



Health Net[®]

**UTILIZATION MANAGEMENT PROGRAM
EVALUATION**

2005 Evaluation of 2004 Program

Health Net of Oregon Evaluation of 2004 Utilization Management Program Evaluation

INTRODUCTION

The Health Net of Oregon Board of Directors has established the Health Net of Oregon Utilization Management Program. This program defines responsibility and oversight for the development, implementation, monitoring, and continuous quality improvement of all healthcare initiatives.

Health Net of Oregon (HNOR) operates a multi-dimensional Utilization Management Program to direct and monitor the use of health care services provided to its members. The program involves prior authorization, concurrent, and retrospective review evaluation of the utilization of services provided to members. The program requires cooperative participation of HNOR, participating practitioners, delegates, hospitals, and other providers to ensure a timely, effective, and medically sound program. 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 of HNOR management or concerns for the plan's fiscal performance. The model is patient centric and empowers the member with knowledge that allows them to become more active participants in health care decisions.

PURPOSE

The purpose of the Utilization Management Program is to provide a comprehensive, integrated process that ensures that HNOR members receive timely, safe and appropriate medical care in the most efficient and cost-effective manner. The Program also provides the process and structure whereby Health Services staff and the Delegation Oversight Committee provide oversight for delegated activities provided by HNOR practitioners, providers and/or third party administrators. The Program interfaces with the quality management system to facilitate the achievement of its goals and objectives.

OBJECTIVES

The objectives of the HNOR Utilization Management Program are:

1. Ensure that qualified health professionals using appropriate clinical information and criteria sets make appropriate utilization management decisions.
2. Establish standards for the timeliness of utilization management decision making.
3. Ensure that the reasons for each denial are clearly documented and communicated to members and practitioners.
4. Establish processes to monitor and oversee utilization of high-risk and high-cost procedures and services.
5. Use written guidelines and criteria based on sound clinical evidence and develop and implement procedures for applying this criteria in an appropriate manner to ensure that current technology and scientific evidence is used in the utilization review decision.
6. Develop processes and tools for authorization, case/disease management, discharge planning and other utilization management functions to improve efficiency, continuity of care and standardization of application.

7. Monitor utilization of selected services against benchmarks and provide feedback to improve the provider's knowledge of current medical evidence in order that the provider can measure their own effectiveness to benchmarks.
8. Establish processes to collect and periodically monitor data, implement interventions, and measure results of the interventions for effective strategies to achieve appropriate utilization.
9. Identify and intervene when quality of care issues are identified individually or through delegated utilization management review of over- or under-utilization.
10. Review of over or under utilization
11. Comply with all applicable federal and state laws, regulation and accreditation requirements.

UTILIZATION MANAGEMENT PROGRAM OBJECTIVES, RESULTS AND EVALUATION, AND 2005 RECOMMENDATIONS

Program Objective	2004 Results/Evaluation	2005 Recommendations
Update and approve 2003 UM Program Evaluations	<ul style="list-style-type: none"> 2003 UM Program Evaluation was reviewed and approved by the Quality Improvement (QIC) at the 1st Qtr 2004 QIC meeting. 	<ul style="list-style-type: none"> Review and approve the 2004 UM Program Evaluation in the 1st Qtr QIC meeting.
Update and approve 2004 UMC Program Descriptions	<ul style="list-style-type: none"> 2004 UM Program Description was reviewed and approved at the 2nd Qtr 2004 QIC meeting. 2005 UM Program Description was reviewed and approved at the 4th Qtr 2004 QIC meeting. 	<ul style="list-style-type: none"> Present for approval the 2005 UM Program Description in the 4th Qtr 2004 QIC meeting.
Update and approve 2004 QI Work Plan*. *Includes annual Work Plan activities for Utilization Management.	<ul style="list-style-type: none"> 2004 QI Work Plan was reviewed and approved at the 2nd Qtr BOD Committee meetings. 2005 QI Work Plan was reviewed and approved at the 4th Qtr QIC meeting. 	<ul style="list-style-type: none"> Continue to present for approval the annual QI Work Plan at the 1st Qtr BOD Committee meetings. Present for approval the 2005 QI Work Plan in the 4th Qtr 2004 QIC meeting.
Update QI Work Plan quarterly *Includes annual Work Plan activities for Utilization Management.	<ul style="list-style-type: none"> QI Work Plan was updated quarterly and reflected any status/changes to QI projects and interventions. Quarterly QI reports were developed and reviewed/approved at quarterly BOD Committee meetings 	<ul style="list-style-type: none"> Continue quarterly QI Work Plan updates and BOD Reports in 2005.
Regulatory Compliance	2004 UM reports were submitted according to SB-21 requirements by due date.	<ul style="list-style-type: none"> Develop and submit state reports by June 30, 2005.
<p>Comply with all applicable federal and state laws, regulation and accreditation requirements.</p> <p>Ensure that qualified health professionals using appropriate clinical information and criteria sets make appropriate utilization management decisions.</p> <p>Establish standards for the timeliness of utilization management decision making.</p> <p>Ensure that the reasons for each denial are clearly documented and communicated to members and practitioners.</p> <p>Use written guidelines and criteria based on sound clinical evidence and develop and implement procedures for applying this criteria in an appropriate manner to ensure that current technology and scientific evidence is used in the utilization review decision.</p>	<p>Assure compliance with ORS 743.807 (2) a, b, and c. This audit reviewed:</p> <ol style="list-style-type: none"> 1. medical director final determination on all denials for of medical necessity and experimental investigational timeliness of decision making 2. timeliness of decision making 3. clear documentation of reasons for denial and communication to members and practioners, including appeal rights 4. No compliance issues identified <p>Assure consistency in clinical reviews through implementation of Inter-Rater Reliability Audits</p> <ol style="list-style-type: none"> 1. Audit process revised for 2004 guidelines 2. 90% performance target established 3. Initial audit completed with average score of 71% 4. Corrective Action Plan developed and implemented 5. Additional training provided to all staff 6. Follow up audit with average score of 94% <p>HNOR was an active participant in the Health Net, Inc. National Medical Advisory Group established to develop written guidelines and criteria based on sound clinical evidence.</p>	<p>Continue to monitor regulatory compliance through at a minimum annual audits</p> <p>Continue with inter-rater reliability audits in 2005</p> <p>Enhance process for improving implementation of National Medical Advisory Group written guidelines and criteria.</p>

Develop policies, processes and tools for authorization, case/disease management, discharge planning and other utilization management functions to improve efficiency, continuity of care and standardization of application.	All policies and procedures were reviewed in 2004. Revisions were made if appropriate. Additional policies/procedures and tools were developed and implemented as needed.	Continue with annual review of policies and procedures
<p>Establish processes to collect and periodically monitor data, implement interventions, and measure results of the interventions for effective strategies to achieve appropriate utilization.</p> <p>Establish processes to monitor and oversee utilization of high-risk and high-cost procedures and services.</p> <p>Review of over or under utilization</p>	Health Care Cost (HCC) Group established for collecting and periodically monitoring data, implementing interventions and measuring results of interventions for effective strategies to achieve appropriate utilization.	Continue with HCC Group in 2005
<p>Monitor utilization of selected services against benchmarks and provide feedback to improve the provider's knowledge of current medical evidence in order that the provider can measure their own effectiveness to benchmarks</p> <p>Review of over or under utilization</p>	<p>Physician intensity audits were conducted for evaluation and management services.</p> <p>Outcomes of audits shared with selected providers</p>	Identify selected services for 2005 review, audit, and review findings with providers when appropriate
Identify and intervene when quality of care issues are identified individually or through delegated utilization management review of over- or under-utilization.	<p>Continuously monitor the quality of care/safety provided to members by participating providers using established Quality Indicators.</p> <p>Total number of potential Quality of Care/Safety and Service cases identified in 2004: 284</p> <ul style="list-style-type: none"> - Total Quality of Care/Safety cases: - Total number of Quality of Care/Safety closed in 2004: 287 - Percent of cases closed in ≤ 45 days: - Assigned severity levels to closed cases: <ul style="list-style-type: none"> - Level 1: 277 - Level 3: 6 	<ul style="list-style-type: none"> • Continue with monitoring of Quality of Care/Safety • Continue to monitor delegates for over and under utilization and compliance with HNOR UM standards and regulatory requirements

- Level 2: 3 - Level 4: 1

All level 3 and 4 issues were presented to the Peer Review Committee for review and recommendation. Follow up was based on the committee recommendations. Cases were tracked for adverse trends; none were identified

Monitoring of Delegates

1. Annual reviews conducted on all established Delegates* in 2004:
2. Pre-assessment reviews completed on prospective Delegate in 2004:
3. Corrective Actions Plans (CAPs) were submitted for a number of delegated UM functions for noncompliance with state regulatory requirements.

8 of 10 2004 CAPS were closed

*Review findings may not be completed by year-end

Goal #4 Identify Opportunities for improvement in the health status of members through the development and implementation of health promotion, preventive education, and disease management programs

Objective	Results/Evaluation	2005 Recommendations
Develop/Implement health management system to help members make informed decisions and/or manage their chronic condition or disease.	<ul style="list-style-type: none">Implemented the Health Dialog decision support program in 2nd Qtr of 2004	<ul style="list-style-type: none">Evaluate the effectiveness of the program in 2005