Health Net Inc. a subsidiary of

SPECIAL NEEDS PLANS

MODEL OF CARE

Health Net of California H0562 Chronic Condition (C-SNP) 2019

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OVERVIEW

Health Net is an affiliate of Centene Corporation, a nationally recognized MCO offering Medicare, Medicaid, Commercial, Exchange, Medicare/Medicaid and US Department of Defense and Veterans affairs sponsored health insurance coverage for people of all ages and at all stages of life. In California, Health Net provides a coordinated C-SNP Model of Care for members with diabetes, congestive heart failure or cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorders). The Jade C-SNP is offered in Los Angeles, Kern, Orange and San Diego counties.

Special Needs Plans

2019 C-SNP MODEL OF CARE DESCRIPTION

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

MOC 1.A DESCRIPTION OF OVERALL SNP POPULATION

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

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

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

- Once a day MP will receive a daily feed with all the previous day's enrollments in the Jade Plan. The member records are then assigned to each rep. based on effective date.

- The Attestation Unit (AU) must initiate the first attempt by phone call and/or by fax (if the Provider's office requests a fax be sent) of any newly enrolled C-SNP member within five (5) business days once the member is enrolled.

- The AU will continue the Provider outreach until either a verbal attestation or a signed Attestation Form is received. This process will continue until the last day of the members second month of enrollment to verify the member's qualifying chronic condition.

Documentation needed to proceed/make outreach to Provider

- Pre-Qualification Form and/or Attestation Form

- Look for the documentation in FileNet using both a HICN and/or searching by name.

- If BOTH the Pre-Qual and/or Attestations forms are NOT found, this must be brought to the attention of **Lead/Supervisor.**

- Member will need to be contacted to obtain a verbal pre-qualification over the phone.
- Once pre-qualification has been obtained, the form will be uploaded to FileNet.
- The AU will then begin the outreach to the Provider.

Steps taken after the 2nd month of enrollment

- On the 1st business day of the month the LEAD or LEAD designee will export a list of all active Jade members. The list of members exported will include those who were newly enrolled during the previous month however they were unable to be attested or do not qualify to remain enrolled in the Jade C-SNP plan.

    1) All Notices must be ordered by the 7th calendar day of the 2nd month of enrollment.
    2) In addition before ordering the notice for those who were unsuccessfully attested Membership will conduct a search in FileNet and OMNI by name and by HICN for any attestations or verbal attestations that may have been received.
    3) If by the end of the 2nd month of enrollment, there is no reply from the Physician or the Physician attests that the member does not qualify. The disenrollment transaction will be submitted

Additionally, HN will conduct follow up calls to the provider as needed to request verification of the qualifying condition. If confirmation is received either verbally or in writing, documentation is completed and updated to reflect this confirmation. HN will document in the appropriate system with all outreach attempts and outcomes and will retain a copy of any communication received in writing in the enrollee's file.

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

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

Notice Requirements:

Request for Additional Information: To obtain information to complete the enrollment request, HN must contact the individual to request the information within **ten calendar days** of

receipt of the enrollment request. The request may be written or verbal but in either case the request must be made within ten calendar days.

Combination Acknowledgement and Confirmation Notice: A notice acknowledging and confirming an enrollee/member enrollment. This notice is sent within 7 calendar days of the availability of the Transaction Reply Report (TRR).

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

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

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

Health Net's chronic disease Jade SNP for diabetes, chronic heart failure (CHF) and cardiovascular disorders provides healthcare services for residents of Kern, Los Angeles, Orange, and San Diego counties in the state of California. California is a large and populous state with several distinct geographic regions. The specific targeted areas include Kern County at the southern end of the Central Valley and three of Southern California's most populous counties encompassing the Los Angeles, Long Beach and San Diego metropolitan areas. San Diego County shares the Mexico border. Los Angeles, Orange, and San Diego are coastal, ethnically diverse regions with multiple large urban centers. According to the latest estimates of the U.S. Census Bureau, the populations of Los Angeles, Orange, and San Diego counties numbered over 10.1 million, 3.1 million, and 3.3 million people respectively as of July 1, 2016. Additionally, Los Angeles and Orange counties had higher proportions of foreign-born residents (34.7% and 30.5%, respectively) compared to California (27.0%) and the United States (13.2%); whereas San Diego County had a slightly lower proportion of foreign-born residents (23.5%) compared to California.[1,2,3] In contrast, Kern County is comprised of urban and rural areas in the Central Valley region that includes the large cities of Bakersfield and Delano. The county is widely known for its agricultural commodities and petroleum production. As of 2016, the population of Kern County reached 884,788 residents with nearly one in eleven persons (9.0%)

[1] United States Census Bureau. Quickfacts: Los Angeles County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[2] United States Census Bureau. Quickfacts: Orange County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[3] United States Census Bureau. Quickfacts: San Diego County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

being 65 years of age or older. More than half of Kern County residents are of Hispanic or Latino origin (52.8%) and less than one-fourth are foreign-born individuals (20.3%).[4]

The CA SNP includes members living in urban and rural areas of Kern, Los Angeles, Orange and San Diego counties still struggling with financial instability and poverty. The percentage of individuals living below the poverty level in Los Angeles County is 16.3%, more than the rate for both California and the nation (14.3% and 12.7%, respectively).[5] Particularly in Los Angeles, clusters of impoverished households are located in South Los Angeles and areas adjacent to the central downtown region. Many residents of these neighborhoods are Latino and foreign-born. As evidenced in the Orange County Community Indicator Report 2017, the cost of living in Orange County is almost double the U.S. average (87% higher) which could have a greater impact on older SNP members living on a fixed retirement income. Although less than Los Angeles County, families in one-third of Orange County neighborhoods face financial instability and 13% of residents live in poverty.[6] In comparison, the median household income of Kern County was $49,026 in 2015 and almost one-fifth (19.4%) of all families in Kern County had incomes below the poverty level. Poverty disproportionately affects Kern County residents and contributes to greater housing instability and food insecurity.[7] Furthermore, according to the American Community Survey, 14.5% of individuals in San Diego County, between 2009 and 2013, were living in households with income below 100% of the Federal Poverty Level (FPL). Also, a greater proportion of Latinos, African Americans, Native Americans, and individuals of some other race were in poverty compared to the overall San Diego population.[8]

Self-reported ethnicity information gathered from the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[9] for HN California Medicare, inclusive of the SNP population, revealed that respondents were 82 percent White, 6 percent African American, and 16 percent Other. Of the aforementioned ethnicities, 31 percent of members designated themselves as Hispanic or Latino. About 45% reported a high school or less education and 55% had some college education or higher.

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[4] United States Census Bureau. Quickfacts: Kern County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[5] United States Census Bureau. Quickfacts: Los Angeles County, California. Retrieved December 4, 2017, from www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/PST045216

[6] Orange County Community Indicators Report. Retrieved December 6, 2017, from www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OC_Community_Indicators_2017.pdf

[7] Kern County Public Health Services Department. Community Health Assessment, 2015-2017. Retrieved December 6, 2017, from http://kernpublichealth.com/wp-content/uploads/2017/04/Community-Health-Assessment_04.18.17_1.pdf

[8] Penn TE, Delange N (2016). San Diego 2016 Community Health Needs Assessment. Retrieved December 26, 2017, from http://hasdic.org/2016-chna/

[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

An epidemiological and demographic analysis is conducted annually to assess the clinical needs of Health Net's SNP members (Jade, Amber I and Amber II). Demographic information from the most recent report identifies the average age of SNP members as of December 31, 2016 was 70.23, which was higher than the 2015 average age of 67.97 years. However, the SNP population continues to be younger than the non-SNP Medicare population by almost 3.3 years The Jade SNP population is comprised of 50 percent males and 50 percent females based on the latest HN HRA[10] data.

Social determinant data from the 2016 HN Health Risk Assessment (HRA) specific to the Jade SNP population identifies several deficits. About 45% of report they cannot shop for their own food and 48% report that they cannot cook their food. In addition, 24% of members depend on friends for transportation and 12.5% report trouble getting to doctor and dentist appointments. Barriers to accessing transportation are psychosocial factors that can contribute to missing doctor appointments, picking up prescriptions, and attending social events. A significant number (16%) also report that they do not have adequate social support. SNP members that cannot afford the essentials or perform tasks on their own, such as food shopping and cooking, buying clothes, dressing themselves and attending family events, experience a social deficit that can impact their physical and mental health.

Additional SNP Jade responses to the 2016 HN HRA revealed that English was the primary language for 63.4 percent, followed by Spanish (30.6%), Vietnamese (0.99%), Tagalog (0.93 %), Chinese (0.61%) and Korean (0.52%). Although 96% of these members reported they can read in their own language, health literacy may still be an issue. In order to address health literacy issues, Health Net provides culturally acceptable and readable materials for required threshold languages for vital documents. "Clear and Simple" guidelines at the eighth grade reading level are followed for additional materials. Health Net customer service representatives who speak Spanish or other languages are also available and required interpreter and language line services are provided. In 2016, Health Net received the Multicultural Health Care Distinction by the National Committee for Quality Assurance (NCQA) for the third time since 2012. Health Net has earned the two-year distinction for all three lines of business (Commercial, Medicaid and Medicare).

Please see MOC 1.A.3 for cognitive factors and co-morbidities of the Jade SNP population.

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

Cardiovascular Disease (CVD), which includes heart disease, heart failure, stroke and hypertension, accounts for one in three deaths in California, making it the leading cause of death in the state. The total number of deaths from CVD exceeds the combined number of deaths from diabetes, chronic liver disease/cirrhosis, accidents, Alzheimer's disease, influenza and pneumonia, and chronic lower respiratory diseases. Data collected on the presence of

[10] 2016HRAFrequinciesMY2016OverallSNPbyPBP

cardiovascular disease in California indicate that high blood pressure is present in one in four adults, high cholesterol is present in one in three adults, and nearly one in four adults is obese.[11] Diabetes is a major risk factor for cardiovascular disease. One in twelve adults (2.3 million) in California is diagnosed with diabetes. Diabetes is the seventh leading cause of death in California claiming nearly 8,000 lives annually.[12] People with diabetes ages 60 years old or older are 2-3 times more likely to report an inability to walk one-quarter of a mile, climb stairs, or do housework compared to people without diabetes in the same age group.[13]

Residents of Kern County experience a disproportionate burden of chronic disease compared to all other California counties. Chronic diseases/issues that were ranked highly include: obesity, high blood pressure, asthma, diabetes, cancer, heart disease and stroke. In fact, coronary heart disease (with 138.2 deaths/100,000 population) and cancer (with 156.1 deaths/100,000 population) account for more than one third of all deaths in Kern County. Additionally, diabetes is the sixth leading cause of death in Kern County (with 35.1 deaths/100,000 population); and Kern County is ranked worst in the state in terms of diabetes-related mortality. Furthermore, Kern County continues to have a higher proportion of obese adult residents (38.5%) compared to the rest of the state (28.0%). Being obese is clearly linked with an increased risk of serious health conditions such as diabetes, heart disease, stroke, and cancer.[14]

In comparison, the Jade SNP varies from the state population because members must have diabetes, CHF or cardiovascular disorders to enroll. Data from the 2016 HRA for Jade SNP members identifies the following incidence of medical, mental, cognitive and co-morbid conditions self-reported by members:

- 81% have diabetes
- 75% have hypertension
- 29% have impaired vision
- 28% have memory problems
- 20% have experienced a heart attack/have coronary artery disease
- 17% have asthma/chronic obstructive pulmonary disease (COPD)
- 12% have osteoporosis
- 10% have chronic kidney disease
- 9% have experienced heart failure

[11] Conroy SM, Darsie B, Ilango S, Bates JH (2016). Burden of Cardiovascular Disease in California. Sacramento, California: Chronic Disease Control Branch, California Department of Public Health.

[12] Conroy SM, Darsie B, Ilango S, Bates JH (2014). Burden of Diabetes in California. Sacramento, California: Chronic Disease Control Branch, California Department of Public Health.

[13] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[14] Kern County Public Health Services Department. Community Health Assessment, 2015-2017. Retrieved December 6, 2017, from http://kernpublichealth.com/wp-content/uploads/2017/04/Community-Health-Assessment_04.18.17_1.pdf

- 7% have mental health problems

Additional epidemiological and demographic analysis is conducted to assess the clinical needs of Health Net's Medicare SNP members (Jade, Amber I and Amber II). The SNP population is a subset of the Medicare population, and has an additional set of care requirements mandated by the Centers for Medicare and Medicaid (CMS). Another purpose of this activity is to identify trends in the SNP sub-categories and age groups. Top 10 diagnoses and Top 20 prescriptions in combination with member demographic information, are presented to assess the medical and behavioral health characteristics of this population.

In the Inpatient setting, Respiratory Failure, Septicemia, Other Nervous System Disorders and Acute and Unspecified Renal Failure were common to all age groups, both SNP and non-SNP. Other Connective Tissue Disease was in the Medicare non-SNP top 10 list, but not in the SNP top 10 list. Although Diabetes was common to all groups, SNP members tended to be hospitalized more than non-SNP members when Diabetes came with complications.

A member's age seemed to have a more direct bearing on the top 10 diagnoses list in the Inpatient setting than whether or not a member was SNP or non-SNP. Members 65 and above, SNP or otherwise, tended to be hospitalized for Acute Cerebrovascular Disease. Likewise SNP and non-SNP members 50 and above were more likely to be hospitalized for Congestive Heart Failure, Cardiac Dysrhythmias, Pneumonia and Coronary Atherosclerosis/Other Heart Disease. On the other hand, Mood Disorders, Schizophrenia and Epilepsy Convulsions were more pronounced in SNP members 49 and younger.

More commonality can be found in the Outpatient and Emergency settings. In the Outpatient setting, Diabetes Mellitus (both with and without complications), Essential Hypertension, Spondylosis, Other Connective Tissue Disease and Other Non-Traumatic Joint Disorders were common among all SNP and non-SNP age groups. Cataracts were more likely to be found in members 50 and older than in younger members, regardless of whether they were SNP members or not. In both SNP and non-SNP groups, Other Skin Disorders and Glaucoma were in the top 10 list of members 65 and older while members under 65 were more likely to have Other Nutritional Endocrine and Metabolic Disorders, and Other Upper Respiratory Infections. Epilepsy and Mood Disorders were more likely to be found in members younger than 50.

In the Emergency setting, six of the top 10 diagnoses were common to all age groups, both SNP and non-SNP: Diabetes with and without Complications, Spondylosis, Other Connective Tissue Disease, Other Skin Disorders and Disorders of Lipid Metabolism were common to all. Members 65 and older, regardless of whether they were SNP members or not, were more likely to seek treatment at Emergency rooms for Cataracts. Likewise, members 50 and older, both SNP and non-SNP, were commonly treated at Emergency rooms for Essential Hypertension.

Mycosis was more likely to occur in SNP, rather than in non-SNP, members 65 and over in an Emergency room setting. SNP members, younger than 65, were more likely to be treated at the Emergency room for Abdominal Pain and Other Non-traumatic Joint Disorders. Epilepsy and

Other Nervous System Disorders were more common causes of visits to the Emergency room for members 49 and under.

There was a greater correlation between the Non-SNP Medicare population and the 65-and-over SNP group than with the younger SNP age ranges in all settings.

There were very little differences in the top ten diagnoses among the Amber I, the Amber II and the Jade plans. If a diagnosis was in the top ten list of one but not another, it would be in the top 20 of the latter. With few exceptions, the top ten diagnoses in all settings in all plans were chronic conditions.

The Top 10 SNP inpatient and outpatient behavioral health diagnoses fell under the broad categories of Schizophrenia, Schizoaffective Disorders, Major Depressive Disorders and Bipolar Disorders. Health Net databases were also queried for behavioral health diagnoses, and the top 10 were obtained.

From January 1 through December 31, 2016, roughly 37.4% of the SNP population (8,297 out of 22,213) had a mental health diagnosis present in Health Net medical claims and encounters. Note that these were oftentimes not the primary diagnoses in the medical claims/encounter data.

Nineteen of the top 20 Enhanced Therapeutic Classification (ETC) drug categories in the SNP population as a whole are also in the top 20 drugs for the Non-SNP Medicare population. Medical Supplies, Musculoskeletal Therapy Agents and Antipsychotics are three medication categories that are in the SNP Top 20 list but not in the non-SNP Medicare list.

In review of the Average Days' Supply, Non-SNP Medicare members were more likely to have been on the indicated medication for a much longer time period than SNP members. However, SNP members without exception have much higher utilization rates than non-SNP Medicare members. Among the SNP population, medication duration was longest for Diabetic Therapy agents and shortest for Non-Narcotic Analgesics.

The utilization patterns of the SNP 65-and-over age group most closely resembles that of the Non-SNP Medicare population since 19 of the top 20 medications are in both lists. The patterns start to diverge in the 50-to-64 age range, but the most noticeable differences can be found in the under-50 age group.

Antipsychotics, one of the Top 20 most utilized drugs in the younger age groups, are not prominent in the Non-SNP Medicare population. Antipsychotic utilization is found mostly in the under-65 SNP age group and has a particularly high per capita utilization in the 49-and-under age range. It is ranked 17th in the 50-to-64 range but is 7th in the under-50 group.

Drugs with greater utilization for members aged 65 and over but whose utilization is not as pronounced in younger members are Anticoagulants, Calcium and Bone Metabolism Regulators

and Minerals/Electrolytes. The dose days per member tends to increase for these drugs as members get older. Members younger than 50 don't have the extent of prostatic problems as members 50 and older since members 50 and older have much greater utilization of Prostatic Hypertrophy Agents. Drugs with greater utilization for members aged 49 and under but have lower utilization in members older than 49 are Antipsychotics, Musculoskeletal Therapy Agents, Corticosteroids and Antiparkinson Therapy.

As for the similarities, the most utilized drug categories in all SNP and Non-SNP Medicare groups are those for Diabetic Therapy, Antihypertensive Therapy Agents, Antihyperlipidemics and Beta Adrenergic Blockers.

There is a strong association between the Top 10 medical diagnoses and the Top 20 prescriptions for the SNP population. SNP members tend to be hospitalized for Diabetes complications than non-SNP members. Analgesics and antidepressants continue to be in the Top 20 most prescribed drug categories, suggesting high occurrences of pain and depression.

However, there are marked differences between the SNP under-50 group and the older SNP population. SNP members under 50 years old tend to have a greater percentage of psychiatric disorders and antipsychotic medication than those older than 50. With regards to anticonvulsants, Dose Days per members tends to decrease with age.

Additionally, there is a greater correlation between the Non-SNP Medicare population and the 65-and-over SNP group than with the younger SNP age ranges in all settings as well as in drug utilization.

Diabetes, hypertension, hyperlipidemia/metabolic disorders and heart disease are prevalent not just in the SNP group but in the Medicare population as a whole, suggesting the need for more effective interventions to target chronic conditions.

Monitoring and surveillance of diagnoses and prescription lists are important in the development of programs and interventions to improve the quality of health care Health Net provides to all of its Medicare SNP members.

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

The specific C-SNP type will be: Severe and Disabling Chronic Disease SNP for Diabetes, CHF, and Cardiovascular Disorders in Kern, Los Angeles, San Diego and Orange counties. Please see MOC 1.A.3 for disease incidence and prevalence including behavioral health disorders.

Unique characteristics of the Jade SNP population were identified through the 2016 HN HRA data. Overall, limitations and barriers reported suggest Jade SNP members are less mobile or independent with 32% having difficulty walking, 29% reporting weakness, 23% reporting shortness of breath and 22% with a fall in the past 12 months. About 15% experienced one or more hospital or nursing home admissions in the past 6 months and 26% required urgent or

emergency room care. The majority appear to have the resources they need to buy food, although 41% reporting difficulty affording food.

In addition, 39% of Jade SNP members reported that pain regularly interfered with performing daily activities with an average pain score rating of 6.7 out of 10. However, only about 31% of members reported effective pain control. Also, 27% of Jade SNP members indicated that they were bothered by emotional problems (such as feeling anxious, depressed, or irritable) in the past 6 months.

The purpose of targeting this population is to demonstrate that an improved Model of Care emphasizing case management and coordination of services can improve outcomes and balance utilization for members with diabetes, CHF, and/or cardiovascular disorders. SNP members with diabetes are at risk for complications such as cardiovascular disease, lower limb amputations, infections, kidney failure, non-healing wounds, hypertension, neuropathies and eyesight loss. SNP members with CHF are at risk for complications such as impaired kidney function, pulmonary congestion, weakness, arrhythmias, angina, pedal edema and heart attacks. SNP members with cardiovascular disorders such as cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders are at risk for myocardial infarction, falls, stroke, pulmonary complications, circulatory impairment and leg wounds. In addition, members with one or more of these chronic conditions and accompanying side-effects may require complex medication regimens to treat symptoms and avoid complications.

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

1.B SUBPOPULATION-MOST VULNERABLE BENEFICIARIES

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

The most vulnerable populations will be identified in order to direct resources towards the members with the greatest need for case management services. Examples of vulnerable populations include but are not limited to:

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

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

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

- Mental Health conditions – members with behavioral health(BH) disorders may be at risk for additional complications due to their BH treatment and to barriers obtaining and coordinating their care

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

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

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

To identify the most vulnerable population within the SNP, the member's stratification is determined when the clinical assessment is conducted by Case Managers. Upon member status changes such as complications or inpatient admissions and at least annually, stratification could be revised based on the determination of the Case Manager. The stratification is determined across three dimensions: medical, psychosocial, and cognitive/functional. The case manager reviews pertinent available data during assessments/reassessments which include utilization and predictive model results. If stratification levels are revised based on reassessment, it is documented in the medical management system.

Specialty Services and Benefits

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

- **Transportation Services:** Health Net provides transportation services to Jade SNP members as part of their core supplemental benefits; this includes a variable number of medically related trips annually according to the individual SNP plan. Members are provided with the benefit and contact information for transportation services upon enrollment so they can access services directly. The member can bring a caretaker or family member for no charge.

Members may ask the driver to stop at a pharmacy for prescription pick-up after a physician visit, and the stop will not count as an additional trip. Moreover, convenient curb-to-curb or door-to-door assistance is offered depending upon the member's need. The expected outcome is that provision of transportation services will promote member access to medical services and compliance with the medical goals of the Care Plan.

- **Dental/Vision Benefit:** Members are provided with vision and dental benefits, provider directories and contact information for dental and vision services upon enrollment so they can access these services directly. The member's Case Manager will also educate members about these benefits and encourage them to obtain regular dental and vision care. The expected outcome is that members will have improved oral health, prevention or early detection of dental and visual complications and access to eyewear as needed.

    - **Vision Benefit:** Jade members have core supplemental vision benefits. The vision benefit includes an annual routine eye exam and eyewear allowance for frames and lenses or contact lenses every two years. This is especially important for diabetics, elderly and those with hypertension who are at greater risk of vision loss and complications.

    - **Dental Benefit:** Depending on the individual plan, Jade members have core supplemental dental benefits or can purchase these benefits as an optional supplemental package. Dental benefits can range from diagnostic x-rays, preventive cleaning and services, restorative amalgam dental treatments and discounts for other services to a comprehensive dental benefit. Good oral care has been linked to general medical health.

- **Hearing Services:** Jade members have core supplemental hearing aid benefits. Hearing aid coverage includes an annual hearing exam and hearing aids and fitting every three years. The hearing aid provider sends a patient guide with detailed information on hearing loss, hearing aids and what to expect during first appointment. The expected outcome of this benefit is improved communication and comprehension for members along with the accompanying social and medical benefits.

- **myStrength:** myStrength is a web-based and mobile-app tool available to all Health Net members to address depression, anxiety, substance use, pain management and insomnia. myStrength can also be used by providers to support their patients in managing their behavioral health conditions. The expected outcome is that SNP members with behavioral health conditions will have an additional option and support tool to self-manage and meet their behavioral health needs.

- **Fitness:** Jade members are offered a Fitness Program at no additional cost. The fitness benefits include a membership at a participating fitness facility and access to exercise classes (available at some facilities). It also includes online educational materials and exercise programs for members who do not utilize the gym.

- **Medication Therapy Management (MTM):** All SNP members are enrolled in the MTM program with quarterly medication reviews by a pharmacist. The review looks for evidence of noncompliance, gaps in care, duplication or potential for adverse reactions and the member, physician and HN Case Manager receive the results of the review when problems are identified, in addition to information on how to speak with a pharmacist directly. This communication among the team members facilitates follow-up with the member regarding medication issues. The pharmacy reviews will be provided automatically and the member is provided with the contact information for the pharmacist to access additional medication information, if desired. The expected outcome is increased knowledge of their medication profile, improved compliance, and decreases in gaps in care, duplication of medications and adverse reactions.

- **Disease Management:** SNP members have access to a health care professional for education and counseling regarding health concerns and biometric monitoring when indicated. The focus is on members with chronic disease such as diabetes, chronic heart failure, COPD and asthma to improve disease management and decrease unplanned admissions. In addition to providing educational materials and educating the member how to manage their disease process, there is access to interactive programs on the member portal regarding smoking cessation, increasing physical activity and weight management and a comprehensive library of health information. Care gap reminders are also sent for gaps in care such as preventive screening and medication adherence. Members are provided with education and contact information about how to access disease management services upon enrollment. The member's Case Manager and providers can also refer members to disease management as indicated. The expected outcome is for members to have improved knowledge and management of their disease process resulting in a decrease in unnecessary utilization and improved quality of life.

- **Chronic Disease specific:** Depending on the region and specific SNP plan, members in Chronic Disease SNPs may have access to such benefits as zero or lower costs for diabetic monitoring supplies, diabetes self-management training, Medicare covered routine or intensive cardiac rehab, supplemental podiatry visits, oxygen or covered pulmonary rehab services. Additionally, select cardiovascular and diabetic drugs are made available to SNP members for zero dollars out-of-pocket. Add-on benefits are re-evaluated annually to meet member needs.

- **Case Management for Special Needs:** All SNP members are enrolled in case management. In addition, for a small subset of members with conditions such as ESRD, catastrophic or end-of-life situations, members may be enrolled in more specialized case management programs which include home visits. The member's Case Manager or provider will refer the member for the services.

- **Social Workers and/or Case Managers:** County–specific research is conducted to identify and connect members with additional resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps, financial

assistance, support groups, home delivered groceries and meals, in-home supportive services, transportation, etc.

- In addition, SNP members may receive the following interventions as indicated by their individualized Care Plan:

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

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

Age – As of December 31, 2016, the HNCA SNP average was 70 years. The older a member is, the more likely they are to have degenerative diseases such as failing vision, hearing, impaired cognition, changes in kidney and liver function and loss of mobility. All of these can impact their ability to understand and manage their disease process, follow a healthy exercise routine and metabolize medications and puts them at greater risk of adverse drug reactions and falls and injuries.

Gender – The Jade SNP population is comprised of 50% males and 50% females. It is important to women's health that they receive regular screening for breast and cervical cancer and osteoporosis in particular. Research has also identified that women are less likely to obtain the necessary screening for cardiovascular disease than men. In addition to routine screening for chronic diseases such as hypertension, coronary artery disease and diabetes, men require regular screening for disorders of the prostate.

Ethnicity – Self-reported ethnicity information gathered from the 2017 CAHPS® for HNCA Medicare, inclusive of the SNP population, revealed that respondents were 82% White, 6% African American, 16% Other. Of the aforementioned ethnicities, 31% of members designated

themselves as Hispanic or Latino. California has a large immigrant population. From the "Racial and Ethnic Disparities in Health Care in Medicare Advantage" report released in 2016 by the CMS Office of Minority Health, health disparities exist for Black and Hispanic populations. Utilizing CAHPS/HEDIS data collected in 2014, the Office identified that Black and Hispanic populations had significantly lower results compared to Whites for some access, preventive care and health outcomes. For access to care, these included getting needed and specialist care, getting appointments and care quickly and getting prescription drugs. Significantly lower rates for preventive care were observed for annual flu vaccine and colorectal cancer screening. Important health outcome rates such as control of blood sugar and blood pressure were also lower, especially for the Black population.

Language barriers – For non-English speakers, language can be a communication road block and have a negative impact on quality care and health outcomes. English was the primary language reported for 63.4% of Jade SNP members, followed by Spanish (30.6%), Vietnamese (0.99%), Tagalog (0.93 %), Chinese (0.61%) and Korean (0.52%). Language barriers are addressed with ongoing action plans that include distribution and utilization of a cultural and linguistic provider toolkit and continued provision of a comprehensive Language Assistance Program. Health Net provides required language and interpreter services to meet member needs.

Health Literacy - Self-reported member information gathered from the 2017 HNCA CAHPS®, inclusive of the SNP population, revealed that 45% reported a high school education or less and 55% have had some college education or higher. The 2016 HN Jade SNP HRA data indicated that 96% of members can read in their own language. However, research has shown that even college educated persons can have very low health literacy. Low health literacy can impact the ability of members to understand and follow the instructions provided to manage their conditions. Easy to understand language and communication is promoted in Health Net member materials.

Socioeconomic status – About 41% of Jade SNP members report having trouble affording to buy food. Not being able to afford the essentials, such as food, clothing, transportation, and housing creates a social deficit and can lead to behavioral health problems such as depression. Not being able to purchase fresh fruits and vegetables due to price or mobility issues and buying high caloric and high sodium processed foods instead can result in poor control of chronic diseases such as diabetes, CHF and cardiovascular disorders. Low income members with concerns about additional costs for healthcare visits, medications or testing supplies may avoid medical appointments or preventive care.

Other – The 2016 HN HRA data indicated that 45% of Jade SNP members report that they cannot shop for their own food and 48% reported that they cannot cook their food. About 24% relied on friends as the main mode of transportation; 4% use the services of a medical specialty van, and 4% use public transportation. In addition, 16% report that they do not receive adequate social support. These factors can have an impact on member's physical and emotional health and ability to follow their doctor's treatment plan. Members who live alone may require

assistance with additional long-term care supports and services such as delivered meals, help with household chores and identification of social supports in the community. Members without transportation may have difficulty making doctor's appointments for preventive and routine care.

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

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

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

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

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

Ethnicity – To address health disparities for some populations, the Disease Management and Health Education programs develop educational material and interactive programs available in English and Spanish on chronic diseases and conditions such as fall prevention, osteoporosis, diabetes, depression, high blood pressure, weight management, preventive screening and smoking cessation. Case Managers, and if indicated Disease Managers reach out to members, including Hispanics and African Americans identified with care gaps to encourage regular follow-up care with their doctors. Bi-lingual Case Managers and educational materials in English

and Spanish are made available as much as possible. The member portal also has educational material on chronic disease and online interactive programs promoting exercise and to help members attain their ideal weight.

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

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

Socioeconomic status – HN has designed special benefits for the SNP Jade plan to meet the needs of older adults who are on a fixed income. Due to the high prevalence of chronic conditions such as hypertension and diabetes, a pharmacy benefit covers much of the cost for regular prescription drugs to manage chronic diseases. This can include zero or lower costs for select cardiovascular and diabetic drugs, and diabetic testing supplies. With respect to other challenges, Health Net provides medically related transportation services and hearing aid coverage for Jade SNP members.

Other – In addition to a comprehensive network of behavioral health providers for members with behavioral health needs, Health Net provides *mystrength*, an online tool for members described in MOC1.B.1. To meet the needs of members with diabetes, CHF and cardiovascular disease, Health Net has additional disease management services as described in SNP MOC 1.B.1 under specialty services.

MOC 1.B.4 Identify and Describe Established Relationships with Partners in the Community to Provide Needed Resources

HN Case Managers and Social Worker's maintain a good working knowledge of community resources in the member's geographic location and provide the member with coordination of

services to assist them to meet their needs. This includes establishing relationships with the providers of services. Social Workers and/or Case Managers conduct county–specific research to identify and connect members with the resources in their community to meet their individual needs. These can range from assistance for home modifications such as ramps to financial assistance, support groups and in-home supportive services.

Health Net collaborates with its participating provider groups in order to enhance member care. Actionable data is shared on a regular basis with providers on care gaps, member pharmacy issues, results of member surveys and other data for providers to follow-up and perform outreach with members. Health Net also provides access to online clinical practice guidelines and member educational tools around chronic heart failure and diabetes to provider partners for optimum disease management. The online provider portal provides access to member level data on the HRA, authorizations, claims and other information.

Health Net partnered with the Alzheimer's Association in 2014 to provide training for Case Managers working with members diagnosed with dementia and other related disorders. A case consultant is available to care managers for up to 6 months after training has been completed to provide consultation and to participate in care conferences. The first year of the training is a pilot with modifications occurring in the 2nd and 3rd years. There is also a Caregiver Education component for families caring for relatives with dementia. In September 2016, the Alzheimer's Association collaborated with Health Net and its delegate case managers to implement the Dementia Specialist Program.

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

Health Net partners and collaborates with California Quality Collaborative (CQC) to provide training and share best practices, successes and challenges in patient care and clinical operations to medical groups, Independent Practice Associations (IPAs) and PPGs. Topics, webinars and symposiums vary annually but include Practice Facilitation Initiatives, Opioid Safety and Avoiding Readmissions to improve outcomes and patient experience.

Representatives from Health Net's clinical services attend the Right Care Initiative –a collaborative to improve critical prevention metrics for heart attack, stroke and diabetes complications through patient-centered, evidence-based medicine. Monthly meetings in southern and northern California locations provide an interactive educational platform for local health care leaders and other stakeholders to exchange proven clinical strategies used to achieve benchmark outcomes and discuss ways to apply evidence-based practices in local

settings. Topics in 2017 included: “Achieving Change at Large Scale, Lessons for Improving Patient Outcomes From Around The World”, “Prevention of Cardiovascular Disease: What’s New in Hypertension and Dyslipidemia”, “Clinical Strategies for Multi-Cultural Patients” , “LA Firefighters 10 year CVD Reduction Success Story “,No More Broken Hearts Foundation “, “Kaiser Permanente Systemic Lipid Treatment and Risk Reduction “, “Diabetes Management Strategies Effectively Deployed within One National Top Performer “,Heart Failure and Other Patients on High-Risk Medications: Reducing Readmissions and Preventing ADEs”.

Health Net supports the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients’ efforts to improve quality, safety and affordability of health care. The Partnership for Patients focuses on making hospital care safer, more reliable and less costly through the achievement of (1) reducing hospital-acquired conditions (HACs) by 20% and (2) reducing 30-day hospital readmissions by 12%. In order to achieve these goals, the Partnership for Patients has replaced and expanded the Hospital Engagement Networks (HENs) with a new similar initiative called Hospital Improvement and Innovation Networks (HIINs), which includes hospital associations and health systems. Health Net has pledged to work towards attaining the goals of this initiative and most Health Net contracting hospitals and respective providers are already collaborating with HENs to share best practices, report and share quality data, and identify effective strategies to reduce HACs and readmissions.

MOC 2: CARE COORDINATION

MOC 2.A SNP STAFF STRUCTURE

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

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

Centene Corporation provides executive and operational support to Health Net and offers specialty affiliates and contracted vendors that serve Health Net. These include affiliates who may participate in the care of Medicare members such as: *Envolve* Pharmacy Solutions for Pharmacy Benefit Management (PBM); *Envolve People Care – MHN* Behavioral Health Management, and *US Medical Management* for in home physician services.

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

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

Administrative Functions

The following describes the specific employed or contracted staff that performs administrative functions for the C-SNP program, by functional area. Each department has a VP/Director/Manager responsible for oversight of activities pertinent to their specialty area.

Enrollment and Eligibility Verification

Enrollment Specialist and Enrollment Supervisor are responsible for the following:

- Verify Medicare and Medicaid eligibility
- Process enrollments and voluntary and involuntary disenrollment according to CMS guidelines and within CMS required timeframes
- Maintain an internal member database and ensure data accuracy by conducting reconciliation with CMS (TRR- Transaction Replay Report) and State Medicaid files

Member Service

Member Service Representative and Member Services Supervisor are responsible for the following:

- Handle inbound/outbound call center activities
- Conduct new member welcome call to introduce the member to the Member Service unit, explains benefits, answers questions, assist with PCP selection
- Verify Eligibility
- Answer member inquiries

Claims

Claims Specialist are responsible for the following:

- Process claims for contracted and non-contracted providers
- Assess payment accuracy and conducts recoveries of overpayment

Appeals and Grievances (A&G)

A&G Coordinators are responsible for the following:

- Intake and resolution of member grievances according to CMS timelines

- Coordinates with the Quality Management department in the resolution of member quality of care complaints
- Intake of reconsiderations and coordination with the Medical Management department for resolution
- Intake for appeals processing

Provider Services

Provider Services Representative, Credentialing Specialist and Director of Network Management are responsible for the following:

- Receive and resolve provider inquiries
- Manage Health Net website provider directory
- Setup & Contracting for Providers
    - Primary resource between providers and plan
    - Investigate and communicate resolutions to provider issues
    - Recruit new providers
    - Credential and re-credential providers
    - Manage providers' education
    - Ensure access and availability to providers to meet members' needs.

Marketing/Communications

Marketing Manager and Marketing Team are responsible for the following:

- Develop communication articles and materials for distribution to stakeholders
- Develop and distribute member & provider educational materials
- Develop marketing materials

Finance

Chief Financial Officer is responsible for the following:

- Collect and analyze financial data to support operations
- Develop and manage the financial budget and conduct appropriate planning including actuarial projections
- Manage risk management program
- Monitor HCC risk adjustment

Training

Compliance Director, Director Medical Management, Director Network Management and Director Service Coordination are responsible for the following:

- Assess and identify individual and group training needs through key business indicators and develop various training curricula, materials and aids
- Coordinate training efforts to meet training demands through peer shadowing, classroom classes and online presence

- Oversee the auditing of team results and identify gaps in training and implement improvements in training programs

Regulatory & Compliance
Compliance Director is responsible for the following:

- Assure statutory and regulatory compliance
- Maintain the storage and distribution of healthcare records
- Ensure compliance with HIPAA and Medicare guidelines
- Manage and implements the Compliance Program
- Monitor Fraud, Waste and Abuse
- Provides report to CMS

Directors/Managers of each function and the Vice President, Compliance, Chief Operating Officer and Chief Financial Officer oversee administrative functions.

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

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

VICE PRESIDENT MEDICAL MANAGEMENT

Registered Nurse

- Oversee clinical and administrative staff
- Direct and coordinate activities of the medical management department and aids the appropriate corporate staff in formulating and administering organizational and departmental policies
- Review analysis of activities, costs, operations and forecast data to determine department progress and staffing requirements to meet stated goals and objectives
- Serve as a member of management committees on special studies
- Administer and ensure compliance with National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, state and other activities, meetings and seminars

- Participate in provider education and contracting, as necessary
- Develop departmental objectives and organize activities to achieve success
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage, budget and forecast in support of strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, state and/or other accreditation processes
- Ensure compliance of SNP MOC training at hire and annually thereafter for clinical staff
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers, such as hospitals and state agencies, as required to facilitate plan goals and objectives and to ensure the appropriate use of clinical practice guidelines and integrate care transition protocols
- Coordinate with Medical Director to educate and communicate expectations with oversight of appeal and grievance operations

DIRECTOR OF MEDICAL MANAGEMENT

Knowledgeable on Medicare regulations and special needs populations, in addition to being a Licensed RN or Nurse Practitioner

- Oversee clinical and administration of care management services provided to Medicare members including SNP
- Develop department objectives and organizes activities to achieve objectives
- Evaluate and implements changes to medical service functions and performance in relation to company mission, philosophy, objectives and policies
- Manage budget and forecast for strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices
- Analyze statistical utilization data on programs
- Participate in NCQA, State and/or other accreditations of the plan
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers such as hospitals and State agencies, as required, to facilitate the SNP plan goals and objectives
- Coordinate with Medical Director to educate and communicate expectations with providers
- Oversight and management of case management staff and activities

BEHAVIORAL HEALTH MANAGER (PRACTITIONER)

Masters or Doctoral degree in a behavioral health (BH) field and five to seven years of related experience

- Oversee clinical and administrative staff
- Implement, monitor and direct the behavioral health care aspects of Health Net's Care Management and Service Coordination services
- Participate in care management and service coordination rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care serves as the liaison between Health Net and the BH-MCOs

DIRECTOR QUALITY IMPROVEMENT

Licensed RN or Nurse Practitioner, Master level

- Oversee clinical and administrative staff
- Support corporate initiatives through participation on committees and projects
- Develop, review and implement QI activities in coordination with Medicare and State requirements
- Develop, implement, analyze and report Quality Improvement Projects (QIP) and Chronic Care Improvement Projects (CCIP) for the SNP population
- Analyze results of studies and initiate quality improvement projects/initiatives
- Evaluate and recommend performance improvement initiatives and program or process changes to all functional areas
- Research and incorporate best practices into quality improvement initiatives
- Monitor activities to maintain compliance with NCQA accreditation standards
- Coordinate development, documentation and implementation of the QI Program, QI Program Evaluation, and Work Plan including SNP Quality Improvement Program
- Oversee day-to-day operations of the QI Department (QI, Credentialing)

MEDICAL DIRECTOR

Physician who holds an unrestricted license to practice medicine in the state of California and is Board Certified with experience in direct patient care and long term care

- Oversee clinical and administrative staff
- Serve as a clinical resource for CM and members' treating providers
- Work with providers to ensure providers use nationally recognized clinical protocols developed by professional specialty groups or federally funded research (e.g., National Guideline Clearinghouse, Agency for Healthcare Research and Quality (AHRQ), American Medical Association (AMA), etc.)
- Participates in multi-disciplinary rounds on a regular basis to discuss, educate and provide guidance on cases as needed
- Monitor peer-reviewed medical journals to infuse research supported system and practices into Managed Health Service's care management model

- Provide a point of contact for providers with questions about the care management and service coordination processes
- Communicate with practitioners as necessary to discuss care management and service coordination issues
- Review and processing of clinical appeals

PHARMACY DIRECTOR - ENVOLVE PHARMACY SOLUTIONS (PBM)

Registered Pharmacists with active license and clinical expertise

- Oversee clinical and administrative staff
- Ensures compliance with pharmacy requirements and guidelines

CLINICAL PHARMACIST- ENVOLVE PHARMACY SOLUTIONS (PBM)

Registered Pharmacists with active license and clinical expertise

- Ensures there is a consolidated pharmaceutical therapy plan, in conjunction with the members' provider
- Provides member outreach to improve pharmaceutical outcomes as needed to address and try to resolve drug related problems (medication adherence, interactions, etc.)

CARE (CASE) MANAGER II (CM)

Licensed RN (May also hold Certified Care Manager credential)

- Oversee clinical, non-clinical and administrative staff
- Manage SNP members, in particular, those belonging to the most vulnerable populations and requiring LTSS services
- Identify needs and create a care plan, with the help of the member and provider, to help the member achieve their goals
- Support ongoing member engagement with an appropriate medical home
- Address the member's individual needs, strengths, preferences and goals
- Educate members on their conditions and promotes self-management skills including the understanding signs and symptoms that indicate a need to contact the PCP, and when it is appropriate to seek urgent or emergent care
- Support medication adherence
- Engage in member-centric discharge planning
- Ensure timely initiation of post-discharge services and care
- Link members to available community supports
- Coordinate with the behavioral health care managers and providers as needed for members receiving services through the BH MCO
- Communicate and coordinate with the member and their caregivers, practitioners, behavioral health providers, disease management staff and other members of the ICT

to ensure that the member's needs are addressed and care transitions are communicated

MANAGER, MEDICAL MANAGEMENT

Registered Nurse with active license

- Implement changes to medical service functions and performance in relation to Medicare guidelines, company mission, philosophy objectives and policies
- Manage budgets and forecast for strategic planning and key initiatives and balance current future needs effectively
- Research and incorporate best practices into operations.
- Assure compliance of work processes with Medicare Advantage and CMS regulations.
- Responsible for the statistical analysis of utilization data.
- Participates in NCQA accreditation of the Plan.

PROGRAM SPECIALISTS SOCIAL WORKERS (MSW)

Licensed Master's prepared social worker with a background in social services or other applicable health related field

- Works under direction of CM, performing member outreach and care coordination of dually eligible members
- Identify and facilitate access to community resources and social services coordination
- Advocate for the members
- Provide education on benefits and available social services
- Arrange for member transportation
- Assist the CMs in discharge planning and/or transitions to another level of care

PROGRAM COORDINATOR (PC) I

Non-clinical staff person working under the direction and oversight of a CM II.

- Provides administrative support to CC/CM team.
- Collects data and/or completes Health Risk Assessment.
- May participate in providing information to CM II for care plan.

PROGRAM COORDINATOR (PC) II

Highly trained, non-clinical staff person working under the direction and oversight of a CM II.

- Collect data and/or complete for Health Risk Assessment and other surveys
- Supports Manager in operation processes of SNP membership

BEHAVIORAL HEALTH CARE MANAGERS

Licensed Master's or doctoral level clinician with degree in social work, psychology, or related field or equivalent experience with 3+ years of experience in a social service or health care related setting

- Complete BH assessments with member/caregiver/provider to obtain information regarding client status, functional, cognitive capabilities, support system and need for services
- Coordinate chronic condition, disease and health management services
- Monitor delivery of services and follow-up with members/caregivers/providers through member face-to-face assessments and/or reassessments
- Authorize and coordinate referral for services
- Ensure provider services are delivered without gaps and identify functional deficiencies in plans of care
- Assist in coordinating the development of informal or voluntary services to integrate into the ICP
- Collaborate with discharge planners, physicians and other parties to ensure appropriate discharge plan
- Conduct reassessment and update the ICP
- Coordinate acute care, behavioral health, and other services for members

CONCURRENT REVIEW NURSE (RN CASE MANAGERS)

Licensed RN, LPN or LVN

- Manage and monitor member's inpatient staff in coordination with the CM and member's PCP to facilitate discharge arrangements
- Review and audit patient charts through on-site and telephonic review to ensure medical necessity and appropriate level of care
- Act as clinical resources to referral staff and make appropriate referrals
- Provide patient and provider education
- Enter data related to assessments, authorizations and reviews into the system
- Review and audit patient charts through on-site hospital visits

MEMBER CONNECTIONS REPRESENTATIVES

- Perform member outreach, education and home safety assessments
- Assist with community outreach events such as health fairs
- Participate on the Integrated Care Team

MEDICAL MANAGEMENT TRAINER

- Train all Medical Management staff
- Provide support to Provider Relations department on training and education of providers
- Provide training on systems and applications
- Provide further CM training support as requested

PHARMACY TECHNICIAN ENVOLVE PHARMACY SOLUTIONS (PBM)

- Receive and respond to provider/member and pharmacy calls regarding the prior authorization and formulary process
- Intake of complaints and grievances related to the pharmacy prior authorizations

SR. DIRECTOR OF MEDICAL MANAGEMENT

- Develop department objectives and organize activities to achieve objectives
- Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy objectives and policies
- Manage budget and forecast for strategic planning and key initiatives
- Coordinate with operating departments on research and implementation of best practices.
- Responsible for the statistical analysis of utilization data on programs
- Participate in NCQA, State, and/or other accreditations of the Plan
- Organize and present new concepts, programs and tools to staff and other plan departments
- Develop communication plans with external providers such as hospitals and State agencies as required to facilitate plan goals and objectives
- Coordinate with Medical Director to educate and communicate expectations with providers

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

Health Net develops, reviews, approves and maintains role based job descriptions for every employee. These job descriptions create the foundation for all training, supervision, monitoring and feedback regarding employee performance. Job descriptions include roles and responsibilities, reporting structure, education and licensing requirements, as well as the skills and competencies necessary to effectively perform in the position. Initial orientation and training includes a detailed review of the individual's job description. Annual performance evaluations includes an assessment of the employee's performance compared to expectations delineated in the job description.

The organizational charts at the end of this document summarize how Health Net integrates administrative and operational oversight with clinical care coordination for members.

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

Health Net has a contingency plan to avoid a disruption in care and services and ensure continuation of critical services for SNP members when existing staff can

no longer perform their roles and meet their responsibilities. If administrative or executive staff is unable to fulfill their roles, resources are diverted among corporate or regional offices within the Health Net network.

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

In the event of a natural disaster or an emergency, Health Net immediately implements Centene's business continuity plan, which involves diverting calls and services to other regional health plans within the Centene network. This plan ensures continuity of care and service for our members. Due to the sensitive nature of business continuity plans, the information below is a general overview.

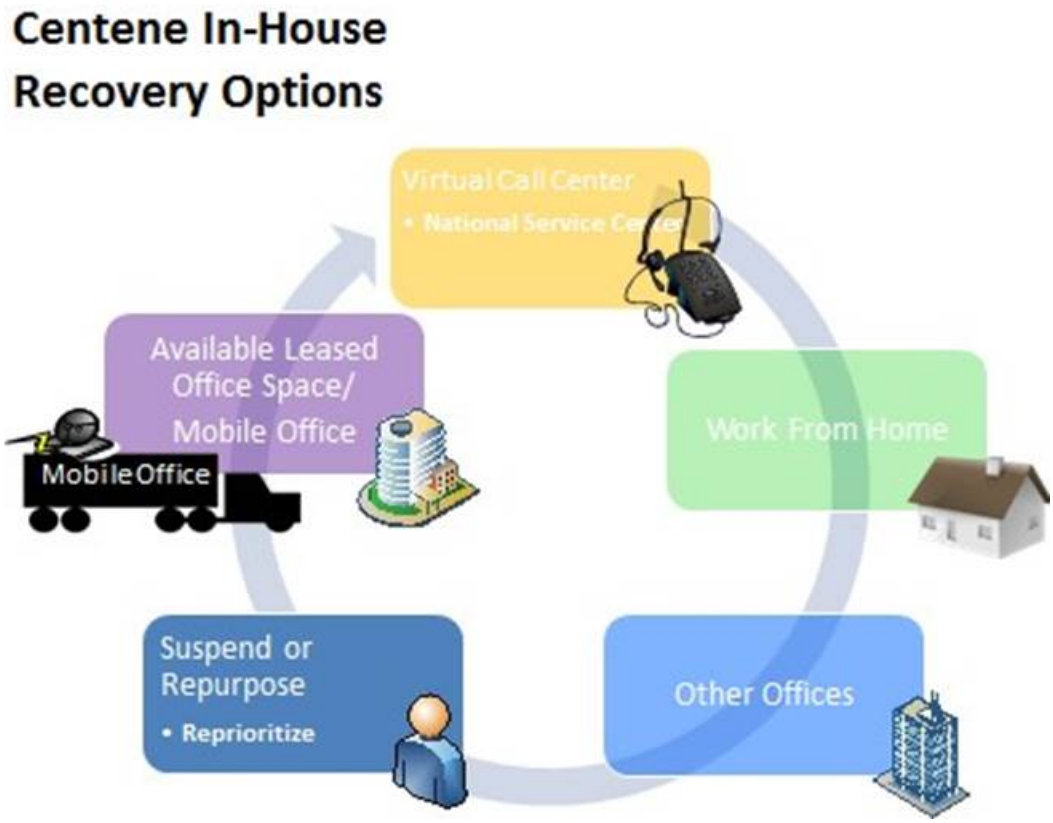
Hierarchy for Decisions

The local business units are organized into a local crisis response team. In the event of a disaster, the local response teams utilize the support of the Centene Crisis Management Team in St. Louis. The Corporate Crisis Management Team reports to Health Net's Executive Management Team.

Business Continuity Governance

Chain or Recovery Options

Options include forwarding Call Center calls to the National Service Center, employees working from home if viable, utilizing other offices within the same State or other Health Net resources throughout the corporation, suspending or repurposing employees to assist as needed, and/or declaring a disaster with our recovery contractor to bring in mobile office trailers, or locate brick and mortar office space through Real Estate Investment Trusts (REITs). One or all of these measures are activated to maintain operations.



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

Health Net requires that employees involved with the SNP program undergo SNP MOC training within 90 days of hire, annually, and on an ad hoc basis when circumstances warrant (e.g., policy change, need for improvement, coaching). The Health Net Compliance Officer, in conjunction with the VP Medical Management, are responsible for the oversight of the delivery of initial and annual web-based MOC training.

Additional mandatory training modules includes information on:

- Compliance Program
- Fraud, Waste and Abuse
- Code of Conduct
- HIPAA
- Cultural Competency
- Conducting administrative activities necessary for the operation of the Part D benefit
- Medicare Marketing

- Marketing the prescription drug benefit to Medicare beneficiaries
- Medicare Member Eligibility
- Medicare Medical Management Training:
    - Medicare Overview Medical Management Operations
    - Medicare Utilization Management Process
    - Medicare Model Of Care
    - Medicare Guidance on Coverage Policy
    - Medicare Jimmo v. Sebelius
    - TruCare Training (electronic medical management system)
    - InterQual Training
- Customer Service and Call Center Operations Standards
- Appeals and Grievance Process
- Administering the compliance program and operations, i.e., the Part D Officer and his/her staff
- Business Ethics and Conduct policy and other compliance related policies, procedures, standards

Health Net's SNP Model of Care training includes informational and interactive slides that cover MOC topics such as: Goals of the MOC, SNP population, Provider network, Additional benefits, Case Management, HRA, ICP, ICT, Care transitions, Coordination of Medicare and Medicaid, and the Quality Improvement Program. A sample from the training slides is included on the next page:

Special Needs Plans (SNPs) Model of Care

Annual Training

Presentation For:
Employees

Cornerstone
2017

Janis E. Carter
Health Net

Health Net

Special Needs Plan (SNP) Background

SNPs were created as part of the Medicare Modernization Act in 2003. Medicare Advantage plans must design special benefit packages for groups with distinct health care needs, providing extra benefits, improving care and decreasing costs for the frail and elderly through improved coordination:

- Dual Eligible or D-SNP for members eligible for Medicare and Medicaid
- Chronic Disease or C-SNP for members with severe or disabling chronic conditions – an initial attestation that patient has specific condition is required from provider
- Institutional or I-SNP for members requiring an institutional level of care or equivalent living in the community

There are 3 distinct types of SNPs.

Health Net SNPs

Health Net has two types of SNPs:

- **D-SNPs** for members that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- **C-SNPs** for members with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required depending on the specific plan:

1. *Diabetes*
2. *Chronic Heart Failure*
3. *Cardiovascular Disorders:*
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region and type of SNP

SNPs provide additional benefits for members

Patient Centric

- Patient is informed of and consents to Case Management
- Patient participates in development of their Care Plan
- Patient agrees to the goals and interventions of their Care Plan
- Patient informed of Interdisciplinary Care Team (ICT) members and meetings
- Patient either participates in the ICT meeting or provides input through the Case Manager and is informed of the outcomes
- Patient satisfaction with the SNP Program is measured annually

Evidence Based Case Management (CM)

- All SNP patients are enrolled in case management and notified of their Case Manager single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and Health Risk Assessment (HRA) to focus resources on most vulnerable (frail, disabled, chronic diseases)
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, Health Net's Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a change in the patients condition or transition of care
- Multiple attempts are made to contact the patient including mailed surveys and e-mail reminders
- The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail
- Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan

Completion of the HRA is also a Star Measure.

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The ICP Addresses All Risks identified in the HRA and/or Other Sources

HRA/Assessment/Claims	Risks
Medical History Gap Reports Utilization Reports	Diabetes Obesity Lack of medication adherence Recent ER visit for fall
Labwork/ biometrics	HgA1c - 9 BMI – 31
Mental Health	Positive depression screen
Health Behaviors	Does not get annual Flu vaccine
Psychosocial	No transportation to Dr. appts

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Goals are Specific, Measureable and Include Date

Risk	Specific and Measurable Goal Established with Patient
Poor Medication Adherence	Patient will report taking diabetes medications daily at each monthly call and will not be on care gap list by March.
Positive Depression Screen	Patient will report discussing emotional health with PCP at next doctor appointment on April 20th.
Obesity – BMI	Patient will lose 5 pounds over next 6 months
Fall Risk	Patient will report going to gym once per week during monthly calls
Lack of Annual Flu vaccine	Patient will get flu vaccine by November 1.
Lack of transportation	Patient will successfully utilize transportation benefit for next doctor appointment on April 20th

A goal is identified for each risk.

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ICP Includes Actions to Achieve Goals

Risks	Actions to Achieve Goals
Poor control of Diabetes Obesity Poor medication adherence Recent ER visit for fall	Provide Diabetes and diet education. Set exercise and weight loss goals with patient Review medication regime and provide adherence tips to address individual barriers Fall prevention education and to discuss with doctor
HgA1c - 9 BMI – 31	Monitor lab work and weight for improvement
Positive depression screen	Referral to MHN
Does not get annual Flu vaccine	Educate on importance of vaccine, address barriers to obtaining vaccine
No transportation to Dr. appts	Educate on benefit and provide contact information

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Implementation of the ICP is Documented

Goal	Case Manager Notes
Poor Control of Diabetes	*Reviewed diet with patient – she reports eating smaller portions since last call and diet education.*
Poor Medication Adherence	*Review of diabetes medications and proper admin– patient verbalizes understanding. Encouraged to use pill box.*
Positive Depression Screen	*Patient refused referral to MHN – states she will discuss with her doctor at April visit.*
Obesity – BMI	*Patient states she only lost 2 lbs at Doctor visit yesterday. Reviewed concept of steady and slow weight loss.*
Fall Risk	*Patient reports she is taking 15 minute walk once a day and will increase to 20 minutes next week.*
Lack of Annual Flu Vaccine	*Review of importance of Flu vaccine – patient still concerned it will make her sick. Addressed barriers.*
Lack of Transportation	*Patient has contacted transportation company and arranged ride to 4/20 Dr. appointment*

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Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT which communicates regularly to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members

Medical Expert
Social Services Expert
Mental/Behavioral Health Expert – when indicated

- Additional Team Members could be

Pharmacist
Health Educator
Restorative Therapist
Nutrition Specialist
Nursing/Disease Management

- Communication plan for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers

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Care Transition Protocols

Good transitional care is key to decrease readmissions.

Patients are at risk of adverse outcomes when there is transition between settings (in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health)

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medications, treatments, providers and contacts) of the patient's care plan transferred between care settings before, during and after a transition
- Patient knows their health information and can communicate to other healthcare providers in different settings
- Patient is educated about health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

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Specialized Provider Network

- A comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners is provided to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided internally when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts audits to monitor that delegated medical groups meet the SNP Model of Care requirements

Providers are also required to complete Model of Care training.

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Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program offers:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal


Diabetes — Summary of Medical Guide

Adult

Exam/Test	Type 1
Risk	
Complete exam	
Glycemic control	

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D-SNPs -Coordinating Medicare and Medicaid

The goals for coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members are informed of benefits offered by both programs
- Members are assisted to maintain Medicaid eligibility
- Member has access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid

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Quality Improvement Program

Health Plans offering a SNP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met
- Collecting SNP specific HEDIS® measures (see appendix)
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the SNP population
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness.
- Communicating goal outcomes to stakeholders

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Care Management and Service Coordination Staff Training

Care Management and Service Coordination staff receive, at time of hire and annually Medicare Boot Camp Training that includes, but are not limited to the following:

- Care Management and Service Coordination policies and procedures and regulatory requirements
- Member-Centered Care Planning
- Care Manager / Care Coordinator roles and responsibilities
- Motivational interviewing and readiness to change techniques
- Medicare Assessments
- Member Outreach
- Documentation
- ICP and ICT Processes
- Care Transitions
- Provider Relations
- Member Outcomes
- Care Management and Service Coordination (including appropriate documentation of tasks in TruCare)
- Behavior management strategies
- Behavioral health 101
- De-escalation techniques

Training to Ensure Coordination of Benefits. Staff receive Medicare/Medicaid specific training that describes how the programs intertwine and their specific roles and responsibilities when a member is enrolled in the SNP:

- Coordination and management of dual Members
- Specific characteristics of the population
- Services to meet specialized needs
- Medicare and Medicaid covered benefits
- Engagement techniques

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

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

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

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

Coordination of Benefits and Dual Appeals and Grievance Training. The Managers of Medical Management and Trainers provide additional training specific for integrated care team staff regarding coordination of Medicare/Medicaid, Members rights and responsibilities, appeal and grievance policies, procedures and processes.

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

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

The appropriate department Directors, Managers, and Supervisors are responsible for oversight of the SNP Model of Care training for their respective departments and associates. 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 SNP Model of Care. This training may be offered in a classroom, teleconference, or self-study environment as appropriate.

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

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

Challenges with employed and contracted staff completing the SNP MOC training include the time taken away from the regular workday to complete the training, repetitiveness of annual

training and time for managers to monitor that training is completed. To address these issues, the training is updated regularly, is interactive and informative and can be completed in a reasonable amount of time. The tracking system allows managers to run reports showing any associates that have not completed the training.

MOC 2.B HEALTH RISK ASSESSMENT TOOL (HRAT)

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

Health Risk Assessment Tool (HRAT). The Health Risk Assessment (HRA) tool is an internally designed tool developed to identify the needs of SNP plan members by evaluating medical, psychological, functional, environmental, social and cognitive needs. The assessment also gauges the member's medical and mental health history to effectively coordinate care and identify any barriers that should be addressed to improve care outcomes. The HRA generates the initial list of problems based on the member's self-reported data, and based on a scoring methodology, determines the level of severity/risk.

Member Engagement and Initial Assessment. For the initial screening, the Vendor staff contacts the member to conduct the HRA within 90 days of the member's effective date. If vendor contacts are unsuccessful the Care Team conducts at least three phone attempts made at different dates and times to engage the member. All outreach attempts (successful or unsuccessful) are documented in a Care Management/Service Coordination Outreach note in the clinical documentation system (TruCare). When CM or other staff call members for other purposes and notice that the HRA has not been completed, they attempt to complete the assessment. Members unable to be contacted via telephone are mailed a letter requesting that they call the care management team. Outreach continues to complete the assessments of those members unable to be reached within 90 days. CM staff research available information such as claims, pharmaceutical, providers for additional contact information when unable to reach member.

Risk Stratification and Development of ICT. Once the HRA is completed, reviewed and scored, the CM updates the ICP. The CM, based on the initial HRA results, assists the member in choosing the members of their Interdisciplinary Care Team (ICT). The member may include, their PCP and any healthcare professionals and other support individuals of their choice. The ICT helps develop the Individualized Care Plan (ICP). If the HRA not completed, CM reviews other available information such as pharmacy, utilization and claims to complete an ICP for every member.

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

Sharing the Results of the HRAT with the ICT and Creation of ICP. The CM contacts the member and/or caregiver via phone, the various problems and member goals identified are discussed, treatment and service options are presented to the member/caregiver, and the ICP is developed/updated, which includes goals, interventions and time frames.

Using the HRAT Results to Update the ICP. Annually thereafter, or when the member's conditions or health status changes significantly, such as an inpatient admission or transition to a higher level of care, the HRA is updated by the CM or other assigned staff with CM oversight. Results of the updated HRA are discussed with the members of the ICT. The member and/or caregiver is invited to participate in the ICT meeting, and the ICP is revised and adjusted to reflect member needs and preferences and any changes identified by the HRA. The member retains the right to change who participates on the ICT at any time.

Tools to be utilized are approved and based on our population characteristics.

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

Health Net conducts an initial comprehensive Health Risk Assessment (HRA) for each new SNP member to evaluate the individual's physical, psychosocial, and functional needs. An annual reassessment is conducted for each of the SNP member as part of the ongoing care plan evaluation. The HRA assessment can be performed telephonically, electronically or by mail. To achieve this, the following procedures are followed:

- Vendor or case manager performs telephonic outreach to complete the HRA with all new SNP members within 90 days.
- If the member was not reached via telephone after three attempts, the HRA is mailed to the member to complete within the first 90 days of enrollment. A postage paid return envelope is provided to assist the member with returning the information.
- HN Case Managers can also complete the HRA directly into the electronic medical management system if they contact a member who has not completed the HRA or if there is a change in member status
- The vendor is provided in advance with the list of continuing members due for a reassessment HRA so it can be completed within one year of the initial or previous HRA
- HN Case Managers also reach out to members who have refused to participate in case management upon a change in status such as a hospitalization and at least annually to promote case management services and complete the HRA if the member agrees

- Information/data collected from the HRA is evaluated to determine individual members' needs and assists with development of a Care Plan and coordination of care and shared with the Interdisciplinary Care Team members.

The Care Plan and member needs are re-evaluated on a regular basis, such as when the annual HRA reassessment is completed or updated as member health status changes, or a care transition has occurred to ensure that the Care Manager has the most current physical, psychosocial, and functional needs information for effective, timely and continuous patient care coordination.

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

Once the initial HRA has been completed, it is updated as needed based on changes to the member's health, functional and environmental conditions, transition in care or increased risk for hospitalization based on information provided through predictive modeling. All assessments are documented in TruCare with date/time stamps for each activity, including documentation of the CM or other staff completing the activity. Each HRA is scored based on an algorithm that weights members' responses and their individual clinical assessment.

Communicating Information to the ICT. Member clinical status, HRA results and other clinical data is shared during the ICT meetings. The ICP is updated based on ICT discussion and includes interventions and goals, and the associated timeframes. The updated ICP may be shared with the member/caregiver face-to-face, verbally by phone or sent via mail.

Using HRAT Results to Improve the Care Management Process. CM frequency of member contact to assess progress with the new ICP is determined by the level of the member's risk score and acuity level. Frequency of contacts is adjusted based on member's preference and progress based on CM clinical judgment.

- High – Including members identified as "most vulnerable"
    - Minimum continuous monitoring and review/outreach every 30 days; or more frequently as needed
    - Completion of an ICP no later than 120 days of enrollment
    - Telephonic reassessment when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, his/her caregiver or provider
- Moderate – Identified inpatient and post discharge individuals.
    - Close monitoring during the post discharge period for 30-60 days.
    - Update of the ICP during the 30-60 day period.

- Telephonic reassessment during the 30-60 days period to consider appropriate re-stratification to High or Low.

- Low – Member is stable but results of the Medicare CM Assessment/HRA indicate risk for a potential complication
  - Minimum continuous monitoring and review/outreach once a year or more frequently as needed
  - Completion of an ICP no later than 120 days of enrollment
  - Telephonic reassessment when there is a change in the member's health status or needs, a significant health care event, or as requested by the member, his/her caregiver or provider

MOC 2.C INIDVIDUALIZED CARE PLAN (ICP)

MOC 2.C.1 Essential Components of the ICP

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

Essential Elements of the ICP - The ICP includes self-management goals and objectives, a description of authorized services specifically tailored to the member's needs including type, duration, frequency, and provider, timeframe for reassessment, short and long-term goals for health promotion and prevention, referrals and interventions, barriers, the member's personal healthcare needs and preferences, and timeframes for completion.

An ICP typically includes the following:

- Prioritized goals – both short term and long term goals are determined with the member and are specific, measurable, attainable, realistic and timely
- Identification of barriers to meeting goals and person-centered recommended solutions for each barrier including language, cultural/spiritual preferences, literacy (general and health), functional impairments, sensory and/or cognitive impairments, motivation, health disparities, access (geographic location, transportation), and lack of family, caregiver and/or informal supports
- Resources to be utilized, including appropriate level of care and member preference

- Interventions based on the member's identified problems, strengths, resources, barriers and agreed upon goals
- Self-management plans created to support members in managing their health, including specific technology supports, tools, and disease management/health education
- Collaboration with ICT including involvement of family, caregivers, providers and other formal and informal supports
- Schedule for ongoing communication with the member and ICT, based on acuity, needs, preferences and agreed upon goals
- Timeframes and interim outcomes that create points in time for which achievement towards goals is measured, including the specific manner in which progress is demonstrated
- Education provided to the member, family/caregiver including written materials, telephonic or in person education, health coaching, and referral to other available information such as that found on the member/caregiver portals or through community organizations and advocacy groups (e.g. Alzheimer's Association, Brain Injury Association of PA, etc.)

Interventions and Activities Included in the ICP - Interventions and activities may include care coordination for authorization of needed services such as transportation, home health care, equipment, supplies, ancillary services such as physical, occupational or other rehabilitation therapies, and referrals for preventive screenings. They also include health education needs, member self-management activities and goals, and evidence based disease management parameters such as HgbA1c every 6 months and annual dilated eye exam for diabetics. The ICP identifies barriers to achieving goals (financial, cultural, linguistic, lack of family support, cognitive impairments, etc.) and the strategies for overcoming these barriers. Finally, the ICP identifies gaps in care and services that require mitigation and the method for obtaining needed care and service, including collaboration and coordination of care and services provided by other health care and community based organizations, and supports (in-home meals, home repair, falls assessment, in-home support services, etc.). Interventions may include, but are not limited to the following:

- Guiding the member in achieving optimal health through the monitoring of specific clinical indicators
- Coordinating covered and non-covered benefits
- Coordinating inpatient and outpatient services
- Managing transitions in care settings.
- Educating member and supporting self-management activities
- Addressing barriers to care, including access to non-network providers as appropriate
- Assessing outcomes and updating the ICP on a regular basis

- Assisting with referrals to services appropriate for members nearing end of life such as Advanced Directives or hospice care
- Arranging for in-home visits to assess risk for falls and needed accommodations

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

The member and/or member's caregiver is included in the ICP development whenever possible, and information from the primary care provider, specialists, non-professional caregivers, health records, specialist records and pharmacy data are used to aid in the full development of the ICP. Every member of the ICT aims for ensuring the member and/or his or her caregiver is engaged and empowered within the process and in decision-making. Health Net employees empower members and/or caregivers through education, open communication, and partnership. Such empowerment encourages member and caregiver involvement, engagement and improved success in meeting established goals.

CM as "One Point of Contact" - In the course of developing the ICP, referrals are made, as needed, to the appropriate team members/providers of needed care. For example, if the individual indicated difficulty with housing, utilities, buying food or other financial concerns, the assigned CM would provide linkage to community resources if appropriate, and communicate the results back to the ICT. However, if behavioral health needs are identified, the CM coordinates with the BH providers to ensure a whole person approach towards care management. Wherever possible, the CM serves as the single/one point of contact for the member, but is responsible for introducing to the member and/or their caregiver to any new members of the team prior to any outreach by these individuals. The intent of this outreach is to ensure the member and/or their caregiver is aware of the role this new individual has, along with when they can anticipate outreach/contact. For example, the CM introduces the DM Health Coach in cases where health education and outreach is included as an intervention in the ICP.

Assessment – During the assessment process, the CM collects information about the member's mental and physical condition, functional status, and formal and informal social support system to identify their needs and develop the ICP. In addition to information collected during the assessment, supplemental information is gathered from other relevant sources (i.e. primary care provider, professional caregivers, non-professional caregivers, health records, and educational institutions/records, historical claims data, prior assessment, etc.), which are utilized to further refine the ICP. Ongoing reassessments occur when there is a change in the member's health status or needs, a significant healthcare event, or as requested by the member, their PCP or their caregiver.

Identifying problems **–** The CM asks open- and closed-ended questions to obtain key information. He/she practices active listening to appropriately identify the member's problems.

In order to achieve the best possible health outcome, the CM collaborates with the member, his or her circle of support/caregiver, and the PCP to identify problems and barriers to meeting goals. Examples of identified problems/barriers may include but are not limited to:

- Lack of knowledge about disease process
- Lack of available resources
- Limited or no family support
- Psycho-social needs
- Low literacy/health literacy
- Language and culture
- No transportation or ability to schedule appointments

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

Establishing goals – The CM collaborates with the member/caregiver, provider, and ICT members when establishing care plan goals and a member driven self-management plan. The care plan includes the member's preferences and a description of the services tailored to the member's needs. The goals are specific, realistic, individualized and measurable.

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

Implementing Interventions – The CM executes specific care management activities and/or interventions to accomplish the goals in the ICP. Selected interventions are usually inclusive of the member's willingness to participate, time sensitive and measurable. For example a CM may do the following:

- Implement a self-management plan which demonstrates:
    - Documentation of the action the member takes to improve the care
    - Documentation of member agreement to perform the action
- Document actions the CM takes in monitoring the ICP to ensure member compliance

- Identify/contract with providers needing to be involved
- Identify services or equipment which are not a covered benefit but may be a cost effective intervention
- Provide education based on health education needs
- Educate on medication
- Reinforce and explain why the member needs to be adherent to treatment plan
- Anticipate any obstacle to meeting treatment goals (e.g., transportation, ability to schedule appointments)
- Establish effective date for start of services
- Contact member and/or caregiver and initiate education and other activities

Evaluation and Reassessment - The CM performs ongoing assessments in order to evaluate the member's progress toward the goals or identify barriers impeding the achievement of such goals. The CM completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year.

Updating the ICP - The CM updates the ICP at least annually, and at the time of a significant change in status (inpatient hospitalization, change in level of care or care setting, etc.) and/or, as needed, in response to other information obtained. Examples could be HRAT re-assessments; information obtained from providers, members and caregivers; claims data that may identify patterns of over or under-utilization including medication non-adherence; and any additional information related to health conditions, functional status, barriers to care, community supports and the member's response to interventions in the existing care. Updates are based on the member's status, needs, and preferences including cultural and linguistic preferences. The CM and ICT rely upon evidence-based practices in developing appropriate interventions.

Changing Risk Categories - For example, a member who is stratified as low risk but has an admission, new diagnosis, or increased utilization is reassessed to determine if there are changes in his/her health and/or and functional status that require him/her to be placed at a higher risk level with associated adjustments in the ICP. Members may temporarily move to a higher risk level during an acute phase of care (i.e. a member who has elective joint replacement surgery with full recovery) or from a higher level to a lower level as their health and functional status improves as a result of attaining self-management goals (i.e. a member with diabetes achieves stable blood glucose levels through medication adjustments and improved dietary habits). This often leads to a modification or change in the care management/care coordination plan in its entirety or in any of its component parts, as follows:

- Determine if treatment ICP goals have been attained (the goals are evaluated and refined based on member acuity)
- Measure member/caregiver/significant other's satisfaction with services

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

MOC 2.C.3 Personnel responsible for development of the ICP including member/caregiver involvement

The assigned CM is responsible for the development of the ICP, in collaboration with the members and/or their family/caregiver, and the members of the ICT. CMs may be assigned high, moderate or low risk members. High risk BH members may be assigned to BH CMs that can best meet their needs.

The CM continuously attempts to engage the member/designee and provider(s) in care planning discussions related to goals, preferences, activities and interventions. Our CM is trained in motivational interviewing and member engagement strategies in order to maximize member engagement in care planning. Copies of the ICP are provided to the member/designee and PCP upon request and the document is used to guide discussion during telephonic contacts. Our goal is for the individual care plan to be a "living document" that provides a framework for managing the member's care and services. As a member's needs and preferences evolve over time, the care plan, along with the composition of the Integrated Care Team, also evolves and changes.

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

Documentation -All documentation of assessments, ICP and related follow-up communications are captured and updated in TruCare, our clinical documentation system. This system is only accessible by Health Net staff; however, the ICP is shared via facsimile/mail/telephone to the primary care providers. Member records are maintained in accordance with HIPAA, state and federal privacy laws and professional standards of health information management.

Oversight - The CM is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers or other involved parties. The information available in TruCare includes, but is not limited to the following:

- Notes, including a summary of team conferences and all communications with the member/family, healthcare providers and any other parties pertaining to the member's care
- Physician treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available

- Facility admission information and discharge plans
- MemberConnections outreach attempts to connect with a hard-to-reach or unable to locate member
- The ICP, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc.

Using Evidence Based Criteria - The CM is trained in the Medicare, Medicaid benefits, and supplemental benefits offered to the most vulnerable SNP population. Training enables the CM to facilitate care for the member through the prior authorization process and educating the member as to available benefits and community services and other supports. CMs have access to evidence-based clinical resources to help determine standards of care for this population. Health Net provides the following resources of medical criteria:

- InterQual® Care Planning Procedures Criteria
- National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) policies for Medicare Part A & B services
- Clinical coverage and practice guidelines

Communicating Changes in Member Status to the ICT - The CM is in a unique position to know and understand all facets of the member's condition and abilities. It is the responsibility of the CM, as a member of the ICT, to inform other team members about any changes in the member's health status so that the team is able to track the progress of the ICP and make any modifications needed to improve outcomes or support a member during a significant health event or transition in care.

Reviewing, Analyzing and Updating the ICP - The ICT, as the on-going evaluation of the ICP occurs, continues to change in order to include other members so as to ensure the member has access and coordination of all needed care. The ICT, led by the CM, are responsible for reviewing, analyzing and revising of the care plan with a multi-disciplinary focus. The ICT also considers alternatives for health care delivery, available funding options, and other methods to help the member progress.

The ICP is reviewed and modified by the CM for any significant life/health event as needed, but no less than annually after the initial assessment. Modifications involve the entire ICT, including the member and/or their caregiver. The CM or a member of the ICT team completes the ICP changes after the review and with the assistance of the full ICT, and with the involvement of the member or member's caregiver. The PCP's input is critical as well.

Life/health events may include recent new diagnoses or complications of prior diagnoses, recent hospital stays, caregiver changes, living arrangement changes, or even financial changes. Revisions need to be reasonable, understood and accepted by the member and/or their caregiver to encourage full and active participation with the ICP.

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

Members and their caregivers are engaged in any changes to the ICP and providers are notified anytime there is a change in the ICP. Communication may be verbal or in writing. All communication is documented in TruCare.
ICP communications may occur in a variety of formats based on the member's care coordination needs including, but not limited to:

- Face-to-face meetings – Internal or external meeting with caregivers (with or without other members of the ICT, such as a home health care nurse, or members of our internal integrated care team)
- Telephonic – Direct calls with member/member's representative and/or providers
- Case reviews/rounds - Internal meetings with ICT

MOC 2.D INTERDISCIPLINARY CARE TEAM (ICT)

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

Health Net has an Integrated Care Team (ICT), which may utilize Program Specialists, Care Managers, Pharmacy Coordinators, Behavioral Health Coordinators, Program Coordinators, Member Connections Representatives, pharmacists and Medical Directors. The external team is comprised of primary care providers, specialty care providers, behavioral health providers, ancillary services, community based organization representatives, faith-based representatives, various state agencies, and other members as appropriate to the member's needs and preferences. The member is invited to participate as well.

ICTs are generally comprised of multidisciplinary clinical and nonclinical staff and are led by CM with support by Medical Directors. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, which permits the licensed professional staff to focus on the more complex and clinically based service coordination needs, works closely with the utilization management staff to coordinate care when members are hospitalized and assist with discharge planning and prior authorization activities. The teams utilize a common clinical documentation system to maintain centralized health information for each member, which includes medical, behavioral health and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated, based on severity and complexity of the member's needs**.**

The following are the individuals who are involved in the Care Management functions performed by Health Net:

Medical Director The Medical Director oversees the care management program and ICTs and is responsible for managing the medical review activities pertaining to care and service coordination, utilization review, quality improvement, complex, investigational and/or experimental services. The Medical Director assures that providers use and adhere to appropriate clinical practice guidelines and integrated care transition protocols. In conjunction with the Vice President of Medical Management, the Medical Director evaluates the effectiveness of the care management and care coordination programs at least annually.

Vice President of Medical Management The Vice President of Medical Management is responsible for the day-to-day operations and clinical oversight of the care management program including compliance and preservation of MMP medical information in accordance with HIPAA and contractual requirements. The Vice President of Medical Management monitors the provision of services to assure there is a seamless transition of care across settings and providers and that clinical services are appropriate and timely. These functions are accomplished by regularly occurring audits and random attendance at ICT meetings.

Care Managers Care Managers (CM) are experienced RN case managers (preferably with CCM certification). CMs establish and implement the ICP/ICT for D-SNP members not receiving LTSS, coordinate team activities to ensure that needed care and services are provided, outreach to obtain authorization for necessary care services, educate members on self-management techniques, and provide ongoing assessment of the member's response to care and services. CMs work directly with the member and his/her support system to achieve an optimal level of health and function. They hold a key position in the ICT.

Program Specialists Masters prepared social workers are responsible for the identification and facilitation of access to community resources and social services coordination for D-SNP members not receiving LTSS services. They hold a vital membership position on the ICT. Social workers advocate for the members, provide education on benefits and available social services, make arrangements for member transportation, and assist with discharge planning.

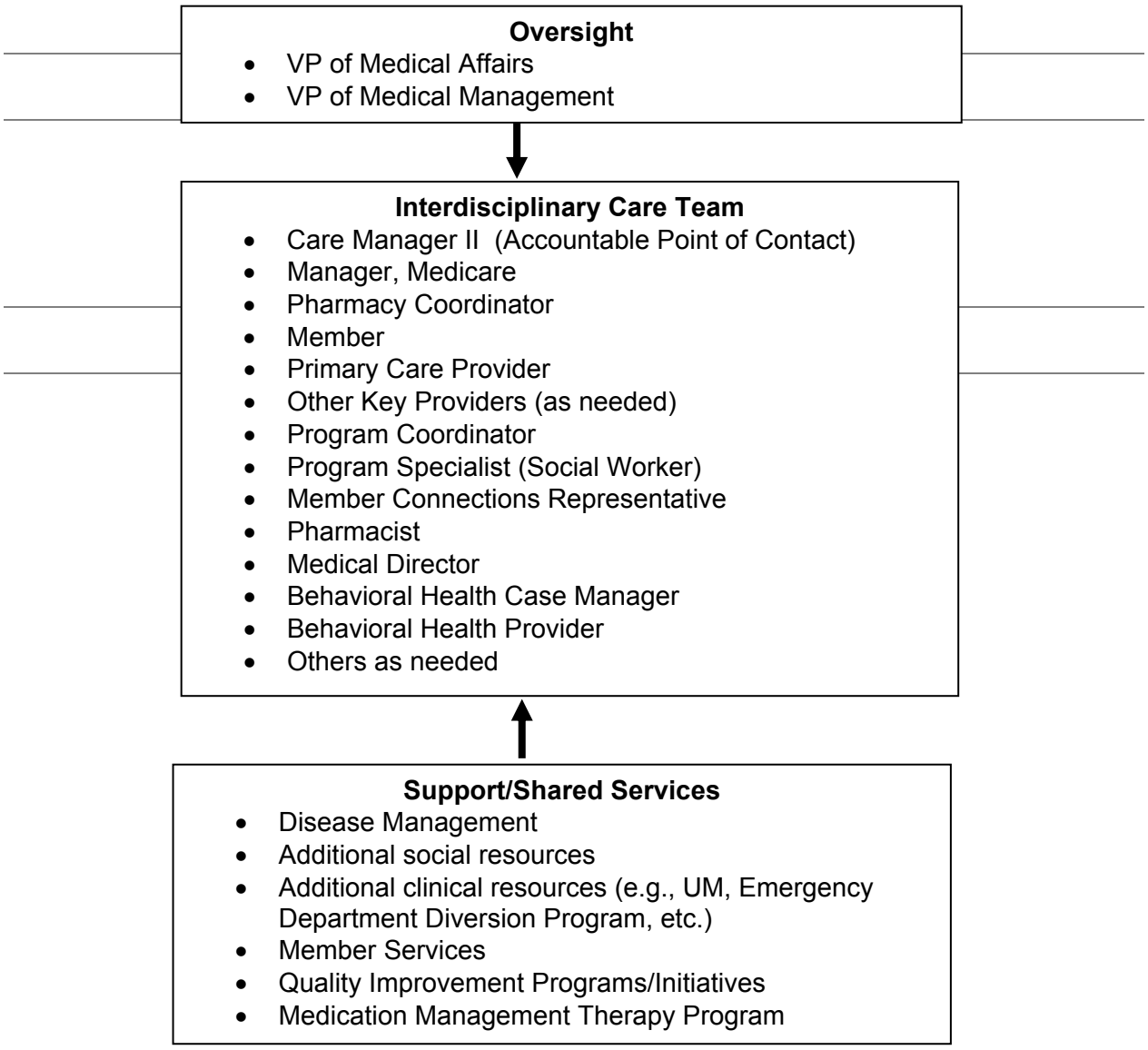
Program Coordinators The Program Coordinators have administrative and clinical support experience and are utilized to collect member and/or provider demographic information, completing data entry, establish case files, coordinate non-clinical services and provide administrative support to the team as needed. Program Coordinators may also assist the CM in scheduling appointments and following up on services for the D-SNP member.

Behavioral Health Case Manager The Behavioral Health Case Manager is the team member with the primary responsibility of ensuring behavioral health needs are identified and addressed. In addition to participating on the ICT, the Behavioral Health Case Manager also

attends the integrated care management rounds to facilitate identification of behavioral health issues for D-SNP members.

Pharmacist/Pharmacy Coordinator The pharmacist and/or pharmacy coordinator, in conjunction with the member's provider, ensures there is a consolidated pharmaceutical therapy plan, identify drug interactions, minimize side effects, and work with the D-SNP members to establish a pharmaceutical therapy program.

Utilization Review (UM/CM) Nurses/Manager The Utilization Nurse/Case manager (RN) reviews the appropriateness of medical service requests to promote efficiency and maximize allocation of resources. The manager provides operational and administrate oversight to this department.



The Medical Director and the Vice President of Medical Management are responsible for articulating a clear vision for Health Net's Care Management and Care Coordination Programs and ensuring the appropriate Health Net staff is available to participate in the ICT.

Challenges around member access to providers, care and/or services are communicated directly to Provider Services. The Director of Medical Management is responsible for semi-annual review and reporting of ICT activities to the Utilization Management Committee (UMC).

Interdisciplinary Case Review Rounds - the CM leads weekly interdisciplinary case review rounds. The Medical Director participates during rounds to review identified complex cases as appropriate. The Medical Director is board certified and licensed in an appropriate discipline.

Each team includes, but is not limited to:

- Care Manager
- Pharmacist
- Member Connections Representatives (as needed)
- Utilization review (UM) nurses (as needed)
- Behavioral health Case Manager/ Mental health specialist
- PCP and Specialty providers

Member Engagement in the ICP Development - The ICT facilitates the participation of the member and the member's caregiver or other members of their circle of support in the development of the ICP. The member may participate in person, via telephone or through written information provided by the member/caregiver, depending on the status and/or the member's preference. Health Net may attempt to engage members during home assessments, during concurrent review and discharge planning, via telephonic contacts, and through follow up outreach letters targeting specific members and more generically through the use of a member newsletter. Our goal is to ensure the member/caregiver is able to actively participate in the development of an ICP that increases self-management, improves mobility and functional status, addresses limitations and barriers, establishes reasonable goals and creates an improved satisfaction with health status and healthcare services that result in improved quality of life. In compliance with CMS regulations, Health Net may offer member incentives to increase the member's participation in self-management.

Additional Sources of Information - Information from the primary care provider, specialists, non-professional caregivers, health records, specialist records, pharmacy data and predictive modeling aids in the full development of the ICP. The member's involvement is critical as this allows the member to be engaged in their own care and service management.

Documentation of the ICP - The CM assigned to the member is responsible for the facilitation of communication among the team and documentation of the ICP in TruCare.

ICT Role in Transitions of Care - In our efforts to maintain an ongoing partnership and to improve a member's status/condition, we have staff (i.e., Utilization Management Nurses) available telephonically for all facilities, to promote transition of care. Our goals and objectives are below:

- Early identification of members not engaged in care/service management services
- Increase identification, coordination and member awareness of discharge planning needs

- Ongoing partnership/relationship with area providers

To achieve our objectives, we may also conduct onsite health risk assessments of members and provide education regarding health options, community resources, member diagnosis/condition, and plan benefits (transportation, etc.). The CMs and the onsite staff also serve as liaisons between the facilities, PCP and the ICT. CMs assist members that were a "no show" for their scheduled follow-up appointments with rescheduling. All staff document interactions in TruCare.

Health Net's Member Handbook includes a clear description of the Care Management program.

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

Roles and Responsibilities of ICT Members - Each member of the ICT, including the member, caregivers, PCP and CM contribute to the development and implementation of an effective interdisciplinary care process by offering personal, professional and cultural knowledge and perspectives.

- Clinical Staff, including physicians, registered nurses, pharmacists, nutritional and rehabilitation specialists provide input on evidence based clinical guidelines and standards of care, specific disease states and medical conditions and available therapies.
- Social Workers contribute knowledge of the bio-psychosocial and financial impacts of chronic illness and disability as well as the social supports available to our members.
- Behavioral Health Case Managers lend expertise on integrating physical and behavioral care and services and linking members to the appropriate behavioral health providers.
- Primary Care Providers share the member's medical history, including both successful and unsuccessful treatments, the member's level of health literacy and understanding of their disease, their ability to self-manage and any issues of non-adherence to prescribed treatment. Our primary care providers are trained on conducting assessments, including the types of information that should be forwarded to the ICT for inclusion in the care planning.
- Members and their caregivers are able to interpret the member's personal experience for the team, including cultural context, health care and functional goals, perceived needs, barriers and preferences, and choice of least restrictive setting, allowing the team to customize a care and service plan of activities and interventions to meet the needs of the individual member.

Leveraging Information to Improve Member Outcomes – Health Net's CMs make use of all available data, including historical and ongoing claims data, in home assessments, pharmacy

data, utilization data, information obtained from members, caregivers, providers and formal and informal supports, to achieve a better overall understanding of the health status (physical and mental) and functional status of D-SNP members. In-home assessments often identify acute as well as chronic issues of concern. The CM ensures that acute issues are quickly brought to the attention of the member's PCP and the chronic issues of concern are brought into the ICT process and addressed in the member's ICP.

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

Member-Centric Team Approach - The composition of the ICT is member-centric and is designed to improve the health status of dual D-SNP members by offering an integrated, person centered approach to care planning and service coordination. Team members are selected based on the individual needs and preferences of the member and their ability to offer knowledge and expertise in developing an ICP that best meets the unique needs of an individual member. The ICT is responsible for the following:

- Developing and implementing individualized care plan with the member and/or caregiver's participation
- Conducting care coordination meetings on regular basis, according to the member's condition and needs; these meetings may be held face-to-face, via conference call or web-based interface
- Conducting regular case review meetings
- Detecting possible transitions in care or change in health status after a request for prior authorization is received from the member's PCP or facility
- Distributing reports to team members
- Maintaining records of team meetings
- Documenting meetings using the "Interdisciplinary Care Team" note type in TruCare

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

It is the responsibility of the CM to facilitate communication among the member/caregiver and applicable team members and to ensure documentation of ongoing information exchange. All Health Net staff involved in the member's care has access to the TruCare record and document all interactions with the member, including authorizations and care plans.

ICT Communication - Case review rounds are conducted weekly, with individual members discussed as frequently as necessary, based upon their complexity and level of need. During the meetings, the team discusses the progress of the member and provide recommendations for changes to the ICP. The Medical Director may reach out to the member's physicians to obtain clinical information on an as needed basis. The ICP is available on the

member/caregiver and Provider portals, along with care gap alerts. The Provider portal also includes a Member Health Record.

Communicating Health Information to Members and Providers - In addition to developing, implementing, and communicating the ICP, Health Net develops educational newsletters intended for both the members and contracted providers that address general health information, and introduce standards of care and services in addition to reminders for ongoing care such as preventive health services or smoking cessation.

Resolving Communication Barriers - To overcome communication barriers, and support member's engagement in care and service planning, the following strategies enhance communication with members who have hearing impairment, language barriers and/or cognitive deficiencies:

- Hearing impaired: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
  - Speech reading (lip reading)
  - Written and visual aids
  - Visual language systems (telecommunications device for the deaf TDD)
  - Interpreters

- Language barrier:
  - Health Net utilizes translation services when no staff is available to provide translation services.
  - Members may request to have printed materials translated into another language free of charge

- Cognitive deficiencies: Depending on the degree of impairment, the following combination of techniques may be used to enhance communication:
  - Repeat information
  - Write important elements; use pictures
  - Choose best time of day to communicate
  - Keep the environment calm
  - Keep the environment quiet
  - Keep the communication simple and/or going slowly

Documenting and Addressing Member Dissatisfaction - Any member complaint or grievance identified by the ICT in their interaction with the member, their caregiver, or provider is carefully recorded and forwarded immediately to the Grievance and Appeals department for resolution and tracking.

Ongoing Communication Strategies - The success of the ICT in developing, maintaining, and updating a person centered ICP depends on strong communication. To that end, Health Net

develops several avenues for communication. The ICT (including the member/caregiver) is kept informed through conference calls, email communications, mailings and reports. The ICP is available to ICT staff in TruCare. To ensure complete and consistent documentation Health Net documents all ICT reviews and activities in TruCare.

MOC 2.E CARE TRANSITION PROTOCOLS

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

Health Net uses comprehensive, member-centric discharge planning policies and procedures to ensure seamless, safe transitions and to reduce the risk of readmissions. CMs conduct discharge planning and post-discharge follow-up using policies, procedures and processes described in the SNP Transition of Care/Post Hospital Discharge Call work process.

The Transition of Care Work Process coordinates care for members moving from one care setting to another to ensure continued quality of care, reduce any potential risk to member safety, and facilitate a controlled plan so that the member receives care in the least restrictive care setting. Transitional care settings include the member's home, active home health care, acute care facilities, nursing facilities (skilled and custodial), and rehabilitation facilities. Transitions from one care setting to another involve both planned and unplanned transitions

Below we describe:

- Key elements of discharge planning policies and procedures
- Pre-discharge activities, including collaboration with the member/family and community resources involved at discharge and thereafter
- Follow-up activities after discharge to support a successful transition and reduce readmission risk.
- Integrated care team, to support a seamless transition process through collaborative care and discharge planning.

Discharge Planning Policies and Procedures
Health Net uses an integrated, person-centered model of health, behavioral health in discharge planning activities to ensure a person-centric, holistic perspective. We consistently review and adopt best practices related to reducing readmissions, which support efficient and effective care coordination, and contribute to improved quality outcomes.

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

Collaborative, Comprehensive Assessment and Planning - Effective discharge planning involves our concurrent review staff collaborating in person or via phone not just with the facility

discharge planning staff, but also the member/caregiver, the PCP, treating physical and behavioral health (BH) providers and CMs to comprehensively assess and develop interventions to address physical, behavioral, psychosocial, environmental, financial, cultural, and linguistic needs and barriers, including functional limitations that indicate a need for dual eligible members. The CM coordinates communication with the member, caregiver and/or family and between the discharging provider, the PCP and other applicable treating and providers. They also provide education related to available covered services, health options, and recommended care according to clinical practice guidelines. Cases are reviewed, as needed, with Health Net's own integrated care team, which includes nurses and BH clinicians, care managers, care coordinators, - social workers, pharmacist, UM nurses, disease management staff, and our Member Connections Representatives.

The concurrent review nurse/RN case managers ensures that the member's discharge plan includes referrals to appropriate post-discharge supports, including services such as home care, DME, transportation, prescriptions, and supplies, as well as community resources needed to support a safe discharge and reduce readmission risk. For example, the concurrent review nurse/RN case managers identify community resources such as food pantries, Meals on Wheels, and utility assistance programs, and incorporate them as applicable into the transition plan. The case manager contacts these resources prior to discharge to arrange for timely initiation of services when the member returns home.

Member/Family Engagement and Education - Timely communication of information to the member/caregiver or family and assisting the member to understand their condition and needs are important tools in reducing readmission risk. Our concurrent review nurse/case manager attempts to contact the member/caregiver or family in person or via phone while they are inpatient to discuss diagnoses, test and procedures, pending tests, medication lists, rationale for medication changes, contact information for the discharging physician, and all instructions and recommended follow-up care on the discharge plan. The concurrent review nurse/case manager also ensures that the member is knowledgeable about "red flags," which are indications that their condition is worsening or that they are experiencing a medication side effect, and how to respond, including self-management strategies and when to call their provider. They utilize the "teach back" method to verify that the member/caregiver understands by having the member/caregiver restate the discharge instructions and self-care concepts in their own words.

MOC 2.E.3 How organization transfers elements of the members ICP between health care settings when member experiences a transition

Communication of Information to the Next Care Setting - The CM ensures that all treating providers have full information about the member's care history and current needs as well as the context for planned care. The CM also ensures that they know whom to contact with questions regarding the member's care history or follow-up care. For admissions, the CM provides information to the facility regarding the member's ICP, authorized services and

providers to support assessment and discharge planning. The concurrent review nurse/case manager alerts the PCP of any transition in care setting. The concurrent review nurse or the CM collaborates with the facility treating physicians and BH providers, as appropriate, to facilitate discharge planning and follow-up as needed. The concurrent review nurse or the CM coordinates and facilitates provider communication, and ensures that the PCP and all treating providers, including formal and informal community supports, as appropriate, are involved in the planning for the anticipated transition. The discharge plan is incorporated by the CM into the ICP.

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

All SNP members are provided their Individual Care Plan that can be shared with providers in other care plan settings and/or health specialists outside of their primary care network. Any member may request that he or she be allowed to inspect and/or obtain a copy of any of their Protected Health Information that is maintained by or for Health Net in a designated record set. The member, or any other person who is qualified to act as the member's personal representative under state or federal law, may make the request.

Arranging Timely and Appropriate Primary Care and Specialist Follow-up Prior to Member Discharge - Prompt follow-up with the PCP or other outpatient specialty provider after discharge is critical in preventing readmission. Our concurrent review nurse/case manager takes steps prior to discharge to ensure that the member receives timely and appropriate follow-up care. These steps include but are not limited to scheduling follow-up appointments and transportation, as needed; verifying anticipated start date/time for community based care and services and working with the CM and the member/family to fill any gaps between discharge and initiation of community services.

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

Post-Discharge Outreach, Education, and Assessment - The assigned CM conducts post-discharge follow-up with the member within 72 hours of notification of discharge to verify that they have been able to get prescriptions, equipment, and supplies. They review with the member/caregiver the discharge plan to ensure they understand the importance of accessing recommended follow-up care, address barriers to accessing follow-up care, and review red flags and the process for contacting the PCP or other providers when complications arise. The CM educates the member/caregiver about how to use our after-hours nurse advice line.

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

Medication Reconciliation - Medication reconciliation is a critical element of care transitions and preventing readmission due to medication error or adverse event when a member has poly-pharmacy, low health literacy, or communication barriers. The CM ensures that the member is able to safely use medications in accordance with their discharge plan and confirms that the member has picked up his/her medications. Medication reconciliation may be done telephonically by a RN case manager, pharmacist, or by a home health agency RN. This includes checking the accuracy of medication lists; identifying changes in medication regimen, duplication of therapy and/or potential interactions with medications in the home; and assuring that the member/caregivers understands changes and side effects that should be reported to his/her PCP. It also includes communicating the discharge medication regimen to the PCP.

Pre-Discharge Activities - When Health Net identifies that a member has been admitted or has a scheduled admission, the concurrent review nurse/case manager begins working with the facility staff, providers, and the member to coordinate care, ensures a safe discharge, and reduces readmission risk. Discharge planning of an inpatient admission starts as early in the admission as possible. The concurrent review nurse/case manager conducts onsite or telephonic reviews and outreaches to facility staff to obtain clinical information, assesses members' conditions, needs, and potential discharge. The concurrent review nurse and/or the CM participates in facility care conferences, as needed, to identify barriers, discuss the member's progress, and help develop and coordinate the discharge plan. He/she also notifies and shares information with the PCP and other treating providers, such as BH providers to ensure an integrated approach to services and discharge planning, and ensures necessary authorizations are in place for ordered services such as home care services. Nurses conducting telephonic concurrent review and discharge planning ensures that transition plans are person-centered, meet the members clinical needs, consider the members' goals and preferences, and supports them in achieving desired health outcomes, including being able to safely reside in the least restrictive setting of their choice, while preventing readmission.

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

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

For members with complex needs, Health Net conducts multi- disciplinary rounds to support the concurrent review nurse/case manager. This case review process brings a holistic look at members' needs, risk factors, preferences, goals, and barriers to achieving desired goals, and develops recommendations for the discharge plan and post-discharge services to successfully support the member's transition out of the hospital and prevent readmission.

Collaborating with the Member/Family - During admission, our concurrent review nurse, or CM attempts to talk in-person or via phone with at-risk members, their provider(s), and family/supports as appropriate, to the following:

- Assess health status, care plan changes, any needs such as unmet education or psychosocial needs, reasons for unplanned admissions and ED visits, and potential risks and barriers in their environment which potentially will, or in the case of readmission, have interfered, with a successful recovery. Assessment also includes the evaluation of the member's functional status, health literacy, self-management skills, social and community supports and culture and language needs
- Provide education about the member's condition, red flags, and other topics (as described above)
- Conduct medication reconciliation
- Involve the member in discharge/service planning
- Assist the member as needed with choosing providers of post-discharge services
- Educate the member and their caregivers about available Health Net support to help connect caregivers to support groups and other community resources

Collaborating with Community Resources to be Involved at Discharge and Thereafter - The goal of Health Net's Transition of Care is to provide whole health management across the continuum of care as well as to identify and address social determinants of health, which impact the member's health outcomes and ability to remain in the least restrictive setting of their choice. To accomplish this, the concurrent review nurse/CM go beyond a purely clinical approach to developing discharge plans by identifying and addressing barriers related to physical, behavioral, socioeconomic, functional status, and other needs such as food, housing, or other assistance.

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

Pre-Discharge Education - The CM attempts to discuss the final discharge plan and instructions with the member (and applicable family/informal supports). This includes assisting the member with developing actions to prevent avoidable ER and inpatient utilization, if the member's condition and cognitive status permits such interaction at that time.

General Discharge/Post-Discharge Procedures

The concurrent review nurse or the CM handling discharge planning collaborates with facility staff to ensure that these appointments are scheduled before the member is discharged from the facility. The CM contacts the member via telephone within 72 hours of discharge.

During the follow-up phone call to members, the CM does the following:

- Review and reinforce discharge instructions, and provide additional education to ensure the member understands his/her condition, needed follow-up, and the importance of adherence and timely follow-up. This activity is critical because discharge instructions typically provide limited information, and the member's health literacy level may limit their understanding. Additionally, the member may not retain any education received in the hospital due to such issues as stress, pain, or medications.
- Complete a medication reconciliation of newly prescribed medications and all others the member may be taking to identify any potential issues, such as duplication or contraindications; identify any barriers to the member's compliance in taking the medications, provide education on why the medication is needed and the appropriate way to take the medication.
- Ensure a follow-up is scheduled, and assist as needed with scheduling follow-up appointments, arrange transportation if needed, and address any other barriers to timely access.
- Confirm initiation of home care and the delivery of medical equipment/supplies.
- Assist the member in determining if they understand what symptoms they should look for, what to do when they have those symptoms, and how to contact their PCP in order to reduce avoidable ED visits and readmissions. The CM educates the member on how to contact the Case Manager or, after hours, how to use our 24/7 Nurse Advice line if they have any questions.

Ensuring Members Are Connected With Community Resources - During the post-discharge contact described above, the CM confirms whether the member has accessed the community resources in the transition plan. If not, the CM follows-up directly with the community resources to discuss the member's needs and ensure services are available and are provided timely.

For members whose hospitalization resulted from a BH issue, the CM collaborates with the BH Coordinator for continued behavioral health needs.

Post-Discharge Monitoring - The CM follows the member's progress throughout the post-discharge transition period. Typically, follow-up for members extends 30 days from discharge, but may extend beyond 30 days depending on the member's needs and condition. Any member identified as needing more intensive education and support following discharge may receive a referral for a home health provider to ensure the member understands the importance of, and is accessing follow-up care appropriately, and adhering to medication regimens. Once the

member is stable, the CM assesses the member for ongoing care management needs and referral for disease management education and health coaching.

Integrated Care Management for Ongoing Needs - Members who continue to need monitoring and support is supported by Health Net's own integrated care team. This team includes a social worker, BH clinician, pharmacist, health coach and non-clinical supports. Furthermore, the CM, which constitutes the "one point of contact" for the member and the providers, communicate the newly updated ICP to the ICT. The ICT collectively reviews and provides interdisciplinary input on the member's needs and care. Team members, regardless of background, receive training on basic information about detecting and appropriately referring for potential medical and behavioral needs. Clinical staff receives more in-depth training on the causes, evidence-based treatment, components of care, potential barriers to care, and expected outcomes of both medical and BH conditions, particularly those that often occur co-morbidly. This approach helps to avoid unnecessary readmissions by ensuring an integrated approach to each member's ongoing needs and care.

MOC 3: PROVIDER NETWORK

MOC 3.A SPECIALIZED EXPERTISE

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

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

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

- Primary Care Providers such as family care practitioners and internists provide chronic disease management such as diabetic and cardiovascular care and coordination with the ICT, and referrals to specialists and ancillary services such as home care and restorative therapists

- Behavioral health practitioners meet the counseling and psychoactive medication needs of members with mental health disorders such as depression, substance abuse, schizophrenia and paranoid disorders

- Cardiologists provide cardiac medication and disease management as needed for members with CHF, hypertension, cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorders

- Endocrinologists provide medication and disease management expertise as needed for diabetics, hypothyroidism, hyperthyroidism and other endocrine disorders

- Neurologists are available as needed to treat members with cerebrovascular disease, stroke, Alzheimer's and dementias, peripheral neuropathies and other nerve tissue disorders

- Pulmonologists provide treatment for members with respiratory conditions such as asthma, COPD and other airway disorders

- Gastroenterologists provide treatment for conditions such as irritable bowel disease, Chrohn's disease, digestive disorders and colonoscopy and stoma care.

- Nephrologists provide treatment members with disorders of the kidneys such as chronic renal failure, electrolyte disorders, kidney stones and infections

- Dermatologists provide medication and treatment for members with skin cancers, wound care, skin infections and other skin disorders

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

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

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

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

Following initial approval into the network by the Credentialing Committee, practitioners are re-credentialed within 36 months. Practitioner re-credentialing includes reviewing Health Net captured performance data that provide an assessment of indicators representing professional competence and conduct. Practitioners identified in the initial or re-credentialing processes with adverse actions will be investigated in accordance with *Policy/Procedure #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 re-credentialing 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 Incorporated (HNI), Behavioral Health Division, Managed Health Network (MHN) is responsible for the credentialing/re-credentialing of the Health Net behavioral health care network. MHN credentials and re-credentials practitioners in accordance with state and federal regulatory requirements and accrediting entity standards prior to providing health care services to Health Net members. Health Net credentials those behavioral health care practitioners not credentialed by MHN. Please see the Health Net Credentialing and Re-credentialing Policy for complete information:

The practitioner must complete all items on a Health Net approved application and submit all requested supporting documentation. The verification time limit for a Health Net approved application is 180 days. The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely, including but not limited to:

- *Present illegal drug use*
- *History of loss of license or certification*
- *History of criminal/felony convictions*
- *History of loss or limitation of privileges or disciplinary actions with any health care entity*
- *Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance*
- *Current malpractice insurance coverage*

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

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

The practitioner must possess a current, valid license or certificate issued by the state in which the practitioner is applying to practice. The verification time limit is 180 days. Licenses that are limited, suspended or restricted will be subject to investigation, administrative termination or denial, as outlined in *Policy/Procedure #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.

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

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

By completing and signing the re-credentialing application, the practitioner:
a.) affirms the completeness and truthfulness of representations made in the application;
b.) indicates a willingness to provide additional information for the credentials process;
c.) authorizes Health Net to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review, and
d.) releases Health Net and its independent contractors, agents and employees from any liability connected with the credentialing review.

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

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

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

Health Net's Care Managers successfully engage our provider network to participate in and work with the ICT and to contribute to the ICP through the following steps:

- Sharing the identification of health care and service needs and risks
    - CM staff conduct the Medicare CM Assessment/HRA by phone, in the member's home, residence site or facility
    - By completing such an assessment, the CM will determine the specialty providers, allied health or support services (durable medical equipment, home health services, meals and other home and community-based services) needs of the member
    - CMs share results and analysis of the Medicare CM Assessment/HRA with the member's PCP and with all other healthcare providers and other staff, "the ICT", identified by the CM as necessary to handle the member's identified needs and preferences
    - CM performs outreach to PCP to share issues and concerns and to obtain feedback and resolution of issues
- Developing the member's individualized care plan with the member and/or caregiver, PCP and other external ICT members based on the member's health care, social and functional needs
    - Care Managers develop an initial ICP that is adjust vased on the subsequent ICT discussions. CMs lead the initial ICT meeting, as well as all subsequent meetings, where the member's specific needs are addressed; proposed course(s) of action are presented to the member/caregiver by the members of the ICT and based on the

member's desires. The ICP is developed with specific goals and steps to follow.

- Providing the PCP and other members of the ICT with one point of contact at Health Net to coordinate care and ensure service delivery
    - Members of the ICT receive as single "one point of contact": the member's CM
    - CMs help educate the provider network in general and the ICT, in particular, on services and benefits available to the member
    - CMs serve as the point of contact to the members of the ICT to facilitate and authorize all needed benefits and services, provide appropriate information about the UM rules and monitor timely delivery of services
- Notifying the PCP and other members of the ICT of care transition and/or significant clinical, behavioral, functional or social status change that their assigned health plan member may encounter to ensure smooth transition of care with the proper adjustment of services
    - CMs, for example, provide members of the ICT documentation related to a member's transition from home care to a nursing facility, a discharge from the hospital to a nursing facility, a visit to the emergency room
    - CMs are responsible for communicating to the ICT, the participants' change in health status, the need for modification to the member's ICP,
    - CMs request, from the ICT, information related to preventative health screenings being completed or remind them of gaps in care that need to be closed

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

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

Clinical practice guidelines (CPGs) are developed and/or adopted to reduce variation in practice and improve the health status of members. Health Net adopts nationally recognized, evidence-based clinical practice guidelines for medical and behavioral health conditions through the national Medical Advisory Council (MAC). Health Net Medical Directors are involved in the review and update process for clinical practice guidelines through MAC and meet at least 10 times per year. 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. Physicians are informed about current preventive care guidelines

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

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

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

Health Net recognizes that nationally developed procedures and guidelines are often designed for standard medical cases, but may not apply to members with complex needs. Such cases include challenges related to medication, prescriptions, facility placement, surgical intervention and other medical treatments.

In a broad context, all standard criteria/guidelines (e.g., NCD, LCD, InterQual, Clinical Practice Guidelines) and Health Net developed clinical protocols/standards are reviewed at least once a year and adopted in consultation with network providers. Adopted or revised guidelines are then distributed via online postings, faxes, portals and/or newsletters to network providers. Network providers are also able to request updates via mail. General revision challenges, such as changes in member population, new scientific evidence, or evolving industry standards, dictate when updates are needed on an ad-hoc basis. In addition, revisions are also considered and/or implemented annually. For example, changes to cancer screening protocols necessitating guideline revisions.

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

Process to Modify CPG and/or Clinical Protocols - More specifically, when a member with complex needs fails to meet applicable medical criteria/guidelines during the UM process for prior-authorization, the case is referred to Health Net's Medical Director. The Medical Director reviews all pertinent clinical information, including applicable peer review literature. He/she considers relative information during the review, such as member's age, comorbidities, complications, current treatment, psychosocial factors and home environment. Once the Medical Director concludes a clinical decision, such decision is communicated to the ICT, the

member's PCP and the member/caregiver as needed, to ensure medically appropriate care or service is provided and within the allowed benefits. The Medical Director makes him/herself available to discuss his/her decision with the ICT, at the team's request and convenience. Lastly, the ICP is adjusted according to the final decision and the new adjusted ICP is distributed to the ICT members, and verbally shared with the member/caregiver. The Care Managers (CM) monitor the timely delivery of the requested services to the member.

When network providers identify challenges/don't agree based on their own experience with clinical protocols, they are able to do the following:

- Request a change in Health Net guidelines by submitting evidence to be considered on an individual prior authorization request
- Request a revision of the overall guideline
- Request a peer-to-peer review
- Submit an appeal form for any adverse determination/denials

In all instances, providers are encouraged to submit additional clinical evidence for consideration or information about a particular case.

Overall, these methods help Health Net revise and address challenges/exceptions to clinical practice guidelines for the unique health needs of members.

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

Health Net's Care Coordination provides crucial connections when members transition from one care setting to another. This activity is critical to providing a safe and smooth transition. Health Net's CMs mediate member transitions to/from the hospital, home, nursing facility or to a totally new care setting and involve the member/caregiver as well as all care providers responsible for the services and supports in the new setting.

Transition protocols include the following:

- Addressing the member's individual needs, strengths, preferences, and goals
- Educating the member/caregiver on his/her condition
- Supporting medication adherence and reconciliation
- Ensuring timely initiation of post-discharge services and care such as post-discharge office visits and other services, home health care services, etc.
- Linking member to available community supports

These protocols are implemented and managed by Health Net clinical resources.

CCRs ensure that the member's PCP receives notification within 24 hours of care transition. CMs request the documentation related to the transition in care, e.g., completed discharge

summary, history and physical, specialty consultation reports, and any pertinent information such as main issues, post-discharge required services. CMs communicate with the PCP, update the ICP and provide updates to the ICT members and the member/caregiver. Finally, they follow-up on all outlined tasks with the member, providers and ancillary services to ensure that all activities outlined in the transition plan and in the updated ICP are completed in a timely fashion. This process ensures a seamless transition for the member and reduces readmission risk.

In the event that a provider is non-compliant or resistant to working with the CM, the network team mediates the conflict by providing outreach and facilitating compliance discussions. They also deliver training to providers if there is an educational gap related to the care transition protocol.

3.C MOC TRAINING FOR THE PROVIDER NETWORK

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

Providers responsible for the administration or delivery of the SNP Model of Care are provided initial and annual training. Training is offered through multiple learning environments to meet individual learning needs. SNP members would not receive care on a routine basis from an out of network provider because the product is HMO based - they would be set up with an in-network provider for ongoing care. Methodology may be lecture format, interactive (web-based, video conference) or self-study (printed materials, electronic media). Comprehensive MOC training includes topics of: Goals of the MOC, SNP Population, Additional benefits, Case Management, HRA, ICP, ICT Care transitions, Coordination of Medicare and Medicaid and the Quality Improvement Program. Representative slides from the 42 page deck are provided here:

Health Net

Learning Objectives

Program participants will be able to:

- List the three overall goals of the SNP Model of Care
- Describe the three qualifying medical conditions for patients in the Health Net Jade C-SNPs
- Name two actions providers can take to assist patients in the Dual Eligible Amber D-SNPs to access care
- Understand the important components of the care plan and team based care to improve care coordination for SNP patients
- Name two principles important to improve transition care management
- Identify three outcomes being measured to evaluate the Model of Care

2

Health Net

Goals of Special Needs Plans

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Assuring appropriate utilization of services

Improve Outcomes

- Improving patient health outcomes

4

Health Net

Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNPs for patients with chronic and disabling disorders known as the Jade SNPs - one or more of the following chronic diseases is required depending on the specific plan:

1. Diabetes
2. Chronic Heart Failure
3. Cardiovascular Disorders:
   - Cardiac Arrhythmias
   - Coronary Artery Disease
   - Peripheral Vascular Disease
   - Chronic Venous Thromboembolic Disorder

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Health Net

Vulnerable SNP Sub-Populations

Populations at greatest risk are identified in order to direct resources towards the patients with increased need for case management services.

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled- patients who are unable to perform key functional activities independently such as ambulation, eating or toileting, such as members who have suffered an amputation and blindness due to their diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of Life- patients with terminal diagnosis such as end-stage cancers, heart or lung disease

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Health Net

Benefits to Meet Specialized Needs

- **Decision Power Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region
- In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation** – these benefits vary by region and type of SNP

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Health Net

Communication Systems

Multiple communication systems are necessary to implement the SNP care coordination requirements:

- An **Electronic Medical Management System** for documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with enrollment, eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new member information to SNP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

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Health Net

Language/Communication Resources

SNP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication and have negative impact on health outcomes.

- Office interpretation services- in-person and sign-language with minimum of 3-5 days notice
- Health Literacy - training materials and in-person training available)
- Cultural Engagement – training materials and in-person training available
- Health Net translates vital documents
- 711 relay number for hearing impaired

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Health Net

Evidence Based Case Management (CM)

- All SNP patients enrolled in case management and notified of CM single point of contact by letter/follow-up phone call
- Patients may opt out of active case management but Case Manager continues to attempt an annual contact or when change in status or transition in care.
- Patients are stratified according to their risk profile and Health Risk Assessment (HRA) to focus resources on most vulnerable (frail, disabled, chronic diseases)
- Patients with only a behavioral health diagnosis (drug/alcohol, schizophrenia, major depressive, bipolar/paranoid) receive primary case management from MHN, Health Net's Behavioral Health provider
- Contingency planning is in place to avoid disruption of services for events such as disasters

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Health Net

Health Risk Assessment (HRA)

- An HRA is conducted to identify medical, psychosocial, cognitive, functional and mental health needs and risks
- Health Net attempts to complete initial HRA telephonically within 90 days of enrollment and annually or if there is a change in the patients condition or transition of care
- Multiple attempts are made to contact the patient including mailed surveys and e-mail reminders
- The patient's HRA responses are used to identify needs, incorporated into the member's care plan and communicated to care team via electronic medical management system, the provider portal or by mail
- Patient is reassessed if there is a change in health condition and these and annual updates are used to update the care plan

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Health Net

Individualized Care Plan (ICP)

Created for each patient by the Case Manager with input from the care team. The patient and/or caregiver is involved in development of and agrees with the care plan and goals:

- Based on the patient's assessment and identified problems
- Goals are prioritized considering patient's personal preferences and desired level of involvement in the process
- Updated when change such as new diagnosis/hospitalization or at least annually and communicated to ICT and patient
- Accessible/shared with members of the ICT including patient and provider
- Includes patient's self-management plans and goals
- Includes description of services tailored to patient's needs
- Includes barriers and progress towards goals

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Health Net

Interdisciplinary Care Team (ICT)

The Health Net, MHN or delegated Case Manager coordinates the ICT which communicates regularly to manage the patient's medical, cognitive, psychosocial and functional needs. The patient and/or caregiver is included on the ICT whenever possible:

- Required Team Members

Medical Expert
Social Services Expert
Mental/Behavioral Health Expert – when indicated

- Additional Team Members could be

Pharmacist
Health Educator
Restorative Therapist
Nutrition Specialist
Nursing/Disease Management

- Communication plan for regular exchange of information within the ICT including accommodations for members with sensory, language or cognitive barriers

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Health Net

Care Transition Protocols

Patients are at risk of adverse outcomes when there is transition between settings (in or out of hospital, skilled or custodial nursing, rehabilitation center, outpatient surgery centers or home health)

- Patients experiencing an inpatient transition are identified and managed (pre-authorization, facility notification, census)
- Important elements (diagnoses, medications, treatments, providers and contacts) of the patient's care plan transferred between care settings before, during and after a transition
- Patient knowledgeable of health information to communicate care to other healthcare providers in different settings
- Patient is educated about health status and self-management skills: discharge needs, meds, follow-up care, signs of change and how to respond (discharge instructions, post-discharge calls)

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Specialized Provider Network

- Health Net maintains a comprehensive network of primary care providers and specialists such as cardiologists, neurologists and behavioral health practitioners to meet the health needs of chronically ill, frail and disabled SNP patients
- Team based case management is provided by Health Net when it is not delegated to the patient's primary care provider and medical group
- Delegated medical groups must demonstrate capability to meet the team based care requirements
- The Delegation Oversight team conducts audits to monitor that delegated medical groups meet the SNP Model of Care requirements

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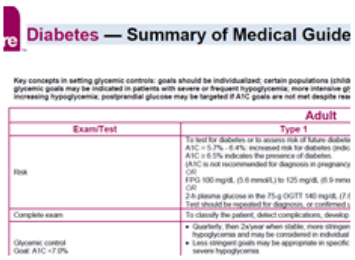
Jade C-SNPs – Diabetes

In addition to a Provider Network with practitioners and specialists skilled in managing patients with Diabetes, the program has:

- Disease Management to assist patients to manage their Diabetes
- Interactive programs for healthy activity and weight control
- Additional benefits (vary by plan) can include zero cost for Diabetic monitoring supplies, low cost Podiatrist visits
- Clinical Practice Guidelines for Diabetes and other chronic diseases located on the Provider Portal


Diabetes — Summary of Medical Guide

Key concepts in setting glycemic controls: goals should be individualized; certain populations (child
glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive gl
increasing hypoglycemia; postprandial glucose may be targeted if A1C goals are not met despite rea

	Adult
Exam/Test	Type 1
Risk	To test for diabetes or to assess risk of future diabete A1C = 5.7% - 6.4% increased risk for diabetes (indic A1C = 6.5% indicates the presence of diabetes (A1C is not recommended for diagnosis in pregnancy OR FPG 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmo OR 2-h plasma glucose in the 75-g OGTT 140 mg/dL (7. Test should be repeated for diagnosis, or confirmed
Complete exam	To classify the patient, detect complications, develop
Glycemic control Goal: A1C <7.0%	• Quarterly, then 2x/year when stable; more stringen hypoglycemia and may be considered in individual • Less stringent goals may be appropriate in specific severe hypoglycemia

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D-SNPs -Coordinating Medicare and Medicaid

The goals of coordination of Medicare and Medicaid benefits for members that are dual-eligible:

- Members informed of benefits offered by both programs
- Members assisted to maintain Medicaid eligibility
- Member access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Members informed of rights to pursue appeals and grievances through both programs
- Members assisted to access providers that accept Medicare and Medicaid

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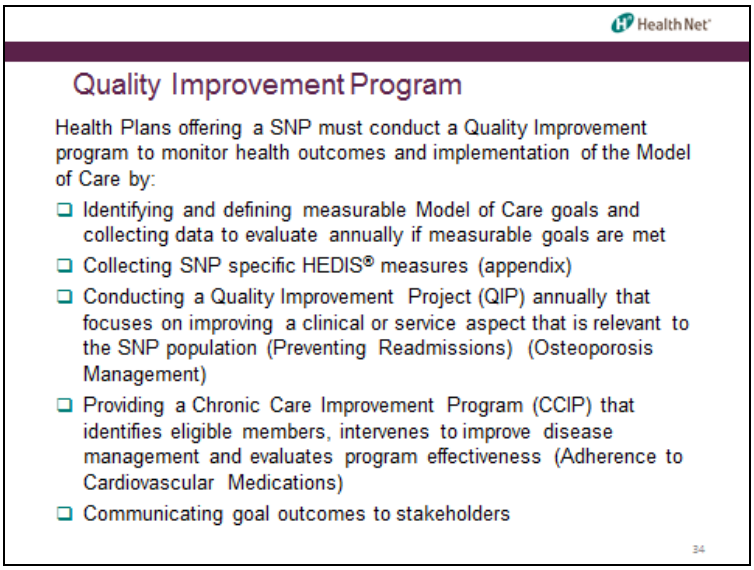
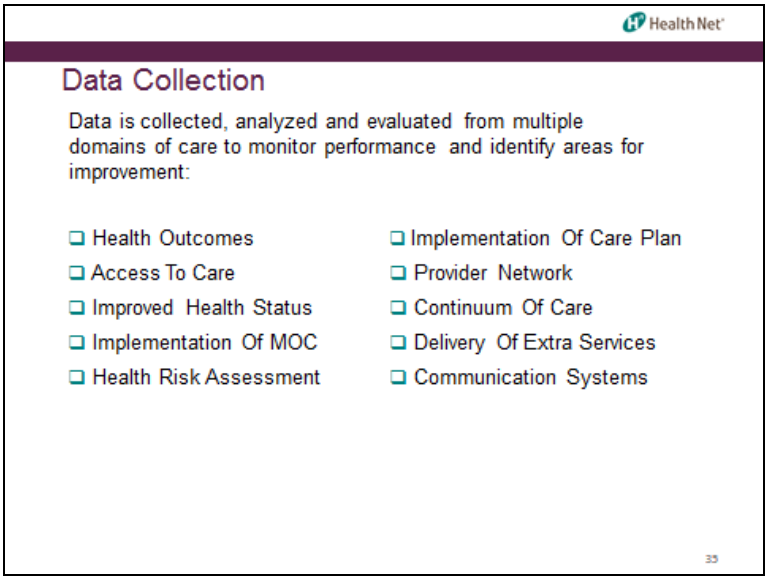




The SNP MOC training is updated annually and presented as a provider webinar. The updated training is then posted on the provider web portal and the provider manual so it is accessible to providers at any time. This training is also available to delegated groups to use with their staff. Health Net also offers additional provider webinars on topics that are relevant to the Model of Care such as chronic disease management and best practices throughout the year. These topics vary each year and new topics are selected based on provider interest and initiatives to improve outcomes.

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

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

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

In addition, Delegation Oversight completes annual audits of SNP delegated groups. One of the elements of this audit is confirming that there is documented evidence of SNP MOC training. As part of the annual provider compliance training, participating provider groups also complete attestation for SNP MOC training as applicable.

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

There are a number of challenges associated with completing MOC training for network and out-of-network providers that include the following:

- Providers lack time to complete MOC training due to the demands of patient care
- Providers are asked to complete MOC training from multiple managed care plans resulting in lost productivity and duplication of effort
- Providers have variable MOC knowledge. Newly participating providers may benefit from the training whereas an established network provider may be very familiar with the program and care management processes detailed in the MOC.
- Out-of-network providers have no contractual responsibility to complete MOC training

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

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

MOC4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

4.A MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

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

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

At the organization level, the Quality Improvement Program evaluates that appropriate services are delivered to SNP members by looking at a comprehensive set of utilization, access, satisfaction, audit and clinical measures to measure improvement and effectiveness of the Model of Care and to identify areas for improvement. Appropriate clinical measures such as diabetic and cardiovascular measures are collected to evaluate a chronic disease SNP. Controlling Blood Pressure, Beta Blockers after a Heart Attack, Annual Monitoring of Medications, Part D Medication Adherence (diabetes, RAS antagonists, statins) and the administrative HEDIS Comprehensive Diabetic Care measure (CDC) is collected at the plan benefit package to measure that the appropriate clinical services are delivered for Jade SNP member's unique needs. The Medicare provider network, inclusive of SNP is monitored for availability of primary care providers, behavioral health providers and high volume specialists including nephrologists, ophthalmologists, gastroenterologists and surgeons important to members with chronic disease.

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

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

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

- **Health Outcomes And Use Of Evidence Based Practices** – Health Care Effectiveness Data and Information Set (HEDIS®) measures, utilization metrics for access to ambulatory health services, behavioral health, ER visits, hospital readmits

- **Access to Care** – member surveys, appeals and grievances re: access, monitoring of provider network, utilization reports, HEDIS® preventive care metrics

- **Improvement in Health Status** – related HEDIS® measures, responses to HRA questions re: health status, pain, functional status, self-management

- **Implementation of Model of Care** – process reports from medical and behavioral health case management and delegation oversight

- **Health Risk Assessment** – initial and annual completion rates and refusals

- **Implementation of Care Plan** – audits of case management records and Care of Older Adults COA HEDIS® measure

- **Specialized Provider Network** – delegation oversight audits, availability of providers and facilities including behavioral health providers and specialists, member surveys, HEDIS® clinical measures

- **Continuum of Care** – related HEDIS® measures such as Medication Reconciliation, Plan All Cause Readmissions and Follow up after Hospitalization for Mental Illness and response to survey question regarding transitions

- **Delivery of Extra Services** – utilization for transportation, Decision Power, Complex Case Management, Medication Therapy Management program, dental and vision benefits

- **Integrated Communications**- Customer Call Center (service level, abandonment rate), satisfaction survey, website registration

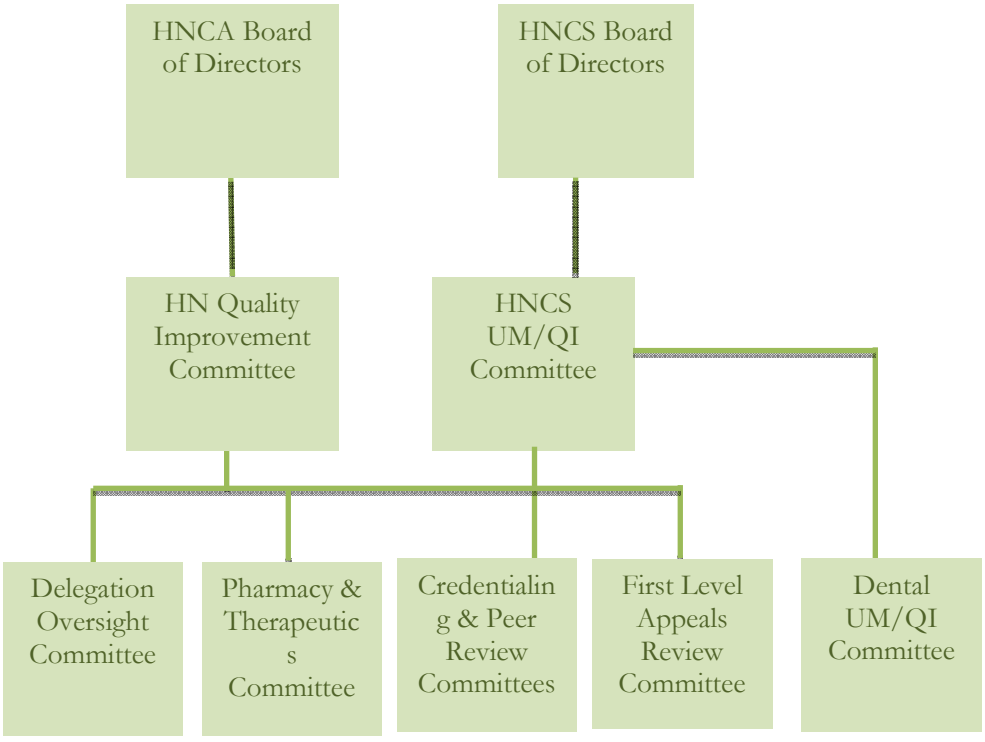
MOC 4.A.3 How leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process

The Health Net Board of Directors has ultimate authority and responsibility for oversight of the QI Program, including review and approval of the annual QI Program Description, Work Plan and Evaluation. The Board delegates the responsibility for implementing the QI Program to the Health Net Quality Improvement Committee (HNQIC) and the Health Net Community Solutions Utilization Management Quality Improvement (HNCS UM/QI) Committee.

Functions:

- Establish strategic direction for the QI Program
- Receive quarterly updates from Quality Management, and review reports from QI Committees, delineating actions taken and performance improvements at least annually
- Ensure the QI Program and Work Plan are implemented effectively and result in improvements in care and service
- Assess and recommend, as needed, resources to implement quality improvement activities

Health Net Quality Improvement Committee Organizational Chart



QI Committee Structure

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

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

1. Health Net Quality Improvement Committee

HNQIC has responsibility for oversight of the QI Program and is responsible for monitoring the quality and safety of care and services rendered to Commercial and Medicare Health Net members. The Committee is chaired by Regional Medical Director identified by the Chief Medical Officer and meets at least quarterly.

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

HNQIC Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Board of Directors or Executive Management Team at least annually
- Recommends policy decisions, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement

- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement including SNP Model of Care goals
- Oversees the CMS QI Program, receiving periodic reports on CMS-required QI activities
- Provides support and guidance to health plan associates on quality improvement priorities and projects
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service

2. Health Net Community Solutions UM/QI Committee

The Health Net Community Solutions (HNCS) UM/QI Committee encompasses Health Net's Medi-Cal line of business and includes the Cal MediConnect dual eligible demonstration. The committee is charged with monitoring the medical management and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The HNCS UM/QI Committee is chaired by a Medical Director identified by the Chief Medical and Health Care Services Operations Officer and meets at least quarterly. The Dental UM/QI Committee reports to the HNCS UM/QI Committee and the HNCA Board of Directors. The Public Policy Committee includes Health Net members and provides regular reports to the HNCS UM/QI Committee.

HNCS UM/QI Committee Functions:

- Reviews and approves the Annual QI and UM Program Description, Work Plan and Evaluation
- Reports to the Health Net Community Solutions Board of Directors at least annually
- Recommends policy decisions
- Analyzes and evaluates the results of focused audits, studies, quality of care and safety issues and quality of service issues
- Monitors for compliance and other quality improvement findings that identify trends and opportunities for improvement
- Provides input and recommendations for corrective actions and monitoring previously identified opportunities for improvement
- Provides support and guidance to health plan associates on quality improvement priorities and projects including MMP model of care goals
- Monitors data for opportunities to improve member and practitioner perception of satisfaction with quality of service

3. QI Sub-Committees & Workgroups

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

Pharmacy & Therapeutics Committees (P & T)

The Health Net Pharmacy and Therapeutics (P&T) Committees are decision-making bodies that meet quarterly to develop and update the company's drug formulary, or drug list. The P&T Committees' primary goal is to assure continuous member access to quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a national strategy to optimize pharmacotherapy that is cost-effective for members.

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

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

Credentialing & Peer Review Committees

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

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

Delegation Oversight Committee (DOC)

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

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

Medical Advisory Council (MAC)

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

Dental UM/QI Committee

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

The Dental UM/QI Committee is chaired by the Dental Medical Director and meets at least quarterly, independently of the HNCS UM/QI Committee. The findings and action of the Dental UM/QI Committee's Quality Improvement Program are presented at the quarterly meetings of the HNCS UM/QI Committee and the HNCA Board of Directors. Annually the Dental Medical Director presents the written report on the status of dental

QI activities. The HNCS Committee approves the overall dental Quality Improvement System Manual (QIS) and the annual dental QIS report, directs the operational dental QIS to be modified on an ongoing basis.

Customer Experience Council and Steering Team

The Customer Experience Council (CX Council) and Steering Team is responsible for building and enhancing business capabilities to improve customer experience outcomes and is supported by a team of market researchers, Six Sigma Black/Green Belts, business analysts, program managers, change management and organizational development associates. The team monitors performance metrics around healthcare costs, clinical and service quality, employee engagement, membership retention and growth, and critical process-specific key performance indicators to tackle issues and facilitate changes. The council is chaired by the VP of Customer Experience and consists of members jointly accountable for achieving the customer experience objectives and initiatives that will be established each year or quarter as the program scales and refines targets. Each council member can be responsible for driving short and long term process and working teams, and reports to the monthly council meetings on project status, milestones, barriers, and progresses made.

Other:

QI Clinical & Service Workgroup

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

Other Committees and Workgroups:

Committees and workgroups are convened at Health Net to address specific products or requirements and may not report directly to the Quality Improvement Committee. Current examples include the Medi-Cal Governance Committee, the Medicare STARS Governance Committee and Provider Engagement Performance Management (PEPM) Governance Committee.

Key Associate Resources & Accountability

1. **Chief Medical Officer**

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

2. Chief Medical Director – Medi-Cal

Chief Medical Director reports to the CMO for Medical Affairs for Medi-Cal and is responsible for development and implementation of strategies for access to care, improved quality outcomes, regulatory compliance and cost of care management. Reporting to Chief Medical Director will be designated Medi-Cal medical directors and the Director of Tele-health. In this role, the Chief Medical Director will work closely with the Medical Affairs and Management teams, and cross-functional teams to create a culture of quality and accomplish the goals of the Triple Aim (Better Health. Better Care. Lower Cost)

3. Medical Director QI

The Medical and Health Care Services Operations Officer designates a Medical Director to provide clinical and administrative physician leadership to the QI Program, including:

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

4. Vice President Quality Management

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

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

- Wellness, Health Education and Cultural & Linguistic program and services are developed and implemented for all members

5. Behavioral Health Medical Director

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

6. Medical Directors

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

7. Director of Quality Improvement

The Commercial/Medicare and Medi-Cal Directors of Quality Improvement report to the VP of Quality Management. Responsibilities related to the QI Program include:

- Overall management of the QI Program including the behavioral health QI program
- Resolves barriers that prevent appropriate monitoring of quality of care and quality of services
- Assures implementation of quality improvement activities
- Reviews reports, identifying issues, formulating policies and procedures and makes recommendations to the QI committees
- Provides consultation to Quality Management associates
- Maintains accreditation and QI compliance
- Direct and lead a cross functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships and leading to affect appropriate and substantive interventions among leaders.
- Continuously assess the data and information available on Medicare STAR performance, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manage vendor relationships as necessary to support the processes to improve STARS performance.

8. Director Of Data Analysis

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

- Assure identification of opportunities for quality improvement activities, related to achieving quality outcomes (Stars, NCQA accreditation, member satisfaction, etc.).
- Review reports and guide the analytic approach across all lines of business, and make recommendations to QI Committees.
- Assure implementation of quality improvement metrics and outcome measures.
- Ensure delivery of in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement.
- Continuously assess the data and information available on Medicare STAR performance, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Ensure collaboration with HEDIS staff to identify areas of opportunity.
- Provide feedback on Quality outcomes and progress to Corporate and Market leadership.

9. Quality Improvement Managers

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

- Implements the structural components of the QI Program
- Maintains accreditation and compliance to QI requirements
- Organizes and directs activities designed to illustrate process improvement
- Oversight and management of rating programs such as Medicare Stars, Commercial and Exchange OPA Stars and Medi-Cal External Accountability Set (EAS)
- Oversee Facility Site Review and identifies issues regarding PCP and High Volume Specialty providers (including BH, Ancillary and CBAS) facility's physical accessibility.

10. Quality Improvement Research & Analysis Manager

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

- Assures implementation of quality improvement metrics and outcome measures
- Conducts an in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement

- Identifies data to be collected for selected studies and reviews format and methodology for appropriateness. Evaluates and analyzes relevant findings

11. Quality Analytics Program Managers

Quality Analytics Program Managers are responsible for identifying, managing and tracking clinical, quality, correct coding, documentation and data submission projects that advance the objectives of Health Net's strategic goals.

Responsibilities include:

- Working across functional teams to develop performance trackers and tools as needed to meet national performance targets and drive quality improvement.
- Addressing the DHCS Corrective Action Plan (Medi-Cal), Medicare Stars ratings, and Undertakings requirements (commercial) by providing insight through statistical analysis of utilization and member data to identify opportunity areas that inform QI intervention.
- Facilitating the development of internal and external reports and the delivery of data as needed to support and monitor the action plans to accomplish the Triple Aim: 1) to improve member experience, 2) improve the quality of care and 3) to reduce health care costs.

12 Quality Improvement Analysts

The Quality Improvement Analysts reporting under the Quality Analytics Program Managers conduct in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify opportunities for improvement.

Responsibilities include:

- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.
- Review and assist in study design/methodology and provide data to be utilized for QI studies to meet regulatory requirements.
- Review and analyze the study findings and recommend corrective actions and next-steps.
- Establish and implement programs and initiatives to meet NCQA requirements.
- Continuously assess the data and information available on plan performance, to identify trends and risk areas.
- Provide support, guidance and collaboration to stakeholders in other Health Net Departments to assure implementation, analysis and follow-up of activities.

12. Quality Improvement (QI) Specialists

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

- Conducts the evaluation and review of the effectiveness of the QI Program and prepares documents for submission to the QI Committees, Executive Management Team and the Board of Directors
- Provides support, guidance and collaboration to Health Net departments to assure implementation, analysis and follow-up of activities per the QI Work Plan
- Reviews and/or revises policies and procedures on an annual basis, or as necessary
- Identifies data to be collected for selected studies and reviews format and methodology for appropriateness. Reviews and analyzes the findings and recommends corrective actions and re-measurement as applicable
- Establishes and implements programs and initiatives to meet NCQA requirements
- Maintains regulatory compliance
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

13. Director Of Health Education/Wellness/Cultural And Linguistic Services

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

- Overall management of the health education, wellness and cultural and linguistic related programs including health disparities reduction efforts.
- Direct and oversee department-led interventions and programs that address HEDIS® measures and identify and ensure action is taken on priorities.
- Review reports, identify issues, formulate policies and procedures and make recommendations to the QI committees.
- Provide consultation to Quality Management associates.

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

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

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

Established quality improvement activities implemented to improve health outcomes, access and member satisfaction are inclusive of SNP members and new activities are developed as a result of analysis of SNP specific data and guidance from the HNQIC. SNP specific measureable

goals and outcomes are integrated into the QI Workplan. Some examples of activities integrated into the overall performance improvement plan to meet SNP specific goals and health outcome objectives include:

- Quality Improvement Project to Prevent Diabetes
- Chronic Care Improvement Program to Promote Appropriate Osteoporosis Management for Older Women
- Medication Therapy Management program with quarterly medication reviews, appropriate provider and member interventions including access to a pharmacist
- High Risk Drugs to Avoid in the Elderly Program
- Medication Adherence to Improve Cardiac Health
- Decrease the use of Multiple Narcotics and High Dose Tylenol
- Promote Preventive Care: initiatives to improve flu/pneumonia vaccine, breast cancer screening, colorectal cancer screening, diabetic retinal exam
- Activities to Improve Diabetic Care measures

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

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

MOC 4.B MEASURABLE GOALS AND HEALTH OUTCOMES

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

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

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

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

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

Table 4.1

DATA SOURCE	MEASURABLE GOALS AND TIMEFRAME
Improved Access to Essential Services: Medical, Mental Health and Social Services	
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 1% or achieve 83% for Q12 "In the last 12 months, not counting the times you needed emergency care, how often did you get that appointment as soon as you thought you needed?" in measurement year
HEDIS®	Percent of members with access to preventive or ambulatory health services (AAP) will achieve 93% in measurement year

Improved Access to Affordable Care	
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 2% or achieve 70% for Q6 "How often did your case manager give you phone numbers or names of other groups to help you meet your health needs? In measurement year
Improved Coordination of Care Through an Identified Point of Contact	
SNP Part C Report	Overall completion of HRA (initial and reassessment) will improve by 3% or meet National Part C Average* of 69% in measurement year
SNP Satisfaction Survey	Rate for "Always/Usually" will increase by 2% or achieve 70% for Q6 "How often did your case manager give you phone numbers or names of other groups to help you meet your health needs? In measurement year
Improving Seamless Transitions of Care Across Health Care Settings, Providers and Health Services	
SNP Satisfaction Survey	Members responding “Yes” to “Did you have the information you needed upon discharge regarding medications and follow-up care?" will improve by 1% or meet 85% in measurement year
HEDIS®	Members with Medication Reconciliation documented post-discharge will improve by 2% or meet the National Part C Average of 50% in measurement year
Improved Access To Preventive Health Services	
HRA	Continuing members reporting obtaining Flu Vaccine will improve by 1% or meet National Part C Average of 71% in measurement year
HEDIS®	Rate for Comprehensive Diabetes Care - Diabetic Retinal Exam will improve by 1% or meet National Part C Average of 72% in measurement year
Assuring Appropriate Utilization of Services	
HEDIS®	Rate for Emergency Department Utilization (AMB ED) will decrease from previous year
HEDIS®	All Cause Readmission rate in 30 days (>65 years) will decrease by 0.5% or meet National Part C Average of 10% in measurement year
Improving Beneficiary Health Outcomes	
HEDIS®	Rate for High Risk Drugs in the Elderly (1 drug) will improve by 1% or meet Quality Compass Medicare Average of 11% in measurement year
HEDIS®	Rate for Osteoporosis Management will improve by 1% or meet National Part C Average of 41% in the measurement year
HEDIS®	Rate for Controlling Blood Pressure will improve by 1% or meet National Part C Average of 72% in the measurement year

National Part C Averages from 2018 Star Ratings Technical Notes (9/2017)

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

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

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

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

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

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

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

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

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

Health Net also completes the SNP MOC Plan Performance Monitoring and Evaluation (PPME) database annually as required by CMS that includes the measures, time frames, re-measurement, goals met/unmet and if Corrective Action plan taken.

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

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

Outcomes from the HEDIS®, CAHPS®, HRA, Medication Therapy Management (MTMP), utilization, communication systems and other program indices are analyzed at least annually. Action taken for metrics that do not meet goals can include Quality Improvement Projects or activities such as member outreach, provider education or system and process changes designed to impact the measure outcomes and improve care or service. Interventions can include automated or livecalls, newsletters, health calendars, emails, and educational materials designed to improve Flu/Pneumonia Vaccination, diabetes care, colorectal cancer screening,

cardiac health and member satisfaction. Below is an example from the annual SNP MOC of actions taken when the goal for diabetic eye exam was not met.

Members obtaining Diabetic Retinal Exam will improve by 1% or meet National Part C Average of 70%	• Mailer on steps to access vision care and importance of annual eye exam sent to 15K members with a care gap in Qtr 3 • Provider report cards on current performance on this measure provided and discussed during JOMs • PPG teleconference on 5/18/16, on Diabetes attended by 201 • 2016 Health Planner/Calendar mailed to all Medicare members Qtr 4 promotes annual eye exam • IVR call to members with care gap in July/2016 provided education and encourages annual eye exam • Live calls to 1K members with multi-gaps in care in Qtr 4

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. Based on CAHPS® results, Health Net has provided doctor's offices with educational newsletters, after-hours provider script, and a patient experience toolkit with materials in multiple languages for improving access to care. Results of access monitoring through surveys and appeals and grievance data and applicable actions for improvement are communicated to the Health Net Quality Improvement Committee (HNQIC) for review and approval.

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

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

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

Health Net has collaborated with a CAHPS® certified vendor to develop and conduct a survey to assess the experience of the SNP population with the Case Management program. This SNP satisfaction survey asks members to rate their experience with: their Case Manager, care coordination between case manager and provider, access, and ease of obtaining appointments. A random sample of eligible SNP members is selected to participate in the SNP Satisfaction survey annually in Q3. The administered survey should take no longer than ten minutes to complete and the goal is to complete 400 member surveys. The response rate is monitored to collect an adequate sample size. The questionnaire is programmed in English and Spanish into the Computer Assisted Telephone Interview (CATI) system, and bilingual interviewers will conduct the survey via the telephone. At least three call attempts will be made to reach respondents. The survey results are produced for each region and stratified by SNP type (D-SNP vs. C-SNP).

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

Table 4.2

QUESTIONS
Q1. Have you received help from a case manager or health team member in the past 12 months? This help could be from someone in your doctor office or from Health Net.
Q2. How often did the case manager or health team help you get the doctor visits or services you needed?
Q3a. How often was the help from your case manager to meet your health needs easy to understand and follow? Q3b. How often did your case manager or health team treat you with courtesy and respect? Q3c. How often did your case manager or health team give you the help you needed for your health needs?
Q4. How often did you make changes that improved your health because of help from your case manager or health team?
Q5. How often was any written health information from your case manager or health team useful and easy to follow?
Q6. How often did your case manager give you phone numbers or names of other groups to help you meet your health needs?
Q7. What is your overall satisfaction with the case management program?
Q8. How likely are you to get a flu shot or test for cancer because the case manager or health team asked you to?
Q9. How likely are you to take your medications regularly because of help from the case manager or health team?
Q10a. How would you describe your ability to understand what your doctor tells you? Q10b. How would you describe your ability to follow what your doctor tells you?
Q11. In the last 12 months, not counting the times you needed emergency care, did you make any appointments for your health care at a doctor's office or clinic?
Q12. In the last 12 months, not counting the times you needed emergency care, how often did you get that appointment as soon as you thought you needed?
Q13a. In the last 12 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? Q13b. In the last 12 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?

QUESTIONS
Q14. In the last 12 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
Q15. Specialists are doctors like surgeons, heart doctors, allergy doctors, psychiatrists, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make appointments to see a specialist?
Q16. In the last 12 months, how often was it easy to get appointments with specialists?
Q17. If you were discharged from a hospital or nursing home in the past year, did you have the information you needed regarding medications and follow-up care?

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

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

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

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

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

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

change health behaviors. The table below from the annual evaluation describes actions taken to address member survey responses regarding getting information to meet health needs.

Got information needed to meet health needs will increase by 2% or ≥ 70%	• Staffing increased to provide Case Management in-house instead of through vendor - standardizes processes to provide member information • Change to new case management documentation platform as part of transition activities in Qtr 3 • Articles in 2017 Health Planner/Calendar mailed to about 243K members in Nov/2016 provides resources to obtain information

4D. ONGOING PERFORMANCE IMPROVEMENT OF THE MOC

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

The annual evaluation of the SNP MOC identifies clinical and nonclinical outcomes that could be improved to better meet the needs of SNP members. Results could be used to provide improved educational materials or new and innovative methods of member and provider outreach to improve preventive and chronic care health outcomes such as increasing adherence to diabetic and cardiovascular drugs, obtaining annual diabetic eye exam and obtaining the flu vaccine.

Case Managers can gain a better understanding of how to meet member needs from the responses on the member SNP satisfaction survey such as accessing care and making health behavior changes. Changes have also been made to the medical information management system to allow more efficient completion of HRA surveys and development of the individualized care plan for the member and ICT. Changes and additions to benefit design specific to SNP members such as zero cost sharing for select cardiovascular or diabetic drugs, improved dental benefits, or increase in the number of trips for the free medical transportation benefit could also be made.

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

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

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

Multiple data sources are utilized to evaluate the SNP MOC that are collected and acted upon by various departments. Data is collected at intervals that allow timely intervention by the affected department. For example, the customer service department evaluates their ability to answer calls in a timely manner on a daily, weekly and monthly basis and has a back-up system in place to make immediate adjustments when performance goals are not being met. They also anticipate the need for an increase staffing during times of high call volume such as annual enrollment. The pharmacy department monitors performance for medication adherence and drugs to avoid in the elderly on a monthly basis and provides timely interventions with members and/or providers when care gaps are identified.

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

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

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

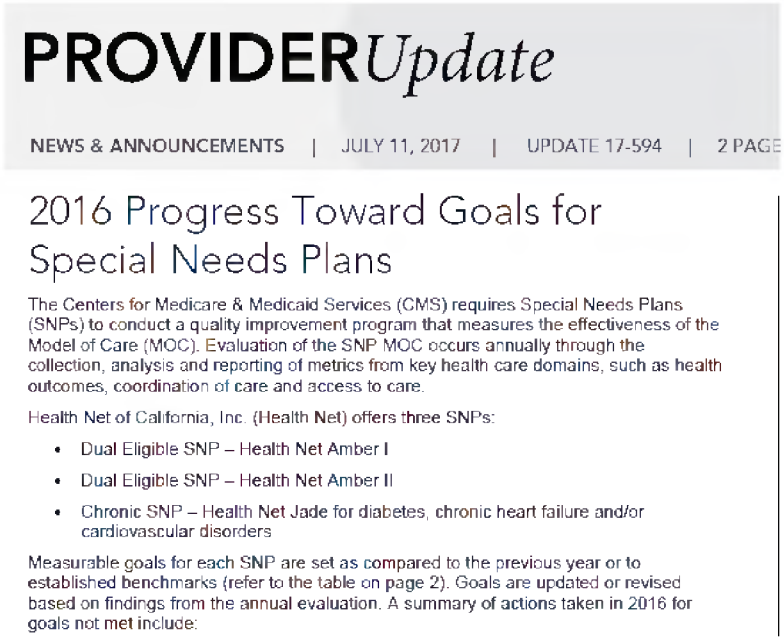
Results of the data analysis and recommendations of HNQIC are considered in determining quality improvement activities, projects and specialized services and benefits. In addition, program outcomes are communicated during annual provider webinars and attendees have the opportunity to ask questions or provide feedback. Providers also represent and communicate member issues at HNQIC and during regularly scheduled operational meetings. Electronic and print copies of the evaluation of the SNP Model of Care is prepared annually, reported to the HNQIC and as requested, to regulatory and accreditation organizations and is recorded in the minutes and preserved as an official record.

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

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

Providers and members are informed of outcomes through educational programs, meetings, updates, newsletters, and provider and member portal online articles. The Medicare

Newsletter includes, "Health Net's Commitment to Quality" informing members of Health Net's progress towards goals for key HEDIS® and Customer Satisfaction metrics including improvement from the previous year and comparison to national benchmarks. The SNP specific HEDIS® Care of Older Adults metrics are included. A Provider Update also summarizes the SNP MOC evaluation and progress towards goals.



PROVIDER*Update*

NEWS & ANNOUNCEMENTS | JULY 11, 2017 | UPDATE 17-594 | 2 PAGE

2016 Progress Toward Goals for Special Needs Plans

The Centers for Medicare & Medicaid Services (CMS) requires Special Needs Plans (SNPs) to conduct a quality improvement program that measures the effectiveness of the Model of Care (MOC). Evaluation of the SNP MOC occurs annually through the collection, analysis and reporting of metrics from key health care domains, such as health outcomes, coordination of care and access to care.

Health Net of California, Inc. (Health Net) offers three SNPs:

- Dual Eligible SNP – Health Net Amber I
- Dual Eligible SNP – Health Net Amber II
- Chronic SNP – Health Net Jade for diabetes, chronic heart failure and/or cardiovascular disorders

Measurable goals for each SNP are set as compared to the previous year or to established benchmarks (refer to the table on page 2). Goals are updated or revised based on findings from the annual evaluation. A summary of actions taken in 2016 for goals not met include:

Provider communications throughout the year inform providers of the outcomes of the quality improvement program and projects. Provider webinars on various topics are conducted and can include information on quality outcomes for measures regarding preventive care, behavioral health, chronic disease management and member satisfaction. Provider meetings are scheduled regularly throughout the year and "Report Cards" are discussed with the medical group's performance on quality metrics and resources available to improve performance.

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

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

- Annual webinars are conducted with Provider Groups on varied program outcomes and progress towards goals. Results from quality measures related to preventive care, chronic disease management, behavioral health, care transitions and member satisfaction are reviewed according to the webinar topic.

- The annual SNP Program Evaluation is reported to the HNQIC committee comprised of multiple internal and external stakeholders. In addition to the outcomes, the report includes a barrier analysis, opportunities and summary of interventions to address low performance.
- A Provider Update is produced annually summarizing the SNP MOC evaluation and progress towards goals.
- A summary of the SNP MOC Goals is presented annually to the Health Net Board of Directors.
- An Online News article, "Quality Improvement Outcomes and Progress" is published annually for providers and includes key outcomes compared to the previous year and to national standards for multiple lines of business. Examples of the measures of clinical care included in the online news article are: Advance Care Planning, Functional Assessment, Medication Review, and Pain Assessment.
- The Medicare newsletter article, "Health Net's Commitment to Quality" informs members of Health Net's progress towards the goal of improving care and outcomes and is produced annually. Categories include: Measures of Clinical Care, Service, and Health Outcomes.

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

- Ad hoc online provider e-mail alerts and faxed communications are produced periodically throughout the year to provide updates on a variety of topics or quality initiatives. The communications are developed by the QI, Pharmacy or other departments and disseminated by Provider Communications or Provider Network Management.
- Additional provider communication and education is provided by QI employees on varied topics such as coordination of care, preventive care, etc during regularly occurring operational meetings (usually quarterly) with Regional Medical Directors and provider groups.
- Provider webinars (6) are scheduled on varied topics around chronic disease management, behavioral health, preventive care and other relevant topics. Topics for the webinars change each year according to the initiatives targeted for improvement as a result of ongoing data collection and monitoring. At each webinar, providers are encouraged and given the opportunity to ask questions or share observations or best practices.

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

Health Net has provided extensive resources to the SNP program to meet the comprehensive data collection, analysis, evaluation and communication requirements. The Medicare QI Manager, BSN, CPHQ leads a team of 8 Senior QI Specialists and Program Managers with

nursing and/or advanced public health backgrounds. SNP members are incorporated into the initiatives to improve healthcare outcomes for all Medicare members including improving diabetic and cardiovascular measures, the Chronic Care Improvement Program (CCIP) and the Quality Improvement Programs (QIP).. The Medicare QI Manager or delegate annually reports SNP progress towards goals to the HNQIC and to stakeholders through Provider webinars. Senior QI Specialists develop the Provider Update, online news article and Medicare newsletter article annually reporting clinical outcomes.

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

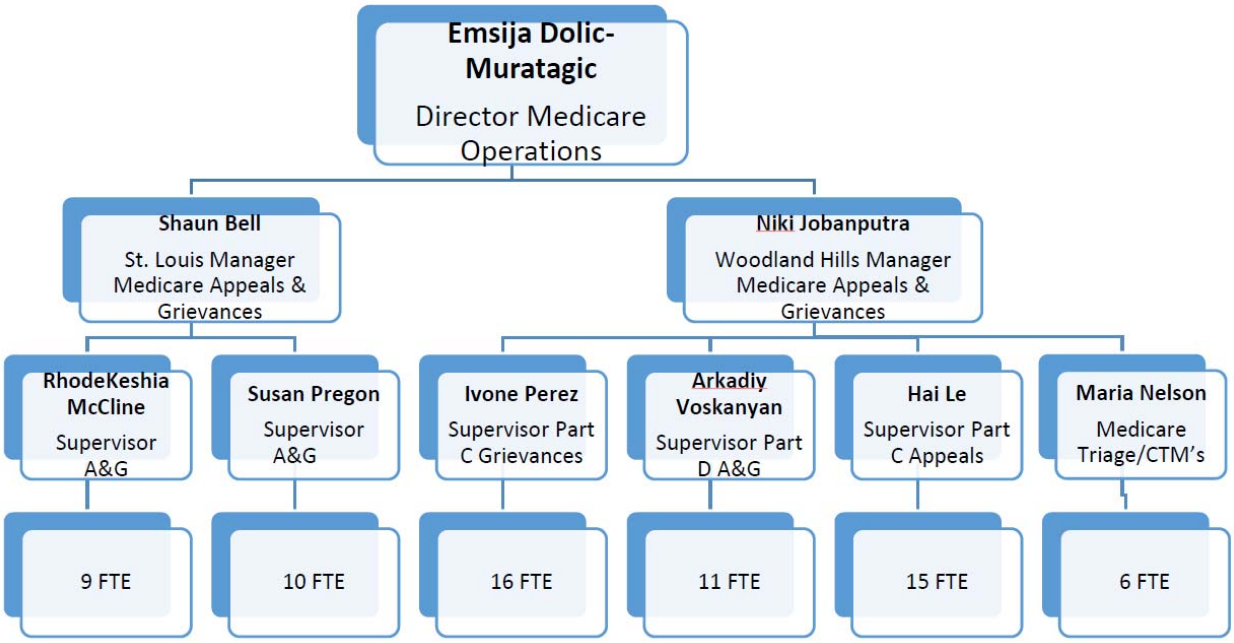
The QI Director holds a Masters in Exercise Studies and a Bachelor of Science in Physical and Health Education. She has multiple years of experience with the Medicare, Stars and SNP programs and provides resources and guidance for the QI Medicare Manager and communicates updates on the SNP MOC evaluation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

ORGANIZATIONAL CHARTS

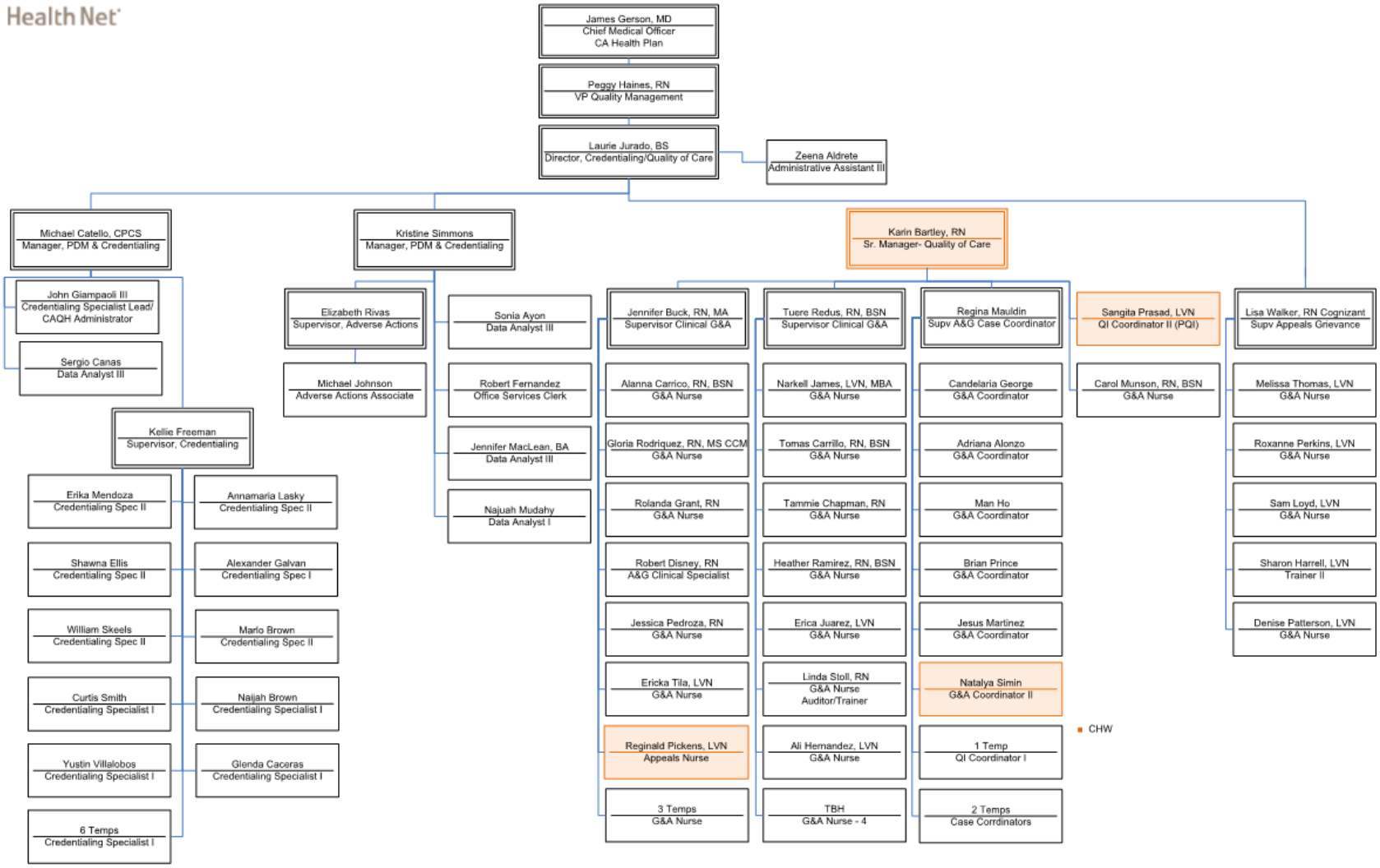
These organizational charts represent the complete departments and not the SNP line of business only.

February 2018

Member Appeals & Grievances



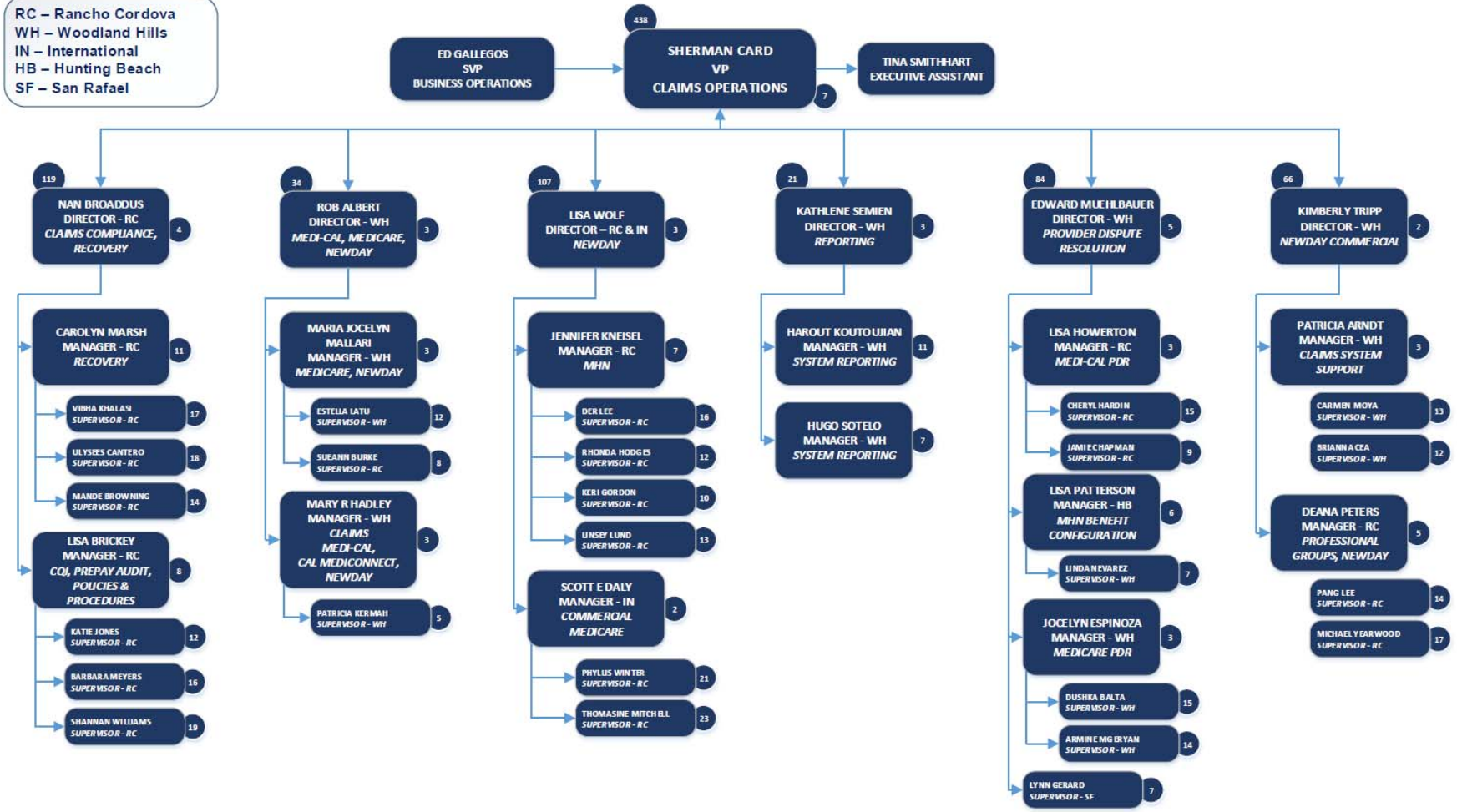
Credentialing/Clinical Appeals/PQI



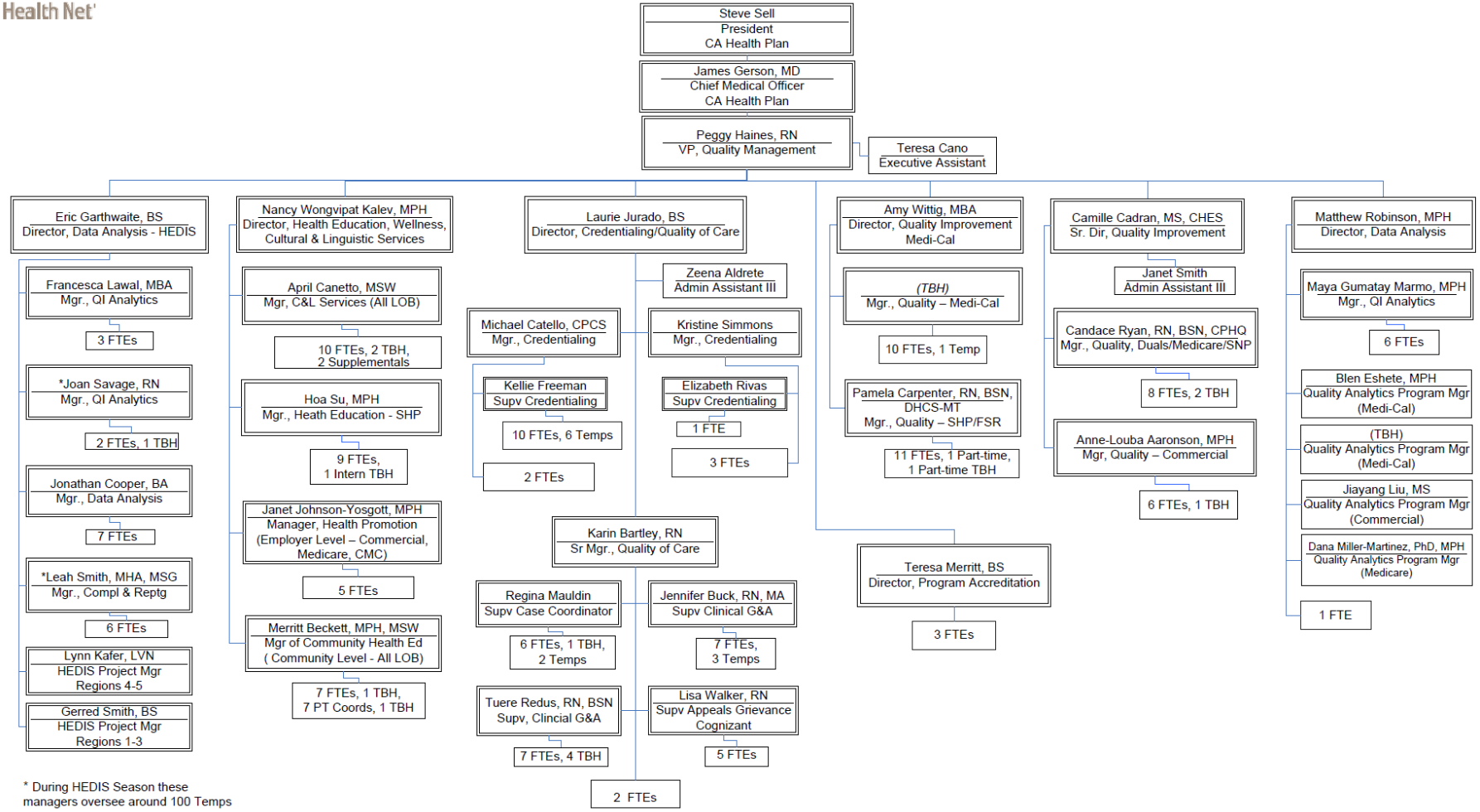
Health Net

CLAIMS OPERATIONS

RC – Rancho Cordova
WH – Woodland Hills
IN – International
HB – Hunting Beach
SF – San Rafael



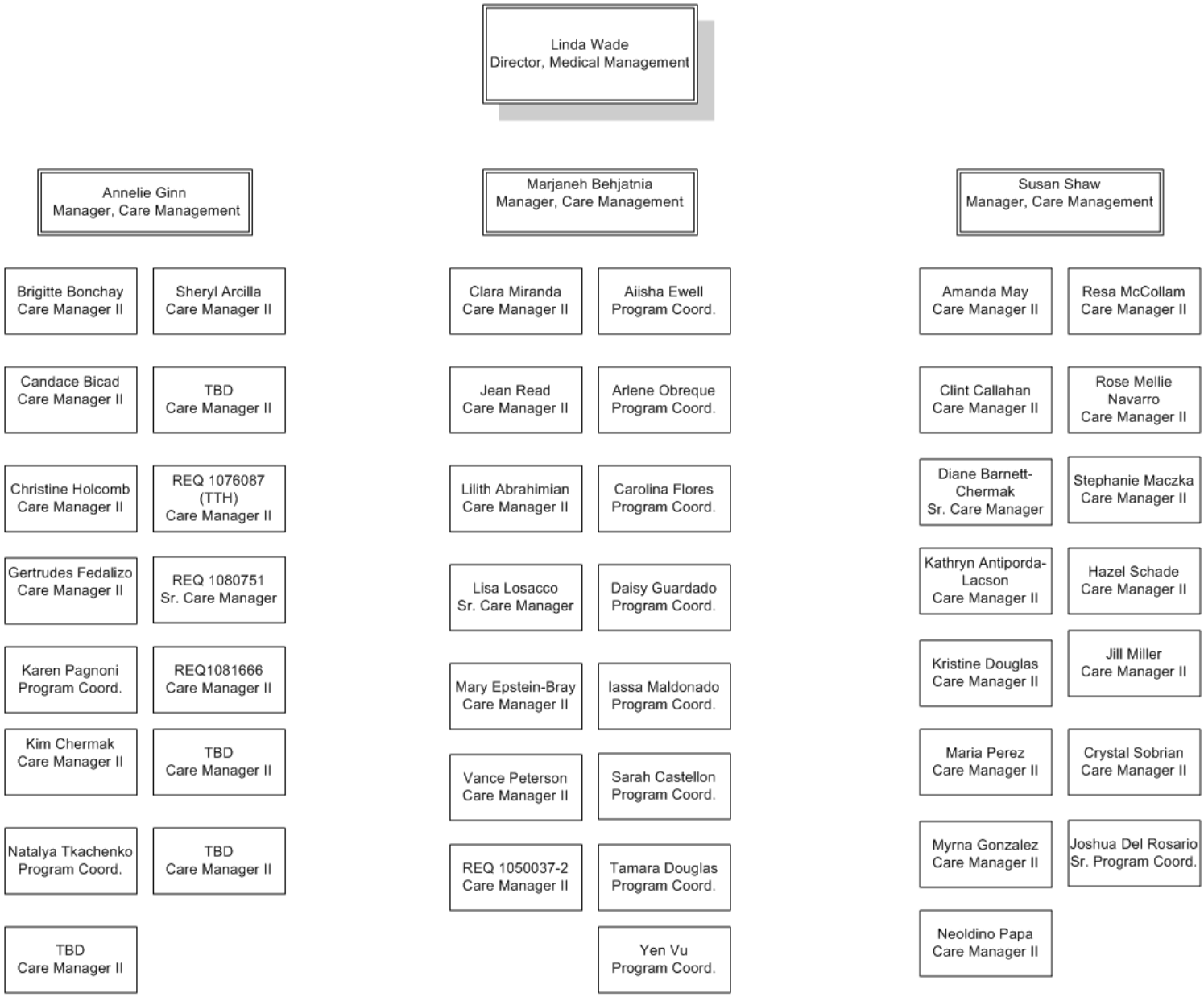
Quality Management



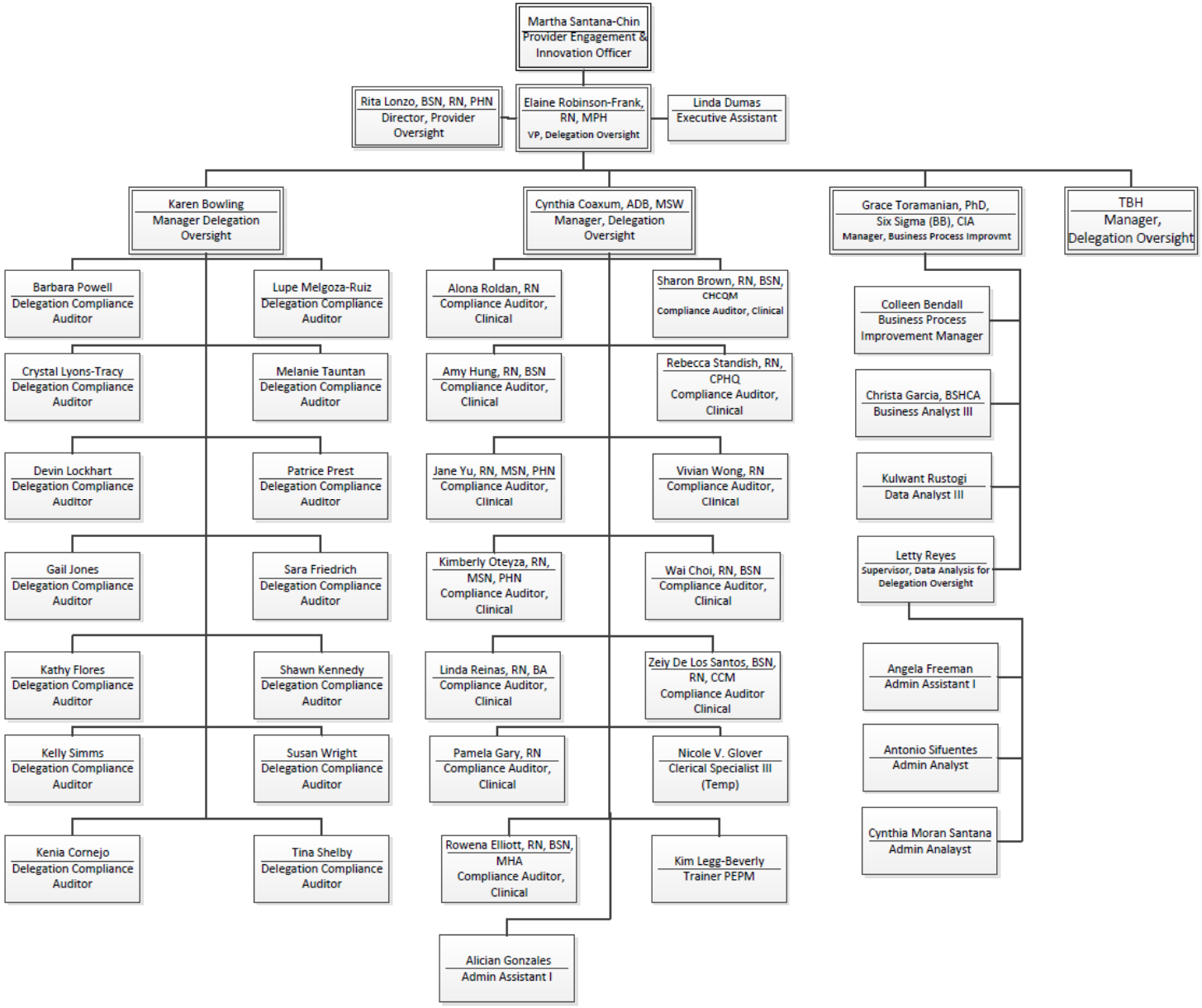
* During HEDIS Season these managers oversee around 100 Temps

Health Net

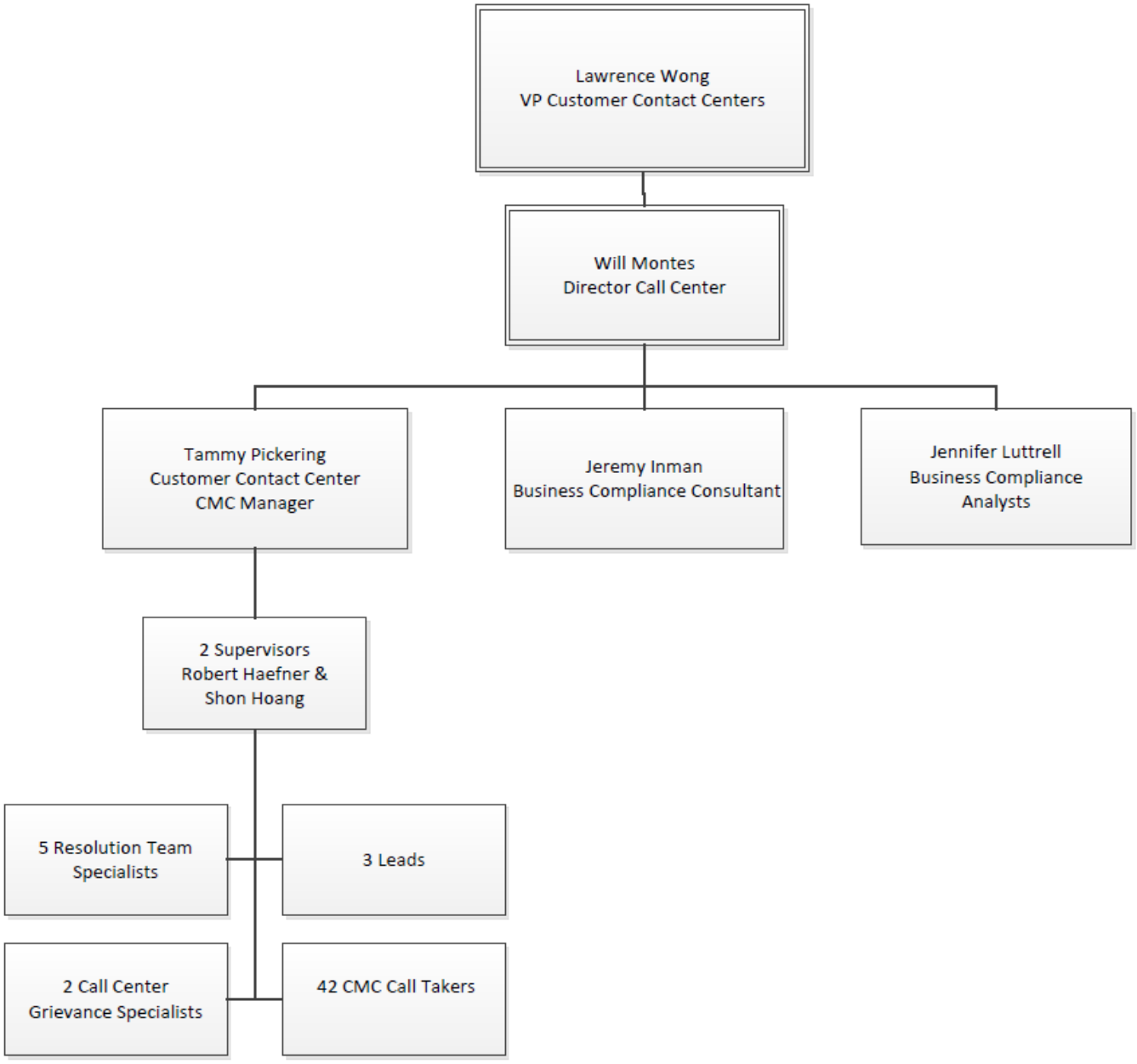
SPEACIAL NEEDS PROGRAM (SNP) CASE MANAGEMENT



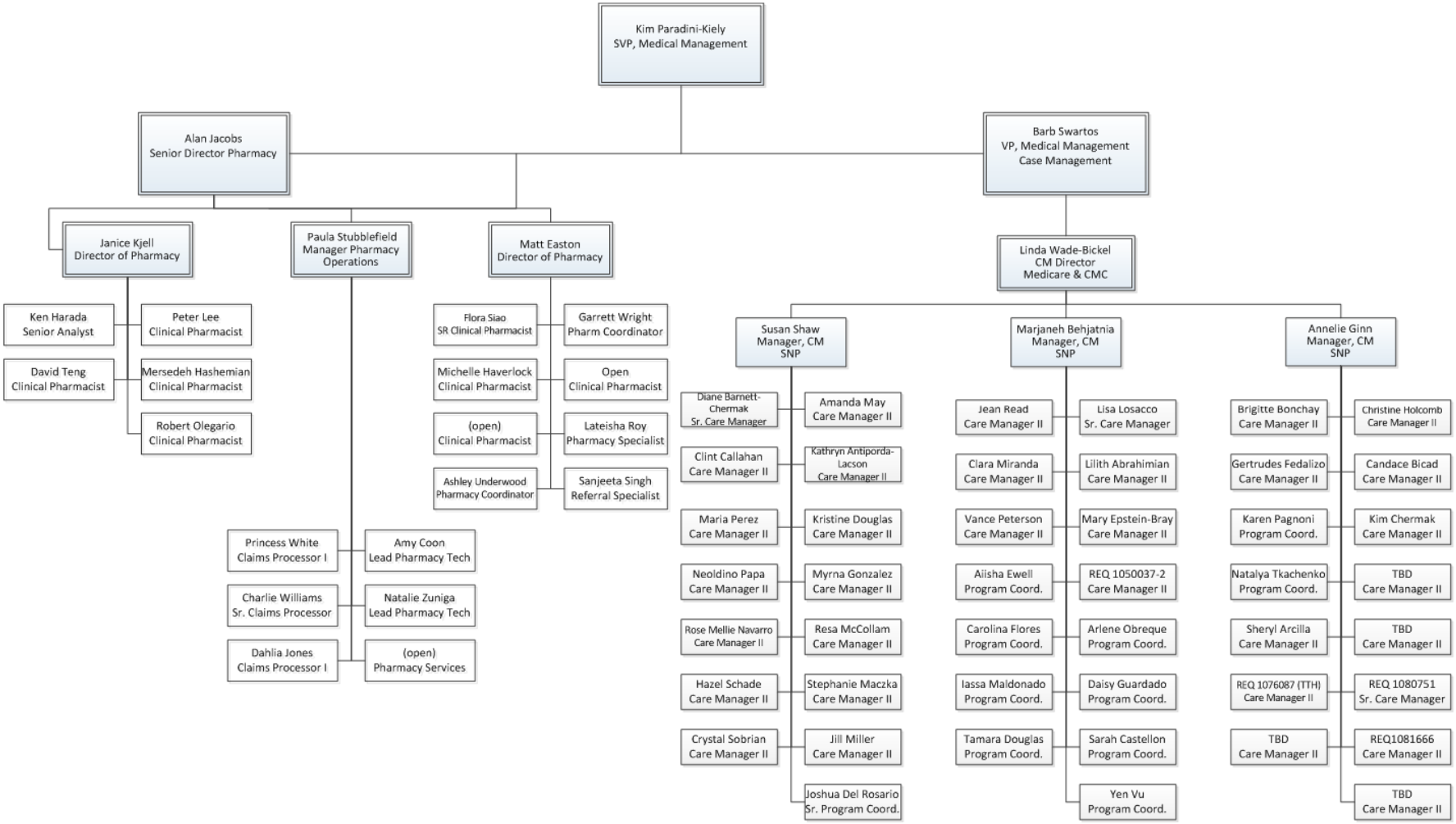
Delegation Oversight



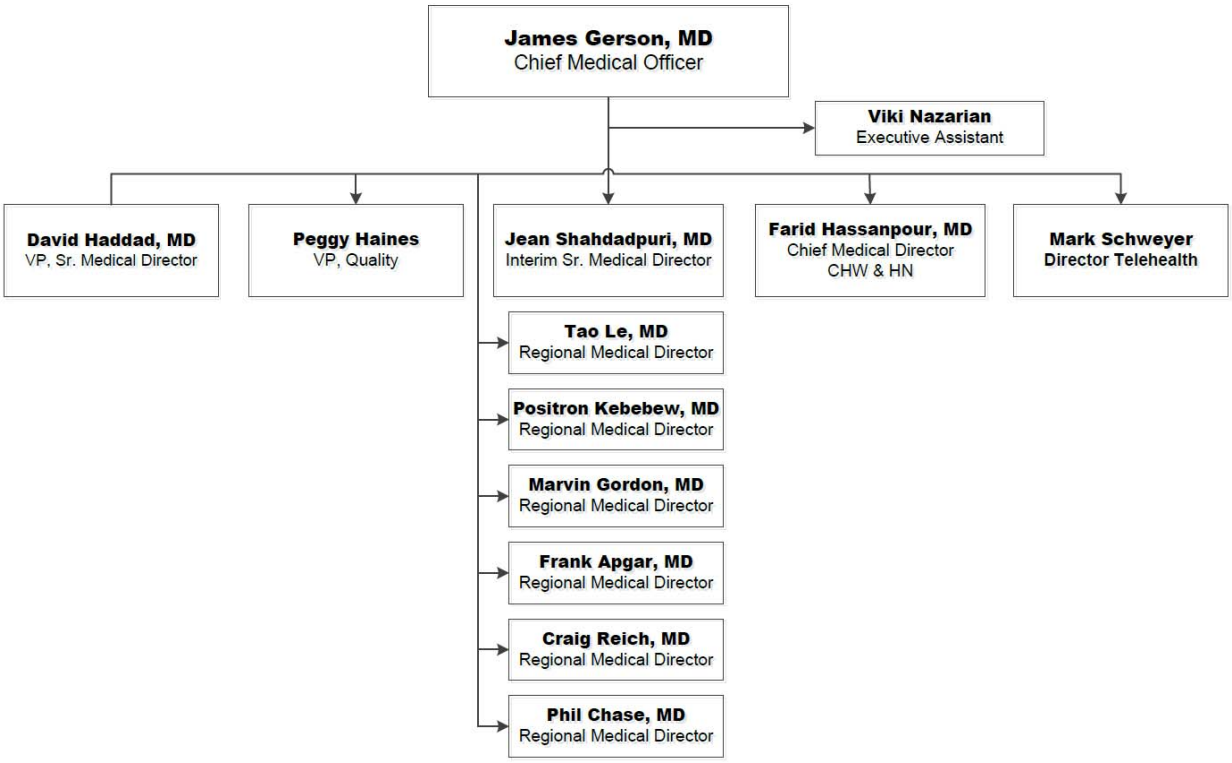
Customer Call Center Oversight 2018

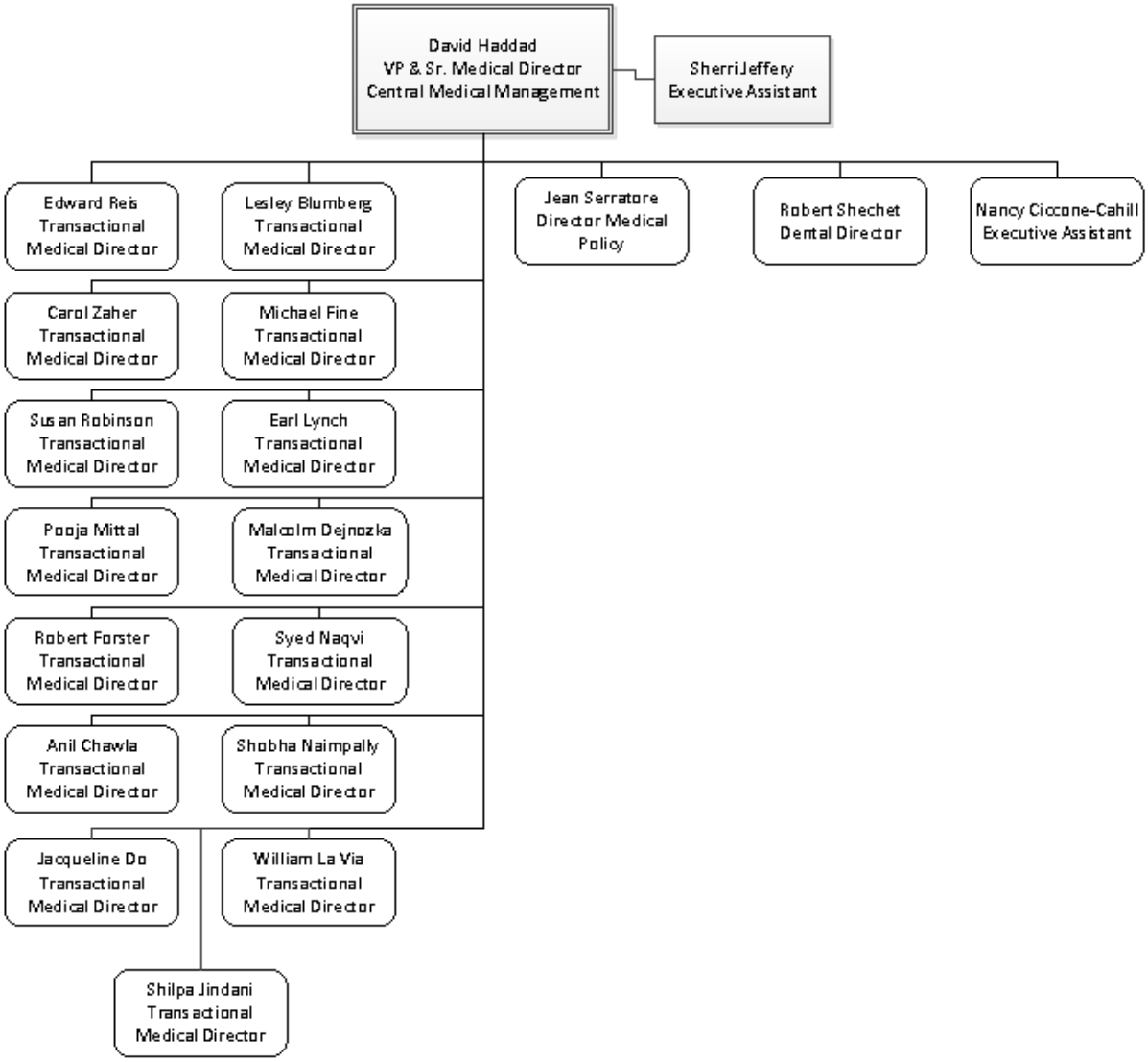


Medical Management

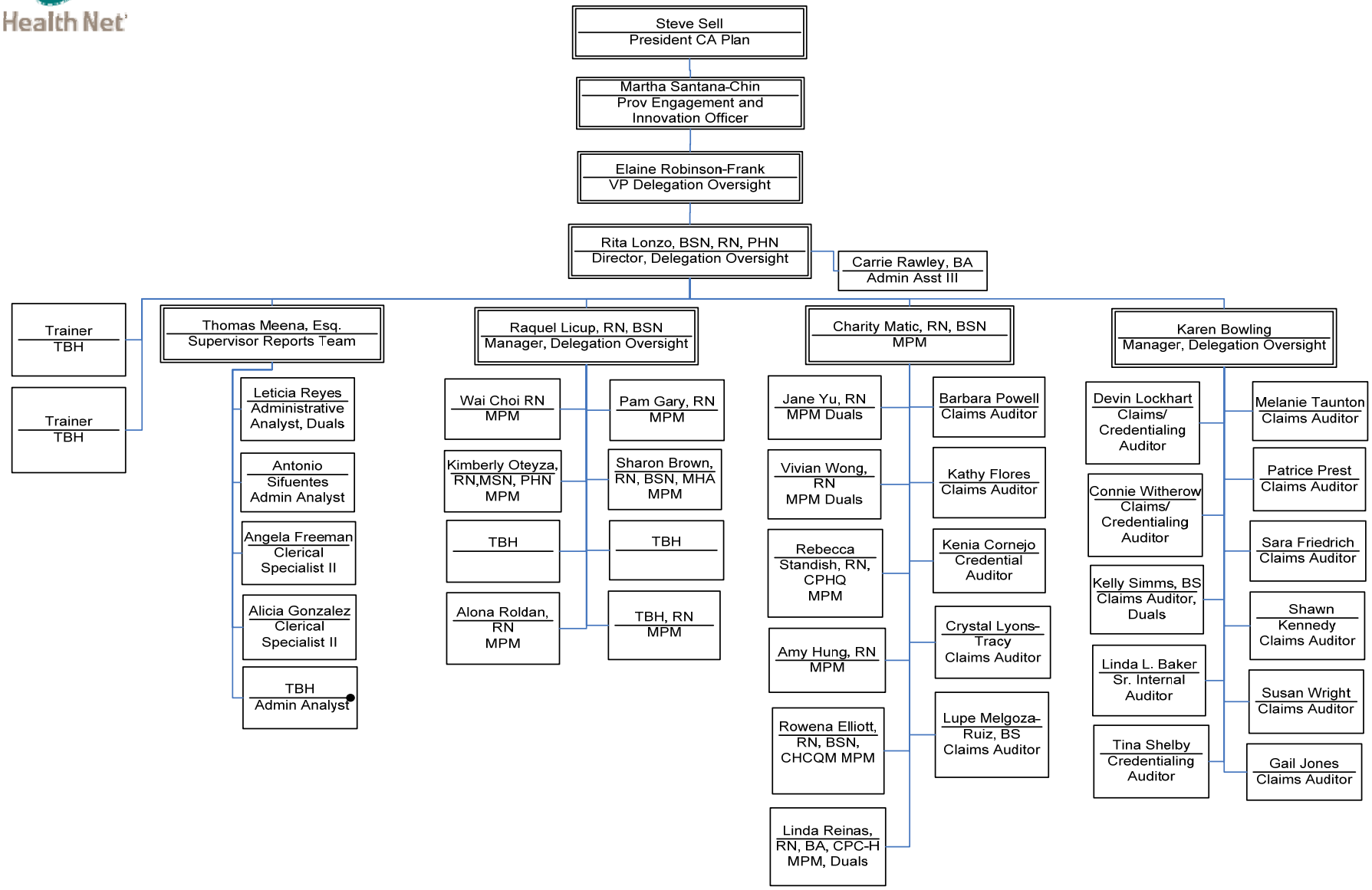


Medical Management Medical Directors



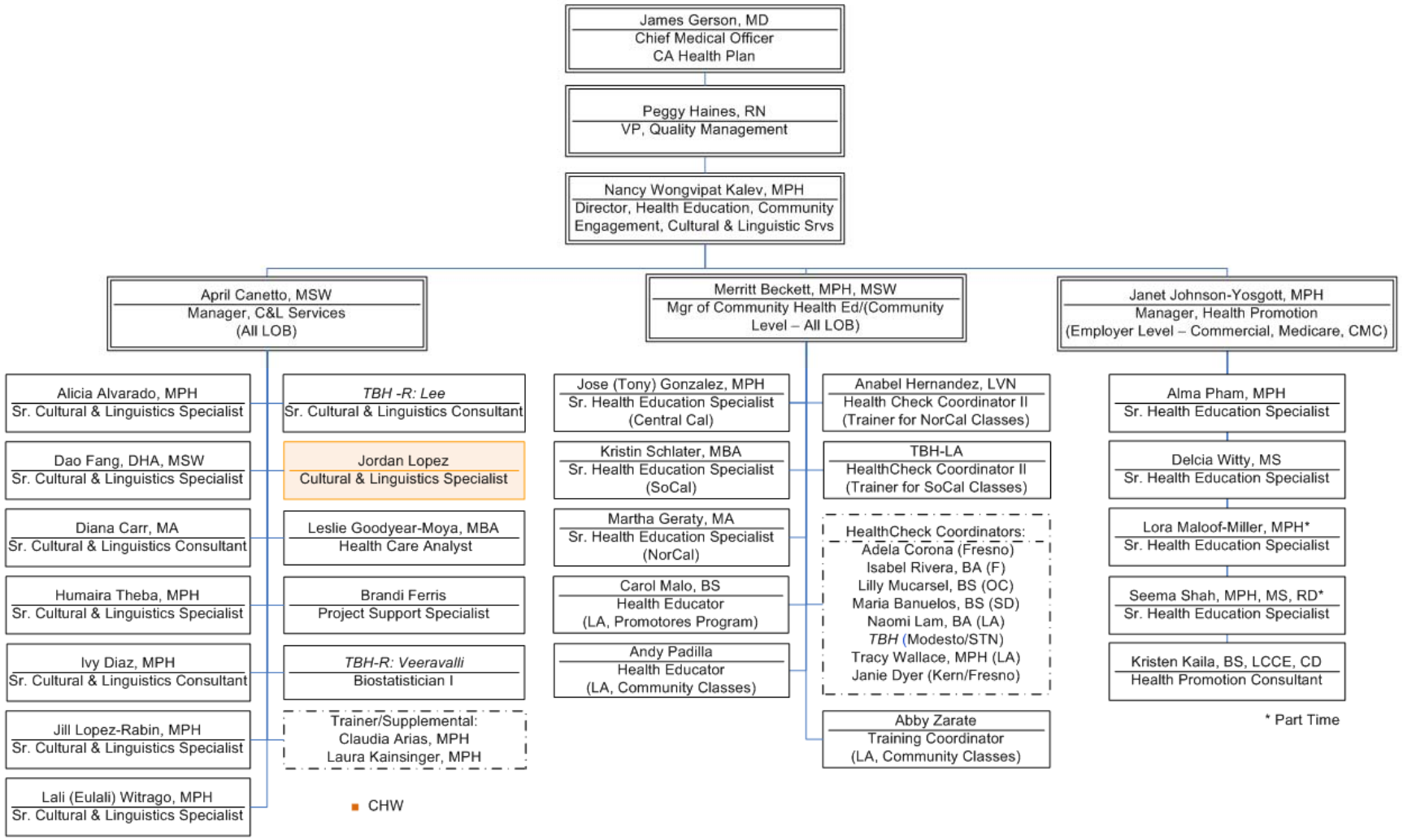

David Haddad
VP & Sr. Medical Director
Central Medical Management
Sherri Jeffery
Executive Assistant
Edward Reis
Transactional
Medical Director
Lesley Blumberg
Transactional
Medical Director
Jean Serratore
Director Medical
Policy
Robert Shechet
Dental Director
Nancy Ciccone-Cahill
Executive Assistant
Carol Zaher
Transactional
Medical Director
Michael Fine
Transactional
Medical Director
Susan Robinson
Transactional
Medical Director
Earl Lynch
Transactional
Medical Director
Pooja Mittal
Transactional
Medical Director
Malcolm Dejnozka
Transactional
Medical Director
Robert Forster
Transactional
Medical Director
Syed Naqvi
Transactional
Medical Director
Anil Chawla
Transactional
Medical Director
Shobha Naimpally
Transactional
Medical Director
Jacqueline Do
Transactional
Medical Director
William La Via
Transactional
Medical Director
Shilpa Jindani
Transactional
Medical Director

Delegation Oversight

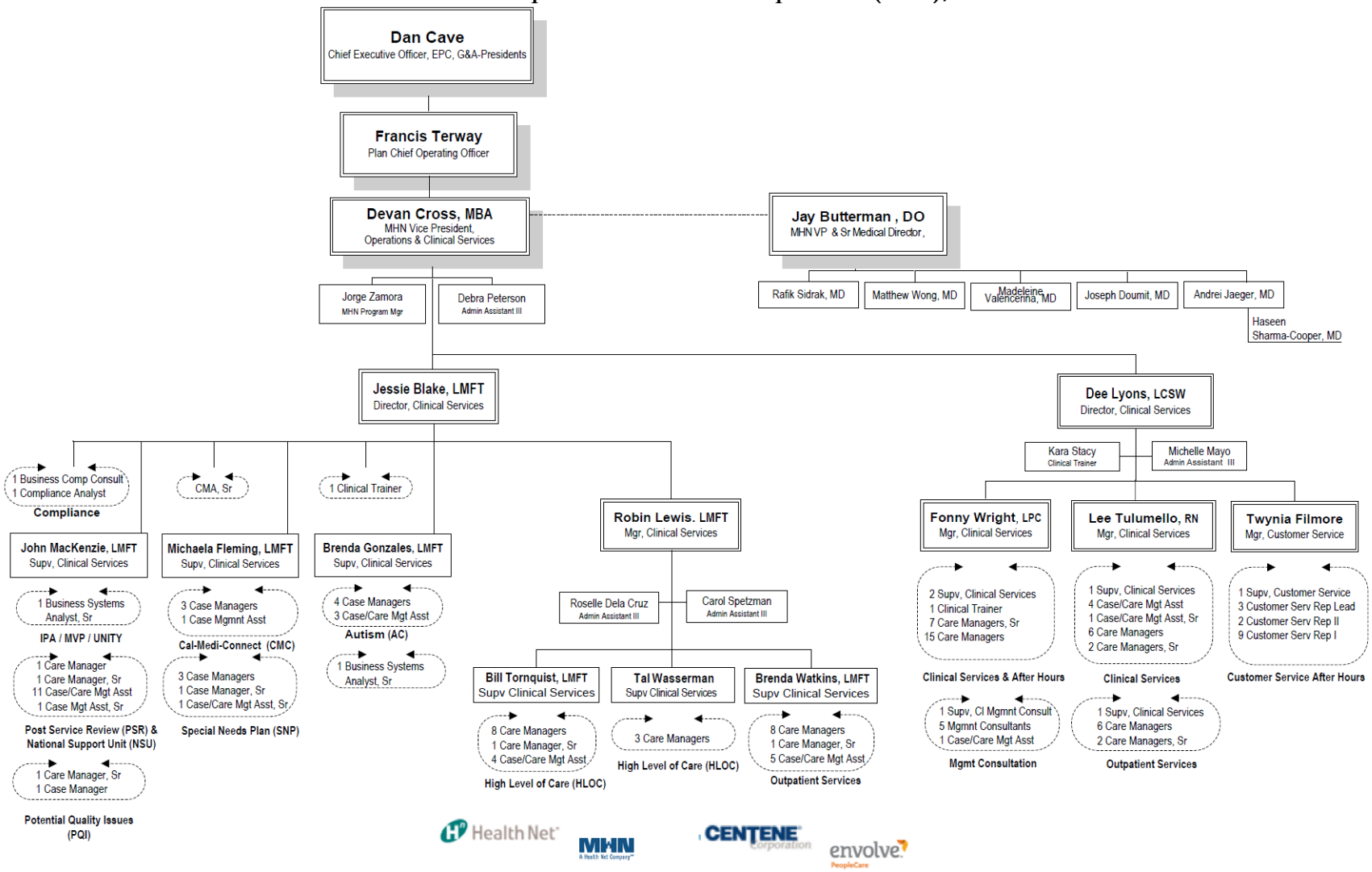


Health Net

Cultural & Linguistic Services and Wellness Oversight



Clinical Operations Envolve People Care (EPC)/MHN



Health Net

Pharmacy Operations Oversight and Clinical

Enrollment & Eligibility – Administrative