adults Rate	NA
Percent members that answered "Yes" to: "Did you get a flu shot since September 1, 2009?"	66.3%
Percent members that answered "Yes" to: "Have you ever had a pneumonia shot?"	69.0%
Assuring Appropriate Utilization of Services	**HN Medicare**
Hospital admit rate (PTMPY)	252.6
Hospital readmit rate - 30 day	14.9%
Emergency Room rates (PTMPY)	271.5
SNF days (PTMPY)	1,144.9
Utilization Metrics Behavioral Health	**MHN SNP**
Acute Psychiatric Inpatient admit rate (PTMPY)	24.9
Acute Psychiatric Inpatient readmit rate -30 day	22.3%
Detox Inpatient admit rate (PTMPY)	2.1
ER visit rate MHN (PTMPY)	12.5
Partial Hospitalization Program (PHP) Admits/1000	2.7
Intensive Outpatient Program (IOP) Admits/1000	4.7
Residential Treatment Center (RTC) Admits/1000	0.7
IHSS Hours/1000	TBD
Home Health Visits/1000	TBD
Long Term Care Admits/1000	TBD
Improving Beneficiary Health Outcomes	
HEDIS® Measures	**Medicare Average**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.5%
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	61.0%
Bronchodilator	76.1%
Persistence of Beta-Blocker Treatment After a Heart Attack	82.6%
Osteoporosis Management in Older Women Who Had a Fracture	20.4%
Antidepressant Medication Management	
Effective Acute Phase Tx	63.3%

Health Outcomes Measurement	
Effective Continuation Phase Tx	50.2%
Annual Monitoring for Patients on Persistent Medications	
ACE Inhibitors or ARBs	90.1%
Digoxin	92.3%
Diuretics	90.4%
Anti-Convulsants	69.8%
*Potentially Harmful Drug-Disease Interactions in the Elderly**	
Falls + Tricyclic Antidepressants/Antiphycotics	16.8%
Dementia+Tricyclic Antiderpressants/Anticholinergic Agents	28.7%
CRF+Nonaspirin NSAIDs/Cox-2 Selective NSAIDs	11.7%
Total	23.4%
*Use of High Risk Medications in the Elderly**	
1 Drug	23.3%
2 or More Drugs	5.8%
Comprehensive Diabetes Care – LDL Screening (C-SNP only)	87.2%
	SNP Mean
Controlling High Blood Pressure	52%
Annual Monitoring for Patients on Persistent Medications Total	90%
HEDIS® Care for Older Adults (COA)	
Advance Care Planning	16%
Medication Review	53%
Functional Status Assessment	28%
Pain Screening	38%
***Satisfaction with Health Status and Healthcare Service**s*	**Medicare Avg**
Member Survey CAHPS Measures	
Overall Rating of Health Plan	84.1%
Overall Rating of Care received	85.4%
Overall Rating of Personal Doctor	92.5%
Composite score for CAHPS “Health Plan Customer Service”	91.0%

EXAMPLES:

In addition to the metrics collected for each goal in Table 9, Health Net also monitors HRA completion rates, delivery of add-on services, member's health status and communication systems. The following data sources will be collected and analyzed as part of the annual evaluation of the Dual Eligible SNP Model of Care to evaluate quality and health outcomes for the Dual Eligible SNP program. See Table 9 for specific metrics.

- **Health Outcomes** – HEDIS® measures, utilization metrics for admits to hospital/SNF, ER visits, hospital readmits, member survey

- **Access to Care** – member satisfaction surveys, appeals and grievances re: access, provider after hours surveys, monitoring of provider network, utilization reports
- **Improvement in Health Status** – related HEDIS® measures, responses to HRA questions re: health status, pain, functional status, self-management
- **Implementation of Model of Care** – NCQA Structure and Process measures, Delegation Oversight audits of Medical Groups
- **Health Risk Assessment** –initial and annual completion rates
- **Implementation of Care Plan** –audits of case management records
- **Provider Network** – Geo-access surveys for adequacy of network, % open panels, provider to member ratios, hospital bed capacity, member and provider satisfaction surveys
- **Continuum of Care** – related HEDIS® measures, response to HRA question regarding transitions, transition of care audits
- **Delivery of Extra Services** – utilization for transportation, Decision Power, Alere Case Management, Medication Therapy Management program,
- **Integrated Communications**- Member Services Contact Center (average speed to answer, abandonment rate), member and provider satisfaction surveys

11b. Personnel Responsible to Collect, Analyze, Report MOC Evaluation

Health Net has provided extensive resources to the Dual Eligible SNP program to meet the comprehensive data collection, analysis and evaluation requirements. The Dual Eligible SNP QI Program Manager, BSN, CPHQ is dedicated to the program along with Master or Bachelor prepared Research Analysts in Public Health, Biostatistics, Epidemiology and Business Economics who also participate in the data collection, analysis and program evaluation.

EXAMPLES:

- The QI Manager for the Dual Eligible SNP Program holds a Bachelor of Science in Nursing and is a Certified Professional in HealthCare Quality, CPHQ. She has 4 years of experience working with the Dual Eligible SNP Program at Health Net and has participated in the NCQA evaluation process of the Dual Eligible SNP program since 2008. She has attended multiple CMS and NCQA conferences and webinars to further her knowledge of Dual Eligible SNP regulations and standards and participated as a speaker at the January 2010 NCQA Conference on Special Needs Plans in Baltimore.

- The QI Manager of Health Net's Research and Analysis team holds a Masters in Epidemiology and heads up a team of 5 Master or Bachelor prepared Senior Analysts who are available to support the Dual Eligible SNP QI Manager with statistical analysis and reports. The QI team also has a DrPH in Biostatistics who has assisted with the Dual Eligible SNP reports and evaluations.

11c. Improvement of the MOC

The analyzed results of the Dual Eligible SNP MOC are reported annually to the Dual Eligible SNP Governance committee and the CMACQC. Metrics are identified for potential improvement when they are substantially below the available reference value or performance goal.

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. Although improvement activities have been implemented for the majority of the identified areas, the implemented actions that follow (Table 10) address the metrics prioritized for improvement.

EXAMPLES:

- Table 10 below is an excerpt from the 2010 Dual Eligible SNP program evaluation showing actions taken to address barriers and improve Dual Eligible SNP Program outcomes.

Table 10

Opportunity	Action Taken to Address Identified Barriers to Improved Performance
Health Outcomes and Use of Evidence Based Practices	
(DAE) High Risk Drugs in Elderly - 1 Drug DAE) High Risk Drugs in Elderly - 2 Drugs	High Risk Medications in the Elderly is a Health Net Pharmacy Services initiative with annual mailing of member profiles and educational materials to providers. In 2010, the medication profiles of 70,986 Medicare members were reviewed and 10,845 were targeted for intervention. Provider outreach occurred in September 2010 and outcomes at 6 months demonstrated 65% decrease in use of targeted medications. Educational materials are also available on the provider and member portals. Plans to enhance this project for 2011 will be more frequent identification of members, increase targeted high risk medications and a member intervention.
(OMW) Osteoporosis Management Women	The Quality Improvement Department and Health Net Pharmacy conduct an osteoporosis initiative. In July 2010, the intervention was increased from annual to monthly outreach to reach more high-risk members. Medicare members targeted for the outreach are aged 65 to 90 with an osteoporotic fracture in the previous three months who have not received a bone-mineral density (BMD) test or are not on active osteoporosis treatment.

Opportunity	Action Taken to Address Identified Barriers to Improved Performance
	Educational materials are mailed to members and patient profiles/intervention alerts are faxed to the members' physicians. Members are also encouraged to obtain personalized assistance from Decision Power Health Coaches. Educational materials are posted on healthnet.com member and provider portals.
Emergency Room Utilization	Health Net Case Managers and Decision Power Health Coaches educate SNP members on self-management of chronic disease in order to avoid emergencies and promote regular visits to the PCP. All new members receive enrollment verification calls. Health Net associates verify member understanding and provide education if necessary on accessing services in a managed care health plan. In Jan 2011, Health Net began calling Medicare members to encourage annual physicals and assist members to make appointments with their PCP so diseases can be properly managed in the doctor's office avoiding inappropriate trips to the ER. The 2011 Medicare Mailer includes an article, "When is the Emergency Room the Right Choice?" discussing the difference between urgent care and emergent care.
Access to Care	
(FSO) Flu Vaccine (PNU) Pneumonia Vaccine	The 2010 Medicare newsletter mailed to all Medicare members includes a tear-out chart with guidelines for preventive screening and specific articles on the importance of flu and pneumonia vaccines. In addition, Health Net conducts annual call and postcard campaigns for at risk Medicare members to remind them to obtain their flu and pneumonia vaccines. Decision Power Health Coaches and Health Net Case Managers also remind and encourage members to obtain Flu and Pneumonia vaccines in addition to other preventive care. The Dual Eligible SNP program also includes a transportation benefit ranging from unlimited trips for HNCA's largest Dual Eligible SNP to 20 one way trips for the HNAZ Dual Eligible SNP to further promote access to preventive care.
Transitions of Care	
Emergency Room Utilization	Health Net Case Managers and Decision Power Health Coaches educate SNP members on self-management of chronic disease in order to avoid emergencies and promote regular visits to the PCP. All new members receive enrollment verification calls. Health Net associates verify member understanding and provide education if

Opportunity	Action Taken to Address Identified Barriers to Improved Performance
	necessary on accessing services in a managed care health plan. In Jan 2011, Health Net began calling Medicare members to encourage annual physicals and assist members to make appointments with their PCP so diseases can be properly managed in the doctor's office avoiding inappropriate trips to the ER. The 2011 Medicare Mailer includes an article, "When is the Emergency Room the Right Choice?" discussing the difference between urgent care and emergent care.
Transitions of Care	
Notification of Admission to Non-acute Facility	The transition of SNP members transferred to non-acute from an acute facility including establishment of the Care Plan is managed by the concurrent review team. In July/2011, a Provider Update, "Inpatient Notification Requirements", was sent to ancillary providers, (Skilled Nursing, Acute Rehab, Long-Term Facilities) educating and reminding them of this contractual requirement.
(FUH) F/U after Mental Health Hospitalization -7 day	MHN Service Team schedules aftercare appointments with member within 7 days of discharge MHN Service team documents scheduled appointment in D/C assessment in Unity to communicate to care team MHN Service Team or Case Manager calls member within 5 days of discharge to remind and encourage completion of F/U visit
Implementation of Individualized Care Plan	
Delegated Care Plan Established	The Delegation Oversight team established monthly reporting requirements from delegated PPGs in the fourth quarter of 2010, "Case Management Engagement Reporting for Delegated PPGs". The report includes the number of SNP members, acuity levels, and percent of completed assessments and Care Plans to monitor and enforce this metric. Four medical groups that did not meet the requirements in 2010 were de-delegated for Dual Eligible SNP.
Implementation of Individualized Care Plan	**Action Taken**
Delegated File Review Compliance	The Delegation Oversight team provides education and support to the delegated groups on the SNP Model of Care requirements, including the documentation requirements for file review. In addition, the topic for the monthly SNP PPG Teleconference on 11/18/2009 attended by 44 participants was "Creating the Care

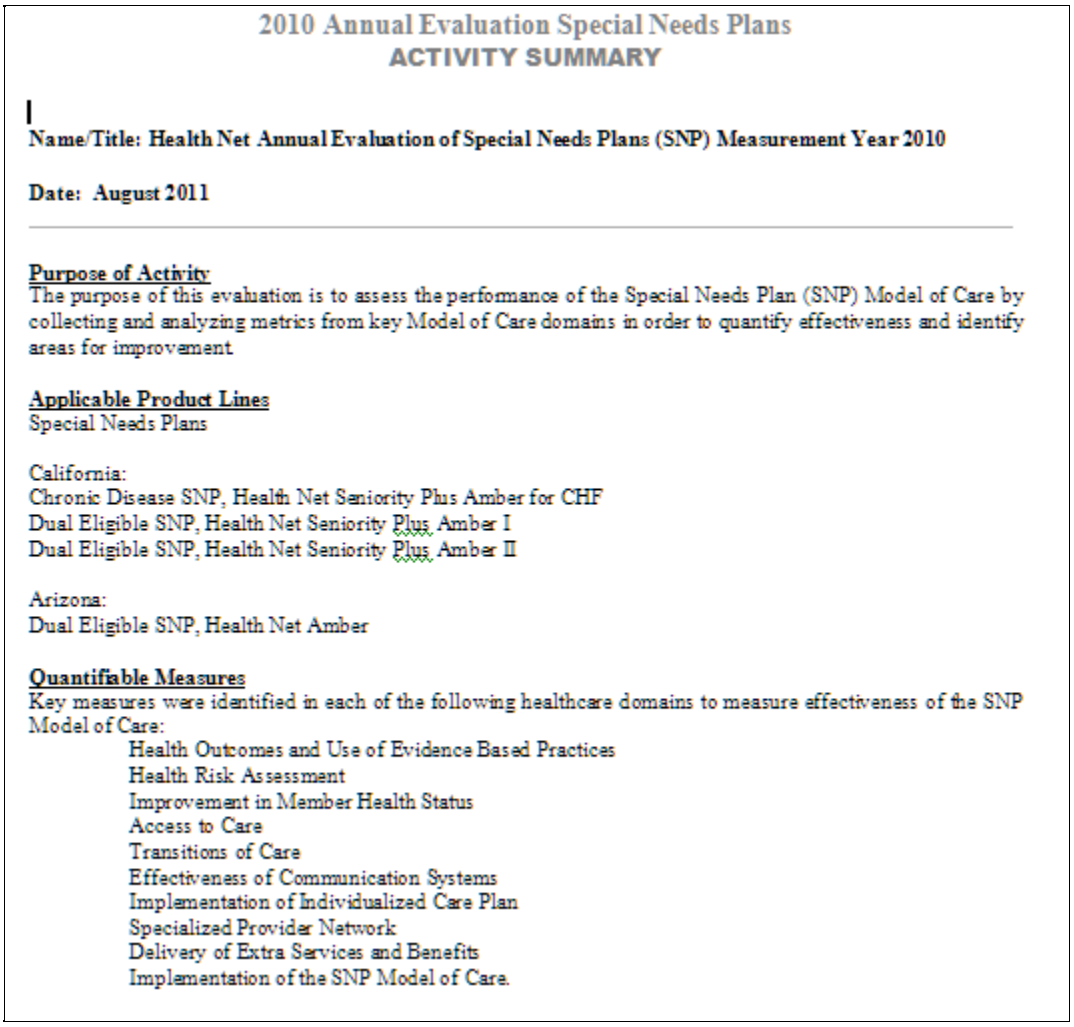
Opportunity	Action Taken to Address Identified Barriers to Improved Performance
	Plan".
Care for Older Adults (COA)	Monthly educational teleconferences for the SNP delegated PPGs are conducted to educate PPGs of SNP requirements. On 1/27/2010 the topic for the SNP educational teleconference attended by 66 participants was "SNP HEDIS® Measures". The Vice President of HEDIS® Management educated PPGs on the specific Care for Older Adults (COA) measure and documentation requirements. In Jan 2011, Health Net began calling Medicare members to encourage annual physicals and assist members to make appointments with their PCP which is necessary to complete the components of this standard (annual medication review, pain and functional assessment). The Dual Eligible SNP program also includes a transportation benefit ranging from unlimited trips for HNCA's largest Dual Eligible SNP to 20 one way trips for the HNAZ Dual Eligible SNP to further promote annual physical appointments.

11d. Documentation of the MOC Evaluation

The data elements collected correspond with the goals of the Dual Eligible SNP Model of Care and include data from HEDIS®, CAHPS, the HRA, utilization reports, appeals and grievance, surveys, delegation oversight, provider network, pharmacy services and MHN. Goals are set based on available benchmarks from NCQA, CMS or internal standards as applicable and are detailed in Table 2 under element 2b. Corrective action plans will be implemented as indicated for internal departments, external vendors or delegated medical groups for data elements that do not meet performance standards.

EXAMPLES:

- The 2010 Annual Dual Eligible SNP Evaluation is approved by members of the Dual Eligible SNP Governance Committee and retained as an official record according to Health Net's Record Retention policy. The complete document is 36 pages and includes quantifiable measures, quantitative and qualitative analysis, barrier and opportunity analysis, actions taken to address barriers and data definitions.



2010 Annual Evaluation Special Needs Plans
ACTIVITY SUMMARY

Name/Title: Health Net Annual Evaluation of Special Needs Plans (SNP) Measurement Year 2010

Date: August 2011

Purpose of Activity
The purpose of this evaluation is to assess the performance of the Special Needs Plan (SNP) Model of Care by collecting and analyzing metrics from key Model of Care domains in order to quantify effectiveness and identify areas for improvement.

Applicable Product Lines
Special Needs Plans

California:
Chronic Disease SNP, Health Net Seniority Plus Amber for CHF
Dual Eligible SNP, Health Net Seniority Plus Amber I
Dual Eligible SNP, Health Net Seniority Plus Amber II

Arizona:
Dual Eligible SNP, Health Net Amber

Quantifiable Measures
Key measures were identified in each of the following healthcare domains to measure effectiveness of the SNP Model of Care:

Health Outcomes and Use of Evidence Based Practices
Health Risk Assessment
Improvement in Member Health Status
Access to Care
Transitions of Care
Effectiveness of Communication Systems
Implementation of Individualized Care Plan
Specialized Provider Network
Delivery of Extra Services and Benefits
Implementation of the SNP Model of Care.

11e. Personnel with Oversight for Monitoring/Evaluating MOC Effectiveness

Ongoing and annual data is collected, analyzed and reported to the Dual Eligible SNP Governance Committee. Results of the data analysis and recommendations of the Dual Eligible SNP Governance Committee are considered in determining quality improvement activities, projects and specialized services and benefits. Electronic and print copies of the evaluation of the Dual Eligible SNP Model of Care will be prepared annually, reported to the Care Management Access and Clinical Quality Committee (CMACQC), and, as requested, to regulatory and accreditation organizations and preserved as an official record.

EXAMPLES:

- The QI Director holds a Masters in Public Health and a Bachelor of Science in Nursing. She has had experience with the Dual Eligible SNP program since its inception at Health Net and provides resources and guidance for the QI Manager of the Dual Eligible SNP program.

The Dual Eligible SNP Governance Committee represents management and leadership of key departments responsible for implementation of the Dual Eligible SNP Program per list below:

Dual Eligible SNP Governance Committee Role/Area of Expertise
VP Provider Network
VP Medicare Programs
VP HEDIS Management
VP Clinical Services
VP Clinical Operations
Supervisor Customer Service
Senior Writer
Senior Research Analyst
QI Specialist
QI Manager SNP
QI Manager Medicare
Project Manager
Medical Director
Manager QI Research and Analysis
Manager Provider Network
Manager Program Relationships
Manager Product Development
Manager Health Care Analysis
Manager Delegation Oversight
Manager Compliance and Reporting
Manager Compliance
Manager Clinical Operations MHN
Managers Case Management
Director Dual Eligible SNP Case Management
Director Quality Improvement
Director Pharmacy MTM
Director Membership Ops
Director Health Care Services
Director Disease Management
Director Delegation Oversight
Director Compliance
Clinical Supervisor MHN Dual Eligible SNP
Chief Medical Director

11f. Communication of Improvements to MOC to Stakeholders

Providers and members will be informed of outcomes through educational programs, updates, newsletters, and provider and member Web - portal online articles and postings. The Medicare Newsletter includes an annual article, "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 if the results are above the CMS National Average. An annual Online News article reports similar information to providers according to product line. Provider Updates throughout the year inform providers of the outcomes of the quality improvement program and projects.

EXAMPLES:

- Annual Teleconference with Dual Eligible SNP Provider Groups on program outcomes occurred on 5/25/11 and is scheduled for 7/25/2012. Outcomes from a variety of HEDIS®, CAHPS, access, Transitions of Care, Care Planning, IDCT, HRA metrics were presented followed by a discussion of how to improve results.
- Annual Online News article for providers includes key outcomes compared to previous year and national standards for multiple lines of business.
- Annual Dual Eligible SNP Program evaluation of the metrics included in Table 2 under Element 2b is reported to the Dual Eligible SNP Governance and CMACQC committees. In addition to the outcomes, the report includes a barrier analysis, opportunities and summary of interventions to address low performance.
- Annual Medicare newsletter informs members of Health Net's progress towards the goal of improving care and outcomes. The table below was included in the 2011 newsletter.

California

Measures of clinical care	*Improved from previous year*	*Above national average*
Flu vaccinations obtained		⬆
Breast cancer screening	⬆	⬆
Osteoporosis management	⬆	⬆
Cholesterol less than 100	⬆	⬆
Good control of high blood pressure		⬆
Proper medication after a heart attack	⬆	⬆
Measures of service		
Getting needed care	⬆	
Getting care quickly	⬆	⬆
Measures of health outcomes		
Treatment of urinary leakage problems in older adults who have a problem		
Managing risk of fall in older adults who have had a fall or have problems with balance or walking	⬆	⬆
Advising physical activity to older adult		⬆

MQR #7a – Attachment 5

7a. Sanctions and Penalties

Medi-Cal Programs

Health Net Community Solutions, Inc. ("Health Net") contracts with the California Department of Health Care Services ("DHCS") for the Two Plan Model and the Geographic Managed Care ("GMC") model for Medi-Cal enrollees in several counties, including Los Angeles under the Two Plan Model and San Diego under GMC. Health Net has been licensed by the California Department of Managed Health Care ("DMHC") as a full service health care service plan since 2005 and is a wholly owned subsidiary of Health Net of California, Inc. ("HNCA"), also a licensed full service health care service plan since 1991. A list of DMHC sanctions and penalties applicable to Health Net's Medi-Cal operations is set forth on page 3 of this Attachment 5.

Medicare Programs

Health Net's parent, HNCA is contracted with CMS under the MA-PD program in twenty-one California counties and, for D-SNP enrollees, in several counties, including the past six years in Los Angeles County and four years in San Diego County. Another wholly owned subsidiary of HNCA, Health Net Life Insurance Company ("HNL") is contracted with CMS for the PDP program in California and other states.

In January 2010, we were notified by CMS that, due to certain pharmacy claims processing errors, none of our stand-alone PDP plans would receive auto-assignment of Low Income Subsidy ("LIS") eligible Medicare beneficiaries under CMS' LIS auto-assignment process, effective February 1, 2010. In May 2010, CMS accepted our corrective action plan, which requires us to report to CMS on a regular basis. On September 24, 2010, CMS notified us that, based on CMS' LIS readiness assessment, CMS would not reassign any current LIS beneficiaries to HNL for the 2011 plan year, and that the January 2010 decision regarding LIS auto-assignment will remain in effect until the issues identified in the January 2010 notification and CMS' August 2010 audit (described in more detail below) are corrected.

In August 2010, CMS conducted an audit of our Medicare Advantage, Medicare Advantage Prescription Drug and stand-alone PDP plan operations, including the areas of membership accounting, premium billing, Part D formulary administration, Part D appeals, grievances and coverage determinations, and our compliance program. Based on the results of the audit, effective November 20, 2010, CMS imposed sanctions suspending the marketing to and enrollment of new members into our Medicare Advantage, Medicare Advantage Prescription Drug and stand-alone PDP plans. These sanctions related to compliance with certain Part D regulations, but did not impact the enrollment status of our existing Medicare enrollees and we have continued to provide benefits to and serve our Medicare Advantage and stand-alone PDP members. CMS allowed us to enroll existing members of our group/employer plans into our Medicare Advantage and PDP plans as they became eligible for Medicare products.

Ensuring that Health Net maintains compliance with federal, state and local regulatory provisions has always been a priority for the company; however, following the August 2010 CMS audit, it became clear that our Medicare compliance efforts required enhancement. From that day forward, from the mailroom to the boardroom, we have worked to instill a culture of compliance throughout the organization – to make compliance part of our every day work. We understand that we must have a culture of compliance throughout the entire company that relies on an integrated, process-driven approach that maps to Medicare requirements, to applicable regulatory requirements for all lines of business and has rigorous oversight of not only ourselves but our vendors. Ultimately this environment will best serve our members.

On August 1, 2011, CMS lifted the sanctions, and we resumed marketing our Medicare Advantage and stand-alone PDP products and enrolling beneficiaries with effective dates on or after September 1, 2011. The freeze continues on HNL's stand-alone PDP products from receiving auto-assignment of LIS eligible Medicare beneficiaries under CMS' LIS auto-assignment process. However, LIS members can make their own choice to enroll in our products during the annual enrollment period, or in the month they become eligible for PDP coverage.

Sanctions and Penalties Taken by the Department of Managed Health Care for 2006-2010 (with review periods 2007-2011) for Health Net Community Solutions, Inc., Medi-Cal Operations

Description of Investigation	2009 Enforcement Penalty
Exceeded 30 day grievance	$ 2,500
Denial letter failed to include DMHC phone number, TDD phone number, etc.	$ 2,500
2009 Total	**$ 5,000**

Description of Investigation	2011 Enforcement Penalty
2008 Routine Exam Claims & PDR -Routine Examination of Claims Settlement Practices and Provider Dispute Resolution - Final Report issued 10/12/09. A single penalty of $500,000 was paid in relation to deficiencies identified from 2006, 2007 and 2008 Claims and PDR examinations, with $250,000 pended subject to outcome of 2011 Claims and PDR Routine Examination. This fine applied to commercial and Medi-Cal deficiencies, but only the 2008 and 2011 Examinations included Medi-Cal Claims and PDRs. For Claims, deficiencies were in timely forwarding of misdirected claims, accurate reimbursement, accurate entry of receipt date, clear explanation of claims determination. For PDRs, deficiencies were errors in determination letters, inaccurate receipt date, delay in payment date, inaccurate written determination letters, handling of amended provider disputes, medical records handling and reprocessed PDRs. The Corrective Action Plans have all been completed. 2011 - Deficiency in timely resolution of PDRs pending.	$500,000
2011 Total	**$500,000**

MQR #8a – Attachment 6

8. High Quality

Health Net is compliant with the DHCS and CMS standards for a comprehensive Quality Improvement Program including NCQA SNP-specific performance requirements. Performance metrics for the Medi-Cal Managed Care program incorporate health outcomes, health assessments, access and satisfaction including appeals and grievances. The DHCS also requires quality improvement projects with clearly defined performance indicators. Performance metrics for the Medicare SNP program incorporate health outcomes, health risk assessment, access, satisfaction, transitions of care, communication systems, care planning, provider network, Model of Care and delivery of add-on services. CMS also requires annual quality improvement projects and a chronic care improvement program focusing on the management of chronic conditions.

Medi-Cal

The past three years of Healthcare Effectiveness Data and Information Set ("HEDIS") and Consumer Assessment of Healthcare Providers and Systems ("CAHPS") results for Medi-Cal are included in Attachments 7 and 8. Health Net collects, tracks, and reports Medi-Cal HEDIS (External Accountability Set) rates by county and in aggregate for NCQA accreditation. Annual CAHPS surveys for the Medi-Cal population are fielded and rates are tracked and reported in order to meet DHCS and NCQA standards. To ensure contracted providers are meeting DHCS accessibility requirements for Seniors and Persons with Disabilities, facility site reviews are conducted for primary care physicians, specialists and hospitals every 3 years as reported in attachment 9. The Quality Improvement ("QI") Department develops and conducts 2 Quality Improvement Projects ("QIPs") meeting the DHCS requirements. The current QIPs consist of an individual QIP: Improving Cervical Cancer Screening For Aged and Disabled members selected by the health plan and a statewide QIP: Reducing Hospital Readmission rates selected by DHCS. In Los Angeles County, two HEDIS metrics: Appropriate Treatment of Children with Upper Respiratory Infections and Timely Postpartum Visit are below the minimum performance level. Corrective actions have been developed to focus on improving these metrics. Other rates have improved including immunization rates which continue to improve in Los Angeles County along with well child visits including adolescent visits.

Medicare

The past three years of HEDIS, the Medicare Health Outcomes Survey ("HOS") and two years of CAHPS results for SNP are included in attachments 10, 11 and 12 respectively. A supplemental table for HOS including the third year of Cohort 13 is in attachment 13. In 2010, Health Net began conducting a SNP specific CAHPS to improve the evaluation of SNP satisfaction and identify areas for improvement. The 2011 results were received in January and the full report will be completed in February of 2012. Attachment 12 is a preliminary snapshot comparing 2010 and 2011 with significance testing noting denominators of less than 100.

Overall, HEDIS results for D-SNPs have improved the past three years and exceed or equal the available SNP Mean provided by CMS in all but one, Pain Screening, a sub-measure of Care of

Older Adults (COA). The two metrics with decrease in performance involve small denominators and should be viewed with caution, for example, Osteoporosis Management (denominator 60-83). The HOS outcomes are a combination of SNP and MA members and improved in four of the seven measures. The 2010 SNP specific CAHPS results were overall in line with CMS National Medicare rates with lower rates in Getting Needed Care and Getting Care Quickly noted. Health Net implemented multiple quality improvement activities in 2011 to address HEDIS, HOS and CAHPS outcomes such as member outreach through phone and mail to encourage preventive screening, flu/pneumonia vaccine reminders, member and provider newsletters and articles, member educational calendars, provider teleconferences and educational resources such as Improving Member Experience and Depression Management toolkits.

CMS also requires annual Quality Improvement Projects ("QIPs") and a Chronic Care Improvement Program ("CCIP") for MA and SNP. Health Net conducts combined QIPs for the MA and SNP populations, to maximize efficient use of resources, and SNP specific QIPs. Current Health Net QIPs include: Improve HRA Completion Rates for SNP Members, Decrease Use of High-Risk Drugs in the Elderly, Improve Fall Risk Management and Improve Management of Urinary Incontinence. The QI Medicare team coordinates with multiple departments when performance through HEDIS, CAHPS, HOS or other metrics is below goals to analyze barriers, develop strategies and activities to improve outcomes and monitor data to evaluate QIP effectiveness.

Health Net's CCIP is administered as part of its Decision Power Program. Decision Power is a whole person approach to wellness and disease management that includes algorithms to identify members for outreach, a member portal with secure electronic health record, a comprehensive data base of evidence based educational materials on diseases and conditions, interactive programs for weight management, increasing physical activity and tobacco cessation and 24 hour access to experienced Health Coaches with extensive training. The CCIP focuses on five chronic diseases common in the elderly: diabetes, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, and hypertension. Members identified with these disorders receive educational materials and outreach from a Health Coach to assess educational needs, develop self-management skills and promote compliance with their physician's treatment plan. HEDIS metrics relevant to these disorders are utilized to evaluate program effectiveness.

Please see Dual Eligible Demonstration Project Narrative Section 5 regarding access and availability standards.

Health Net

2011 HNCA HEDIS® Medi-Cal Report
San Diego County
ACTIVITY SUMMARY

TO: QI CLINICAL AND SERVICE WORKGROUP
FROM: Manjula Patel, Sr. Research Analyst, QI Research & Analysis
DATE: October 4, 2011 (Revised October 21, 2011) (Revised 2/17/12)
SUBJECT: Reporting Year (RY) 2011 HNCA HEDIS® Medi-Cal Report - San Diego County

This report has been summarized for the Dual Eligible Demonstration Project submission. Data tables for counties other than Los Angeles and San Diego have been removed. The Barrier Analysis section is included to provide examples of Quality Improvement activities.

Purpose of Activity
The purpose of this report is to present and evaluate the RY 2011 Health Net of California (HNCA) HEDIS® (Healthcare Effectiveness Data and Information Set) Medi-Cal rates based upon Health Net's performance in the measurement year (MY) 2010. Analysis of Health Net's performance allows for the identification of barriers and opportunities for improvement.

Quantifiable Measures
HEDIS® measures presented in this report are based on RY 2011 HEDIS® External Accountability Set (EAS) measures that are selected and required by the Department of Health Care Services (DHCS). These measures are to be reported by Health Plans contracted with Medi-Cal Managed Care Division (MMCD). The DHCS selected performance measures are used in the auto assignment and default algorithm, and are selected based on members' needs and program priorities. The Default Measures are six selected measures from the EAS measures that are evaluated in a 2 Plan contracted County. The health plan with a higher rate of these default measures will receive the contract for that county.

Tables detail the HEDIS® measures reported for HNCA Medi-Cal. These measures are categorized into the following domains:

- Effectiveness of Care
- Access/Availability of Care
- Use of Services

Threshold(s) /Benchmark(s):
Medi-Cal HEDIS® results are compared to the Minimum Performance Level (MPL) and High Performance Level (HPL) as indicated by the DHCS MMCD. MPLs and HPLs for the RY2011 HEDIS scores are based on the RY2010 National Medicaid 25th and 90th percentiles found in NCQA's *Audit Means, Percentiles, and Ratios.*

The DHCS MPL is a critical reference value for HEDIS® metrics as performance below the MPL requires a Corrective Action Plan (CAP) which is issued to the health plan by DHCS. The NCQA Quality Compass (QC) RY 2010 National 50th and 75th percentiles are additionally included as reference values for comparison of RY 2011 HEDIS® rates.

A 'NA' is shown in the report tables where the DHCS-MPL, DHCS-HPL, NCQA 50th and 75th percentiles are unavailable.

Methodology/Sampling/Time Period
HEDIS® measures reported by Health Net were specified using one of the following data collection methodologies – administrative methodology or hybrid methodology. Data collection was conducted per HEDIS® Technical Specifications for RY 2011. RY 2011 rates are statistically tested against Health Net's RY 2010 results, where applicable, using a Chi-Square Test of Proportions, with an alpha of 0.05.

Administrative Methodology
Identification of denominators and numerators are made using transaction data or other Health Net administrative databases. The denominators consist of the total eligible population as determined by continuous enrollment, age, inclusion criteria, and contraindications. The numerators are identified within Health Net's administrative systems and consist of members within the denominator who were identified as having a qualifying procedure or diagnosis.

Hybrid Methodology
Identification of numerator compliance is conducted through administrative and medical record data extraction. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Health Net reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service required for the numerator.

Non-Trendable Measures
The following measures are considered non-trendable between the specified consecutive years during 2009-2011 due to HEDIS® related factors including technical specification changes and introduction of new metrics:

2011 vs. 2010
None

2010 vs. 2009
Use of Appropriate Medications for People with Asthma
- Lowered upper age limit from 56 to 50 years of age. Modified age stratifications to '5-11' years, '12-50' years and 'Total'. 'Total' is still trendable.

Childhood Immunizations Status
- Added hepatitis A, rotavirus, and influenza vaccines
- Added Combinations 4 through 10

Comprehensive Diabetes Care
- Newly reported measure HbA1c Adequate Control (<8.0%)
- Newly reported measure Blood Pressure Controlled 130/80
- Newly reported measure Blood Pressure Controlled 140/90

Lead Screening in Children
- Newly reported measure

Pharmacotherapy Management of COPD Exacerbation
- Newly reported metric

Weight Assessment & Counseling for Children/Adolescents
- Newly reported metric

Results

The RY 2011 HEDIS® Medi-Cal and prior year results for metrics (Accreditation and County Specific) are presented in Tables 1 through 3. Primary interventions in 2010 associated with HEDIS® metrics are presented in the tables.

Table 1. Summary of HEDIS® Measures – Medi-Cal RY 2009-2011, 2011 Reference Standards: EAS Accreditation Metrics

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Effectiveness of Care									
Childhood Immunizations [H]	*CAIR Statewide Registry*								
Combo 3 [D]		76.16	73.32	75.93	2.61	63.50	82.00▲	71.05	76.54▲
Weight Assessment & Counseling for Children/Adolescents [H]	*Fit Families for Life – Coaching Program* *PM160*								
BMI Screening - Total		N/A	NR	63.46	N/A	13.00	63.00	29.20	45.24
Counseling on Nutrition - Total		N/A	NR	70.43	N/A	34.30	67.90	46.23	57.18
Counseling on Physical Activity - Total		N/A	NR	50.96	N/A	22.90	56.70	35.04	45.03
Breast Cancer Screening - Total	*HEDIS Outreach*	48.48	51.23	49.54↓	-1.69	46.20	63.80▲	51.88▲	59.54▲
Cervical Cancer Screening [H D]	*CCS Reminder Calls* *HEDIS Outreach*	71.27	73.53	69.77	-3.76	61.00	78.90▲	N/A	N/A
Appropriate Treatment, Children w/ URI	*AWARE* *HEDIS Outreach*	81.29	84.47	83.10↓	-1.37	82.10	94.90▲	85.78▲	90.65▲
Avoidance of Antibiotic Tx in Adults w/ Acute Bronchitis	*AWARE* *HEDIS Outreach*	28.60	29.34	21.48↓	-7.86	19.70	35.90▲	23.56▲	27.00▲
Comprehensive Diabetes Care [H]	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*								
HbA1c Testing [R11 D]		84.56	86.24	86.24	N/A	76.00	90.20▲	81.10	86.43▲
HbA1c Poor Control (>9.0%)* [R11]		40.31	38.76	38.76	N/A	53.4	27.7▲	43.07	33.69▲
HbA1c Adequate Control (<8.0%) [R11]		NR	50.46	50.46	N/A	38.70	58.80▲	46.63	54.37▲
Diabetic Retinal Exam [R11]		63.46	63.07	63.07	N/A	41.40	70.10▲	54.01	63.69▲
LDL-C Screening [AR11]		79.76	80.73	80.73	N/A	69.30	84.00▲	75.36	80.15
LDL-C Control (<100 mg/dL) [R11]		36.54	36.24	36.24	N/A	27.20	45.50▲	33.76	40.92▲

Table 1 (Contd). Summary of HEDIS® Measures – Medi-Cal RY 2009-2011, 2011 Reference Standards: EAS Accreditation Metrics

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Medical Attention for Nephropathy	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*	82.16	82.11	84.12	2.01	72.50	86.20▲	77.78	82.73
Blood Pressure Controlled 140/80		N/A	N/A	NR	N/A	N/A	N/A	N/A	N/A
Blood Pressure Controlled 140/90		NR	62.61	64.65	2.04	53.50	73.40▲	61.43	68.49▲
Use of Imaging Studies for Low Back Pain		81.59	79.81	79.92	0.11	72.00	84.10▲	76.28	79.84
Access/Availability of Care									
Prenatal and Postpartum Care [H]	*IVR/Customer Service Call* *T4baby* *HEDIS Outreach* *Pregnancy Packets*								
Timeliness of Prenatal Care [D]		84.86	88.24	90.02	1.78	80.30	92.70▲	85.92	89.89
Postpartum Care		57.80	61.54	62.95	1.41	58.70	74.40▲	65.44▲	70.29▲
Use of Services									
Well-Child Visits [H]									
Visits in the 3rd, 4th, 5th, 6th Years [D]	*HEDIS Outreach*	78.05	77.44	79.81	2.37	65.90	82.50▲	N/A	N/A
Adolescent Well-Care Visits [H D]	*AWC Reminder Calls* *AWC Initiative* *RFQP CHDP-LA* *HEDIS Outreach*	39.44	40.14	45.93	5.79	38.80	63.20▲	N/A	N/A

Table 2. Summary of HEDIS® Measures (EAS) – Medi-Cal RY 2009-2011, 2011 Reference Standards: San Diego County

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Effectiveness of Care									
Childhood Immunizations [H]	*CAIR Statewide Registry*								
Combo 3 [D]		75.51	75.29	69.82	-5.47	63.50	82.00▲	71.05▲	76.54▲
Weight Assessment & Counseling for Children/Adolescents [H]	*Fit Families for Life – Coaching Program* *PM 160*								
BMI Screening - Total		N/A	56.02	51.34	-4.68	13.00	63.00▲	29.20	45.24
Counseling on Nutrition - Total		N/A	64.58	61.31	-3.27	34.30	67.90▲	46.23	57.18
Counseling on Physical Activity - Total		N/A	36.11	43.07↑	6.96	22.90	56.70▲	35.04	45.03▲
Breast Cancer Screening - Total [A]	*BCS Reminder Calls* *HEDIS Outreach*	45.29	44.22	42.24 MPL	-1.98	46.20▲	63.80▲	51.88▲	59.54▲
Cervical Cancer Screening [H A D]	*CCS Reminder Calls* *HEDIS Outreach*	60.59	68.20	58.12 MPL	-10.08	61.00▲	78.90▲	N/A	N/A
Appropriate Treatment, Children w/ URI [A]	*AWARE* *HEDIS Outreach*	92.96	93.75	92.26	-1.49	82.10	94.90▲	85.78	90.65
Avoidance of Antibiotic Tx in Adults w/ Acute Bronchitis [A]	*AWARE* *HEDIS Outreach*	31.67	24.83	18.12 MPL	-6.71	19.70▲	35.90▲	23.56▲	27.00▲
Comprehensive Diabetes Care [H]	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*								
HbA1c Testing [A D]		89.62	88.67	84.59	-4.08	76.00	90.20▲	81.10	86.43▲
HbA1c Poor Control (>9.0%)* [A]		N/A	39.09	46.53	7.44	53.4	27.7▲	43.07▲	35.69▲
HbA1c Adequate Control (<8.0%)		NR	51.56	41.99↓	-9.57	38.70	58.80▲	46.63▲	54.37▲
Diabetic Retinal Exam [A]		60.21	65.16	47.43↓	-17.73	41.40	70.10▲	54.01▲	63.69▲
LDL-C Screening [A]		83.74	80.74	73.41↓	-7.33	69.30	84.00▲	75.36▲	80.15▲
LDL-C Control (<100 mg/dL)		52.60	37.96	31.42	-6.54	27.20	45.50▲	33.76▲	40.92▲

Table 2 (Contd). Summary of HEDIS® Measures (EAS) – Medi-Cal RY 2009-2011, 2011 Reference Standards: San Diego County

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Medical Attention for Nephropathy [A]	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*	85.12	83.57	82.18	-1.39	72.50	86.20▲	77.78	82.73▲
Blood Pressure Controlled 140/80		N/A	N/A	NR	N/A	N/A	N/A	N/A	N/A
Blood Pressure Controlled 140/90		NR	64.31	53.78↓	-10.53	53.50	73.40▲	61.43▲	68.49▲
Use of Imaging Studies for Low Back Pain		N/A	78.39	74.07	-4.32	72.00	84.10▲	76.28▲	79.84▲
Access/Availability of Care									
Prenatal and Postpartum Care [H A]	*IVR Customer Service Call* *T4baby* *HEDIS Outreach* *Pregnancy Packets*								
Timeliness of Prenatal Care [D]		88.53	93.56	88.84↓	-4.72	80.30	92.70▲	85.92	89.89▲
Postpartum Care		58.49	65.87	62.47	-3.40	58.70	74.40▲	65.44▲	70.29▲
Use of Services									
Well-Child Visits [H]									
Visits in the 3rd, 4th, 5th, 6th Years [D]	*HEDIS Outreach*	67.65	68.42	72.80	4.38	65.90	82.50▲	N/A	N/A
Adolescent Well-Care Visits [H D]	*AWC Reminder Calls* *AWC Initiative* *HEDIS Outreach*	37.12	32.06	37.14 MPL	5.08	38.80▲	63.20▲	N/A	N/A

Table 3. Summary of HEDIS® Measures (EAS) – Medi-Cal RY 2009-2011,2011 Reference Standards: Los Angeles County

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Effectiveness of Care									
Childhood Immunizations [H]	*CAIR*								
Combo 3 [D]	*Statewide Registry*	77.22	73.09	77.10	4.01	63.50	82.00▲	71.05	76.54
Weight Assessment & Counseling for Children/Adolescents [H]	*Fit Families for Life – Coaching Program*								
BMI Screening - Total	*PM160*	N/A	62.56	63.61	1.05	13.00	63.00	29.20	45.24
Counseling on Nutrition - Total		N/A	73.26	71.33	-1.93	34.30	67.90	46.23	57.18
Counseling on Physical Activity - Total		N/A	46.74	53.73↑	6.99	22.90	56.70▲	35.04	45.03
Breast Cancer Screening - Total [A]	*HEDIS Outreach*	49.20	52.31	50.09↓	-2.22	46.20	63.80▲	51.88▲	59.54▲
Cervical Cancer Screening [H A D]	*CCS Reminder Calls* *HEDIS Outreach*	73.17	75.44	69.50	-5.94	61.00	78.90▲	N/A	N/A
Appropriate Treatment, Children w/ URI [A]	*AWARE* *HEDIS Outreach*	80.27	83.75	81.32↓ MPL	-2.43	82.10▲	94.90▲	85.78▲	90.65▲
Avoidance of Antibiotic Tx in Adults w/ Acute Bronchitis [A]	*AWARE* *HEDIS Outreach*	29.17	30.97	20.18↓	-10.79	19.70	35.90▲	23.56▲	27.00▲
Comprehensive Diabetes Care [H]	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*								
HbA1c Testing [A D]		84.67	86.84	84.03	-2.81	76.00	90.20▲	81.10	86.43▲
HbA1c Poor Control (>9.0%)* [A]		N/A	39	40.74	1.74	53.4	27.7▲	43.07	37.69▲
HbA1c Adequate Control (<8.0%)		NR	50.24	46.30	-3.94	38.70	58.80▲	46.63▲	54.37▲
Diabetic Retinal Exam [A]		64.40	64.59	55.32↓	-9.27	41.40	70.10▲	54.01	63.69▲
LDL-C Screening [A]		80.24	81.58	80.79	-0.79	69.30	84.00▲	75.36	80.15
LDL-C Control (<100 mg/dL)		36.46	36.36	37.27	0.91	27.20	45.50▲	33.76	40.92▲

Table 3 (Contd). Summary of HEDIS® Measures (EAS) – Medi-Cal RY 2009-2011,2011 Reference Standards: Los Angeles County

Measure	2010 Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	DHCS MPL (%)	DHCS HPL (%)	QC National 50th Percentile	QC National 75th Percentile
Medical Attention for Nephropathy [A]	*Diabetes – Be in Charge !SM Disease Management Program* *I AM CHAD*	82.45	82.06	86.57	4.51	72.50	86.20	77.78	82.73
Blood Pressure Controlled 140/80		N/A	N/A	NR	N/A	N/A	N/A	N/A	N/A
Blood Pressure Controlled 140/90		NR	61.72	63.89	2.17	53.50	73.40▲	61.43	68.49▲
Use of Imaging Studies for Low Back Pain		N/A	77.81	80.02	2.21	72.00	84.10▲	76.28	79.84
Access/Availability of Care									
Prenatal and Postpartum Care [H A]	*IVR/Customer Service Call* *T4baby* *HEDIS Outreach* *Pregnancy Packets*								
Timeliness of Prenatal Care [D]		82.98	85.35	86.57	1.22	80.30	92.70▲	85.92	89.89▲
Postpartum Care		56.18	58.14	58.21 MPL	0.07	58.70▲	74.40▲	65.44▲	70.29▲
Use of Services									
Well-Child Visits [H D]									
Visits in the 3rd, 4th, 5th, 6th Years	*HEDIS Outreach*	78.63	77.15	79.10	1.95	65.90	82.50▲	N/A	N/A
Adolescent Well-Care Visits [H D]	*AWC Reminder Calls* *AWC Initiative* *RFQP CHDP* *HEDIS Outreach*	38.43	40.14	46.21	6.07	38.80	63.20▲	N/A	N/A

Barrier Analysis

By understanding the barriers that affect quality, Health Net can identify methods to overcome those barriers and create interventions to improve quality. Table 4 summarizes performance barriers and quality activities/initiatives for metrics for key HEDIS measures.

Table 4 – Barriers for HEDIS® Metrics Associated with 2010-2011 Core QI Initiatives

Measure(s)	Initiative	Barrier
Adolescent Well-Care (AWC) Visits	HEDIS® Outreach (includes face to face discussion/education with providers) AWC Initiative RFQP CHDP Submission	• Adolescents are more often healthy and parents/adolescents feel that they do not need to see a provider yearly. • Adolescents are a tough group to reach by phone and mail in addition to inaccurate phone and mailing addresses. • Adolescents more often do not want to see their physicians with their parents. • Physicians have limited resources to conduct member outreach.
Appropriate Treatment for Children with URI	AWARE Initiative (Alliance Working for Antibiotic Resistance)	• Providers and members may not be aware of the most current CPG for URI. • Providers have limited funds to produce educational materials for members. • PCPs may not be aware that other providers are prescribing antibiotics inappropriately to their patients • Members are accustomed to receiving antibiotics for URI. • Providers feel pressured by members to write a prescription.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	AWARE	• Members believe that antibiotics are needed to cure bronchitis. • Physicians have limited time and resources to educate members about appropriate antibiotic use. • Providers may not be aware of the most current clinical practice guideline for treating bronchitis. • Providers feel pressured by members to write a prescription.
Breast Cancer Screening	Breast Cancer Screening IVR Call to Members	• Members do not believe that BCS is important • Physicians have limited resources to conduct outreach to

Measure(s)	Initiative	Barrier
	HEDIS® Outreach In 2011, revised and translated well woman pad in English, Spanish, Vietnamese, Hmong and Chinese. PPG Mailing of Kern BCS Numerator Negatives	members for mammograms • Members were confused of conflicting BCS recommendations from USPSTF and ACS • Referral process is cumbersome • Providers more often do not know who among their members are due for mammograms.
Cervical Cancer Screening	Cervical Cancer Screening IVR Call to Members Member Newsletters Provider Updates/Online News Revised Well Woman Pad translated in Spanish, Hmong, Chinese and Vietnamese population, CCS SPD Provider Mailings	• Members are not aware that early detection through Pap testing results in better chance for recovery. • Members think that Pap testing is complicated and too uncomfortable a procedure. • Members think that since they are not sexually active, Pap testing may not be needed • Providers may not be aware that SPDs need Pap testing. • Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources • Providers may not be aware that preventive screening rates are lower for members with disabilities.

Measure(s)	Initiative	Barrier
Comprehensive Diabetes Care	Diabetes – Be in Charge !SM Disease Management Program. I AM CHAD (Improving Adherence to Medication for Cholesterol, Hypertension, Asthma and Diabetes): Pharmacy intervention. Provider letters with list of their patients due for diabetic retinal eye exam with diabetic flow sheet. Eligibility Unit calls DRE numerator negative members to set up appointments. Provider Update. Vision Services will send letters to all diabetic members reminding them to have an annual DRE. Provider Update published the Updated Diabetes and Cardiovascular Reference Guide (PRG) collaboratively developed with the CMA Foundation and announced free Diabetes webinar. McKesson DM program had refresher training with their DM nurses emphasizing the CDC HEDIS measures, had added in their pre-enrollment message the importance of DRE, the care plan assessment form had placed the CDC measures on the top of the list, and HbA1c and LDL management will be emphasized in communicating with member's providers.	• Member deficit about proper clinical care for specific conditions. • Lack of member screening. • Provider may have a deficit of guidelines or may not be aware of HN educational resources. • Lack of provider time during visit. • Difficulty in identifying members with a particular disease for a timely intervention. • Non adherence/compliance with prescribed pharmaceuticals (for measures with a Rx therapy). • Change in Medi-Cal vision care benefit may have created confusion with both members and providers

Measure(s)	Initiative	Barrier
Prenatal and Postpartum Care	HEDIS® Outreach Text4baby (Postpartum Care IVR/Customer Service Call Pregnancy Matter Packets	• Members may feel well after the delivery and may not feel that a follow-up is needed • Members may have multiple pregnancies and deliveries and feel that they know how to tale care of self and baby • Mothers lack knowledge of the importance of follow-up for self and baby • Mothers who had C-sections often have follow-up appointments two weeks after delivery and do not have follow-up after that visit
Weight Assessment and Counseling for Nutrition and Physical Activity for Adolescents.	Fit Families for Life (FFFL)	• Very low response rate to satisfaction/evaluation survey even though members are incentivized with a monthly gift card drawing. • FFFL Coaching program had increased participation and interest, but the continuation rate of members to stick with the outbound coaching program has not shown much improvement due to the inability to reach members due to phones being disconnected, or leaving voice mails. • The other challenge to the program is that all outcomes are self reported. Since it is a telephonic coaching program, there is no way to validate that the member improved their behaviors or lost weight.
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	HEDIS® Outreach	• Wait times for appointments may be long. • Lack of continuity with a clinician or institution. • Physicians have limited resources to conduct member outreach. • Race, language and gender barriers.

California 2010 QIP Summary Form
Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population

DEMOGRAPHIC INFORMATION			
Plan Name:	Health Net of California		
Study Leader Name:	Rosario J. Richards	Title: Senior QI Specialist	
Telephone Number:	818-676-7288	E-Mail Address: rosario.j.richards@healthnet.com	
Name of Project/Study:	Improve Cervical Cancer Screening among Female Medi-Cal Seniors and Persons with Disabilities		

Type of Study: ☒ Clinical ☐ Non clinical ☒ HEDIS ☒ IQIP ☐ SGC ☐ Statewide Collaborative	Section to be completed by HSAG Year 1 Validation Initial Submission Resubmission Year 2 Validation Initial Submission Resubmission Year 3 Validation Initial Submission Resubmission
Date of Study: HEDIS® RY 2010 to HEDIS® RY 2012	
Type of Delivery System: MCP	
Number of Medi-Cal Members in Plan 731,741 Number of Medi-Cal Members in Study 9,293	Baseline Assessment Remeasurement 2 Remeasurement 1 Remeasurement 3
Type of Submission: ☐ Proposal ☒ Annual Submission ☐ Resubmission Submission Date: August 31, 2011	Year 1 validated through Step Year 2 validated through Step Year 3 validated through Step

California 2010 QIP Summary Form
Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population

A. Activity I: Choose the study topic. QIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; member characteristics data such as race/ethnicity/language; other fee-for-service data; or local or national data related to Medicaid risk populations. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on member health, functional status, or satisfaction. The topic may be specified by the state Medicaid agency or CMS, or it may be based on input from members. Over time, topics must cover a broad spectrum of key aspects of member care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of members should not be consistently excluded from studies).

Study topic:

Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population from 21 through 64 years of age

This study topic was selected based on the result of the Health Net 'All County' SPD CCS HEDIS® RY 2009 preliminary analysis showing that the RY 2009 CCS administrative rate among Health Net's contracted 'All County' Medi-Cal SPDs was 14% lower than the 'All County' Medi-Cal non-SPD population rate (48.9% vs. 62.9%) and the HEDIS® RY2009 CCS administrative rate among SPDs was 7.6% lower than the HEDIS® RY2009 MPL of 56.5%. In addition, the CCS rates were much lower when compared to the non-SPD population within each of the seven Medi-Cal counties. According to the National Health Interview Survey, women with disabilities are 15% less likely to have visited an OB/GYN in the past year and most importantly, when women with disabilities visit an OB/GYN, they are 20% less likely to receive a Pap smear than women without disabilities who visit an OB/GYN.[1]

The Urban Institute research of Record has shown that one in every six persons on Medicaid can be classified as a "younger person with disability"—that is, a child or an adult under age 65 who qualifies for Medicaid coverage in part because of a disability.[2] As of 2005, almost 22% of the U.S. population suffered from at least one disability, and this proportion is increasing.[3] Furthermore, functional impairment is overrepresented in the poor, aged, and minority groups. Consequently, it is important that Medi-Cal managed care plans like Health Net attend to the health care needs of their disabled members. One of the most pressing concerns is the underutilization of preventive care. Research shows that a lower percentage of adults with a disability receive certain cancer screenings compared to the general population[4]

This disparity is particularly striking considering the frequency that seniors and persons with disabilities (SPDs) see a health care provider. Multiple studies have shown that

[1] Drew, J. 2002. Differentials in Access to Cervical Cancer Screening For Women with Disabilities in the US. Results from Health Interview Surveys. www.allacademic.com/meta/p182513_index.html -

[2] D. Liska, B. Bruen, A. Salganicoff, P. Long, and B. Kessler. *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*. 3rd ed. Kaiser Commission on the Future of Medicaid, 1997.

[3] Centers for Disease Control and Prevention. (2009). Prevalence and most common causes of disability among adults: United States, 2005. *MMWR*, *58(16)*, 421-426.

[4] Wei, W., Findlay, P. A., & Sambamoorthi, U. (2006). Disability and receipt of clinical preventive services among women. *Women's Health Issues*, *16(6)*, 289-296.

[5] Young, N. L., Steele, C., Fehlings, D., Jutai, J., Olmsted, N., & Williams, J. I. (2005). Use of healthcare among adults with chronic and complex disabilities of childhood. *Disability and Rehabilitation*, *27(23)*, 1455-1460.

A. Activity I: Choose the study topic. QIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; member characteristics data such as race/ethnicity/language; other fee-for-service data; or local or national data related to Medicaid risk populations. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on member health, functional status, or satisfaction. The topic may be specified by the state Medicaid agency or CMS, or it may be based on input from members. Over time, topics must cover a broad spectrum of key aspects of member care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of members should not be consistently excluded from studies).

SPDs average roughly one doctor visit per month, yet only a small minority (less than one-quarter in one study) has a primary care physician (PCP).[5,6] Providing primary and preventive care can not only improve quality of life and member satisfaction but also lower spending. This is critical considering that although SPDs comprise less than 20% of all Medicaid beneficiaries, they account for over 40% of program costs.[7] The need to prevent and manage chronic conditions in Medi-Cal members with disabilities is paramount.

Based on these findings, Health Net aims to increase cervical cancer screening among Medi-Cal women with disability over 21 years of age.

The literature suggests that having members initiate dialogue about preventive screenings can potentially increase usage. Similarly, increasing access to necessary screenings has the potential to prevent or reduce the impact of diseases that, if undetected, could negatively impact member health and raise costs. These interventions have high potential to improve health outcomes, increase member satisfaction, and enhance care capacity for a portion of Health Net's Medi-Cal population.

Comparison of SPD and non-SPD Health Net Medi-Cal members in the pre-baseline and baseline analysis showed that CCS rates were much lower among the SPD population within each of the seven Health Net contracted Medi-Cal counties (Table 1 and Table 2). Statistically significant differences were seen within all seven counties and in the 'All Counties' rate. These results indicate the need to focus interventions aimed at increasing CCS rates within the SPD population at each county.

Note: '*All county' SPD includes all Health Net contracted counties (Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus and Tulare) in Measurement Years (MY) 2009, and 2010. Starting MY 2011 (Remeasurement 2), Fresno County will not be included in the interventions, analysis, and report. Fresno, Madera and Kings Counties contracted with CalViva Health effective March 1, 2011. As a result of the CalViva Health Medi-Cal contract with DHCS, Remeasurement 2 report for Health Net will only include Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties. Fresno County will not be included in the Remeasurement 2 report.*

Tables 1 and 2 below show the comparison of the CCS results between SPDs and non-SPDs in each of the seven Health Net contracted counties during the Pre-baseline and Baseline periods

Table 1. Pre-Baseline Results: Study Indicator 1 (%) SPD vs. Non-SPD by County: January 1 through November 30, 2009

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[6] Trupin, L., & Rice, D. P. (1998). Health status, medical care use, and number of disabling conditions in the United States. *Disability Statistics Abstracts*, *9*, 1-4.

[7] Truffer, C. J., Klemm, J. D., Hoffman, E. D., & Wolfe, C. J. (2008). *2008 actuarial report on the financial outlook of Medicaid*. Washington, DC: Department of Health and Human Services.

A. Activity I: Choose the study topic. QIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; member characteristics data such as race/ethnicity/language; other fee-for-service data; or local or national data related to Medicaid risk populations. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on member health, functional status, or satisfaction. The topic may be specified by the state Medicaid agency or CMS, or it may be based on input from members. Over time, topics must cover a broad spectrum of key aspects of member care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of members should not be consistently excluded from studies).

	SPD		Non-SPD	
County	**N**	**%**	**N**	**%**
Fresno*	483	33.7	6103	51.8
Kern*	681	32.0	2832	42.8
Los Angeles*	5006	40.4	50,995	45.1
Sacramento*	614	30.6	4571	43.1
San Diego*	334	31.4	3857	37.4
Stanislaus*	257	38.9	1753	51.8
Tulare*	152	35.5	2154	56.5
All Counties*	7527	37.9	72,265	45.5

* Statistically significant difference (p-value ≤0.05) between SPD/non-SPD populations

Table 2. Baseline Results: Study Indicator 1 (%) SPD vs. Non-SPD by County: January 1, 2009 through December 31, 2009

	SPD		Non-SPD	
County	**N**	**%**	**N**	**%**
Fresno*	490	40.2	5,367	62.1
Kern*	711	40.9	2,571	55.3
Los Angeles*	5,320	50.8	43,311	62.1
Sacramento*	647	39.6	3,883	60.5
San Diego*	378	42.1	3,039	54.0
Stanislaus*	275	44.7	1,700	60.1
Tulare*	160	40.6	1,982	66.1
All Counties*	7,981	47.5	61,853	61.4

* Statistically significant difference (p-value ≤0.05) between SPD/non-SPD populations

B. Activity II: Define the study question(s). Stating the question(s) helps maintain the focus of the QIP and sets the framework for data collection, analysis, and interpretation.

Study question:

Do targeted member, provider and health plan interventions increase CCS rates among women age 21 to 64 years old in the eligible Medi-Cal population who are categorized as Seniors and Persons with Disability (SPD)?

An Eligible Study Member is defined as a Medi-Cal member who was included in the eligible population for the CCS HEDIS® measure based on 2011 HEDIS ® Technical Specifications, Volume 2 and are defined as part of the SPD population as defined in Activity IV.

Note: For Pre-Baseline and Baseline the member eligibility specification were based on the 2010 HEDIS® Technical Specifications. For Remeasurement 2, the member eligibility specification will be based on the 2012 HEDIS® Technical Specifications.

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

Study indicators:

Study Indicator 1 is a HEDIS® metric, 'Cervical Cancer Screening (CCS)'. It determines the percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or the two years prior to the measurement year. The denominator population for the metric in this QIP includes all eligible Medi-Cal women 24-64 years of age as of December 31 of the measurement year who are in the SPD population. Calculation of who received one or more Pap tests to screen for cervical cancer during the measurement year or the two years prior to the measurement year among this population is found through administrative data. The eligible population is defined in Activity III and Activity IV. The most current reported measurement in Activity IX is based on the 2011 HEDIS® Technical Specifications, Volume 2.

This study topic was selected based on the Health Net All County SPD cervical cancer screening HEDIS® RY2009 result that showed 'All County' CCS administrative rate among Medi-Cal SPDs was 14% lower than the 'All County' non-SPD Medi-Cal administrative rate (48.9% vs. 62.9%). This finding was confirmed both in the Pre-baseline HEDIS®-like RY 2010 preliminary results (January 1 2009 through November 30, 2009) and the Baseline HEDIS® RY 2010 results. Statistically significant differences were seen within all seven counties and in the 'All Counties' rate as shown in Tables 1 and 2 above. The HEDIS®-like RY2010 (pre-baseline) CCS administrative "all counties" rate among SPDs (37.9%) was 7.6% lower than the non-SPD population rate (45.5%) and the baseline HEDIS® RY 2010 CCS administrative "all counties" rate among SPDs (47.5%) was 13.9% lower than the non-SPD rate (61.4%). These results indicate the need to focus interventions aimed at increasing CCS rates within the SPD population.

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

Study Indicator 1 **The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year**	**Describe the rationale for selection of the study indicator:** Study Indicator 1 calculates the percentage of Medi-Cal SPD women 21 to 64 years of age who received one or more Pap tests during the measurement year or the two years prior to the measurement year. This measure is based on the Cervical Cancer Screening (CCS) measurement specifications in HEDIS® 2011 Technical Specifications. This study topic was selected based on the Health Net 'All County' SPD cervical cancer screening HEDIS® RY2009 result that showed 'All County' CCS administrative rate among Medi-Cal SPDs was 14% lower than the 'All County' non-SPD Medi-Cal administrative rate (48.9% vs. 62.9%). This finding was confirmed both in the Pre-baseline HEDIS®-like RY 2010 preliminary results (January 1 2009 through November 30, 2009) and the Baseline HEDIS® RY 2010 results (January 1 2009 through December 31, 2009). Statistically significant differences were seen within all seven counties and in the 'All Counties' rate as shown in Tables 1 and 2 above. The HEDIS®-like RY2010 (pre-baseline) CCS administrative "all counties" rate among SPDs (37.9%) was 7.6% lower than the non-SPD population rate (45.5%) and the baseline HEDIS® RY 2010 CCS administrative "all counties" rate among SPDs (47.5%) was 13.9% lower than the non-SPD rate (61.4%). These results indicate the need to focus interventions aimed at increasing CCS rates within the SPD population. According to the National Health Interview Surveys, women with disabilities are 15% less likely to have visited an OB/GYN in the past year and, most importantly, when women with disabilities visit an OB/GYN, they are 20% less likely to receive a Pap smear than women without disabilities visiting an OB/GYN.[8] Finally, this population is generally considered high risk, high cost and need more support when compared with the other groups by nature of their health care status. The SPD population was selected over the non-SPD Medi-Cal population for this QIP due to studies that show one of every six persons on Medicaid can be classified as a "younger person with a disability"— that is, a child or an adult under age 65 who qualifies for Medicaid coverage in part because of a disability.[9] As of 2005, almost 22% of the U.S. population suffered from at least one disability, and this proportion is increasing.[10] Additionally, functional impairment is over-represented in the poor, aged, and minority groups. Medi-Cal managed care plans like Health Net should therefore focus on attending to the health

[8] Drew, J. 2002. Differentials in Access to Cervical Cancer Screening For Women with Disabilities in the US. Results from Health Interview Surveys. www.allacademic.com/meta/p182513_index.html -

[9] D. Liska, B. Bruen, A. Salganicoff, P. Long, and B. Kessler. *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*. 3rd ed. Kaiser Commission on the Future of Medicaid, 1997.

[10] Centers for Disease Control and Prevention. (2009). Prevalence and most common causes of disability among adults: United States, 2005. *MMWR*, *58(16)*, 421-426.

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
	needs of all their disabled members. One of the most pressing concerns is the underutilization of preventive care. Research shows that adults with disability receive certain cancer screening rates lower when compared to those without disability.[11]
Numerator: (no numeric value)	The number of members in the denominator population who received one or more Pap tests during the measurement year or the two years prior to the measurement year, identified with any of the codes in Table CCS-A in the below attachment. Please refer to the denominator defined below For a complete description of the 2011 HEDIS® Technical Specifications for the CCS metric, please see the attached.  Z:\WH\Common05\ CommQI\1 STAFF FO The population used for Study Indicator 1 was chosen based on the criteria in these specifications for the Medicaid population using administrative specifications and the optional exclusion criteria for women who had a hysterectomy with no residual cervix. In addition, the population for Study Indicator one excludes members who are not coded as SPDs (Aged/Blind/Disabled-See Activity IV for list of codes).
Denominator: (no numeric value)	Female Medi-Cal SPD (coded as Aged/Blind/Disabled-See Activity IV for list of codes) members aged 24 to 64 years old as of December 31 of the measurement year, who are continuously enrolled during the measurement year defined as no more than a one month gap of enrollment and who have not had a hysterectomy with no residual cervix (Identified with any of the codes in Table CCS-B in the above attachment) as noted as far back as possible in the member's history through December 31 of the measurement year as identified through administrative data.
Baseline Measurement Period	January 1, 2009 through December 31, 2009 (A Pre-Baseline result, January 2009 – November 2009 was reported because initial measurement was taken prior to end of the standard baseline measurement period (December 31, 2009) and prior to the standard 90-day claims data run-out period. 90 days is considered sufficient time for claims data collection and reporting to be mostly complete. Although these results are

11 Wei, W., Findlay, P. A., & Sambamoorthi, U. (2006). Disability and receipt of clinical preventive services among women. *Women's Health Issues*, *16(6)*, 289-296.

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
	not final and are therefore not comparable to any finalized results, they provide a valid method to compare the Medi-Cal SPD and non-SPD populations, and the SPD subgroups because the data has been pulled consistently for all subgroups.)
Baseline Goal	A 1% improvement from baseline to Remeasurement 1 (for all seven counties) and another 1% improvement from Remeasurement 1 to Remeasurement 2 for all six counties and for "All County" administrative rate. A total increase of 2% improvement from baseline to Remeasurement 2 for each of the six counties and the "All County" administrative rate. **Note: '***All county' SPD includes all Health Net contracted counties (Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus and Tulare) in Measurement Years (MY) 2009, and 2010. Starting MY 2011, Fresno County will not be included in the interventions, analysis, and report. Fresno, Madera and Kings Counties contracted with CalViva Health effective March 1, 2011. As a result of the CalViva Health Medi-Cal contract with DHCS, Remeasurement 2 report for Health Net will only include Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties. Fresno County will not be included in the Remeasurement 2 report.*
Remeasurement 1 Period	January 1, 2010 through December 31, 2010
Remeasurement 2 Period	January 1, 2011 through December 31, 2011
Benchmark	N/A
Source of Benchmark	N/A

D. Activity IV: Use a representative and generalizable study population. The selected topic should represent the entire eligible population of Medicaid members with system wide measurement and improvement efforts to which the study indicators apply. Once the population is identified, a decision must be made whether or not to review data for the entire population or a sample of that population. The length of members' enrollment needs to be defined to meet the study population criteria.

California 2010 QIP Summary Form
Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population

Study population:
Study indicator 1 includes all female SPD Medi-Cal members age 24 to 64 years old as of December 31 of the measurement year, who were identified in the eligible population of the 'Cervical Cancer Screening (CCS)' 2011 HEDIS® metric. The study population needs to be continuously enrolled as defined by no more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). These female Medi-Cal members need to be in the SPD (Aged, Blind/Disabled, and Disabled) capitation groups identified with the following Medi-Cal Aid Codes:

Aged: 10, 14, 16, 17, 18, 1E, 1H
Blind/Disabled: 20, 24, 26, 27, 2E, 6A
Disabled: 36, 60, 63, 64, 66, 67, 68, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y

A complete description for each of the above AID Codes is provided in the document below.

CA_DMH_Aid_Codes
MasterChartRev_10F

A complete description of all eligibility criteria for the HEDIS® CCS metric is provided below.

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These specifications are based on the 2011 HEDIS® Technical Specifications, Volume 2. The population used for Study Indicator 1 was chosen based on the criteria in these specifications for the Medicaid population using administrative specifications and the optional exclusion criteria for women who had a hysterectomy with no residual cervix and the additional requirement that the member of the SPD population as described in the study indicator above.

Note: For Pre-Baseline and Baseline the member eligibility specification were based on the 2010 HEDIS® Technical Specifications. For Remeasurement 1 the member eligibility HEDIS® specifications will be based on the 2011 HEDIS® Technical Specifications, and for Remeasurement 2, the member eligibility HEDIS® specifications will be based on the 2012 HEDIS® Technical Specifications.

Note: This study population includes the entire eligible population and is not a sample.

E. Activity V: Use sound sampling methods. If sampling is used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Sampling methods:

No Sampling was used. All SPD female Medi-Cal members age 24 to 64 years old as of December 31 of the measurement year who were identified in the eligible population of the 'Cervical Cancer Screening (CCS)' 2011 HEDIS® metric in all counties were included.

County	Measure	Sample Error and Confidence Level	Sample Size	Population	Method for Determining Size (Describe)	Sampling Method (Describe)
	Study Indicator 1: No sampling was used. All eligible SPD members identified in the HEDIS® eligible population in all counties were included in the study	N/A	N/A	Measurement Period: January 1, 2010 – December 31, 2010 (Remeasurement 1 RY 2011)	N/A	N/A
All Counties				9,293 SPD members found through Health Net Administrative Data		
Fresno				1445 SPD Members		
Kern				663 SPD Members		
Los Angeles				5,320 SPD Members		
Sacramento				1051 SPD Members		
San Diego				320 SPD Members		
Stanislaus				292 SPD Members		

Tulare				202 SPD Members		

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that the data collected on QIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

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Data Collection:

Data collection for Remeasurement 1 was based on administrative data RY HEDIS® 2011 Specifications

Administrative data is systematically collected by the plan for all 7 counties throughout the measurement period. The Health Net HEDIS® team organizes and prepares the data for the audit software data integration (see flow chart diagram attached below) to calculate the HEDIS® rates for NCQA submission. Upon receipt of the Final Audit Report (Summer of HEDIS® Reporting Year) the Quality Improvement (QI) Department collects the final HEDIS® data from the HEDIS® team to data mine and analyze Study Indicator 1. Therefore the data collection cycle for the plan and the HEDIS® team is continuous while the data collection and data analysis cycles by the QI Department is once a year.

Because the pre-baseline measurement period occurred prior to the end of the 2009 Measurement Year (MY) and the Health Net HEDIS® team did not complete the final results of the RY 2010 HEDIS® CCS metric until the summer of 2010, the QI Department collected the pertinent data directly from the Health Net data systems to obtain pre-baseline results of all seven counties for this QIP. This data extraction occurred on December 1, 2009 and therefore excluded December 2009 claims/encounter and enrollment data and was pulled prior to the standard 90-day claims data run-out period that is considered sufficient time for claims data collection and reporting to be mostly complete. Therefore, the pre-baseline measurement is based on data that is considered to be mostly complete from January 1, 2009 through August 31, 2009 for all seven counties. Although these results are not the final results and are therefore not comparable to any finalized results, they have provided a valid method to compare the Medi-Cal SPD and non-SPD populations, and SPD subgroups in support of the study topic because the data was pulled consistently for all subgroups. The official baseline results are based on the final RY2010 HEDIS® data prepared by the Health Net HEDIS® team and the Remeasurement 1 results are based on the final RY2011 HEDIS® data prepared by the Health Net HEDIS® team. The QI department extracted enrollment data directly from the Health Net data systems to identify the SPD population within the RY2010 HEDIS® and RY2011 HEDIS® data prepared by the Health Net HEDIS® team.

Timeline for Collection of Baseline and Remeasurement Data:

Pre Baseline: Data was collected for January 1, 2009 through November 30, 2009 (Data collection occurred prior to standard 90 day claims data run-out period)

Baseline: Data was collected for January 01, 2009 through December 31, 2009.

Remeasurement 1: Data was collected January 01, 2010 through December 31, 2010.

Remeasurement 2: Data to be collected for January 01, 2011 through December 31, 2011.

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that the data collected on QIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Calculation of Study Indicators

Study Indicator 1

Study indicator 1 calculates the percentage of eligible Medi-Cal SPD women 24 to 64 years of age as of December 31 of the measurement year who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

Step 1 Data Collection: For the pre-baseline results included in this QIP, member data for all seven counties were obtained directly from the Health Net data systems by the Senior Research Analyst S. Clark, MSPH. Data for the Medi-Cal population is stored in QCARE within Health Net's IBM Mainframe and is pulled using the TSO environment that connects to the IBM mainframe where QCARE is located. Within the TSO environment, SAS® software is utilized for all data extractions.

For the baseline results of all seven counties as reported in 2010, the QI Department Research and Analysis Team (QIRA) received the final HEDIS® datasets for the CCS HEDIS® metric for each county from the HEDIS® team in the form of text files. The datasets contain the member and provider information for each Health Net member identified in the eligible population (denominator) for this HEDIS® metric. Each member is classified with a coding system to identify their eligibility in the numerator and in the denominator as defined in the RY2010 HEDIS® Technical Specifications for the CCS HEDIS® metric. The QI department then extracted enrollment data from QCARE to identify and isolate the SPD population within the RY2010 HEDIS® data prepared by the Health Net HEDIS® team.

For the Remeasurement 1 results of all seven counties as reported in 2011, the QI Department Research and Analysis Team (QIRA) received the final HEDIS® datasets for the CCS HEDIS® metric for each county from the HEDIS® team in the form of text files. The datasets contain the member and provider information for each Health Net member identified in the eligible population (denominator) for this HEDIS® metric. Each member is classified with a coding system to identify their eligibility in the numerator and in the denominator as defined in the RY2011 HEDIS® Technical Specifications for the CCS HEDIS® metric. The QI department then extracted enrollment data from QCARE to identify and isolate the SPD population within the RY2011 HEDIS® data prepared by the Health Net HEDIS® team.

Step 2 Data Analysis – Calculate Study Indicator 1. For each county, divide the total number of SPD members identified in the numerator by the total number of SPD members identified in the denominator found in the CCS HEDIS® dataset for each HEDIS® reporting year. A higher rate indicates appropriate cervical cancer screenings (i.e. the proportion who received one or more Pap tests to screen for cervical cancer during the measurement period). Multiply ratio by 100 to calculate the percentage.

$$Study\ Indicator\ 1 = \left(\frac{Total\ \ Number\ of\ \ SPD\ Members\ in\ \ the\ HEDIS\ \ Numerator}{Total\ \ Number\ of\ \ SPD\ Members\ \ in\ the\ HEDIS\ \ Deno\min ator} \right) x\ 100$$

All Study Indicator 1 results will be reported for each of the seven Health Net contracted counties as well as the combined 'All County' Rate. The results will additionally be stratified and analyzed by age, language and ethnicity at both the individual county and 'All County' levels.

Note: '*All county' SPD includes all Health Net contracted counties (Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus and Tulare) in Measurement Years (MY) 2009, and 2010. Starting MY 2011, Fresno County will not be included in the interventions, analysis, and report. Fresno, Madera and Kings Counties contracted with CalViva Health effective March 1, 2011. As a result of the CalViva Health Medi-Cal contract with DHCS, Remeasurement 2 report for Health Net will only include Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties. Fresno County will not be included in the Remeasurement 2 report.*

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that the data collected on QIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Data Sources

[ ] Hybrid (medical/treatment records and administrative)

[ ] Medical/Treatment Record Abstraction
Record Type
[ ] Outpatient
[ ] Inpatient
[ ] Other _____

Other Requirements
[ ] Data collection tool attached
[ ] Data collection instructions attached
[ ] Summary of data collection training attached
[ ] IRR process and results attached

[ ] Other data

Description of data collection staff (include training, experience, and qualifications):

[X] Administrative Data
Data Source
[X] Programmed pull from claims/encounters
[ ] Complaint/appeal
[ ] Pharmacy data
[ ] Telephone service data /call center data
[ ] Appointment/access data
[ ] Delegated entity/vendor data _____
[X] Other Monthly FAME membership data

Other Requirements
[ ] Data completeness assessment attached
[ ] Coding verification process attached

[ ] Survey Data
Fielding Method
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Other _____

Other Requirements
[ ] Number of waves _____
[ ] Response rate _____
[ ] Incentives used _____

F. Activity VIb: Determine the data collection cycle.	Determine the data analysis cycle.
[X] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): For all Counties	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): For all counties

F. Activity VIc. Data analysis plan and other pertinent methodological features.

Estimated degree of administrative data completeness: 84.8 percent.

For the Study, Health Net will use administrative data only based on RY 2010, RY 2011 and RY 2012 HEDIS® Specifications to compare results from baseline, Remeasurement 1 and Remeasurement 2, respectively to have consistency and validity of results in all seven counties.

Describe the process used to determine data completeness and accuracy.

In HEDIS® RY 2011, the degree of administrative data completeness was found to be 84.8% complete for the CCS metric compared to hybrid data completeness based on HEDIS® data for the entire Medi-Cal CCS eligible population. Data completeness was calculated using the results for the Medi-Cal Accreditation CCS Metric (all counties) by the following formula:

$$Data\ Completeness = \left(\frac{Number\ of\ Numerator\ Events\ found\ in\ Administrative\ Data}{Total\ Number\ of\ Reported\ Numerator\ Events\ (Administrative\ \&\ Medical\ Record\ Data)} \right) x\ 100$$

In addition, the most recent HEDIS® Final Audit Report as attached below validated that Health Net met the RY2011 HEDIS® Technical Specifications.

HEDIS® measures are specified for one or more of three data collection methods – Administrative, Hybrid or Survey. Health Net utilizes the Administrative and Hybrid methods on a number of applicable HEDIS® metrics. The Administrative method is used to identify the eligible population and numerator using administrative data found in the

organization's databases. Hybrid method is used to identify the numerator using both administrative and medical record data. Medical records may have information on a visit by a Health Net member that is not found in the administrative databases. Factors that may influence the lack of administrative data relate to the incompleteness of encounter information relayed to the health plan from Participating Physician Groups (PPGs), who may assume financial responsibility for certain services. Payment from the health plan is not required in the transfer of encounter data; unlike in cases where a claim is filed for payment from the health plan to the PPG. To determine administrative data completeness, Health Net's HEDIS® data of the Cervical Cancer Screening metric, which is calculated using both administrative and hybrid methods, is provided below. The table includes results for the entire Medi-Cal CCS eligible population in addition to the results for the SPD sub-population within this group.

	HEDIS® RY 2011 (%)			
	# of Numerator Events: Administrative Data	**# of Numerator Events: Medical Records**	**Total Number of Reported Numerator Events (Administrative Data+Medical Records)**	**% Complete**
Cervical Cancer Screening	1446	259	1705	84.81

Supporting documentation:
Final RY2011 HEDIS® Audit Report

MCAL HEDIS 2011
Compliance Audit Fina

Flow chart diagram of HEDIS® administrative data collection to be utilized during baseline and Remeasurement years.
Supporting documentation:

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G. Activity VIIa: Include improvement strategies. (Interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "Hired four customer service representatives" as opposed to "Hired customer service representatives"). Do not include intervention planning activities.

County	Date Implemented (MMYY)	Check if Ongoing	Interventions	Barriers That Interventions Address
*If interventions are across all counties, plans can enter "All" in the County column. **Note: '***All county' SPD includes all Health Net contracted counties (Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus and Tulare) in Measurement Years (MY) 2009, and 2010. Starting MY 2011, Fresno County will not be included in the interventions, analysis, and report. Fresno, Madera and Kings Counties contracted with CalViva Health effective March 1, 2011. As a result of the CalViva Health Medi-Cal contract with DHCS, Remeasurement 2 report for Health Net will only include Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties. Fresno County will not be included in the Remeasurement 2 report.*				
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	01/10		Health Net's customer contact center are provided access to the list of providers and offices that provide access and accommodation to SPD members in all seven counties. New and current SPD members who contact HN customer contact center verify the type of accommodation available at a provider site. Accommodations provided by provider offices include but are not limited to: ▪ accessible parking spaces ▪ doorways have a minimum of 32" wide and opens at 90 degrees ▪ elevator wide enough for wheelchair and have Braille buttons ▪ electronic beds ▪ accessible scales These data are collected through the Facility Site Review audits and Physical Accessibility Review Surveys. These results are shared with HN customer contact center.	▪ Challenge in identifying providers who can provide SPD access in all seven counties
All Counties o Fresno	04/10		Published an article in the Provider E-newsletter the importance of preventive health care screening i.e.	▪ Providers may not be aware that SPDs need Pap testing

o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare			CCS that include SPD population for all seven counties	▪ Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	04/10		Sent all providers in the seven counties list of their SPD eligible members due for CCS (Pap Testing). The letter encouraged providers to reach out to their patients listed who are due for Pap testing. Letters were sent to 911 PCPs and 196 clinics in all counties.	▪ Providers may not be aware that SPDs need Pap testing ▪ Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	05/10		Health Net identified 6,863 SPD members in all seven counties who did not have CCS in the last two years. An IVR reminder call in English and Spanish was initiated encouraging CCS negative SPD women to make appointment with their doctor for Pap testing. Reach rate for the IVR call was 43.4%	▪ Members are not aware that early detection through Pap testing results in better chance for recovery ▪ Members think that Pap testing is complicated and too uncomfortable a procedure ▪ Members think that since they are asexual Pap testing may not be needed ▪ SPD members are not told that they need Pap test also
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	05/10		Health Net published an article in the member newsletter titled 'Be Well with Health Net" that discussed the importance of CCS screening- Pap test. The newsletters were mailed to all members in all counties	▪ Members are not aware that early detection through Pap testing results in better chance for recovery ▪ Member thinks that Pap testing is complicated and too uncomfortable a procedure ▪ Members think that since they are asexual Pap testing may not be needed ▪ SPD members are not told that they need Pap test also
All Counties o Fresno o Kern o LA	06/10		Office sites in all seven counties are evaluated for appropriate medical equipment and physical accessibility to the facility for SPDs by facility site review RNs. These data are compiled, updated and	▪ Pulling data to determine Providers who have appropriate equipments to examine members is difficult and time consuming ▪ Some provider's offices do not have health

o Sacramento o San Diego o Stanislaus o Tulare			shared with customer contact center to share with new and concurrent SPD members.	care equipments for examining members with disabilities. ▪ Providers do not believe accessible facilities are needed. ▪ Lack of financial resources to procure appropriate medical equipment for SPDs.
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	09/10		The selected health education topic in September was Preventive Screening Guideline. One topic that was emphasized was CSS – Pap testing every one to three years for women 21-64 years old. To promote the topic selected the Customer Solution Specialists' (CSS) distributed Well Woman Pad and Women Screening guidelines to providers reminding them to have their patients including SPD women 21-64 years old who are due for Pap testing be scheduled for testing.	▪ Providers may not be aware that SPDs need Pap testing ▪ Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Fresno o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	11/10		The Member Newsletter published an article titled: "Women: Check up on your health". The article emphasized the importance of cervical cancer screening through Pap testing for those women 21 years and older every one to three years and to call their doctor for appointment. The newsletter also provided the customer service center and nurse advice line phone numbers to call for questions.	▪ Members are not aware that early detection through Pap testing results in better chance for recovery ▪ Member thinks that Pap testing is complicated and too uncomfortable a procedure ▪ Members think that since they are asexual Pap testing may not be needed ▪ SPD members are not told that they need Pap test also
All Counties o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	04/11		Providers in the six counties (Kern, LA, Sacramento, San Diego, Stanislaus and Tulare) were sent list of their SPD eligible members who are due for CCS (Pap Testing) and encouraged them to reach out to these members for Pap testing. Letters were sent to 775 PCPs and 171 clinics with a total member of 5,575 members who are due for Pap testing.	▪ Providers may not be aware that SPDs need Pap testing ▪ Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Kern o LA o Sacramento	04/11		Published an article in the Provider E-newsletter titled: 'Educating Female Patients on Cervical Cancer Screening and Risk Factors'. The article also encouraged providers to counsel women over	▪ Providers may not be aware that SPDs need Pap testing ▪ Providers may not perform Pap testing to SPDs since it is time consuming and some

o San Diego o Stanislaus o Tulare			age 40 beyond child bearing age to continue this important testing that includes SPDs.	takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	05/11		Health Net identified 5,434 SPD members in all six counties who did not have CCS in the last two years and made an IVR reminder call in English and Spanish encouraging them to make appointment with their doctor for Pap testing. Reach rate for the IVR call was 43.4%	▪ Members are not aware that early detection through Pap testing results in better chance for recovery ▪ Members think that Pap testing is complicated and too uncomfortable a procedure ▪ Members think that since they are asexual Pap testing may not be needed ▪ SPD members are not told that they need Pap test also
All Counties o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	05/11		In May 2011, providers who responded to the provider member profile mailing were sent letters acknowledging their efforts in improving CCS and addressing the concerns they have about the list of members sent to them. The letter was signed by the Health Net Senior Medical Director and follow-up calls were made by Health Net's Sr. QI Specialist for providers who had comments and concerns that were not covered by the letter.	▪ Providers may not be aware that SPDs need Pap testing ▪ Providers may not perform Pap testing to SPDs since it is time consuming and some takes up more staff resources ▪ Providers may not be aware that preventive screening rates are lower for members with disabilities.
All Counties o Kern o LA o Sacramento o San Diego o Stanislaus o Tulare	07/11		Revised the Well Woman Pad and translated to English, Spanish, Vietnamese, Chinese and Hmong. The Well Woman sheet reminds women to have Pap testing at recommended age and intervals with a tear out to document their last and next Pap testing schedule. These pads are delivered for providers to remind women due for Pap testing and to set up appointment as appropriate	▪ Members think that since they are asexual Pap testing may not be needed ▪ SPD members are not told that they need Pap test also

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, developing and implementing system wide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or member level.

Interventions:

Describe interventions/improvement strategies for each measurement period.

Selection of CCS among SPDs as a QIP is based on available data and studies by literature searches of Medline, PubMed, and NIH. Once a topic is selected as a Quality Improvement Project, barrier analysis is performed and specific barriers are selected to develop initiatives to improve outcomes. Interventions selected are further evaluated for its effectiveness considering time frame and resources needed for implementation. In addition, the proposed QIP topic is presented to the Health Net State Health Program (SHP) Utilization Management (UM)/Quality Improvement (QI) Committee to solicit ideas for causal/barrier analyses and interventions that could lead to improved results. Health Net believes that improvement of CCS among SPD Health Net members will enhance health care status.

On a regular basis at least monthly, the Health Net State Health Program (SHP) Quality Improvement (QI) team meets to discuss the status of quality improvement activities. Discussions include status of initiatives, barriers and/or enhancements to implemented initiatives, processes and responses of targeted population. Once the results of the measurements are in, a brainstorming session is held to analyze QI metrics' results, evaluation of interventions implemented and opportunities for improvement. Annually, Health Net presents the QIP to the State Health Program UM/QI Committee for further analysis, evaluation and plan for interventions.

Barrier analysis is performed to plan for interventions in all seven counties. The QI team in the development of specific barriers put into consideration the analysis performed on age, ethnicity, language and degree of incidence among the targeted population at least annually. A Cause and Effect Fishbone Diagram is developed to identify specific member, provider and health plan barriers. Barriers identified are prioritized and interventions are selected based on its effectiveness and timeliness to initiate the activity to achieve the most impact on outcomes. The baseline results showed more than a 13% CCS difference between SPD and non-SPD populations in the 'All County' results and the difference between SPDs and non-SPDs within each of the seven counties ranged from 11 to 25 percent. As a result of these analyses, interventions implemented were aimed to target the entire Health Net population of SPDs in each of the seven counties with similar interventions in all counties.

Below is the Health Net's fishbone diagram to identify barriers and to plan initiatives believed to increase CCS among female SPD Medi-Cal members in all seven counties
Note: The barriers identified in the diagram apply to all seven counties.

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G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, developing and implementing system wide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or member level.

Analysis by Age, Language and Ethnicity in all seven counties in measurement year 2009

Data Analysis by Age
The MY2009 results were stratified by county and age group, and an adjusted Chi-Square Test of Proportions with an alpha of 0.05 was used to test for differences between age categories for the 'All Counties' results and for the county specific results. (Tables 4a & 4b) There was a significant difference in rates by age group for the 'All County' data and for Fresno, Los Angeles and Sacramento counties, with cervical cancer screening rates decreasing with increasing age. Kern, San Diego, Stanislaus, and Tulare counties did not have statistically significant differences in the CCS rates between age categories. However, each individual county did have a similar age trend, with the exception of Tulare. The inconsistent trend in Tulare is likely due to the lower precision of the estimates due to the small sample sizes in the age strata.

Data Analysis by Language
Note: Testing for language-based differences in rates was done in the 'All Counties' data for those language subgroups with at least 50 members and a similar analysis was done for each county individually. Members with no valid language data or did not have a valid language value in the administrative data (from member eligibility FAME files) are removed from the analysis.

To test for a significant difference in CCS rates for MY2009 between language subgroups that were comprised of at least 50 SPD members within individual counties and at the 'All County' level, a Chi-Square Test of Proportions was conducted using an alpha of 0.05. The 'All Counties' result demonstrated significant differences by language. Spanish and Vietnamese speakers had the highest rates, and the rate for English speakers was about 10% lower than Spanish and Vietnamese speakers. The lowest rates were observed for Cambodian and Hmong speakers. In Los Angeles county, the CCS rates were significantly different between language categories. Spanish speakers had the highest rate with English and Vietnamese speakers trailing slightly behind. Cambodian speakers in L.A. county had a rate that was far below the other groups with a 30% difference compared to Spanish speakers. In Sacramento county, Hmong speakers had a significantly lower rate compared to English speakers. No statistically significant differences were seen between language subgroups in Fresno and Kern counties, though this result could be related to the relatively small sample size for the Spanish-speaking subgroup. Differences between language subgroups in San Diego, Stanislaus, and Tulare counties were not tested because only one language strata had a sample size of 50 or greater in each of these counties. (Tables 6a & 6b)

Data Analysis by Ethnicity
Note: Testing for ethnicity-based differences in rates was done in the 'All Counties' data for those language subgroups with at least 50 members and a similar analysis was done for each county individually. Members with no valid ethnicity data or members who declined to state their ethnicity in the administrative data (from member eligibility FAME files) are removed from the analysis.

To test for a significant difference in CCS rates for MY2009 between ethnic subgroups that were comprised of at least 50 SPD members within individual counties and at the 'All County' level, a Chi-Square Test of Proportions was conducted using an alpha of 0.05. There were significant differences between ethnic subgroups found in the 'All Counties' results. Lower rates were observed for White, Other Asian/Pacific Islander, and Alaskan Native/American Indian ethnicities as compared to Blacks and Hispanics. There were also significant ethnicity differences observed in the Los Angeles and Fresno county specific data, where trends for the higher volume ethnic groups ($N \geq 50$) nearly mirrored that of the 'All Counties' data. No statistically significant differences were seen between language subgroups in Kern, Sacramento, San Diego, and Tulare counties and the sample

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, developing and implementing system wide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or member level.

sizes were too small to make valid statistical comparisons between language groups in the county of Stanislaus. (Tables 8a & 8b)

Describe interventions:
Health Net's interventions for all seven counties are similar and are based on past research, barrier analysis, age, ethnicity and language analysis, and cost-effectiveness of each activity. In addition, interventions were implemented noting the baseline SPD and non-SPD CCS results that showed a 13% difference in the 'All County' results and 11 to 25 percent difference among the seven counties.

Based on analysis by age, ethnicity and language for MY2009 and MY2010, providers of all CCS negative members were notified of their patients needing Pap testing and members were reminded through IVR reminder call in English and Spanish in all counties. In addition, the Well Woman pad was revised and made available in English, Spanish, Hmong, Vietnamese and Chinese versions to address those who have indicated speaking a different language than English.

These interventions are planned to increase the proportion of eligible SPDs who receive timely cervical cancer screenings by accomplishing the following: (1) increasing awareness among members and providers about the importance of cervical cancer screening and (2) delivering targeted, regular reminders to members and providers urging them to have the pap test performed.

Interventions from Baseline to Remeasurement 1: MY 2010 (January 1, 2010 through December 31, 2010)

Initiatives Implemented: All Counties

Health Plan Level
The FSR nurses audit, collect and update provider's data in all seven counties who provide accommodation and access to SPDs. This information is shared with the customer contact center who shares with SPD members who needed appropriate SPD access with their providers

Provider Level
- Published an article in the Provider E-newsletter the importance of preventive health care screening like CCS for the SPD population in April 2010
- Sent Providers at all seven counties list of their SPD eligible members needing CCS (Pap Testing) encouraging them to reach out to these members for Pap testing. Letters were sent to 911 PCPs and 196 clinics to all counties in May 2010
- Community Solution Specialists' (CSS) Health Education topic for the month of September 2010 was Preventive Screening guidelines. The CSS distributed Well Woman Pad and Women Screening guidelines reminding providers to have their members tested per guideline including SPDs. Testing includes Pap testing for women 21- 64 years old every one to three years.
- In March 2011, Health Net published an article in the Provider E-newsletter the importance of CCS for the SPD population. The article also informed providers that they will be receiving a list of their patients who are due for Pap testing
- In April 2011, providers in the six counties (Kern, LA, Sacramento, San Diego, Stanislaus and Tulare) were sent list of their SPD eligible members needing CCS (Pap Testing) encouraging them to reach out to these members. Letters were sent to 775 PCPs and 171 clinics with a total member of 5,575 members who are due for Pap testing (April 2011)

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, developing and implementing system wide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or member level.

- Published an article in the Provider E-newsletter titled: 'Educating Female Patients on Cervical Cancer Screening and Risk Factors'. The article also encouraged providers to counsel women over age 40 beyond child bearing age to continue this important testing - April 2011

Member Level

- Health Net identified 6,863 SPD members who were CCS negative in all seven counties. IVR reminder calls were made to these CCS negative members to make appointment with their doctor for Pap testing. Reach rate for the IVR call was 43.4%. This initiative was implemented in April 2010
- Health Net published an article in the member newsletter at all seven counties emphasizing the importance of cervical cancer screening for women 21 -64 year olds and emphasized its importance to SPD members. The newsletter was published in May 2010
- Health Net's customer contact center is provided access to the list of providers and offices that provide access and accommodation for SPD members in all seven counties so that new and current SPD members who contact HN customer contact center may be given list of providers who can accommodate members with special needs.
- Health Net identified 5,434 SPD members in all six counties who did not have CCS in the last two years and made an IVR reminder call in English and Spanish encouraging them to make appointment with their doctor for Pap testing. Reach rate for the IVR call was 43.4% - May 2011
- Revised and distributed to provider's offices the Well Woman Pad describing the importance of regular women screening. The Well Woman pad was translated to English, Spanish, Vietnamese, Chinese and Hmong. The Well Woman sheet reminds women to have Pap testing at recommended age and intervals with a tear out noting their last and next Pap testing schedule. July2011

Remeasurement 1 to Remeasurement 2:

For Remeasurement 1 to Remeasurement 2 the Health Net Cultural and Linguistic team and Health Education Team was contacted and asked to include CCS topic in their monthly Community Advisory Committee (CAC) meetings to obtain member feedback that will help identify and address barriers and develop possible interventions to improve CCS rates among multiple ethnic groups including bur not limited to Hmong, Russian and Cambodian population.

Note: *Starting MY 2011 all interventions will be implemented to six counties. Fresno county was removed from the QIP process since Fresno is currently part of another Health Plan, CalViva Health, effective March 1, 2011.*

H. Activity VIIIa. Data analysis: Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g. data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and p values.

Describe data analysis and interpretation:

Baseline Measurement:

Study Indicator 1

The baseline performance rates will be calculated by age category, language, and ethnicity for 'All Counties' and for each of the seven Medi-Cal counties. All rates for Study Indicator 1 will be calculated as described in Activity VIa. The Remeasurement 2 overall rate for "All Counties" and each of the six counties will be compared to the established goal of an overall 2% increase from Baseline with a goal of 1% improvement from Baseline to Remeasurement 1 and another 1% improvement from Remeasurement 1 to 2.

H. Activity VIIIa. Data analysis: Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g. data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and p values.

To test for a significant increase between Baseline to Remeasurements 1 and 2, a continuity-adjusted Chi-Square Test of Proportions will be conducted at an alpha of 0.05 for the overall "All Counties" rates as well as for each county rates.

Note: No internal factors were identified that may threaten the validity of the findings for Study Indictor 1.

Baseline Measurement:

Fresno: The Baseline Measurement was calculated for the entire eligible Fresno county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

Kern: The Baseline Measurement was calculated for the entire eligible Kern county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

Los Angeles: The Baseline Measurement was calculated for the entire eligible Los Angeles county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

Sacramento: The Baseline Measurement was calculated for the entire eligible Sacramento county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

San Diego: The Baseline Measurement was calculated for the entire eligible San Diego county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa

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Stanislaus: The Baseline Measurement was calculated for the entire eligible Stanislaus county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

Tulare: The Baseline Measurement was calculated for the entire eligible Tulare county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa

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All Counties: The Baseline Measurement was calculated for the entire eligible 'All Counties' population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa.

Baseline to Remeasurement 1:

Fresno: Remeasurement 1 will be calculated for the entire eligible Fresno county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Fresno County rate. A continuity-

H. Activity VIIIa. Data analysis: Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g. data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and p values.

adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Kern: Remeasurement 1 will be calculated for the entire eligible Kern county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Kern County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Los Angeles: Remeasurement 1 will be calculated for the entire eligible Los Angeles county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Los Angeles County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Sacramento: Remeasurement 1 will be calculated for the entire eligible Sacramento county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Sacramento County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

San Diego: Remeasurement 1 will be calculated for the entire eligible San Diego county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the San Diego County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Stanislaus: Remeasurement 1 will be calculated for the entire eligible Stanislaus county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Stanislaus County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Tulare: Remeasurement 1 will be calculated for the entire eligible Tulare county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the Tulare County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

All Counties: Remeasurement 1 will be calculated for the entire eligible 'All County' population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 1, there is a goal of a 1% increase from the Baseline Measurement of Study Indicator 1 for the 'All County' rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

Remeasurement 1 to Remeasurement 2:

Kern: Remeasurement 2 will be calculated for the entire eligible Kern county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the Kern County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change.

H. Activity VIIIa. Data analysis: Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g. data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and p values.
Los Angeles: Remeasurement 2 will be calculated for the entire eligible Los Angeles county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the Los Angeles County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **Sacramento:** Remeasurement 2 will be calculated for the entire eligible Sacramento county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the Sacramento County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **San Diego:** Remeasurement 2 will be calculated for the entire eligible San Diego county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the San Diego County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **Stanislaus:** Remeasurement 2 will be calculated for the entire eligible Stanislaus county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the Stanislaus County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **Tulare:** Remeasurement 2 will be calculated for the entire eligible Tulare county population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the Tulare County rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **All Counties:** Remeasurement 2 will be calculated for the entire eligible 'All County' population as defined in Activity IV and then stratified by age, language, and ethnicity as described in Activity VIa. For Remeasurement 2, there is a goal of a 1% increase from Remeasurement 1 and an overall 2% increase from Baseline of Study Indicator 1 for the 'All County' rate. A continuity-adjusted Chi-Square test of proportions will be conducted at an alpha of 0.05 to test for a statistically significant change. **Note:** *Fresno County is contracted with CalViva Health effective March 1, 2011 and will not be included in interventions, analysis, and Remeasurement 2 report*

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.
Interpretation of study results (address factors that threaten the internal or external validity of the findings for each measurement period): **The submission must include an interpretation of each county's study indicator result for every measurement period. For Baseline, the interpretation should include study indicator results for each county compared to the established goal for that county. For all subsequent Remeasurements, the interpretation should also include**

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

statistical testing results including p values.

Baseline Measurement:

Study Indicator 1

Data Analysis by SPD

Table 3 presents the Study Indicator 1 results for the Baseline (Measurement Year 2009) and Remeasurement I (Measurement Year 2010) measurement periods as defined in Activity III. The Measurement Year (MY) 2009 results indicate the percentage of SPD women age 24 to 65 as of December 31, 2009 who were eligible in the denominator for the CCS metric as defined in Activity III who received one or more Pap tests to screen for cervical cancer within calendar years 2007 through 2009 as found in HN administrative data. The MY2010 results indicate the percentage of SPD women age 24 to 65 as of December 31, 2010 who were eligible in the denominator for the CCS metric as defined in Activity III who received one or more Pap tests to screen for cervical cancer within calendar years 2008 through 2010 as found in HN administrative data. The MY2009 and MY2010 results are stratified by SPD/non-SPD cohorts and by county. To test for a significant difference between the MY2009 and MY2010 results, a Continuity Adjusted Chi-Square test of Proportions was conducted at an alpha level of 0.05.

Table 3. Baseline/Remeasurement 1 Results: Study Indicator 1 (%) MY2009 vs. MY2010 by County

	2009		2010		P-Value
County	N	%	N	%	2010 vs. 2011
Fresno	490	40.2	1,445	45.5*	0.0483*
Kern	711	40.9	663	41.5	0.8791
Los Angeles	5,320	50.8	5,320	50.5	0.7712
Sacramento	647	39.6	1,051	37.4	0.3987
San Diego	378	42.1	320	43.4	0.7727
Stanislaus	275	44.7	292	47.9	0.4942
Tulare	160	40.6	202	46.5	0.3084
All Counties	7,981	47.5	9,293	47.2	0.6586

* Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010

The goal for the Remeasurement 1 was to increase the 'All Counties' SPD rate as well as each of the seven individual counties' SPD rates by 1% comparing MY2009 and MY2010. This goal was met for the SPD populations in Fresno, San Diego, Stanislaus and Tulare counties. In addition, the increase in Fresno county was statistically significant. However, the goal of a 1% increase was not realized in the other three counties or in the 'All counties' SPD rate. These results indicate the need to further perform barrier analysis and continue to focus interventions aimed at increasing CCS rates within the SPD population, especially in those counties that did not have an increase. The goal for the Remeasurement 2 will be to increase the 'All Counties' SPD rate as well and each of the individual counties' SPD rates by 1% comparing the 2010 and 2011 measurement years and an overall 2% increase when comparing the baseline and 2011 measurement years.

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

Data Analysis by Age

Tables 4a & 4b present the Study Indicator 1 results for the Baseline (MY2009) and Remeasurement I (MY2010) Measurement periods as defined in Activity III stratified by county and age group. A continuity adjusted Chi-Square Test of Proportions with an alpha of 0.05 is used to test for differences in each age category between measurement years and a Chi-Square Test of Independence with an alpha of 0.05 is used to test for differences within each measurement year between age categories within counties for the 'All Counties results' and for the county specific results. Cervical cancer screening rates are shown to decrease with increasing age across all counties and at the 'All County' level in MY2010 with statistically significant differences seen in Fresno, Los Angeles, Sacramento, San Diego, and the 'All Counties' rates. Although there was a statistically significant increase in Fresno county in the 'All Ages' rate, there were no statistically significant differences between MY2009 and MY2010 results within the age stratifications in any of the seven counties or at the 'All County' level. However, although not statistically significant, in Fresno and Tulare, there were increases in each age group, with an increase of 7% in the 41-55 year olds in Fresno county and an increase of over 11% in the 24-40 year olds in Tulare county. In Stanislaus there was a 7% increase seen in the rate for the 56-64 year olds. In Sacramento, there were decreases in the 24-40 year old and 56-64 year old age groups with nearly a 9% decrease in the youngest age group, although not statistically significant.

Table 4a. Study Indicator 1 (%) SPD Results by Age, County, and HEDIS® Measurement Year 2009-2010

	FRESNO				KERN				LOS ANGELES				SACRAMENTO			
	2009*		2010*		2009		2010		2009*		2010*		2009*		2010*	
Age Group	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
24-40 Years	124	57.3	344	61.6	194	45.4	195	45.1	1319	55.2	1282	53.2	168	51.8	243	43.2
41-55 Years	212	37.7	630	44.6	361	41.0	307	41.0	2492	51.5	2469	52.3	312	37.5	511	39.7
56-64 Years	154	29.9	471	34.8	156	35.3	161	37.9	1509	45.7	1569	45.4	167	31.1	297	28.6
All Ages	490	40.2	1445	45.5 ▲	711	40.9	663	41.5	5320	50.8	5320	50.5	647	39.6	1051	37.4

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤ 0.05) between age categories

Table 4b. Study Indicator 1 (%) SPD Results by Age, County, and HEDIS® Measurement Year 2009-2010 (Continued)

	SAN DIEGO				STANISLAUS				TULARE				ALL COUNTIES			
	2009		2010*		2009		2010		2009		2010		2009*		2010*	
Age Group	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
24-40 Years	120	46.7	99	51.5	77	53.2	83	50.6	52	40.4	64	51.6	2054	53.2	2310	52.5
41-55 Years	171	43.3	152	43.4	127	43.3	129	48.1	71	42.3	84	47.6	3746	47.7	4282	48.3
56-64 Years	87	33.3	69	31.9	71	38.0	80	45.0	37	37.8	54	38.9	2181	41.8	2701	40.8
All Ages	378	42.1	320	46.6	275	44.7	292	48.0	160	40.6	202	46.5	7981	47.5	9293	47.2

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤ 0.05) between age categories

Data Analysis by Language

Tables 5a & 5b present the Study Indicator 1 results for the Baseline (MY2009) and Remeasurement I (MY2010) Measurement periods as defined in Activity III stratified by county and language. Members with no valid language data or did not have a valid language value in the administrative data (from member eligibility FAME files) are removed from the analysis. Note that percentages with at least 50 Eligible Study Members in the category are bolded and the cell is un-shaded. Because of the sparse data in this table, valid significance testing could not be done using all Language categories. Testing for differences in rates between measurement years and between language categories within counties was done on the 'All Counties' data for those language subgroups with at least 50 members (Tables 6a & 6b). A similar analysis was done for each county individually.

Table 5a. Study Indicator 1 (%) SPD Results by Language, County, and HEDIS® Measurement Year 2009-2010

	FRESNO				KERN				LOS ANGELES				SACRAMENTO			
	2009		**2010***		**2009**		**2010**		**2009***		**2010***		**2009***		**2010***	
Language	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
American Sign Language	-	-	3	66.7	-	-	-	-	12	50.0	8	75.0	1	100	2	100
Arabic	-	-	-	-	-	-	-	-	9	33.3	9	44.4	-	-	1	0.0
Armenian	11	18.2	20	35.0	-	-	-	-	9	33.3	11	18.2	1	0.0	2	0.0
Cambodian	5	20.0	11	27.3	2	100	1	100	**91**	**28.6**	**87**	**29.9**	8	50.0	8	62.5
Cantonese	-	-	-	-	-	-	-	-	19	52.6	21	57.1	19	36.8	30	43.3
English	**323**	**44.0**	**987**	**47.0**	**584**	**40.9**	**553**	**41.6**	**3698**	**49.9**	**3766**	**49.7**	**366**	**44.3**	**610**	**38.2**
Farsi	1	100	1	100	-	-	-	-	11	63.6	8	62.5	2	50.0	3	33.3
Hmong	15	13.3	**101**	**22.8**	-	-	-	-	-	-	-	-	**85**	**29.4**	**98**	**36.7**
Japanese	-	-	-	-	1	0.0	-	-	1	0.0	2	50.0	-	-	1	0.0
Korean	-	-	-	-	-	-	-	-	4	25.0	4	0.0	-	-	-	-
Lao	2	0.0	10	30.0	1	0.0	-	-	1	0.0	1	0.0	25	20.0	27	33.3
Mandarin	-	-	-	-	-	-	-	-	12	66.7	11	54.6	-	-	-	-
Mien	-	-	-	-	-	-	-	-	-	-	-	-	8	25.0	21	33.3
Other Chinese	-	-	-	-	-	-	-	-	2	100	5	80.0	-	-	-	-
Other Non-English	4	25.0	14	42.9	-	-	-	-	4	25.0	4	0.0	10	10.0	18	16.7
Other Sign Language	1	100	1	100	-	-	-	-	1	100	1	0.0	-	-	-	-
Russian	6	50	10	80.0	-	-	-	-	2	50.0	1	100	12	25.0	**82**	**20.7**
Samoan	-	-	-	-	-	-	-	-	2	50.0	1	0.0	-	-	-	-
Spanish	**67**	**41.8**	**139**	**52.5**	**69**	**52.2**	**67**	**44.8**	**969**	**58.2**	**948**	**58.4**	15	60.0	23	65.2

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

Tagalog	-	-	-	-	1	0.0	1	0.0	8	37.5	9	44.4	5	60.0	6	50.0
Thai	-	-	-	-	-	-	-	-	1	0.0	1	0.0	-	-	-	-
Turkish	-	-	1	100	-	-	-	-	-	-	-	-	-	-		
Vietnamese	1	0.0	3	66.7	-	-	-	-	**50**	**54.0**	49	67.4	29	65.5	36	58.3
All Languages	**436**	**41.5**	**1301**	**45.7**	**658**	**42.1**	**622**	**42.0**	**4907**	**51.2**	**4947**	**51.1**	**587**	**41.2**	**968**	**37.7**

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

Table 5b. Study Indicator 1 (%) SPD Results by Language, County, and HEDIS® Measurement Year 2009-2010

	SAN DIEGO				STANISLAUS				TULARE				ALL COUNTIES			
	2009		**2010**		**2009**		**2010**		**2009**		**2010**		**2009***		**2010***	
Language	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
American Sign Language	-	-	-	-	-	-	-	-	-	-	-	-	13	53.8	13	76.9
Arabic	6	50.0	2	50.0	1	0.0	1	0.0	-	-	-	-	16	37.5	13	38.5
Armenian	-	-			-	-	-	-	-	-	-	-	21	23.8	33	27.3
Cambodian	1	0.0	1	0.0	1	0.0	1	100	-	-	-	-	**108**	**30.6**	**109**	**33.0**
Cantonese	-	-			-	-	-	-	-	-	-	-	38	44.7	**51**	**49.0**
English	**290**	**41.0**	**246**	**43.1**	**220**	**45.9**	**234**	**48.7**	**117**	**38.5**	**150**	**46.0**	**5598**	**47.4**	**6546**	**47.2**
Farsi	3	66.7	3	66.7	1	0.0	2	50.0	-	-	-	-	18	61.1	17	58.8
Hmong	-	-	-	-	1	0.0	-	-	1	0.0	1	0.0	**102**	**26.5**	**200**	**29.5**
Japanese	-	-	-	-	-	-	-	-	-	-	-	-	2	0.0	3	33.3
Korean	-	-	-	-	-	-	-	-	-	-	-	-	4	25.0	4	0.0
Lao	4	50.0	2	100	-	-	-	-	2	0.0	2	0.0	35	20.0	42	33.3
Mandarin	1	100	-	-	-	-	-	-	-	-	-	-	13	69.2	11	54.5
Mien	-	-	-	-	-	-	-	-	-	-	-	-	8	25.0	21	33.3
Other Chinese	-	-	-	-	-	-	-	-	-	-	-	-	2	100	5	80.0
Other Non-English	5	60.0	3	66.7	4	25.0	5	40.0	2	0.0	2	0.0	29	24.1	46	28.3
Other Sign Language	-	-	-	-	-	-	-	-	-	-	-	-	2	100	2	50.0
Russian	-	-	-	-	1	0.0	1	0.0	-	-	-	-	21	33.3	**94**	**27.7**
Samoan	-	-	-	-	-	-	-	-	-	-	-	-	2	50.0	1	0.0
Spanish	24	41.7	24	45.8	13	76.9	21	76.2	30	50.0	39	51.3	**1187**	**56.6**	**1261**	**57.0**
Tagalog	-	-	-	-	-	-	-	-	-	-	-	-	14	42.9	16	43.8

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

Thai	-	-	-	-	-	-	-	-	-	-	-	-	1	0.0	1	0.0
Turkish	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	100
Vietnamese	-	-	-	-	-	-	-	-	-	-	-	-	**80**	**57.5**	**88**	**63.6**
All Languages	**334**	**41.9**	**281**	**44.1**	**242**	**46.3**	**265**	**50.6**	**152**	**39.5**	**194**	**45.9**	**7316**	**48.2**	**8578**	**47.8**

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

To test for a significant difference in CCS rates between MY2009 and MY2010, a continuity adjusted Chi-Square Test of Proportions was conducted using an alpha of 0.05. To test for significant differences within each measurement year between language categories, a Chi-Square Test of Independence was conducted using an alpha of 0.05 (tables 6a & 6b). All significance testing was conducted within individual counties and at the 'All County' level for those language subgroups that were comprised of at least 50 SPD members. The 'All Counties' results were statistically significantly different between language groups and demonstrate that Vietnamese speakers had the highest rates, followed by Spanish speakers, and the rate for English speakers was about 10% lower than Spanish speakers. The lowest rates were observed for Cambodian, Hmong and Russian speakers. No statistically significant differences were seen between measurement years in any of the individual counties or at the 'All County' level, though this result could be related to the relatively small sample sizes in many of the subgroups. There were non-statistically significant increases in the CCS rates for English speakers in most counties, aside from Sacramento, with a 6.1% decrease and Los Angeles which virtually remained the same. Although Hmong speakers had lower rates than any other language groups in many counties, the rate increased by nearly 10% in Fresno county, moving from 13.3% to 22.8%. Additionally, there was more than a 7% increase in Sacramento county and the 'All Counties' rate increased by 3% among Hmong speaking members. The rates for Spanish speakers increased by nearly 11% in Fresno and decreased by over 7% in Kern, bearing in mind the relatively small number of Spanish speakers in these counties. The results for San Diego, Stanislaus, and Tulare counties mainly reflect English speakers since English was the only language subgroup consisting of 50 or greater in each of these counties.

Table 6a Study Indicator 1 (%)HEDIS® Measurement Year 2009-2010 SPD Results by Language and County for Language Subgroups with N≥ 50

	FRESNO				KERN				LOS ANGELES				SACRAMENTO			
	2009		**2010***		**2009**		**2010**		**2009***		**2010***		**2009***		**2010***	
Language	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cambodian	5	20.0	11	27.3	2	100	1	100	**91**	**28.6**	**87**	**29.9**	8	50.0	8	62.5
Cantonese	-	-	-	-	-	-	-	-	19	52.6	21	57.1	19	36.8	30	43.3
English	**323**	**44.0**	**987**	**47.0**	**584**	**40.9**	**553**	**41.6**	**3698**	**49.9**	**3766**	**49.7**	**366**	**44.3**	**610**	**38.2**
Hmong	15	13.3	**101**	**22.8**	-	-	-	-	-	-	-	-	**85**	**29.4**	**98**	**36.7**
Russian	6	50	10	80.0	-	-	-	-	2	50.0	1	100	12	25.0	**82**	**20.7**
Spanish	**67**	**41.8**	**139**	**52.5**	**69**	**52.2**	**67**	**44.8**	**969**	**58.2**	**948**	**58.4**	15	60.0	23	65.2
Vietnamese	1	0.0	3	66.7	-	-	-	-	**50**	**54.0**	49	67.4	29	65.5	36	58.3
All Languages	**436**	**41.5**	**1301**	**45.7**	**658**	**42.1**	**622**	**42.0**	**4907**	**51.2**	**4947**	**51.1**	**587**	**41.2**	**968**	**37.7**

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

Table 6b Study Indicator 1 (%)HEDIS® Measurement Year 2009-2010 SPD Results by Language and County for Language Subgroups with N> 50 (continued)

	SAN DIEGO				STANISLAUS				TULARE				ALL COUNTIES			
	2009		**2010**		**2009**		**2010**		**2009**		**2010**		**2009***		**2010***	
Language	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cambodian	1	0.0	1	0.0	1	0.0	1	100	-	-	-	-	**108**	**30.6**	**109**	**33.0**
Cantonese	-	-	-	-	-	-	-	-	-	-	-	-	38	44.7	**51**	**49.0**
English	**290**	**41.0**	**246**	**43.1**	**220**	**45.9**	**234**	**48.7**	**117**	**38.5**	**150**	**46.0**	**5598**	**47.4**	**6546**	**47.2**
Hmong	-	-	-	-	1	0.0	-	-	1	0.0	1	0.0	**102**	**26.5**	**200**	**29.5**
Russian	-	-	-	-	1	0.0	1	0.0	-	-	-	-	21	33.3	**94**	**27.7**
Spanish	24	41.7	24	45.8	13	76.9	21	76.2	30	50.0	39	51.3	**1187**	**56.6**	**1261**	**57.0**
Vietnamese	-	-	-	-	-	-	-	-	-	-	-	-	**80**	**57.5**	**88**	**63.6**
All Languages	**334**	**41.9**	**281**	**44.1**	**242**	**46.3**	**265**	**50.6**	**152**	**39.5**	**194**	**45.9**	**7316**	**48.2**	**8578**	**47.8**

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010.
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

Data Analysis by Ethnicity

Tables 7a & 7b presents Study Indicator 1 results for the Baseline (MY2009) and Remeasurement I (MY2010) measurement periods as defined in Activity III stratified by county and by ethnicity. Members with no valid ethnicity data or members who declined to state their ethnicity in the administrative data (from member eligibility FAME files) are removed from the analysis. Note that percentages with at least 50 Eligible Study Members in the category are bolded and the cell is un-shaded. Because of the sparse data in this table, valid significance testing could not be carried out using all ethnicity categories. Testing for differences in rates between measurement years and between ethnicity categories within counties was done on the 'All Counties' data for those ethnicity subgroups with at least 50 members (Tables 8a & 8b). A similar analysis was done for each county individually.

Table 7a. Study Indicator 1 (%) SPD Results by Ethnicity, County, and HEDIS® Measurement Year 2009-2010

	FRESNO				KERN				LOS ANGELES				SACRAMENTO			
	2009*		**2010***		**2009**		**2010**		**2009***		**2010***		**2009**		**2010***	
Ethnicity	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alaskan Native or American Indian	7	42.9	10	50.0	9	33.3	5	20.0	27	48.1	25	52.0	6	33.3	8	37.5
Asian Indian	1	0.0	5	20.0	-	-	-	-	1	100	1	0.0	2	0.0	4	0.0
Other Asian or Pacific Islander	35	20.0	**152**	**30.9**	4	0.0	3	0.0	**208**	**39.9**	**217**	**42.4**	**153**	**39.2**	**192**	**43.8**
Black	**67**	**55.2**	**240**	**58.8**	**126**	**42.9**	**109**	**48.6**	**1779**	**51.6**	**1786**	**54.0**	**148**	**45.9**	**235**	**46.0**
Cambodian	2	50.0	7	42.9	2	100	1	100	36	27.8	27	14.8	1	0.0	-	-
Chinese	-	-	-	-	-	-			22	54.5	24	50.0	1	100	5	40.0
Filipino	1	100	5	20.0	2	50.0	-	-	14	28.6	12	25.0	4	50.0	8	12.5
Guamanian	-	-	-	-	-	-			1	100	1	100	-	-	-	-
Hawaiian	-	-	-	-	-	-			-	-	1	0.0	-	-	-	-
Hispanic	**210**	**41.9**	**505**	**48.7**	**184**	**45.7**	**161**	**46.0**	**1777**	**53.7**	**1750**	**52.5**	**58**	**34.5**	**95**	**33.7**
Japanese	-	-	-	-	-	-	-	-	1	0.0	1	0.0	-	-	-	-
Korean	-	-	-	-	-	-	-	-	6	33.3	3	0.0	-	-	-	-
Laotian	-	-	15	6.7	1	0.0	-	-	1	0.0	-	-	15	0.0	16	12.5
Samoan	-	-	-	-	-	-	-	-	6	50.0	4	0.0	-	-	-	-
Vietnamese	1	0.0	2	50.0	-	-	-	-	17	58.8	21	76.2	9	77.8	15	73.3
White	**121**	**33.9**	**355**	**40.0**	**331**	**38.1**	**339**	**38.4**	**1039**	**47.4**	**1030**	**45.3**	**165**	**39.4**	**319**	**30.1▼**
Other	12	41.7	41	58.5	2	50.0	-	-	48	37.5	46	37.0	37	27.0	**53**	**26.4**
All Ethnicities	**457**	**40.0**	**1337**	**45.8▲**	**661**	**41.0**	**618**	**41.9**	**4982**	**50.6**	**4949**	**50.7**	**599**	**39.2**	**950**	**37.2**

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

Table 7b. Study Indicator 1 (%) SPD Results by Ethnicity, County, and HEDIS® Measurement Year 2009-2010 (continued)

	SAN DIEGO				STANISLAUS				TULARE				ALL COUNTIES			
	2009		**2010**		**2009**		**2010**		**2009**		**2010**		**2009***		**2010***	
Ethnicity	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alaskan Native or American Indian	3	33.3	1	100	3	66.7	3	33.3	2	0.0	2	50.0	**57**	**42.1**	**54**	**46.3**
Asian Indian	-	-	-	-	1	100	1	100	-	-			5	40.0	11	18.2
Other Asian or Pacific Islander	17	47.1	11	72.7	4	0.0	6	66.7	10	20.0	12	25.0	**431**	**37.1**	**593**	**40.1**
Black	**75**	**48.0**	**70**	**47.1**	21	61.9	20	45.0	8	62.5	8	50.0	**2224**	**50.9**	**2468**	**53.2**
Cambodian	1	0.0	1	0.0	-	-	-	-	-	-	-	-	42	31.0	36	22.2
Chinese	-	-	1	100	1	100	1	100	-	-	-	-	24	58.3	31	51.6
Filipino	3	33.3	5	60.0	-	-	1	0.0	1	0.0	1	0.0	25	36.0	32	25.0
Guamanian	-	-	-	-	-	-	-	-	-	-	-	-	1	100	1	100
Hawaiian	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0.0
Hispanic	**64**	**40.6**	**62**	**40.3**	**52**	**51.9**	**58**	**56.9**	**69**	**40.6**	**89**	**44.9**	**2414**	**50.9**	**2720**	**50.3**
Japanese	-	-	-	-	-	-	-	-	-	-	-	-	1	0.0	1	0.0
Korean	-	-	-	-	-	-	-	-	-	-	-	-	6	33.3	3	0.0
Laotian	1	0.0	-	-	-	-	-	-	1	0.0	1	0.0	19	0.0	32	9.4
Samoan	-	-	-	-	-	-	-	-	-	-	-	-	6	50.0	4	0.0
Vietnamese	-	-	-	-	-	-	-	-	-	-	-	-	27	63.0	38	73.7
White	**170**	**38.8**	**134**	**37.3**	**171**	**40.4**	**172**	**45.6**	**57**	**40.4**	**69**	**49.3**	**2054**	**43.0**	**2418**	**41.2**
Other	7	57.1	7	28.6	-	-	1	100	1	100	-	-	**107**	**36.4**	**149**	**39.6**
All Ethnicities	**341**	**41.6**	**292**	**42.1**	**253**	**44.7**	**263**	**48.7**	**150**	**39.3**	**183**	**45.4**	**7443**	**47.4**	**8592**	**47.3**

▲▼Statistically significant difference (p-value ≤0.05) between 2009 and 2010 Measurement Years.
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

To test for a significant difference in CCS rates between MY2009 and MY2010, a continuity adjusted Chi-Square Test of Proportions was conducted using an alpha of 0.05. To test for significant differences within each measurement year between ethnicity categories, a Chi-Square Test of Independence was conducted using an alpha of 0.05 (tables 8a & 8b). All significance testing was conducted within individual counties and at the 'All County' level for those ethnic subgroups that were comprised of at least 50 SPD members. Lower rates ($p<0.0001$) continue to be observed in the 'All County' rates for White and Other Asian/Pacific Islander ethnicities as compared to Blacks and Hispanics, while the rate for Alaskan Native/American Indians became closer to the rates for Blacks and Hispanics, increasing in MY2010 by over 4%, although not statistically significant. Fresno county had increases in each of the ethnic subgroups and the overall increase was statistically significant at nearly 6%. CCS SPD rates in Stanislaus and Tulare counties increased in the Hispanic and White ethnic subgroups, although the changes were not statistically significant. Kern county increased by nearly 6% in Black ethnic subgroup, while in Sacramento, there was nearly a 5% increase for 'Other Asian/Pacific Islanders'. The only subgroup that had a statistically significant decrease (9%) were those of White ethnicity in Sacramento county.

Table 8a Study Indicator 1 (%) HEDIS® Measurement Year 2009-2010 SPD Results by Ethnicity and County for Ethnicity Subgroups with N> 50

	FRESNO				KERN				LOS ANGELES				SACRAMENTO			
	2009*		**2010***		**2009**		**2010**		**2009***		**2010***		**2009**		**2010***	
Ethnicity	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alaskan Native or American Indian	7	42.9	10	50.0	9	33.3	5	20.0	27	48.1	25	52.0	6	33.3	8	37.5
Other Asian or Pacific Islander	35	20.0	152	30.9	4	0.0	3	0.0	**208**	**39.9**	**217**	**42.4**	**153**	**39.2**	**192**	**43.8**
Black	**67**	**55.2**	**240**	**58.8**	**126**	**42.9**	**109**	**48.6**	**1779**	**51.6**	**1786**	**54.0**	**148**	**45.9**	**235**	**46.0**
Hispanic	**210**	**41.9**	**505**	**48.7**	**184**	**45.7**	**161**	**46.0**	**1777**	**53.7**	**1750**	**52.5**	**58**	**34.5**	**95**	**33.7**
White	**121**	**33.9**	**355**	**40.0**	**331**	**38.1**	**339**	**38.4**	**1039**	**47.4**	**1030**	**45.3**	**165**	**39.4**	**319**	**30.1▼**
Other	12	41.7	41	58.5	2	50.0	-	-	48	37.5	46	37.0	37	27.0	**53**	**26.4**
All Ethnicities	**457**	**40.0**	**1337**	**45.8▲**	**661**	**41.0**	**618**	**41.9**	**4982**	**50.6**	**4949**	**50.7**	**599**	**39.2**	**950**	**37.2**

▲▼Statistically significant difference (p-value ≤0.05) between MY2009 and MY2010
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

Table 8b Study Indicator 1 (%) HEDIS® HEDIS® Measurement **Year 2009-2010 SPD Results by Ethnicity and County for Ethnicity Subgroups with N> 50 (Continued)**

	SAN DIEGO				STANISLAUS				TULARE				ALL COUNTIES			
	2009		**2010**		**2009**		**2010**		**2009**		**2010**		**2009***		**2010***	
Ethnicity	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alaskan Native or American Indian	3	33.3	1	100	3	66.7	3	33.3	2	0.0	2	50.0	**57**	**42.1**	**54**	**46.3**
Other Asian or Pacific Islander	17	47.1	11	72.7	4	0.0	6	66.7	10	20.0	12	25.0	**431**	**37.1**	**593**	**40.1**
Black	**75**	**48.0**	**70**	**47.1**	21	61.9	20	45.0	8	62.5	8	50.0	**2224**	**50.9**	**2468**	**53.2**
Hispanic	**64**	**40.6**	**62**	**40.3**	**52**	**51.9**	**58**	**56.9**	**69**	**40.6**	**89**	**44.9**	**2414**	**50.9**	**2720**	**50.3**
White	**170**	**38.8**	**134**	**37.3**	**171**	**40.4**	**172**	**45.6**	**57**	**40.4**	**69**	**49.3**	**2054**	**43.0**	**2418**	**41.2**
Other	7	57.1	7	28.6	-	-	1	100	1	100	-	-	**107**	**36.4**	**149**	**39.6**
All Ethnicities	**341**	**41.6**	**292**	**42.1**	**253**	**44.7**	**263**	**48.7**	**150**	**39.3**	**183**	**45.4**	**7443**	**47.4**	**8592**	**47.3**

▲▼Statistically significant difference (p-value ≤0.05) MY2009 and MY2010
* Statistically significant difference (p-value ≤0.05) between language categories.
- No Eligible Study Members in this category.

Baseline Measurement:

Fresno: The baseline rate for SPDs in Fresno county was 40.2% and was statistically significantly lower than the Non-SPD rate of 62.1% (Table 2). A statistically significant difference between age groups was seen in Fresno county (Table 4a) with cervical cancer screening rates decreasing with increasing age. No statistically significant differences were seen in Fresno county between language subgroups (Table 6a). Ethnic subgroups showed statistically significant differences in this baseline measurement (Table 8a) with Whites being the lowest performing group followed by Hispanics. Blacks had the highest rate by 13.3% as compared to Hispanics.

Kern: The baseline rate for SPDs in Kern county was 40.9% and was statistically significantly lower than the Non-SPD rate of 55.3% (Table 2). No statistically significant differences were seen between age groups in Kern county (Table 4a). However, the rates demonstrated a decrease in cervical cancer screening rates with increasing age. No statistically significant differences were seen in Kern county between language (Table 6a) or ethnic subgroups (Table 8a).

Los Angeles: The baseline rate for SPDs in L.A. county was 50.8% and was statistically significantly lower than the Non-SPD rate of 62.1% (Table 2). A statistically significant difference between age groups was seen in L.A. county (Table 4a) with cervical cancer screening rates decreasing with increasing age. Statistically significant differences between language categories was seen in this county (Table 6a) with Spanish speakers having the highest rate and English and Vietnamese speakers trailing slightly behind. Cambodian speakers had a rate that was far below the other groups with a 30% difference compared to Spanish speakers. Ethnic subgroups showed statistically significant differences in this baseline measurement (Table 8a) with Other Asian or Pacific Islanders being the lowest performing group followed by Whites. Hispanics had the highest rate and Blacks were only

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

slightly lower than the highest performing group.

Sacramento: The baseline rate for SPDs in Sacramento county was 39.6% and was statistically significantly lower than the Non-SPD rate of 60.5% (Table 2). A statistically significant difference between age groups was seen in Sacramento county (Table 4a) with cervical cancer screening rates decreasing with increasing age. Statistically significant differences between language categories was seen in this county (Table 6a) with Hmong speakers having a rate of nearly 15% lower than English speakers. No statistically significant differences were seen between ethnic groups (Table 8a).

San Diego: The baseline rate for SPDs in San Diego county was 42.1% and was statistically significantly lower than the Non-SPD rate of 54% (Table 2). No statistically significant differences were seen between age groups in San Diego county (Table 4b). However, the rates demonstrated a decrease in cervical cancer screening rates with increasing age. No statistically significant differences were seen in San Diego county between language (Table 6b) or ethnic subgroups (Table 8b).

Stanislaus: The baseline rate for SPDs in Stanislaus county was 44.7% and was statistically significantly lower than the Non-SPD rate of 60.1% (Table 2). No statistically significant differences were seen between age groups in Stanislaus county (Table 4b). However, the rates demonstrated a decrease in cervical cancer screening rates with increasing age. No statistically significant differences were seen in Stanislaus county between language (Table 6b) or ethnic subgroups (Table 8b).

Tulare: The baseline rate for SPDs in Tulare county was 40.6% and was statistically significantly lower than the Non-SPD rate of 66.1% (Table 2). No statistically significant differences were seen between age groups in Stanislaus county (Table 4b). However, the rates demonstrated a decrease in cervical cancer screening rates with increasing age. No statistically significant differences were seen in Stanislaus county between language (Table 6b) or ethnic subgroups (Table 8b).

All County: The baseline 'All County' rate for SPDs was 47.5% and was statistically significantly lower than the Non-SPD rate of 61.4% (Table 2). A statistically significant difference between age groups was seen (Table 4b) with cervical cancer screening rates decreasing with increasing age. Statistically significant differences between language categories were seen (Table 6b) with Spanish and Vietnamese speakers having the highest rates and English speakers about 10% lower than the groups with the highest rates. The lowest rates were found for Cambodian and Hmong speakers. Ethnic subgroups showed statistically significant differences in this baseline measurement (Table 84b) with lowest rates being observed for Other Asian/Pacific Islander, Alaskan Native/American Indian, and White ethnicities as compared to Blacks and Hispanics.

Baseline to Remeasurement 1:

Fresno: The goal for the Remeasurement 1 was to increase the 'All Counties' SPD rate as well as each of the seven individual counties' SPD rates by 1% comparing MY2009 and MY2010. This goal was met for the SPD populations in Fresno county with a statistically significant increase of over 5% (Table 3). Compliance in this county decreased with age in MY2010 ($p<0.0001$) and although there were no statistically significant increases in MY2010 compared to MY2009 when looking across the three age strata in Fresno county, there were increases within each group, ranging from 4% to 7% (Table 4a). Although in MY2010 Hmong speakers had lower rates than any other language group in Fresno county ($p<0.0001$), the rate increased by nearly 10% compared to MY2009, although not statistically significantly. Also, the rates for Spanish speakers increased by nearly 11%, although not statistically significantly (Table 6a). Increases in Fresno were seen in each of the applicable ethnic subgroups, with increases ranging from 3.6% in the Black population to 6.8% in the 'Hispanic' ethnic subgroup. The CCS SPD rate for the white ethnic subgroup was the lowest in MY2010 compared to those of Black or Hispanic ethnicity ($p<0.0001$)

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

(Table 8a).

Kern: The goal of a 1% increase was not realized in Kern county with an increase of only 0.6% (Table 3). Compliance in this county decreased with age in MY2010, although not statistically significantly, and there were no statistically significant changes from MY2009 to MY2010 in any of the age categories with the largest being a 2.6% increase in the 56-64 year olds (Table 4a). The Spanish speaking SPD subpopulation saw a non-statistically significant decrease in the CCS rate by over 7%, although not statistically significant (Table 6a). There were no statistically significant differences found between ethnicity groups in Kern county and no statistically significant changes were seen in any ethnic subgroup in this county. However, the CCS SPD rate increased by nearly 6% in black ethnic subgroup (Table 8a).

Los Angeles: The goal of a 1% increase was not realized in Los Angeles county with a non-significant decrease of 0.3% (Table 3). Compliance in this county decreased with age in MY 2010 ($p<0.0001$) and there were no statistically significant changes within any of the age categories with the largest being a 2% decrease in the 24-40 year olds (Table 4a). In MY2010, Cambodian speakers had the lowest CCS rate among SPDs in Los Angeles county, while Spanish speaker had the highest ($p<0.0001$). There were no statistically significant changes in any of the language subgroups although the Vietnamese speakers had a 13% increase, bearing in mind the MY2010 results for this language subgroup were comprised of less than 50 eligible study member, so no valid significance testing was done (Table 6a). There were no notable changes in any of the ethnic subgroups in LA county, and the Other Asian/Pacific Islander and White ethnic groups remain at the bottom when compared to Blacks and Hispanics ($p<0.0001$) (Table 8a).

Sacramento: The goal of a 1% increase was not realized in Sacramento county with a non-significant decrease of 2.2% (Table 3). Compliance in Sacramento county decreased with age in MY2010 ($p=0.0071$). There was a decrease of nearly 9% in the 24-40 year olds and a decrease of 2.5% in the 56-64 year olds (Table 4a). Russian speakers were found to have the lowest CCS rate in MY 2010 ($p=0.0084$) and although English speakers remained the most compliant when compared to Hmong and Russian speakers, there was a decrease of 6.1% in the CCS SPD rate for English speakers while Hmong speakers had an increase of over 7%, although both of these changes were not statistically significant (Table 6a). The only ethnic subgroup that had a statistically significant change in the CCS SPD population was those of White ethnicity in Sacramento county, with a 9% decrease compared to MY2009, and the MY2010 rate for whites was one of the lowest when compared to the other ethnic groups in this county ($p=0.0004$). However, there was nearly a 5% increase for the 'Other Asian/Pacific Islanders' ethnic group, although not statistically significant (Table 8a).

San Diego: The goal of a 1% increase was met for the SPD populations in San Diego county with a 1.3% increase (Table 3). Compliance in this county decreased with age in MY2010 ($p=0.04$) and there were no statistically significant changes in any of the age categories with the largest being a nearly 5% increase in the 24-40 year olds (Table 4b). There were no notable changes in any of the language subgroups (Table 6b) or ethnic subgroups (Table 8b) in this county.

Stanislaus: The goal of a 1% increase was met for the SPD populations in Stanislaus county with a 3.2% increase (Table 3). Compliance in this county decreased with age in MY2010, although not statistically significantly, and there were no statistically significant changes in any of the age categories, although the rate for 41-55 Year olds increased by nearly 5% and the rate for 56-64 Year olds increased by 7% (Table 4b). There were no notable changes in any of the language subgroups in this county (Table 6b), and although no changes were statistically significant in any of the ethnic subgroups, both rates for Whites and Hispanics increased by 5% (Table 8b).

Tulare: The goal of a 1% increase was met for the SPD populations in Tulare county with a 5.9% increase (Table 3). Cervical cancer screening rates are shown to decrease with increasing age in Tulare county in MY2010, although not statistically significantly, and although not statistically significant, there were increases in each age group with an increase

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.

of over 11% in the 24-40 year olds (Table 4b). The overall results for Tulare counties mainly reflect English speakers since English was the only language subgroup consisting of 50 or greater and this language group had a 7.5% increase in the MY2010 compared to the MY2009 (Table 6b). CCS SPD rates in this county increased in the Hispanic and White ethnic subgroups by 4% and 9%, respectively, although the changes were not statistically significant (Table 8b).

All County: The goal of a 1% increase was not realized in the 'All Counties' rate with a non-statistically significant decrease of 0.3% (Table 3). Cervical cancer screening rates are shown to decrease with increasing age at the 'All County' level in MY2010 ($p<0.0001$) with negligible change in any of the age subgroups when comparing the MY2009 and MY2010 rates (Table 4b). The 'All Counties' results demonstrate that Spanish and Vietnamese speakers had the highest rates, and the rate for English speakers was about 10% lower than the Spanish speakers ($p<0.0001$). The lowest rates were observed for Cambodian, Hmong, and Russian speakers. No statistically significant differences were seen within language categories between measurement years (Table 6b). In MY2010, the lowest rates continue to be observed in the 'All Counties' rates for White and Other Asian/Pacific Islander ethnicities as compared to Blacks and Hispanics ($p<0.0001$), while the rate for Alaskan Native/American Indian Indians became closer to the rates for Blacks and Hispanics, increasing in MY2010 by over 4%, although not statistically significantly. (Table 8b)

Remeasurement 1 to Remeasurement 2:
Kern
Los Angeles
Sacramento
San Diego
Stanislaus
Tulare
All County

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete p values, and statistical significance.

Evidence of "real" improvement

The data extraction for the pre-baseline results occurred prior to the end of the 2009 Measurement Year and prior to the standard 90-day claims data run-out period that is considered sufficient time for claims data collection and reporting to be mostly complete. Therefore, the pre-baseline measurement is based on data that is considered to be mostly complete from January 1, 2009 through August 31, 2009. These results are not final and are therefore not comparable to any finalized results.

The official baseline results were reported in 2010 based on the final RY2010 HEDIS® data prepared by the Health Net HEDIS® team.

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete p values, and statistical significance.

Quantifiable Measure No. 1: The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year						
Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance and p value
Pre-Baseline Measurement Period: January 1-November 30, 2009	**Pre-Baseline** The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year				**Industry Benchmark:** N/A **Goal:** 2% improvement in 'All County' and individual county administrative rates from Baseline to Remeasurement 2 with 1% improvement for each Remeasurement 1 & 2 in 'All County' and individual county administrative rates	N/A
	County Name: Fresno	163	483	33.75		
	County Name: Kern	218	681	32.01		
	County Name: LA	2022	5006	40.39		
	County Name: Sacramento	188	614	30.62		
	County Name: San Diego	105	334	31.44		
	County Name: Stanislaus	100	257	38.91		
	County Name: Tulare	54	152	35.53		
	All County	2850	7527	37.88		
Baseline: Measurement HEDIS® RY 2010 Measurement Period: January 1 2009 through December 31, 2009	**Baseline:** The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year				**Goal:** 2% improvement in 'All County' and individual county Administrative rates from Baseline to Remeasurement 2 with 1% improvement for each Remeasurement 1 & 2 in 'All County' and	N/A

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete p values, and statistical significance.

Quantifiable Measure No. 1: The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance and p value
					individual county administrative rates	
	County Name: Fresno	197	490	40.2		
	County Name: Kern	291	711	40.9		
	County Name: LA	2,701	5,320	50.8		
	County Name: Sacramento	256	647	39.6		
	County Name: San Diego	159	378	42.1		
	County Name: Stanislaus	123	275	44.7		
	County Name: Tulare	65	160	40.6		
	All County	3,792	7,981	47.5		
Remeasurement 1: Measurement HEDIS® RY 2011 Measurement Period: January 1 2010 through December 31, 2010	**Remeasurement 1** The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year				**Minimum Performance Level (MPL): 61.0** **Goal:** 1% improvement for Remeasurement 1 in 'All County' and individual county administrative rates compared to Baseline	**Adjusted Chi-Square Test of Proportions with an alpha of 0.05**
	County Name: Fresno	657	1,445	45.5	The goal of a 1% increase was met in Fresno, San Diego, Stanislaus, and Tulare counties, but was not met in	0.0483
	County Name: Kern	275	663	41.5		0.8791
	County Name: LA	2,685	5,320	50.5		0.7712
	County Name: Sacramento	393	1,051	37.4		0.3987
	County Name: San Diego	139	320	43.4		0.7727
	County Name: Stanislaus	140	292	47.9		0.4942

California 2010 QIP Summary Form
Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete p values, and statistical significance.

Quantifiable Measure No. 1: The percentage of eligible Medi-Cal SPD women who received one or more Pap tests during the measurement year or the two years prior to the measurement year

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance and p value
	County Name: Tulare	94	202	46.5	Kern, Los Angeles, Sacramento, or the 'All County' rate.	0.3084
	All County	4,383	9,293	47.2		0.6586

Describe any demonstration of meaningful change in performance observed from Baseline and each measurement period (e.g., Baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or Baseline to final Remeasurement) for each study indicator:

The goal for Remeasurement 1 was to increase the 'All Counties' SPD rate as well as each of the seven individual counties' SPD rates by 1% comparing Baseline to Remeasurement 1. This goal was met for Fresno, San Diego, Stanislaus and Tulare counties. However, no meaningful improvement was observed in the 'All County' rate or within the individual counties of Kern, Los Angeles, and Sacramento.

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete p values, and statistical significance.

Quantifiable Measure 2:

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance and p value
	Remeasurement 2					
	County Name: Kern					
	County Name: LA					
	County Name: Sacramento					
	County Name: San Diego					
	County Name: Stanislaus					
	County Name: Tulare					
	All County					

J. Activity X: Describe sustained improvement. Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variations, population changes, sampling errors, or statistically significant declines that may have occurred during the Remeasurement process

Sustained improvement:

Baseline to Remeasurement 1

Fresno: There was a statistically significant increase in Study Indicator 1 from baseline to Remeasurement 1 of 5.3% in Fresno county. The size of the SPD population eligible to be included in the denominator for Study Indicator 1 increased nearly threefold from MY2009 to MY2010. This substantial change in the population in this county as well as the interventions described in activity VII may have had an impact on increasing the proportion of SPD members who received their Pap test to screen for cervical cancer in MY2010. Similarly, although these members are new to Health Net, these members may have the same providers. Consequently, continuity of care and service was not affected by the change in health plan membership.

Kern: There was a 0.6% improvement observed in Kern county however the goal of 1% improvement from Baseline to Remeasurement 1 was not met. Based on age, language and ethnicity analysis and further barriers identified, interventions will be proposed, evaluated and implemented with the goal of achieving 2% sustained improvement from baseline to Remeasurement 2 in Kern County.

Los Angeles: There was a 0.3% decrease observed in Los Angeles county and the goal of 1% improvement from Baseline to Remeasurement 1 was not met. Based on age, language and ethnicity analysis and other barriers identified, interventions will be proposed, evaluated and implemented with the goal of achieving 2% sustained improvement from baseline to Remeasurement 2 in Los Angeles County.

Sacramento: There was a 2.2% decrease observed in Sacramento county and the goal of 1% improvement from Baseline to Remeasurement 1 was not met. Based on age, language and ethnicity analysis and other barriers identified, interventions will be proposed, evaluated and implemented with the goal of achieving 2% sustained improvement from baseline to Remeasurement 2 in Sacramento County.

San Diego: The goal of a 1% increase was met for the SPD population in San Diego county with a 1.3% increase. The interventions described in activity VII may have had an impact on increasing the proportion of SPD members who received their Pap test to screen for cervical cancer in MY2010.

Stanislaus: The goal of a 1% increase was met for the SPD population in Stanislaus county with a 3.2% increase. The interventions described in activity VII may have had an impact on increasing the proportion of SPD members who received their Pap test to screen for cervical cancer in MY2010.

Tulare: The goal of a 1% increase was met for the SPD populations in Tulare county with a 5.9% increase. The interventions described in activity VII may have had an impact on increasing the proportion of SPD members who received their Pap test to screen for cervical cancer in MY2010.

All County: There was no improvement observed in the 'All Counties' rate with a non-statistically significant decrease of 0.3% from Baseline to Remeasurement 1. Based on age, language and ethnicity analysis and other barriers identified, interventions will be proposed, evaluated and implemented with the goal of achieving 2% sustained improvement from baseline to Remeasurement 2.

California 2010 QIP Summary Form

Improve Cervical Cancer Screening (CCS) among Seniors and Persons with Disabilities (SPD) in the female Medi-Cal population

MQR #8a, Attachment # 9

Medi-Cal Facility Site Review/Medical Records Review 2011

Activity Summary

Name/Title: **Carol Spencer, RN, CPHQ, Manager QI State Health Programs**

Departments Involved: **QI, Medi-Cal Facility Site Review**

Date: **September 29, 2011**

Purpose of Activity:
This report displays completed activity and results of the DHCS required PCP Facility Site (FSR) and Medical Record Reviews (MRR) for all contracted Medi-Cal counties using the Medi-Cal Managed Care Division (MMCD) Policy Letter 02-02 FSR/MRR audit tool. The results are analyzed for the purpose of monitoring and improving the performance of PCPs against DHCS and Health Net standards.

Threshold(s)/Benchmark(s):
MMCD Policy Letter 02-02 requires FSR/MRR for initial sites with a periodicity of every 3 years. The FSR/MRR passing score is 80%. Corrective actions must meet DHCS time frames.

Methodology/Sampling/Time Period:
Data are extracted from the FSR database; data are reviewed, aggregated, analyzed and reported.

The time period reflected in this FSR and MRR activity report is for 1st and 2nd quarters 2011. For comparisons, data from previous quarters/years are included. It includes sites reviewed by Health Net for all counties: Los Angeles, Fresno, Tulare, Sacramento, San Diego, Kern, San Bernardino, Orange, Riverside, Stanislaus, Kings and Madera.

Results/Quantitative Analysis:
Health Net completed 79 Facility Site Reviews (FSR) and 60 Medical Record Reviews (MRR) (minimum of 10 charts per site are reviewed for a total of 600 records reviewed) in the first two quarters of 2011. Corrective Action Plans (CAPs) are required for scores below 90% and for deficiencies in any Critical Elements (CE); CAPs must be approved and corrections verified. 45% of FSRs and MRRs required on-site focused reviews to verify corrections.

- The overall mean FSR score (all counties) was 97% for the first two quarters of 2011. (Figure 1)
- The overall mean MRR score (all counties) was 91% for the first two quarters of 2011. (Figure 2)

Figure 1

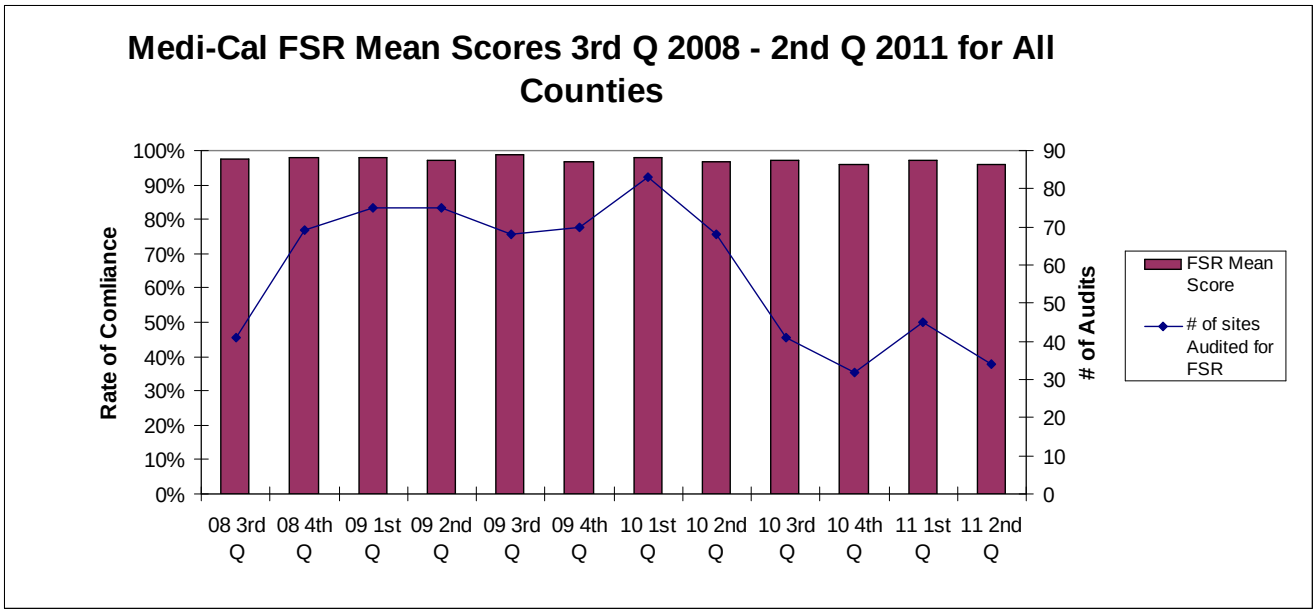
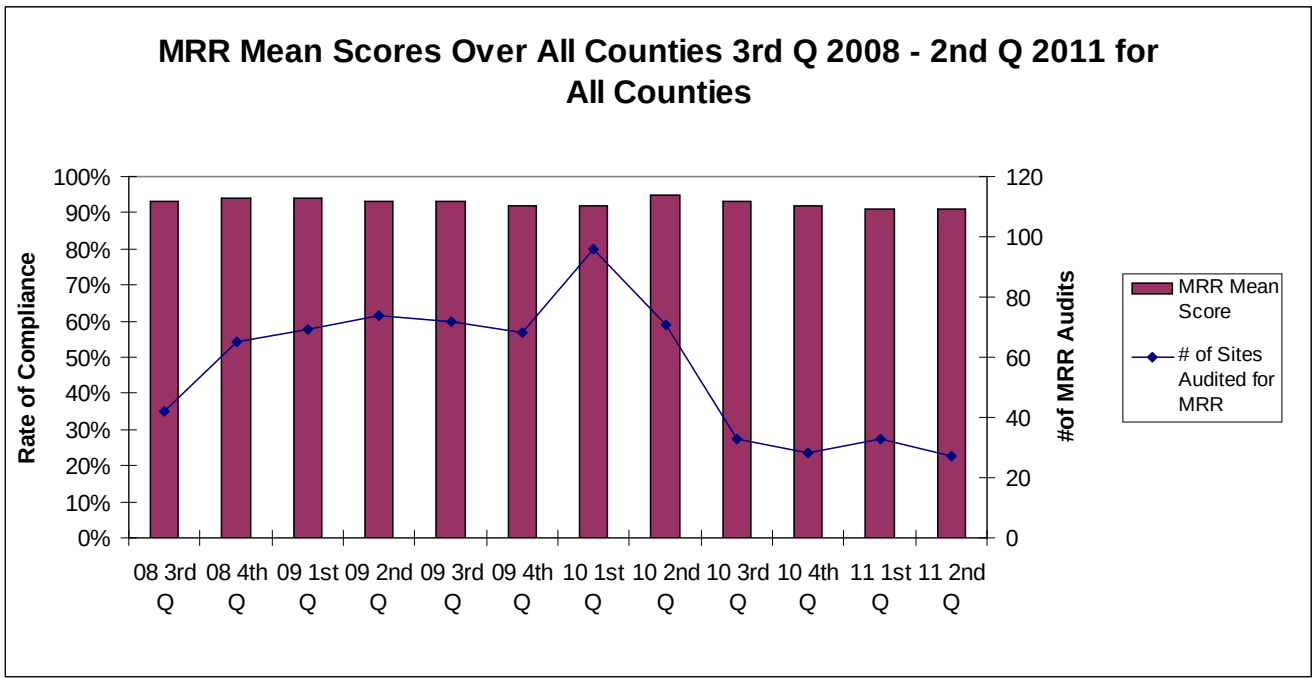


Figure 2



Medical Record Review (MRR) for Preventive Care

The MRR results are presented in over all counties' mean scores for the 6 sections (Format, Documentation, Continuity/Coordination, Pediatric Preventive Care, Adult Preventive Care and OB Preventive care).

- The Adult Preventive Care mean scores over all counties for the first two quarters of 2011 were 79%. (Figure 3)

- The Pediatric Preventive Care mean scores over all counties for the first two quarters of 2011 were 85%. (Figure 4)

Figure 3

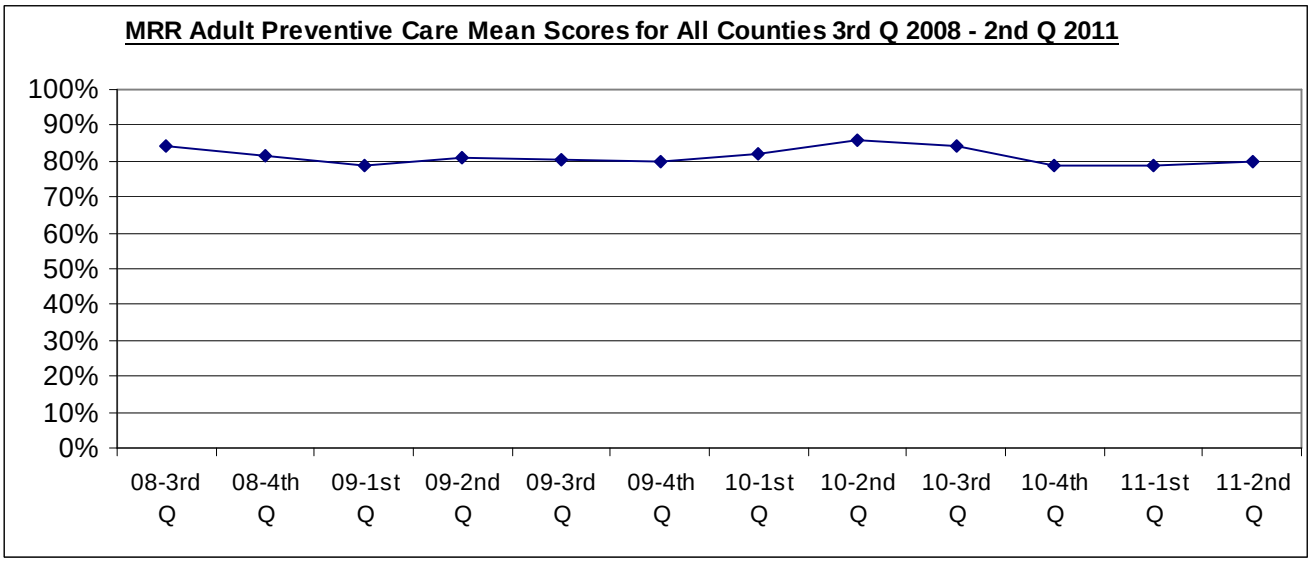
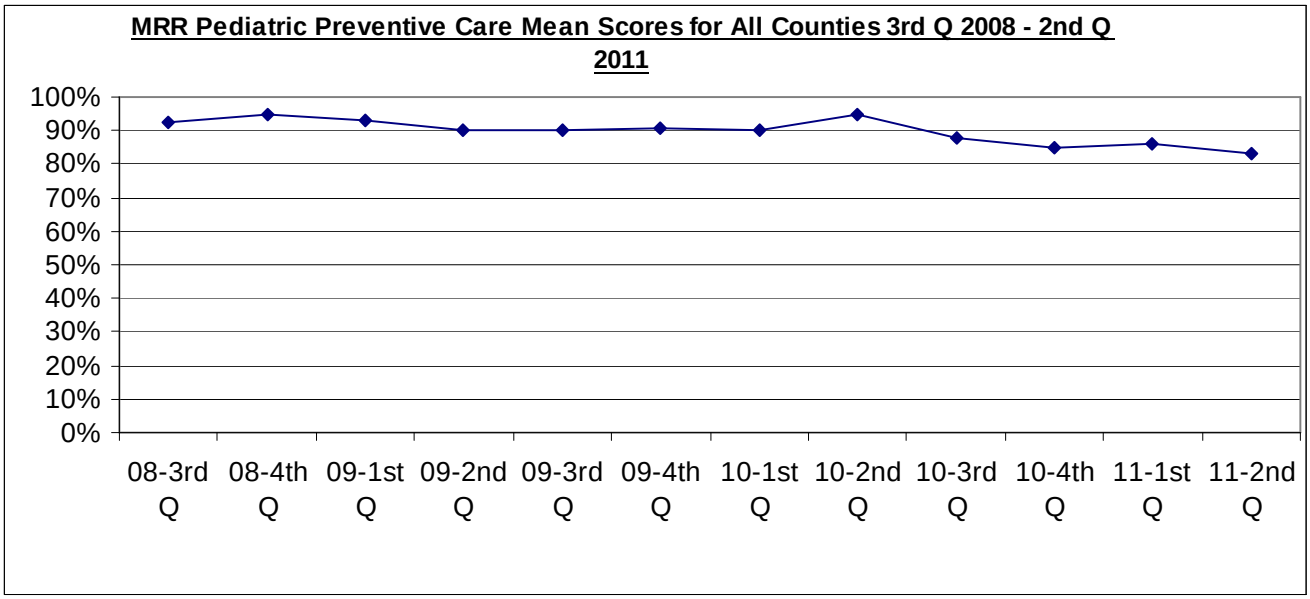


Figure 4



Specific MRR Criteria: (Table 1)

- Individual Health Education Behavioral Assessment (IHEBA) over all counties continued to vary significantly quarter to quarter since different PCPs are reviewed and the volume is low. The Adult IHEBA mean completion rate was 82% for the first two quarters of 2011. Pediatric IHEBA mean completion rate was 94% for the first two quarters of 2011. Some PCPs refuse to use the IHEBA, while others do not document review and interventions as indicated for the IHEBA.

- Pediatric Initial Health Assessment (IHA) compliance scores overall counties were 89%. Adult IHA scores averaged 96% for the first two quarters of 2011.

- Documentation of Interpreter Services and Primary Language criteria demonstrated a mean rate of 100% and 89% respectively for the first two quarters of 2011.

Table 1

Quarter / Year	Interpreter Services	Trained Interpreters	Primary Language	Ped IHA	Ped IHEBA	Ped Dental Assessment	Adult IHA	Adult IHEBA
3rd Q 2008	100%	90%	98%	100%	88%	91%	100%	80%
4th Q 2008	100%	97%	79%	100%	97%	88%	100%	88%
1st Q 2009	100%	91%	85%	100%	92%	89%	96%	93%
2nd Q 2009	99%	95%	77%	100%	82%	87%	100%	86%
3rd Q 2009	100%	100%	92%	98%	95%	89%	93%	90%
4th Q 2009	100%	91%	88%	100%	97%	80%	100%	97%
1st Q 2010	100%	95%	90%	100%	98%	88%	98%	93%
2nd Q 2010	100%	93%	97%	100%	100%	86%	100%	88%
3rd Q 2010	100%	92%	100%	100%	100%	88%	100%	86%
4th Q 2010	100%	94%	96%	100%	88%	81%	100%	94%
1st Q 2011	100%	95%	93%	88%	100%	88%	92%	91%
2nd Q 2011	100%	97%	83%	91%	86%	90%	100%	70%

Corrective Action Plans:

Corrective Action Plans (CAPs) have 3 components, Critical Element (CE) CAP, FSR CAP and MRR CAP. CE CAPs are due in 10 business days from the date of the FSR. FSR and MRR CAPs are due in 45 calendar days from the date of the review.

PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal to 90% did not have to submit a CAP (exempt pass).

Below are the exempt pass rates (Table 2).

Table 2
No CAP Required (Exempt Pass):

CAP	2008 3rd Q	2008 4th Q	2009 1st Q	2009 2nd Q	2009 3rd Q	2009 4th Q	2010 1st Q	2010 2nd Q	2010 3rd Q	2010 4th Q	2011 1st Q	2011 2nd Q
FSR-CE	76%	78%	79%	79%	97%	74%	75%	76%	97%	94%	67%	62%
FSR	71%	75%	69%	57%	87%	67%	66%	63%	56%	60%	62%	35%
MRR	79%	72%	81%	78%	83%	76%	79%	83%	85%	78%	82%	63%

For all the counties, the CE CAP submission compliance rate within 10 business days was 100% in the first two quarters of 2011. FSR CAP compliance within 45 days of the FSR data mean rate was 97%. MRR CAP compliance within 45 days for MRR data had the mean rate was 98%. Any PCPs that were not on track to meet timelines rates were addressed through technical assistance, for office staff at the non-compliant sites, as well as a focused onsite review of medical records.

Physical Accessibility Review Survey (PARS):

PARS reviews provide access level information to health plan provider directories. A provider site is considered to have **Basic** level access when it demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic level access, all Critical Elements (29) must be met. If a provider site has deficiencies in 1 or more Critical Elements, the level of access is **Limited**. PARS reviews are performed on a three year periodic cycle, unless the provider site has made access improvements or at the request of the provider site. The new PARS audit tool was implemented in February 2011. In the first two quarters of 2011, Health Net has completed 32 PARS reviews for all counties, with 28% designated as having Basic level access. As part of the PARS, Accessibility indicators are defined and will be included in the Health Net provider directory and member web portal to help members select their provider that meets any special needs. The Accessibility Indicators are: Parking, Exterior Building, Interior Building, Exam Room, Restroom, electronic Exam Table and accessible Weight Scale. No corrective actions are required.

Interim Reviews:

88 Interim Reviews were completed during the first two quarters of 2011. An Interim Review is a DHCS required monitoring activity to evaluate the PCP site between the 3-year periodic FSR cycle; the minimum review includes the 9 Critical Elements.

FSR/MRR Educational Trainings for Provider Sites:

Certified Site Review Nurses may provide educational trainings prior to the actual FSR/MRR evaluation. Educational Trainings allow provider sites to become familiar with the DHCS regulations and FSR/MRR processes. For the first two quarters of 2011, Certified Site Review Nurses performed 133 educational trainings.

Grievances about Facilities:

Certified Site Review Nurses conduct onsite inspections for grievances filed with Health Net that are related to facilities and access. During the first two quarters of 2011, 32 grievance site visits were completed; only 4 sites were noted to have the grievance substantiated requiring a corrective action plan. These review results are submitted to the Appeals and Grievance and Credentialing Departments.

Delegation Oversight:

Health Net delegates FSR/MRR to Molina Health Care in Los Angeles County. Comparison of the scores between Health Net and Molina demonstrate similar outcomes for FSR and MRR.

- The inter-rater reliability for FSR and MRRs in Los Angeles County sites reviewed by Health Net, Molina was within 3% variance (threshold is 10%). All RN Reviewers are also required to participate in the DHCS sponsored Statewide MRR inter-rater reliability annual process.

Barrier Analysis:

- Comparisons of data show trends only since the FSRs and MRRs are for different PCPs each quarter.

- Audit data show low numbers for audits for some counties when reported for each quarter thus skewing rates.

- Data sharing among collaborating health plans requires ongoing data management for accuracy of addresses, status, and release for Medi-Cal in Health Net systems to open PCPs for member assignment.

- Reporting of specific criteria is only available for Health Net due to non-electronic systems of data collection and limited resources of the health plans.

- PCPs refuse to use the IHEBA stating it is not helpful, it is time consuming and is not culturally sensitive to name a few.

Interventions Already Taken:

- Interim reviews (between 3 year periodic cycle reviews) are completed as required by MMCD 02-02 on all PCP sites to monitor continued compliance of critical elements and maintenance of corrected deficiencies.

- Completed CAP follow-up collaboratively with participating health plans.

- Pre-audit education for FSR and MRR is offered to PCPs.

- To assist compliance to the DHCS FSR/MRR requirements, a pre-audit packet of materials is given to the PCP prior to the scheduled FSR/MRR.

- Preventive care information for children, teens and adults was provided for all provider sites statewide as part of the PCP outreach to improve quality of care.

- All Facility Site Review RNs participated in the DHCS training for FSR and the MRR inter-rater reliability annual process.

Additional data demonstrating county specific results are provided in Tables 3-8.

Table 3
FSR County Scores 3rd Q 2008 – 2nd Q 2011

County	08 3rd Q	08 4th Q	09 1st Q	09 2nd Q	09 3rd Q	09 4th Q	10 1st Q	10 2nd Q	10 3rd Q	10 4th Q	11 1st Q	11 2nd Q
Los Angeles	97%	99%	97%	97%	99%	97%	97%	97%	96%	97%	97%	96%
Riverside	97%	no audits	95%	95%	no audits	98%	100%	98%	100%	no audits	95%	94%
San Bernardino	95%	no audits	97%	91%	99%	91%	98%	92%	99%	93%	96%	98%
San Diego	99%	99%	100%	100%	100%	100%	99%	96%	96%	no audits	97%	95%
Fresno	98%	94%	99%	96%	98%	98%	99%	97%	96%	97%	96%	92%
Tulare	no audits	100%	99%	95%	98%	96%	99%	no audits	no audits	no audits	91%	99%
Sacramento	100%	96%	99%	99%	99%	96%	97%	98%	100%	95%	100%	91%
Kern	96%	100%	no audits	100%	98%	100%	99%	no audits	93%	no audits	99%	99%
Stanislaus	no audits	99%	97%	99%	100%	97%	92%	98%	93%	no audits	100%	95%
Orange	100%	96%	100%	99%	no audits	95%	99%	100%	no audits	no audits	100%	100%
Kings/Madera	no audits	no audits	no audits	no audits	no audits	no audits	no audits	no audits	97%	92%	100%	no audits
FSR Mean Score	***98%***	**98%**	**98%**	**97%**	**99%**	**97%**	**98%**	**97%**	**97%**	**96%**	**97%**	**96%**
# of sites Audited for FSR	***41***	***69***	***75***	***75***	***68***	***70***	***83***	***68***	***41***	***32***	***45***	***34***

Table 4
Number of Sites Audited

County	2008 # of Sites Audited 3rd Q	2008 # of Sites Audited 4th Q	2009 # of Sites Audited 1st Q	2009 # of Sites Audited 2nd Q	2009 # of Sites Audited 3rd Q	2009 # of Sites Audited 4th Q	2010 # of Sites Audited 1st Q	2010 # of Sites Audited 2nd Q	2010 # of Sites Audited 3rd Q	2010 # of Sites Audited 4th Q	2011 # of Sites Audited 1st Q	2011 # of Sites Audited 2nd Q
Los Angeles	21	47	34	36	29	45	41	42	18	23	28	20
Riverside	1	no audits	1	1	no audits	1	1	1	1	no audits	2	1
San Bernardino	5	no audits	6	2	2	2	4	3	1	1	1	1
San Diego	7	1	7	5	12	4	6	3	9	no audits	3	1
Fresno	2	4	12	9	12	9	7	12	1	2	3	2
Tulare	no audits	4	3	7	4	2	3	no audits	no audits	no audits	2	3
Sacramento	1	2	6	4	5	4	13	2	6	5	2	2
Kern	2	1	no audits	5	3	1	1	no audits	1	no audits	1	2
Stanislaus	no audits	7	5	3	1	1	5	4	1	no audits	1	1
Orange	2	3	1	3	no audits	1	2	1	no audits	no audits	1	1
Kings/Madera	no audits	no audits	no audits	no audits	no audits	no audits	no audits	no audits	3	1	1	no audits
Overall # of Audits	**41**	**69**	**75**	**75**	**68**	**70**	**83**	**68**	**41**	**32**	**45**	**31**

Table 5
Adult Preventive Care Criterion Rates

County	08-3rd Q	08-4th Q	09-1st Q	09-2nd Q	09-3rd Q	09-4th Q	10-1st Q	10-2nd Q	10- 3rd Q	10- 4th Q	11 – 1st Q	11 – 2nd Q
Los Angeles	83%	81%	80%	85%	80%	80%	78%	81%	77%	79%	78%	77%
Riverside	92%	no data	no data	no data	no data	79%	86%	no data	no data	no data	no data	78%
San Bernardino	85%	no data	81%	98%	84%	100%	88%	74%	98%	90%	91%	91%
San Diego	69%	no data	78%	87%	88%	85%	97%	93%	92%	no data	94%	NA
Fresno	77%	74%	87%	86%	66%	75%	84%	85%	80%	91%	93%	no data
Tulare	79%	87%	81%	84%	89%	100%	87%	no data	no data	no data	no data	77%
Sacramento	82%	84%	76%	68%	83%	70%	77%	no data	no data	71%	100%	no data
Kern	93%	77%	no data	82%	86%	87%	56%	no data	no data	no data	no data	85%
Stanislaus	no data	82%	70%	56%	74%	88%	87%	85%	80%	no data	no data	NA
Orange	98%	86%	no data	81%	83%	60%	83%	99%	88%	no data	no data	100%
Kings/Madera	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	76%	no data
Overall Average	**84%**	**82%**	**79%**	**81%**	**80%**	**80%**	**82%**	**86%**	**84%**	**79%**	**79%**	**80%**

Table 6
Pediatric Preventive Care Criterion Rates

County	08-3rd Q	08-4th Q	09-1st Q	09-2nd Q	09-3rd Q	09- 4th Q	10-1st Q	10-2nd Q	10- 3rd Q	10–4th Q	11– st Q	11–2nd Q
Los Angeles	90%	90%	88%	86%	90%	87%	79%	87%	87%	88%	83%	79%
Riverside	89%	no data	no data	no data	95%	100%	84%	100%	98%	no data	no data	NA
San Bernardino	86%	no data	86%	98%	84%	100%	96%	no data	100%	79%	91%	71%
San Diego	86%	100%	94%	91%	95%	93%	95%	93%	81%	77%	74%	79%
Fresno	94%	83%	98%	91%	87%	95%	97%	97%	94%	93%	100%	no data
Tulare	98%	95%	95%	87%	92%	91%	82%	no data	no data	no data	no data	91%
Sacramento	92%	no data	100%	88%	92%	90%	99%	100%	100%	78%	100%	no data
Kern	100%	100%	no data	92%	78%	100%	no data	no data	98%	no data	no data	100%
Stanislaus	no data	99%	89%	90%	100%	93%	97%	100%	91%	no data	no data	81%
Orange	97%	97%	no data	no data	no data	91%	79%	90%	98%	no data	no data	100%
Kings/Madera	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	96%	no data
Overall Average	**92%**	**95%**	**93%**	**90%**	**90%**	**91%**	**90%**	**95%**	**88%**	**85%**	**86%**	**83%**

Table 7
MRR Overall Counties-Mean Section Scores 3rd Q 2008 – 2nd Q 2011

County	08-3rd Q	08-4th Q	09-1st Q	09-2nd Q	09-3rd Q	09-4th Q	10-1st Q	10-2nd Q	10-3rd Q	10-4th Q	11-1st Q	11-2nd Q
Los Angeles	90%	90%	91%	92%	92%	90%	90%	91%	88%	91%	90%	89%
Riverside	89%	no data	no data	no data	98%	94%	95%	98%	99%	no data	no data	93%
San Bernardino	86%	no data	93%	97%	93%	99%	94%	90%	100%	93%	94%	90%
San Diego	86%	100%	95%	96%	97%	96%	98%	96%	96%	92%	94%	92%
Fresno	94%	83%	94%	91%	90%	93%	93%	94%	93%	96%	95%	no data
Tulare	98%	95%	92%	92%	93%	93%	92%	no data	no data	no data	no data	91%
Sacramento	92%	no data	96%	91%	95%	94%	94%	97%	99%	92%	100%	no data
Kern	100%	100%	no data	94%	88%	96%	78%	no data	98%	no data	no data	98%
Stanislaus	no data	99%	94%	87%	96%	96%	94%	96%	93%	no data	no data	93%
Orange	97%	97%	no data	94%	87%	83%	91%	94%	96%	no data	no data	99%
Kings/Madera	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	93%	no data
Overall Average	**92%**	**95%**	**94%**	**93%**	**93%**	**92%**	**92%**	**95%**	**93%**	**92%**	**91%**	**91%**

Table 8
Selected Criteria by County for 3rd Q 2010 to 2nd Q 2011

3RD QUARTER 2010

County	Interpreter Services	Trained Interpreters	Primary Language	Pediatric IHA	Pediatric IHEBA	Ped Dental Assessment	Adult IHA	Adult IHEBA
Los Angeles	100%	83%	100%	100%	100%	78%	100%	100%
Riverside	100%	100%	100%	100%	100%	100%		
San Bernardino	100%	100%	100%	100%	100%	100%	100%	100%
San Diego	100%	100%	100%	100%	100%	83%	100%	NA
Fresno	100%	100%	100%	100%	100%	100%	100%	0%
Tulare								
Sacramento	100%	100%	100%	100%	100%	100%		
Kern	100%	100%	100%	100%	NA	100%		
Stanislaus	100%	100%	100%	NA	NA	NA	100%	NA
Orange			100%	NA	100%	100%	NA	100%
Kings/Madera	100%	100%						
OVERALL	**100%**	**92%**	**100%**	**100%**	**100%**	**88%**	**100%**	**86%**

4TH QUARTER 2010

County	Interpreter Services	Trained Interpreters	Primary Language	Pediatric IHA	Pediatric IHEBA	Ped Dental Assessment	Adult IHA	Adult IHEBA
Los Angeles	100%	96%	92%	100%	100%	89%	100%	100%
Riverside								
San Bernardino	100%	100%	100%	100%	100%	100%	100%	100%
San Diego			100%	NA	NA	100%	100%	100%
Fresno	100%	100%	100%	100%	0%	100%	100%	50%
Tulare								
Sacramento	100%	80%	100%	100%	100%	50%	100%	100%
Kern								
Stanislaus								
Orange								
Kings/Madera	100%	100%						
OVERALL	**100%**	**94%**	**96%**	**100%**	**88%**	**81%**	**100%**	**94%**

1ST QUARTER 2011

County	Interpreter Services	Trained Interpreters	Primary Language	Pediatric IHA	Pediatric IHEBA	Ped Dental Assessment	Adult IHA	Adult IHEBA
Los Angeles	100%	93%	89%	89%	100%	85%	86%	100%
Riverside	100%	100%						
San Bernardino	100%	100%	100%	100%	100%	100%	100%	NA
San Diego	100%	100%	100%	50%	100%	100%	100%	NA
Fresno	100%	100%	100%	100%	100%	100%	100%	50%
Tulare	100%	100%						
Sacramento	100%	100%	100%	100%	100%	100%	NA	NA
Kern	100%	100%						
Stanislaus	100%	100%						
Orange	100%	100%						
Kings/Madera	100%	100%	100%	100%	100%	100%	100%	100%
OVERALL	**100%**	**95%**	**93%**	**88%**	**100%**	**88%**	**92%**	**91%**

2ND QUARTER 2011

County	Interpreter Services	Trained Interpreters	Primary Language	Pediatric IHA	Pediatric IHEBA	Ped Dental Assessment	Adult IHA	Adult IHEBA
Los Angeles	100%	95%	63%	50%	100%	83%	100%	100%
Riverside	100%	100%	100%	NA	NA	NA	100%	NA
San Bernardino	100%	100%	100%	100%	NA	100%	100%	NA
San Diego	100%	100%	100%	100%	100%	100%	NA	NA
Fresno	100%	100%						
Tulare	100%	100%	100%	100%	67%	100%	100%	0%
Sacramento	100%	100%						
Kern	100%	100%	100%	100%	100%	100%	100%	50%
Stanislaus	100%	100%	100%	100%	0%	100%	NA	NA
Orange	100%	100%	100%	100%	100%	100%	100%	NA
Kings/Madera								
OVERALL	**100%**	**97%**	**83%**	**91%**	**86%**	**90%**	**100%**	**70%**

MQR #8b, Attachment 10

2011 HNCA HEDIS® Medicare SNP Report

ACTIVITY SUMMARY

TO: QI CLINICAL AND SERVICE WORKGROUP
FROM: Matthew Robinson, Sr. Research Analyst, QI Research & Analysis
DATE: September 23, 2011
SUBJECT: Reporting Year (RY) 2011 HNCA HEDIS® Medicare SNP Report

Purpose of Activity

The purpose of this report is to present and evaluate the RY 2011 Health Net of California (HNCA) HEDIS® (Healthcare Effectiveness Data and Information Set) Medicare SNP rates based upon Health Net's performance in the measurement year (MY) 2010. The SNP HEDIS population is further broken down into the three major SNP sub-groups: Amber I, Amber II, and Chronic CHF Special Needs Plans. Analysis of Health Net's performance in the SNP product line allows for the identification of barriers and opportunities for improvement.

Quantifiable Measures

Tables 1A-3B (beginning on Page 3) details the HEDIS® measures reported for HNCA Medicare SNP. These measures are categorized into the following domain:

- Effectiveness of Care

Threshold(s) /Benchmark(s):

HNCA's RY 2011 Medicare SNP HEDIS® rates are compared to RY 2010 National 75th and 90th percentiles from the National Committee for Quality Assurance (NCQA) *2011 Accreditation Benchmarks and Thresholds – Mid-Year Update* for the Medicare product line. These reference standards are therefore only available for those measures that are required for accreditation. Additionally HNCA's RY 2011 Medicare SNP HEDIS® rates are compared to the RY 2011 CCHRI Medicare CA averages. These averages are based on the rates of the California Cooperative Healthcare Reporting Initiative (CCHRI) participating plans in 2011 and are computed by taking the sum of these rates and dividing them by the number of plans. The CMS SNP Mean is also put in place of the CCHRI Medicare Average when available. An 'N/A' is denoted in the report tables where performance thresholds are not available.

Methodology/Sampling/Time Period

HEDIS® measures reported by Health Net were specified using one of the following data collection methodologies – administrative methodology or hybrid methodology. Data collection was conducted per HEDIS® Technical Specifications for RY 2011. RY 2011 rates are statistically tested against Health Net's RY 2010 results, where applicable, using a Chi-Square Test of Proportions, with an alpha of 0.05.6

Administrative Methodology

Identification of denominators and numerators are made using transaction data or other Health Net administrative databases. The denominators consist of the total eligible population as determined by continuous enrollment, age, inclusion criteria, and contraindications. The numerators are identified within Health Net's administrative systems and consist of members within the denominator who were identified as having a qualifying procedure or diagnosis.

Hybrid Methodology

Identification of numerator compliance is conducted through administrative and medical record data extraction. The denominator consists of a systematic sample of members drawn from the measure's

eligible population. Health Net reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service required for the numerator.

Non-Trendable Measures

The following measures are considered non-trendable between the specified consecutive years during 2009-2011 due to HEDIS® related factors including technical specification changes and introduction of new metrics:

2011 vs. 2010
None

2010 vs. 2009
Colorectal Cancer Screening (COL)

- Lowered Upper Age Limit from 80 to 75 years of age and removed double contrast barium enema (DCBE) from numerator criteria

Table 1A. Summary of HEDIS® Measures – HNCA Medicare SNP AMBER I RY 2009-2011, 2011 Reference Standards

Measure	Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Effectiveness of Care								
Colorectal Cancer Screening [H,☆]	*Member & Physician Newsletter /Adult Screening Tear-Out card*	48.68	53.10	56.07	2.97	67.70▲	62▲	69▲
Glaucoma Screening in Older Adults[☆]		30.97	46.72	52.13	5.41	N/A	75▲	78▲
Care for Older Adult [H,☆]	*Provider group teleconference on SNP specific HEDIS measures including COA*							
Advance Care Planning		15.28	21.58	30.07↑	8.49	23[SNP]	N/A	N/A
Medication Review		56.25	76.10	77.62	1.52	53 [SNP]	N/A	N/A
Functional Status Assessment		15.05	13.92	30.54↑	16.62	28 [SNP]	N/A	N/A
Pain Screening		67.36	50.35	46.15	-4.20	38 [SNP]	N/A	N/A
Use of Spirometry Testing in Assessment and Diagnosis of COPD	*HD Decision Power*	N/A[D]	N/A[D]	N/A[D]	N/A	30.66	33	38
Pharmacotherapy Management of COPD Exacerbation	*MTM*							
Systemic Corticosteroid		N/A[D]	N/A[D]	N/A[D]	N/A	63.51	N/A	N/A
Bronchodilator		N/A[D]	N/A[D]	N/A[D]	N/A	77.30	N/A	N/A
Controlling High Blood Pressure (<140/90mm Hg) [H]	*I AM CHAD*	62.12	64.34	64.60	0.26	52 [SNP]	66▲	70▲
Persistence of Beta-Blocker after Heart Attack	*HD Decision Power/MTM*	N/A[D]	N/A[D]	N/A[D]	N/A	81.85	83	88
Osteoporosis Management in Women who had a Fracture[☆]	*Osteoporosis Program: Provider & Member Mailings Member Mailer Article Adult Screening tear-out card*	N/A[D]	N/A[D]	N/A[D]	N/A	28.58	22	29
Antidepressant Medication Management	*Antidepressant Medication Management Program / MTM*							
Acute Phase Treatment Completion		N/A[D]	N/A[D]	N/A[D]	N/A	67.93	68	74
Cont. Phase Treatment Completion		N/A[D]	N/A[D]	N/A[D]	N/A	51.74	56	63
Follow-Up After Hospitalization for Mental Illness	*MHN Pgm to Encourage FU after Hosp. For Mental Illness*							
30-Day Follow up [A]		N/A[D]	N/A[D]	N/A[D]	N/A	44.68	N/A	N/A
7-Day Follow up		N/A[D]	N/A[D]	N/A[D]	N/A	32.30	56	63

Table 1B. Summary of HEDIS® Measures – HNCA Medicare SNP AMBER I RY 2009-2011, 2011 Reference Standards

Measure	Program/Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Annual Monitoring for Patients on Persistent Medications								
ACE Inhibitors or ARBs		81.91	88.95	89.27	0.32	89.66▲	N/A	N/A
Digoxin		N/A[D]	N/A[D]	N/A[D]	N/A	91.33	N/A	N/A
Diuretics		83.51	89.50	90.98	1.48	89.77	N/A	N/A
Anticonvulsants		N/A[D]	58.54	76.19	17.65	62.42	N/A	N/A
Total [A]		81.69	87.83	89.37	1.54	90 [SNP]	91▲	94▲
Medication Reconciliation Post-Discharge [H]	*Provider group teleconference on SNP specific HEDIS measures including COA*	45.31	50.49	57.38	6.89	30[SNP]	N/A	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly*								
Falls + Tricyclic Antidepressants or Antipsychotics*	*Drugs to Be Avoided in the Elderly Program (HNPS)*	N/A[D]	N/A[D]	21.15	N/A	17.55▲	N/A	N/A
Dementia + Tricyclic Antidepressants or Anticholinergic Agents*		N/A[D]	39.47	41.67	2.20	25.18▲	N/A	N/A
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs*		N/A[D]	NR[D]	NR[D]	N/A	10.82	N/A	N/A
Total*		28.57	31.43	30.94	-0.49	20.74▲	N/A	N/A
Use of High-Risk Medications in the Elderly* [A]	*Drugs to Be Avoided in the Elderly Program (HNPS)*							
At Least 1 Prescription* [A]		28.57	28.73	27.97	-0.76	22.31▲	17▲	13▲
At least 2 Prescriptions* [A]		6.95	5.97	6.46	0.49	4.74▲	3▲	2▲

↑ Statistically significant increase in compliance in RY2011 as compared to RY2010, p<0.05
↓ Statistically significant decrease in compliance in RY2011 as compared to RY2010, p<0.05
▲ Lower performance of HN 2011 rate compared to benchmark (NCQA 90th %ile), QC National 50th Percentile, or the CCHRI Avg
D Denominator <30 and therefore not reportable per NCQA specifications
A Medicare Accreditation Measure
SNP CMS SNP Mean
* Lower rate indicates better performance
H Hybrid Measure
N/A Not Applicable
☆ CY2012 CMS Star Measures
⊥ Measure not trendable due to technical specification changes since the previous year; no significance testing was conducted

Table 2A. Summary of HEDIS® Measures – HNCA Medicare SNP AMBER II RY 2009-2011, 2011 Reference Standards

Measure	Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Effectiveness of Care								
Colorectal Cancer Screening [H☆]	*Member & Physician Newsletter Adult Screening Tear-Out card*	41.67	46.98	54.40↑	7.42	67.70▲	62▲	69▲
Glaucoma Screening in Older Adults[☆]		32.08	41.42	46.86↑	5.44	N/A	N/A	78▲
Care for Older Adult [H ☆]	*Provider group teleconference on SNP specific HEDIS measures including COA*							
Advance Care Planning		12.76	21.35	19.91	-1.44	23[SNP]	N/A	N/A
Medication Review		55.22	75.41	69.21	-6.20	53 [SNP]	N/A	N/A
Functional Status Assessment		11.60	13.46	26.39↑	12.93	28 [SNP]	N/A	N/A
Pain Screening		64.27	47.33	37.96↓	-9.37	38 [SNP]	N/A	N/A
Use of Spirometry Testing in Assessment and Diagnosis of COPD	*HD Decision Power*	N/A[D]	14.29	19.85	5.56	30.66▲	33▲	38▲
Pharmacotherapy Management of COPD Exacerbation	*MTM*							
Systemic Corticosteroid		58.11	53.02	77.16↑	24.14	63.51	N/A	N/A
Bronchodilator		86.49	77.18	90.12↑	12.94	77.30	N/A	N/A
Controlling High Blood Pressure (<140/90 mm Hg) [H]	*I AM CHAD*	62.41	55.84	60.14	4.30	52 [SNP]	66▲	70▲
Persistence of Beta-Blocker after Heart Attack	*HD Decision Power/MTM*	N/A[D]	N/A[D]	81.08	N/A	81.85▲	83▲	88▲
Osteoporosis Management in Women who had a Fracture[☆]	*Osteoporosis Program: Provider & Member Mailings Member Mailer Article Adult Screening tear-out card*	N/A[D]	16.67	9.76	-6.91	28.58▲	22▲	29▲
Antidepressant Medication Management	*Antidepressant Medication Management Program/ / MTM*							
Acute Phase Treatment Completion		42.86	59.09	59.05	-0.04	67.93▲	68▲	74▲
Cont. Phase Treatment Completion		34.29	42.42	42.86	0.44	51.74▲	56▲	63▲
Follow-Up After Hospitalization for Mental Illness	*MHN Pgm to Encourage FU after Hosp. For Mental Illness*							
30-Day Follow up [A]		44.78	40.00	49.73	9.73	44.68	N/A	N/A
7-Day Follow up		28.36	28.75	33.16	4.41	32.30	56▲	63▲

Table 2B. Summary of HEDIS® Measures – HNCA Medicare SNP AMBER II RY 2009-2011, 2011 Reference Standards

Measure	Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Annual Monitoring for Patients on Persistent Medications								
ACE Inhibitors or ARBs		80.31	84.53	85.18	0.65	89.66▲	N/A	N/A
Digoxin		87.72	94.83	89.74	-5.09	91.33▲	N/A	N/A
Diuretics		78.91	84.46	85.64	1.18	89.77▲	N/A	N/A
Anticonvulsants		62.26	56.38	67.15↑	10.77	62.42	N/A	N/A
Total [A]		79.23	83.61	84.72	1.11	90 [SNP]▲	91▲	94▲
Medication Reconciliation Post-Discharge [H]	*Provider group teleconference on SNP specific HEDIS measures including COA*	41.30	51.41	53.35	1.94	30[SNP]	N/A	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly*	*Drugs to Be Avoided in the Elderly Program (HNPS)*							
Falls + Tricyclic Antidepressants or Antipsychotics*		15.25	19.57	20.73	1.16	17.55▲	N/A	N/A
Dementia + Tricyclic Antidepressants or Anticholinergic Agents*		36.14	36.17	34.56	-1.61	25.18▲	N/A	N/A
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs*		N/A[D]	25.00	17.65	-7.35	10.82▲	N/A	N/A
Total*		26.11	29.58	28.70	-0.88	20.74▲	N/A	N/A
Use of High-Risk Medications in the Elderly* [A]	*Drugs to Be Avoided in the Elderly Program (HNPS)*							
At Least 1 Prescription* [A]		26.69	24.11	23.73	-0.38	22.31▲	17▲	13▲
At least 2 Prescriptions* [A]		6.95	5.16	5.33	0.17	4.74▲	3▲	2▲

↑ Statistically significant increase in compliance in RY2011 as compared to RY2010, p<0.05
↓ Statistically significant decrease in compliance in RY2011 as compared to RY2010, p<0.05
▲ Lower performance of HN 2011 rate compared to benchmark (NCQA 90th %ile), QC National 50th Percentile, or the CCHRI Avg
D Denominator <30 and therefore not reportable per NCQA specifications
A Medicare Accreditation Measure
SNP CMS SNP Mean
* Lower rate indicates better performance
H Hybrid Measure
N/A Not Applicable
☆ CY2012 CMS Star Measures
⊥ Measure not trendable due to technical specification changes since the previous year; no significance testing was conducted

Table 3A. Summary of HEDIS® Measures – HNCA Medicare SNP Chronic RY 2009-2011, 2011 Reference Standards

Measure	Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Effectiveness of Care								
Colorectal Cancer Screening [H☆]	*Member & Physician Newsletter Adult Screening Tear-Out card*	N/A	N/A	67.61	N/A	67.70▲	62	69▲
Glaucoma Screening in Older Adults☆		N/A	N/A	73.39	N/A	N/A	N/A	78▲
Care for Older Adult [H☆]	*Provider group teleconference on SNP specific HEDIS measures including COA*							
Advance Care Planning		N/A	N/A	30.08	N/A	23[SNP]	N/A	N/A
Medication Review		N/A	N/A	74.80	N/A	53 [SNP]	N/A	N/A
Functional Status Assessment		N/A	N/A	34.96	N/A	28 [SNP]	N/A	N/A
Pain Screening		N/A	N/A	30.08	N/A	38 [SNP]▲	N/A	N/A
Use of Spirometry Testing in Assessment and Diagnosis of COPD	*HD Decision Power*	N/A	N/A	N/A[D]	N/A	30.66	33	38
Pharmacotherapy Management of COPD Exacerbation	*MTM*							
Systemic Corticosteroid		N/A	N/A	N/A[D]	N/A	63.51	N/A	N/A
Bronchodilator		N/A	N/A	N/A[D]	N/A	77.30	N/A	N/A
Controlling High Blood Pressure (<140/90 mm Hg) [H]	*I AM CHAD*	N/A	N/A	78.33	N/A	52 [SNP]	66	70
Persistence of Beta-Blocker after Heart Attack	*HD Decision Power/MTM*	N/A	N/A	N/A[D]	N/A	81.85	83	88
Osteoporosis Management in Women who had a Fracture☆	*Osteoporosis Program: Provider & Member Mailings Member Mailer Article Adult Screening tear-out card*	N/A	N/A	N/A[D]	N/A	28.58	22	29
Antidepressant Medication Management	*Antidepressant Medication Management Program/ / MTM*							
Acute Phase Treatment Completion		N/A	N/A	N/A[D]	N/A	67.93	68	74
Cont. Phase Treatment Completion		N/A	N/A	N/A[D]	N/A	51.74	56	63
Follow-Up After Hospitalization for Mental Illness	*MHN Pgm to Encourage FU after Hosp. For Mental Illness*							
30-Day Follow up [A]		N/A	N/A	N/A[D]	N/A	44.68	N/A	N/A
7-Day Follow up		N/A	N/A	N/A[D]	N/A	32.30	56	63

Table 3B. Summary of HEDIS® Measures – HNCA Medicare SNP Chronic RY 2009-2011, 2011 Reference Standards

Measure	Program/ Intervention	HN RY 2009 (%)	HN RY 2010 (%)	HN RY 2011 (%)	Change from RY 2010 to RY 2011 (%)	CMS SNP Mean / CCHRI CA Avg	Nat'l 75th Percentile	Nat'l 90th Percentile
Annual Monitoring for Patients on Persistent Medications								
ACE Inhibitors or ARBs		N/A	N/A	90.79	N/A	89.66	N/A▲	N/A▲
Digoxin		N/A	N/A	N/A[D]	N/A	91.33	N/A	N/A
Diuretics		N/A	N/A	91.67	N/A	89.77	N/A	N/A
Anticonvulsants		N/A	N/A	N/A[D]	N/A	62.42	N/A	N/A
Total [A]		N/A	N/A	91.10	N/A	90 [SNP]	91	94▲
Medication Reconciliation Post-Discharge [H]	*Provider group teleconference on SNP specific HEDIS measures including COA*	N/A	N/A	42.86	N/A	30[SNP]	N/A	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly*	*Drugs to Be Avoided in the Elderly Program (HNPS)*							
Falls + Tricyclic Antidepressants or Antipsychotics*		N/A	N/A	N/A[D]	N/A	17.55	N/A	N/A
Dementia + Tricyclic Antidepressants or Anticholinergic Agents*		N/A	N/A	N/A[D]	N/A	25.18	N/A	N/A
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs*		N/A	N/A	N/A[D]	N/A	10.82	N/A	N/A
Total*		N/A	N/A	33.33	N/A	20.74▲	N/A	N/A
Use of High-Risk Medications in the Elderly* [A]	*Drugs to Be Avoided in the Elderly Program (HNPS)*							
At Least 1 Prescription* [A]		N/A	N/A	34.68	N/A	22.31▲	17	13
At Least 2 Prescriptions* [A]		N/A	N/A	14.52	N/A	4.74▲	3	2

↑ Statistically significant increase in compliance in RY2011 as compared to RY2010, p<0.05
↓ Statistically significant decrease in compliance in RY2011 as compared to RY2010, p<0.05
▲ Lower performance of HN 2011 rate compared to benchmark (NCQA 90th %ile), QC National 50th Percentile, or the CCHRI Avg
D Denominator <30 and therefore not reportable per NCQA specifications
A Medicare Accreditation Measure
SNP CMS SNP Mean
* Lower rate indicates better performance
H Hybrid Measure
N/A Not Applicable
☆ CY2012 CMS Star Measures
⊥ Measure not trendable due to technical specification changes since the previous year; no significance testing was conducted

Barrier Analysis

By understanding the barriers that affect quality, Health Net can identify methods to overcome those barriers and create interventions to improve quality. Table 4 summarizes performance barriers for metrics with related to 2011 core QI initiatives.

Table 4 – Barriers of Metrics Associated with 2011 Core QI Initiatives

Measure(s)	Initiative	Barrier
Colorectal Cancer Screening (COL)	• *HEDIS gap colorectal call* • *Mailer to habitual noncompliant <60* • *Mailer to HEDIS negative* • *Member Newsletter with adult screening tear-out card* • *Provider update on STAR Initiative/Preventive screening* • *Wellness Calendar*	• Test may be viewed as, "violating", embarrassing and/or painful and may fear a positive cancer dx Literature review indicates: • Multiple touches and varied modalities increase screening rates • Educational information for providers may be a limited intervention • Doctors recommendation may influence screening decision by member • Structural barriers-distance to mammography center, lack of time and/or transportation • Difficult to coordinate collaborative projects with PPG, timelines delayed do to coordination between departments within the PPG.
Glaucoma Screening in Older Adults (GSO)	• *Glaucoma mailer* • *Glaucoma article in Medicare Newsletter* • *Wellness Calendar*	• Limitations with data availability and reliability • Members knowledge of benefits • Member confusion regarding eye benefits Literature review indicates: • Multiple touches and varied modalities increase screening rates • Educational information for providers may be a limited intervention • Doctors recommendation may influence screening decision by member • Structural barriers-lack of time and/or transportation

Table 4 Continued – Barriers of Metrics Associated with 2011 Core QI Initiatives

Measure(s)	Initiative	Barrier
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	• *HD Decision Power*	• Member deficit about proper clinical care for specific conditions • Lack of member screening • Provider may have deficit of guidelines or may not be aware of HN educational resources • Lack of provider time during visit • Difficulty in identifying members with a particular disease for timely intervention.
Controlling High Blood Pressure (CBP)	• *Wellness Calendar*	• Member deficit about proper clinical care for specific conditions • Lack of member screening
Persistence of Beta-Blocker after Heart Attack (PBH)	• *HD Decision Power*	• Member deficit about proper clinical care for specific conditions • Lack of member screening • Provider may have deficit of guidelines or may not be aware of HN educational resources • Lack of provider time during visit • Difficulty in identifying members with a particular disease for timely intervention.
Osteoporosis Management in Women who had a Fracture (OMW)	• *Member & Physician Newsletter Adult Screening tear-out card* • *Improve Treatment of Post-menopausal Osteoporosis (OMW) in Members with Post Osteoporotic Fractures* • Intervention program designed to improve screening and treatment of women age >65 for osteoporosis following a fracture. • *Pilot Quality Improvement Programs: Osteoporosis Management in Women Who Have Had a Fracture* • Transmission of educational materials to members/providers in addition to provider level alerts.	• Medical claims and pharmacy claims are utilized in order to identify target members in the intervention so timely submission essential. • Primary care physician (PCP) may not be aware of the fracture, may not have seen the patient recently or the patient may have switched PCP.

Table 4 Continued – Barriers of Metrics Associated with 2011 Core QI Initiatives

Measure(s)	Initiative	Barrier
Antidepressant Medication Management (AMM)	*Increase Compliance with Antidepressant Medication Management (AMM) Program*	• Costs involved in the treatment of depression • Possible cultural/ethnic perceptions and stigma around behavioral health care, and the lack of resources for providers and members to overcome this obstacle • Limitations with data availability and reliability • Lag in reporting. • Difficulty in implementation and monitoring of interventions.
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)	*Decrease Use of Drugs to be Avoided in the Elderly (DAE)*	• Member reluctance to change medication • MD unaware of medication regimen and/or best choice
Use of High-Risk Medications in the Elderly (DAE)	*Decrease Use of Drugs to be Avoided in the Elderly (DAE)*	• Member reluctance to change medication • MD unaware of medication regimen and/or best choice

MQR #8b, Attachment 11

Western Region Medicare QI Team
Medicare Health Outcomes Survey (HOS)
Combined 2008 Cohort 11 & 2009 Cohort 12 Baseline Report
AZ H0351, CA H0562, OR H5520

Committee Action Required: ☐ **Review & Approve** ☒ **Informational Only** ☐ **Other**

Purpose of Report:
The Medicare Health Outcomes Survey (HOS) provides beneficiary self-reported outcomes measurement for Medicare managed care. The HOS evaluates physical and mental health status and can be used to evaluate clinical outcomes for Health Net, Inc.'s (HN) Medicare populations, including SNP members, as well as assist HN in developing Western Region quality improvement (QI) strategies.

Introduction:
The Centers for Medicare and Medicaid Services (CMS) Medicare Health Outcome Survey, or HOS, is an important part of the CMS' quality improvement activities. Current law authorizes Quality Improvement Organizations (QIOs) to ensure that the medical care that is paid for under the Medicare program meets professionally recognized standards of health care. Collected since 1998, the Medicare HOS is the only patient-reported outcomes measurement in Medicare managed care. The HOS evaluates physical and mental health status using the Veterans RAND 12-Item Health Survey (VR-12), and asks participants a series of questions about their usual activities and perceptions of their physical and mental health status. The goal of the HOS is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, public reporting, Medicare Advantage Organization (MAO) accountability, and improving health outcomes.

The HOS baseline reports are part of a larger effort by CMS to improve the health care industry's capacity to sustain and improve health status and functioning in its Medicare population. The baseline reports are designed to guide each MAO in identifying the overall health of their Medicare population in order to develop programmatic interventions aimed at maintaining or improving health status. For each Cohort, a randomly selected group of members are surveyed for baseline and two-year follow-up information. The follow-up survey measures a plan's ability to maintain or improve the physical and mental health functioning of its beneficiaries over a two-year period.

MAOs are encouraged to use the HOS data to target quality improvement strategies as follows:

- Identify opportunities for quality improvement activities
  - HEDIS measures for which the MAO had substantially lower rates when compared to state or national benchmarks

    - Specific chronic conditions or negative health symptoms that are associated with lower physical and mental health status
    - Conditions or negative symptoms for which the MAO has a disproportionately high prevalence compared to state and national average
- Prioritize and select areas for quality improvement activities
- Set goals and performance objectives for quality improvement activities
- Perform a root cause analysis and develop a quality improvement action plan
- Measure and monitor performance over time
- Provide performance feedback to physicians

Quantifiable Measures Associated with CMS Star Ratings:
The HOS reports provide participating member demographic data broken down into the categories of age, gender, race, marital status, education, annual income and Medicaid status. In addition, the HOS reports contain information on baseline measures of physical and mental health, chronic medical conditions, functional status (i.e. Activities of Daily Living), clinical measures, NCQA HEDIS® measures and other health status indicators.

For the purposes of this report, only the HOS measures that are associated with the CMS Star Rating System will be presented in detail. A brief presentation on Chronic Medical Conditions will also be provided. The following HOS measures are associated with the CMS Star Rating System.

Health Status Measures:
- Physical Component Summary (PCS) Score and the Mental Component Summary (MCS) Score
- Improving/maintaining physical health
- Improving/maintaining mental health

NCQA HEDIS® Measures- There is a total of four NCQA HEDIS® Measures found in the HOS:
- Management of Urinary Incontinence in Older Adults (MUI)
    - Discussing Urinary Incontinence
    - Receiving Urinary Incontinence Treatment
- Physical Activity in Older Adults (PAO)
    - Discussing Physical Activity
    - Advising Physical Activity
- Fall Risk Management (FRM)
    - Discussing Fall Risk
    - Managing Fall Risk
- Osteoporosis Testing in Older Women

A complete list of the questions associated with the above measures can be found in *Attachment B*.

Benchmark(s)/Threshold(s)/Reference Value(s):
For the majority of HOS measures there are no established benchmarks or thresholds. Health Net rates are compared to the results of year-over-year subsequent baseline

reports and the two-year follow-up reports to the HOS Total (national rates) for all measures, with the exception of the NCQA HEDIS® measures.

For the NCQA HEDIS® measures, the Health Net rates are compared to the National 50th and 90th Percentiles as published by the National Committee for Quality Assurance (NCQA) in the ***NCQA Accreditation Benchmarks and Thresholds*** document that is published on an annual basis. The document provides organizations with national benchmarks and national and regional thresholds for HEDIS® measures.

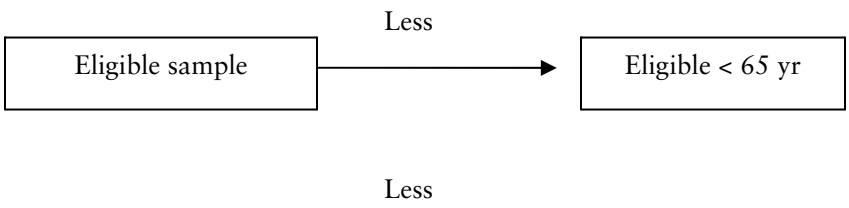
Methodology/Sampling/Time Period:

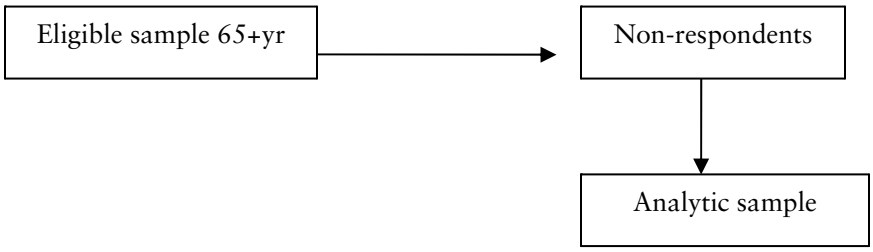
On an annual basis, CMS administers the HOS during the 1st-2nd Quarter, with the electronic distribution of the reports to the participating MAOs during the 3rd- 4th Quarter via the CMS' Health Plan Management System (HPMS). CMS utilizes a mixed method of data collection, involving telephone and mailed surveys, along with prenotification and reminder postcards. The surveys included telephone follow-up in those instances where the beneficiary failed to respond to a second mail survey. Survey vendors used a standardized version of a Computer Assisted Telephone Interviewing (CATI) script to collect the interview data for the survey. Telephone surveys were also performed in English or Spanish for the members who returned incomplete forms in order to obtain missing responses.

For each *Cohort*, a random sample of Medicare beneficiaries is obtained from all participating MAOs. All MAOs with CMS contracts in effect on or before January 1st of the year preceding the year of the Baseline report are required to administer the survey; i.e. MAOs contracted on or before 1/1/2007 were required to administer the 2008 Baseline HOS. MAOs with 500 or fewer members are not required to report HOS. MAOs with 500-1200 members are required to report HOS on all eligible members. MAOs with > 1200 members and < 3000 members are required to submit the HOS on a randomized sample of 1200 beneficiaries.

Members who responded to the *2008 Cohort 11 Baseline* survey were excluded from the *2009 Cohort 12 Baseline* sample. Ineligible members are defined as deceased, not enrolled in the MAO, members with incorrect address and phone numbers and members with a language barrier. The analytic sample includes beneficiaries who completed the HOS in English, Spanish or Chinese. The diagram in Figure #1 illustrates the process of how the analytic sample is obtained for the baseline surveys included in this report.

Figure 1: Distribution of the Sample





The HOS Total sample includes beneficiaries, who completed the survey, both aged and disabled from MAOs participating in the *2008 Cohort 11 Baseline* and *2009 Cohort 12 Baseline,* 286 and 361 respectively. A completed survey is defined as one that could be used to calculate the summary scores in the PCS or MCS.

Table 1: Analytic Samples & Response Rates

Cohort	AZ Sample (Response Rate)	CA Sample (Response Rate)	OR Sample (Response Rate)	HOS Total (Response Rate)
2008 Cohort 11	632 (61.3%)	673 (63.7%)	787 (70.7%)	202,382 (59.0%)
2009 Cohort 12	658 (65.2%)	695 (63.4%)	821 (73.5%)	250,733 (62.6%)

Quantitative Analysis:

The *2008 Cohort 11 Baseline* and *2009 Cohort 12 Baseline* survey results for the Western Region's Medicare product lines are summarized in each of the following sections.

Demographics

The largest percentages for Health Net members who responded to the *2008 Cohort 11 Baseline* and *2009 Cohort 12 Baseline* survey were:

- Age: Arizona ages 70-79; California ages 75-79; and Oregon ages 70-74
- Gender: Females
- Race: White
- Marital Status: Married
- Education: Arizona & Oregon- High School Graduate; California- Some College
- Annual Household Income: Arizona $10,000-$19,000; Oregon $20,000- $49,00; and California $50,000 or more

Table 2 presents detailed demographics by Cohort and CMS contract.

Table 2: Demographics of Health Net's HOS Respondents

Demographic	Arizona (H0351)		California (H0562)		Oregon (H5520)	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Age						
65-69	22.0%	17.6%	18.9%	14.4%	27.2%	22.7%
70-74	23.9%	28.4%	23.6%	25.0%	29.5%	30.9%
75-79	24.7%	27.5%	25.4%	27.5%	20.7%	21.1%
80-84	17.7%	15.7%	17.7%	16.5%	14.5%	14.5%
85+	11.7%	10.8%	14.4%	16.5%	8.1%	10.8%
Gender						
Male	43.0%	40.7%	40.9%	40.4%	44.5%	40.3%
Female	57.0%	59.3%	59.1%	59.6%	55.5%	59.7%
Race						
White	91.8%	91.5%	81.0%	78.8%	98.1%	97.4%
Black	2.1%	2.3%	3.1%	5.3%	1.0%	0.4%
Other/Unknown	6.2%	6.2%	15.9%	15.8%	0.9%	2.2%
Marital Status						
Married	58.7%	57.8%	52.5%	53.8%	64.2%	61.3%
Widowed	27.4%	27.9%	30.7%	29.1%	20.8%	22.6%
Divorced/Separated	11.8%	12.1%	13.2%	12.8%	13.5%	14.6%
Never Married	2.1%	2.2%	3.7%	4.4%	1.5%	1.5%
Education						
Did not graduate HS	21.9%	21.0%	18.2%	20.9%	13.8%	14.0%
High school graduate	33.8%	33.8%	27.1%	25.1%	35.2%	39.8%
Some college	26.5%	25.1%	28.8%	28.9%	29.9%	28.8%
4 yr degree or beyond	17.8%	20.2%	25.9%	25.1%	21.2%	17.4%
Annual Household Income						
< $10,000	9.7%	8.8%	7.1%	6.7%	6.4%	8.4%
$10,000-$19,000	29.1%	29.1%	18.0%	17.2%	21.6%	22.7%
$20,000-$29,000	18.9%	20.0%	15.0%	17.6%	23.8%	23.5%
$30,000-$49,000	19.4%	20.1%	23.5%	23.0%	24.0%	23.4%
$50,000 or more	12.8%	11.8%	26.8%	25.5%	17.1%	16.0%
Don't know	10.1%	10.2%	9.7%	10.0%	7.1%	6.0%

Health Status Measures:

Physical and Mental Component Summary Scores (PCS & MCS)

The health status measures for the HOS consist of PCS and MCS scores. The HOS evaluates physical and mental health status using the Veterans RAND 12-Item Health Survey (VR-12), and asks participants a series of questions about their usual activities and the perceptions of their physical and mental health status. Some of the concepts included in the measure are physical functioning, general health, vitality, social functioning and mental health. The PCS and MCS scores are case-mix adjusted to allow for equitable comparisons across the MAOs, allowing for differences in the demographics, socioeconomic characteristics and chronic medical conditions. The following figures depict the mean case-mix adjusted PCS and MCS scores for the various Health Net CMS contracts and the associated HOS Total by *Cohort*.

Figure 2: Baseline Mean Adjusted Physical Component Summary Scores by Cohort

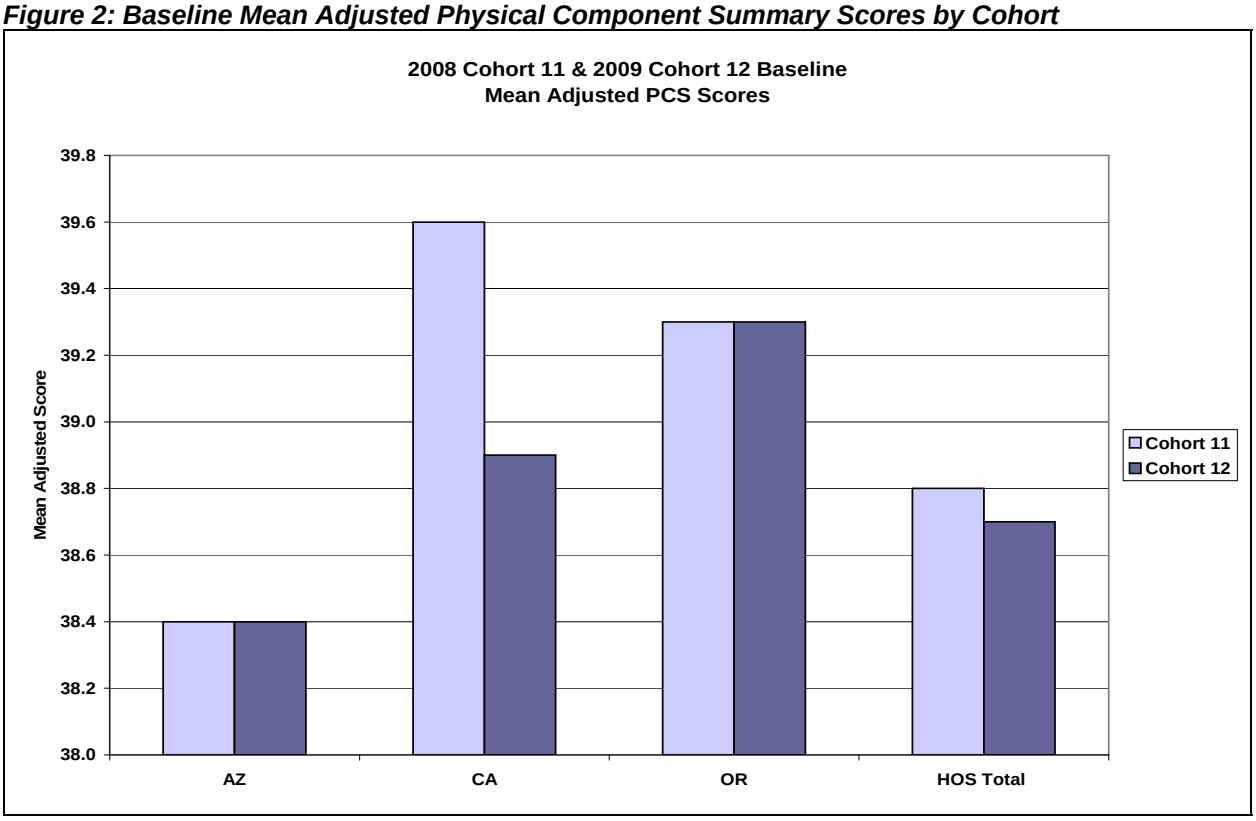
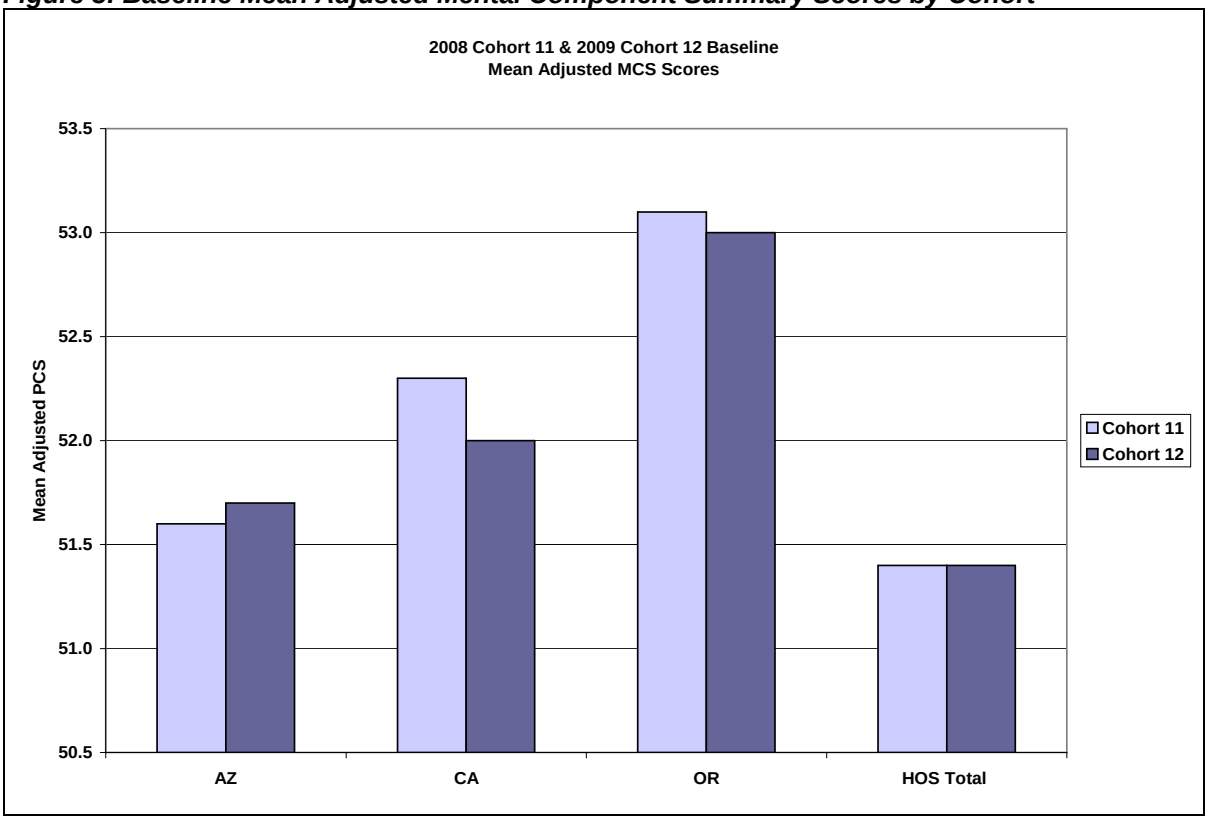


Figure 3: Baseline Mean Adjusted Mental Component Summary Scores by Cohort



General Health and Comparative Health

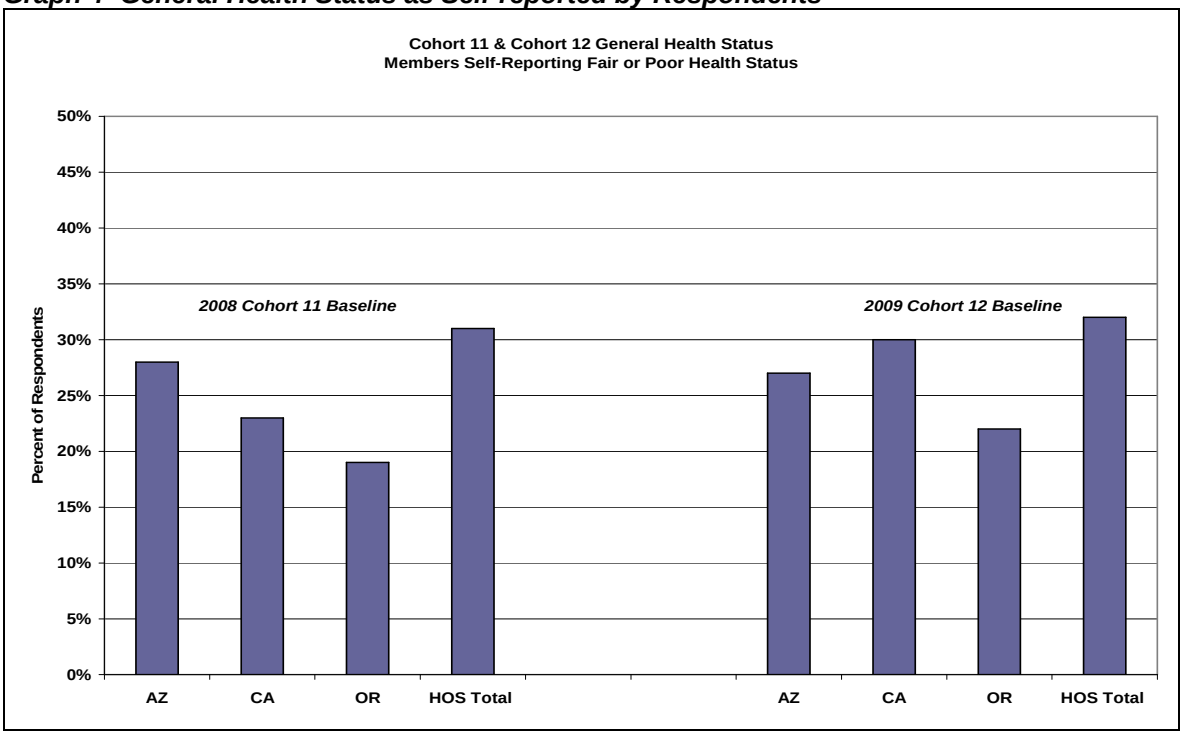
The General Health and Comparative Health measures include the elements of the participant's self-reported health status, and self-reported physical and mental health status compared to one year ago. Deterioration in general health or comparative health status can be used as a tool to forecast members' risk for hospitalization and predict a potential increase in utilization of services.

Compared to the HOS Total respondents, Health Net members reported lower rates of "fair" to "poor" general health status in each of the states, as well as an overall lower rate for the total Health Net respondents. For the *2008 Cohort 11 Baseline* survey, Health Net members from AZ and OR reported higher rates of "fair" and "poor" health status, then the rate reported for the HOS Total population. For the *2009 Cohort 12 Baseline* survey the Health Net reported rates for all three states were lower than the HOS Total. The CA respondents reported the highest rate within the Western Region, representing an increase to 30 percent.

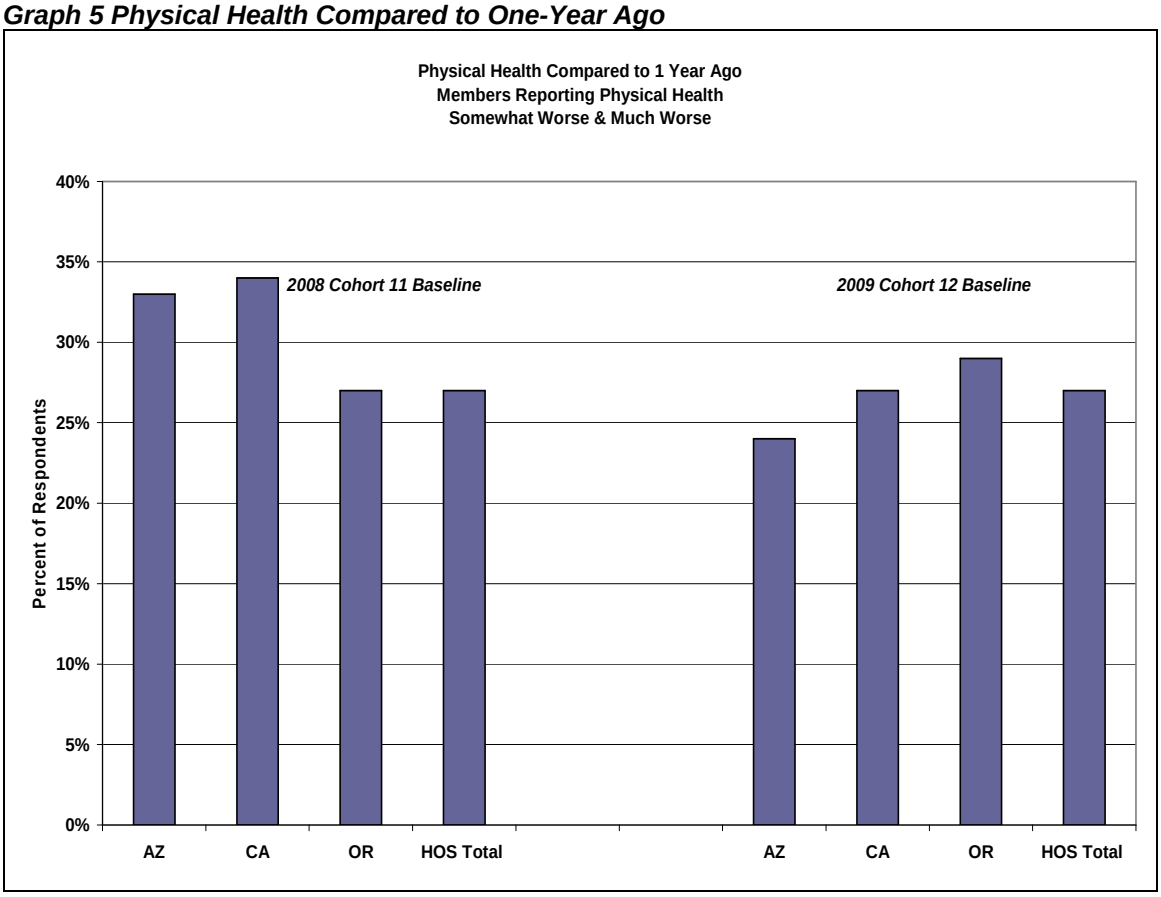
In addition, *2008 Cohort 11 Baseline* respondents for Health Net AZ reported a much higher rate of Mental Health status changes of somewhat worse and much worse than seen in Health Net CA and OR respondents (by 8% & 9% respectively) and was five percent higher than the rate reported for the HOS Total population. For the *2009 Cohort 12 Baseline* survey, Health Net AZ and CA respondents reported similar rates to the HOS Total population, while the Health Net respondents from OR reported lower rates overall (by 2%).

The following figures display the Health Net respondents' self-reported General Health and comparative Physical and Mental Health Status.

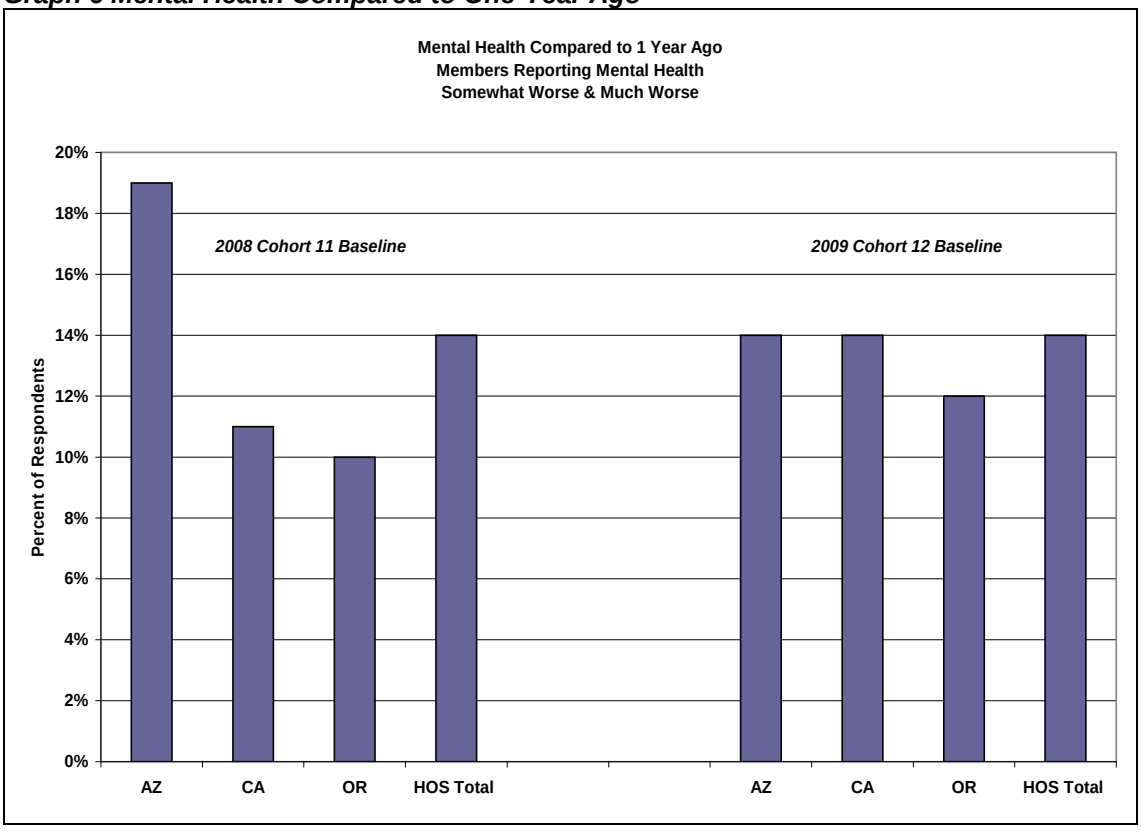
Graph 4- General Health Status as Self-reported by Respondents



Graph 5 Physical Health Compared to One-Year Ago



Graph 6 Mental Health Compared to One-Year Ago



NCQA HEDIS® Measures:

The tables in this section depict the mean HEDIS® rates for each *Cohort* and are calculated from the combination of *Cohort Baseline* and *Cohort Follow-Up* data that was collected during the combined surveys. The rates represent the data obtained from non-duplicated respondents to the two surveys that were administered in 2008 and 2009, and have been rounded to the closest two-digit percentage.

Physical Activity in the Older Adult (PAO)

The PAO measure is comprised of two questions that gather data on a member's discussion of physical activity with a doctor or other health care provider. The two rates that are calculated for this measure are:

- Discussing physical activity
- Advising physical activity

Table 3 discusses the Health Net respondents' rates by state and *Cohort*, compared to the HOS Total populations. Arizona respondents reported lower rates of Discussing Physical Activity and Advising Physical Activity than both CA and OR, as well as the HOS Total population, for both *Cohort 11* and *Cohort 12*. Overall the rates for Advising Physical Activity were similar across the states and HOS Total for Cohort 12.

Table 3 PAO rates by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing Physical Activity	52%	51%	58%	57%	55%	59%	52%	52%
Advising Physical Activity	45%	43%	50%	48%	47%	48%	47%	47%

Management of Urinary Incontinence in Older Adults (MUI)

The MUI measure is comprised of two questions that gather data on a member's discussion of urinary incontinence with a doctor or other health care provider. The two rates that are calculated for this measure are:

- Discussing urinary incontinence (UI)
- Receiving urinary incontinence (UI) treatment

Table 4 discusses the Health Net respondents' rates by state and *Cohort*, compared to the HOS Total populations. Arizona respondents reported lower rates of Discussing UI than both CA and OR. Arizona and California demonstrated lower rates for Receiving UI Treatment than seen in Oregon; however were similar to the HOS Total rates.

Table 4 MUI rates by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing UI	57%	54%	62%	59%	60%	58%	58%	58%
Receiving UI Treatment	35%	36%	37%	36%	46%	42%	36%	36%

Fall Risk Management (FRM)

The FRM measure is comprised of two questions that gather data on a member's discussion of risk for falls with a doctor or other health care provider. The two rates that are calculated for this measure are:

- Discussing fall risk
- Managing fall risk

Overall Health Net respondents reported lower rates in both components of the FRM measure than was seen in the HOS Total population for both *Cohort 11* and *Cohort 12*. Table 5 discusses the Health Net respondents' rates by state and *Cohort*, compared to the HOS Total populations.

Table 5 FRM rates by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing FRM	29%	28%	26%	28%	26%	29%	31%	31%
Receiving FRM	54%	53%	57%	58%	47%	44%	57%	57%

Osteoporosis Testing in Older Women (OTO)

The OTO measure assesses the percentage of women aged 65 and older who report ever having received a bone density test to check for osteoporosis.

Overall Health Net respondents reported higher rates in the OTO measure than were seen in the HOS Total population for both *Cohort 11* and *Cohort 12*. The Health Net respondents from CA reported the lowest rates for the Western Region states in *Cohort 11;* while AZ reported the lowest rate in *Cohort 12.* Table 6 discusses the Health Net respondents' rates by state and *Cohort*, compared to the HOS Total populations.

Table 6 OTO rates by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Osteoporosis Testing Rate	80%	76%	74%	78%	77%	79%	68%	69%

Chronic Medical Conditions:

For *2008 Cohort 11* and *2009 Cohort 12*, the Health Net members reported hypertension, followed by arthritis of the hip/knee and arthritis of the hand/wrist as the top three prevalent chronic conditions. Table 7 illustrates the self-reported rates by state and *Cohort*:

Table 7 Chronic Medical Conditions

Condition	AZ		CA		OR	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Hypertension	62%	62%	66%	65%	57%	59%
Arthritis hip/knee	44%	43%	37%	41%	35%	34%
Arthritis hand/wrist	39%	42%	37%	39%	40%	38%

Table 8 illustrates the self-reported rates by cancer types, broken down by *Cohort* and state, with an overall Western Region rate by *Cohorts*:

Table 8 Cancer Diagnoses

Condition	AZ		CA		OR	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Any Cancer, except skin	17%	15%	19%	17%	17%	17%
Colon/Rectal	3%	3%	1%	2%	1%	2%
Breast	4%	3%	6%	3%	5%	5%

Conclusions:

Health Net members from AZ demonstrate lower mean case mix adjusted rates for both the Physical Component Summary (PCS) Scores and Mental Component Summary (MCS) Scores than was evident in the California or Oregon survey participants. When compared to the HOS Total population, Health Net members reported higher rates of "fair" and "poor" physical and mental health compared to one year ago for both *Cohorts*.

Further analysis was performed on the combined *Cohorts* with a Western Region (WR) approach and perspective on the data. The analysis demonstrated there are similar health outcomes throughout all Health Net Medicare populations that can affect the members' PCS, MCS and General Health status. Those similarities follow:

- Arthritis of the hip/knee is the second most prevalent chronic condition
- Participants report an average of 25 out of 30 days with limited activity
- Over 66 percent of the WR participants report that pain interfered with normal work (housework or outside the house)
- Over 30 percent of the WR participants report moderate to severe arthritic pain
- Between 35-41 percent of the WR participants reported 4 or more chronic medical conditions
- Overall 75 percent of the WR members reported having one or more impaired ADLs, with 26 percent of those reporting 4 or more impaired ADLs.
- Between 41-42 percent of the WR participants reported having urinary incontinence (UI)
- Between 55-58 percent of the WR participants with UI reported that the incontinence is a problem for them
- Overall 23 percent of the WR respondents reported having fallen within the past year
- WR rates for both FRM components are lower than rates seen in the HOS Total population
- WR rates for OTO are higher than those seen in the HOS Total population
- Overall 17 percent of the WR participants report having been diagnosed with some type of cancer, other than skin; CA has the highest rate at 18 percent, followed by OR, then AZ respectively- higher than the HOS Total @ 15 percent
- Overall 2 percent of the WR participants report having been diagnosed with colon/rectal cancer; AZ has the highest rate at 3 percent, followed by CA, then OR respectively

- Overall 4 percent of the WR participants report having been diagnosed with breast cancer; OR has the highest rate at 5 percent, followed by CA, then AZ respectively

The Health Net CMS Star Ratings for relevant HOS measures can be found in the table located in *Appendix A*.

Areas for Opportunities/Interventions Analysis:

Table 9 presents the identified areas with potential opportunities for improvement, recommendations/interventions and follow-up.

Table 9 Potential Quality Improvement Activities

Opportunity	Recommendation(s)/Interventions	Follow-Up
Management of Urinary Incontinence in Older Adults	2011 Western Region QIP IVR Women's' Campaign Add to Health Education Calendar Provider Update Five-Star Quality Rating WR Medicare Member Newsletter	Annually & as needed
Fall Risk Management	Health Education Calendar IVR Women's' Campaign Provider Education Provider Update Five-Star Quality Rating WR Medicare Member Newsletter	Annually & as needed
Osteoporosis Testing in Older Women	IVR Campaign Add to Health Education Calendar Provider Update Five-Star Quality Rating WR Medicare Member Newsletter	Annually & as needed
Management of Arthritic Pain	Health Education Calendar Rheumatoid Arthritis Barrier Survey Collaborate on initiative with HNPS Provider Update Five-Star Quality Rating	Annually & as needed
Cancer screening & member education	Health Education Calendar IVR Women's' Campaign IVR Colorectal Screening Campaign Provider Update Five-Star Quality Rating WR Medicare Member Newsletter	Annually & as needed

Appendix A: Health Net Star Ratings by HOS Measure

HOS Measure	California	Oregon	Arizona
Staying Healthy			
Monitoring Physical Activity	2	2	1
Improving/Maintaining Physical Health	4	4	5
Improving/Maintaining Mental Health	2	2	2
Osteoporosis Testing	4	5	4
Managing Chronic Conditions			
Bladder Control	2	3	2
Risk for Fall	3	1	2

Appendix B: NCQA HEDIS® Measures Frequency of Member Responses Tables

PAO frequency of responses by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing Physical Activity	48%	50%	56%	55%	53%	55%	52%	52%
Advising Physical Activity	43%	46%	49%	46%	46%	46%	47%	47%

MUI frequency of responses by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing UI	40%	36%	44%	41%	46%	44%	58%	58%
Receiving UI Treatment	24%	23%	26%	24%	33%	33%	36%	36%

FRM frequency of responses by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Discussing FRM	21%	21%	17%	18%	15%	17%	31%	31%
Receiving FRM	29%	27%	27%	32%	21%	23%	57%	57%

OTO frequency of responses by State and Cohort

Component	AZ		CA		OR		HOS Total	
	Cohort 11	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*	*Cohort 11*	*Cohort 12*
Osteoporosis Testing Rate	51%	55%	52%	53%	48%	52%	68%	69%

Appendix C: Questions Associated with Quality Initiatives and the CMS Star Rating System

Question #	Question
1	In general, how would you say your health is?
5	During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
8	Compared to one year ago, how would you rate your physical health in general now?
9	Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) in general now?
13	During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?
17	During the past 4 weeks, how would you describe any arthritis pain you usually had?
42	Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?
43	How much of a problem, if any, was the urine leakage for you?
44	Have you talked with your current doctor or other health provider about your urine leakage problem?
45	There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problems?
46	In the past 12 months, did you talk with your doctor or other health provider about your level of exercise or physical activity?
47	In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?
48	A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk to your doctor or other health provider about falling or problems with balance or walking?
49	Did you fall in the past 12 months?
51	Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?
52	Have you ever had a bone density test to check for osteoporosis, sometimes thought of as “brittle bones?” This test may have been done to your back, hip, wrist, heel or finger.

Appendix D: NCQA HEDIS® Measures Specifications

Management of Urinary Incontinence in Older Adults (MUI) - Two components are used to assess the different facets of managing urinary incontinence in the older adult population.

- *Discussing Urinary Incontinence:* the percentage of Medicare members, 65 years of age and older, who reported having a urine leakage problem in the past six (6) months, and who discussed the problem with their current doctor or other health care provider.
- *Receiving Urinary Incontinence Treatment:* the percentage of Medicare members, 65 years of age and older, who reported having a urine leakage problem in the past six months, and who received treatment for their current urine leakage problem.

Physical Activity in Older Adults (PAO) - Two components are used to assess the different facets of promoting physical activity in the older adult.

- *Discussing Physical Activity:* the percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months, and who talked with a doctor or other health provider about their level of exercise or physical activity.
- *Advising Physical Activity:* the percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months, and who received advice to start, increase, or maintain their level of exercise or physical activity.

Fall Risk Management (FRM) - The following components of the measure are used to assess the different facets of fall risk management:

- *Discussing Fall Risk:* the percentage of Medicare members 75 years of age and older, or 65-74 years of age with balance or walking problems or a fall within the past 12 months, who were seen by a doctor or other health provider in the past 12 months, and who discussed falls or problems with balance or walking with their provider.
- *Managing Fall Risk:* the percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, and who received fall risk intervention from their provider.

Osteoporosis Testing in Older Women (OTO) - This measure assesses the number of women 65 years of age and older that report ever having received a bone density test to check for osteoporosis.



MQR #8b, Attachment # 12

Medicare CAHPS 4.0 Measure	2010 Health Net					2011 Health Net					
	CAHPS 4.0 Question Number	Den	Num	Den-Num	Rate	CAHPS 4.0 Question Number	Den	Num	Den-Num	Rate	P-VALUE 2010 VS 2011
Overall Rating of Health Plan	Q32	269	232	37	86.2%	37	342	301	41	88.0%	0.5979
Overall Rating of Care Received	Q9	217	181	36	83.4%	12	339	279	60	82.3%	0.8239
Overall Rating of Personal Doctors	Q20	216	199	17	92.1%	21	278	257	21	92.4%	1
Overall Rating of Specialist	Q24	102	88	14	86.3%	28	192	162	30	84.4%	0.7927
Health Plan Customer Service Composite	Composite				**92.3**	Composite				92.0%	
▪ Give Information Needed	Q28	84	69	15	82.1%	33	121	99	22	81.8%	1
▪ Courtesy and Respect ↓	Q29	86	84	2	97.7%	34	122	106	16	86.9%	0.0133
▪ Forms Easy to Fill Out*	Q31	74	55	19	74.3%	36	95	77	18	81.1%	0.3887
Getting Needed Care Composite	Composite				**81.3**	Composite				91.8%	
▪ Getting Appointments with Specialists	Q22	115	94	21	81.7%	26	206	176	30	85.4%	0.4779
▪ Getting Needed Care, Tests, or Treatment	Q26	152	123	29	80.9%	31	198	161	37	81.3%	1
Getting Care Quickly Composite	Composite				**86.1**	Composite				84.0%	
▪ Getting Needed Care Right Away	Q4	95	84	11	88.4%	4	147	128	19	87.1%	0.9119
▪ Getting Regular/Routine Appointments	Q6	214	172	42	80.4%	6	261	221	40	84.7%	0.2662
▪ Within 15 Min of Appt	Q8	219	114	105	52.1%	8	271	156	115	57.6%	0.2594
Doctors Who Communicate Well Composite	Composite				**89.9**	Composite				96.2%	
▪ Provided Clear Explanations	Q16	219	191	28	87.2%	17	281	256	25	91.1%	0.2095
▪ Listened Carefully	Q17	219	201	18	91.8%	18	278	256	22	92.1%	1
▪ Showed Respect for What Patients Have to Say	Q18	218	201	17	92.2%	19	281	257	24	91.5%	0.8923
▪ Spent Enough Time With Patients	Q19	219	194	25	88.6%	20	281	249	32	88.6%	1
HEDIS® Metrics											
Influenza Vaccination	Q67	264	135	129	51.1%	70	335	184	151	54.9%	0.4007
Pneumonia Shot ↑	Q69	240	103	137	42.9%	71	303	188	115	62.0%	<0.0001
Additional Medicare Specific Metrics											
Getting Medical Equipment	Q11	72	45	27	62.5%	14	116	85	31	73.3%	0.1637
Plan Prescription Drug Coverage											
Overall Rating of Prescription Drug Coverage	Q52	261	232	29	88.9%	60	333	291	42	87.4%	0.6654
Willingness to Recommend Plan for Drug Coverage [1]	Q53	269	247	22	91.8%	61	345	310	35	89.9%	0.4883



MQR #8b, Attachment # 12

Medicare CAHPS 4.0 Measure	CAHPS 4.0 Question Number	2010 Health Net Den	Num	Den-Num	Rate	CAHPS 4.0 Question Number	2011 Health Net Den	Num	Den-Num	Rate	P-VALUE 2010 VS 2011
Getting Needed Prescription Drugs[1]	-				**94.5**	Composite				97.1%	
▪ Ease of Getting Prescribed Medicines	Q47	256	236	20	92.2%	55	330	292	38	88.5%	0.1773
▪ Ease of Filling Prescriptions (combined item)	-					57/59	278	258	20	92.8%	
▪ Ease of Filling Prescriptions at a Pharmacy↓	Q49	215	208	7	96.7%	57	269	246	23	91.4%	0.0271
▪ Ease of Filling Prescriptions by Mail	Q51	21	18	3	85.7%	59	42	39	3	92.9%	0.6489
Getting Information About Prescription Drug Coverage and Cost[1]	-				**86.9**	Composite				88.1%	
▪ Customer Service Give Information↓	Q37	56	48	8	85.7%	45	45	28	17	62.2%	0.0129
▪ Customer Service Courtesy and Respect	Q38	54	49	5	90.7%	46	43	34	9	79.1%	0.1822
▪ Which Drugs Are Covered	Q40	50	44	6	88.0%	48	45	32	13	71.1%	0.0722
▪ Out-of-Pocket Costs	Q42	42	35	7	83.3%	50	59	41	18	69.5%	0.1755

1 Change in phrasing of question when comparing 2010 to 2011 questionnaire.

Denominator less than 100

- Information is either Not Applicable or Not Available.

↓↑ Statistically significant difference between HN 2011 score and the HN 2010 score, p<0.05.

*Different than DSS report

MQR #8b, Attachment 13

HOS Metrics Contract H0562 (MA and SNP combined)

2011 Cohort #13 Results

Measure	2011 Cohort 13
MUI Urinary Incontinence Discuss Rate	57.7
MUI Urinary Incontinence Treat Rate	34.9
PAO Physical Activity Discuss Rate	60.4
PAO Physical Activity Advise Rate	51.2
FRM Fall Risk Discuss Rate	29.3
FRM Fall Risk Manage Rate	57.7
OTO Osteoporosis Testing Rate Women	69.9

MQR #9 – Attachment 14

9. NCQA Accreditation

Health Net's Medicaid product line (Medi-Cal) holds a COMMENDABLE accreditation status from the National Committee for Quality Assurance (NCQA) and Health Net's Medicare product line (including SNP) holds an EXCELLENT accreditation status with the NCQA and is CMS Medicare Advantage Deemed Status.

MQR #11 – Attachment 15

11. Americans with Disabilities Act and Alternative Format

Health Net Community Solutions, Inc. ("Health Net") fully complies with all state and federal disability accessibility and civil rights laws in all areas of service provision, access to facilities and access to information. Health Net ensures that all translation and interpreter service vendors, including alternate format vendors, are fully compliant with ADA requirements through the implementation of quality standards in its contracting, monitoring and quality improvement efforts.

Health Net provides alternative format materials upon request for all member-informing materials, which include materials for members with visual impairment in an alternate form such as large print, Braille, Analog and Digital audio (e.g. AAC, MP3, WMA, WAV), or CDDA (computer disk digital audio), DAISY and Accessible PDF. Health Net records member alternate format preference in the member's record. Health Net will routinely promote the use of sign language services and availability of materials in alternate format to contracted providers through Provider Updates, provider newsletters, and on-site education by the Medi-Cal Facility Site Review (FSR) nurses. Contracted providers will be encouraged to use a qualified sign language interpreter for all medical encounters, when obtaining informed consent and discouraged from using minors, family or friends as interpreters. Health Net will arrange and pay for sign language interpreters at the member or physician request for all dual eligible members. Health Net has a network of sign language vendors for all counties throughout California to assure all dual eligible will have access to interpreter support. Health Net includes sign language services and alternate format services in our Language Assistance Program. All language services are monitored for quality and utilization.

To provide an additional level of support to ensure ADA compliance, Health Net contracts with the Harris Family Center for Disability and the Health Professions (HFCDHP). Since 2006, HFCDHP has provided Health Net expertise and guidance in the development of policies, procedures, provider trainings, identifying new communication technology and staff trainings for accessibility to health care for Seniors and Persons with Disabilities (SPD) members. Health Net, in collaboration with DHCS and HFCDHP, developed a Provider Accessibility Review Survey (PARS) to survey PCP sites to identify sites with Basic and Limited Access. The PARS assessment provides accessibility information for a member's independent access to parking, exterior building, interior building, restrooms, exam room and medical equipment audit. Health Net's Medi-Cal FSR Compliance Department conducts periodic (every 3 years) Physical Accessibility Review Surveys (PARS) to assess the physical accessibility of primary care provider sites. The PARS includes identified high volume specialists, and ancillary providers that serve the SPD population as well as hospitals. Results of the PARS assessment are made available to the Customer Contact Center to assist SPD members in selecting a PCP that can best serve their health care needs. The PCP accessibility status is also provided in the Health Net member web portal and in the Provider Directory.

MQR #12 – Attachment 16

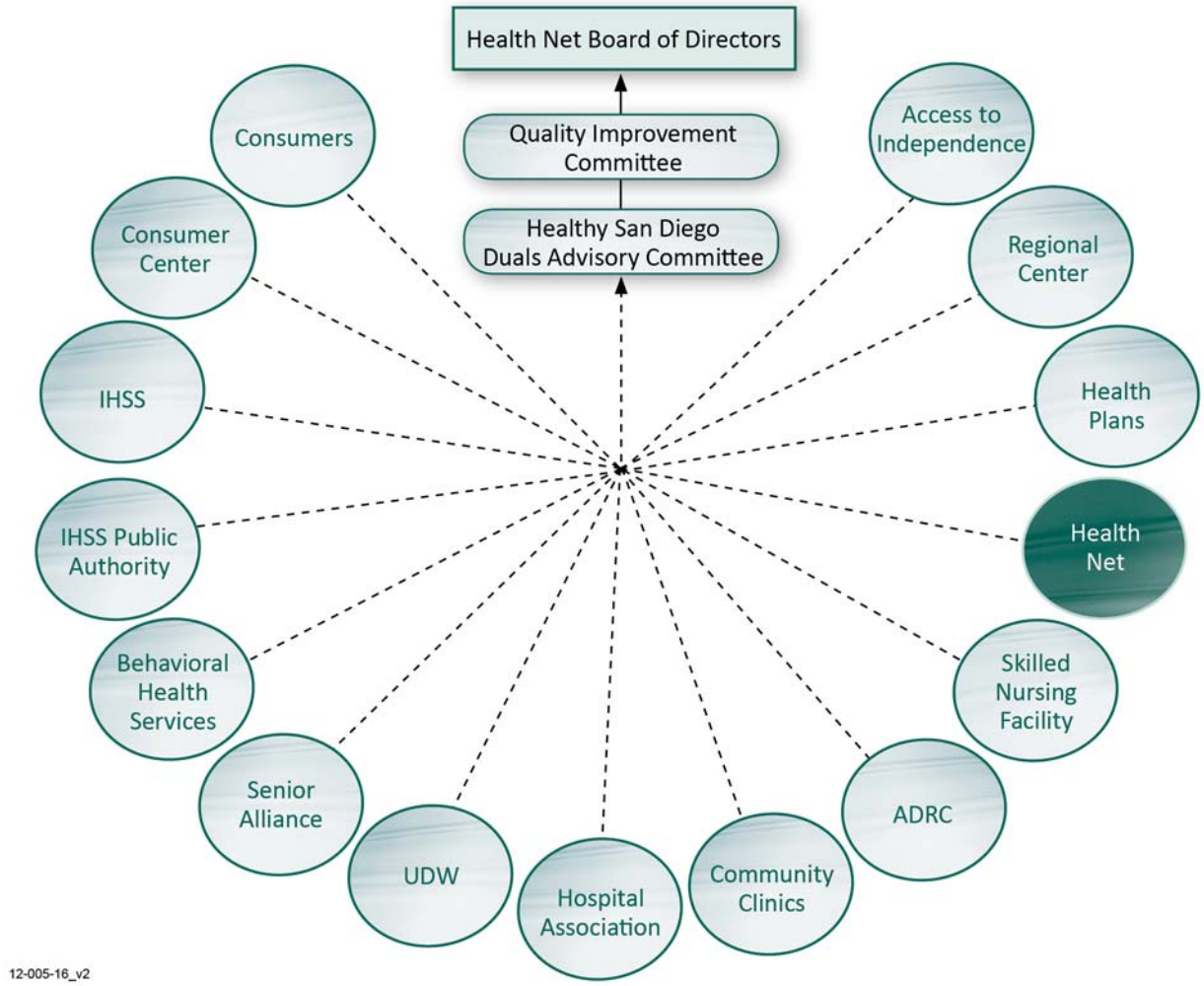
12. Stakeholder Involvement

Option 2 – Advisory Board

Health Net, working in collaboration with Healthy San Diego and the other Healthy San Diego health plans, is developing a Duals Advisory Committee that includes representation from the following organizations:

- Consumer Center for Health Education and Advocacy
- In Home Supportive Services (IHSS)
- IHSS Public Authority
- County Behavioral Health Services
- Program of All-Inclusive Care (PACE)
- Community-Based Adult Service (CBAS)
- Senior Alliance
- United Domestic Workers (UDW)
- Hospital Association of San Diego and Imperial County
- Community clinics
- AIS Aging Services (ADRC)
- Skilled nursing facility
- Consumers
- Health plans
- Regional Center
- Access to Independence

Health Net and the other Healthy San Diego health plans will nominate persons for the Duals Advisory Committee. The criteria and nomination process will be developed. Health Net's senior public programs administrator will be a member of the Duals Advisory Committee. The diagram below illustrates how the Duals Advisory Committee will report to the Health Net Board of Directors via the Health Net Quality Improvement Committee.



Option 3 – Letters of Support

Health Net has attached five letters of support from the community, with sources including advocates for seniors and persons with disabilities, organizations representing LTSS, such as community-based organizations, and/or individual health care providers. **Attachment 16** contains letters from: California Association of Area Agencies on Aging (C4A), California Association of Adult Day Services (CAADS), Casa Pacifica Adult Day Health Care Center, California Foundation for Independent Living Centers (CFILC), and UC San Diego Health System.

Option 4 – Stakeholder Input into Development of Application

The structure of the Duals Advisory Committee and its membership was determined based on feedback provided during the stakeholder group meetings convened by the San Diego Long Term Care Integration Project in February.

Option 5 – Program of Stakeholder Involvement

The San Diego County **Project Narrative, Section 5.4.1** provides a description of Health Net's program of stakeholder involvement.

CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING

February 22, 2012

Toby Douglas
Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Re: Letter of Commitment for Dual Eligible Demonstration Pilot – San Diego County

Dear Director Douglas:

On behalf of the California Association of Area Agencies on Aging (C4A), I am expressing our support and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are committed to continuous collaboration with Health Net and Healthy San Diego toward a successful conclusion.

Health Net has been an articulate and dedicated member of our Advisory Board for the past five years. As the only health plan member, we have come to appreciate and value Health Net's contribution to our Board and its work.

C4A is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net and Healthy San Diego on the Dual Eligible Demonstration Pilot as a partner. Through greater coordination, networking, and resource exchange together we can improve health outcomes through timely access to comprehensive, patient-centered care. We hope our partnership with Healthy San Diego and Health Net in this project will help make the Demonstration Pilot a reality for San Diego County residents.

Please feel free to contact me regarding this letter of commitment and support.

Sincerely,

Derrell Kelch
Executive Director

Cc: Janice Milligan, RN
Director, Public Programs
Health Net Community Solutions

980 Ninth Street, Suite 240 ✦ Sacramento, CA 95814 ✦ Phone (916)443-2800 Fax (916)554-0111
Email: aging@c4a.info ✦ Website: www. c4a.info

CAADS
California Association for Adult Day Services

1107 9th Street
Suite 701
Sacramento, California
95814-3610

Tel: 916.552.7400
Fax: 866.725.3123
E-mail: caads@caads.org
Web: www.caads.org

February 20, 2012

Toby Douglas
Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Director Douglas:

On behalf of the California Association of Adult Day Services (CAADS), I am writing to express our strong support and intended involvement in the Dual Eligible Demonstration Pilot for Los Angeles and San Diego counties, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). Our Board of Directors is committed to participating in this Demonstration with Health Net. We are committed to continuous collaboration with Health Net to achieve the goals of the project and successful outcomes.

Health Net has been an articulate and dedicated supporter of our mission. Over the past year of intensive work with the public programs team at Health Net, we have come to appreciate and value Health Net's contribution to our shared vision and goals.

CAADS is committed to improving the health status of the diverse communities that we collectively serve through our members' provision of CBAS. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot, with CAADS and our provider members serving as partners in this project. Through greater coordination, networking, and resource exchange, together we can improve health outcomes through timely access to comprehensive, patient-centered care. We believe that our partnership with Health Net in this project will help make the Demonstration Pilot a successful reality for Los Angeles and San Diego county Medi-Cal residents with complex chronic conditions who choose to remain living in their community.

Please feel free to contact me at (916) 552-7402 regarding this letter of commitment and support.

Sincerely,

Lydia Missaelides, MHA
Executive Director

Cc: Janice Milligan, RN
Director, Public Programs
Health Net Community Solutions

CAADS Board of Directors

JGELT Corporation
Casa Pacifica Adult Day Health Care Center

1424 30th Street, Suite C
San Diego, CA 92154
Phone 619-424-8181
Fax 619-424-8151

February 17, 2012

To: Rogelio Lopez, Sr. Public Programs Administrator
Health Net of CA

Re: Letter of Support for Dual Eligible Demonstration Pilot

Dear Mr. Lopez:

On behalf of the Casa Pacifica CBAS provider, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful program implementation. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

The Casa Pacifica CBAS is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community partner. Through greater coordination, networking, and resource exchange together we can improve health outcomes through timely access to comprehensive patient-centered care. We respect and share Health Net's mission to help people be healthy, secure and comfortable. We hope our partnership in this project will help make that goal a reality for many more San Diego residents.

Please feel free to contact me at 619-424-8181 regarding this letter of commitment and support.

Sincerely,

Luba Vaisman
President / Administrator
J GELT Corporation/Casa Pacifica ADHC Center CBAS provider

1234 H Street, Suite 100
Sacramento, CA 95814
(916) 325-1690
(916) 325-1695 TDD
(916) 325-1699 FAX

www.cfilc.org

February 23, 2012

Toby Douglas
Director, California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Re: Support & Commitment to Dual Eligible Demonstration Pilot

Dear Director Douglas:

On behalf of the California Foundation for Independent Living Centers (CFILC), I am expressing our support and intended involvement in the Dual Eligible Demonstration Pilot for Los Angeles and San Diego counties, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this Demonstration with Health Net. We are committed to continuous collaboration with Health Net toward a successful conclusion.

Health Net has been an articulate and dedicated supporter of our mission for over five years. We have come to appreciate and value Health Net's contribution to our work.

CFILC is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a partner. Through greater coordination, networking, and resource exchange together we can improve health outcomes through timely access to comprehensive, consumer directed care. We hope our partnership with Health Net in this project will help make the Demonstration Pilot a reality for LA and San Diego county residents.

Please feel free to contact me at (916)326-1690 regarding this letter of commitment and support.

Best regards,

Teresa Favuzzi, MSW
Executive Director

Cc: Janice Milligan, RN Director, Public Programs
Health Net Community Solutions

UC San Diego
HEALTH SYSTEM

February 14, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of UCSD Medical Center and UCSD Medical Group ("UCSD"), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

UCSD is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (619) 471-9393 regarding this letter of commitment and support.

Sincerely,

David Vincent Kraus, JD, MSPH
Chief Contracting Officer
UC San Diego Health System
619-471-9393
dkraus@ucsd.edu

NICK MACCHIONE, FACHE
DIRECTOR

DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY
1600 PACIFIC HIGHWAY, SAN DIEGO, CA 92101-2417
(619) 515-6555 • FAX (619) 515-6556

February 8, 2012

Letter of Agreement to Work in Good Faith:

With the passage of AB 1040 in 1995 supporting the development of integrated care models, in February 1999, with Board of Supervisors support, San Diego County began a 12 year effort to implement an integrated system of care for seniors and persons with disabilities through the Long Term Care Integration Project (LTCIP). San Diego County's Health and Human Services Agency (HHSA), through its Aging & Independence Services (AIS) Department, received funding from a variety of sources including three planning grants and two demonstration grants from the State Department of Health Care Services totaling $750,000, as well as additional funding from the California Department on Aging ($610,000), the County of San Diego ($500,000), the California Endowment ($400,000) and the Alliance Healthcare Foundation ($250,000).

More than 800 stakeholders (health and social service providers, aging and disabled consumers and advocates), have spent more than 30,000 hours over 12 years to envision and recommend a better model of care for low income seniors and persons with disabilities in our community. Their motivation came from the recognition of the difficulty these individuals and their caregivers have in navigating the fragmented and duplicative network of medical, social, and long-term care services.

After thorough examination of various service delivery models, in January 2001 by consensus decision, LTCIP stakeholders recommended exploring the feasibility of using San Diego County's existing geographic Medi-Cal managed care program, Healthy San Diego (HSD), as the preferred delivery system model to explore. Referred to as the "HSD+ model," it would have built on the "medical home" approach provided by the County's Healthy San Diego managed care program for Medi-Cal beneficiaries, which now includes all those seniors and persons with disabilities receiving Medi-Cal only. Though legislation was introduced in 2006 to initiate a pilot integration project built upon the HSD+ model, it was not passed.

In March 2009, the County Board of Supervisors directed staff to pursue reform of the In-Home Supportive Services (IHSS) program. After reviewing available local and State options for reform, staff returned to the Board in November 2009 with a number of recommendations, including reviewing the opportunity to re-initiate long-term care integration as part of the State's 1115 Hospital Waiver renewal. For the past two years, County staff have been tracking the development of the dual eligible demonstration project. San Diego responded to the State's Dual Eligible Request for Information (RFI) and presented San Diego's vision for integration at the State's RFI session in August 2011.

County staff have been meeting with Healthy San Diego plans and with SCAN Health Plan since last summer to discuss the integration opportunities now afforded by the Dual Eligibles Demonstration Project. The plans have communicated a strong interest in working collaboratively with the County to build upon the long-standing efforts of local stakeholders to create an integrated system for the dual eligibles in our community.

Also during the past year, the County contracted with the actuarial firm, PricewaterhouseCoopers, to analyze Medicare, Medi-Cal and home and community based service expenditures to develop a capitated rate for an integrated service delivery system and assist the County with understanding the financial implications for IHSS. Unfortunately, the County consultant has been unable to access needed data to complete these analyses.

As the Director of the Health and Human Services Agency (HHSA), which includes Behavioral Health, Aging Services (including IHSS and the Area Agency on Aging/Aging & Disability Resource Connection) I commit my agency to continue working in good faith with health plans to develop an integrated system of care for the dual eligibles in our community that is consistent with the efforts of the past 12 years. With the receipt of necessary data to complete the actuarial analysis, after continued collaboration with the health plans on program design, and with Board of Supervisors' approval, HHSA will be prepared to engage in a formal agreement with health plans to support the Dual Eligibles Demonstration Project.

Should you have any questions, please contact Pamela Smith, Director, Aging & Independence Services, at (858) 495-5858.

Sincerely,

NICK MACCHIONE, MS, MPH, FACHE
Director

cc: Walt Ekard, Chief Administrative Officer, County of San Diego
Stephen Magruder, Senior Deputy, County Counsel
Dean Arabatzis, Chief Operations Officer, HHSA
Dale Fleming, Director, Strategic Planning and Operational Support, HHSA
Jennifer Schaffer, Ph.D., Director, Behavioral Health
Pamela B. Smith, Director, Aging & Independence Services, HHSA
Mike Van Mouwerik, Director, Financial & Support Services, HHSA

HEALTHY SAN DIEGO

MEMORANDUM OF AGREEMENT
BETWEEN
HEALTH AND HUMAN SERVICES AGENCY
AND
MEDI-CAL MANAGED CARE PLANS

3.0 AGING & INDEPENDENCE SERVICES (AIS)

3.1 BACKGROUND

The County of San Diego, Health and Human Services Agency (HHSA), Aging & Independence Services (AIS) is the umbrella, social service agency for more than thirty different programs for older adults and adults, over the age of 18, with disabilities. The scope of AIS programs includes: Protection, Safety and Advocacy including but not limited to Adult Protective Services and the Ombudsman Program; Health, Fitness and Nutrition including but not limited to Fall Prevention, Chronic Disease Self-Management, Care Transitions and Congregate and Home Delivered Meals; Enrichment and Involvement including but not limited to Intergenerational Programs and Retired Senior Volunteer Program (RSVP); Caregiver Support; Support in the Home including but not limited to In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Senior Options, Advocacy and Referrals (SOAR) and Linkages; Veterans Services; and Medicare and Legal Advocacy including but not limited to Elder Law & Advocacy and the Health Insurance Counseling & Advocacy Program (HICAP). AIS provides information and assistance to people of all incomes through the Aging and Disability Resource Connection (ADRC), which is the gateway to AIS Programs and Services. The Medi-Cal Managed Care Plan is responsible for establishing a provider network that will meet the needs of the Medi-Cal, Senior and People with Disabilities (SPD) population and assure referral to and coordination with supports outside of the plan's benefit package. Both organizations share a common goal of assuring that Medi-Cal SPDs receive a continuum of health care and supportive services across all providers and care settings.

CATEGORY	AGING & INDEPENDENCE SERVICES (AIS)	MEDI-CAL MANAGED CARE PLAN
3.2 LIAISON	a. Designate an AIS liaison as the point of contact for the Plan, to address referral and coordination related activities.	a. Designate Plan liaison as the point of contact with AIS to address referral and coordination related activities.

CATEGORY	AGING & INDEPENDENCE SERVICES (AIS)	MEDI-CAL MANAGED CARE PLAN
3.3 PROVIDER TRAINING	a. AIS Outreach and Education staff will provide training to Plan staff and providers on AIS Programs as requested by Plan and within the capacity of AIS staff to accommodate training requests. b. AIS will make training about working with SPDs, coordinating care, and locating needed services and supports accessible online to Plan and providers. A link to online training modules will be provided by AIS.	a. Request training from AIS Outreach and Education staff for Plan staff and contracted providers on AIS programs as needed. b. Provide link to online training to Plan staff and contracted providers.
3.4 COMMUNICATION AND CARE COORDINATION	a. AIS will provide the following to the Plan: Access and instructions to make referrals to In Home Supportive Services (IHSS) and Case Management Programs via the Web Referral System. The IHSS staff roster monthly. An encrypted e-mail account to communicate issues, questions etc., related to AIS Programs and Services. AIS will review the e-mails and will provide a response by the most appropriate individual within 48 hours. AIS staff will facilitate case discussions with the Plan as needed via WEBEX, e-mail or conference call.	a. Provide service authorization if needed, as well as medical record review information with AIS to facilitate communications and care coordination regarding their mutual member/client population. b. Provide nursing assessments with AIS staff as requested and needed to ensure the most appropriate service delivery by AIS Programs for mutual member/client population. c. Assist AIS care coordination staff as needed to obtain required service documentation to ensure timely and quality delivery of AIS Programs for mutual member/client population.
3.5 DATA EXCHANGE	a. Review, analyze and share relevant AIS data with Plan about their members who are receiving AIS services or are being referred to AIS Programs, as allowed and with needed authorizations obtained.	a. Provide data to AIS about shared members or members who are being referred to AIS Programs, as allowed and with needed authorizations obtained.
3.6 MEMBER OUTREACH AND EDUCATION	a. Distribute informational materials about HSD Plans, enrollment and benefits to SPDs and their providers.	a. Inform SPD members about availability of AIS Programs. Provide AIS Outreach and Education staff with informational materials about HSD Plans, enrollment and benefits to distribute to SPDs and their providers.

CATEGORY	AGING & INDEPENDENCE SERVICES (AIS)	MEDI-CAL MANAGED CARE PLAN
3.7 QUALITY IMPROVEMENT AND ISSUE RESOLUTION	a. Participate in the monthly Health Plan Work Group meetings to address and resolve quality, administrative or operational issues and ensure ongoing communication between AIS and the Plan. b. AIS Liaison will involve appropriate AIS Management Team staff to address and resolve quality, administrative or operational issues presented by Plan in the monthly Health Plan Work Group meetings as needed. c. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this Agreement as appropriate.	a. Address any AIS quality, administrative or operational issues with AIS in the monthly Health Plan Work Group meetings to ensure resolution and ongoing communication between AIS and the Plan. b. If an issue remains unresolved by AIS Liaison, Plan Liaison can request involvement of appropriate AIS Management Team staff to address and resolve quality, administrative or operational issues. c. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with AIS to update this Agreement as appropriate.

HEALTHY SAN DIEGO

MEMORANDUM OF UNDERSTANDING BETWEEN HEALTH AND HUMAN SERVICES AGENCY AND MEDI-CAL MANAGED CARE PLANS

BACKGROUND

This Memorandum Of Understanding (MOU) is made by and between San Diego County Division of Mental Health, Mental Health Plan (hereinafter referred to as MHP) and Medi-Cal Managed Care Plan (hereinafter referred to as Plan) in order to implement certain provisions of Title 9 of the California Code of Regulations, Chapter 11 (Medi-Cal Specialty Mental Health Services).

The purpose of this MOU is to describe the responsibilities of the MHP and the Plan in the delivery of specialty mental health services to Medi-Cal beneficiaries served by both parties. It is the intention of both parties to coordinate care between providers of physical and mental health care. All references in the MOU to "Members" are limited to the Plan's San Diego County Medi-Cal Members.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Liaison **(MHP & Plan Responsibilities)**	The MHP will maintain responsibility for: • Medication treatment and other mental health services for mental health conditions that would not be responsive to physical health care based treatment and meet criteria for specialty Mental Health services. • Consultation services to Plan providers, particularly PCPs about specialty mental health issues and treatments, including medication consultation. • The treatment of physical reactions induced from medications prescribed by the MHP providers. The MHP liaison will coordinate activities with the Plan and will notify the MHP providers of the roles and responsibilities of the MHP Liaison. The MHP will meet with the Plan at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and update the MOU as necessary. The MHP Liaison will be responsible for communicating	The Plan liaison will coordinate activities with the MHP and will notify its contracting Primary Care Providers (PCPs) of the roles and responsibilities of the Plan Liaison. The Plan Liaison will meet with the MHP at least quarterly to resolve issues regarding appropriate and continuous care for members. Will meet at least annually to review and update the MOU as necessary. The Plan will be responsible for communicating suggestions for MOU changes to the Plan leadership and the MHP Liaison. The Plan will also communicate MOU changes to Healthy San Diego (HSD), the State Department of Health Services, and Plan providers. At the discretion of the Plan, the Liaison may represent the Plan in the dispute resolution process. The Plan will provide the MHP with the phone numbers of its member services, provider services, and support programs that provide liaison services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Liaison (MHP & Plan Responsibilities) (continued)	suggestions for MOU changes to the MHP leadership and Plan Liaison. The MHP will also communicate MOU changes to the State Department of Mental Health and MHP providers. At the discretion of the MHP, the Liaison may represent the MHP in the dispute resolution process. The MHP will assist and provide the Plan with the phone numbers of its beneficiary and provider services and support programs that provide liaison services.	With a member's written permission or as otherwise permitted by applicable law, the identification of a patient, Plan member, clinical, or other pertinent information will be shared between the Plan and the MHP and its providers for coordination of care.
Ancillary Mental Health Services	The MHP will provide hospital based ancillary mental health services, other than routine services, to Plan members when medical necessity criteria are met. Ancillary services, are included in the per diem rate and may include but are not limited to electro-convulsive therapy (ECT).	The Plan will arrange ancillary services for the MHP members when medically necessary. The Plan will direct contracting providers to cover ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.
Clinical Consultation and Training	The MHP will provide and make available to Plan Providers clinical consultation and training, including consultation and training on psychotropic medications to meet the needs of a beneficiary whose mental illness is not being treated by the MHP. The MHP will include consultation on medications to Primary Care physician for Plan members on medications whose mental illness is being treated by the PCP. Clinical consultation between the MHP and the PCP will include consultation on a beneficiary's physical health condition. Such consultation will also include consultation by the MHP to the PCP on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the PCP.	The Plan will direct contracting providers to provide clinical consultation and training to the MHP or other providers on physical health care conditions and on medications prescribed through Plan providers. The Plan will direct contracting providers to arrange clinical consultation to the MHP or other providers of mental health services on a member's physical health condition. Such consultation will include consultation by the PCP to the MHP on medications prescribed by the PCP for a Plan member whose mental illness is being treated by the MHP.
Confidentiality of Medical Records	The MHP will arrange for appropriate management of a member's care, including the exchange of medical records information with a member's other healthcare providers or providers of specialty mental health services.	The Plan will arrange for appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers or providers of specialty mental health services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Confidentiality of Medical Records (continued)	The MHP will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization from the member. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.	The Plan will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. All identification and information relating to a member's participation in psychotherapy treatment will be treated as confidential and will not be released without written authorization by the member. The Plan will not release any information pertaining to a member's physical or mental health treatment without a signed release from the member and a signed written statement by the requester describing the information requested, its intended use or uses, the length of time during which the information will be kept before being destroyed or disposed of, and a statement that the information will not be used for other purposes and will be destroyed within the designated timeframe. The timeframe may be extended, provided that the Plan is notified of the extension, the reasons for the extension, and additional intended uses and the expected date that the information will be destroyed. The release of information does not apply to the disclosure or use of the information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity, or for the licensing certification or the disclosure is otherwise prohibited by law.
Diagnostic Assessment	The MHP will evaluate and triage plan members and when authorized will provide specialty mental health services to the Plan members who meet Specialty Mental Health Criteria. The MHP will evaluate a member's symptoms, level of impairment and focus of intervention to determine if a member meets medical necessity criteria for specialty mental health services. When medical necessity criteria is met, the MHP will arrange for an appointment with the appropriate provider. When medical necessity criteria is not met, the MHP staff may refer the member back to the referring PCP, notify the Plan and/or refer the	The Plan or its subcontractors will arrange and pay, at the Medi-Cal rate, for appropriate medically necessary assessments of Plan members to identify co-morbid physical and mental health conditions, to: • Rule out general medical conditions causing psychiatric symptoms • Rule out mental disorders and/or substance-related disorders caused by a general medical condition. • Identify and treat those general medical conditions that are causing or exacerbating psychiatric symptoms. The PCP will be advised to identify and/or treat non-disabling psychiatric conditions that may be responsive to primary care, i.e. mild to moderate anxiety and/or depression or more serious

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Diagnostic Assessment (continued)	member to community resources as appropriate. Individual mental health providers may arrange for records transfer by direct communication with the referring physician.	mental health conditions if stabilized on medication or other physical health based treatment, if within the scope of practice of the member's PCP. The member's PCP or appropriate medical specialist will identify and treat those general medical conditions that are causing or exacerbating psychological symptoms or refer the member to specialty physical health care for such treatment.
Emergency Services & Care – Emergency Room Facility Charges and Professional Services	The MHP will be responsible for the facility charges resulting from the emergency services and care of a Plan member whose condition meets the MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay. The MHP will cover and pay for the professional services of a mental health specialist, subject to submission of a valid claim with appropriate documentation, provided in an emergency room to a Plan member whose condition meets the MHP medical necessity criteria or when the mental health specialist services are required to assess whether the MHP medical necessity is met. Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition does not meet the MHP medical necessity criteria will be assigned as follows: Payment for professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal fee-for-service system, and not the responsibility of the MHP.	The Plan will cover at the Medi-Cal rate the facility charges resulting from the emergency services and care of a Plan member, whose condition meets the MHP medical necessity criteria, when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility. The Plan will cover at the Medi-Cal rate all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose conditions meets the MHP medical necessity criteria. Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a Plan member whose condition does not meet MHP medical necessity criteria will be assigned as follows: The Plan will cover at the Medi-Cal rate the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Home Health Agency Services	The MHP will notify the Plan of members who need home health services or who are receiving home health services through the Home and Community Based Services Waiver Program (HCBS) or the In-Home Supportive Services Program (IHSS). The MHP will pay for medically necessary specialty mental health services solely related to the included mental health diagnoses, or if the MHP determines a Plan member requires necessary Specialty Mental Health Services The MHP is not responsible to provide or arrange for Home Health Agency Services as described in Title 22, Section 51337.	The Plan will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHS. A homebound Plan member is a patient who is essentially confined to his home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relative short duration, e.g., for a short walk prescribed as therapeutic exercise. The Plan is not obligated to cover home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a Plan member. For example, the Plan would not be obligated to cover home health agency services for the purpose of medication monitoring when those services are not typically medically necessary or for a patient who is not homebound. Home health agency services prescribed by Plan providers to treat mental health conditions of Plan members are the responsibility of the Plan.
Hospital Outpatient Department Services	The MHP will be responsible for the payment of specialty mental health services provided by hospital outpatient departments, which are credentialed as MHP group providers for Plan members who meet medical necessity criteria for specialty mental health services. Hospital outpatient services will be reasonably available and accessible to Plan members.	The Plan will cover at the Medi-Cal rate professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contract with its subcontractors and the Department of Health Services (DHS). Separately billable outpatient services related to *electroconvulsive therapy, such as anesthesiologist services* are the contractual responsibility of the Plan.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Laboratory, Radiological, and Radioisotope Services	Laboratory, radiological, and radioisotope services, as described in Title 22, Section 51311 are not the responsibility of the MHP, *except* when provided as hospital based ancillary services and are included in the per diem. Medi-Cal beneficiaries may obtain Medi-Cal covered laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP. The MHP will coordinate with laboratory, radiological, and radioisotope and Plan as appropriate to assist beneficiaries in receiving laboratory, radiological, and radioisotope services, prescribed through the MHP including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedure. Information will be disseminated to the MHP providers primarily through provider meetings conducted by the MHP staff.	The Plan will be responsible for covering at the Medi-Cal rate medical necessary laboratory, radiological, and radioisotope services described in CCR Title 22, Section 51311. The Plan will cover at the Medi-Cal rate laboratory services to Plan members who require the specialty mental health services of the MHP or the Medi-Cal fee-for-service providers, when they are necessary for the diagnosis and treatment of Plan member's mental health condition. The Plan will also cover at the Medi-Cal rate services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan will coordinate these services with the member's specialty mental health provider.
Medical Transportation Services (Emergency and Non-Emergency)	The MHP is responsible for medical transportation services when the transportation is required to transfer an enrollee from one psychiatric inpatient hospital to another psychiatric inpatient hospital, or to another type of 24-hour care facility, when such transfers are not medically indicated. (i.e., undertaken with the purpose of reducing the MHP's cost of providing services.)	The Plan will cover at the Medi-Cal rate all medically necessary emergency and non-emergency medical transportation services for Plan members including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services. The Plan will cover at the Medi-Cal rate medically necessary non-emergency medical transportation services, when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP, when authorization is obtained.
Medical Necessity Criteria for Specialty Mental Health	The MHP will provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.	Beneficiaries whose diagnoses are not included in the applicable listing of MHP covered diagnoses may obtain mental health services through the Medi-Cal fee-for-service system under applicable provisions of Title 22, CCR, Division 3, Subdivision 1 (MMCD Policy Letter 00-01 Rev., page 16).

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Medical Necessity Criteria for Specialty Mental Health (continued)	Medical necessity criteria, is met when a beneficiary has both an included diagnosis and the beneficiary's condition meets specified impairment and intervention criteria. The MHP will accept referrals received through beneficiary self-referral or through referral by another person or organization.	Plan members whose mental health diagnoses are covered by the MHP, but whose conditions do not meet the program impairment and intervention criteria, are not eligible for mental health care under the Medi-Cal fee-for-service program. These beneficiaries are eligible for care from a primary care or other physical health provider. The Medi-Cal fee-for-service system will deny claims from mental health professionals for such beneficiaries
Nursing Facility Services	The MHP will provide medically necessary specialty mental services, typically visits by psychiatrists and psychologists who are credentialed by the MHP in a skilled nursing facility.	The Plan will arrange for nursing facility services for members who meet the Plan's medical necessity criteria for the month of admission, plus one month. The Plan will arrange for disenrollment from the managed care program if the member needs nursing services for a longer period of time. Skilled nursing facility services with special treatment programs for the mentally disordered are covered by the Medi-Cal fee-for-service program. These services are billed to the Medi-Cal fee-for-service system using accommodation codes 11, 12, 31, and 32, for members of any age in facilities that have not been designated as Institutions for Mental Diseases (IMDs). The Plan is responsible for these services in accordance with the terms of the Plans contract for coverage of long term care.
Pharmaceutical Services and Prescribed Drugs **(Out-Of-Plan Services)**	The MHP is not responsible to cover and pay for pharmaceutical services and prescribed drugs, including all medically necessary Medi-Cal psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services, which is included in the per diem rate. The MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist beneficiaries in receiving prescription drugs prescribed through the MHP, including, ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. The MHP will utilize the existing services of the Plan's laboratory or the services of the Plan's contracted laboratory providers, as needed in connection with the administration	The Plan will cover at the Medi-Cal rate pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, ***except*** when provided as inpatient psychiatric hospital based ancillary services or otherwise excluded under the Plan contract. The Plan will cover at the Medi-Cal rate psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions. A Plan may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Pharmaceutical Services and Prescribed Drugs **(Out-Of-Plan Services)** (continued)	and management of psychotropic medications. Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD Policy Letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal Fee-For-Service system whether these drugs are provided by a pharmacy contracting with the plan or by a fee-for-service pharmacy provider.	Application of utilization review procedures should not inhibit a Plan member's access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan will ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. The Plan will not cover prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists; unless, these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited. Reimbursement to pharmacies for psychotropic drugs listed in the Enclosure 2 of the MMCD Policy Letter, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal Fee-For-Service system whether these drugs are provided by a pharmacy contracting with the plan or by a fee-for-service pharmacy provider.
Psychiatric Acute Inpatient Hospital Services	The MHP will be responsible for medically necessary psychiatric inpatient hospital services as described in Title 9, Sections 1810.345 and 1810.350 (b) and (c). Psychiatric Inpatient Hospital Services for a fee-for-service Medi-Cal hospital will include in the per diem rate: • Routine hospital services • All hospital based ancillary services. Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal hospital will include: • Routine hospital services • All hospital based ancillary services, and • Psychiatric inpatient hospital professional services. The MHP will utilize the Plan contracted providers to perform medical histories and physical examinations required for hospital admissions for mental health services for Plan members unless otherwise covered by the hospital's per diem rate.	The Plan will cover and pay at the Medi-Cal rates for all medically necessary professional services to meet the physical health care needs of the Plan members who are admitted to the psychiatric ward of a general acute hospital or a free standing licensed inpatient psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations. The Plan is not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Physician Services	The MHP will not be responsible to provide or arrange and pay for physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, Psychiatrist Services, even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205.	The Plan will cover at the Medi-Cal rate physician services related to the delivery of outpatient mental health services, which are within the PCPs scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses, whose conditions do not meet the MHP medical necessity criteria. The Plan is not required to cover physician services provided by Psychiatrists, Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapist, or other specialty mental health providers. When medically necessary, the Plan will cover at the Medi-Cal rate physician services provided by Specialists such as Neurologists.
Provider Network and Member Education	The MHP will credential and contract with sufficient numbers of licensed mental health professionals to maintain a MHP provider network sufficient to meet the needs of the Plan members. The MHP will continually monitor the MHP provider network to ensure beneficiary access to quality mental health care. The MHP will assist the Plan in arranging for a specific MHP provider when the Plan is unable to locate an appropriate mental health service provider for a Plan member. The MHP will also assist the Plan to develop and update a list of provider or provider organizations to be made available to Plan members. Any updates to the list will be provided to the Plan upon request.	The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental health services as required by contract. Each Plan is contractually obligated to assist Plan members needing specialty mental health services, whose mental health diagnoses are covered by the MHP or whose diagnoses are uncertain, by referring such members to the local MHP. If a member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the member to an appropriate resource in the community, if known to the Plan, that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or other appropriate local provider or provider organization. The PCP will request assistance from the MHP whenever the PCP is unable to arrange for an appropriate MHP provider for a Plan member. The PCP will initiate a referral to the appropriate MHP provider or provider organization as recommended by the MHP. For those services that do not meet the MHP medical necessity criteria, a copy of the referral will be kept in the member's referral chart.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Provider Network and Member Education (continued)		The Plan will collaborate with the MHP to develop and maintain a list of providers or provider organizations to be made available to Plan members.
Referrals	The MHP will accept referrals from the Plan staff, Plan providers and Plan Medi-Cal members for determination of MHP medical necessity. When medically necessity criteria are met, the MHP will arrange for specialty mental health services by a MHP provider. In the case of self-referrals or referrals from providers other than the member's PCP, in which the planned specialty mental health services involves a MHP psychiatrist, the MHP will inform the member's PCP of services to be rendered. The member's consent will be obtained prior to sharing this information. When medically necessity criteria are not met, or if it is felt that the member's mental health condition would be responsive to physical health care based treatment, the MHP will refer the member back to the Plan and the referring physician with the assessment results, diagnosis, need for service and/or recommendations for an appropriate provider to treat the member's symptoms. The MHP will encourage its providers to coordinate care with member's primary care provider. These referrals will be made through a referral form to assist in providing referrals to providers, provider agencies, or other sources of care for services not covered by the MHP. The MHP will encourage providers to secure the HSD Physical and Mental Health Care Coordination Form and guidelines (see attached). Referrals may include a provider with whom the member already has a patient-provider relationship, or a provider in the area that has indicated a willingness to accept referrals. This will include but is not limited to a Federally Qualified Health Center (FQHC), a Rural	The PCP will maintain responsibility for physical healthcare based primary mental health treatment, which includes: • Basic education, assessment, counseling, and referral and linkage to other services for all beneficiaries. The PCP will refer to the MHP for an assessment and appropriate services when: • An assessment is needed by the MHP to confirm or arrive at a diagnosis. • Mental health services other than medications are needed for a beneficiary with a diagnosis included in the responsibilities of the MHP. After the PCP's diagnostic assessment, the Plan or PCP will refer those members whose psychiatric condition would not be responsive to physical health care, to the MHP to determine if MHP medical necessity criteria are met. In the event a member does not meet the MHP criteria, the MHP will inform the Plan and PCP. The Plan will arrange for primary mental health services within the member's PCP's scope of practice. The Plan will encourage its providers to use the HSD Physical and Mental Health Care Coordination Form and guidelines (see attached). When the MHP informs the Plan and PCP that a member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, the Plan will refer for primary mental health services within the member's PCP's scope of practice.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Referrals (continued)	Health Clinic, an Indian Health Clinic, or Indian Clinic. The MHP is not required to ensure a member's access to physical health care based treatment or to treatment from licensed mental health professionals for diagnoses not covered by the MHP. When the MHP has provided specialty mental health services and has determined that the member's health condition has stabilized and that maintenance of the condition would be responsive to physical healthcare based treatment, the MHP will refer the member back to the Plan and referring physician with the assessment and treatment results, diagnosis, need for ongoing service and recommendations for an appropriate provider to treat the member's symptoms. The MHP will utilize the Plan's referral authorization form and with the member's consent will inform the PCP of services provided and/or medications prescribed. The MHP will attempt to coordinate information with the member's other health care providers and ensure that contact with the Plan is made.	
Resolution of Disputes	The MHP will provide a resolution of dispute process in accordance to Title 9, Section 1850.505, Chapter 11. When the MHP has a dispute with the Plan that cannot be resolved to the satisfaction of the MHP, concerning the obligations of the MHP, or the Plan, under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the MHP may submit a request for resolution to the State Department of Mental Health (DMH). A request for resolution by either agency will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be	The Plan will provide a resolution of dispute process in accordance to CCR Title 9, Section 1850.505, Chapter 11 and the Medi-Cal contract between the Plan and the State Department of Health Services (DHS). When the Plan has a dispute with the MHP that cannot be resolved to the satisfaction of the Plan, the Plan may submit a request for resolution to the DHS. A request for resolution by either agency will be submitted to the respective department within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information: 1. A summary of the issue and a statement of the desired remedy including any disputed services that have or are expected to be

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Resolution of Disputes (continued)	delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the department receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the MHP and the Plan will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process or any similar process offered by the Plan or to request a fair hearing. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP has determined that treatment would not be within the PCP's scope of practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.	delivered to the beneficiary and the expected rate of payment for each type of service. 2. History of attempts to resolve the issue. 3. Justification for the desired remedy. 4. Documentation regarding the issue. Upon receipt of a request for resolution, the agency receiving the request will notify the other department and the other party within seven calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the payment for services included by the other party in its request. The other party will submit the requested documentation within 21 calendar days, or the departments will decide the dispute based solely on the documentation filed by the initiating party. A dispute between the Plan and the MHP will not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries, when delay in the provision of services is likely to harm the beneficiary. Nothing in this section will preclude a beneficiary from utilizing the Plan's beneficiary problem resolution process or any similar process offered by the MHP or to request a fair hearing. In the event that the MHP has assessed a beneficiary and determined that Medical necessity criteria are not met because, in the opinion of the MHP, the condition which is the focus of treatment would be responsive to physical health care based treatment and the Plan's PCP has determined that treatment would not be within the PCP's scope of practice, the Medical Director of the MHP or designee and the Medical Director of the Plan or designee will confer and determine an appropriate service plan for the beneficiary.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Service Authorizations	The MHP will authorize evaluation and/or treatment services by mental health specialists who are employed and credentialed by and/or contracted with the MHP for services that meet MHP medical necessity criteria. This will be done through the MHP access programs. Services will be rendered according to the MHP responsibility. MHP staff will be available to assist in coordinating care, including service authorizations. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.	The Plan and its subcontractors will authorize medical assessment and/or treatment services in accordance with the Medi-Cal contract with the State DHS. Plan staff will be available to assist in coordinating care and obtaining appropriate service authorizations. If a dispute occurs between the member and the MHP or the Plan, the member will continue to receive medically necessary health care and mental health care services, including prescription drugs until the dispute is resolved.
Services Excluded from Coverage	The MHP will not be responsible to provide or arrange and pay for the following services: • **Medi-Cal services, that are not specialty mental health services,** • **Prescribed Drugs, and** • **Laboratory, Radiological, and Radioisotope services except** when provided as hospital-based ancillary services and included in the per diem. • **Medical Transportation Services, except** when the purpose of the medical transportation service is to transport a beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP. • **Physician Services**, that are not psychiatric services even if the services are provided to treat a diagnosis included in Title 9, Sections 1820.205 or 1830.205. • **Out-of-State Specialty Mental Health Services except** when it is customary practice for a California beneficiary to receive medical services in a border community outside the State. • **Specialty Mental Health Services,** provided by a hospital operated by the department or the State Department of Developmental Services.	The Plan is not responsible to arrange and cover the services listed below to its members in accordance to the MOU and as contractually required. • **Medi-Cal Services**, that are specialty mental health services. • A copy of the drugs excluded from Plan coverage should be included as part of this MOU package. The drug list can be found as an enclosure to the MMCD Policy Letter 00-01.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Services Excluded from Coverage (continued)	• **Specialty Mental Health Services,** provided to a beneficiary eligible for Medicare, prior to the exhaustion of the beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRG) when the DRG reimbursement covers administrative day services according to Medicare (Part A). • **Specialty Mental Health Services,** provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent that specialty mental health services are covered by the Medi-Cal Managed Care Plan. • **Psychiatric Inpatient Hospital Services,** received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a). • **Medi-Cal Services,** that may include specialty mental health services as a component of a larger service package as follows: 1. **Psychiatrist and Psychologist Services,** provided by adult day health centers. 2. **Home and Community Based Waiver Services** 3. **Specialty Mental Health Services,** authorized by the CCS program to treat CCS eligible beneficiaries. 4. **LEA Services** 5. **Specialty Mental Health Services,** provided by FQHCs, Indian Health Centers, and Rural Health Clinics. 6. **Home Health Agency Services** Beneficiaries whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Div.3, Subdivision 1.	
Services for the Develop-mentally Disabled	The MHP will refer members with developmental disabilities to Regional Centers for covered services such as respite care, out-of-home placement, supportive living services, etc., if such services are needed. When	The Plan's PCPs will refer members with developmental disabilities to Regional Centers for psychiatric and non-medical services such as respite care, out-of-home placement, supportive living services, etc, if such services are needed.

CATEGORY	LOCAL MENTAL HEALTH PLAN (*MHP*)	MEDI-CAL MANAGED CARE HEALTH PLAN (*Plan*)
Services for the Developmentally Disabled (continued)	appropriate, the MHP will inform the Plan, its delegated entity, and the PCP of such referrals.	
Specialty Mental Health Services Providers and Covered Specialty Mental Health Services (EPSDT)	The MHP will utilize medical necessity criteria established for EPSDT supplemental services to determine if a child under the age of 21 with full scope Medi-Cal is eligible for EPSDT supplemental services. If these criteria are met, the MHP will be responsible for arranging EPSDT supplemental mental health services provided by specialty mental health professionals. The MHP will pay for EPSDT supplemental services that are part of the member's specialty mental health treatment. If EPSDT supplemental mental health services or MHP medical necessity criteria are not met, the MHP will refer children who have a CCS eligible condition requiring specialty mental health services to their PCP for a referral to CCS. When the MHP determines that EPSDT supplemental services criteria are not met, and the child's condition is not CCS eligible, the MHP will refer the child to the PCP for treatment of conditions within the member's PCP's scope of practice. The MHP will provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205 and 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. The MHP will not be required to provide or arrange for any specific specialty mental health service, but, will ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as required or applicable. The MHP will provide specialty mental health services only to the extent the beneficiary is eligible for those services, based on the beneficiary's Medi-Cal eligibility under Title 22.	The Plan will assist the MHP and members by providing links to known community providers of supplemental services.

CCS = California Children's Services
DHS = Department of Health Services
DMH = Department of Mental Health
FFS = State Fee-For-Service
FQHC = Federally Qualified Health Center
LEA = Local Education Agencies
MHP = Name of Local Mental Health Plan
PCP = Primary Care Provider
Plan = Name of Health Plan

Arch Health Partners

(sent via electronic mail)

February 14, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Arch Health Partners ("AHP"), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

AHP is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (858) 673-2502 regarding this letter of commitment and support.

Sincerely,

Victoria Lister

Vicky Lister. FACHE
Executive Director
Arch Health Partners
858.673.2502
victoria.lister@archhealth.org

cc: File

Encompass
Family Physicians
Medical Group
Encompass Medical Group
EFPMG / EMG

John Dailey, Exec Dir.

Terry L. Winegar, M.D.
President, EFPMG
255 W. Washington Ave.
El Cajon, CA 92020
(619) 444-7454
(619) 444-4723 FAX

Joseph P. Aiello, D.O.
10225 Austin Dr., Suite 108
Spring Valley, CA 91978
619-670-8028
619-670-9675 FAX

Glenn D. D'Arpa, D.O.
Bryan J. Fox, M.D.
Hanid Audish, D.O
Merilee Summerfield, PA-c
10225 Austin Dr., Suite 101
Spring Valley, CA 91978
(619) 660-6003
(619) 660-0296 FAX

G. David Gibson, M.D.
8875 La Mesa Blvd.
La Mesa, CA 91941
(619) 668-8100
(619) 667-2688 FAX

Dan Hiser, M.D.
6719 Alvarado Road
Suite 203
San Diego, CA 92120
(619) 583-1510
(619) 583-5372 Fax

Michael Jon Feinstein, D.O
Steve Hernandez, PA.-C
Center for Family Health
6280 Jackson Drive, Suite 4
San Diego, CA 92119-3493
(619) 286-9369

John G. Lockie, M.D.
6719 Alvarado Rd. #204
San Diego, CA 92120
(619) 286-7775
Fax (619)286-7778

IPA Affiliates:

Scott Greer, M.D.
Center for Family Health
6280 Jackson Drive, Suite 4
San Diego, CA 92119-3493
(619) 464-1608
(619) 461-8738 Fax

Robert B. Lajvardi, M.D.
7339 El Cajon Blvd. Ste E
La Mesa, CA 91941
(619) 460-7775
(619) 460-7023 FAX

Edward Sheldon, M.D
Gabriel Gil, M.D,
Lomita Family Practice
909 Cardiff
San Diego, CA 92114
(619) 465-3121
(619) 465-6708 Fax

2.10.12

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

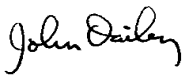
Dear Kerry:

On behalf of Encompass Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

Encompass Medical Group is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at 619-660-5719 regarding this letter of commitment and support.

Sincerely,



John Dailey

Xc: Executive Committee EFPMG/EMG

GREATER TRI CITIES IPA

Independent Physicians – Providing Personal Care

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Greater Tri Cities IPA, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

Greater Tri Cities IPA is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (760) 941-7309 x135 regarding this letter of commitment and support.

Sincerely,

Kathi Toliver
VP Operations, Physicians DataTrust
ktoliver@pdtrust.com

Over 25 years serving San Diego
MPMG
Mercy Physicians Medical Group, Inc.

February 14, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Mercy Physicians Medical Group (MPMG), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

MPMG is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at 619.543.8800 x 10015 regarding this letter of commitment and support.

Sincerely,

La Donna A. Dwyer

La Donna A. Dwyer
Executive Director
NAMM – Mercy Physicians Medical Group
Phone: 619.543.8800 x 10015
E-mail: ladonna.dwyer@nammcal.com

MultiCultural IPA
MultiCultural Primary Care Medical Group, Inc.

4560 Alvarado Canyon Road, Suite 2-A, San Diego, CA 92120
(619) 684-4980 • Fax: (619) 684-4988 • www.multiculturalipa.com

February 14, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of MultiCultural Primary Care Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

MultiCultural Primary Care Medical Group is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact Paul Hernandez at 619-684-4980 regarding this letter of commitment and support.

Sincerely,

Rodney G. Hood, MD
President
MultiCultural Primary Care Medical Group
619-266-3662
rghood@cox.net

PRIMARY CARE ASSOCIATES
Medical Group Inc.

February 15, 2012

Patrice Holloway
Regional Network Director, Provider Network Management
Health Net of California
7755 Center Avenue, Suite 800
Huntington Beach, CA 92647

RE: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Patrice:

On behalf of Primary Care Associated Medical Group, Inc. dba Primary Care Associates Medical Group, Inc. (PCAMG), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

PCAMG is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact Andrea Rico, Director of Contracting, at (909) 605-8176 regarding this letter of commitment and support.

Sincerely,

Nicandro J Marciano D

Nick Marciano, M.D.
Vice President and Treasurer

450 South Melrose Drive, Suite 220 - Vista, California 92081-6664
Tel: 760-542-6757 - Fax: 760-542-6747

SHARP Community Medical Group

San Diego Metro ■ Chula Vista ■ Grossmont ■ Coronado ■ North County

February 16, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Interest for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Sharp Community Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to collaborating with Health Net with the intended goal of achieving a successful conclusion. Additionally, we understand that any agreement we may enter into for the purposes of participating in the Dual Eligible provider network will need to comply with all of the requirements and regulations established by DHCS and CMS.

Sharp Community Medical Group is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (858) 499-4557 regarding this letter of interest and support.

Sincerely,

John Jenrette, M.D.
Cheif Executive Officer
Sharp Community Medical Group
858-499-4557

SHARP

Malcolm Baldrige National Quality Award 2007 Award Recipient

February 16, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Interest for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Sharp HealthCare, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to collaborating with Health Net with the intended goal of achieving a successful conclusion. Additionally, we understand that any agreement we may enter into for the purposes of participating in the Dual Eligible provider network will need to comply with all of the requirements and regulations established by DHCS and CMS.

Sharp HealthCare is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (858) 499-4004 regarding this letter of interest and support.

Sincerely,

Michael W. Murphy.
President and CEO
mike.murphy@sharp.com

SHARP Rees-Stealy Medical Group

February 16, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Interest for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of Sharp Rees-Stealy Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to collaborating with Health Net with the intended goal of achieving a successful conclusion. Additionally, we understand that any agreement we may enter into for the purposes of participating in the Dual Eligible provider network will need to comply with all of the requirements and regulations established by DHCS and CMS.

Sharp Rees-Stealy Medical Group is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (619) 446-1530 regarding this letter of interest and support.

Sincerely,

Donald C. Balfour, M.D.
President
Sharp Rees-Stealy Medical Group
619-446-1530

UC San Diego
HEALTH SYSTEM

February 14, 2012

Kerry Mills
Regional Network Director, Provider Network Management
Health Net of California
3131 Camino Del Rio North, Suite 1100
San Diego, CA 92108

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Kerry:

On behalf of UCSD Medical Center and UCSD Medical Group ("UCSD"), I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

UCSD is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (619) 471-9393 regarding this letter of commitment and support.

Sincerely,

David Vincent Kraus, JD, MSPH
Chief Contracting Officer
UC San Diego Health System
619-471-9393
dkraus@ucsd.edu

February 3, 2012

Hugo Florez
Regional Network Director, Provider Network Management
Health Net, Inc.
1055 E. Colorado Blvd. Suite 300
Pasadena, CA 91325
Phone: (626) 683-6323
Fax: (626) 683-6363

Re: Letter of Commitment for Dual Eligible Demonstration Pilot

Dear Hugo:

On behalf of Vantage Medical Group, I am expressing our interest and intended involvement in the Dual Eligible Demonstration Pilot for San Diego County, as outlined by the State of California Department of Health Care Services (DHCS) in their recently released Request for Solution (RFS). We are interested in participating in this pilot with Health Net. While the details of our participation and relationship remain to be negotiated, we are committed to continuous collaboration with Health Net toward a successful conclusion. Additionally, we understand that any agreement entered into for the purposes of participating in the Dual Eligible provider network, shall comply with all of the requirements and regulations established by DHCS and CMS.

Vantage Medical Group is committed to improving the health status of the diverse communities that we collectively serve. We look forward to working closely with Health Net on the Dual Eligible Demonstration Pilot as a community healthcare partner to achieve greater coordination of benefits, access to care and improved health outcomes.

Please feel free to contact me at (951) 280-7800 regarding this letter of commitment and support.

Sincerely,

Nancy Stephenson

Nancy Stephenson
Associate VP of Network Operations
Vantage Medical Group
2115 Compton Avenue, Suite 301
Corona, CA 92881

Section 2, Attachment 21

Project Abstract and Profile

The project vision is a partnership between Resources for Independence Central Valley (RICV), Independent Living Center of Kern County (ILCKC), Westside Center for Independent Living (WCIL), Community Rehabilitation Services (CRS), Disabled Resource Center, Inc. (DRC), Southern California Rehabilitation Services (SCRS), Independent Living Center of Southern California (ILCSC) and Health Net Community Solutions (HNCS) to create an innovative health home that bridges health and Independent Living Center (ILC) program coordination.

Services subject to health navigation and ILC program coordination would include: medical, health education, health care self-management, mental health, transition services, daily living activities, job development, housing resources, peer support and assistive technology. This in turn, would re-engineer service coordination by bridging health and ILC program coordination for disabled consumers who have Medi-cal or Medicare coverage. The project is a strategic match for the partner organizations which would enhance capacity and the ability to manage services within the current delivery system while maintaining the ILC mission of advocating for independence. The project would fund up to 14 Health Navigators to be located at the designated ILCs in Los Angeles County, Fresno County and Kern County in California and 1 Project Director for 3 years. Health Net Community Solutions provides both Medi-Cal and Medicare managed care programs to beneficiaries in each of these counties. Health Net plans to provide in-kind health education and care coordination training to the Health Care Navigators.

The goals of proposed project "Bridging Health Navigation and ILC Program Coordination are (1) to promote wellness creating a model that integrate and coordinates health and ILC Program services in a consumer-centered setting; (2) base Health Care Navigators at ILCs to assist consumers in navigating the health care delivery system with the aim of promoting wellness and improving health outcomes for consumers with a variety of disabilities; and (3) to reduce overall health care costs by promoting wellness and coordinating services as a core part of the ILC Program. The total budget is $3,389,159 million. The number of projected participants is 10,000 which average 1,640 per center in Los Angeles County where a greater number of consumers reside and an average of 900 per center at the two Central Valley ILCs. The projected total cost of care savings after the third year is approximately $694,335.

The model design is a multi-disciplinary approach to re-engineering service coordination by providing enhanced access to health care as an integral component of the ILC Program with an innovative workforce of Health Care Navigators in a consumer-centered setting. This service coordination enhancement would also be supported by a Project Director, which will provide liaison and support services for the Health Care Navigators and be the primary point of contact to the health plan Public Programs Administrator.

The proposed model would transform the existing health workforce by creating this innovative Health Care Navigator to be located at the designated ILCs. The Health Care Navigators will

promote wellness and health care coordination after extensive training in health education, health promotion and care coordination in a team-based environment. The proposed project "Bridging Health Navigation and ILC Program Coordination" will address and impact the Health Care Innovation Challenge three-part aim of better health, better health care, and lower costs through an enhancement of service coordination for Medi-Cal and Medicare participants.

A NATIONAL MODEL FOR BUILDING A PERSON-CENTERED, COMMUNITY-BASED HEALTH HOME FOR PERSONS WITH COMPLEX CHRONIC CONDITIONS

Project Abstract

The **California Association for Adult Day Services (CAADS)**, a nationally acclaimed non-profit that supports the development of adult day services as an alternative to institutional care, and **Health Net**, a managed care leader and innovator in California, jointly present this proposal to implement a cutting edge model – the ***Community Health Home*** – to link managed care primary care physicians and Community-Based Adult Services (CBAS) providers together to achieve better patient care, better patient health, and lower patient care costs.

The *Community Health Home* takes two systems, the adult day health care (ADHC) model and the managed care system with its network of physicians, each with strengths and expertise in different arenas, and unites them to keep the participant in the center and the model in the community – the *new health home neighborhood*.

This innovative model builds on ADHC's decades of experience in integrating health care and long-term services and supports by adding a Community Health Home Coordinator in eight CBAS sites in Los Angeles County to provide enhanced care coordination for approximately 600 high-care, high-risk Medicaid beneficiaries enrolled in Health Net managed care.

The *Community Health Home* expands on the ADHC model of team-based, person-centered care, which is vital, but under-utilized in California's broader health care continuum. This project has as its goals to:

1. implement the design of a highly desirable, effective, person-centered, community-based health home;
2. reduce acute care admissions, hospital lengths of stay, emergency room visits, and post-acute stays, resulting in lower health care costs;
3. improve the skills and knowledge of formal and informal caregivers through an education, training, and monitoring program that focuses on improving self-management skills;
4. increase participant, formal and informal caregivers, and primary care physician satisfaction rates as a result of participating in the *Community Health Home* program; and
5. replicate the model within other managed care organizations and adult day health programs in various locations throughout California and the nation.

Reduced emergency department visits, acute care admissions, post-acute services (e.g., skilled nursing facility) and outpatient services will result in an approximate 10% decrease in participant health care costs over 36 months. The project budget of $4,476,511 will be used to deploy a new highly trained workforce of eight fulltime registered nurses as Community Health Home Coordinators for the grant project period, and implement a formal and informal education and training program for the medical professionals and caregivers associated with this project.

CAADS and Health Net are committed to enhanced care coordination for CBAS participants and to ensuring sustainability and replicability of this model.

Health Net DRAFT Demonstration Implementation Work Plan - SD County

ID	Task Name	Start	Finish
0	**SD County Dual Eligible Pilot (DEP) Launched**	**Wed 2/1/12**	**Mon 7/1/13**
1	**DEP Launch Assumptions**	**Fri 3/30/12**	**Tue 1/1/13**
2	SD County DEP awarded	Fri 3/30/12	Fri 3/30/12
3	Start of DEP Implementation	Mon 4/2/12	Mon 4/2/12
4	Start of DEP Enrollment	Mon 10/1/12	Mon 10/1/12
5	Readiness Review	Mon 7/30/12	Fri 9/28/12
6	Start of DEP Health Care Delivery	Tue 1/1/13	Tue 1/1/13
7	**DEP program design completed (pre-implementation)**	**Wed 2/1/12**	**Fri 3/30/12**
8	Finalize and approve DEP objectives and goals	Wed 2/1/12	Fri 3/30/12
9	**Gather DEP program requirements**	**Wed 2/1/12**	**Fri 3/30/12**
10	Identify body of law, regulatory, Fed & State requirements	Wed 2/1/12	Fri 3/30/12
11	Identify DEP membership, geography and transaction volume expectations	Wed 2/1/12	Fri 3/30/12
12	Identify program performance and evaluation requirements	Wed 2/1/12	Fri 3/30/12
13	Identify business partner and business interface requirements	Wed 2/1/12	Fri 3/30/12
14	Identify stakeholder and advocacy group engagement and communication requirements	Wed 2/1/12	Fri 3/30/12
15	Identify operational requirements	Wed 2/1/12	Fri 3/30/12
16	Identify technology system and interface requirements	Wed 2/1/12	Fri 3/30/12
17	Identify financial model requirements (revenue, risk sharing, G&A, etc.)	Wed 2/1/12	Fri 3/30/12
18	Identify benefit design requirements for optimizing enrollment into managed care	Wed 2/1/12	Fri 3/30/12
19	Identify enrollment strategy requirements	Wed 2/1/12	Fri 3/30/12
20	Identify DEP resource requirements	Wed 2/1/12	Fri 3/30/12
21	Identify DEP facilities requirements	Wed 2/1/12	Fri 3/30/12
22	Finalize and approve DEP business framework / architecture	Wed 2/1/12	Fri 3/30/12
23	Finalize and approve DEP responsibilities and assignments	Wed 2/1/12	Fri 3/30/12
24	Secure resources for key DEP governance and operating roles	Wed 2/1/12	Fri 3/30/12
25	**DEP implementation mobilization completed**	**Wed 2/1/12**	**Mon 4/2/12**
26	Finalize and approve DEP governance structure and processes	Wed 2/1/12	Fri 2/17/12
27	Conduct DEP implementation planning kick-off meeting	Wed 2/29/12	Wed 2/29/12
28	Secure resources for key implementation roles	Wed 2/29/12	Fri 3/30/12
29	Finalize and approve DEP Implementation Plan	Fri 3/30/12	Fri 3/30/12
30	**DEP Project Management Office (PMO) established**	**Wed 2/1/12**	**Mon 4/2/12**
31	**PMO infrastructure Established**	**Fri 3/16/12**	**Mon 4/2/12**
32	**PMO team established**	**Mon 4/2/12**	**Mon 4/2/12**
33	Identify PMO resources	Mon 4/2/12	Mon 4/2/12
34	Conduct PMO kick-off meeting	Mon 4/2/12	Mon 4/2/12
35	Schedule weekly PMO meetings	Mon 4/2/12	Mon 4/2/12
36	**PMO tools developed and implemented**	**Fri 3/16/12**	**Mon 4/2/12**
37	Implement PMO reporting tool	Mon 4/2/12	Mon 4/2/12
38	Develop implementation status report template	Fri 3/16/12	Fri 3/16/12
39	Develop PMO Policies and Procedures	Fri 3/30/12	Fri 3/30/12
40	Develop Communication Plan	Fri 3/30/12	Fri 3/30/12
41	Develop Change Management Plan	Fri 3/30/12	Fri 3/30/12
42	**Governance structure established**	**Wed 2/1/12**	**Mon 4/2/12**

ID	Task Name	Start	Finish
43	**Steering Committee established**	**Wed 2/1/12**	**Tue 2/7/12**
44	Determine steering committee participants	Wed 2/1/12	Wed 2/1/12
45	Conduct steering committee kick-off meeting	Tue 2/7/12	Tue 2/7/12
46	Schedule weekly steering committee meetings	Tue 2/7/12	Tue 2/7/12
47	**Core Teams established**	**Mon 4/2/12**	**Mon 4/2/12**
48	Determine core team participants	Mon 4/2/12	Mon 4/2/12
49	Develop core team charters	Mon 4/2/12	Mon 4/2/12
50	Conduct core team kick-off meetings	Mon 4/2/12	Mon 4/2/12
51	Schedule weekly core team meetings	Mon 4/2/12	Mon 4/2/12
52	**Contractual / legal agreements to operationalize DEP established**	**Thu 9/20/12**	**Mon 12/31/12**
53	Establish contract / legal agreements with CMS	Thu 9/20/12	Thu 9/20/12
54	Establish contract / legal agreements with DHCS	Thu 9/20/12	Thu 9/20/12
55	Establish contract / legal agreements with subcontracted health plans	Mon 12/31/12	Mon 12/31/12
56	Establish contract / legal agreements with SD County Health Dept	Mon 12/31/12	Mon 12/31/12
57	Establish contract / legal agreements with other necessary partners	Mon 12/31/12	Mon 12/31/12
58	**DEP Functional teams established**	**Fri 3/30/12**	**Mon 4/1/13**
59	**DEP Finance function established**	**Mon 4/2/12**	**Mon 12/31/12**
60	Finalize and approve finance function operating requirements	Mon 4/2/12	Mon 12/31/12
61	Finalize and approve finance function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
62	Finalize and approve finance function IT systems requirements	Mon 4/2/12	Mon 12/31/12
63	Finalize and approve finance function staffing requirements	Mon 4/2/12	Mon 12/31/12
64	**DEP Healthcare Ops functions established**	**Mon 4/2/12**	**Mon 12/31/12**
65	**DEP Provider Network Management function established**	**Mon 4/30/12**	**Fri 9/28/12**
66	Finalize and approve provide network management operating requirements	Thu 5/31/12	Thu 5/31/12
67	Finalize and approve provider network management function IT systems requirements	Thu 5/31/12	Thu 5/31/12
68	Finalize and approve provider network management function staffing requirements	Thu 5/31/12	Thu 5/31/12
69	Finalize and approve provider network management operating policies and procedures	Fri 8/31/12	Fri 8/31/12
70	Finalize and approve provider training and education requirements	Fri 8/31/12	Fri 8/31/12
71	**DEP Provider network established**	**Mon 4/30/12**	**Fri 9/28/12**
72	Finalize and approve provider network sizing requirements	Mon 4/30/12	Mon 4/30/12
73	Provider network gap analysis completed	Mon 4/30/12	Mon 4/30/12
74	**Provider network plan developed**	**Wed 5/30/12**	**Wed 5/30/12**
75	Finalize and approve provider network objectives and goals	Wed 5/30/12	Wed 5/30/12
76	Determine methodologies for paying providers	Wed 5/30/12	Wed 5/30/12
77	Develop plan to engage with providers and encourage them to join the care network	Wed 5/30/12	Wed 5/30/12
78	Obtain information for configuration and credentialing of providers	Fri 8/31/12	Fri 8/31/12
79	Execute provider contracts; certify Medicare standards are met	Fri 8/31/12	Fri 8/31/12
80	Develop provider directory	Fri 8/31/12	Fri 8/31/12
81	Certify network adequacy [during Readiness Review]	Mon 7/30/12	Fri 9/28/12
82	**DEP Medical Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
83	**DEP Quality Management function established**	**Wed 5/30/12**	**Mon 12/31/12**
84	Finalize and approve quality management function operating requirements	Wed 5/30/12	Wed 5/30/12
85	Finalize and approve quality management function IT systems requirements	Wed 5/30/12	Wed 5/30/12

ID	Task Name	Start	Finish
86	Finalize and approve quality management function staffing requirements	Thu 5/31/12	Thu 5/31/12
87	Begin recruiting quality management staff	Fri 6/1/12	Fri 6/1/12
88	Quality monitoring process established	Fri 8/31/12	Fri 8/31/12
89	Finalize and approve quality management operating policies and procedures	Fri 8/31/12	Fri 8/31/12
90	Develop quality management training program and curriculum	Fri 8/31/12	Fri 8/31/12
91	Quality metrics established and validated	Mon 10/1/12	Mon 10/1/12
92	Quality reporting process established	Mon 10/1/12	Mon 10/1/12
93	Deliver quality management staff training	Mon 9/3/12	Mon 12/31/12
94	**DEP Care/Case Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
95	Finalize and approve care/case management operating requirements	Mon 4/2/12	Mon 12/31/12
96	Finalize and approve care/case management operating policies and procedures	Mon 4/2/12	Mon 12/31/12
97	Finalize and approve care/case management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
98	Finalize and approve case/care management function staffing requirements	Mon 4/2/12	Mon 12/31/12
99	**DEP Utilization Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
100	Finalize and approve utilization management operating requirements	Mon 4/2/12	Mon 12/31/12
101	Finalize and approve utilization management operating policies and procedures	Mon 4/2/12	Mon 12/31/12
102	Finalize and approve utilization management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
103	Finalize and approve utilization management function staffing requirements	Mon 4/2/12	Mon 12/31/12
104	**DEP Disease Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
105	Finalize and approve disease management operating requirements	Mon 4/2/12	Mon 12/31/12
106	Finalize and approve disease management operating policies and procedures	Mon 4/2/12	Mon 12/31/12
107	Finalize and approve disease management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
108	Finalize and approve disease management function staffing requirements	Mon 4/2/12	Mon 12/31/12
109	**DEP Referral & Authorizations (R&A) function established**	**Mon 4/2/12**	**Mon 12/31/12**
110	Finalize and approve R&A function operating requirements	Mon 4/2/12	Mon 12/31/12
111	Finalize and approve R&A function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
112	Finalize and approve R&A function IT systems requirements	Mon 4/2/12	Mon 12/31/12
113	Finalize and approve R&A function staffing requirements	Mon 4/2/12	Mon 12/31/12
114	**DEP Pharmacy Benefits Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
115	Finalize and approve pharmacy benefits management operating requirements	Mon 4/2/12	Mon 12/31/12
116	Finalize and approve pharmacy benefits management operating policies and procedures	Mon 4/2/12	Mon 12/31/12
117	Finalize and approve pharmacy benefits management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
118	Finalize and approve pharmacy benefits management function staffing requirements	Mon 4/2/12	Mon 12/31/12
119	Develop formularies	Mon 4/2/12	Mon 12/31/12
120	Certify that the Plan will meet all Medicare Part D requirements (e.g., benefits, network adequacy)	Mon 7/30/12	Fri 9/28/12
121	Submit formularies and prescription drug event data	Fri 6/8/12	Fri 6/8/12
122	**DEP Behavioral Health (BH) function established**	**Mon 4/2/12**	**Mon 12/31/12**
123	Finalize and approve BH operating requirements	Mon 4/2/12	Mon 12/31/12
124	Finalize and approve BH operating policies and procedures	Mon 4/2/12	Mon 12/31/12
125	Finalize and approve BH function IT systems requirements	Mon 4/2/12	Mon 12/31/12
126	Finalize and approve BH function staffing requirements	Mon 4/2/12	Mon 12/31/12
127	**DEP Admin Ops functions established**	**Mon 4/2/12**	**Mon 12/31/12**
128	**DEP Enrollment function established**	**Wed 5/30/12**	**Mon 10/15/12**

ID	Task Name	Start	Finish
129	Finalize and approve enrollment function operating requirements	Wed 5/30/12	Wed 5/30/12
130	Finalize and approve enrollment function IT systems requirements	Wed 5/30/12	Wed 5/30/12
131	Finalize and approve enrollment function staffing requirements	Thu 5/31/12	Thu 5/31/12
132	Begin recruiting enrollment staff	Fri 6/1/12	Fri 6/1/12
133	Finalize and approve enrollment operating policies and procedures	Thu 8/30/12	Thu 8/30/12
134	Develop enrollment training program and curriculum	Thu 8/30/12	Thu 8/30/12
135	Deliver enrollment staff training	Mon 9/3/12	Fri 10/12/12
136	Benefits loaded and configured in system	Mon 10/1/12	Mon 10/1/12
137	Provider contracts loaded into RMCs	Mon 10/1/12	Mon 10/1/12
138	Enrollment systems and applications go-live	Mon 10/1/12	Mon 10/1/12
139	Begin receiving eligibility files from DHCS and CMS	Mon 10/15/12	Mon 10/15/12
140	Enrollment begins	Mon 10/15/12	Mon 10/15/12
141	ID cards, member communications, eligibility communications, post-enrollment kits mailed (10 days after receipt of eligibility files)	Mon 10/15/12	Mon 10/15/12
142	**DEP Claims Processing function established**	**Mon 4/2/12**	**Mon 12/31/12**
143	Finalize and approve claims processing operating requirements	Mon 4/2/12	Mon 12/31/12
144	Finalize and approve claims processing operating policies and procedures	Mon 4/2/12	Mon 12/31/12
145	Finalize and approve claims processing function IT systems requirements	Mon 4/2/12	Mon 12/31/12
146	Finalize and approve claims processing function staffing requirements	Mon 4/2/12	Mon 12/31/12
147	**DEP Member Contact Center function established**	**Wed 5/30/12**	**Mon 10/1/12**
148	Finalize and approve member contact center operating requirements	Wed 5/30/12	Wed 5/30/12
149	Finalize and approve member contact center function IT systems requirements	Wed 5/30/12	Wed 5/30/12
150	Finalize and approve member contact center function staffing requirements	Thu 5/31/12	Thu 5/31/12
151	Begin recruiting member contact center staff	Fri 6/1/12	Fri 6/1/12
152	Finalize and approve member contact center operating policies and procedures	Mon 7/30/12	Mon 7/30/12
153	Develop member contact center training program and curriculum	Mon 7/30/12	Mon 7/30/12
154	Deliver member contact center staff training	Wed 8/1/12	Fri 9/14/12
155	Establish toll free customer service number	Mon 9/17/12	Mon 9/17/12
156	Member contact center go-live	Mon 9/17/12	Mon 9/17/12
157	Establish quality management component for call monitoring	Mon 10/1/12	Mon 10/1/12
158	**DEP Provider Contact Center function established**	**Wed 5/30/12**	**Mon 7/30/12**
159	Finalize and approve provider contact center operating requirements	Wed 5/30/12	Wed 5/30/12
160	Finalize and approve provider contact center function IT systems requirements	Wed 5/30/12	Wed 5/30/12
161	Finalize and approve provider contact center function staffing requirements	Thu 5/31/12	Thu 5/31/12
162	Finalize and approve provider contact center operating policies and procedures	Mon 7/30/12	Mon 7/30/12
163	**DEP Appeals & Grievances (A&G) function established**	**Wed 5/30/12**	**Mon 12/31/12**
164	Finalize and approve A&G function operating requirements	Wed 5/30/12	Wed 5/30/12
165	Finalize and approve A&G function IT systems requirements	Wed 5/30/12	Wed 5/30/12
166	Finalize and approve A&G function operating policies and procedures	Mon 7/30/12	Mon 7/30/12
167	A&G process established	Mon 7/30/12	Mon 7/30/12
168	Certify compliance with A&G processes for beneficiaries and providers described in Demonstration Proposal and Federal-State MOU	Mon 7/30/12	Fri 9/28/12
169	Finalize and approve A&G function staffing requirements	Tue 7/31/12	Tue 7/31/12
170	Begin recruiting A&G staff	Wed 8/1/12	Wed 8/1/12
171	Develop A&G training program and curriculum	Fri 9/28/12	Fri 9/28/12

ID	Task Name	Start	Finish
172	Deliver A&G staf training	Mon 10/1/12	Mon 12/31/12
173	**DEP Program Integrity (PI) function established**	**Mon 4/2/12**	**Mon 12/31/12**
174	Finalize and approve PI function operating requirements	Mon 4/2/12	Mon 12/31/12
175	Finalize and approve PI function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
176	Finalize and approve PI function IT systems requirements	Mon 4/2/12	Mon 12/31/12
177	Finalize and approve PI function staffing requirements	Mon 4/2/12	Mon 12/31/12
178	**DEP Vendor Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
179	Finalize and approve vendor management function operating requirements	Mon 4/2/12	Mon 12/31/12
180	Finalize and approve vendor management function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
181	Finalize and approve vendor management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
182	Finalize and approve vendor management function staffing requirements	Mon 4/2/12	Mon 12/31/12
183	**DEP Fraud / Waste / Abuse (FWA) function established**	**Mon 4/2/12**	**Mon 12/31/12**
184	Finalize and approve FWA function operating requirements	Mon 4/2/12	Mon 12/31/12
185	Finalize and approve FWA function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
186	Finalize and approve FWA function IT systems requirements	Mon 4/2/12	Mon 12/31/12
187	Finalize and approve FWA function staffing requirements	Mon 4/2/12	Mon 12/31/12
188	**DEP Records Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
189	Finalize and approve records management function operating requirements	Mon 4/2/12	Mon 12/31/12
190	Finalize and approve records management function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
191	Finalize and approve records management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
192	Finalize and approve records management function staffing requirements	Mon 4/2/12	Mon 12/31/12
193	**DEP Contract Management function established**	**Mon 4/2/12**	**Mon 12/31/12**
194	Finalize and approve contract management function operating requirements	Mon 4/2/12	Mon 12/31/12
195	Finalize and approve contract management function operating policies and procedures	Mon 4/2/12	Mon 12/31/12
196	Finalize and approve contract management function IT systems requirements	Mon 4/2/12	Mon 12/31/12
197	Finalize and approve contract management function staffing requirements	Mon 4/2/12	Mon 12/31/12
198	**DEP Staffing completed**	**Mon 4/2/12**	**Mon 12/31/12**
199	Validate and finalize operational staffing requirements	Mon 4/2/12	Mon 12/31/12
200	Finalize and approve operational staff roles and responsibilities	Mon 4/2/12	Mon 12/31/12
201	Finalize and approve operational staff job descriptions	Mon 4/2/12	Mon 12/31/12
202	Finalize and approve operational staff recruiting and hiring plan	Mon 4/2/12	Mon 12/31/12
203	Recruit and hire operational staff	Mon 4/2/12	Mon 12/31/12
204	**DEP Training completed**	**Mon 4/2/12**	**Mon 12/31/12**
205	Finalize and approve operational staff training requirements	Mon 4/2/12	Mon 12/31/12
206	Finalize and approve operational staff training materials	Mon 4/2/12	Mon 12/31/12
207	Finalize and approve operational staff training plan and schedule	Mon 4/2/12	Mon 12/31/12
208	Train operational staff	Mon 4/2/12	Mon 12/31/12
209	**DEP Monitoring & Evaluation functions established**	**Tue 5/1/12**	**Mon 4/1/13**
210	**Performance Monitoring & Reporting function established**	**Tue 5/1/12**	**Mon 4/1/13**
211	Finalize and approve performance monitoring & reporting function operating requirements	Wed 5/30/12	Wed 5/30/12
212	Finalize and approve performance monitoring & reporting function IT systems requirements	Wed 5/30/12	Wed 5/30/12
213	Finalize and approve performance metrics	Tue 7/31/12	Tue 7/31/12
214	Finalize and approve performance monitoring & reporting function staffing requirements	Fri 9/28/12	Fri 9/28/12

ID	Task Name	Start	Finish
215	Begin recruiting performance monitoring & reporting staff	Mon 10/1/12	Mon 10/1/12
216	Develop performance monitoring & reporting training program and curriculum	Fri 3/1/13	Fri 3/1/13
217	Finalize and approve performance monitoring & reporting function operating policies and procedures	Fri 3/1/13	Fri 3/1/13
218	Deliver performance monitoring & reporting staff training	Fri 3/29/13	Fri 3/29/13
219	**DEP Information Warehouse (IW) and Reporting established**	**Tue 5/1/12**	**Mon 4/1/13**
220	Define scope and high level requirements	Tue 5/1/12	Thu 5/31/12
221	Define initial staff requirements	Tue 5/1/12	Thu 5/31/12
222	Identify hardware and software requirements	Fri 6/1/12	Mon 7/2/12
223	Hardware and software procured	Wed 8/1/12	Wed 8/1/12
224	**IW developed**	**Fri 6/1/12**	**Mon 4/1/13**
225	Gather and approve functional area business requirements and source files	Fri 6/1/12	Thu 8/23/12
226	Hardware and software installed	Wed 8/15/12	Wed 8/15/12
227	Develop IW technical design	Fri 8/24/12	Mon 11/19/12
228	Complete IW development	Tue 11/20/12	Mon 2/11/13
229	Conduct unit and user acceptance testing	Tue 2/12/13	Mon 3/25/13
230	IW established	Mon 4/1/13	Mon 4/1/13
231	**Performance dashboard developed**	**Wed 8/15/12**	**Mon 4/1/13**
232	Gather and approve dashboard requirements	Mon 10/1/12	Mon 11/26/12
233	Hardware and software installed	Wed 8/15/12	Wed 8/15/12
234	Develop dashboard technical design	Tue 11/27/12	Mon 1/21/13
235	Create performance dashboard	Tue 1/22/13	Mon 3/4/13
236	Conduct unit and user acceptance testing	Tue 3/5/13	Mon 3/25/13
237	Performance dashboard developed	Mon 4/1/13	Mon 4/1/13
238	**Standard reports developed**	**Wed 8/15/12**	**Mon 4/1/13**
239	Gather and approve standard report requirements	Mon 10/1/12	Fri 11/16/12
240	Hardware and software installed	Wed 8/15/12	Wed 8/15/12
241	Design standard reports	Mon 11/19/12	Mon 12/31/12
242	Develop standard reports	Tue 1/1/13	Mon 2/11/13
243	Conduct unit and user acceptance	Tue 2/12/13	Mon 3/25/13
244	Reporting begins	Mon 4/1/13	Mon 4/1/13
245	**DEP Outreach & Communications function established**	**Mon 4/2/12**	**Mon 10/1/12**
246	**DEP Program outreach & communications function established**	**Mon 4/2/12**	**Mon 10/1/12**
247	Finalize and approve outreach & communications management function staffing requirements	Mon 4/2/12	Mon 4/2/12
248	Finalize and approve outreach & communications management function operating requirements	Thu 5/31/12	Thu 5/31/12
249	Finalize and approve outreach & communications management function IT systems requirements	Fri 6/29/12	Fri 6/29/12
250	Develop outreach and communications plan	Fri 6/29/12	Fri 6/29/12
251	Finalize and approve outreach & communications management function operating policies and procedures	Mon 7/16/12	Mon 7/16/12
252	Develop program outreach and communication materials	Mon 9/10/12	Mon 9/10/12
253	Begin program outreach activities	Mon 10/1/12	Mon 10/1/12
254	**DEP Beneficiary communication and education program established**	**Mon 4/2/12**	**Mon 10/1/12**
255	Finalize and approve beneficiary communication and education program staffing requirements	Mon 4/2/12	Mon 4/2/12
256	Finalize and approve beneficiary communication and education program objectives and goals	Fri 6/29/12	Fri 6/29/12
257	Finalize and approve beneficiary communication and education strategy	Fri 6/29/12	Fri 6/29/12

ID	Task Name	Start	Finish
258	Finalize and approve beneficiary communication and education program responsibilities and assignments	Fri 6/29/12	Fri 6/29/12
259	Develop beneficiary communications and education plan	Fri 6/29/12	Fri 6/29/12
260	Develop beneficiary communication materials	Mon 9/10/12	Mon 9/10/12
261	Begin beneficiary communications	Mon 10/1/12	Mon 10/1/12
262	Certify compliance with rigorous education and outreach requirements established by DHCS	Mon 7/30/12	Fri 9/28/12
263	**DEP Provider communication and education program established**	**Mon 4/2/12**	**Mon 10/1/12**
264	Finalize and approve provider communication and education program staffing requirements	Mon 4/2/12	Mon 4/2/12
265	Develop provider communication and education plan and schedule	Fri 6/29/12	Fri 6/29/12
266	Develop provider communications	Mon 9/3/12	Mon 9/3/12
267	Develop provider operations manuals	Mon 9/3/12	Mon 9/3/12
268	Begin provider communications	Mon 10/1/12	Mon 10/1/12
269	**DEP Stakeholder engagement program established**	**Fri 3/30/12**	**Fri 9/14/12**
270	Finalize and approve list of stakeholders	Fri 3/30/12	Fri 3/30/12
271	Finalize and approve stakeholder engagement program objectives and goals	Fri 3/30/12	Fri 3/30/12
272	Finalize stakeholder engagement plan	Mon 4/2/12	Mon 4/2/12
273	Establish External Advisory Group	Mon 4/30/12	Mon 4/30/12
274	Begin stakeholder "town hall" meetings	Fri 9/14/12	Fri 9/14/12
275	**DEP Benefits/Product Development function established**	**Mon 4/2/12**	**Fri 9/28/12**
276	**DEP Benefits design and configuration finalized**	**Mon 4/2/12**	**Fri 9/28/12**
277	Finalize and approve benefit design objectives and goals	Mon 4/2/12	Fri 6/1/12
278	Finalize and approve benefit design framework	Mon 4/2/12	Fri 6/1/12
279	Finalize and approve benefit design framework elements	Mon 4/2/12	Fri 6/1/12
280	Submit proposed plan benefit packages to CMS	Mon 6/4/12	Mon 6/4/12
281	Load benefit configuration in the benefits system	Tue 7/31/12	Tue 7/31/12
282	Validate benefit system accurately configured	Wed 8/1/12	Fri 9/28/12
283	**DEP Systems & Technology functions established**	**Mon 4/2/12**	**Mon 12/31/12**
284	**DEP IT infrastructure established**	**Mon 4/2/12**	**Mon 12/31/12**
285	Finalize and approve IT infrastructure requirements	Mon 4/2/12	Mon 12/31/12
286	Finalize and approve IT infrastructure design	Mon 4/2/12	Mon 12/31/12
287	Build the IT infrastructure	Mon 4/2/12	Mon 12/31/12
288	Test the IT infrastructure	Mon 4/2/12	Mon 12/31/12
289	Implement the IT infrastructure	Mon 4/2/12	Mon 12/31/12
290	Finalize and approve IT infrastructure operations and support requirements	Mon 4/2/12	Mon 12/31/12
291	Finalize and approve IT infrastructure operations and support policies and procedures	Mon 4/2/12	Mon 12/31/12
292	Finalize and approve IT infrastructure operations and support staffing requirements	Mon 4/2/12	Mon 12/31/12
293	**DEP Web services function established**	**Mon 4/2/12**	**Mon 12/31/12**
294	Finalize and approve web services operating requirements	Mon 4/2/12	Mon 12/31/12
295	Finalize and approve web services operating policies and procedures	Mon 4/2/12	Mon 12/31/12
296	Finalize and approve web services function IT systems requirements	Mon 4/2/12	Mon 12/31/12
297	Finalize and approve web services function staffing requirements	Mon 4/2/12	Mon 12/31/12
298	**DEP Service Coordination Partnerships established**	**Wed 5/30/12**	**Mon 7/1/13**
299	Finalize and approve member contact center function IT systems requirements	Wed 5/30/12	Wed 5/30/12
300	Contracts with SD County mental health services executed	Mon 7/2/12	Mon 7/2/12

ID	Task Name	Start	Finish
301	**Contracts with IHSS administration executed**	**Mon 7/2/12**	**Mon 7/1/13**
302	Execute Department of Social Service MOU (Year 1)	Mon 7/2/12	Mon 7/2/12
303	Execute contract with SEIU	Tue 1/1/13	Tue 1/1/13
304	Execute contract with Public Authority	Mon 7/1/13	Mon 7/1/13
305	Execute contracts with LTSS providers	Fri 8/31/12	Fri 8/31/12
306	Establish partnerships with community social support services	Fri 9/28/12	Fri 9/28/12
307	Operational plan for shared administrative services developed and implemented	Tue 1/1/13	Tue 1/1/13
308	Finalize and approve shared services staffing requirements	Fri 6/29/12	Fri 6/29/12
309	Begin recruiting shared services staff	Mon 7/2/12	Mon 7/2/12
310	Develop shared services training program and curriculum	Thu 11/15/12	Thu 11/15/12
311	Deliver shared services staff training	Fri 11/16/12	Mon 12/31/12
312	**Consumer Protections established**	**Mon 7/30/12**	**Fri 9/28/12**
313	Certify compliance with all consumer protections described in Demonstration Proposal and Federal-State MOU	Mon 7/30/12	Fri 9/28/12
314	Certify compliance with rigorous standards for accessibility established by DHCS [during readiness review]	Mon 7/30/12	Fri 9/28/12

Section 6, Attachment 23

Martha J. Smith
Dual Eligible Demonstration Project Manager

Experience

January 2007 to Present:
Health Net, Inc. and Health Net Community Solutions
Dual Eligible Demonstration Project Manager
Chief Provider Contracting Officer

- Responsible for the successful implementation and ongoing compliant operations of the Dual Eligible Demonstration Pilot with primary focus on achieving the goals outlined by DHCS and CMS.
- Previously responsible for all provider network activities for Health Net's Western Region (California, Oregon, Washington and Arizona). This included network development and oversight for all product lines, including Medicare, D-SNP, Medi-Cal, SPDs and Commercial programs. Responsible for negotiating contracts, compliant operations and managing ongoing relationships and provider services with over 60,000 professional providers and over 400 hospitals and their associated organized delivery models, representing approximately $9 billion in annualized expense.

May 2006 to December 2006:
United HealthCare
Vice President, Network Management
Lead the contracting effort necessary to transition from the leased network to directly contracted network during the initial stages of acquisition of PacifiCare. Responsible for introducing United HealthCare standards and ensuring compliance, while rebuilding strategic relationships in the provider market.

April 1996 to May 2006:
Health Net of California
Vice President, Health Plan Network Management
Held progressive managerial positions in Network Management and Operations in both Southern and Northern California. Responsibilities included strategic development, negotiation, compliant operations and oversight of provider networks for multiple product lines, including Medicare, Medi-Cal, Healthy Families, Commercial, and TRICARE programs. Also had responsibility for development and implementation of the statewide provider network strategy for the Medicare product.

October 1993 to April 1996:
California Pacific Medical Center (CPMC)
Director of Contracting & Manager, Department of Pediatrics
Managed the Department of Pediatrics with P&L and operational responsibilities for hospital and clinic based services, including budgeting, human resources, managed care contracting and marketing functions. Also responsible for tertiary and transplant services contracting, including risk contracting done jointly with California Pacific Medical Group, the associated IPA.

February 1991 to October 1993:
Kaweah Sierra Medical Group, Inc.
Director of Practice Development and Public Relations
Operational responsibilities included oversight of nursing, transcription, reception, and medical records staff for this 32-physician multi-specialty staff model medical group. In addition, was responsible for public relations and managed care activities. Developed a comprehensive provider (IPA) network, selected and installed a claims system, negotiated and implemented the group's first capitated risk arrangements.

July 1986 to February 1991:
California Preferred Providers, Inc & Freedom Plan, Inc.
Manager of Contracting and Provider Relations
Responsible for development and management of the provider network (hospital, physician and ancillary) for Commercial product lines, including service area expansions in accordance with Knox-Keene regulations. Also managed operations for the medical utilization review subsidiary, Sentinel Medical Review.

Education

- Master of Science, Health Care Administration, University of LaVerne, LaVerne, CA. December 1993.
- Bachelor of Arts, Business Economics, University of California at Santa Barbara, Santa Barbara, CA. June 1985.

Other Professional and Board Affiliations

- Director, Integrated Health Association Board
- Advisory Council Member, First Health