Quality Improvement

Program Description

Plan Year: 2014

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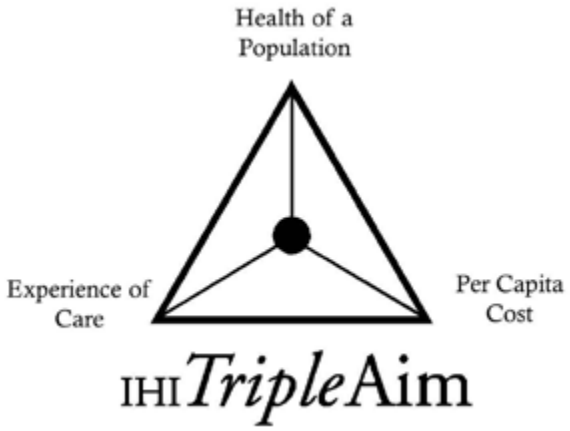
I. Introduction and Mission Statement

CoOportunity Health is a nonprofit health insurance CO-OP – Consumer Operated and Oriented Plan, established under the authority of Section 1322 of the 2010 Patient Protection and Affordable Care Act (ACA). We are governed by our members and exist to offer affordable, consumer-friendly and high-quality health insurance options for individuals and employer groups in Iowa and Nebraska.

The Quality Improvement (QI) Program described in this document supports our mission by engaging members, providers, partners and staff in pursuit of the "Triple Aim." First defined by the Institute for Healthcare Improvement (IHI) in 2008, the Triple Aim provides an organizing framework for strategies that *simultaneously* seek to improve the individual experience of care, improve the health of populations, and reduce the per capita costs of care for populations.



As a new health plan, conceived for the purpose of making quality, affordable healthcare more accessible to those individuals who have been uninsured, underinsured or without quality insurance options, CoOportunity Health is in a unique position to integrate the key principles of QI into our organization's DNA and deliver on our founding promise. To that end, this document describes the processes and resources dedicated to designing, implementing, measuring and evaluating the many initiatives to support this mission.

II. Quality Improvement Goals and Objectives

CoOportunity Health's vision is to enhance the livelihood of our members by providing them with affordable health plans that support their optimal health status and provide an exceptional care experience. During 2014, our initial year of operations, we plan to collect baseline data regarding each of the critical dimensions of this vision: *affordability, health status, and care experience.* We will also be seeking to achieve a full understanding of our membership across the following dimensions:

Membership Profile

- Age
- Gender
- Cultural, ethnic, racial and linguistic needs
- Health status (disease burden/risky behaviors)
- Financial status
- Geographic distribution
- Claim experience (place of service, type of service, average claim expense)

Health Status Objectives

- Identify opportunities to improve member health status and outcomes
- Design, implement and evaluate processes and programs to improve care
- Support member understanding of their current health status, including mental health status, disease burden and risks
- Encourage members to access and receive appropriate preventive care
- Empower members in self-care around healthy behaviors and chronic disease care
- Promote care coordination and access to highly qualified health care providers across sites of care and within community settings

Care Experience Objectives

- Identify opportunities to improve member and provider satisfaction with the care and service provided through the health plan
- Design, implement and evaluate processes and programs to improve member and provider satisfaction with CoOportunity Health
- Ensure network adequacy and timely access to appropriate medical and behavioral health services
- Support the delivery of care and service from providers and health plan staff that meets the cultural, ethnic, racial and linguistic needs of our members

Affordability Objectives

- Identify opportunities to improve the affordability of our health plans
- Design, implement and evaluate processes and programs to improve the total cost of care
- Provide consumer and provider information to address supply-driven health care
- Collaborate with providers to ensure safe, efficient, and effective delivery of care

III. Scope of Program

The goals and objectives of the 2014 QI Program apply to all of CoOportunity Health's lines of business and products, address the spectrum of care and services provided to our entire membership, and require the active participation of our full complement of network providers.

Specifically the scope of the QI Program encompasses:

- All care delivery settings
- Primary care, specialty care
- Medical conditions, behavioral health conditions
- Preventive care, acute care, chronic care
- Members with complex care needs
- Patient safety
- High volume conditions
- Pharmaceutical care
- Member and provider satisfaction with CoOportunity Health operations
- Timely and appropriate response to member complaints and appeals
- Availability and accessibility of care
- Responsiveness of the health plan to the diverse needs of our membership

Delegation

CoOportunity Health's operations are carried out in alliance with two primary business partners: HealthPartners Administrators, Inc. (HPAI), a cooperatively governed, member owned health system and insurer that is NCQA accredited at the Excellent level, and Midlands Choice, the largest, non-insurer owned provider network in Iowa and Nebraska that is fully accredited by URAC as a Credentialing Verification Organization (CVO).

HPAI provides services related to membership and enrollment, claims processing, product and distribution support, member/customer service, utilization management, medical/behavioral management, case management, disease management, pharmacy management, measurement and reporting, including HEDIS® and CAHPS® measurement and reporting.

Midlands Choice provides services related to provider contracting & network management, claims pricing, credentialing and recredentialing, and provider communications.

Delegation agreements between the CO-OP and the delegates describe the obligations and activities of both parties, including the requirement to collaborate with CoOportunity Health on an ongoing basis to identify QI opportunities, implement improvement initiatives,

analyze and measure results, and report outcomes to CoOportunity Health's leadership and QI/Physician Advisory Council.

IV. Program Organization, Oversight & Evaluation

As depicted in Appendices A and B, the **CoOportunity Health Board of Directors** has final authority and ultimate responsibility for the quality of care and services provided to members of the health plan and for oversight of the Quality Improvement Program. It exercises its oversight responsibilities by reviewing and approving the annual QI Program Description, QI Workplan and QI Program Evaluation.

The Board has assigned responsibility for oversight of the quality improvement, integrated care and utilization management programs to the **QI/Physician Advisory Council (QI Council).** Chaired by the CO-OP's Chief Operating Officer, the QI Council's membership includes medical and behavioral practitioners and physicians from Iowa and Nebraska, the CO-OP's medical director, as well as senior CoOportunity Health leaders representing Operations, Provider Relations/Network Administration, Corporate Communications, Integrated Care and Accreditation, Product Development, and Medical Management/Accreditation. It meets at least three times per year and is responsible for providing policy direction to CoOportunity Health's quality, utilization management, and integrated care initiatives and programs, overseeing delegated arrangements, reviewing reports from delegate committees, developing annual QI goals and work plans, ensuring follow-up and practitioner participation as appropriate, evaluating progress toward achieving quality program goals and objectives, and assuring that CoOportunity Health's programs meet customer needs. The chairperson is responsible for leading the QI Council meetings and reporting its findings and recommendations to the Board of Directors as needed but at least annually.

CoOportunity Health's Medical Director serves as a liaison and communication link between the CO-OP, its QI Council and various quality-related committees of the strategic partners who perform delegated functions on our behalf. This includes the Credentials and Peer Review Committees of Midlands Choice, the HealthPartners Pharmacy QUI Committee, and the HealthPartners Medical Directors Committee which recommends medical policy and coverage criteria. A **Behavioral Healthcare practitioner,** who is a member of the QI Council, serves as a liaison and communication link to the Behavioral Health provider community and advises the CO-OP on efforts to monitor and improve behavioral healthcare. Leaders from CoOportunity Health also regularly participate in and receive reports from the HealthPartner Service Quality Committee. When quality improvement opportunities are identified and acted upon by these delegate committees and their organizations on issues that impact CoOportunity Health members, the QI Council is advised of these actions and may offer recommendations for additional or different actions to remedy identified performance gaps.

QI Program Structure – Operational Leadership

We believe commitment to **Quality Improvement must be a shared value**. To that end, responsibilities and functions to ensure its manifestation are broadly embedded in all of the position descriptions, policies and procedures and delegation agreements that make up our operations structure.

CoOportunity Health's **Chief Operating Officer** and its **Medical Director** have primary responsibility for implementation of the Quality Improvement Program. They are supported by the following corporate operations leaders:

The **Vice President of Medical Management and Accreditation** is responsible for communication with and oversight of partners to whom we have delegated quality, credentialing, utilization management, member rights and member connections functions. This leader reports to the Chief Operating Officer and is charged with primary responsibility for day-to-day implementation of the Quality Improvement Program, as well as for tracking indicators, preparation of quality improvement reports and studies, and compliance with all government, regulatory, and accreditation requirements related to these functions. Member of the QI Council.

The **Vice President of Operations and Information Technology** is responsible for communication with and oversight of partners to whom we have delegated Enrollment, Member & Provider Services, Claims Administration, and Analytic & Reporting functions. This leader also ensures the health plan complies with all government, regulatory, and accreditation requirements related to these functions. Member of the QI Council.

The **Vice President of Corporate Communications and Stakeholder Engagement** is responsible for planning and implementing all corporate communications and engagement programs to meet the growth and retention goals of the company. This leader oversees the development and management the company's owned media, including corporate website assets, social media, electronic newsletters, and other stakeholder-specific communications vehicles and helps to ensure member and provider communications meet all appropriate standards and requirements. Member of the QI Council.

The **Vice President of Provider Relations and Network Administration** is responsible for establishing and managing contractual relationships with healthcare provider networks, integrated health care organizations, and individual healthcare providers to meet CoOportunity Health's network adequacy standards. This leader ensures that provider incentives are appropriately aligned with CoOportunity Health's quality goals and objectives. Member of the QI Council.

The **Vice President, Product, Distribution and Market Research** leads and coordinates CoOportunity Health functions related to product development and management, distribution channel development and administration, and sales operations and market research. This leader works collaboratively with the QI Program to identify and quantify member needs, and propose and design products and programs to more effectively meet corporate QI objectives. Member of the QI Council.

The **Leader of Integrated Care and Accreditation** is responsible for planning, design, implementation, and evaluation of initiatives to promote new models and payment arrangements for more patient-centered delivery of care (including Medical Home) which promote care coordination and improved health outcomes. Member of the QI Council.

QI Program Evaluation

An annual written evaluation of the QI Program is completed by appropriate operational leaders during the first quarter of each calendar year. The evaluation is reviewed and approved by the QI Council and the Board of Directors and includes at least the following:

- A description of completed and ongoing QI activities that address *quality and safety of clinical care* provided to CoOportunity Health members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QI activities that address *service quality and the experience of care* for CoOportunity Health members including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QI activities that address the *affordability of CoOportunity Health benefit plans* including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the *overall effectiveness of the QI Program* (structure, communication, resources, practitioner participation), including progress toward influencing network-wide safe clinical practices and addressing the cultural and linguistic needs of our membership.
- *Recommendations for changes* to the QI Program to make it more effective.

V. Program Activities and Initiatives

Establish Baseline Measurements

Measurements during our initial year of operation will focus on collecting baseline data across the following dimensions of health status, service experience, and affordability.

- Membership profile (age, gender, income, health status, cultural/linguistic needs, geographical dispersion)
- Disease burden/risk status, including Behavioral Health status
- Clinical indicators of care (HEDIS®) – collected in 2015 following our initial year of operation
- Utilization profile
  - Preventive/acute/emergent
  - Primary/specialty
  - Medical/behavioral
  - In/Out of network claims
  - Large case claims
  - Admission rates
  - Rx usage by tier
- Member Engagement in Care Management Programs
  - Complex Case Management
  - Disease Management, including Behavioral Health conditions
  - Healthy Incentives
  - Nurse Lines
- Patient Safety
  - Quality of Care or Serious Reportable Events
  - Hospital Safety Report
- Coordination, integration of care
- Service quality
  - Enrollment process
  - Inquiries, complaints and appeals
  - Timeliness and accuracy of claims adjudication
- Member satisfaction (CAHPS®)
- Provider satisfaction
- Network adequacy and access to care
- Premium/cost sharing arrangements relative to service area competitors
- Member perceptions of health plan affordability

These baseline measures will be used by appropriate operational leaders and the QI Council to identify opportunities for specific quality improvement initiatives and activities to

advance accomplishment of our mission. Appendix C provides a more detailed view of our annual QI work plan.

Quality Improvement Initiatives

In our initial year of operations, CoOportunity Health, in concert with our strategic partners, will pursue specific activities and actions to positively impact the health status, service delivery, and affordability our members experience. We anticipate that as our health plan matures, our provider networks evolve, and we are better able to discern our membership profile, our initiatives will become more targeted and our quality improvement activities will more specifically address any identified performance gaps.

1. Promote Member Engagement

From the time consumers begin the enrollment process through their full experience as CoOportunity Health members, they are offered choices and information to help them select the products, providers and plans that best meet their preferences and needs.

- Members are financially rewarded through the *Healthy Rewards* program to complete a health assessment, pursue preventive care and make healthy lifestyle choices. Health assessments are offered online, and in paper form in both English and Spanish.
- A 24-hour nurse line, *CareLine*^{SM}, is available to guide members in their health care decisions or simply offer reassurance to parents of a newborn.
- For members needing help accessing a behavioral health provider or understanding their benefits, the *Behavioral Health Personalized Assistance Line* (PAL) is available.
- We offer *Disease Management* programs to our members with medical or behavioral health conditions for which patient self-care efforts are significant. Appropriate members are identified through claims or other referral sources and invited to engage with health coaches in better understanding and managing their conditions.
- Members identified with complex health needs (physical or developmental challenges, multiple chronic conditions, severe mental illness, HIV/AIDS, organ or tissue transplants) are invited to partner with a "personal nurse navigator" to coordinate their care and ensure access to appropriate services.

2. Support Evidence-Based Clinical Care

Clinical practice guidelines promulgated by the Institute of Clinical Systems Improvement (ICSI) are supported by the CO-OP and highlighted and shared with all network providers.

The ICSI guidelines, which address medical, behavioral health, preventive care, and palliative care, facilitate agreement on elements of care that are medically appropriate and result in the best possible outcomes. The use of clinical practice guidelines allows us to measure the impact of the guidelines on the outcomes of care and reduce inappropriate variation in diagnosis and treatment.

3. Support Patient Safety

With the Institute of Medicine's publications *To Err is Human: Building a Safer Health System* (1999) and *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), healthcare organizations were confronted with the chasm between what we know to be good, safe, quality care and what actually exists in practice. The initiatives described below are our first-line actions to understand and work toward closing this gap.

- *Quality of care* issues are defined as situations, usually linked to the professional care or services provided to a specific patient or client, where a deviation from applicable standards of care is suspected or confirmed. Cases that are identified as having actual or perceived quality of care issues are investigated. Aggregate complaint and appeal data are analyzed on a quarterly basis, at a minimum, to identify specific trends or patterns of care at the health plan, provider or practitioner level that may suggest a need for improvement. The Midlands Choice Peer Review Committee, acting on our behalf, takes appropriate action based on Credentialing policies and procedures when notified of cases involving a *serious reportable event* (as defined by the National Quality Forum).
- *Patient safety education* aimed at both members and providers is shared throughout the year through newsletter articles, website postings, health fairs, and case/disease management conversations and mailings. Topics may include preventing infections in the hospital, safe transitions from hospital to home, preparing for a physician visit, pharmacy safety, and the role of the patient advocate.

4. Promote Integrated Care and Advance Patient-Centered Medical Home

Integrated care brings together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Our approach to integrated care addresses care coordination, service delivery and payment design. We are conducting a CoOportunity Health Integrated Care Study, a program with multiple facets that provides financial and administrative support to advance the development of integrated care, especially advancement of Patient-Centered Medical Homes (PCMH) in Iowa and Nebraska.

- Baseline Data Collection part A: community awareness of PCMH
- Baseline Data Collection part B: data sources used for PCMH management
- Medical Home Implementation Pilot Projects
- Explore needs and options for improved analytics capability

To reduce barriers to care and promote the establishment of a relationship with a primary care provider, many of our health plans include a "Three-for-Free" benefit design which waives the member copay for their first three office visits (medical or behavioral).

5. Reduce Disparities in Healthcare Access

Our target markets represent a wide array of consumers, including those who may have been marginalized in the past by income, language, racial, ethnic, literacy, mental health or other cultural barriers. We seek to better understand and serve this diverse membership by:

- Analyzing, understanding and addressing disparities as a barrier to improving health.
- Using existing race and ethnicity data to inform and modify initiatives as applicable.
- Implementing member and provider communications to address disparities where appropriate including reducing barriers to services for members with complex or multiple conditions.

6. Enhance Pharmacy Management Programs

Enhanced pharmacy benefits administration has the potential to positively impact each dimension of the Triple Aim; health status, experience of care, and affordability. During 2014, in collaboration with our HPAI Pharmacy Management team and our pharmacy benefits manager (PBM), MedImpact, we will pursue strategies to:

- Implement innovative intervention strategies that improve medication adherence, including a refill synchronization program
- Increase engagement, integration, effectiveness and modes of visits of Medication Therapy Management (MTM)
- Achieve generic utilization of 90% through product design, formulary options, member outreach and provider incentives
- Promote specialty management strategies that work to control costs and appropriate use
- Identify, decrease and prevent Fraud, Waste and Abuse (FWA)
- Leverage the role of pharmacists to achieve optimal health goals
- Actively participate in care transitions effort
- Reduce waste of pharmaceuticals
- Implement the Pharmacy Navigator service and take action based on member survey results to enhance member experience with pharmacy benefits

7. Improve Affordability of Healthcare

A key objective of CoOportunity Health's founding legislation, the Patient Protection and Affordable Care Act (ACA), is to significantly reduce the number of uninsured by providing a continuum of *affordable* coverage options. We support the fulfillment of this goal by:

- Addressing cost/trend drivers through identifying and acting on instances/patterns of fraud, waste, overuse or misuse.
- Implementing process improvements to support more efficient, effective medical and behavioral healthcare coverage policies and to ensure adherence to policies.
- Provide members and providers with information to address supply-driven health care.

VI. QI Process and Program Resources

QI Process

CoOportunity Health's QI Process follows a 7-step continuous cycle to identify and drive improvement in our operations and performance.

Step 1: Identify key performance indicators and goals – **Annual Review of QI Program Description** (Senior Leaders, QI Council, and Board of Directors)

Step 2: Measure and report actual performance against standards/goals/benchmarks (Operations and Informatics staff)

Step 3: Identify and conduct root cause analysis of performance gaps (Operations, QI and Informatics staff)

Step 4: Propose and select actions/initiatives to improve performance – development of the **Annual QI Workplan** (Operations, Senior Leaders and QI Council)

Step 5: Assign accountability for improvement activities (Senior Leaders)

Step 6: Implement improvement activities (Operations)

Step 7: Re-measure and report performance results at specified intervals – **Periodic and Annual QI Program Evaluation and Report** (Operations and Informatics staff, QI Council, and Board of Directors)

QI Program Resources – Delegate & Multidisciplinary Staff

In addition to the Leadership roles described in Section IV of this document, program resources for the QI Program also come from various corporate and delegate department staff.

Support for improvement initiatives related to complex case management, disease management, guideline implementation, utilization management and other clinical process improvement measures and outcomes is provided by the staff in the Health and Care Management Division at HealthPartners as well as their staff in the Quality Measurement and Improvement Department.

Service related quality initiatives, including member satisfaction initiatives and those related to inquiries, complaints and appeals, are supported by the Member Services staff at HealthPartners. Additional support for member communications is provided by CoOportunity Health's Manager of Stakeholder Communications.

Quality initiatives related to provider networks, credentialing, peer review functions, provider satisfaction and provider communications are supported by the Contracting and Credentialing staff at Midlands Choice and the Provider Services staff at HPAI. Investigation, trending and analysis of quality-of-care complaints are conducted by Midlands Choice Credentialing staff.

Medical Policy and Coverage Criteria development is performed by the HealthPartners Medical Policy staff supported by the Medical Directors' Committee on behalf of CoOportunity Health. CoOportunity Health's medical director and designated behavioral health practitioner participate on and provide input to this committee and serve as liaisons to the CO-OP's participating provider network.

The Institute for Clinical Systems Improvement (ICSI) is responsible for clinical guideline development, including periodic review and updates. CoOportunity Health adopts the ICSI guidelines and supports their implementation within its provider network. The ICSI guidelines provide the basis for measurement of disease management effectiveness and the measurement and monitoring of clinical indicators and quality improvement initiatives.

QI Program Resources – Programs and Tools

CoOportunity Health has dedicated substantial investment and resources to the acquisition of programs and tools that promote high quality services to our members. These include but are not limited to:

- **Online Member Administrative Support** – Searchable provider directories, health plan benefit summaries, drug formularies, claim look-up functions
- **Online Member Education and Engagement Resources -** In conjunction with *Healthwise Inc.*, we offer members access to a comprehensive database of clinical information and interactive tools via our website.
- **Online Provider Resources –** Eligibility and benefit look-up, claims submittal, remittance look-up, formulary information, cultural care resources, disease and condition management information, forms
- **In-Person Member Support –** Nurseline℠, BabyLine, Personal Assistance Line
- **In-Person Member Coaching -** Disease/Condition Management programs
- **In-Person Member Coach/Advocacy -** Complex Case Management program

QI Tools, Resources and Sources of Data

CoOportunity Health's approach to quality improvement draws on a rich library of tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to guide our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Healthy People 2020, Consumer Assessment of Healthcare Providers and Systems *(*CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS®), Quality Compass
- *Government issued laws, regulations, and guidance,* including those from HHS, CMS, the Centers for Disease Prevention and Control, the U.S. Preventive Services Taskforce, and the National Institutes of Health
- *National Professional Organizations,* such as the American Medical Association, American College of Cardiologists, or the American Psychiatric Association, National Association of Community Health Centers
- *Healthcare Quality Improvement Organizations,* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), the Institute for Clinical Systems Improvement (ICSI), the National Quality Forum (NQF), the Leapfrog Group, and the Agency for Healthcare Research and Quality (AHRQ),
- *National Health Associations,* such as the American Heart Association, the National Cancer Institute, the American Diabetes Association, and Patient-Centered Primary Care Collaborative
- *Organizations focusing on Patient Safety,* such as the Institute of Medicine, and the National Patient Safety Foundation
- *HealthPartners Total Cost of Care (TCOC) and Resource Use* methodology endorsed by the National Quality Forum

QI Program Resources – Data, Information and Analytics Support

The QI Program monitors and evaluates performance data and information from many different sources throughout our organization including but not limited to:

- *Enrollment data,* demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among patient populations.
- *Claims data* (utilization by diagnosis/procedure, provider, treatments/meds, site of care, sequence of care, etc.)
- *Claims cost data*
- *Health appraisal data* to determine disease loads, risks, and health intervention opportunities
- *Complex case management and disease management reports* to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the care spectrum
- *Inquiry, complaint and appeal data*, including investigational data (type of complaint, timeliness and/or appropriateness of resolution)
- Ongoing tracking and trending of *quality or care or serious reportable event data* to identify patient safety issues and assess provider qualifications
- *Member and provider survey data* to assess satisfaction with services and operations
- *Credentialing process data* to measure timeliness of application processing and quality of network providers
- *Network adequacy/accessibility measurement data* to assess provider availability and accessibility
- *HEDIS® data*, including selective medical record reviews, to assess effectiveness of clinical care and services
- *Operations performance data* (accuracy, timeliness of member services and claims administration)
- *Premium Rate data* from competing plans
- Measures of compliance with *member confidentiality/privacy requirements*
- *Integrated Care Study data* as a baseline for future measurement of care coordination performance

The success of CoOportunity Health's Quality Improvement Program requires access to current measures of operational performance and the effectiveness of improvement initiatives. Substantial resources are devoted by HPAI on behalf of CoOportunity Health to the collection, reporting, and analysis of performance data.

Clinical Performance Data: Analysts within the Health Informatics division of HPAI provide decision information support to many of the functions the CO-OP delegates to HPAI. Informatics leverages health plan administrative data into meaningful indicators of clinical performance, utilization trends, and program effectiveness. Informatics supports care improvement through the identification and tracking of members who may benefit from case management, disease management, preventive care, and other population health initiatives.

Member Feedback/Satisfaction Data: HPAI Market Research obtains member feedback through the administration of satisfaction surveys. The data obtained supports analysis at the health plan, provider, and practitioner level.

Utilization Data: Health Informatics supports systematic analysis and benchmarking of utilization trends at the CO-OP system-wide level and, at the provider level, from multiple data systems (enrollment, claims, encounters, pharmacy).

Complaint and Appeal Data: The HPAI Customer Service System (HCSS) supports tracking and trending of CO-OP member complaint and appeal data, including those appeals to an external review organization coordinated through the state departments of insurance.

HPAI Health Informatics has implemented an analytical framework that allows the study of use, intensity, illness burden, and cost using a structured, hierarchical approach. Various classification systems, such as Ambulatory Care Groups, Ambulatory Payment Groups, Diagnosis Related Groups, Episode Treatment Groups, Relative Value Units, etc., are used to assist with case mix analysis. HPAI has statistical consultants on staff to support quantitative analysis of CO-OP clinical and utilization data.

VII. Effective Date and Revision History

Effective Date: January 2014