2026

Health Net Community Solutions, Inc.
and
Community Health Plan of Imperial Valley

Utilization Management Program Description

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Section 1

Introduction and Background

Introduction and Background

Introduction

The Community Health Plan of Imperial Valley (CHPIV) Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CHPIV is responsible for ensuring that utilization management services are available for all its Members. Health Net Community Solutions, Inc. (Health Net) is contracted with CHPIV to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty

care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, custodial care/long term care, intermediate care facility, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of Members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of Member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM Program, participants are educated regarding confidentiality requirements. All protected Member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential Member information are regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, is available to all HN staff via the corporate intranet websites, including “Archer” and “Centene University”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include Member and provider feedback.

Section 2

Purpose

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

Mission

Transforming the health of the communities we serve, one person at a time.

Values

Accountability • Courage • Curiosity • Trust • Service

Health Net Community Solutions UM Purpose

The purpose of Health Net's Utilization Management Program is to design and implement programs that facilitate the highest level of the Member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Community Health Plan of Imperial Valley Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages Members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary medical and behavioral health care services provided to Members, as indicated by clinical criteria
- Provide a mechanism to address issues related to access and timeliness of care
- Initiate documentation to support investigation of potential quality of care concerns
- Identify and resolve issues leading to excessive resource utilization and inefficient delivery of health care services
- Identify and resolve issues that result in either underutilization or over utilization of services
- Assess the impact of cost containment activities on the quality of care provided
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of Members through integration and coordination within PHCO and external Public Health Programs
- Optimize the Member's health benefits by linking and coordinating services with appropriate county and state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Ensure consistent application of all UM functions for Members
- Review and assess health care services for quality, medical necessity and appropriate levels of care
- Identify and evaluate actual and potential quality issues during the review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and primary care providers (PCPs)
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of Member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program regularly to adapt to changes in the health care environment
- Collaborate with county Public Health-Linked Programs to ensure effective care delivery
- Provide equitable access to care by addressing health disparities such as structural racism and social risk, social determinates of health (SDoH), and specific community needs
- Recommend and implement strategies to eliminate health disparities and improve individual and community health outcomes
- Ensure full compliance with mental health parity requirements, applicable laws, regulations, and accreditation standards, fostering equitable access to mental health services.

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed to ensure all Members receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program operates under the clinical supervision of the Health Net, LLC Chief Medical Officer who please a key role in the implementation of the Program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities encompasses timely, direct referrals, prior authorization, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code §1367.01.

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

Health Net has developed, implemented, and continually enhances updates the UM Program to ensure effective processes are in place to review and approve the provision of medically necessary covered services. The plan is staffed with qualified professionals who are dedicated to its implementation and oversight.

The plan ensures the separation of medical decision making from fiscal and administrative management, safeguarding against undue influence on medical decisions. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 28 section 1300.67.3 (a) (1) and California Health and Safety code section 1367 (g), except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) All Plan Letters. Additionally, Health Net's Utilization Management Programs adhere to all applicable requirements set forth NCQA, CMS, DHCS, and DMHC and Managed Risk Medical Insurance Board (MRMIB) for Utilization Management and Care Coordination activities.

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

Utilization Management policies and procedures are available to Members and providers upon request.

Health Net Utilization Management nurses provide decision support, Member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and coordination with community resources to support the Member's plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the Member's Primary Care Physician refers the Member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Direct referrals are designed to enhance the Member's ability to directly access specialists.

Preauthorization/Prior Authorization

Health Net requires delegated PPGs to develop and maintain programs, policies and procedures that meet Health Net's established standards. Health Net Utilization Management staff is responsible for making pre-service decisions for request types that are not delegated.

Decisions about the following require medical necessity review:

- Any covered medical benefits defined by the Evidence of Coverage or Summary of Benefits
- Care, items or services whose coverage depends on specific circumstances.
- Out-of-network services, that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- "Experimental" or "investigational" requests covered by the Plan.

Decisions about the following do not require medical necessity review:

- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care, items or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL).
- "Experimental" or "investigational" requests that are always excluded and are never covered under any circumstances. In these instances, the Plan identifies the specific service or procedure excluded from the benefits plan.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for:

- Elective inpatient admissions,
- Services out of the Community HealthPlan of Imperial Valley service area, if not an emergency or urgent care
- Selected ambulatory surgery,

- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Durable medical equipment,
- Select specialized treatments such as home IV infusion
- Select diagnostic and radiology procedures.
- Medical transportation services when it is not an emergency

The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are:

- medically necessary,
- covered by the Member's benefit plan,
- the most current and appropriate medical or behavioral health interventions utilizing clinical criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence,
- provided by a contracted practitioner or provider, where appropriate or possible, and
- provided in the most appropriate setting.

Health Net, along with its delegated PPGs, does not require prior authorization for the following services or others as required:

- emergency services,
- minor consent services
- adult sensitive care services
    - family planning and birth control including sterilization for adults 21 and older,
    - pregnancy testing and counseling and other pregnancy related services
    - HIV/AIDS prevention and testing
    - sexually transmitted infections prevention testing
    - sexual assault care
    - outpatient abortion services
- preventive services from a participating provider
- basic prenatal care with a participating network obstetrician
- specialist referral (initial referral to participating specialist)
- urgently needed services when the Member is outside their county
- certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider
- MOA 638 Indian Health Service facilities
- biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (FDA approved)
- COVID-19 diagnostic and screening testing
- services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule
- initial mental health and substance use disorder assessments
- adult preventive immunizations from a participating physician or other provider
- second opinion from a participating physician or other provider
- Comprehensive Perinatal Services Program (CPSP) services
- Services related to the California Prenatal Screening (PNS) Program

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

Inpatient Facility Concurrent Review

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

A goal of CCR is to support the Member and Member's health care team to optimize health outcomes when the Member experiences a health status change. This is done in collaboration with the PPG, Member and the Interdisciplinary Care Team to:

1) Ensure services are accessed timely,
2) Educate the Member's health care team about the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to relevant Member resources, such as the behavioral health team, care management, and community resources or carve our programs such as California Children's Services program, the Local Education Agency (LEA) program, or the County Mental Health Program etc.

The CCR nurse supports a smooth transition from the acute care setting or skilled nursing facility (SNF) to the next level of care or community service. This is achieved by bridging the inpatient to outpatient process, facilitating health care services and supporting Member care management programs.
Health Net nurses, Medical Directors, and delegated partners conduct telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, or skilled nursing facilities. Health Net may also monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status.

The inpatient review process occurs within one business day from the day of hospital admission or notification of admission and continues throughout the patient's hospital stay.

For post-stabilization care, the Plan make a decision within 30 minutes whether to approve or disapprove an admission or transfer the Member (if they are currently in a non-participating facility). If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is authorized.

The review process includes application of standardized nationally recognized criteria for medical appropriateness review, evaluation of levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses utilize nationally recognized criteria, including InterQual® criteria, Hayes, and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical staff support pre-service and concurrent review with data entry, receipt and documentation of notifications, and receipt and attachment of clinical content.

Requests that do not meet guidelines or criteria for approval are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess the Member specific care management and disease/ chronic condition management needs and refer such cases to Care Management for evaluation. Concurrent Review Nurses collaborate with Care Managers on all Members identified in active care management.

CCR goals include supporting the Member and Member's health care team to optimize health outcomes in the event the Member experiences a health status change. This is done through work and advocacy with the PPG, Member and/or the interdisciplinary care team to:

1) ensure services are accessed timely,
2) educate to the Member's health care team on the Member's benefit structure and resources,
3) facilitate expeditious authorization of services when appropriate, and
4) facilitate referrals to appropriate Member resources, such as the behavioral health team, care management, and community resources.

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

Discharge Planning

Health Net and/or its delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in collaboration with the practitioner, the Member, and the Member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the Member's admission, whenever

possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to:

- home health care,
- durable medical equipment
- transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation), and/or
- CalAIM Community Support programs, including Recuperative Care and Short-Term Post Hospitalization Housing.

HN Concurrent Review nurses identify potential care management cases and refer them to Care Management and other outpatient programs for post discharge evaluation and/or services.

The criteria used for evaluating and guiding timely discharge planning include nationally recognized criteria such as InterQual®, Hayes, and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care, including the identification of Community Supports and Complex Care Management needs
- Assessment of Member's support system to determine necessary services and support needs
- Development of a discharge plan of care based on short-term medical and psychosocial needs
- Coordination and implementation of services requested in the plan of care
- home health care,
- durable medical equipment and/or
- transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation), and/or.

Post Service/Retrospective Review

Delegated PPGs conduct post service or retrospective review activities in alignment with Health Net standards. Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service or retrospective review of medical records when services rendered have not been pre-authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' Medical Directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the Member received the services and that services meet the criteria for medical necessity. Determinations are processed after obtaining all necessary information required to review the request.

Second Opinion

A Member, the Member's authorized representative or a provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned Members who request a second opinion to a participating physician within their medical group. If a Member requests a second opinion about specialty care from a participating specialist physician who practices outside of the Member's PCP's medical group, the request will be forwarded to Health Net Utilization Management for review. Health Net does not routinely require prior authorization for second opinion services given that the second opinion is provided within or outside the Member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the Member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network. There is no cost to the Member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the Member to obtain a second opinion out-of-network at no cost to the Member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical management information, ensuring accurate and streamlined data management.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver high-quality, cost-effective medical services to Members and their dependents. The foundation for accessing appropriate health care services is the selection of a Primary Care Provider (PCP) and establishment of a relationship with that provider. PCPs include: Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access/Availability to Health Care Services

Health Net conducts ongoing review of the Health Plan's provider network to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to Members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of Member records are met. When gaps or unmet needs are identified, targeted recruitment efforts are initiated to enhance the network and ensure comprehensive coverage for all Members.

Coordination with Quality Improvement Programs

The Health Net Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and Member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve Member care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate Members for Public Health, Long Term Services and Supports (LTSS), CalAIM Community Supports, waiver programs and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers.
- Identifies and refers appropriate Members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate Members for Cultural and Linguistic Services, including Members needing translation of documents or interpreter service for office visits.
- Offers disease/chronic condition management Programs for all Members who meet enrollment criteria for specific gateway conditions regardless of a Member's delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health team administers the Medi-Cal Non-specialty Mental Health Services (NSMHS)carved into the Managed Care Plans.

The behavioral health team provides early and periodic screening, diagnosis and treatment services for Members ages 0 to 20. These services include medically necessary Behavioral Health Treatment (BHT) such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

The behavioral health team will manage specified mental health benefits to adults, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as Members seeking other services not provided by the behavioral health team, will be referred to the County Specialty MHP.

The behavioral health team's utilization management decisions are based on Centene Clinical Policy and evidence-based criteria guidelines set forth by the American Psychiatric Association and the American Psychological Association.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). The behavioral health team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. Community Health Plan of Imperial Valley shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. Community Health Plan of Imperial Valley will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. Community Health Plan of Imperial Valley will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

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

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

The core objective of utilization management at the behavioral health team is to manage available behavioral health care benefits to achieve the best possible clinical outcomes

for Members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, the behavioral health team has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a Member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The behavioral health team utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by the behavioral health team do not require authorization. All behavioral health team staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors.

The behavioral health team coordinates Continuity of Care (COC) for Members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and Members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about Health Net's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are being managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes Community Health Plan of Imperial Valley Chief Medical Officer, Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations.

Continuity and Coordination of Care

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

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

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

- Coordinating transition of care for Members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan Members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a Continuity of Care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible Members may require Continuity of Care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a Member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.

- The Continuity of Care process is facilitated by licensed nurses based on Member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.

- Care Managers are patient advocates and assist Members to ensure that they receive timely and uninterrupted medical care during the transition process.

Primary Care Physician responsibility:

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

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

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, Member and provider education and triage services.

Over and Under Utilization

Health Net requires all providers are required to submit claim/encounter data for all services rendered. Multiple methodologies are utilized to monitor under and over utilization, including referral timeliness, provider appeals, denials, Member appeals and grievances. The types of methods include:

- Annual evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through Member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacy data
- Evaluation of individual direct contract physician practice patterns

Health Net's Utilization Management Department and the behavioral health team facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.
- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance
- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all Members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Population Health Management key performance indicator metrics
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by Members.

- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.
- Provider prescribing patterns including medication utilization metrics

Health Net completes the Quality Management education process with its contracted providers through local interaction with the Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's Utilization Management Program use the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the Member's health status:

1. State law/guidelines such as
    a. Title 22 CCR,
    b. Title 17 CCR,
    c. Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters
    d. California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals.
    e. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v)
2. Plan-specific clinical policy
    a. includes custom content within InterQual® and
    b. other vendor specific criteria;
3. Centene clinical policy
    a. Includes Centene customized clinical policies within InterQual®;
4. Nationally recognized decision support tools
    a. when no specific Plan, or Centene clinical policy exists, tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are applied;
5. Medical necessity decisions for transgender health services are based on the criteria and guidelines set forth by the World Professional Association for Transgender Health (WPATH).
6. Additional considerations (if no guidance from 1-4), when available:
    a) Peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
    b) Recognized United States professional standards of safety and effectiveness for diagnosis, care, or treatment;
    c) Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    d) Medical association publications;
    e) Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
    f) Published expert opinions (e.g., Up-To-Date);
    g) Opinion of health professionals in the area of specialty involved;

h) Opinion of attending provider in case at hand.

Benefit determinations are based on the following:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

Conflict Resolution:
- When Medi-Cal (state Medicaid) coverage provisions conflict with the Plan or Centene specific clinical policies, Medi-Cal coverage provisions take precedence.
- Refer to the Medi-Cal manual for applicable coverage provisions.

Transparency and Accessibility:
- Clinical policies, benefit provision, guideline, protocol or criteria are available upon request, in compliance with Federal and State regulations.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

Medical Necessity and Appropriateness:
- Utilization management decisions are based on medical necessity and medical appropriateness

No Compensation or Incentives for Denial:
- Health Net does not provide compensation to physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and
- Special attention is paid to the risk of under-utilization

Policy Transparency:
- Health Net and its delegates distribute a statement to all practitioners, providers, and employees describing Health Net's policies and restrictions on financial incentives

Decision Making integrity:
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates are prohibited from rewarding practitioners or other individuals conducting utilization review for issuing denials of coverage or service

Independent Oversight:
- Health Net Medi-Cal Medical Directors and the Health Net Community Solutions CMO/VP Medical Director do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net ensures the consistent application of utilization decision criteria through structured processes and evaluations involving both Health Net staff and delegated PPG's such as:

- **Weekly Regional Utilization Management (UM) Rounds** – Use of Rounds facilitates interdisciplinary collaboration to enhance consistent decision-making, optimize patient outcomes, and improve resource management.
- **PPG Collaboration –** PPG management issues are referred to the Provider Oversight Department for resolution.
- **Real-Time Feedback from Leadership** – Continuous guidance and support from medical leadership are provided to reinforce standardized decision-making practices.
- **Ongoing UM Training** – Mandatory training sessions led by the Learning and Development team for all clinical review staff, both new and existing including training that focuses on:
  - Clinical Criteria Hierarchy and its application
  - Identification and utilization of available criteria sources

Inter-Rater Reliability (IRR) Review Process:

New hire and annually, IRR testing are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any new hire and annual IRR test. If a staff Member scores < 90% for any subset the staff must complete remediation and successfully retest within 30 days of completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff or auditing five (5) cases in production, providing two additional testing opportunities to demonstrate remediation success for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader.

IRR results are reported annually at the HNCS Quality Improvement Health Equity Committee Meeting and subsequently to CHPIV.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight, includes a file review of denial files using Health Net Provider Delegation Oversight Interactive Tool (DOIT)
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all Member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

Health Net maintains strict adherence to established time frames for UM decision making to ensure that Members receive timely care. These time frames are designed to minimize disruptions in the provision of healthcare services and are based on the urgency of the clinical situation.

Key Points on Timeliness of Decision Making:

- Turnaround Time (TAT) Standards
  - The TAT standards for decisions making regarding medical necessity and authorization requests are guided by current DHCS, DMHC, and State regulatory guidelines.
  - The most stringent of these guidelines are applied to ensure compliance and consistency.
- Timeliness Communication
  - All decisions regarding authorization or medical necessity are communicated to both the Member and the provider within the required regulatory timeframes.
  - The communication method and timeframe are determined by DHCS, DMHC, and State regulations, whichever set of guidelines has the most stringent requirement
- Delegated Provider's Compliance
  - Health Net's delegated providers are informed of the decision timeliness standards as outlined in the Provider Operations Manual.

By maintaining these standards and monitoring compliance, Health Net ensures that healthcare decisions are made promptly and in accordance with regulatory requirements, ensuring Members receive timely care and services.

Denials

A Member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. The clinical reviewer may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

For any Major Organ Transplant (MOT) denial consideration, the HNCS Chief Medical Officer (CMO), or a delegated HNCS senior Medical Director reviews the request and determines the appropriateness of a denial.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines.

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial

letters into “threshold languages” in collaboration with Health Industry Collaboration Effort (HICE).

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

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the contact telephone number to schedule a conversation with the Medical Director or Pharmacist who issued the denial and the Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all Member medical necessity appeals.

Community Health Plan of Imperial Valley has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CHPIV, Health Net is responsible for appeals for their Members. Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net Medical Director.

Health Net maintains well-publicized and readily available appeal mechanisms for Members and practitioners for medical necessity denials issued by CHPIV or its delegates.

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

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

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

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

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure Members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare/Optum InterQual® criteria, the Hayes, Inc. Medical Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by Members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

Satisfaction with the Utilization Management Process

At least annually, Health Net surveys Members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the HNCS QIHEC where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the HNCS QIHEC Committee.

Communication Services

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

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

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

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

Emergency Services

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

Monitoring of Health Net's Performance in Providing and Management of Utilization Management Services

CHPIV monitors Health Net performance via a combination of Quality-based and Compliance-based approaches. Various metrics (e.g., prior auth denials, auth approval turn-around times) are monitored on a continuous basis. Other metrics (e.g., case file reviews) are audited on a quarterly/semiannual/yearly cadence. Health Net's performance is also reviewed via participation in various committees (e.g., Quality Improvement Health Equity Committee, UM Review Committee).

Evaluation of the Health Net UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CHIPV UM Program Description is forwarded to CHIPV for review and approval. This ensures that all relevant policies, procedures, and protocols are aligned and in accordance with CHPIV's standards before they are finalized and implemented. The review and approval process is a key step in ensuring the consistency, compliance, and quality of the UM program.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Community Health Plan of Imperial Valley Staff Resources and Accountability

CHPIV Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO)

The CHPIV CMO/CHEO's responsibilities include chairing the Quality Improvement Health Equity Committee and work group, providing oversight of Quality Improvement Health Equity Programs, and assuring that the Quality Improvement, Health Equity and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in Utilization Management operations. This position makes recommendations to the LHA Commission to initiate major program revisions and communicates the LHA Commission's directives to both internal and external stakeholders.

Department Resources

CHPIV staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CHPIV UM Program. These administrative and clinical staff work with CHPIV's CMO/CHEO and Director of Medical Management to oversee UM activities for CHPIV's Medi-Cal Members and provider network. The resources and responsibilities of departments most involved in the UM process are described below.

Medical Management Team

The Medical Management team will include a CMO/CHEO, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CHPIV and HNCS will ensure that staff involved with the Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.

CHPIV Quality Improvement Health Equity Committee

The purpose of the CHPIV Quality Improvement Health Equity Committee (QIHEC) is to provide oversight and guidance for CHPIV's QI, HE, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into development of medical policies.

The QIHEC Committee monitors the quality and safety of care and services rendered to Members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QIHEC Committee is given its authority by and reports to the Imperial Local Health Authority (LHA) Commission in an advisory capacity. Members of the committee are appointed by the LHA Commission Chairperson. The Committee is chaired by the CHPIV CMO/CHEO.

Committee size is determined by the LHA Commission with the advice of the CMO/CHEO.

The QIHEC Committee is composed of Participating health care providers, including physicians, behavioral health practitioners, as well as other health care professional's representative of the CHPIV and the Health Net provider network. The Committee composition may also include Commission Members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee Membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

Health Net LLC's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI Utilization Management operations.

The CMO has overall decision-making responsibilities for Health Net medical matters. The CMO oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other PHCO leadership team Members. PHCO departments for which they have clinical oversight responsibility to include: Quality Improvement, Utilization Management, Care Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/Chronic Condition Management.

The CMO's responsibilities include, but are not limited to: leading the health plan in California PHCO initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Health Net Community Solutions (HNCS) CMO/ Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the HNCS CMO/VP Medical

Director is responsible for QI activities for these programs. The HNCS CMO/VP Medical Director is the chair of the Health Net Community Solutions Quality Improvement Health Equity Committee and is actively involved in implementing the UM Program. The HNCS CMO/VP Medical Director reports to HN LLC's CMO.

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and care management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net Members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost-effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement and Health Equity Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Vice President of Population Health and Clinical Operations (VP PHCO)

The VP PHCO is a registered nurse with experience in utilization management and care management activities. The VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The VP PHCO reports to the Plan Chief Operating Officer. The VP PHCO, in collaboration with the HNCS CMO/VP Medical Director, assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

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

Utilization Management (UM) Resources

Director/Senior Director, PHCO

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the Member's benefit structure.
- Emphasizes continuity of transition of care, assisting Members in obtaining access to care, and Member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e., Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of Members to Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and
- All UM, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of Members to County CCS offices when eligible
- Referral of Members to LTSS and Waiver Programs
- Referral of Members to CalAIM Community Supports
- Coordination with Regional Centers to ensure Medi-Cal Members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible Members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance

- Coordination with County programs, such as County social services for in home support services and County mental health
- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Team Medical Director and Medical Staff

The behavioral health Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of behavioral health program and clinical policies, the behavioral health team Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The behavioral health team Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN Members. The behavioral health team Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, Member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the HNCS QIHEC. The behavioral health team Medical Staff sits on the following committees: HNCS QIHEC, HN Credentialing Committee, the Pharmacy and Therapeutics Committee, and the HN Medical Advisory Council.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions (HNCS) Quality Improvement Health Equity Committee (QIHEC)

The HNCS QIHEC reports directly to the HNCS Board of Directors. The committee is charged with the monitoring of the PHCO and quality of care and services rendered to Members within HNCS including identification and selection of opportunities for improvements, monitoring interventions and addressing UM, QI, PMH and Health Equity activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the HNCS QIHEC quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI. The Committee membership also includes practicing network physician representatives. The HNCS QIHEC is co-chaired by the HNCS CMO/VP Medical Director and the Chief Health Equity Officer for HNCS and meets quarterly.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs), contracted vendors and strategic partners (delegated partners).

Health Net has established processes in place to assess and determine the appropriateness delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment.

Health Net has an experienced team of Compliance Auditors for oversight of delegated entities. At least annually, Delegation Oversight audits delegated partners which include file and policy and procedure reviews. Delegates are required to provide monthly turn around time reporting. This reporting is reviewed for completeness and required performance standards. The Delegation Oversight team also routinely conducts system validation checks to evaluate the delegates' data quality. If an auditor discovers a below standard performance during an auditing or monitoring activity, a Corrective Action Plan (CAP) is requested from the delegate. All CAP remediations are evaluated, tracked and validated prior to closure. These oversight processes are established to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CHPIV's monthly Management Oversight Meeting.

Delegation Oversight Committee

The purpose of the Delegation Oversight Committee (DOC) is to provide a forum for discussion of the delegates' performance and to address significant risks with health plan leadership. During this meeting oversight activities and recommendations of the subcommittee DOW, audit results and corrective actions are discussed. As needed the DOC will discuss remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing oversight
- Financial sanctions through a capitation deduction
- Membership freeze
- Required change in Management Services Organization
- Denial of business expansion or changes
- De-delegation, and/or contract termination
- Terminating the organization's contract with Health Net.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate’s program.

A review of the contracted delegates shall be conducted annually or more frequently as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net’s review upon request.

Section 6

Utilization and Care Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

Health Net's Vice President of PHCO annually prepares the CHPIV Utilization/Care Management Program Evaluation and presents the evaluation to CHPIV for review.

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

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

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

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

UM/CM Program Work Plan

Health Net Community Solutions CMO/VP Medical Director and Vice President Population Health and Clinical Operations annually develop the CHPIV UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Imperial Local Health Authority Approval

Imperial County Local Health Authority Commission has reviewed and approved this Program Description.

_____ Date _____
Lee Hindman, Imperial County
Local Health Authority Commission Chairperson

_____ Date _____
Gordon Arakawa, MD, PhD
Chief Medical Officer/Chief Health Equity Officer
Chair, Community Health Plan of Imperial Valley QIHEC Committee

Health Net Medi-Cal Utilization Management Program Approval

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

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Matthew Bensley Vice President of Population Health and Clinical Operations