LA County
Coordinated Care Initiative
Quarterly Stakeholder Workgroup

Meghan Speidel
Lourdes Birba
Linda Wade-Bickel

January 20, 2016

Health Net®

Agenda

A. Delivering Coordinated Care

B. Overview of Health Net's Care Coordination Process

C. How the CCI enables the delivery of Coordinated Care

D. Approach for Using Data to Facilitate Care Coordination

E. Focus on Improving Member Engagement

F. Member Impact

G. Questions and Discussion

Health Net

Delivering Coordinated Care

Care1st Health Plan
Yes, it's all about you.

CareMore
It's what we do.™

Health Net®

L.A. Care Health Plan®

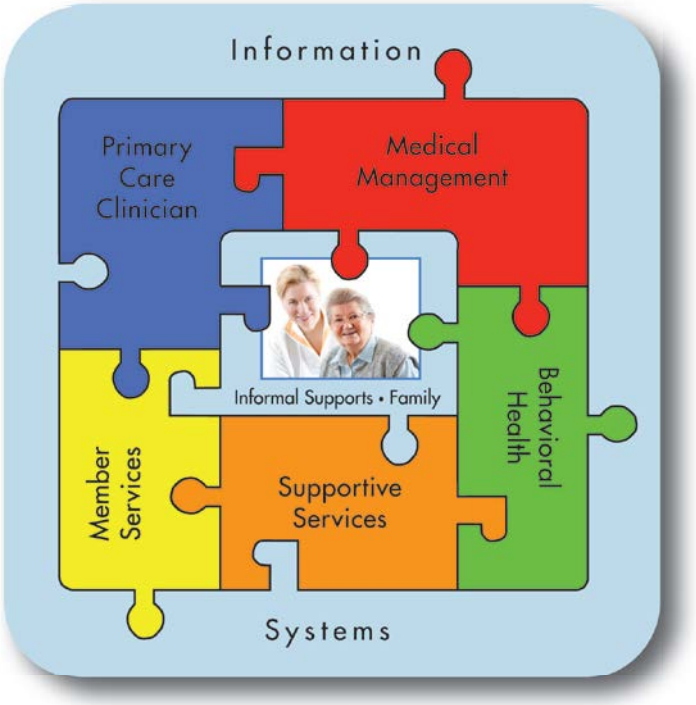
Molina® Healthcare

Delivering on the Care Coordination Promise

The current fragmented delivery of care leads to

- Beneficiary confusion
- Poor care coordination
- Inappropriate utilization
- Unnecessary costs.

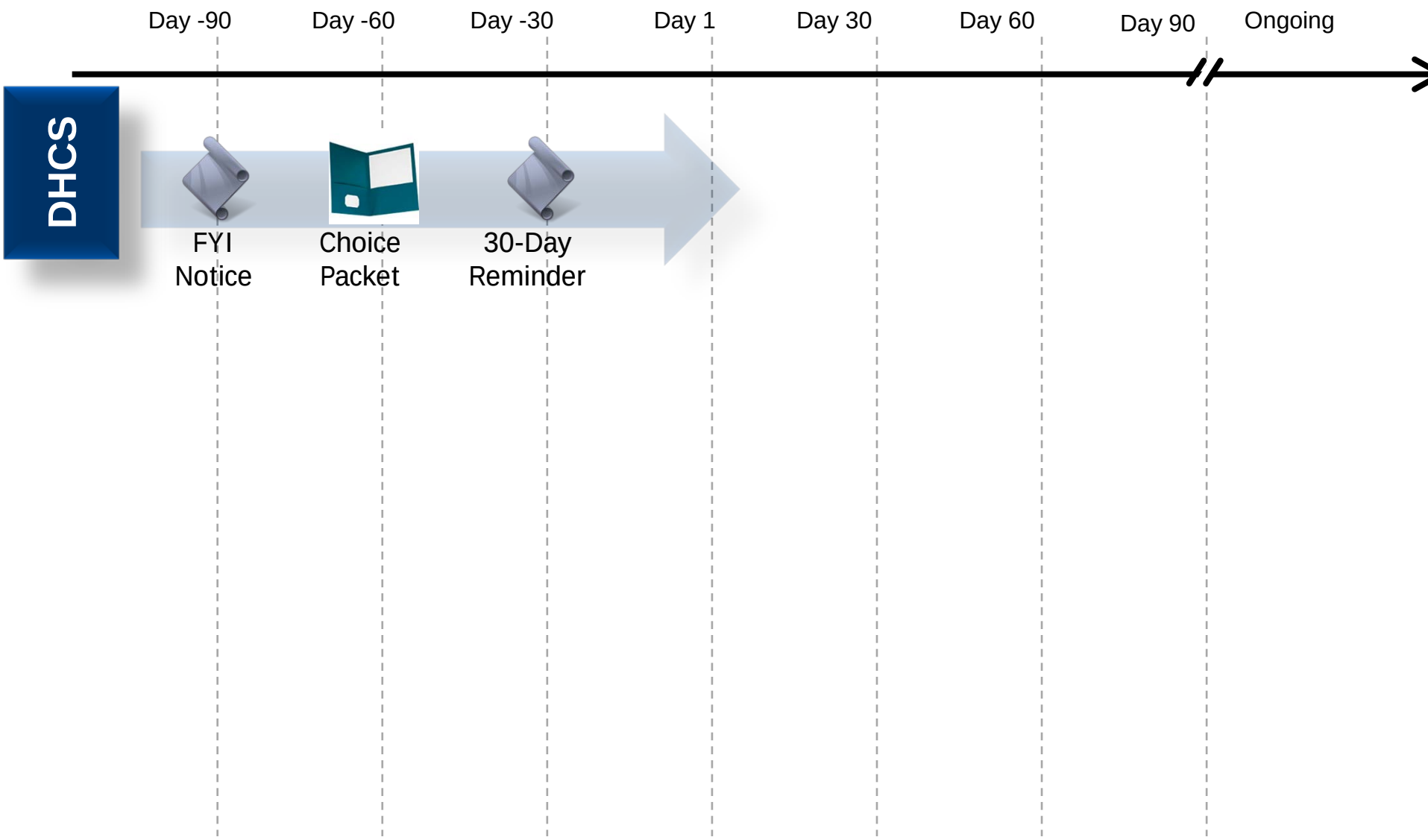
A Person-Centered Approach, delivered in a Managed Care environment, aims to improve the coordination of care, minimize beneficiary confusion, and ensure that the best care is delivered in the most appropriate setting



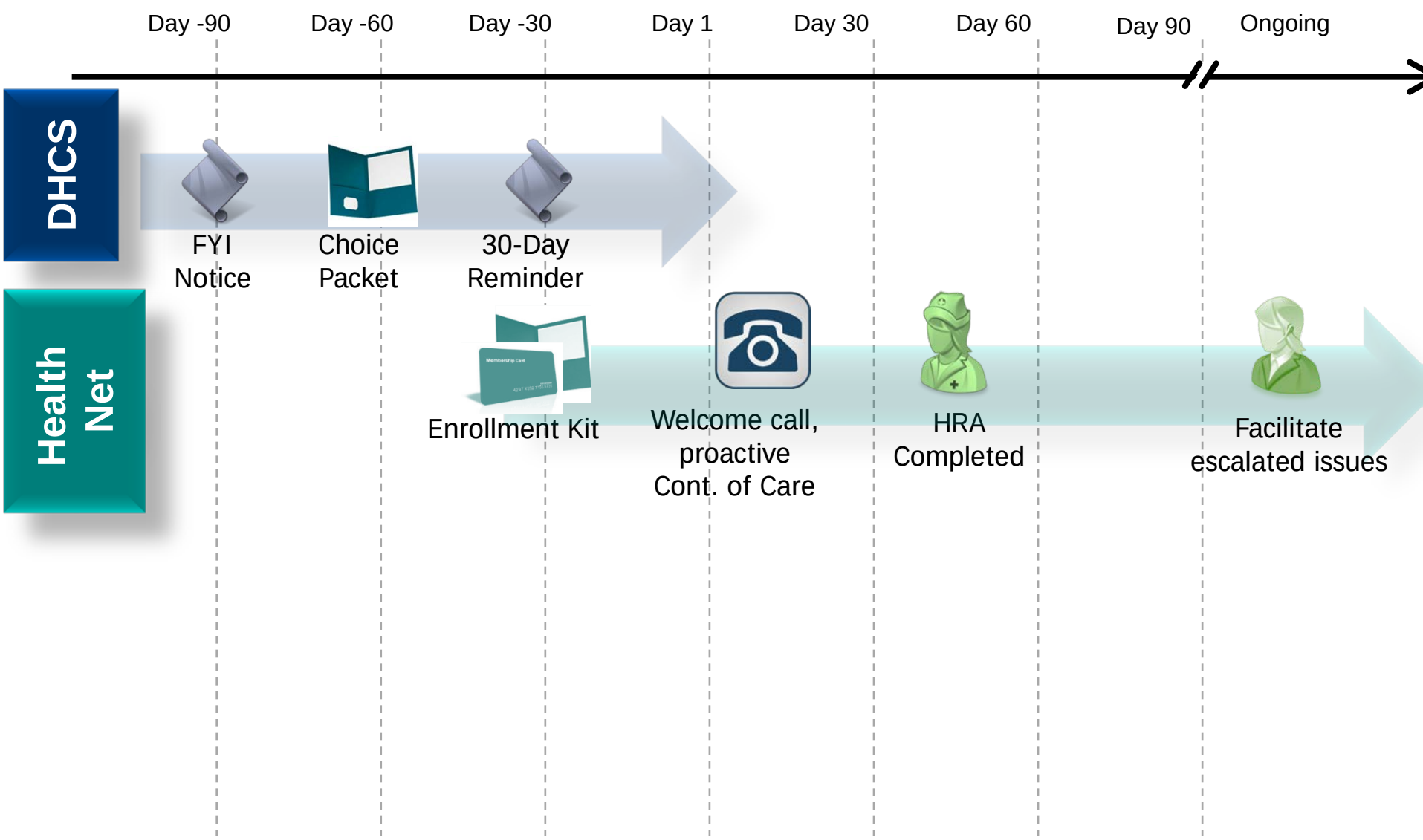
From: Burwell and Saucier. *Care Management Practices in Integrated Care Models for Dual Eligibles.* AARP, 2010.

Health Net's Care Coordination Process

Member Experience



Member Experience



Member Experience

Day -90 | Day -60 | Day -30 | Day 1 | Day 30 | Day 60 | Day 90 | Ongoing

DHCS

FYI Notice

Choice Packet

30-Day Reminder

Health Net

Enrollment Kit

Welcome call, proactive Cont. of Care

HRA Completed

Facilitate escalated issues

Case Management

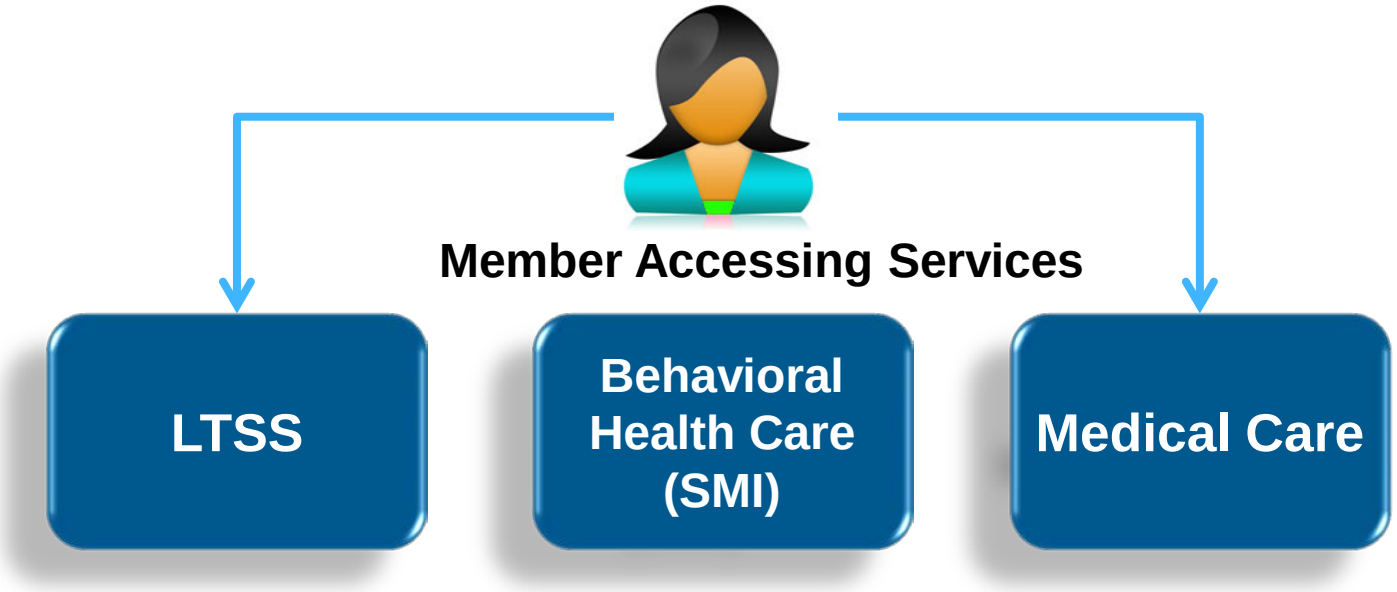
Build Care Plan w/ Member

Care Team Meeting

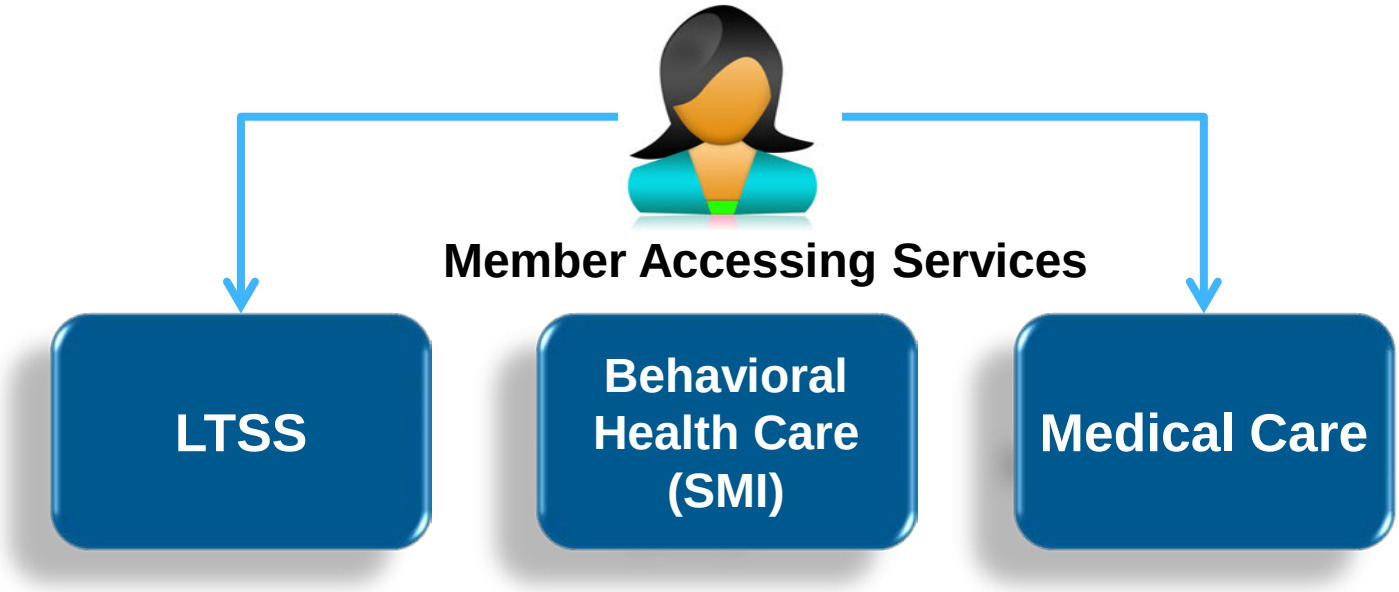
Update/ revise care plan

How the CCI enables the delivery of Coordinated Care

FFS World for a Dual Eligible Beneficiary

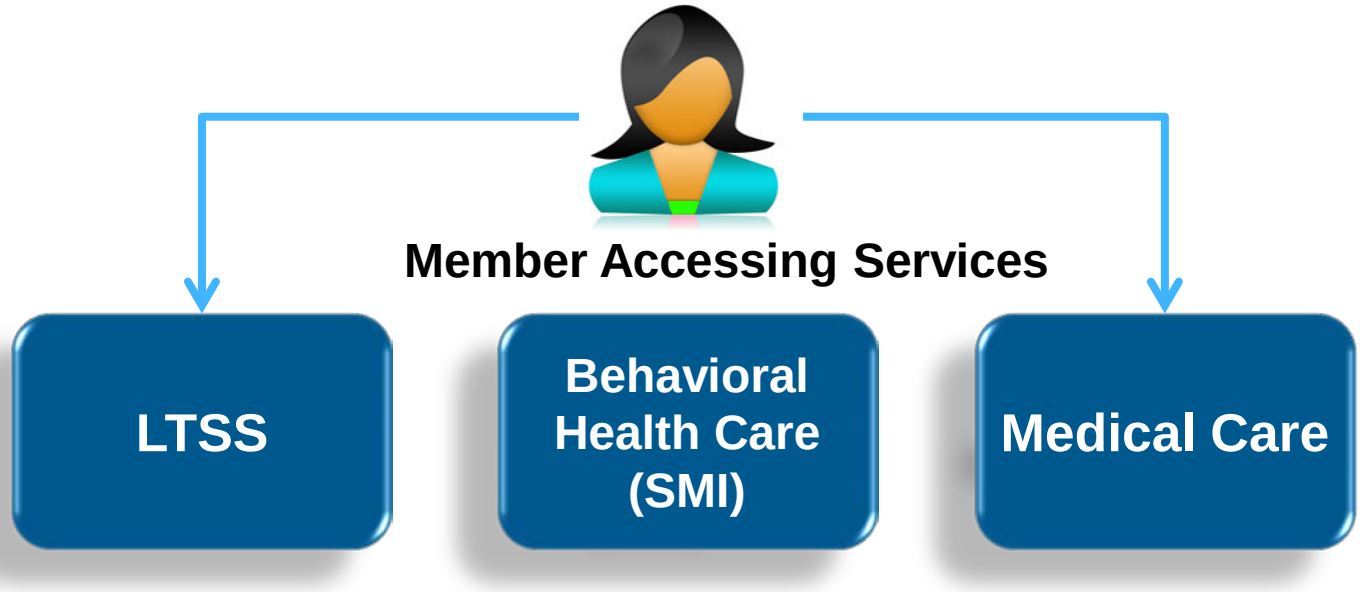


FFS World for a Dual Eligible Beneficiary



Who knows the beneficiary is accessing services?

FFS World for a Dual Eligible Beneficiary



Who knows the beneficiary is accessing services?

Who holds the data/ information related to the health services?

FFS World for a Dual Eligible Beneficiary

Member Accessing Services

LTSS

Behavioral Health Care (SMI)

Medical Care

County

FFS World for a Dual Eligible Beneficiary

Member Accessing Services

LTSS

Behavioral Health Care (SMI)

Medical Care

County **State**

FFS World for a Dual Eligible Beneficiary

Member Accessing Services

LTSS	Behavioral Health Care (SMI)	Medical Care
County State	**County Dept. of Mental Health**	

FFS World for a Dual Eligible Beneficiary

Member Accessing Services

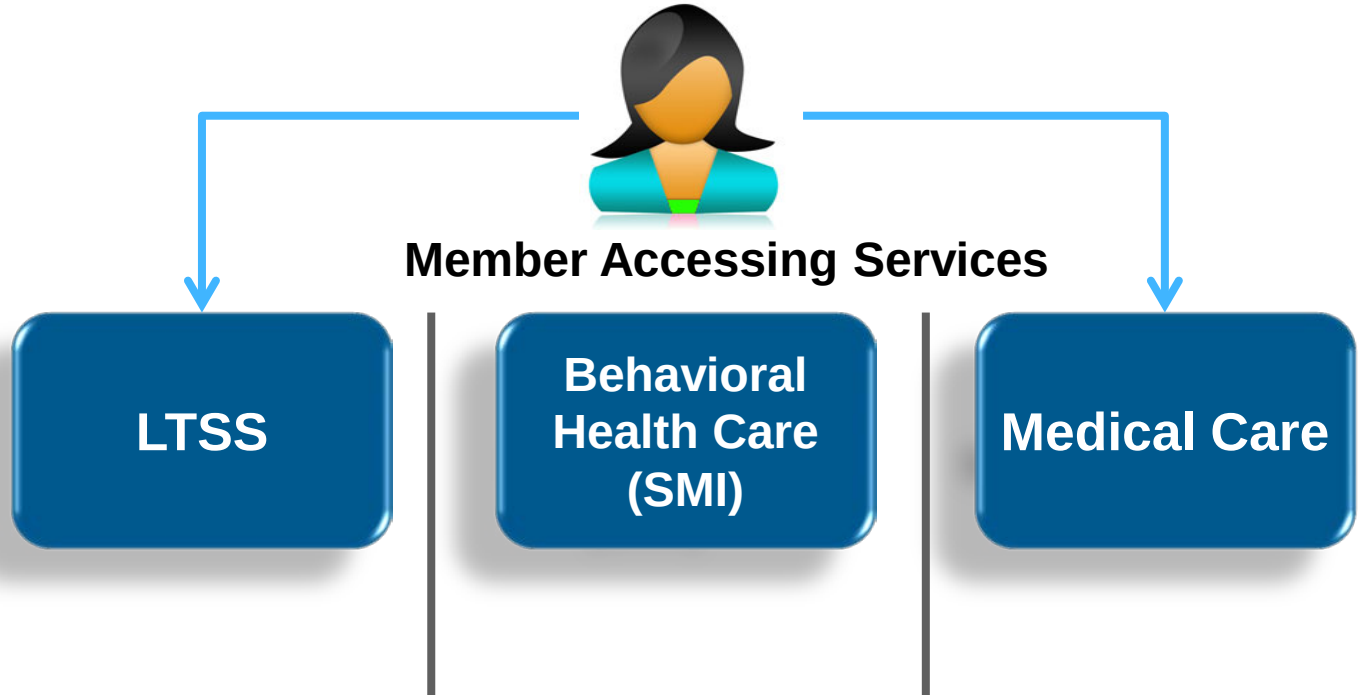
LTSS	Behavioral Health Care (SMI)	Medical Care
County State	County Dept. of Mental Health	CMS

FFS World for a Dual Eligible Beneficiary

Member Accessing Services

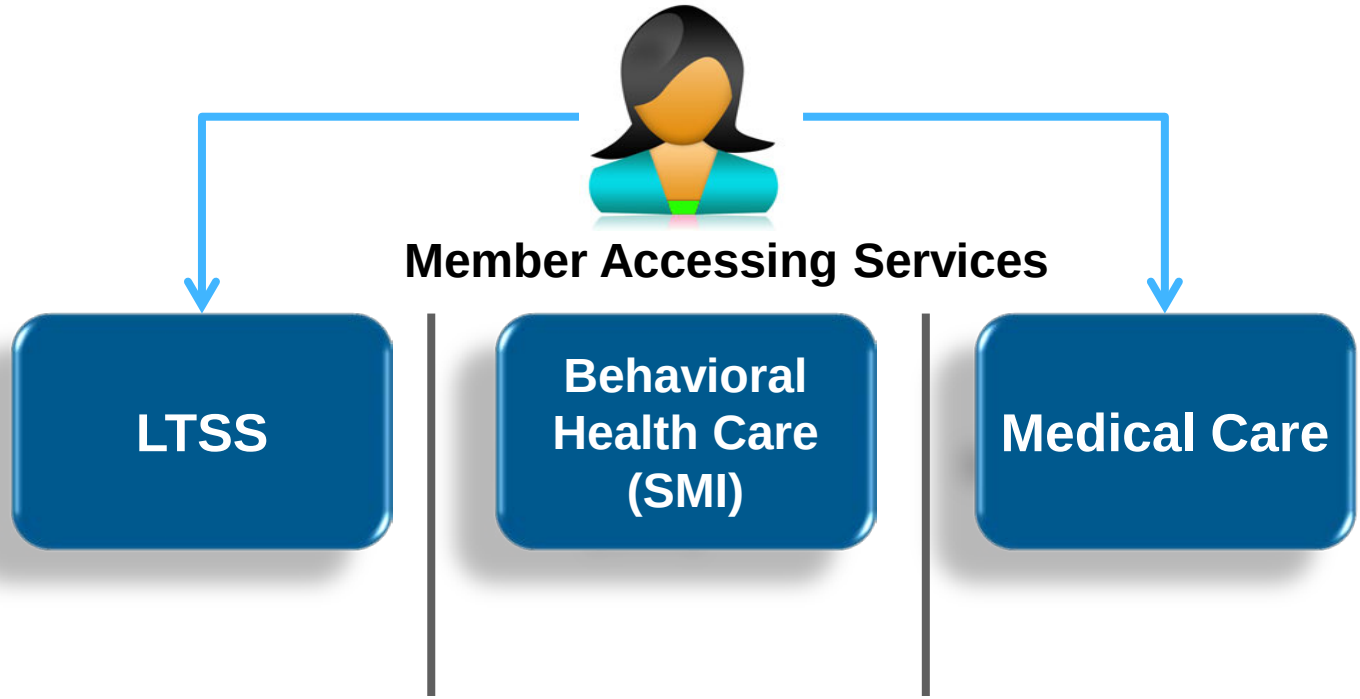
LTSS	Behavioral Health Care (SMI)	Medical Care
County State	**County Dept. of Mental Health**	**CMS State**

FFS World for a Dual Eligible Beneficiary



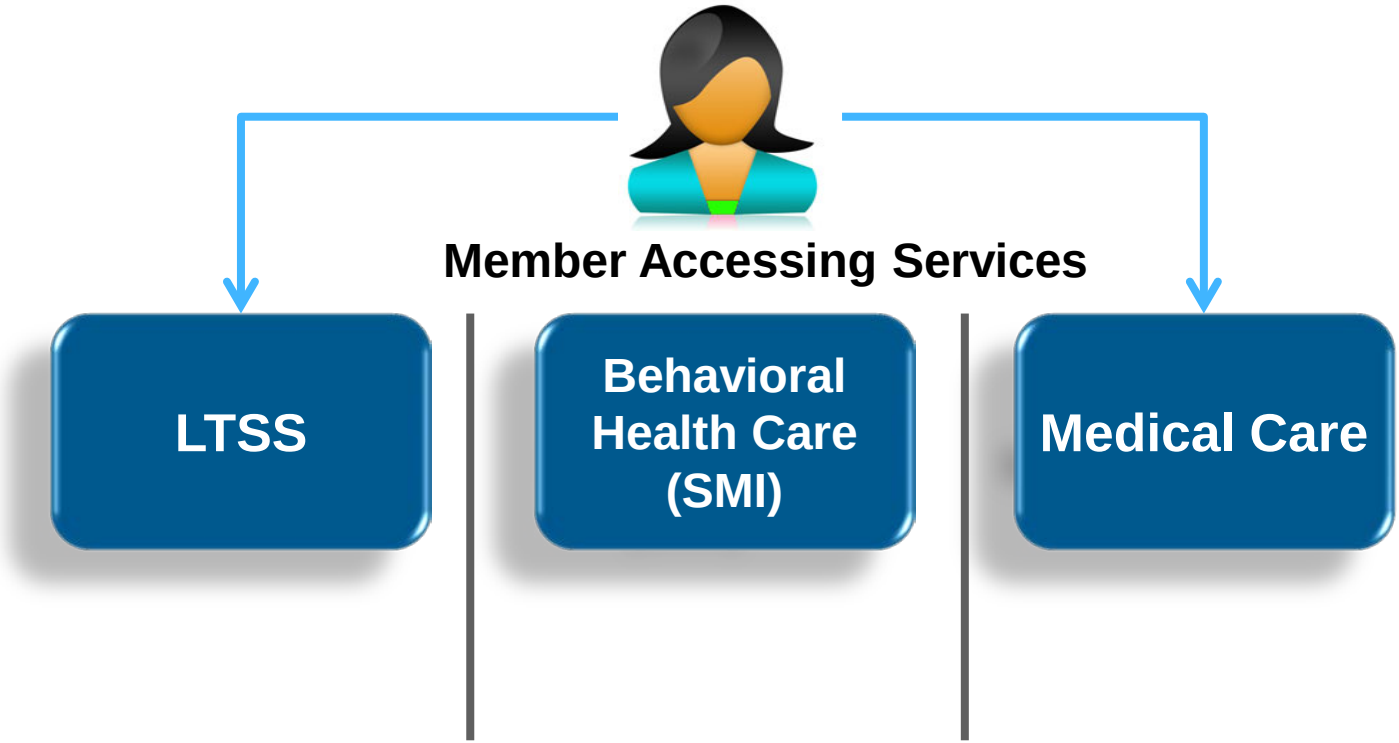
This silo model creates problems for beneficiaries who have multiple and diverse needs, and who are accessing care from multiple provider types

FFS World for a Dual Eligible Beneficiary



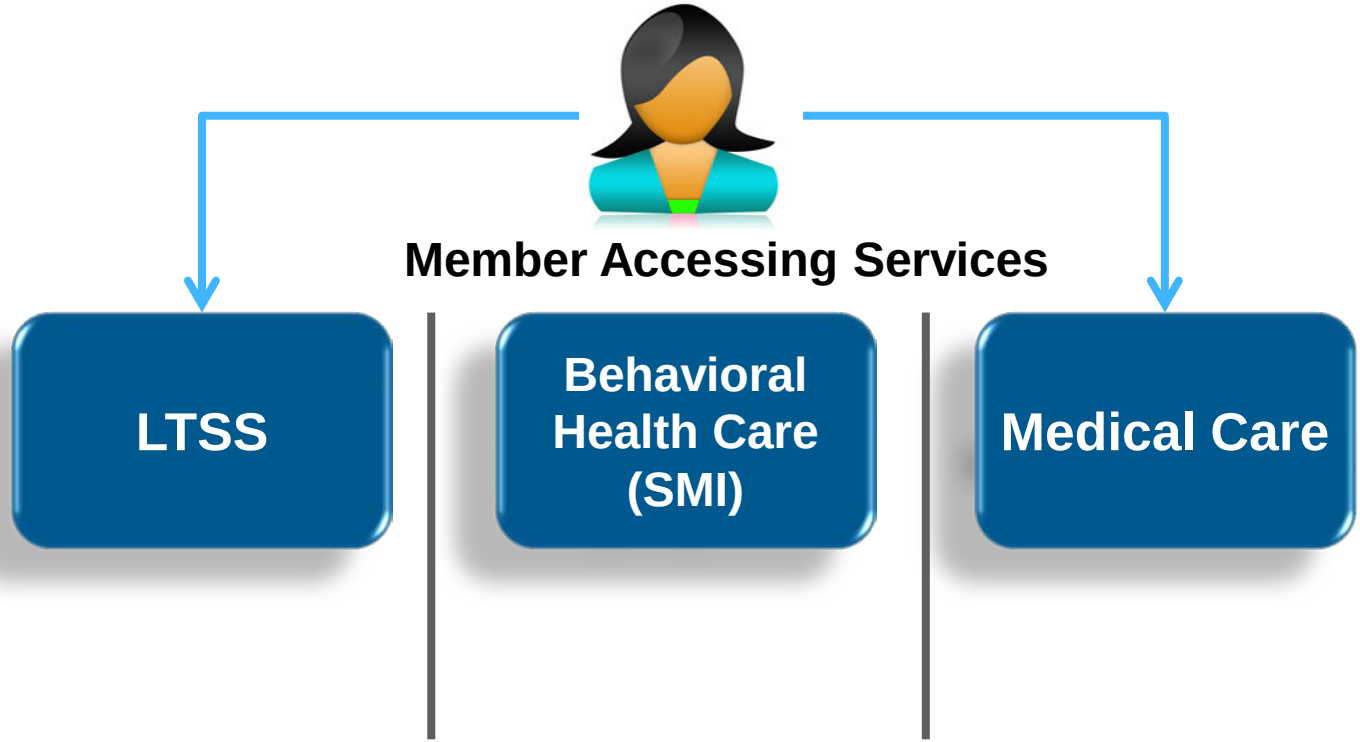
In this model, no one Care Provider ever knows the full spectrum of services or care the member is receiving

FFS World for a Dual Eligible Beneficiary



This can result in….

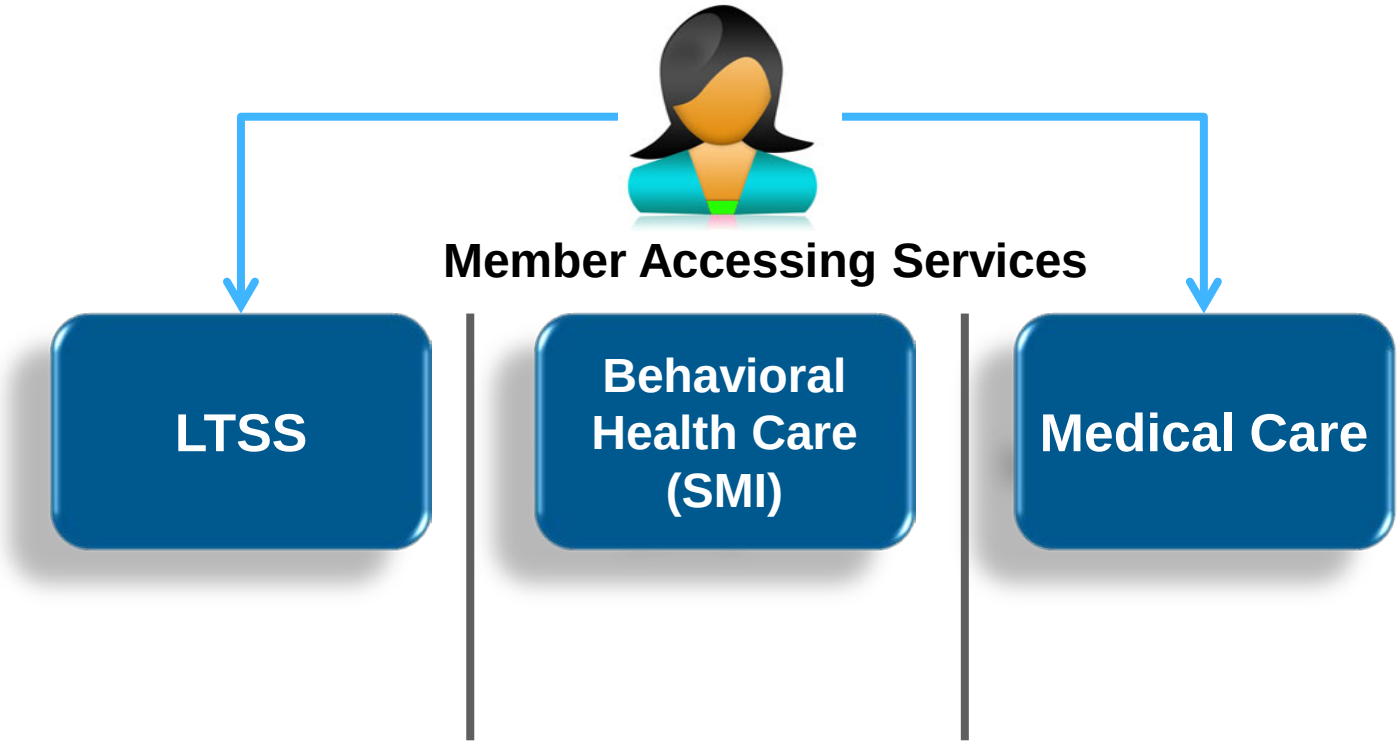
FFS World for a Dual Eligible Beneficiary



This can result in….

- *Serious and avoidable health issues for the member*

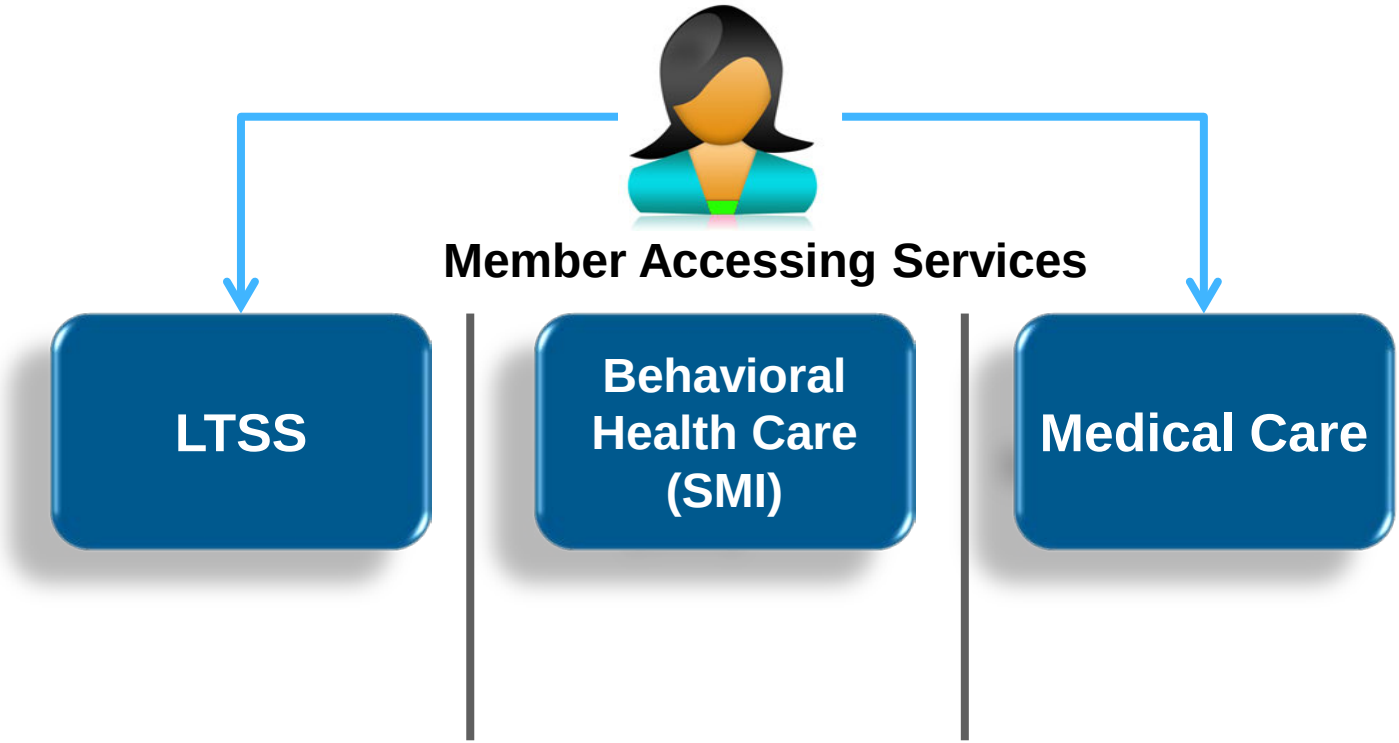
FFS World for a Dual Eligible Beneficiary



This can result in….

- *Serious and avoidable health issues for the member*
- *Undue burden on member/ member family*

FFS World for a Dual Eligible Beneficiary

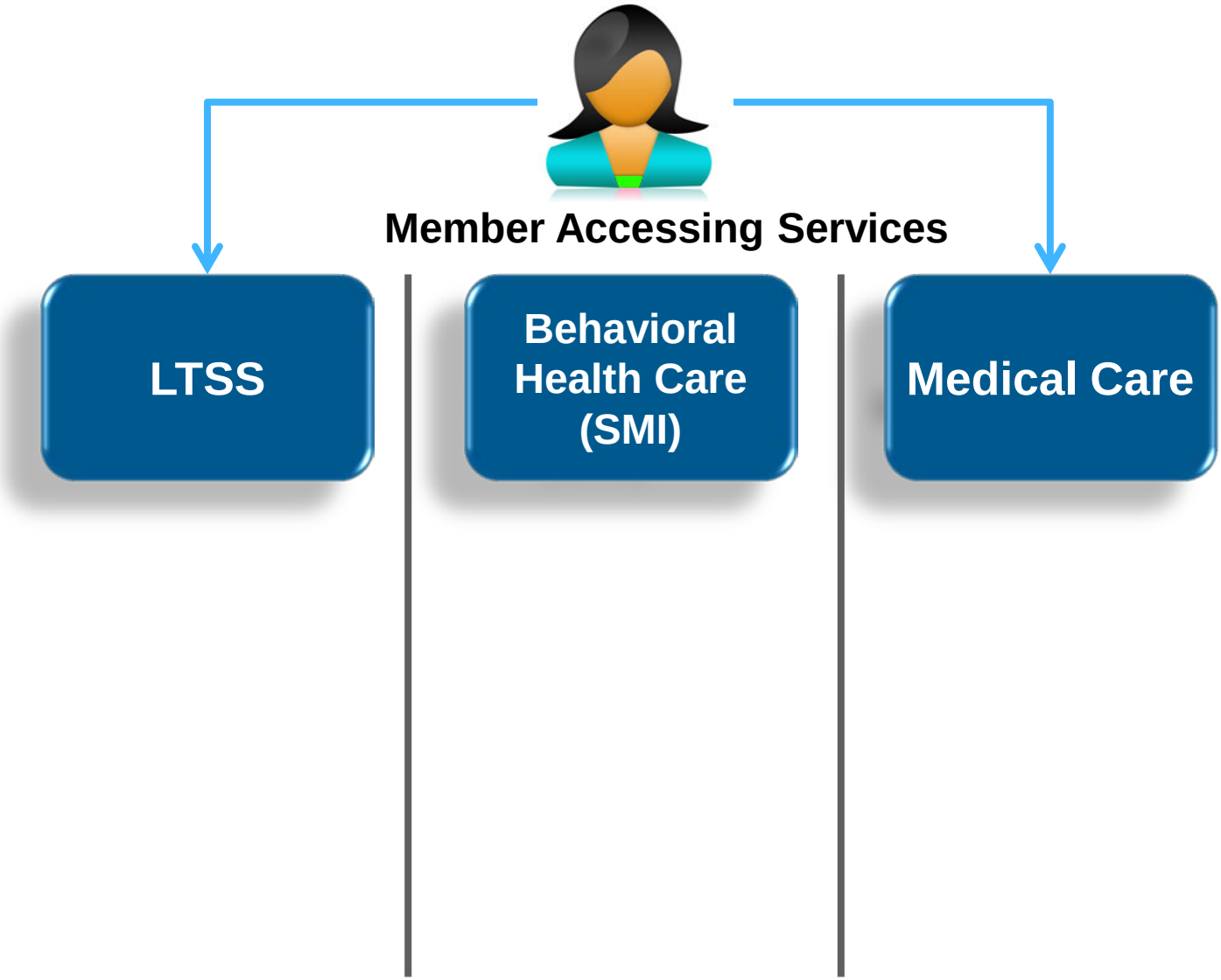


This can result in….

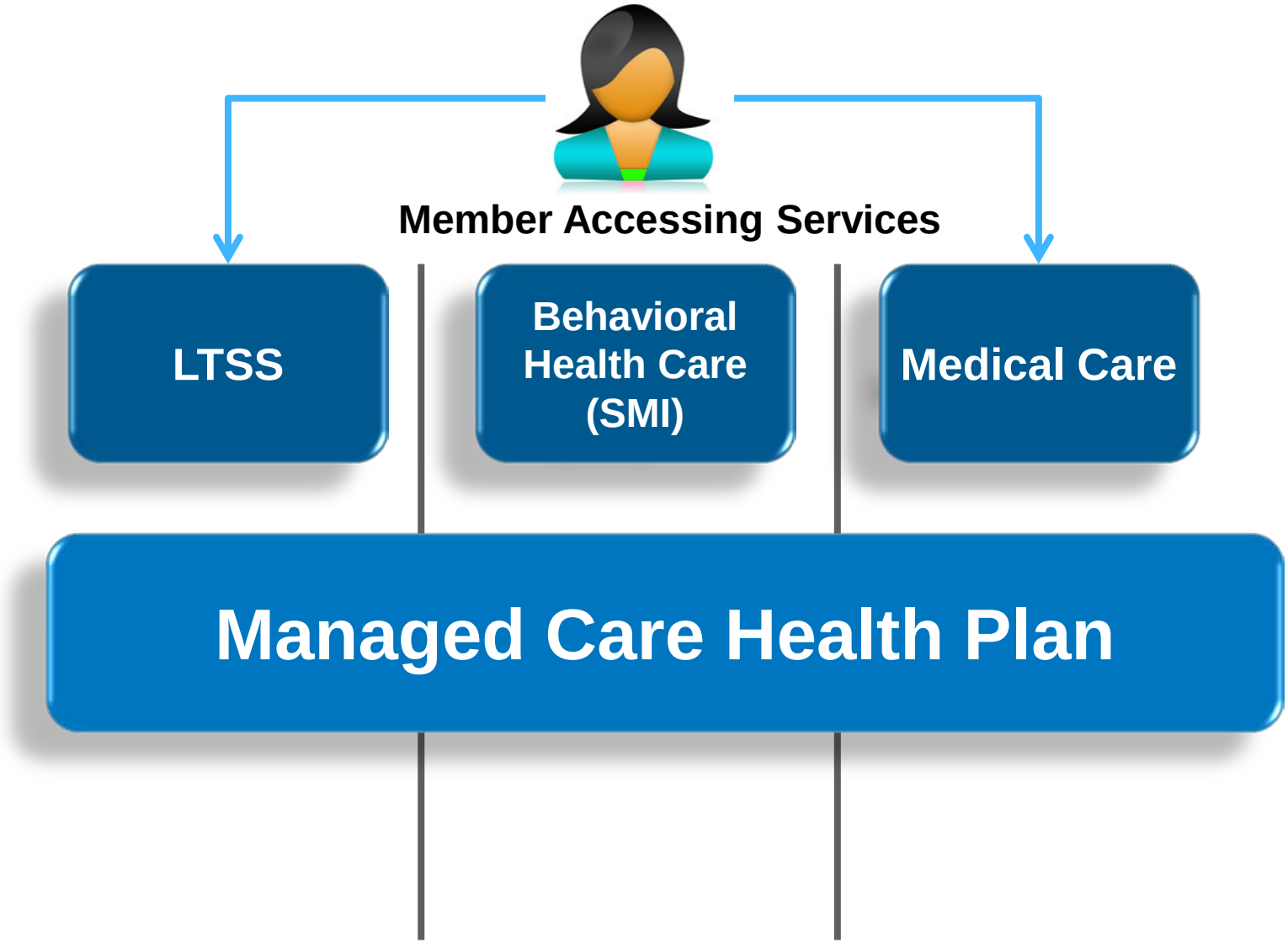
- *Serious and avoidable health issues for the member*
- *Undue burden on member/ member family*
- *Duplicative & unnecessary services*

Managed Care World for a Dual Eligible Beneficiary

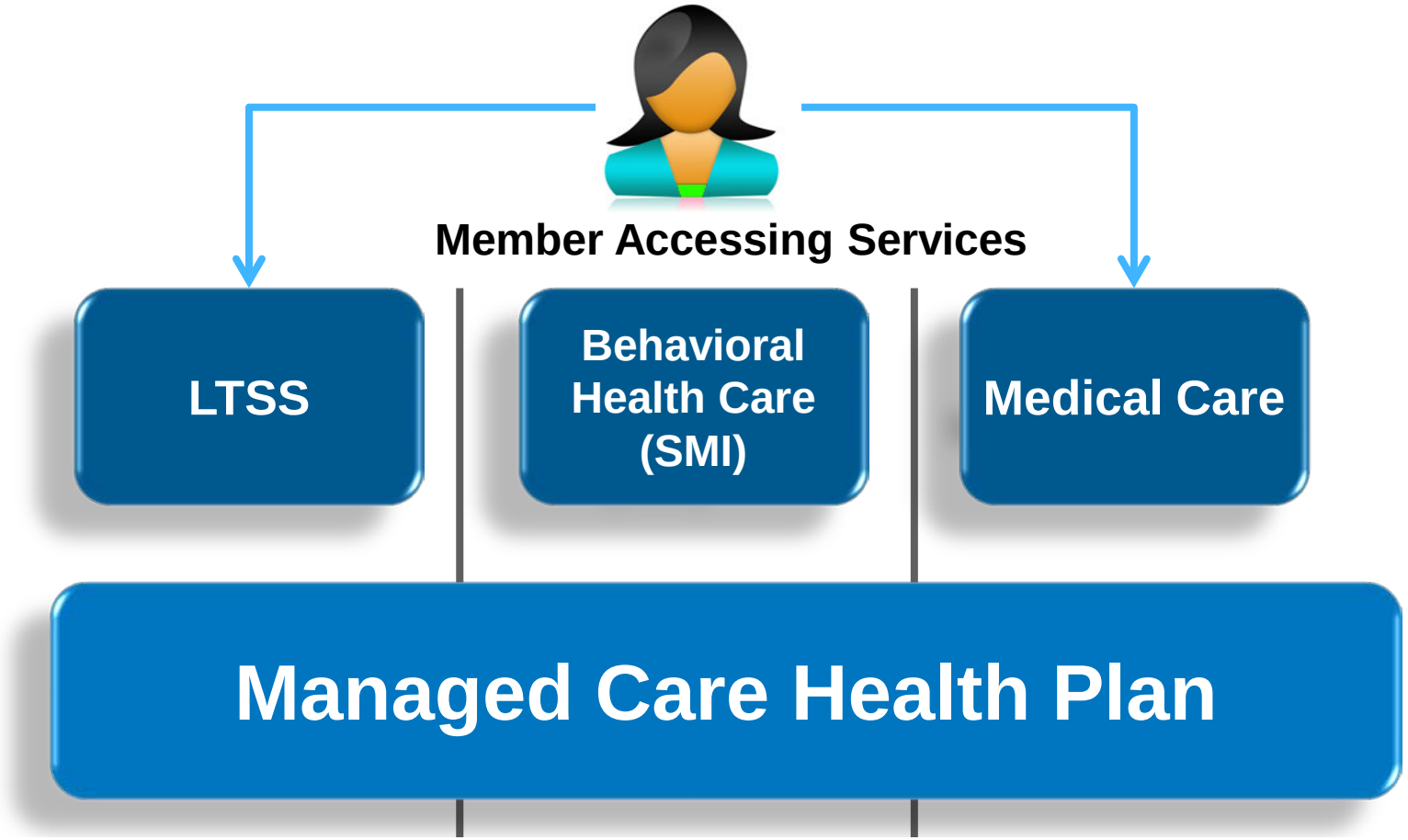
Managed Care World for a Dual Eligible Beneficiary



Managed Care World for a Dual Eligible Beneficiary



Managed Care World for a Dual Eligible Beneficiary



One of the BIG opportunities with managed care, is the Plan has the opportunity to make information accessible to all Care Providers. Information is CRITICAL to enabling true care coordination

"Now that Health Plans have access to a new level of data and information across all care providers…..what are we DOING to build a coordinate care model??"

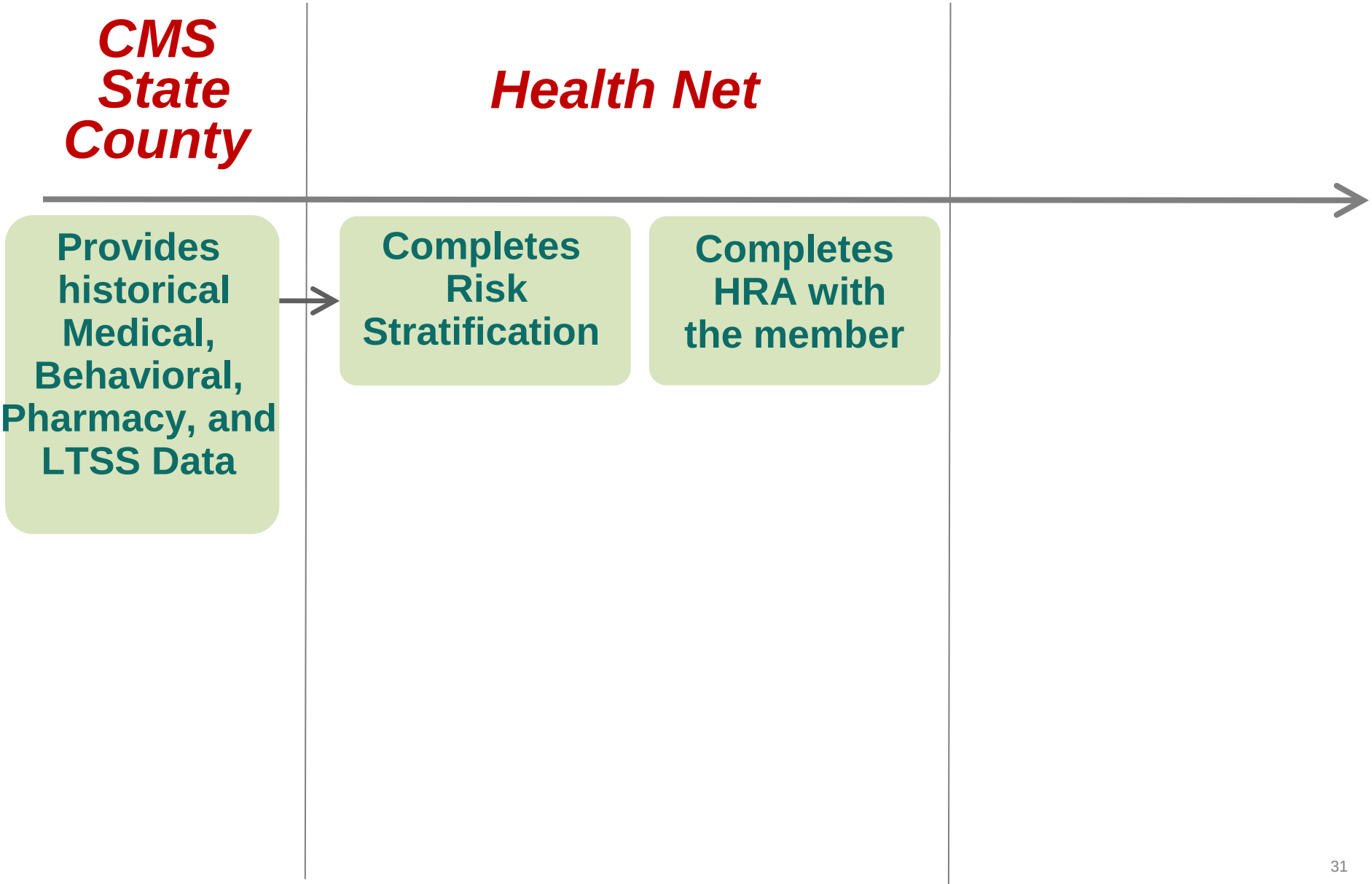
Health Net's Approach for Using Data & Information to Enable Care Coordination

Health Net's Approach

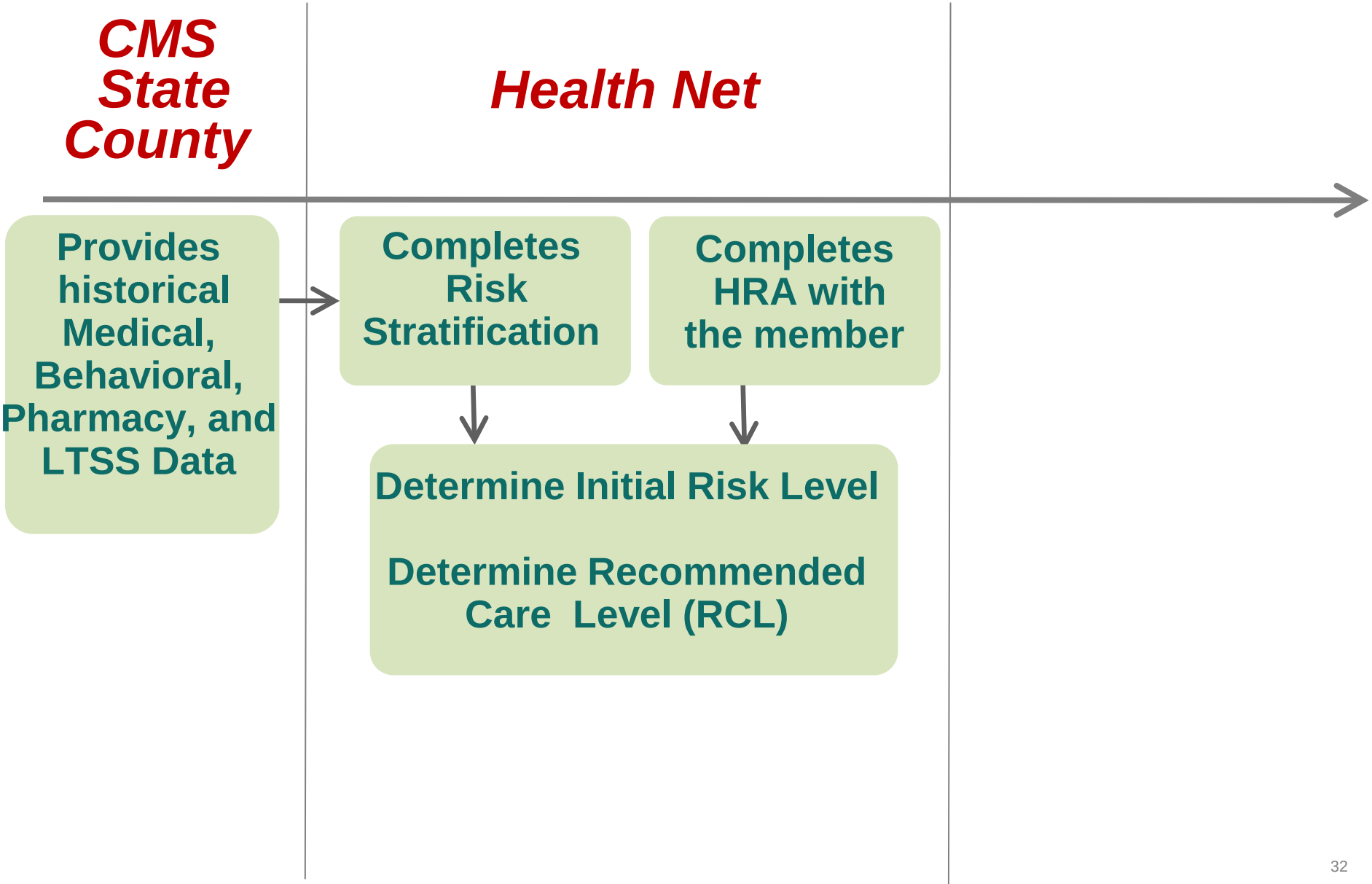
CMS
State
County

Provides historical Medical, Behavioral, Pharmacy, and LTSS Data

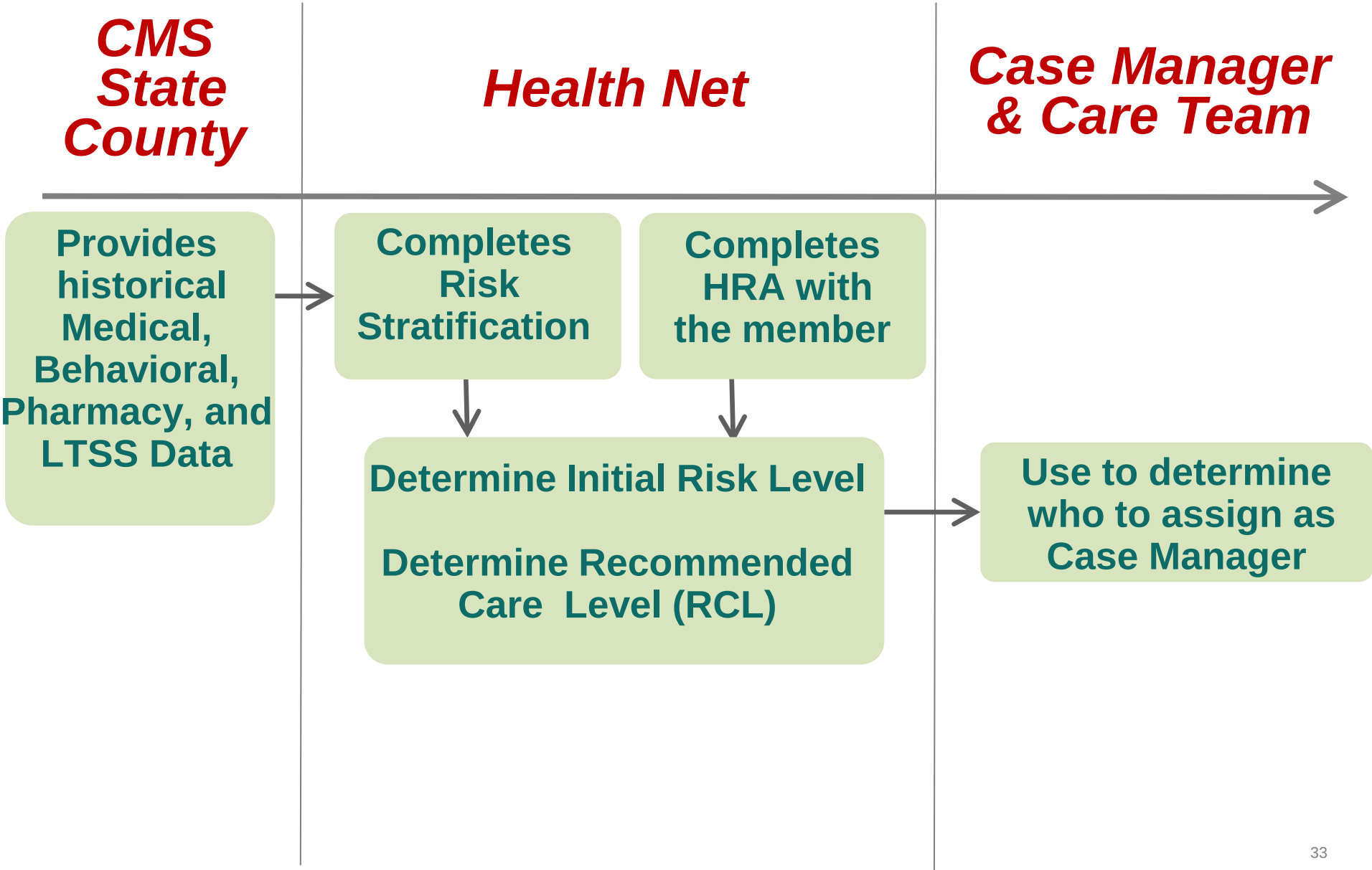
Health Net's Approach



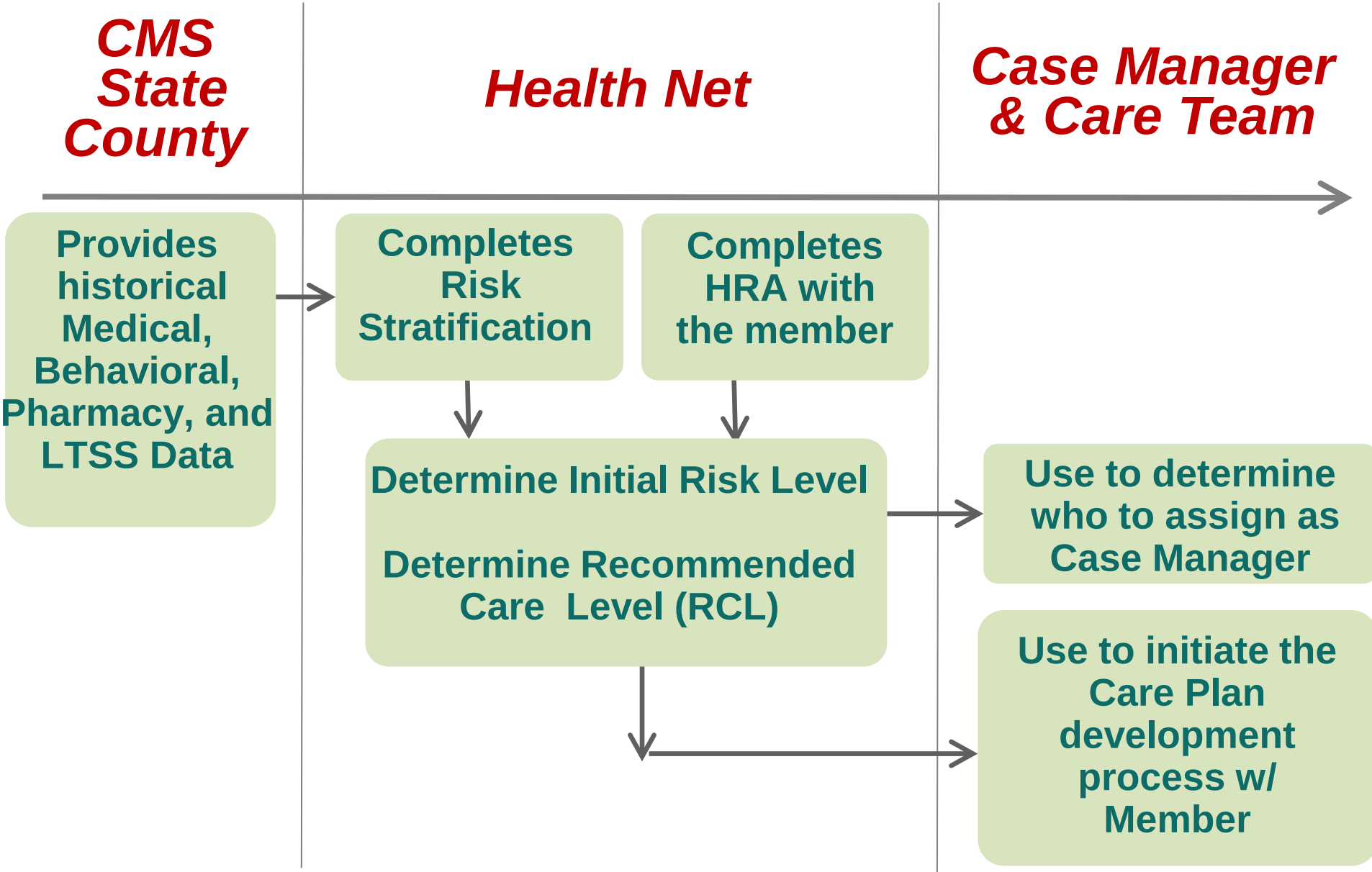
Health Net's Approach



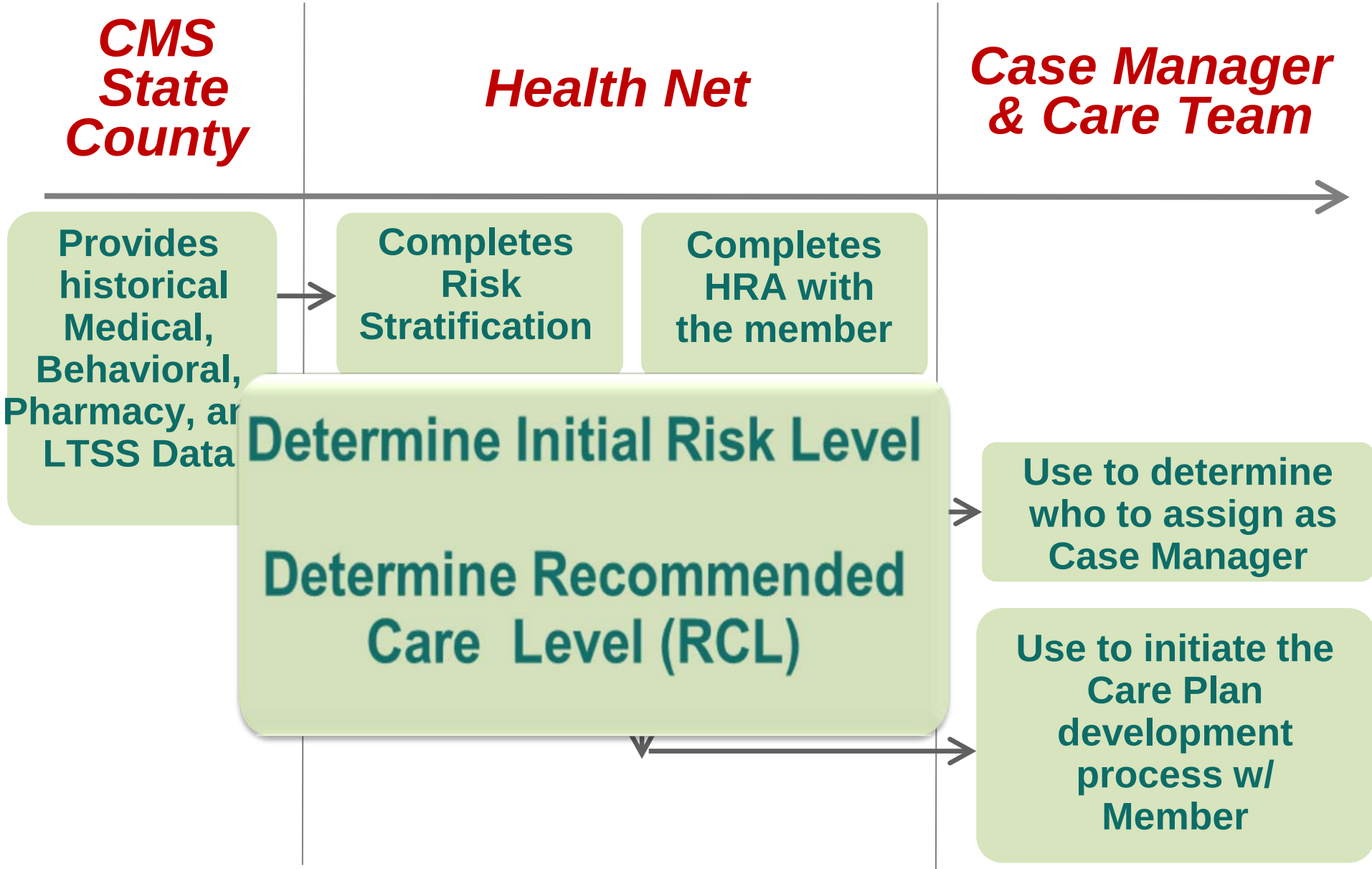
Health Net's Approach



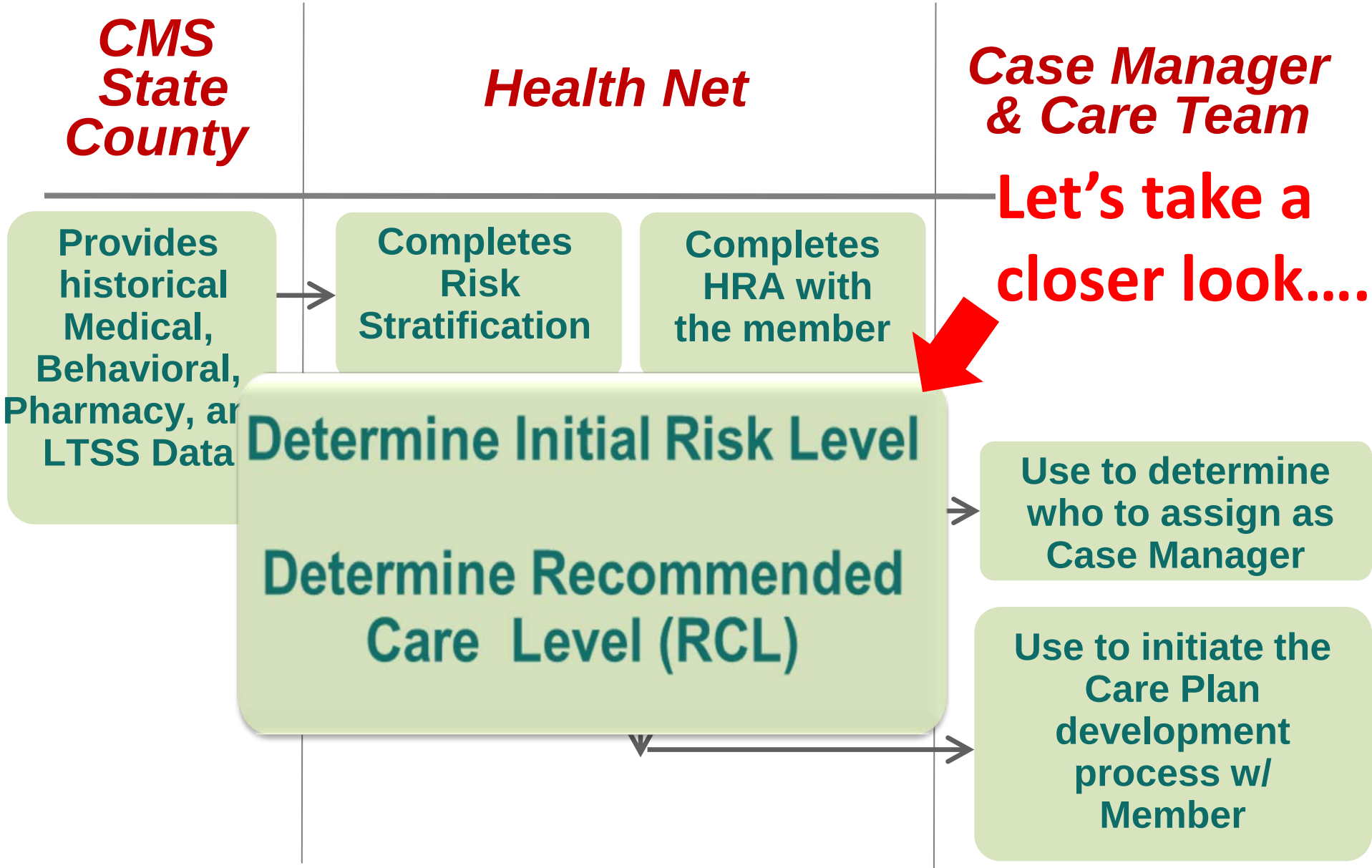
Health Net's Approach



Health Net's Approach



Health Net's Approach



Using Recommended Care Levels

- Health Net uses all of the historical claim and authorization data as well as the HRA data to **risk stratify** our members.
- The **output of the risk stratification provides a Recommended Care Level (RCL)** for each member which is provided to the member's physician and care team.
- The RCL will show if the member is High, Moderate, or Low risk for Medical, Behavioral, and Social needs
- In the example to the right, this member would be **managed by a Behavioral Health care team**, as they stratified as Behavioral RCL High.
- **Care managers and care teams use these care levels** to help triage members, direct care, and coordinate medical, behavioral and social needs for the member.

Recommended Care Level Example

Overall **Care Level**	**High**	The overall RCL is the sum of the medical, behavioral and social RCLs. If it is high, member has immediate care needs in one or more of the three care domains
Medical **Care Level**	**Low**	A member stratifies as Medical High if member has an acute care history and is at risk of an inpatient stay
Behavioral **Care Level**	**High**	A member stratifies as BH High if member has an acute care history for BH (e.g., 1+ BH hospitalization in past 90 days, 3+ BH hospitalizations in past year, etc.)
LTSS **Care Level**	**High**	A member stratifies as Social High if member has any noted Nutritional deficiencies, Alzheimers/ dementia,, 2+ falls in past year, etc.

Using Recommended Care Levels

Additional Use of Data:

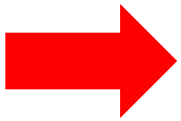
Health Net and Case Managers also use the **Recommended Care Levels** to help anticipate future needs and proactively manage the member's care to **support members living independently.**

Recommended Care Level	
Overall Care Level	High
Medical Care Level	Low
Behavioral Care Level	High
LTSS Care Level	High

Using Recommended Care Levels

Additional Use of Data:

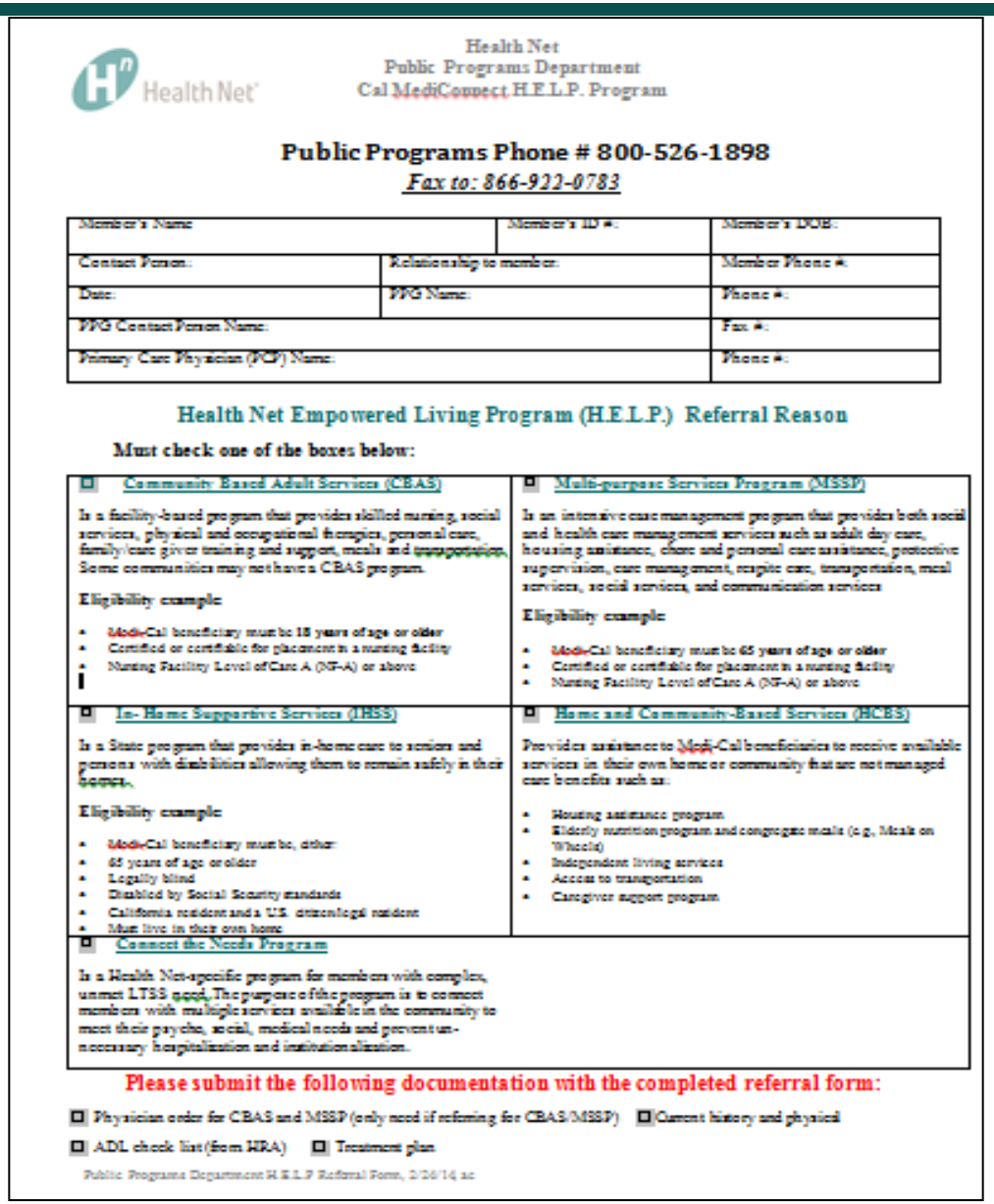
…For example, a member with an LTSS Care Level of "high" who isn't receiving any home and community based services, is someone **who may have unmet need** and could benefit from a program like IHSS, or CBAS, etc.



Recommended Care Level	
Overall Care Level	High
Medical Care Level	Low
Behavioral Care Level	High
LTSS Care Level	High

H.E.L.P. TEAM

- To support our case managers and encourage the use of LTSS and other Home and Community Based Services to promote independent living, **Health Net created a dedicated team called the Health Net Empowered Living (H.E.L.P.) Team**



Health Net
Public Programs Department
Cal MediConnect H.E.L.P. Program

Public Programs Phone # 800-526-1898
Fax to: 866-922-0783

Member's Name:	Member's ID #:	Member's DOB:
Contact Person:	Relationship to member:	Member Phone #:
Date:	PPG Name:	Phone #:
PPG Contact Person Name:		Fax #:
Primary Care Physician (PCP) Name:		Phone #:

Health Net Empowered Living Program (H.E.L.P.) Referral Reason

Must check one of the boxes below:

☐ Community Based Adult Services (CBAS)

Is a facility-based program that provides skilled nursing, social services, physical and occupational therapies, personal care, family/care giver training and support, meals and transportation. Some communities may not have a CBAS program.

Eligibility example:

- Medi-Cal beneficiary must be 18 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ Multi-purpose Services Program (MSSP)

Is an intensive case management program that provides both social and health care management services such as adult day care, housing assistance, chore and personal care assistance, protective supervision, case management, respite care, transportation, meal services, social services, and communication services

Eligibility example:

- Medi-Cal beneficiary must be 65 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ In- Home Supportive Services (IHSS)

Is a State program that provides in-home care to seniors and persons with disabilities allowing them to remain safely in their homes.

Eligibility example:

- Medi-Cal beneficiary must be, either:
- 65 years of age or older
- Legally blind
- Disabled by Social Security standards
- California resident and a U.S. citizen/legal resident
- Must live in their own home

☐ Home and Community-Based Services (HCBS)

Provides assistance to Medi-Cal beneficiaries to receive available services in their own home or community that are not managed care benefits such as:

- Housing assistance program
- Elderly nutrition program and congregate meals (e.g., Meals on Wheels)
- Independent living services
- Access to transportation
- Caregiver support program

☐ Connect the Needs Program

Is a Health Net-specific program for members with complex, unmet LTSS needs. The purpose of this program is to connect members with multiple services available in the community to meet their psyche, social, medical needs and prevent un-necessary hospitalization and institutionalization.

Please submit the following documentation with the completed referral form:

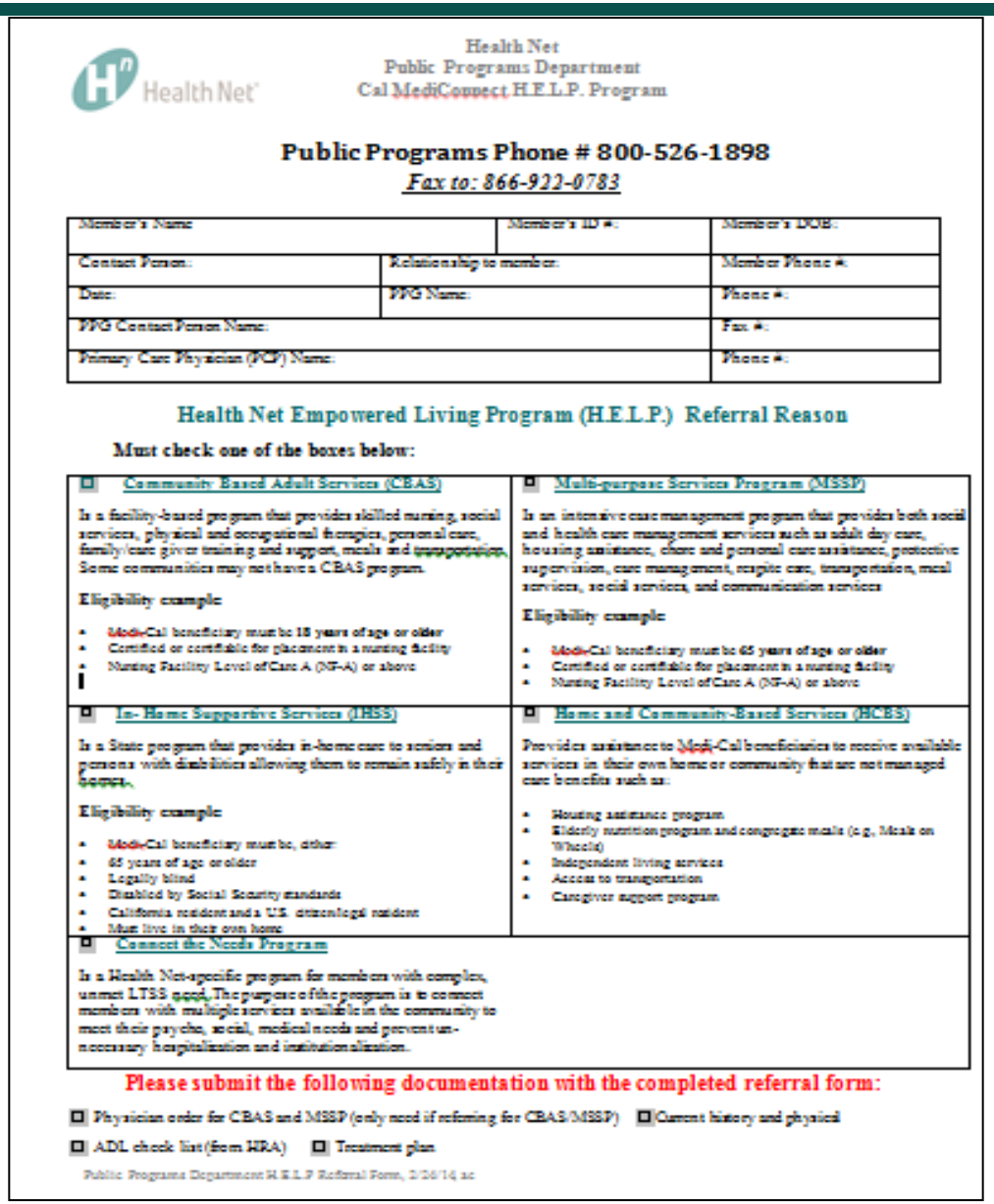
☐ Physician order for CBAS and MSSP (only need if referring for CBAS/MSSP) ☐ Current history and physical

☐ ADL check list (from HRA) ☐ Treatment plan

Public Programs Department H.E.L.P Referral Form, 2/26/14 ac

H.E.L.P. TEAM

- To support our case managers and encourage the use of LTSS and other Home and Community Based Services to promote independent living, **Health Net created a dedicated team called the Health Net Empowered Living (H.E.L.P.) Team**
- The **H.E.L.P. Team's** role is to manage the LTSS referral process for our members



Health Net
Public Programs Department
Cal MediConnect H.E.L.P. Program

Public Programs Phone # 800-526-1898
Fax to: 866-922-0783

Member's Name:	Member's ID #:	Member's DOB:
Contact Person:	Relationship to member:	Member Phone #:
Date:	PPG Name:	Phone #:
PPG Contact Person Name:		Fax #:
Primary Care Physician (PCP) Name:		Phone #:

Health Net Empowered Living Program (H.E.L.P.) Referral Reason

Must check one of the boxes below:

☐ Community Based Adult Services (CBAS)

Is a facility-based program that provides skilled nursing, social services, physical and occupational therapies, personal care, family/care giver training and support, meals and transportation. Some communities may not have a CBAS program.

Eligibility example:

- Medi-Cal beneficiary must be 18 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ Multi-purpose Services Program (MSSP)

Is an intensive case management program that provides both social and health care management services such as adult day care, housing assistance, chore and personal care assistance, protective supervision, case management, respite care, transportation, meal services, social services, and communication services

Eligibility example:

- Medi-Cal beneficiary must be 65 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ In- Home Supportive Services (IHSS)

Is a State program that provides in-home care to seniors and persons with disabilities allowing them to remain safely in their homes.

Eligibility example:

- Medi-Cal beneficiary must be, either:
- 65 years of age or older
- Legally blind
- Disabled by Social Security standards
- California resident and a U.S. citizen/legal resident
- Must live in their own home

☐ Home and Community-Based Services (HCBS)

Provides assistance to Medi-Cal beneficiaries to receive available services in their own home or community that are not managed care benefits such as:

- Housing assistance program
- Elderly nutrition program and congregate meals (e.g., Meals on Wheels)
- Independent living services
- Access to transportation
- Caregiver support program

☐ Connect the Needs Program

Is a Health Net-specific program for members with complex, unmet LTSS needs. The purpose of the program is to connect members with multiple services available in the community to meet their psyche, social, medical needs and prevent un-necessary hospitalization and institutionalization.

Please submit the following documentation with the completed referral form:

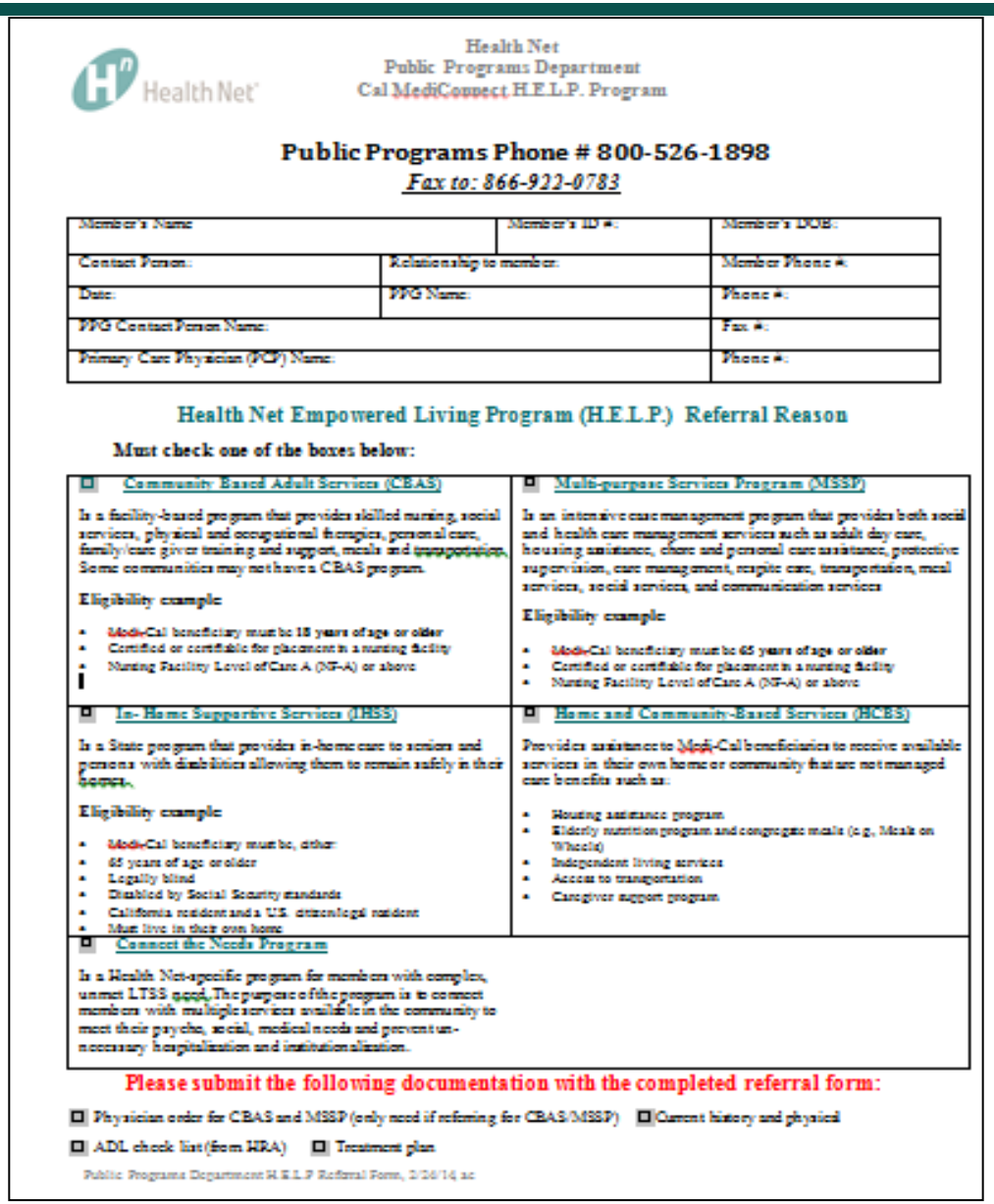
☐ Physician order for CBAS and MSSP (only need if referring for CBAS/MSSP) ☐ Current history and physical

☐ ADL check list (from HRA) ☐ Treatment plan

Public Programs Department H.E.L.P Referral Form, 2/26/14 ac

H.E.L.P. TEAM

- To support our case managers and encourage the use of LTSS and other Home and Community Based Services to promote independent living, **Health Net created a dedicated team called the Health Net Empowered Living (H.E.L.P.) Team**
- The **H.E.L.P. Team's** role is to manage the LTSS referral process for our members
- Case managers call our **H.E.L.P. Team** for support in submitting and tracking new LTSS or HCBS referrals.



Health Net
Public Programs Department
Cal MediConnect H.E.L.P. Program

Public Programs Phone # 800-526-1898
Fax to: 866-922-0783

Member's Name:	Member's ID #:	Member's DOB:
Contact Person:	Relationship to member:	Member Phone #:
Date:	PPG Name:	Phone #:
PPG Contact Person Name:		Fax #:
Primary Care Physician (PCP) Name:		Phone #:

Health Net Empowered Living Program (H.E.L.P.) Referral Reason

Must check one of the boxes below:

☐ Community Based Adult Services (CBAS)

Is a facility-based program that provides skilled nursing, social services, physical and occupational therapies, personal care, family/care giver training and support, meals and transportation. Some communities may not have a CBAS program.

Eligibility example:

- Medi-Cal beneficiary must be 18 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ Multi-purpose Services Program (MSSP)

Is an intensive case management program that provides both social and health care management services such as adult day care, housing assistance, chore and personal care assistance, protective supervision, case management, respite care, transportation, meal services, social services, and communication services

Eligibility example:

- Medi-Cal beneficiary must be 65 years of age or older
- Certified or certifiable for placement in a nursing facility
- Nursing Facility Level of Care A (NF-A) or above

☐ In- Home Supportive Services (IHSS)

Is a State program that provides in-home care to seniors and persons with disabilities allowing them to remain safely in their homes.

Eligibility example:

- Medi-Cal beneficiary must be, either:
- 65 years of age or older
- Legally blind
- Disabled by Social Security standards
- California resident and a U.S. citizen/legal resident
- Must live in their own home

☐ Home and Community-Based Services (HCBS)

Provides assistance to Medi-Cal beneficiaries to receive available services in their own home or community that are not managed care benefits such as:

- Housing assistance program
- Elderly nutrition program and congregate meals (e.g., Meals on Wheels)
- Independent living services
- Access to transportation
- Caregiver support program

☐ Connect the Needs Program

Is a Health Net-specific program for members with complex, unmet LTSS needs. The purpose of the program is to connect members with multiple services available in the community to meet their psycho, social, medical needs and prevent un-necessary hospitalization and institutionalization.

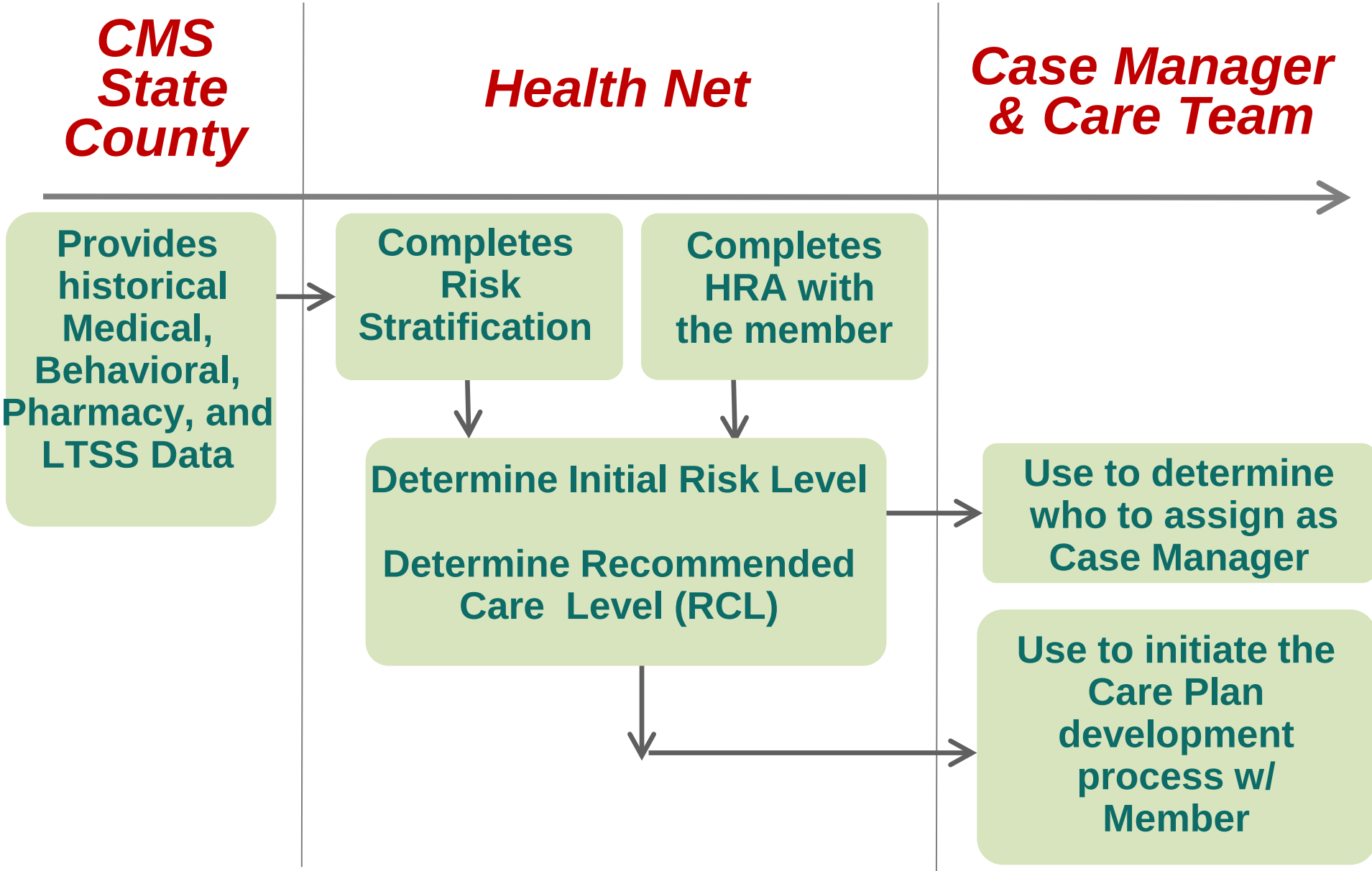
Please submit the following documentation with the completed referral form:

☐ Physician order for CBAS and MSSP (only need if referring for CBAS/MSSP) ☐ Current history and physical

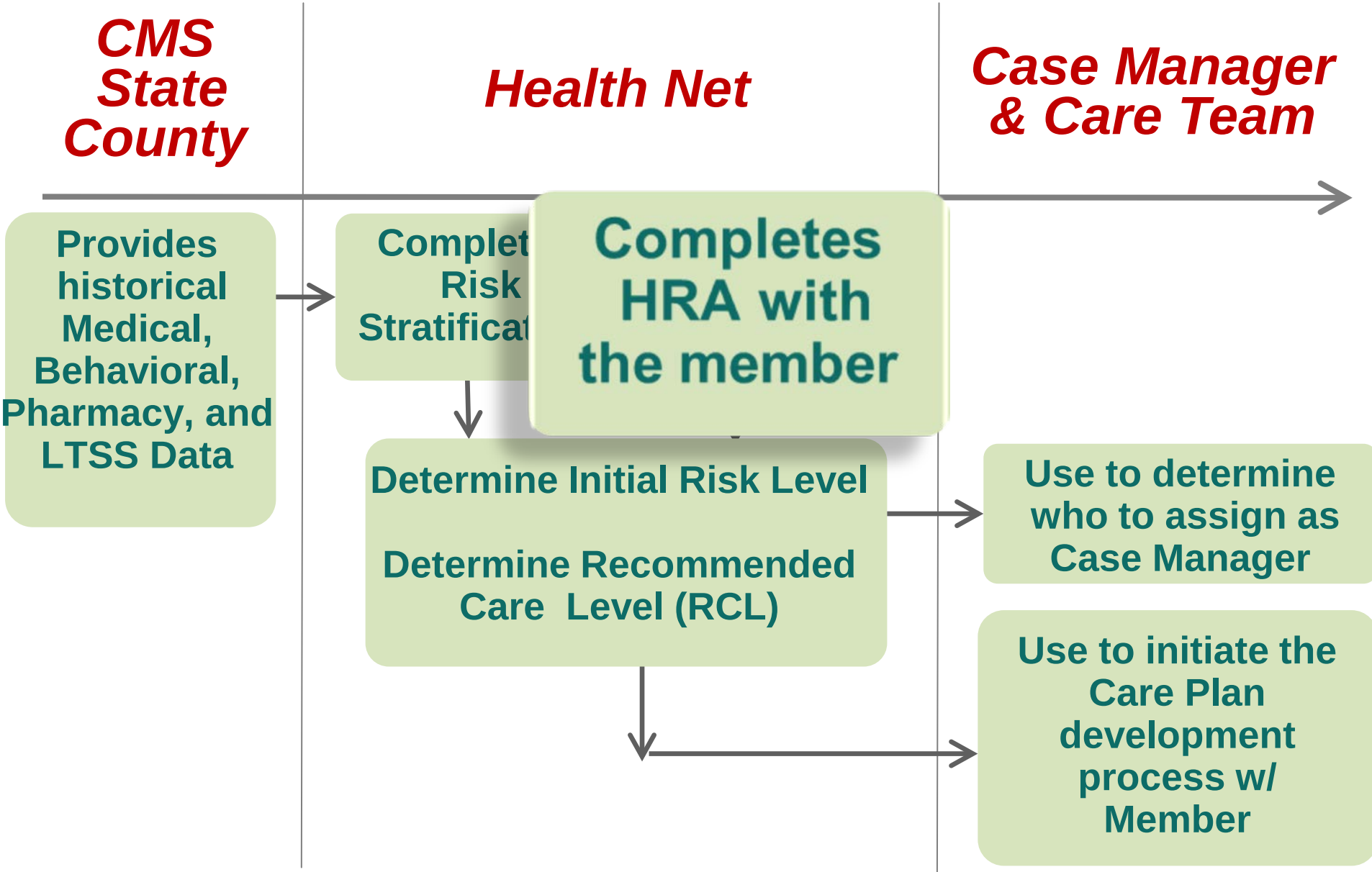
☐ ADL check list (from HRA) ☐ Treatment plan

Public Programs Department H.E.L.P. Referral Form, 2/26/14 ac

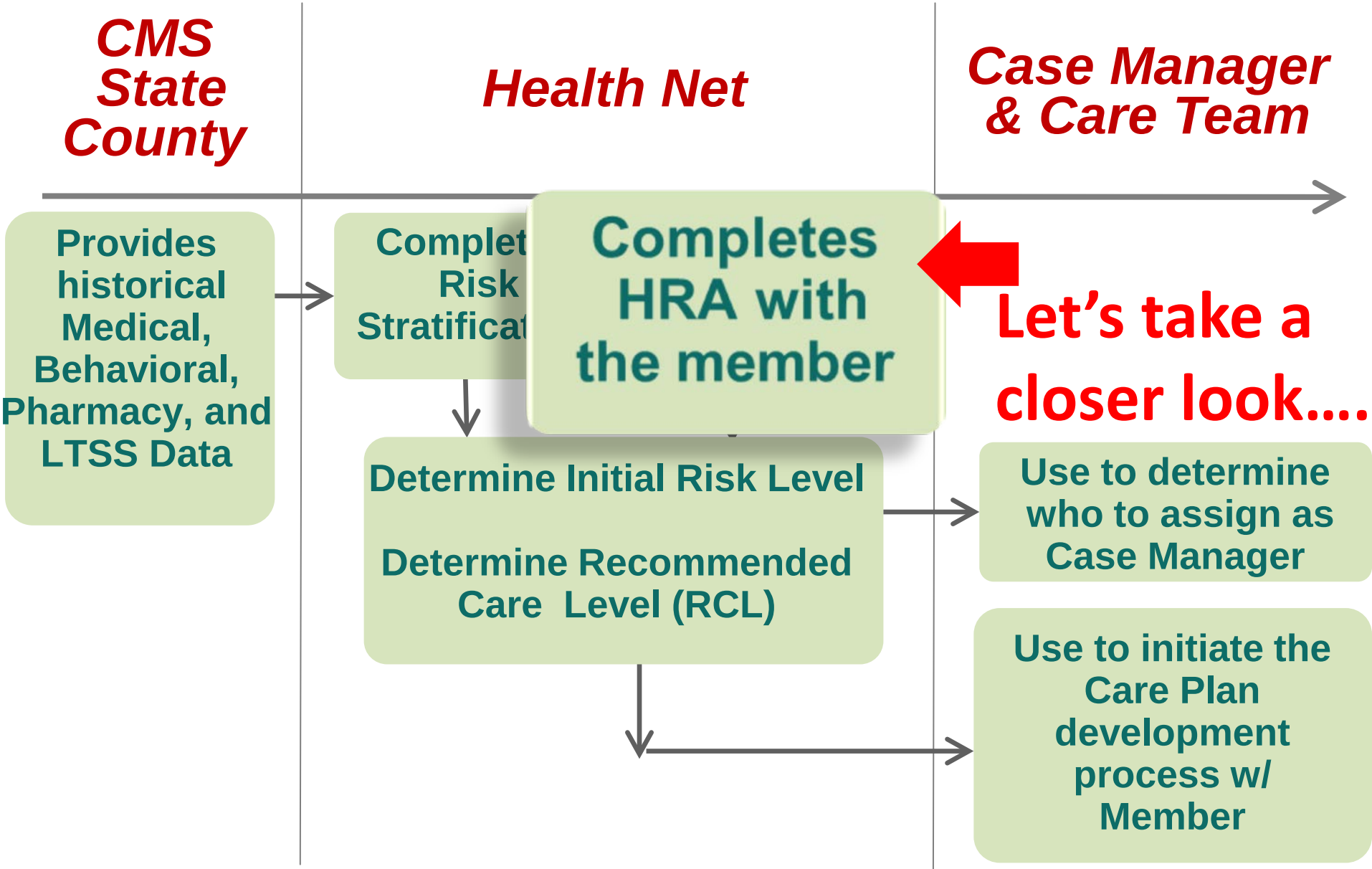
Health Net's Approach for Using the Data to Enable Care Coordination

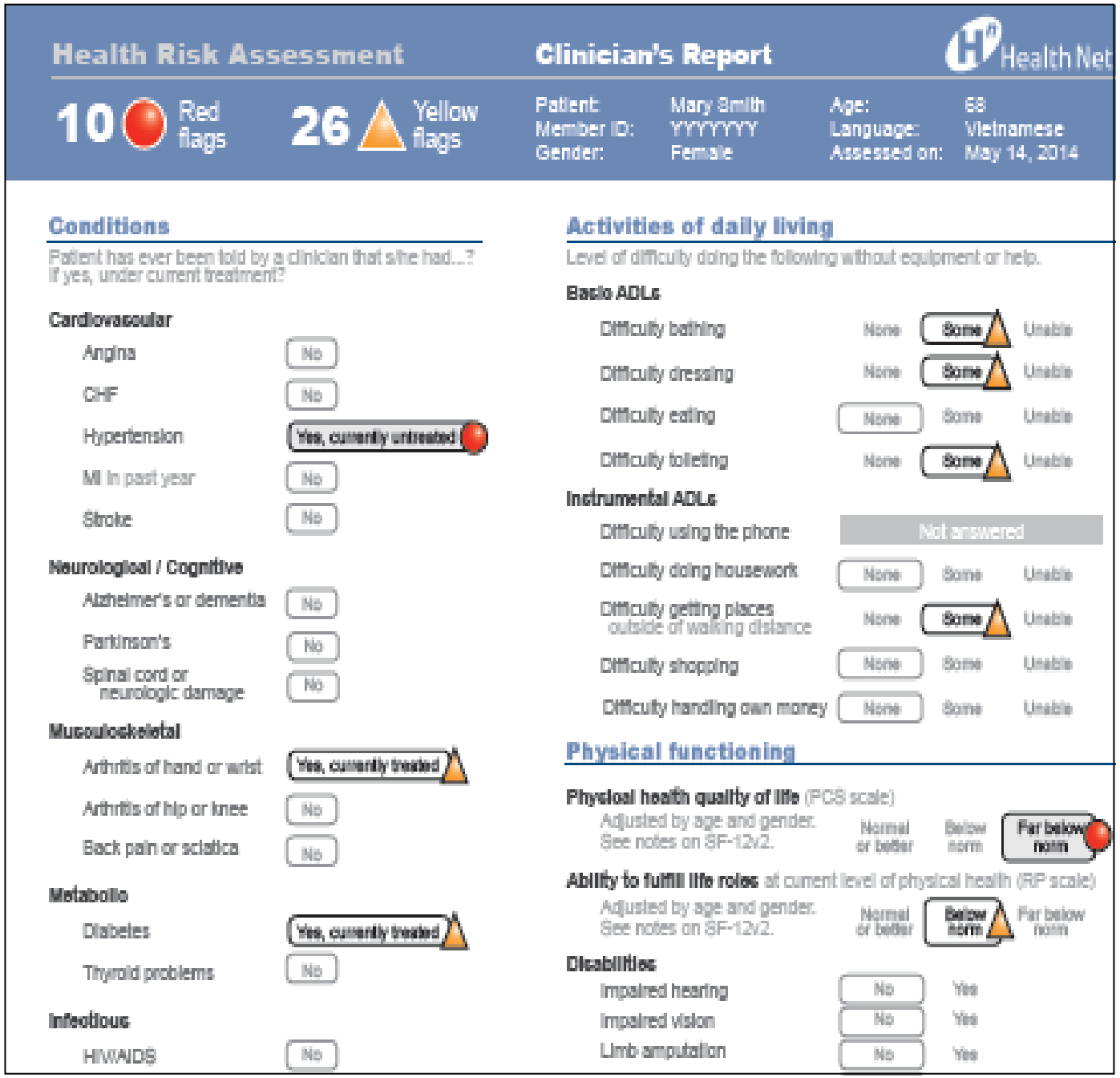


Health Net's Approach for Using the Data to Enable Care Coordination



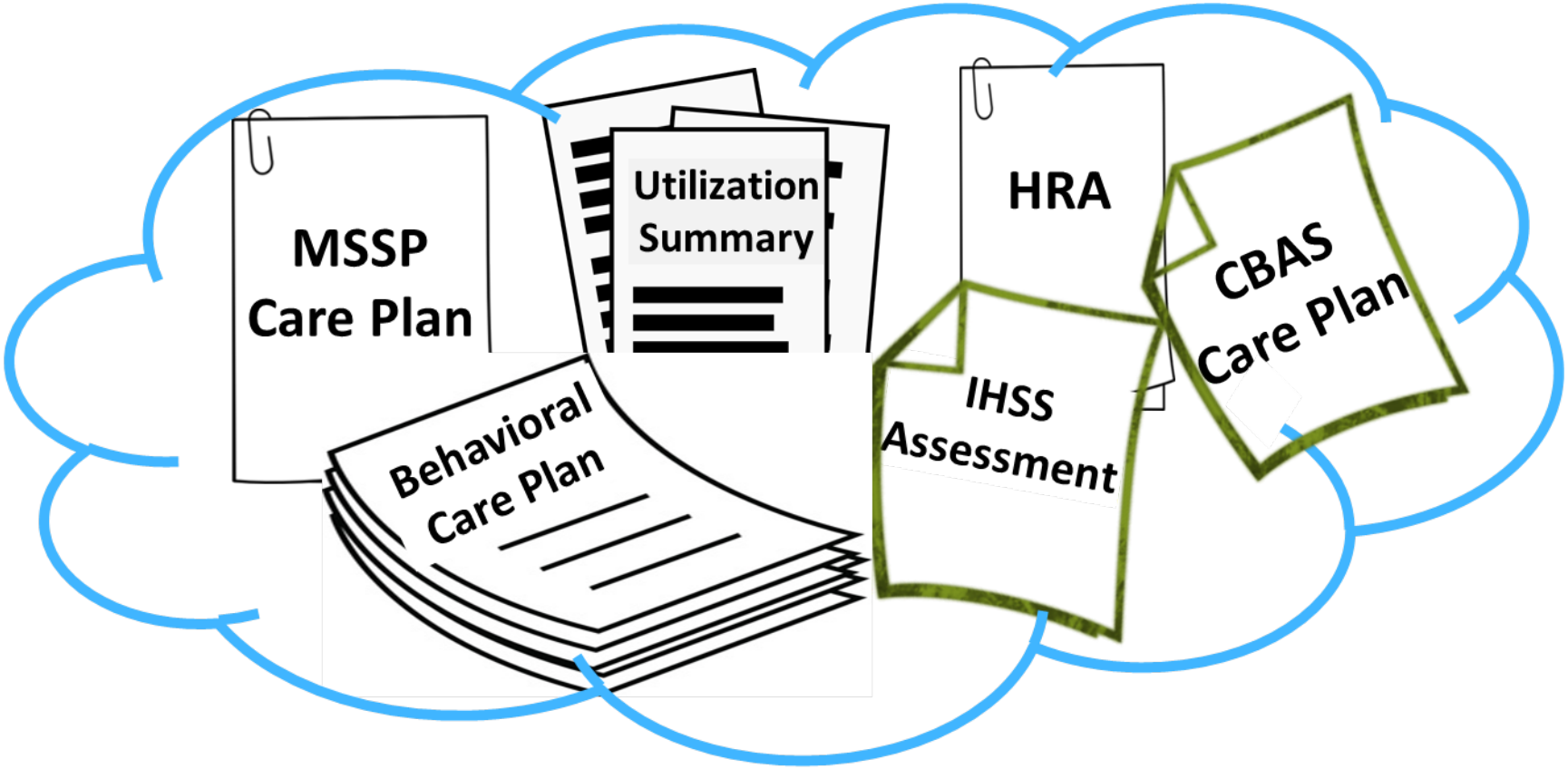
Health Net's Approach for Using the Data to Enable Care Coordination





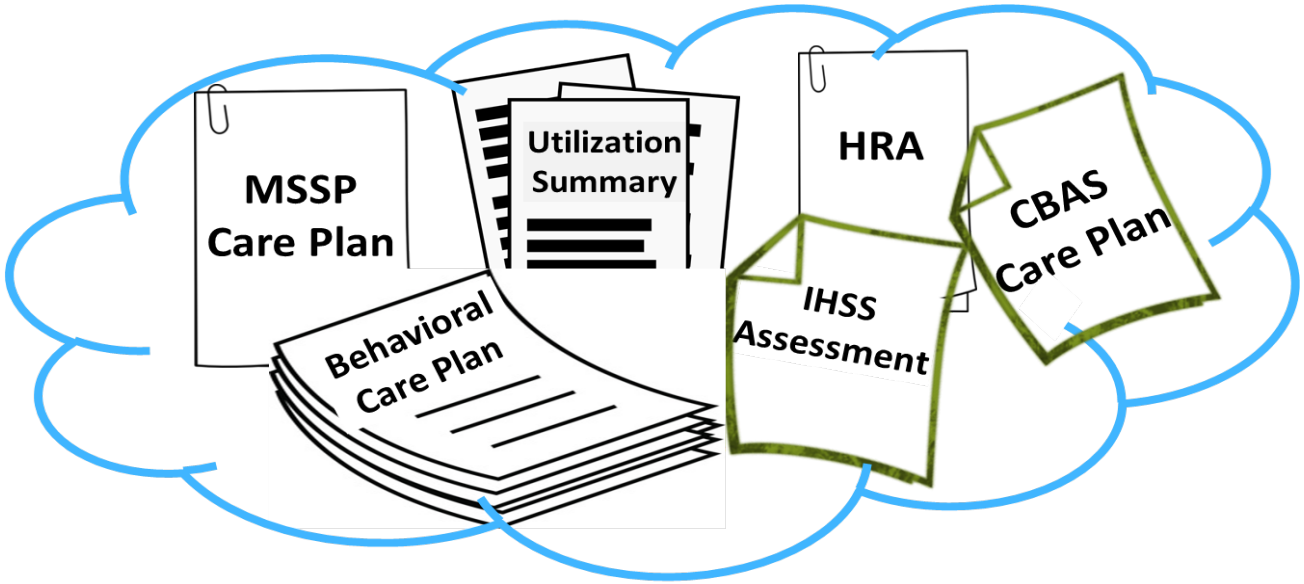
“But doesn’t Health Net delegate? How does all of this work for delegated groups?

Provider Portal



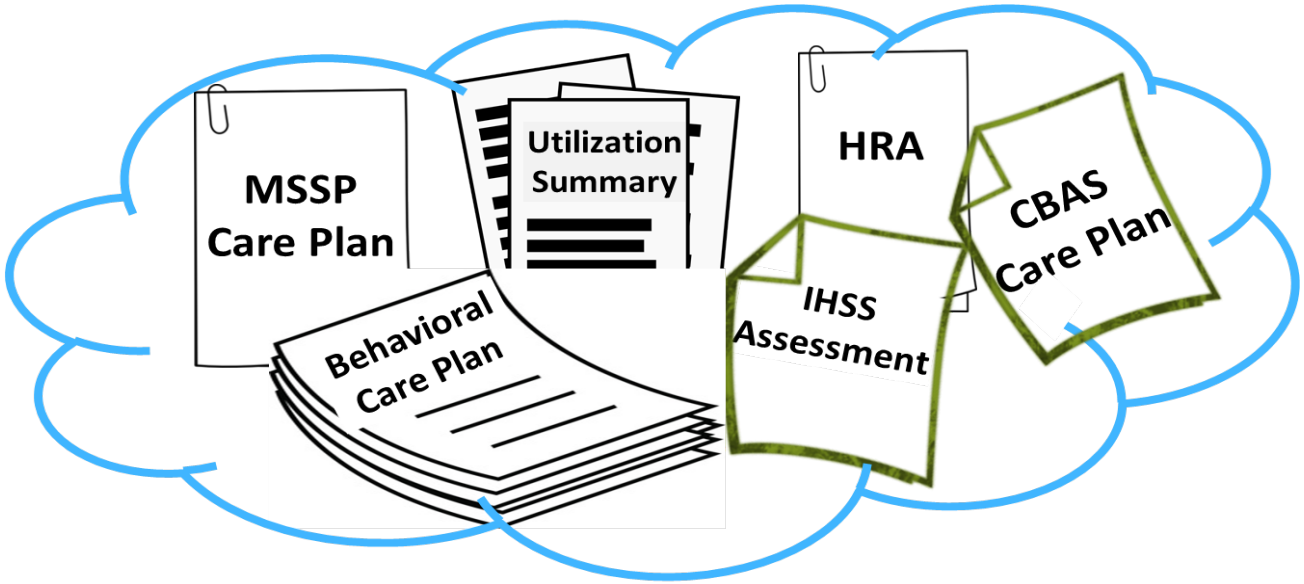
Health Net has built the “Provider Portal” which is our Electronic Platform for enabling Care Coordination with our Provider Groups who are delegated for Care Management.

Provider Portal



….The Case Manager uses the information available on the Provider Portal to understand what type of care the member is receiving and coordinate with those providers as needed.

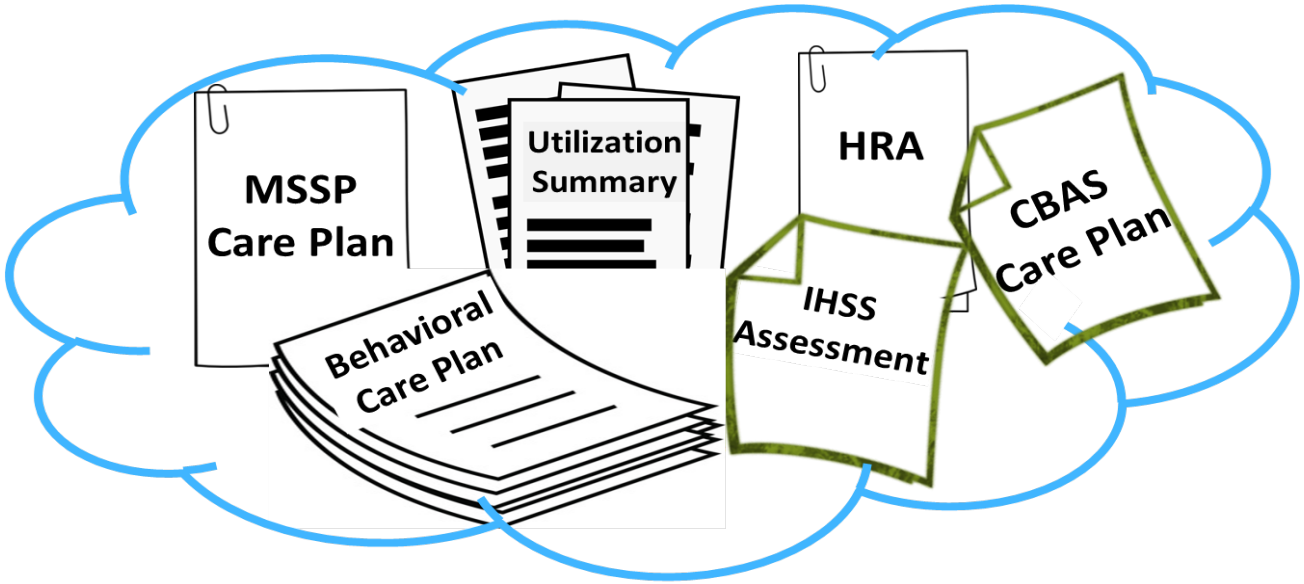
Provider Portal



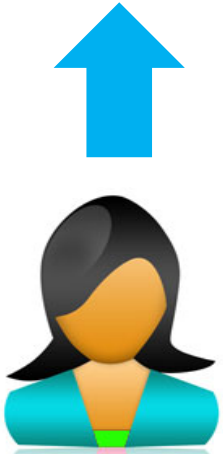
….The Provider Portal is the electronic platform that enables the

Interdisciplinary Care Team Process

Provider Portal

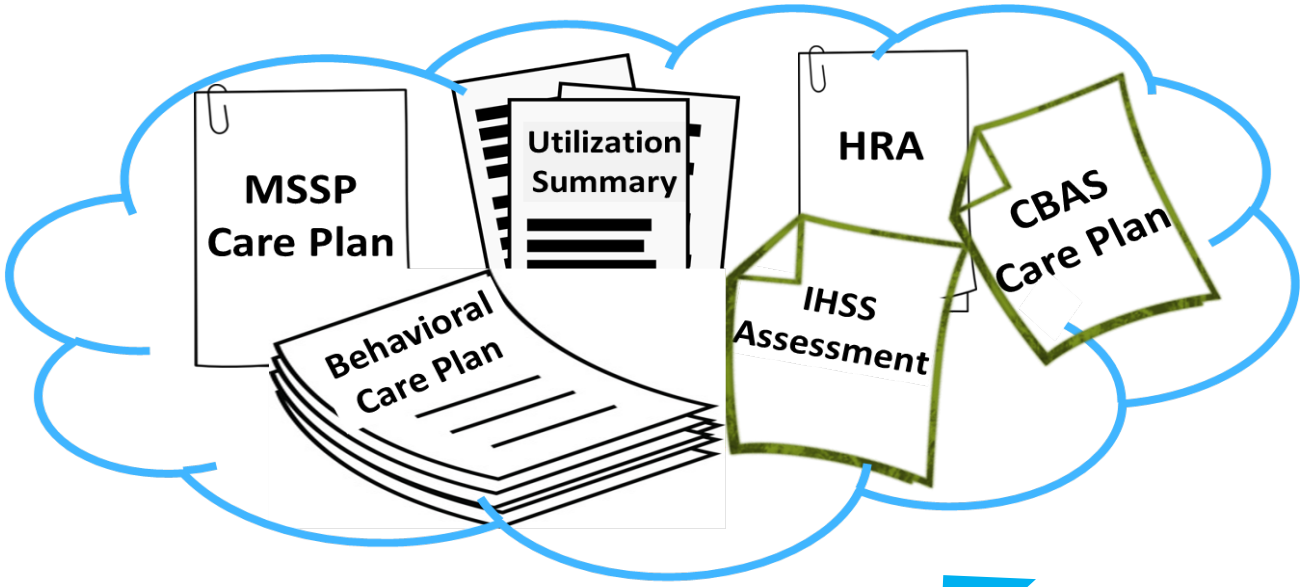


….Not only does the member have access to the Portal

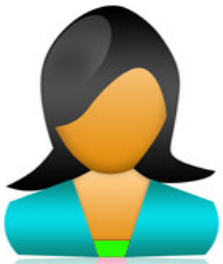


Member

Provider Portal



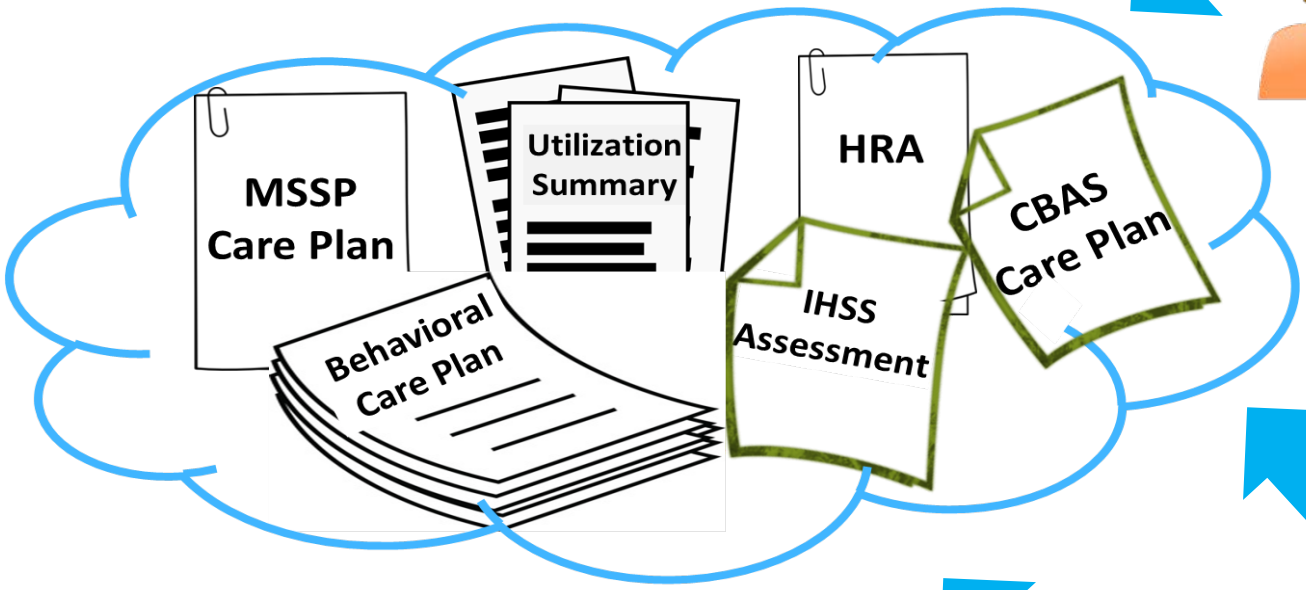
….The member's doctor also has access…



Member

Primary Care Physician

Provider Portal



LTSS Providers

Pharmacist

Primary Care Physician

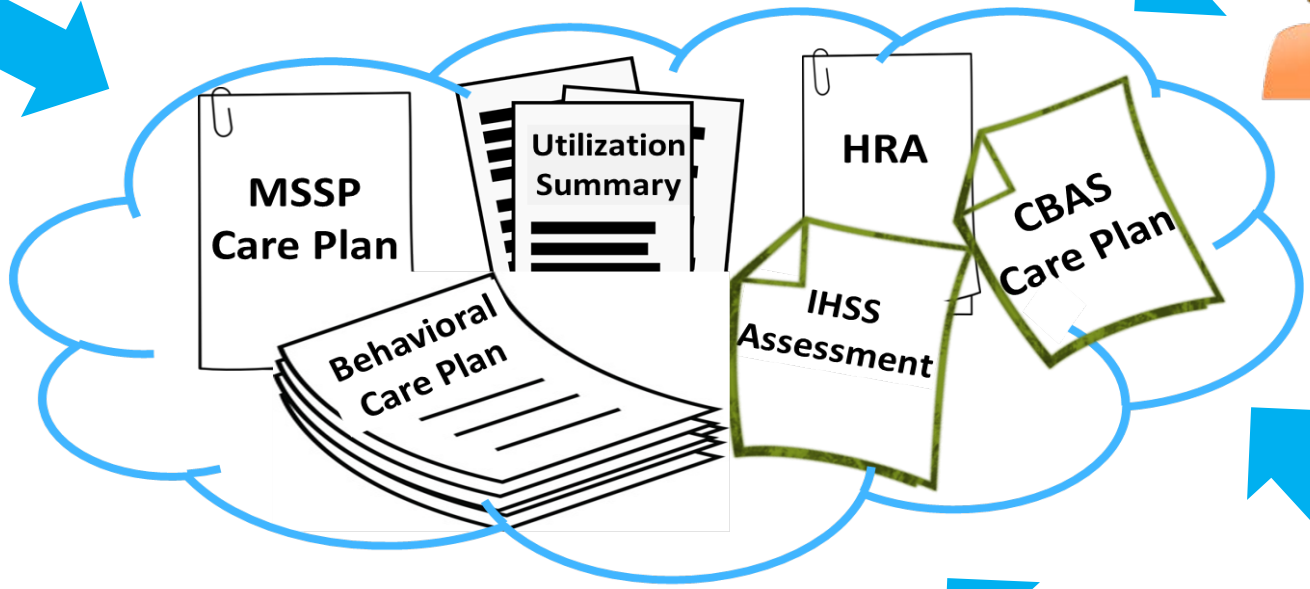
Member

….Along with other providers who have a HIPAA verified treatment relationship OR whom the member authorizes

Provider Portal

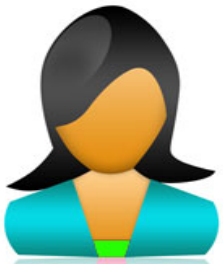
Specialist

Caregiver



LTSS Providers

Pharmacist



Member

Primary Care Physician

….Along with other providers who have a HIPAA verified treatment relationship OR whom the member authorizes

Ensuring Strong Performance

Provider Group Selection

- ✓DSNP Model of care
- ✓Have complex CM infrastructure
- ✓Medicare & Medi-Cal experience
- ✓Have strong hospital partner
- ✓Have needed geographic coverage

Delegation Process

- ✓Pre Delegation audit
- ✓Contract Negotiation
- ✓90 Day Post “Go Live” Audit
- ✓Annual Reassessments

Ongoing Performance Oversight

- ✓Annual Policy and Procedure Audits
- ✓Quarterly UM audits
- ✓Quarterly File Review Audits
- ✓Monthly KPIs monitoring via performance dashboard and PPG report cards
- ✓Bi-Monthly training/ “Huddles” for best practice sharing/ open dialogue
- ✓Qtrly In person performance 1:1s

Focus on Improving Member Engagement

Focus on Improving Member Engagement

Alzheimer's Collaboration

- Goal: Provide education to care coordinators to support improving the quality of life of both patients with Alzheimer Disease and related Dementias and their caregivers.
- Timely action should:
  - Provide care coordinators with the knowledge, tools and resources to most effectively assist members and their caregivers with managing the disease process.
  - Improve overall satisfaction for the member and caregivers.

IHSS Caregiver Engagement Pilot

- Goal: Afford interested members the ability to allow their caregiver's to communicate with the care coordinator and/or other members of the care team to act more quickly to address issues that may arise as the member's conditions change using a simple training and communication process.
- Timely action should:
  - Protect the member's independence, safety and autonomy by improving communication & discussing options of care
  - Better support the member by allowing their care team to advocate for the appropriate services for the member when they need it
  - Improve overall service and satisfaction for the member
  - Provide the member with better care and result in better health

Focus on Improving Member Engagement

Alternative Contact Information

- Goal: To improve contact information and enable care teams to actively engage difficult to find members.
- Timely action should:
  - Home visits to facilitate completion of HRA
  - Use alternative sources of information to locate members
  - Deploy “investigative” staff to find members

Welcome Calls

- Goal: To deliver an unparalleled level of service that proactively meets the complex needs of members, starting with welcome calls placed within the first couple of weeks of enrollment
- Timely action should:
  - Ensure that new members receive enrollment kits and ID cards
  - Ensure members are assigned to the PCP of their choice
  - Inform them of the HRA process and what to expect
  - Ensure awareness of the CMC benefits and how to use them
  - Identify and arrange for Continuity of Care, appointments, and/or Transportation needs
  - Capture the members most current contact information
  - Welcome and reassure and provide contact information.
  - Inform of availability of IHSS Caregiver Engagement Program

Focus on Improving Member Engagement

Partner with Advocates

- Goal: Obtain and welcome input from advocacy organizations to inform program focus and changes necessary to improve services for members..
- Timely action should:
  - Be responsive to the needs of members.
  - Strive to achieve high impact sustainable change.
  - Open to innovation.

Member Impact

Cal MediConnect Delivers on the Promise

Addressing root cause first is more likely to impact outcomes.

Social Supports Converge with Health Care

- Social and behavioral factors contribute to functional status and the onset and progression of disease

Social Supports & Services

Case : Basic Needs

Member is in his 50s with history of multiple heart conditions, Hepatitis, depression and severe anxiety. He had been living in a rented poorly maintained home that the owner refused to repair and his social security payments were very low. He received IHSS services but his care giver was working an additional 10 to 12 unauthorized hours a month and the member had not been able to get additional hours approved.

"When new housing was found for me, I finally felt like it is much calmer here". He states "no one could ever figure out why my payments (Social Security) were so low, but now I'm happy that I received help and now having my case looked into. I'm doing much better than when we first started talking."

Cal MediConnect Delivers on the Promise

Members need and appreciate care coordination support

- Approximately 15% of In home supportive service providers are a spouse and 51% are other relatives, some of whom also have health care needs

Improved Care Coordination

Case: Supporting the family caregiver

Our Member, a bi-lingual woman in her 60s with multiple medical conditions, is the full time caretaker for her mother who has Alzheimer's. When Member joined Cal MediConnect, she reported feeling overwhelmed as she felt she couldn't provide her mother with the care she needed given her own personal conditions.

"I am feeling better and more hopeful and it's all because of you. If you hadn't kept calling me and encouraging me, I would still be where I was before."

Cal MediConnect Delivers on the Promise

Behavioral Health Integration

Case: Critical Behavioral Health Intervention

A female member in her 40s diagnosed with Bipolar I Disorder, Schizoaffective Disorder and Major Depressive Disorder has had suicide attempts, which led to inpatient hospitalization. She has one co-occurring medical issue—liver damage as a result of a bout of Hepatitis C—that requires monitoring but no treatment at this time. Member lives in the basement of a church and has a recent history of domestic violence.

The case manager submitted a referral to the LA County Full Service Partnership (FSP) Program. The county navigator outreached to the member in the hospital and member requested to return to the Native American Counseling Center (NACC), from which she had received services in the past. Member was accepted into the NACC and has her first appointment with the mental health therapist scheduled. Together they will determine the member's priority needs and create a care plan. Member will receive weekly home visits by her case manager, a social worker to assist her with housing, a psychotherapist and group therapy. Member will also receive psychiatric medication management.

This member acknowledges that she is in the first stages of a journey to regain the life and independence that she once enjoyed and she is optimistic and hopeful to have the resources she needs to get ahead.

Care Team Connections

- ***Over 80%*** **of members who have stayed enrolled for 6 or more months have had a meaningful care team connection and/or helped develop their care goals and plan for the year.**

- **Our high performing provider groups have been able to connect with members to discuss their care goals and/or participate in the care team *95%* of the time**

Program Feedback & Monitoring

SCAN Foundation survey

Survey Objective: To evaluate and track over time the transitioning of beneficiaries to coordinated care under Cal MediConnect.

- **High-level findings:**
  - Large majorities of CMC enrollees express confidence or satisfaction with the health care services they are receiving
  - More than 7 in 10 CMC enrollees are satisfied with aspects of health services that were measured in the survey
  - CMC enrollees were somewhat less likely to express very high levels of confidence and satisfaction than opt outs in areas such as managing their health conditions and choice of doctors
  - Large majorities of individuals not in CMC are satisfied with their fee for service providers

Considerations to SCAN Foundation survey

- Most CMC enrollees are satisfied and confident about their care, despite challenges of starting a new program of this magnitude, where plans are expected to do more for less
  - This is a positive reflection that individuals that have been enrolled in CMC health plans are satisfied and confident
- The results are likely impacted by retention levels: We believe that if members stayed in the plans longer, confidence and satisfaction would increase
- CMC health plans deliver on stringent program requirements, high quality standards, and strong beneficiary protections not required in fee for service
- Competition among the plans push all to strive for continuous improvement, to the benefit of members
- Ultimately, there is always opportunity for improvement and our interest is to continue to improve the program with your feedback

Appendix

Quality Withhold Metrics

2014 - 2015
HRA - Members with an HRAs completed within 90 days of enrollment
Consumer Advisory Board - Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements
Customer Service - how easy it is for members to get info/help from the plan when needed (“did plans give you the info you needed?”, “did the plan treat you w/ respect?”, “were the forms easy to fill out?”)
Encounters – 80% timely encounters submissions
Getting Appointments Quickly- Percent of best possible score the plan earned on how quickly members get appointments and care (how often did you get care as soon as you needed it, how often did you get an appointment when needed, did you see the Dr. w/in 15 min of appointment time)
Care Plan Goals - Members with a documented discussion of care goals in care plan
County BH Coordination Members receiving Medi-Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plans as indicated by having an ICP with the primary behavioral health provider
Case Management Outreach - Members who have a case manager and have at least one case manager contact during the reporting period
MOUs w/ County BH - Policies and procedures attached to the MOU with county BH agency(ies) around assessments, referrals, coordinated care planning, and information sharing
Physical Access - Established physical access compliance policy and individual who is responsible for physical access compliance

Quality Withhold Metrics

2015 - 2016
Encounters* – 80% timely encounters submissions
Care Plan Goals - Members with a documented discussion of care goals in care plan
Case Management Outreach - Members who have a case manager and have at least one case manager contact during the reporting period
Plan All Cause Readmissions* - Enrollees discharged from a hospital who were readmitted within 30 days.
Annual Flu Vaccine* - Percent enrollees surveyed through CAPHS saying they received a flu shot prior to flu season
Follow-up after hospitalization for mental illness* - % of member discharges who were hospitalized for treatment of selected BH disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a BH practitioner within 30 days of discharge
Reducing the risk of falling* – Percent of Enrollees who report via the HOS survey that they discussed their problems around falling, walking or balancing with their doctor and got treatment for it.
Controlling blood pressure* - Percentage of Enrollees who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
Part D medication adherence for oral diabetes medications* - Percent of Enrollees with a prescription for oral diabetes medication who fill their prescription 80% or more of the time.
Behavioral Health Shared Accountability Outcome Measure - Reduction in emergency department use for seriously mentally ill and substance use disorder Enrollees

Ensuring Strong Performance

Provider Group Selection

- DSNP Model of Care Infrastructure
- Medicare / Medi-Cal Experience
- Strong financial solvency performance
- Strong Quality Performance
- Coverage
  - Focus on Ethnic Markets
  - Geographic focus in high density areas

Delegation Process

- Pre-Delegation Audit
- Requirements Review
- Contract Negotiation
- 90 Day Post “Go Live” Audit
- Annual Reassessments

Ongoing Monitoring

- Monthly Reporting
- Provider Data Sharing and Provider Group Huddles
- Sharing Best Practices
- Performance Monitoring
- Focus Audits

Questions