Fresno Kings Madera

Regional Health Authority

Commission Meeting February 15, 2018

Exhibits:

- 7.B 2017 Annual Quality Improvement Work Plan Evaluation
- 8.B 2017 Annual Utilization Management Case Management Work Plan Evaluation
- 9.A 2017 Annual Compliance Evaluation
- 10.A 2018 Compliance Program Description
- 11.A 2018 Code of Conduct
- 12.A 2018 Anti-Fraud Plan
- 13.A 2018Privacy and Security Plan

Item #7

Attachment 7.B

2017 Annual
QI Work Plan Evaluation

CalViva Health
2017
Quality Improvement
End of Year Evaluation

Attachment S

02/8/2018

CalViva Health 2017 Quality Improvement Work Plan

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CalViva Health 2017 Quality Improvement Work Plan

I. Purpose

The purpose of the CalViva Health's Quality Improvement Program Work Plan is to establish objectives for the QI Program and review clinical, service and safety related outcomes against the priorities and objectives established by the Program. An assessment of critical barriers is made when objectives have not been met.

II. CalViva Health Goals

1. We will anticipate, understand and respond to customer needs and be customer-driven in everything we do.
2. We will hire and retain the best people, create the best climate, provide the best tools to do the best job and build a spirit of warmth, friendliness and pride throughout the company.
3. We will dedicate ourselves to a standard of excellence in all of our customer relationships.
4. We will promote better outcomes for our customers through improved provider relationships and through the promotion of evidence-based health care.
5. We will provide efficient, simple and high quality administrative services that get things right the first time.
6. We will build excellent business systems and processes and demonstrate the highest degree of integrity in all aspects of the operation of our business.

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2017. The development of this document requires resources of multiple departments.

CalViva Health 2017 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CDC:	Comprehensive Diabetes Care
CM:	Case Management
CP:	Clinical Pharmacist
CVH:	CalViva Health
DHCS:	Department of Health Care Services
DM:	Disease Management
DMHC:	Department of Managed Health Care
DN:	Direct Network
FFS:	Fee-for-Service
HE:	Health Education
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
PCP:	Primary Care Physician
PIP:	Performance Improvement Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
QI:	Quality Improvement
SPD:	Seniors and Persons with Disabilities
UM:	Utilization Management

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)

1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Timely Appointment Access to Primary Care Physicians and Specialists is measured through seven metrics. The specific goal is 80% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the ICE-DMHC PAAS Tool and the CVH PAAS Tool.

Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 80% for all metrics. Timely Appointment Access is monitored using the ICE-DMHC PAAS Tool.

After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey. This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007 Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements	P	Q4	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q1 - Q4	CVH/HN
Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q1	CVH/HN
Complete all Provider Updates for informing CalViva Health providers of PAAS and PAHAS Survey results, with educational information for improvement (no later than 3 months after results survey have been finalized).	P	Q3 (for 2016 results)	CVH/HN
Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability.	P	Q4	CVH/HN
Complete a CAP as necessary – when CalViva providers are below standard; including additional interventions for providers not meeting standards two consecutive years.	P	Q3-Q4	CVH/HN
Annual review, update and distribution of Patient Experience Toolkit, After-Hours Script, Guidelines for compliance and Monitoring and Appointment Scheduling Tip sheet	P	Q1-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• MY2017 Provider Appointment Survey contract executed with Sutherland Global in July 2017. Surveys scheduled to begin in September 2017. • Provider Update distribution calendar updated January 2017. Provider Update for MY2016 Provider Appointment Availability and After-Hours Results will be sent in September 2017. Provider Update for MY2017 Provider Appointment Availability and After-Hours Survey Prep was sent out in August 2017. • P&P PV-100 Accessibility of Providers and Practitioners was reviewed and updated in March 2017. • Provider Update with MY2016 survey results will be sent out 9/8/17. • MY2017 After-Hours survey contract executed with AllTran in August 2017. Surveys to begin September 2017. • CVH PPG CAP packets will be mailed the second week of September 2017. Provider Relations staff training will be conducted once the PPG packets have been mailed. Provider relations staff will begin provider onsite visits to deliver individual informational CAP packets and conduct onsite audits by the end of September 2017. • Annual review of educational materials conducted in January 2017. CVH Patient Experience Toolkit and Appointment Access Tip sheet required edits. Final versions of Toolkit and Tip Sheet approved in June 2017 and will be distributed with the CAP packets.	• MY2017 PAAS surveys were conducted by Sutherland Global and concluded 12/31/17. • Provider Updates were distributed timely: MY2016 PAAS & After-Hours Results distributed 9/23/17 Update #17-741 and MY2017 PAAS & After-Hours Survey Prep distributed 8/30/17 Update #17-740. • CVH P&P PV-100 reviewed and updated 3/16/17. • MY2017 After-Hours surveys conducted by Alltran and concluded 12/13/17. • 19 CVH PPG packets sent 12/18/17 with Improvement Plans due to HN by 1/18/18. Provider relations staff training did not occur due to change in outreach campaign design. PR staff in Fresno assisted by incorporating the Appointment Scheduling Tip Sheets into their HEDIS Care Gap outreach campaign. 223 provider educational CAP packets were mailed on 12/19/17. 40 repeat noncompliant providers were contacted regarding in-office audits that were conducted January 9-12, 2018. Phone audits were conducted January 12-17, 2018 for providers unavailable at the time of the in-office audit. • Educational materials were reviewed and updated as needed. The revised Toolkit was approved on 9/7/17 and was distributed to all providers receiving a CAP.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate RY 2017	Rate RY 2018	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall=90.0% Fresno=89.6% Kings=91.3% Madera=92.3%	TBD	CVH Performance Ry2016	Overall= 83.4% Fresno=82.3% Kings=93.1% Madera=82.9%
Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall=81.4% Fresno=84.0% Kings=60.0% Madera=81.8%	TBD	CVH Performance RY2016	Overall= 76.1% Fresno=87.6% Kings=80.9% Madera=60%
Access to Urgent Care Services that do not require prior authorization – Wait time not to exceed 48 hours	80%	Overall=76.8% Fresno=79.2% Kings=55.5% Madera=77.7%	TBD	CVH Performance RY2016	Overall= 72.5% Fresno=71.3% Kings=67.7% Madera=81.6%
Access to Urgent Care Services that require prior authorization – Wait time not to exceed 96 hours	80%	Overall= N/A Fresno=N/A Kings=N/A Madera=N/A	TBD	CVH Performance RY2016	Overall= 55.5% Fresno=50% Kings=44.4% Madera=73%

					N/A
Access to First Prenatal Visit – Within 10 business days of request	80%	Overall=94.2% Fresno=92.5% Kings=100% Madera=100%	TBD	CVH Performance RY2016	Overall= 84.2% Fresno=80.2% Kings=100% Madera=100%
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall=84.3% Fresno=83.9% Kings=100% Madera=70.0%	TBD	CVH Performance Ry2016	Overall= 77.3% Fresno=73.6% Kings=92.8% Madera=88%
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall=82.2% Fresno=81.2% Kings=100% Madera=70.0%	TBD	CVH Performance RY2016	Overall= 90.4% Fresno=88.3% Kings=92.8% Madera=100%
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall=100% Fresno=100% Kings=100% Madera=N/A	Overall=100% Fresno=100% Kings=100% Madera=N/A TBD	CVH Performance RY2016	Overall= 90.9% Fresno=90.9% Kings=N/A Madera=N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall=94.1% Fresno=94.5% Kings=92.7% Madera=93.8%	TBD	CVH Performance RY2016	Overall= 92.3% Fresno=94.6% Kings=79.4% Madera=83.3%
AH Urgent Care - Ability to contact an on-call provider within 30 minutes for urgent issues	90%	Overall=83.1% Fresno=84.1% Kings=74.0% Madera=93.8%	TBD	CVH Performance RY2016	Overall= 86.5% Fresno=87.1% Kings=90.9% Madera=80%

Analysis: Intervention Effectiveness w Barrier Analysis	Overall CVH did very well this measurement year and was noncompliant for two standards: 1. Urgent care appointments not requiring prior auth within 48 hours (PCP & Specialists) 2. AH urgent care – ability to contact an on-call provider (PCP) within 30 minutes for urgent issues 1. CAPs were issued to noncompliant PPGs and in-office audits were conducted for providers who were noncompliant for two consecutive years. 2. Onsite office audits revealed potential for improving education to provider offices on standards and survey methodology. 3. Survey Prep Provider Update needs to advise provider offices to state they offer same-day/walk-in appointments when asked about urgent care appointments within 48 hours metric.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Confirmed box should be checked. Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

1-2: Improve Member Satisfaction

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Member Satisfaction by DHCS was last evaluated in RY 2014 and results were aligned close to the Medicaid State Average. Member perception of quality of care and care coordination is multifaceted and affected by the provider, the plan, member demographics and individual health status and experience so evaluation and intervention are directed towards touchpoints by the member.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The following CAHPS Metrics will be used to evaluate the effectiveness of the interventions:

1. Getting Needed Care (Ease to get appointment with specialist, and ease to get care, tests, and treatment);
2. Getting Care Quickly (Getting care right away (urgent), getting appointment as soon as needed (routine) and see doctor within 30 minutes of apt. time
3. Rating of all health care
4. Rating of personal doctor
5. How well do doctors communicate (did your doctor explain things in a way that was easy to understand and did the doctor listen to the patient)

The goal for member satisfaction is to reach the Quality Compass 50th percentile.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Annually review, update, distribute and promote the 2016 Patient Experience(PE) Toolkit to providers	P	Q1-Q2	CVH/HN
Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q1-Q2	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the PE Toolkit to educate and empower members and improve their overall experience	P/M	Q1-Q2	CVH/HN
Annually, review, update and enhance materials on Interpreter services 24/7 to remind providers of the availability of these services and how to access them	P	Q1-Q2	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services	M	Q2	CVH/HN
Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members	P/M	Q1-Q2	CVH/HN
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3	CVH/HN

Section B: Mid-Year Update on Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**

• Review of the Patient Experience (PE) Toolkit completed by QI in April/May 2017. Toolkit resent to QI by Provider Communications in late June for a second round of reviews. Review of new sections completed by QI in July. • Review of the Appointment Scheduling Tip Sheet completed in April; distribution scheduled by Prov Comms. • Review of "Talking with my Doctor" agenda setting form completed by Q1 in April/May 2017. No changes were required. • All contracted providers were sent a provider update in July that reminded them of the availability of interpreter services from CalViva. The provider update included information on how to access interpreter services, information on the new restrictions on the use of bilingual staff as interpreters and on the use of minors and accompanying adults as interpreters. The provider update also reminded providers that interpreters must be made available at the time of the appointment to be compliant with the access and availability regulations. Lastly, the provider update encouraged all contracted providers to take cultural competency training. • Access Standards article will be included in Winter 2017 newsletter, which will reach member homes in November. Interpreter Services article will be in Fall 2017 newsletter, which reaches member homes in August. • The Nurse Advice Line is promoted in each newsletter to encourage use of the service by members. • Scaled-back member survey to assess effectiveness of interventions implemented delayed to 2018 for review and revisions to align with broader strategy to reach 75th percentile	• Review of Toolkit and associated pieces was reviewed and a final revised version approved for distribution on 9/7/17.Appointment Scheduling Tip Sheet was reviewed as part of the Toolkit review. Approved for distribution on 9/7/17. • "Talking with my Doctor" form was reviewed as part of the Toolkit review. Approved for distribution on 9/7/17

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	RY Rate 2017	RY Rate 2018	Baseline Source	Baseline Value
CAHPS metric: Getting Needed Care	Exceed RY2017 All Plans Medicaid Average	N/A	TBD	RY 2016 CVH results	78%
CAHPS metric: Getting Care Quickly	Exceed RY2017 All Plans Medicaid Average	N/A	TBD	RY 2016 CVH results	74%
CAHPS metric: Rating of All Health Care	Exceed RY2017 All Plans Medicaid Average	N/A	TBD	RY 20146CVH results	69%
CAHPS metric: Rating of Personal Doctor	Exceed RY2017 All Plans Medicaid Average	N/A	TBD	RY 2016 CVH results	77%
CAHPS metric: How well doctors communicate	Exceed RY2017 All Plans Medicaid Average	N/A	TBD	RY 2016 CVH results	90%

Analysis: Intervention Effectiveness w Barrier Analysis	• RY2017 Rate N/A as DHCS CAHPS is only done every 2 years

Initiative Continuation Status	☐ Closed	☐ Continue Initiative Unchanged	☒ Continue Initiative with Modification

II.QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)

2-1: Meet or Exceed HEDIS® Minimum Performance Levels for Cervical Cancer Screening

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve women's health by ensuring eligible women receive preventive healthcare services.

Rationale: Pap testing is an effective method for early detection of cervical cancer. According to the American Cancer Society an estimated 12,820 cases of invasive cervical cancer are expected to be diagnosed in 2017 and a projected 4,210 deaths to occur from cervical cancer.[1] Kings county performance demonstrated significant improvement from 51.12% in RY 2015 to 54.99% in RY 2016 and exceeded the MPL of 54.33%. Fresno county remained well above the MPL but a slight decrease from 64.74% in RY 2015 to 61.05% in RY 2016 was noted. Madera county had a strong 58.68% compliance rate in RY 2015 however the RY 2016 rate slipped below the MPL to 52.87%.

[1] American Cancer Society. Cancer Facts & Figures 2017. Atlanta: American Cancer Society; 2017.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Cervical Cancer Screening HEDIS measure: Goal – meet or exceed HEDIS RY2017 MPL of 48.18%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with high volume, low compliance providers in Madera County to distribute provider profiles to target clinics that include lists of members due for Pap test to facilitate scheduling of screening	P	Q1, Q2, Q3, and Q4	CVH/HN
Direct member incentive given at point of care to eligible CVH members to increase cervical cancer screening rates.	M	Q2, Q3, and Q4	CVH/HN
Implement health education via phone along with $10 gift card for completing the education call. Educator will also remind member that a $25 gift card will be given for the completion of their cervical cancer screening.	M	Q1, Q2, Q3, and Q4	CVH/HN
Complete "Call to Action" Mailing-Pap test reminder mailing	M	Q1	CVH/HN
Provider Tip Sheets will be disseminated to CVH providers.	P	Q2, Q3, and Q4	CVH/HN
Provider level incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores	P	Q3 and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Targeted high volume, low compliance provider group in Madera County for noncompliant CCS member appointment scheduling outreach. In Q1 a provider profile was distributed 1/23/17. The provider profile activity resulted in 51 patients scheduled of the denominator of 166 or 30.7%. The goal of 30% was met.
- In Q2, follow-up on scheduled appointments was performed by the high volume, low compliance clinic in Madera County. The 30% target was reached and exceeded. Twenty-nine (29) of the 51 scheduled CCS appointments were completed resulting in a rate of 56.9%

Section B: Analysis of Intervention Implementation (due end of Q4)

- Continued to support high volume, low compliance provider group for noncompliant CCS member appointment scheduling outreach in Madera County in Madera County. Q3 and Q4 distributed provider profiles to facilitate scheduling of screenings for members coming due.
- "Call to Action" mailers distributed to all CVH counties: Q3 (1680 members); Q4: (813 members).
- In Q3 and Q4, members were offered a $25 gift card for completing their Pap test via the. A total of 162 members completed their test and received the incentive: Fresno (1), Kings (65), Madera (96).

• During the PDSA cycle, incentives at the point of care were offered to members that completed their Pap test. All members who completed their Pap test (29) received the $25 incentive. • Eleven (11) of the 29 members who completed their cervical cancer screening during the Q2 PDSA cycle, also participated in health education via phone, and received a $10 gift card for their participation. • Quarter 1 member mailer was sent to 31,600 CalViva Health females members in need of a cervical cancer screening in all 3 counties. Quarter 2 member mailer was sent out to 19,614 CalViva health female members in need of a cervical cancer screening in all 3 counties. Mailers included: Definition of cervical cancer, explanation of Pap test, patient testimonial and reminder card to complete by member. • Provider Tips Sheets were finalized in Q2 and made available to providers via the Provider Portal.	• In Q3 and Q4, members received a reminder call, and were offered an opportunity to receive health education via phone. Members that completed the education received a $10 gift card for their participation. A total of 165 members completed the phone education: Fresno (0), Kings (74), Madera (91). • Provider Tips Sheets available to providers via the Provider Portal. • Providers were offered a $50 incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores. In 2017, 53 providers in Fresno, 3 providers in Kings and 10 providers in Madera received the incentive for closing care gaps for CCS. In Fresno County 3,780 care gaps were closed, in Kings County 76 care gaps were closed, and in Madera County 464 care gaps were closed.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
Cervical Cancer Screening (CCS)	Meet or Exceed DHCS MPL 48.18% (2017)	Fresno: 61.22% Kings: 57.95% Madera: 57.56%	TBD	RY 2016 CVH results	Fresno: 61.05% Kings:54.99% Madera: 52.87%

Analysis: Intervention Effectiveness w Barrier Analysis

Based on the overall HEDIS rates for RY 2017, the CCS goals were exceed for all three counties.

Successes:

- Working with a high volume low compliance clinic in Madera County, we were able to schedule 51 patients scheduled of the denominator of 166 (30.7%) in Q1 2017 by distributing a Provider Profile (list of patients needing their exam) to the clinic. The goal of 30% was exceeded. At the end of Q2 2017, 29 of the 51 scheduled CCS appointments in Madera County were completed resulting in a rate of 56.9%. The goal of 30% was exceeded.
- Learning from past CCS activities that resulted in high “no-show” rates, health education (via phone) was offered to members during their appointment reminder call and a $10 gift card was provided for participants. A $25 gift card was also offered for completing their Pap test. In Q3 and Q4 efforts were focused on how to sustain the improvement and support the clinic to continue these efforts.
- A provider incentive of $50 per care gap closed encouraged providers to outreach to members and get them in for care. Seventy-two providers participated in 2017, closing a total of 4,320 care gaps in all three counties.

Barriers:

- Reasons for incomplete appointments included: patient cancellations, appointments rescheduled outside of the audit timeframe and patients failing to attend their CCS appointment (“no show”).

Lessons Learned:

	• The offer of an incentive at the point of care may have encouraged members to complete their Pap test. Distributing the member incentive at the point of care ensures that all eligible members receive the incentive by removing the additional steps generally required to obtain an incentive. These additional steps would include completing the incentive form, having it signed by the provider and mailing it to the health plan. Additionally, there is no waiting to receive this type of incentive. • The clinic staff did report fewer "no shows" compared to previous experience for CalViva members when they were offered this incentive and reminded they would receive it at the time of their appointment.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-2: Meet or Exceed HEDIS® Minimum Performance Levels for Immunizations Among the Pediatric Population

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☐ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve child health by ensuring CVH children receive timely age-appropriate vaccinations.

Rationale: Regular visits ensure that children are up-to-date on their immunizations and protected against preventable diseases. Evidence suggests that appropriate vaccination coverage is linked to improved health outcomes and cost savings. A study examining completion of the childhood vaccination scheduled in a 2009 United States (US) birth cohort indicated prevention of approximately 42,000 early deaths and 20 million cases of disease in their lifetime. Moreover, the analysis showed that routine vaccinations may lead to an offset of approximately $69 billion in total societal costs. Additionally, the Health People 2020 Immunizations and Infectious Disease goals targets 90% of children to receive all doses of individual vaccines (i.e. DTaP, IPV, MMR, Hb, HepB, and varicella), 80% to receive all doses of rotavirus vaccine, and 80% to receive all doses in the 4:3:1:3:3:1:4 series by age 19 to 35 months.[1,2] In RY2016, Kings County remains under the MPL, despite a considerable increase in performance from the prior year (63.03% for RY2016 compared to 57.76% in RY2015), highlighting the continued opportunity for improvement. Improvement in Kings County is critical given that measures that do not meet or exceed the MPL for three consecutive years require corrective action to improve scores.

[1] Kurosky, S.K. (2016). Completion and compliance of childhood vaccinations in the United States. Vaccine. 34(3). 387-394.
[2] Ventola, C.L. (2016). Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance. Pharmacy and Therapeutics. 41(7). 426-436.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Childhood Immunizations HEDIS measure: Goal – meet or exceed HEDIS RY2017 MPL 64.30%

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with high volume, low compliance providers in Kings County to distribute provider profiles to 5 targeted clinics to facilitate scheduling appointments for immunization/well-child visits for children turning 2 years and 13 years.	P	Q1, Q2, Q3 and Q4	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q3	CVH/HN
Continue direct member incentive for completion of childhood immunizations to improve rates	M	Q1, Q2, Q3, and Q4	CVH/HN
Implement "HEDIS Clinics" that are focused on closing Care Gaps at a central provider location in Kings County. Offer appointment times outside of regular business hours to accommodate member schedules.	P/M	Q2, Q3, and Q4	CVH/HN
Educational Interactive Voice Response (IVR) call reminding parents about the safety of vaccines and the importance of timely vaccinations and well child visits.	M	Q2, Q3, and Q4	CVH/HN
CA Immunization Registry (CAIR) Provider Outreach - Obtain CAIR ID from high-volume providers to assess level of registry participation. Provider Relations team to outreach to high volume, low performing providers and encourage participation in immunization registries and stress the benefits of participation.	P	Q2, Q3, and Q4	CVH/HN
Provider level incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores	P	Q3, and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Targeted high volume, low compliance provider group in Kings County for noncompliant CIS member appointment scheduling outreach. A provider profile was distributed in November 2016, and returned on 1/18/2017. We were unable to evaluate the SMART objective due to challenges with data capture for our Provider Profile and inconsistencies were not identified and communicated when new Gap in Care lists were used.
- In Q2, a provider profile of 90 members was provided to the clinic to review, and schedule immunization appointments before the member's 2nd birthday. All members in the profile had birthdays between March and August 2017. A total of 23 appointments (43%) were scheduled of the 53 patients outreached during the PDSA cycle, exceeding our SMART Objective of 30%. Of the 23 members who were successfully scheduled, 7 completed their appointments. One (1) completed incentive card brochure has been received to date by a member who completed their appointment
- In Q1, the high volume, low compliance provider decided to forgo "HEDIS Clinics", and pursue a new approach to more proactively outreach to patients through chart preparations and highlighting key HEDIS measures.
- Deferred Q2 Educational Interactive Voice Responses call in order to finalize scripting updates, and will continue activities in Q3 and Q4.
- At the start of the Q2 PDSA Cycle, the clinic staff had completed the CAIR 2.0 training and the system was functioning at the clinic level. The system allowed the staff to check on

Section B: Analysis of Intervention Implementation (due end of Q4)

- In place of the member newsletter article mailed to the member's home, a blog post was add to the member portal titled "National Infant Immunization Week: Ensure Your Child Is Fully Protected from Preventable Diseases." The post focused on five important reasons members should vaccinate their children: protection against vaccine preventable diseases, vaccine safety and effectiveness, the importance of preventative care for families and future generations, and member time and cost savings.
- In an effort to encourage members to complete their CIS-3 series, a member incentive ($25 gift card) was offered to members who completed the CIS-3 series and mailed in their incentive form. A total of 2 members received the incentive in Q3 and Q4.
- Due to scripting delays through Q3 and Q4, the educational IVR call to remind parents about the safety of vaccines and the importance of timely vaccinations and well child visits was delayed through 2017.
- Providers were offered a $150 incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores. In 2017, 43 providers in Fresno, 1 providers in Kings and 4 providers in Madera received the incentive for closing care gaps for CIS-3. In Fresno County 469 care gaps were closed, in Kings County 4 care gaps were closed, and in Madera County 89 care gaps were closed.
- In Q3, CalViva Health submitted a proposal for "Improving Childhood Immunizations – Combination 3 Rates" Performance Improvement Project (PIP) for Fresno County, which was

member immunization status, and complemented the clinic's EMR. Incorporating the use of CAIR 2.0 into our plan allowed us to more accurately identify and outreach to non-compliant members. • Provider Relations outreached to 80 providers in Kings and Fresno Counties to encourage participation in the immunization registry. Thirteen (13) providers responded to the CAIR Provider Outreach with their CAIR ID to further investigate their participation. CalViva Health's Quality Improvement Specialist requested MCP access to the CAIR 2.0 system.	accepted by the state. Although Fresno County's rates exceed the MPL, the rates have been declining over the last three years. In an effort to ensure rates do not fall below the MPL, CalViva Health has proposed working with a high volume, low compliance provider group in Fresno County. • In Q4, the MCP met with a high volume, low performing provider group in Fresno County to establish a partnership for the PIP. The provider group worked with the MCP to develop the driver diagram for Module 1, and establish a data collection process for Module 2. • Modules 1 and 2 were completed and submitted in Q4.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
Childhood Immunization Combo 3	Meet or Exceed DHCS MPL 64.30% (2017)	Fresno: 65.00% Kings: 67.71% Madera: 72.22%	TBD	RY 2016 CVH results	Fresno= 66.96 Kings=57.76 Madera=69.54
Well-Child Visits 3-6 Years	Meet or Exceed DHCS MPL 65.54%	Fresno: 74.43% Kings: 73.32% Madera: 86.22%	TBD	RY 2016 CVH results	Fresno=76.80 Kings=64.82 Madera= 83.16

Analysis: Intervention Effectiveness w Barrier Analysis

Based on RY2017 HEDIS rates for CIS-3 all counties exceed the MPL. For W34 all counties exceed the RY2017 MPL.

Successes:

1. In Q2 2017, we exceeded our target of 30% of patients with scheduled appointments, with 23 out of 53 patients scheduled (43%). Seven (7) of the 23 patients completed their appointments (30.4%).
2. At the start of the Q2 PDSA Cycle, the clinic staff had completed the CAIR 2.0 training and the system was functioning at the clinic level.
3. A provider incentive of $150 per care gap closed encouraged providers to outreach to members and get them in for care. Forty-eight providers participated in 2017, closing a total of 481 care gaps in all three counties.
4. Completed Performance Improvement Project Proposal to improve childhood immunization rates in Fresno County, which was accepted by the state.
5. Established a partnership with a Fresno County provider group, committed to working with CalViva Health throughout the duration of the PIP (through June 2019).

Barriers:

1. In Q1, We were unable to evaluate the SMART objective due to challenges with data capture for our Provider Profile and inconsistencies were not identified and communicated when new Gap in Care lists were used.
2. Scripting delays through Q4 resulted in the IVR not taking place in 2017.
3. Provider Relations Outreach resulted in low participation by provider due to reluctance to share their CAIR ID, which would allow the MCP to assess provider participation in the CAIR system.

Lessons Learned:

1. Patients with scheduled appointments were more likely to complete their appointment compared to patients that were reached via voicemail.
2. The offer of an incentive may have encouraged members to schedule their child's immunization appointment. Two completed incentive brochures were received from the members who have completed their appointments to date in Kings County. We may want to explore offering incentives that are given out at the point of care to encourage members to both schedule and then attend their appointments.
3. In the future, we will collaboratively establish the type of data presented to the Provider, the information to be gathered by the Provider and the frequency of check-in calls or meetings throughout the study cycle to effectively monitor data collection.
4. The delay in the IVR scripting in 2017, and the IVR results from 2016 indicating a low reach rate and member engagement, suggest that an IVR may not be the most effective method to reach parents. The low IVR reach rate way potentially due to calling during business hours when parents or guardians of members were working or were attending to competing tasks. In 2016, among members reached, only one member requested scheduling assistance; other parents/guardians indicated they would schedule their own appointments, or already had an appointment scheduled.
5. The use of the CAIR 2.0 system allowed the staff to check on member immunization status, and complemented the clinic's EMR. Incorporating the use of CAIR 2.0 into our plan allowed us to more accurately identify and outreach to non-compliant members.

Initiative Continuation Status	☐ Closed	☐ Continue Initiative Unchanged	☒ Continue Initiative with Modification

Section A: Description of Intervention (due Q1)

2-3: Monitoring Patients on Persistent Medications (MPM)

☐ New Initiative ☒ Ongoing Initiative from prior year

Initiative Type(s)	☒ Quality of Care	☐ Quality of Service	☒ Safety Clinical Care

Reporting Leader(s)	Primary:	CalViva Health Medical Management	Secondary:	Health Net QI Department and Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: Reduce the occurrence of preventable adverse drug events for CalViva Health members on Persistent Medications (MPM).

Rationale: For patients managing chronic diseases, medication adherence is paramount in improving overall health benefits. However, there is still not enough information on how to improve adherence in a cost-effective manner (Seabury, 2014). The CDC estimates that approximately over one million individuals are seen in emergency departments for adverse drug events in which case many are preventable. (Centers for Disease Control and Prevention , 2017). As a patient advances in age, there is a likelihood that he/she will take more medications to care for their chronic diseases. It is even more likely that the older adult population (65 years and older) are twice as likely to visit emergency departments for adverse drug events (Centers for Disease Control and Prevention, 2012). Therefore, it is imperative that this population not only adhere to their medication but seek regular care with their provider to make sure that their current medication is correct for them or adjust as needed by conducting routine laboratory tests.

Centers for Disease Control and Prevention. (2012, October 2). *Medicatin Safety Program*. Retrieved January 23, 2018, from Adults and Older Adults Adverse Drug Events: https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html

Centers for Disease Control and Prevention . (2017, June 19). *Medication Safety Program.* Retrieved January 23, 2018, from Adverse Drug Event Monitoring: https://www.cdc.gov/medicationsafety/program_focus_activities.html

Seabury, S. G. (2014). Understanding and Overcomming Barriers to Medication Adherence: A Review of Research Priorities. *Journal of Managed Care and Speciality Pharmacy*, 775-783.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Monitoring of Patients on Persistent Medication (MPM) HEDIS measure: Goal meet or exceed HEDIS RY 2017 MPL for ACE/ARBs 85.63% and Diuretics 85.18%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with a high volume, low compliance provider in Kings County to distribute the health plan's Gap In Care List of members who need completion of annual laboratory testing and to contact members for test completion.	P	Q1, Q2, Q3, and Q4	CVH/HN
Conduct regular meetings with the Kings County provider to receive updates on improvement activities and status check on GIC list completion.	P	Q1, Q2, Q3, and Q4	CVH/HN
Insertion of the MPM labs in the Adventist Health 2017 HEDIS Chart Prep	P/M	Q2-Q4	CVH/HN
Provider Tip Sheets will be disseminated to CVH providers	P	Q3	CVH/HN
Pilot a member text (SMS) message to replace the ELIZA IVR calls	M	Q3 and Q4	CVH/HN
Provider level incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores	P	Q3 and Q4	CVH/HN
Implement "Health Tags" educational health message (with reminder form health tech) on members' prescription pharmacy bag labels in Madera County.	M	Q3 and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Targeted a high volume, low compliance provider group in Kings County to distribute the health plan's Gap in Care list of noncompliant members who need to complete the annual laboratory testing for MPM. In Q1, CVH distributed a provider profile in which 21.6% (8/37) of members completed their annual laboratory testing which exceeded the SMART Aim of 5%. In Q2, CVH redistributed the provider profile in which 59.9% (100/167) of members completed their annual laboratory testing for MPM thus far in 2017. This exceeded the SMART Aim Of 30%. Of the 100 members, 72 had both serum potassium and serum creatinine labs confirmed as documented in their medical record.
- Conducted bi-weekly multi-discplinary MPM Improvement Team meetings to discuss successes and challenges in the process, barriers, results and any issues identified.
- In Q2, upon CVH's recommendation, Adventist Health included the MPM measure in their 2017 HEDIS Chart Prep for patients who still need to complete their laboratory screening.
- In Q3 and Q4, will launch the CVH Health Tags campaign. The member's prescription bag will have message attached on the importance of completing required annual laboratory testing as well as the pharmacy techinican reiterating the message verbally.

Section B: Analysis of Intervention Implementation (due end of Q4)

- In Q3, the MPC met with a high volume, low performing provider group in Madera County to distribute the health plan's Care Gap report of non-compliant members who needed to complete their annual laboratory testing for MPM. By December 31, 2017 50% (63/126) ot the members had completed their required laboratory testing which will help meet or exceed the measure's MPL.
- In Q4, members in the high volume, low performing clinic in Madera County were offered a $25 VISA card for completing their annual laboratory testing by December 31, 2017. A total of 10 cards were distributed in December 2017 and this incentive will carry over into 2018.
- In Q3, the *Annual Monitoring for Patients on Persistent Medications* Tip Sheet was placed on the Provider Portal for providers to review and download.
- In Q3, the CVS Health Tags campaign was launched in all three counties. The campaign ran from September 5, 2017 to December 31, 2017. The MCP delivered to CVS the following number of eligible members to receive the message: Fresno 2,803 eligible members, Kings 225 eligible members, and Madera 394 eligible members.
- In Q4, health education outreached to 206 members to encourage members to complete their annual laboratory testing.
- Providers were offered a $50 incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores. In 2017, 36 providers in Fresno, 1 provider in Kings and 5 providers in Madera received the incentive for closing care gaps for MPM. In Fresno County 1,089 care gaps were closed, in Kings County 6 care gaps were closed, and in Madera County 41 care gaps were closed.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)

Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)					
Measure(s)	**Specific Goal**	**Rate 2017**	**Rate 2018**	**Baseline Source**	**Baseline Value**
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL 85.63% (2017)	Fresno: 85.74% Kings: 90.43% Madera: 82.64%	TBD	RY 2015 CVH results	Fresno: 84.94% Kings: 83.07% Madera: 83.98%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL 85.18% (2017)	Fresno: 86.24% Kings: 90.78% Madera: 82.20%	TBD	RY 2016 CVH results	Fresno: 85.07% Kings: 84.26% Madera: 83.57%

Analysis: Intervention Effectiveness w Barrier Analysis

Based on the RY2017 HEDIS rates for MPM, Fresno and Kings Counties exceeded the MPL.

Successes:

- In Q2 for Kings County, distributing the Provider Profile to the clinic yielded 59.9% (100/163) members completing their annual laboratory testing for MPM, thereby exceeding the SMART AIm of 30%.
- The clinic staff drilled down to the type of test completed, and 72/100 members has completed both serum potassium and serum creatinine test which is a positive impact on the HEDIS rates.

Barriers:

- It is important that physicians select the correct test either a metabolic lab panal or the combination fo both serum creatinine and serum potassium to allow for a positive HEDIS impact for this measure.

Lessons Learned

- Supplying the clinic with a Provider Profile an effective method to facilitate completion of annual laboratory testing for MPM.
- Reconciling the list of members with claims data a second time successfully captured the correct population of patients that needed testing in 2017.
- A clinic champion for quality initiatives improves implementation.
- Regular data check-in points allow the Improvement Team to address the critical questions or issues in a timely manner.
- Obtaining staff feedback is crucial to successful intervention implementation. Scheduling bi-weekly meetings is crucial to hear staff successes, challenges, and solutions to barriers to maximize improvement efforts.

Initiative Continuation Status ☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-4: Controlling High Blood Pressure

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve the cardiovascular health of CalViva members by identifying high blood pressure, controlling it through lifestyle changes and medication management and monitoring it over time

Rationale: Often, high blood pressure has no warning signs and therefore it becomes difficult to manage a condition that one may not know they have. In the United States, 1 in 3 adults has high blood pressure [1,3] placing them at increased risk for heart disease and stroke, which are two leading causes of death. [2,3] Detection via regular screenings are key to preventing avoidable complications and deaths.

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[1] Merai R, Siegal C, Rakotz M, Basch P, Wright J, Wong B; DHSc., Thrope P. CDC Grand Rounds: A Public Health Approach to Detect and Control Hypertension. MMWR Morb Mortal Weekly Rep, 2016 Nov 18;65(45):1261-1264.

[2] Yoon SS, Fryar CD, Carroll MD. Hypertension Prevalence and Control Among Adults: United States, 2011-2014. NCHS data brief, no 220. Hyattsville, MD: National Center for Health Statistics; 2015.

[3] Centers for Disease Control and Prevention. November 30, 2016. "High Blood Pressure." https://www.cdc.gov/bloodpressure/index.htm. Date accessed: January 12, 2017.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Controlling High Blood Pressure HEDIS measure: Goal – meet or exceed HEDIS RY 2017 MPL of 46.87%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with high volume, low compliance provider in Fresno County to utilize a list of members which to identify those who need a blood pressure assessment and/or have uncontrolled blood pressure and schedule their appointments.	P	Q1, Q2, Q3, and Q4	CVH/HN
Clinic QI staff will provide ongoing education to all clinical staff using the Heart Healthy education materials from American Heart Association, DASH Diet, etc utilizing a variety of methods (class, posters) in an effort to improve knowledge of current recommendations for managing hypertension including obtaining an accurate BP reading.	P	Q1, Q2, Q3, Q4	CVH/HN
Health Educator will provide targeted clinic with Healthy Heart, Healthy Lives materials and education opportunities for members on controlling blood pressure in both English and Spanish.	P/M	Q1 and Q2	CVH/HN
Provider Tip Sheet on Hypertension will be disseminated to CVH providers.	P	Q3	CVH/HN
Healthy Heart, Healthy Lives brochure will be mailed to members with uncontrolled high blood pressure in both English and Spanish.	M	Q2	CVH/HN

Relaunch of IVR calls to non-compliant members of Fresno County in both English and Spanish.	M	Q3	CVH/HN
Clinic staff will utilize the Chronic Disease Self-Management curriculum with members.	M	Q2	CVH/HN
Health educators will work with Patient Navigators to conduct Controlling Blood Pressure education classes for members.	M	Q2, Q3, Q4	CVH/HN
Provider level incentive for PCPs participating in Med-Cal to close Care Gaps and improve HEDIS scores.	P	Q3 and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Targeted a high volume, low compliance provider group in Fresno County to identify members who need blood pressure assessment and/or have uncontrolled blood pressure and to schedule their appointments. In Q1, 80.2% (73/91) of members scheduled am appointment which exceeded the SMART Aim of 30%. In Q2, 76.4% (68/89) of members completed at least one appointment to monitor their blood pressure which exceeded the SMART Aim of 30%.
- In both Q1 and Q2, Clinic QI Staff conducted provider and staff education utilizing education materials from the American Heart Association and DASH Diet. In addition, providers and staff received education through examination of actual case studies and placement of blood pressure posters in the nurses triage station. In addition, the clinic staff extended the education to members by providing the Chronic Disease Self-Management cirriculum.
- In Q1, the health educator provided the clinic with 100 copies of the *Healthy Heart Healthy Lives* education materials in both English and Spanish. In Q2, the health educator conducted an inservice training with six (6) patient navigators on the *Healthy Heart Healthy Lives* education materials with an emphasis on controlling blood pressure. Member education classes are scheduled for Q3.
- In Q2, the Quality Improvement Department mailed members the *Healthy Heart Healthy Lives* Brochure with 2,275 English brochures mailed and 1,138 Spanish brochures mailed. The IVR launch has been delayed until Q3 to obtain the most current list of non-compliant members who are eligible to receive the automated call.
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Section B: Analysis of Intervention Implementation (due end of Q4)

- In Q1, the MCP's health educator conducted in-service training with 8 clinic Patient Navigators to guide them on the Health Education and Nutrition Information Line. This service provides telephonic nutrition service and health education. Training included review of the *Health Hearts for Healthy Lives* packet.
- In Q2 the high volume, low performing provider group in Fresno County had 80.2% (73/91) of their members schedule an appointment which met and exceeded the SMART Aim of 30% appointments scheduled.
- In Q2, a member blog article listing tips to control blood pressure was posted on the health plan's webpage.
- In Q2, an online provider news article titled "Assisting your practice to improve quality scores for hypertension" was posted online.
- In Q3, an IVR for Controlling Blood Pressure was launched to members in Fresno County with 2,655 members receiving the call in English and 1,062 members receiving the call in Spanish.
- In Q3, 120 providers were mailed the *Hypertension – Controlling Blood Pressure Tip Sheet.* The delay in mailing was due to finalizing the list of primary care physicians to maximize outreach efforts to a greater number of providers. In addition, providers and staff were informed about controlling blood pressure materials such as the "Measure Up, Pressure Down" toolkit.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate Ry 2018	Baseline Source	Baseline Value
HEDIS® Controlling High Blood Pressure	Meet or Exceed DHCS MPL 47.69% (2017)	Fresno: 56.93% Kings: 55.61% Madera: 59.80%	TBD	CVH Performance Ry2016	Fresno: 47.96% Kings: 58.77% Madera: 57.99%

Analysis: Intervention	Based on the RY2017 HEDIS rates for CBP, Fresno, Kings, and Madera Counties exceeded the MPL.

Effectiveness w Barrier Analysis	• **Successes:** In Q1, the MCP's health educator conducted in-service training with 8 clinic Patient Navigators to guide them on the Health Education and Nutrition Information Line. This service provides telephonic nutrition service and health education. Training included review of the *Health Hearts for Healthy Lives* packet. • In Q2 for Fresno County, 76.4% (69/89) members at the high volume, low performing clinic had completed at least one appointment to monitor their blood pressure in 2017 thereby exceeding the SMART AIm of 30%. • Staff and provider education Kick-off was held in February 2017 for all clinical staff to educate on key issues such as how to take a blood pressure correctly, clinical inertia and "nurse-only" visits to follow up on blood pressures that were outside established parameters. The education continued through the quarters with case studies to keep the momentum going after the initial kick-off presentation. • Member education packets in English and Spanish were prepared for distribution to all patients at the time of their clinic visit. A total of 110 packets were distributed to members in 2017. • The staff at the clinic did attempt to re-engage with the 13 members that had not been seen since 2016. Members had their appointments scheduled either at the intervention site or other clinics within the organization to resume care for controlling blood pressure. . • **Barriers:** In collaboration with the high volume, low performing provider we found through our bi-weekly multi-disciplinary, team meetings that the MCP's list of 107 members was not consistent with the clinic's list of 110 patients assigned to this clinic and identified as needing an appointment hypertension management. Through our work with the team we learned that while the Health Plan data correctly identified that an opportunity for improvement existed, the clinic's patient list was more current, specific and sensitive when trying to identify this hybrid measure population. • **Lessons Learned** • By utilizing the clinic's internal patient list, future population specific targeting may be accomplished by the clinic without intervention by the Health Plan. • A clinic champion is critical to successful intervention implementation. • Obtaining staff feedback is crucial to successful intervention implementation. CalViva Health continues to schedule bi-weekly meetings to hear staff successes, challenges, and solutions to barriers to maximize improvement efforts. • Receiving clinic data at designated check points during the PDSA cycle allowed for the Improvement Team to address the issue of member/patient list inconsistency that might not otherwise have been identified until the end of the first PDSA cycle.

Initiative Continuation Status	☒ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-5: Increase Appropriate Antibiotic Prescribing (AAB)

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	Primary:	CalViva Health Medical Management	Secondary:	Health Net QI Department

Rationale and Aim(s) of Initiative

Overall Aim: To reduce and eliminate the number of prescriptions for antibiotics inappropriately prescribed to CalViva Health adult members with bronchitis.

Rationale: Antibiotic resistance is both costly and a major public health issue, totaling up to $20 billion in direct healthcare costs.[1] Every year, at least 2 million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die as a result.[2] In general, antibiotic-resistant infections result in longer and/or more expensive treatments, longer hospital stays, additional doctor visits, and increased disability and mortality risk.[1] According to the CDC, the use of antibiotics is "the single most important factor leading to antibiotic resistance around the world."[2]

Barriers to appropriate antibiotic prescribing include providers not ordering the appropriate laboratory tests to confirm if an antibiotic is needed, and patients demanding an antibiotic. [1] To help address these barriers, CalViva helps promote the Choosing Wisely® patient education materials and is also involved with the California Medical Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) annual campaign to promote appropriate antibiotic use among providers and patients. According to a meta-analysis published in the British Medical Journal patients prescribed an antibiotic for a respiratory infection consistently developed bacterial resistance to that antibiotic; this effect was greatest in the first two months immediately after treatment [pooled odds ratio 2.37 (CI 1.42-3.95)] but could persist for up to 12 months. This contributes to an increased number of organisms resistant to first line antibiotics, which may lead to increased use of second line antibiotics.[3] Therefore, it is crucial that providers have updated tools and information to ensure that antibiotics are not prescribed inappropriately or overprescribed.

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[1]Centers for Disease Control and Prevention (CDC). Antibiotic Resistance Threats in the United States, 2013. April 2013. Available at http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf. Downloaded January 17, 2014.

[2]Centers for Disease Control and Prevention (CDC, Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.

[3]Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. 2010. Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. BMJ. 2010 May 18;340:c2096.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Appropriate Antibiotic Prescribing for Adults with Acute Bronchitis (AAB) will be used to evaluate the effectiveness of interventions. This measure provides the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates appropriate treatment of adults with acute bronchitis). Baseline period uses HEDIS RY2016 outcomes. For RY2016, Fresno county was well above the DHCS RY 2016 minimum performance level (MPL) for AAB of 22.12% with a score of 37.62% (1,252 numerator events out of 2,023 in the denominator). The denominators for Kings and Madera were much smaller than Fresno's denominator. Both Kings and Madera county were below the MPL. Kings scored 21.38%, missing the MPL by only 0.74% (125 numerator events out of 159 in the denominator). Madera county scored 19.69% which was 2.43% below the MPL (204 numerator events out of the 254 in the denominator). Please refer to Section C for the goals and benchmarks for this metric.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement "Health Tags" educational health message on members' prescription pharmacy bag labels in Kings and Madera Counties.	M	Q2-Q4	CVH/HN
"Choosing Wisely" Antibiotics Awareness provider and member educational flyers available on CVH web site.	P	Q1	CVH/HN
Mail new 2016-2017 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use. (sent to select antibiotic high prescribers)	P	Q1	CMAF/CVH/HN

Provider Relations to distribute provider education materials to targeted providers that have been identified as high prescribing over two consecutive years. Materials will include the new AWARE toolkit and Choosing Wisely® resources on the appropriate use of antibiotics and best practices to avoid overprescribing antibiotics	P	Q2/Q3	CVH/HN
Participate in 2017-2018 AWARE toolkit revision planning.	P	Q3/Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• New: In Q1, a flyer was sent to providers via a "fax blast" by Provider Relations about a online patient simulator resource to practice real-life conversations about antibiotics. • The "Choosing Wisely" educational flyers were made available on the CVH web site starting Q2. • New: In in addition to mailing the AWARE toolkits, we also made the educational materials available to providers via the Lunch and Learns hosted by Provider Relations in Q2. • The distribution of provider education materials in the new AWARE toolkit to targeted providers by Provider Relations was completed in Q2.	• In Q1 2017, California Medical Association Foundation mailed 342 AWARE toolkits to the high-prescribing providers in Fresno, Kings, and Madera Counties. • In Q2, Provider Relations delivered an additional 110 toolkits to high prescribing providers in all three counties. In addition, the Provider Relations Team conducted a 15-20 minute training on the purpose of the toolkit and its contents. • Q4 2016, Provider Education – "Lunch and Learn Events" analysis of providers (PCPs, NP, PA) crossed referenced with provider locations revealed that the greatest opportunity for improvement was with NP followed by PCP and then PAs in clinics or emergency departments. • CVS Health Tags is a member focused activity in which a specifically developed message about the use of antibiotics is placed on the prescription bag for all eligible members when he/she picks up a prescription at CVS stores. The campaign ran from 05/23017-12/31/2017 in Kings County with 208 prescription messages delivered and Madera County with 288 prescription messages delivered.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB): Kings County	Directional improvement to meet or exceed the MPL for RY2017 (22.12%; 25th percentile)	29.56%	TBD	CVH Performance Ry2016	21.38%
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB): Madera County	Directional improvement to meet or exceed the MPL for RY2017 (22.12%; 25th percentile)	18.26%	TBD	CVH Performance Ry2016	19.69%

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • The RY2018 data for November showed that Madera County's AAB compliance rate was at 34% which is marginally below the 75th percentile of 34.70%. It is anticipated that the AAB compliance rate for Madera will exceed the 75th percentile by December 2017. • The combination of different activities (AWARE toolkit, provider member education materials, Lunch and Learns, and CVS Health Tags) helped improve the overall compliance rate for this measure. • For 2018, high volume prescribing providers will receive the AWARE toolkit. Provider Relations will hand deliver 126 toolkits in all three counties and provide a similar training as in year's past.

	• In addition to the toolkit, Provider Relations will distribute a newly developed AAB tip sheet for providers which define the HEDIS definition for AAB and identify best practice approaches to increase the number of compliant member for the AAB measure. • <u>Barriers:</u> • Due to the delay in the distribution date of AWARE Toolkits and time required to develop and implement other innovative interventions (CVS Health Tags) the interventions were implemented after the end of MY2016. Therefore, these interventions could not have influenced RY2017 result's. • With the implementation of different interventions, Madera County missed the MPL for AAB by only 9 members. However, significant upward trends have been made in RY2018 for the county to meet and exceed the 75th percentile for the AAB measure. • **Lessons Learned** • The timing in launching any intervention is crucial and should correlate with the timing of the flu outreach efforts. • In RY2018, the implementation of different activities helps improve greatly the overall compliance rate for the AAB measure with an upward trend of meeting the 75th percentile. • The continued outreach efforts made by the Provider Relations Team helps foster the education messages for this measure. • Continued analysis of the data will help identify if mid-level providers such as NPs and PAs are also high volume prescribing providers and what types of education resources can be provided to this group.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)

3-1: Comprehensive Diabetes Care – PIP

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve the health of CalViva Health members diagnosed with diabetes.

Rationale: The National Institutes of Health (NIH) estimates that 9.3 percent (about 29.1 million) of the U.S. population currently suffers from Diabetes. After adjusting for age and gender differences, on average, people with diabetes incur medical costs that are about 2.3 times higher than those of their diabetes-free peers.[1] Indirect costs include increased absenteeism and reduced productivity while at work for the employed population. American Diabetes Association (ADA) reports the total cost of diagnosed diabetes have risen by 41 percent over a five year period. (245 billion in 2012) [2]

The Hemoglobin A1c (HbA1c) test measures blood glucose control in individuals diagnosed with type 1 and type 2 diabetes. According to the American Diabetes Association, regular glucose testing with an at-home finger stick glucometer, and receiving a Hemoglobin A1c (HbA1c) laboratory test at least annually, are both best practice standards of care for individuals with diabetes.[3]

1

[1]NIH, "National Diabetes Statistics Report, 2014", http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

[2]American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2012", http://care.diabetesjournals.org/content/36/4/1033.full?loc=dorg_statistics

[3] Position Statement: American Diabetes Association, Standards of Medical Care in Diabetes, 2013, Diabetes Care, January 2013, 36:Supplement 1 S11-S66;doi:10.2337/dc13-S011

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Comprehensive Diabetes Care (CDC) measure HbAIc Testing: Goal – meet or exceed HEDIS RY 2017 MPL 82.98%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with a high volume, low compliance provider in Fresno and Kings Counties to distribute Provider Profiles of members who need to complete HbAIc testing to improve the Clinic's Huddle list to include CVH members.	P	Q1, Q2, Q3, and Q4.	CVH/HN

Continue implementing the Live Well and Stay Healthy Diabetic Log which offers a $50 gift card to for members who complete specified diabetic testing.	M	Q1, Q2, Q3, and Q4	CVH/HN
Continue to provide DM health education to members of targeted clinic.(including nutrition, B/P, Diabetes)	M	Q1-Q4	CVH/HN
Provider level incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores	P	Q3 and Q4	CVH/HN
Complete PIP activities by August 2017	P	Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Targeted a high volume, low compliance provider groups in Fresno and Kings Counties to distribute the health plan's Gap in Care list of noncompliant members who needed to schedule an appointment to complete their HbA1c testing. As of Q1, 57.7% (41/71) of the members had completed their HbA1c test or have an appointment scheduled for test completion.
- In Q1 & Q2, the clinics' investigation into their medical records revealed that during the transition from ICD-9 to ICD-10 codes, some providers were using incorrect codes which resulted in some members being identified as diabetic when they may have not been diabetic.
- In Q1 and Q2, the health educators received a total of 30 completed diabetic logs and forms in which the members received a $50 gift card for completing the screening of four submeasures (HbA1c, kidney test, eye exam, and blood pressure measure). Specifically, Fresno County had 19 members who completed the diabetic log, followed by Kings County with 4 members, and Madera County with 7 members.
- In Q1 and Q2, 43 CalViva Health members participated in the diabetes health education classes and received a $10 gift card upon completion of the class. Specifically, Fresno County had 20 members attend the classes, Kings County had 23 members attend the classes, and Madera County had zero members attend the classes.

Section B: Analysis of Intervention Implementation (due end of Q4)

- From January through June 2017, a total cumulative population of 1,209 members had completed their HbA1c testing at one of the seven participating UHC Clinics. By June 30th, 77.7% of the population had met and exceeded the baseline goal 76% completion rate for HbA1c testing.
  In Q3, Modules 4 and 5 were completed and submitted to HSAG.
- By Q4, 44 members had received diabetes education along with a $10 gift card for Fresno and Kings Counties. In Fresno, Kings, and Madera Counties, 38 members completed their comprehensive diabetes screening and received a $50 gift card.
- Providers were offered a $50 incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores for CDC-HbA1c testing. In 2017, 64 providers in Fresno, 3 providers in Kings and 9 providers in Madera received the incentive for closing care gaps for MPM. In Fresno County 4,547 care gaps were closed, in Kings County 264 care gaps were closed, and in Madera County 608 care gaps were closed.
- In Q4, implemented Member Outreach Team (MOT) services to call members and assist scheduling appointments for HbA1c in Madera County. Of 288 members, 63 (21.96%) members were reached with 23.8% of members who scheduled an appointment.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
Comprehensive Diabetes Care - HbA1c Testing	Meet or Exceed DHCS MPL 82.98%	Fresno: 84.19% Kings: 86.62% Madera: 86.62%	TBD	RY 2016 CVH results MPL	Fresno=80.29 Kings=76.64 Madera=87.10

Analysis: Intervention Effectiveness w Barrier Analysis	Based on the RY2017 HEDIS rates for CDC HbA1c Testing, Fresno, Kings, and Madera Counties exceeded the MPL. Successes: • From January through June 2017, the HbA1c testing compliance rate among members in Fresno and Kings Counties who attended one of the seven participating clinics showed a progressive increase from 6.2% to 77.7%

- By June 30, 2017, a total cumulative population of 1,209 members had completed their HbA1c testing at one of the seven participating high volume, low provider clinics which 77.7% of the population having met or exceeding the baseline goal of 76% completion rate for HbA1c testing.
- The clinic was able to schedule members utilizing the Provider Profile as an adjunct to the clinic's daily Huddle List – the clinic's internal list of members who have scheduled an appointment at the clinic site.
- Through this partnership with the clinic, the MCP gained a better understanding of the clinic processes in order to assist them with their quality improvement efforts.
- Health education had a positive impact with 44 member completing diabetes for Fresno and Kings Counties and 38 member completing their comprehensive diabetes screening for Fresno, Kings, and Madera Counties.

Barriers:
In partnership with the high volume, low performing clinic, the MCP learned that of the 126 members on the seven Provider Profiles, the clinic identified 31 members who did not have the diabetes diagnosis. Through further investigation, the following information was found:

1. Some members were miscoded for diabetes diagnosis.
2. Some members were not assigned to that specific clinic.
3. Some members had not been seen at the clinic for at least 18 months and therefore were not included in patient outreach efforts.
4. Some members were assigned to the clinic but recently had a HbA1c test.
5. Some members were assigned to the clinic and needed a HbA1c test.

Lessons Learned:

- The (QI) Director for the targeted high volume, low performing clinic conducted an initial review of the seven (7) Provider Profiles submitted to identify the status of the patients before sending the files out to the 7 clinics to begin outreach efforts. The initial findings from this review included the Items 1-5 listed in the Barrier section.

- The MCP's Provider Profiles were used in conjunction with the clinic's daily "Huddle List". Once a member is scheduled for an appointment they will automatically show up on the clinic's Huddle List. This list is used on a daily basis by the clinical team to ensure that all patients who come in for a visit complete their preventive testing/screening, including HbA1c.

- The combined efforts of the Provider Profile and the clinic's Huddle List captured a greater number of CVH members who need preventive testing associated with many HEDIS measures, thereby, increasing the performance rate for this measure.

- Further investigation into medical records by the clinic revealed that during the transition from ICD-9 to ICD-10 codes, some providers (such as optometrist and health educators) were using incorrect codes which resulted in some patients being identified as diabetic per 2017 HEDIS Technical Specifications when they were not truly diabetic. The member may have been at risk for diabetes or receiving screening. This may have also occurred at another provider visit outside of the clinic's system.

- The Quality Improvement Research Analyst discovered that running a claims report and bumping it for eligibility up against the Provider Profile prior to submitting to the clinic helped reduce the number of members who recently completed their HbA1c test. Therefore, subsequent profiles will be more up to date.

Initiative Continuation Status	☒ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

3-2 Postpartum Care - PIP

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve the health of new mothers by ensuring that women attend a postpartum visit.

Rationale: The American Congress of Obstetrics and Gynecologist (ACOG) and National Committee for Quality Assurance (NCQA) recommend women have postpartum visits between three and eight weeks after delivery. This is an important visit during with healthcare providers can address with patients any complications that may have occurred during pregnancy, any underlying medical conditions, health of the infant, breastfeeding and breast health, maternal/infant bonding, and family planning. In RY 2016, CVH remained below the MPL (55.47%) in 1 of 3 counties, Kings County (50.24%). CVH will continue to work with a high volume, low performing clinic in Kings County on the Postpartum PIP. Modules 1, 2, 3 and 4 have all been submitted. Module 5 will be completed in June 2017.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Postpartum Care HEDIS measure: Goal – meet or exceed HEDIS RY2017 MPL (55.47%).

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue to work with a high volume, low compliance OB Clinic in Kings County to schedule postpartum care visits after delivery.	P	Q1, Q2, Q3, and Q4.	CVH/HN
Implement postpartum $25 member incentive on-site for members who complete timely postpartum care visits using PDSA methodology	P/M	Q1, Q2, Q3 and Q4	CVH/HN
Implement Postpartum Member Incentive by sending a $25 gift card to members for whom we receive a correctly completed and timely Postpartum Care Notification Form from their provider in all CVH Counties	M	Q1, Q2, Q3 and Q4	CVH/HN
Integrate postpartum care incentive offer into member education conducted by Comprehensive Perinatal Services Program (CPSP) educator.	M	Q2, Q3 and Q4	CVH/HN
Implement Eliza IVR calls to all pregnant and postpartum members with reminders for postpartum care and live assistance to schedule appointments.	M	Q1, Q2, Q3 and Q4	CVH/HN
Implement Baby Showers with members with education about the importance of postpartum visit.	M	Ongoing	CVH/HN
Provider Tip Sheet on Postpartum Care will be disseminated to CVH providers.	P	Q2	CVH/HN
Provider level incentive for PCPs participating in Medi-Cal to close Care Gaps and improve HEDIS scores	P	Q3 and Q4	CVH/HN
Complete PIP activities by August 2017	P/M	Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

- Continued to work with a high volume, low compliance OB Clinic in Kings County to schedule postpartum care visits after delivery increase timely postpartum completion rates from 57.6% (April 2016) to 66.7% (April 2017). Two interventions were developed to achieve the SMART Aim goal: 1) collecting contact information specific to the Postpartum Recovery Period while the patient was hospitalized, and 2) offering CalViva Health members a $25 VISA gift card at the point of care for completing a timely postpartum care visit. All PIP Modules (1-5) were completed and submitted to HSAG.

Section B: Analysis of Intervention Implementation (due end of Q4)

- One hundred seventy-two (172) members completed their postpartum visit to get the $25 gift card. One hundred forty (140) members learned about the postpartum visit through QI promotional mailing and 77 members got the incentive information from their provider.
- The Interactive Voice Response-ELIZA (IVR) calls continued in Q3 and Q4 to all pregnant and postpartum members with reminders for postpartum care and live assistance to schedule appointments.
- In Q3-Q4, 2017, 72 members participated in a babyshower in Fresno County and received the $10 gift card. No babyshower was conducted in Kings and Madera Counties.

- In Q1 and Q2 2017, a total of 982 CalViva Health Postpartum Member Incentive brochures were sent to members who recently delivered based on the member lists provided by the Quality Improvement Research Analyst Team. In Q1 2017, a total of 21, $25 gift cards were given out at the point of care at a high volume, low compliance clinic in Kings County.
- In Q2, 185 forms were returned and by both members and providers to receive a $25 gift card. Of the completed forms, 100% were correctly completed. During the quarter, forms were received from all three CalViva Health Counties: 144 were from Fresno County (77.8%), 5 were from Madera County (2.7%), and 36 were from Kings County (19.5%).
- In February 2017, the Clinic Management and the Comprehensive Perinatal Services Program (CPSP) educators integrated the postpartum care incentive offer into the existing member education conducted by CPSP educators (for CalViva Health Members).
- Baby Showers to educate members about the importance of postpartum visit took place on April 19th and June 22nd. On April 19th, 3 members attended the event, and observations were made to improve future events: 1) the venue was not clear to all members, 2) the time conflicted with end of the school day for mothers, and 3) mother's did not received reminder calls about the event. For the June 22nd event, the venue was moved to a well known community location (First 5 Family Resource Center), the time was adjusted to 10-11am, and the health educators supported the CPSP specialist by following-up with members to remind them of the event. The Postpartum HEDIS Tip Sheets are distributed by the Provider Relations Reps as they conduct their visit to OB offices.
- An Eliza IVR call attempted to reach 3,024 members who recently delivered with reminders for postpartum care and live assistance to schedule appointments. Of those attempted, 1,005 were reached (40%); 25 opted to transfer to schedule their appointment, and 114 opted to be emailed regarding their appointment.

- The Postpartum HEDIS Tip Sheets are distributed by the Provider Relations Reps as they conduct their visit to OB offices.
- In Q3, CalViva Health submitted a proposal for a Performance Improvement Project (PIP) to address disparities in postpartum care in Fresno County, which was accepted by the state. CalViva Health identified a disparity within a large Federally Qualified Health Center (FQHC) in Fresno County. Within the Fresno County FQHC, a high performing clinic within a similar geographic area, and comprised of similar members demographics has a postpartum rate of 73% (Kerman Clinic), compared to the targeted low performing clinic (Mendota Clinic) with a postpartum rate of 50%.
- Providers were offered a $50 incentive for providers participating in Medi-Cal to close Care Gaps and improve HEDIS scores. In Q3, 978 postpartum forms, from approximately 56 unique providers were submitted. Fresno continues to be the highest incentive form submitting county for PNIP across California.
- In Q4, the MCP met with the provider group in Fresno County to discuss the disparity identified, and to establish a partnership for the PIP. The provider group worked with the MCP to develop the driver diagram for Module 1, and establish a data collection process for Module 2.
- CalViva Health also conducted focus group discussions with 8 CalViva Health members, who were eligible for postpartum care visits in reporting year 2017, and residing in the cities of Kerman and Mendota to identify barriers to receiving postpartum care. Women who were compliant and non-compliant for their postpartum care visit attended. The facilitators conducted two discussions in Spanish, and one discussion in English. The barriers identified during the focus group discussions included: lack of knowledge of the importance, and timing of the postpartum visit, and stigma of postpartum depression.
- Key informant interviews were also conducted in the Kerman and Mendota communities with community-based organizations (CBOs), clinic staff, nurses and a medical doctor. During the interviews, participants discussed their knowledge of postpartum care, and identified member barriers to seeking care during the postpartum period. Barriers included: lack of transportation; lack of childcare; members do not have any knowledge around the importance of the postpartum care visit; members are deterred by appointment scheduling process, which can require time navigating a phone tree, and waiting for a return phone call to schedule.
- Modules 1 and 2 were completed and submitted in Q4.

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2017)

Measure(s)	Specific Goal	Rate 2017	Rate 2018	Baseline Source	Baseline Value
Postpartum Care Visits	Meet or Exceed DHCS MPL 55.47%	Fresno: 68.03% Kings: 61.07% Madera: 64.09%	TBD	RY 2016 CVH results	Fresno: 67.59% Kings: 50.24% Madera: 58.76%

Analysis: Intervention Effectiveness w Barrier Analysis	In RY 2017, CVH exceed the MPL in all counties. CalViva Health identified a disparity within a large Federally Qualified Health Center (FQHC) in Fresno County and will conduct a Performance Improvement Project (PIP) with the FQHC through June 2019.

Successes:

- The Postpartum Care PIP in Kings County was completed in August 2017.
- A total of 172 members completed the requirements for the member incentive and received their gift cards.
- A positive trend continued for postpartum visit completion since the implementation of the post-of-service member incentive.
- The Postpartum Care Disparities PIP was approved by the state, and Modules 1 and 2 were completed and submitted for approval.
- The FQHC with the identified disparity in Fresno County is engaged in partnering on the Postpartum Care Disparities PIP through June 2019.

Barriers:

- Babyshowers were not well attended by members, and observations were made to improve future events: 1) the venue was not clear to all members, 2) the time conflicted with end of the school day for mothers, and 3) mother's did not received reminder calls about the event.
- The barriers identified during the focus group discussions with CalViva Health members for the Postpartum Care Disparities PIP included: lack of knowledge of the importance, and timing of the postpartum visit, and stigma of postpartum depression.
- Additional barriers identified by community based organizations, clinic staff and providers included: lack of transportation; lack of childcare; members do not have any knowledge around the importance of the postpartum care visit; members are deterred by appointment scheduling process, which can require time navigating a phone tree, and waiting for a return phone call to schedule.
- Each mailing cycle was affected by outdated member addresses resulting in 10% of the incentive mailers being returned to the health plan.

Lessons Learned:

- Compared to Q1-Q2, Q3-Q4 had 3% less members attending a babyshower but had a 14% increase in postpartum visit completed. QI partnered with Healthy Beginnings in Kings County to immediately award 22 members who completed the postpartum visit. This contributed to the 14% increase in postpartum visit.
-

Initiative Continuation Status	☒ Closed	☐ Continue Initiative Unchanged	☐ Continue Initiative with Modification

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN	They are included in new member welcome packets. It is an ongoing activity	☒		The Preventive Guideline Screening is included in every new member welcome packet.
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Approved by QIUM Committee and distributed via Provider Updates	☒		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for Asthma, Diabetes, Congestive Health Failure (CHF) and ensure vendor conducts member and provider enrollment mailers and outbound calls.	CVH/HN	Weekly meetings are held with the vendor for program oversight. Weekly review of the enrollment counts and monitoring of a sample of the Disease Management charts is done quarterly for engagement activities.	☒		Ongoing. Will repeat activity anew in 2018
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
3. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN	C&L 2017program description and work plan reports complete and submitted accordingly. Mid-year work plan and mid-year LAP report to be completed during Q3.	☒		C&L continues to promote and provide cultural and linguistic services and trainings to providers, staff and members to ensure members have access culturally and linguistically appropriate services inclusive of language services.
4. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN	MY2016 PAAS and After-hours survey results are ready. CAP packets scheduled to go out no later than August 30th. Training with Fresno PR staff scheduled for September 12th.	☒	12/19/17	There was a delay in getting Cap packets out. CAP packets were distributed 12/18/17 and Improvement Plans are due back by 1/18/18. Fresno PR staff were unable to assist with outreach campaign due to timing and other scheduled activities so training did not take place. They did include the Appointment Scheduling Tip Sheet in their HEDIS campaign outreach. Access team staff member conducted in-office audits of repeat noncompliant providers the week of 1/9-1/12/18.
5. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/ HN	DMHC extended filing date to June 9th. Filed on time.	☒	6/9/17	TAR filed timely

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
6. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN	A&C committee continues to meet regularly to address improvement opportunities.	☒		Ongoing activities. A&G continues to meet to address for improvement.
7. Group Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistics health education materials, services and Quality Improvement (QI) programs.	CVH/HN	C&L continues to promote C&L/LAP program and services to members and providers.	☒		C&L continues to promote and provide cultural and linguistic services and trainings to providers, staff and members to ensure members have access culturally and linguistically appropriate services inclusive of language services.
8. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement: Analyze and inform Provider Network Management areas for increased contracting with a particular provider to improve availability. (bi-annual: next report 2017)	CVH/HN	Report development currently in progress. Anticipate report will be completed in September.	☒		C&L Geo Access report was completed and submitted during Q3 2017. Report was approved by both QI/UM and Access Committees and also presented to the Public Policy Committee. C&L has shared finding with Provider Network Management.
9. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	Report was presented and approved QI/UM Work group 8/23/2017	☒		IHA continues to be monitored to insure compliance has been met.
QUALITY AND SAFETY OF CARE					
1. Complex Case Management – Utilize Stratified Data to Identify High Risk Members and Engage them in Case Management Programs: Evaluate clinical outcomes for members enrolled in Complex Case Management	Axis Point Health/CVH/HN	Information is presented in the Key Indicator Report and also in the quarterly Case Management reports presented to the QI workgroup.	☒		Ongoing activity reported in Key Indicator report and presented to QI workgroup
CREDENTIALING / RECREDENTIALING					
4. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN	Credentialing reports continue to be submitted on a regular bases and are monitored for potential improvements	☒	12/2017	All CalViva practitioners/providers were completed in accordance with credentialing and recredentialing standards for content and timeliness.
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	CVH/HN	Quarterly reports being submitted and reported to the QI/UM Committee.	☒		Quarterly Performance Indicator Report, and three annual surveys: Provider Satisfaction, Member Satisfaction and Provider Appointment Availability Survey. They are all on-track, either having been presented or will be presented as scheduled.
QUALITY IMPROVEMENT					

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure practitioner offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 & 15-023	CVH/HN	Ongoing monitoring conducted. Bi-annual report of quarterly monitoring of FSR/MRR and PARS to QI	☒		Continues of Bi-Annual and Quarterly reports of FSR/MRR and PARS are sent to QI.
2. Evaluation of the QI program: Complete QI Work Plan evaluations annually.	CVH/HN	Ongoing monitoring conducted.	☒		Work is currently in progress
CLINICAL DEPRESSION FOLLOW-UP					
3. Development and distribution of provider educational resources on screening for clinical depression and follow up (12 years and older)	CVH/HN	Provider Update distributed 04/11/17, emphasizing the importance of screening for depression and timely follow-up for those with positive screens. The updated outlined validated screening tools, along with suggested billing codes for administering and documenting the depression screening and for follow-up on positive screens. 153 providers received the update via fax and 42 via mail. On 08/25/17 started distributing a survey through Provider Relations, to assess current provider and office practices around administering and documenting depression screening and follow-up. The first 50 respondents will receive a free year subscription to podcasts that provide Continuing Medical Education (CME) credits. In August 2017, started provider education on behavioral health HEDIS metrics, including depression screening and follow-up plan for adolescents and adults. Provider relations staff inform providers at all their site visits and Lunch and Learns	☒	12/29/2017	YE Update you can say that 36 providers across all product lines returned the depression screening surveys. The survey results are still being tallied. Preliminary results suggest that there are opportunities pertaining to having patients complete a screening tool on the day of their visit and self-completing a tool (such as in the waiting room). There is also opportunity in ensuring patients with positive screens have the consent forms signed to support coordination of care and communication with BHPs to ensure proper referrals and communication.

Item #8

Attachment 8.B

2017 Annual UMCM
Work Plan Evaluation

CalViva Health 2017 Utilization Management/ Case Management End of Year Evaluation

Attachment T

Created: January 14th, 2017
Updated: February 8th, 2018

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support UM decisions.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Qualified licensed and trained professionals make UM decisions.	HN has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. HN HCS (for nurses) National Credentialing (for physicians) and Pharmacy (for pharmacists) maintain records of health professionals' licensure and credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for RNs	Monthly As needed Ongoing Ongoing Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Provide continuing education opportunities to staff for 2017 : • Palliative Care • How to approach end of life with cultural competence • Fraud Waste, and Abuse • Advanced Non- Small Cell Lung Cancer offerings from Continuing Clinical Education department. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Ongoing. Current process of verification of CME standing, verification of certification, participation in InterQual training and IRRtesting. In place and up to date. Conduct training for RNs Ongoing within team structure and delivered by Plan Training team.	None	New hire training increased to 4 weeks to provide additional training for role specific activities for Medical Management staff.	Ongoing Started 7/7/2017 Ongoing Ongoing Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Continuing educational opportunities provided to staff. All staff participated in IRR and InterQual training and have met objectives in December 2017.	None	None	Completed

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.2 Review and coordinate UM compliance with California legislative and regulatory requirements	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Review new legislation and regulations, either through e-mail or department presentation. Ongoing with EPCO attendance and dissemination throughout MM. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Up to date Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. Up to date	Multiple changes regarding the Mega Reg with policy updates.	Continue to assess implications of changes in regulation and update our policies and procedures to reflect.	Ongoing Ongoing Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Review new legislation and regulations, either through e-mail or department presentation. Ongoing with EPCO attendance and dissemination throughout MM. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Up to date Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. Up to date	Multiple changes regarding Mega Reg with policy updates	Continue to assess implications of changes in regulation and update our policies and procedures to reflect.	Ongoing

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	DHS, DMHC, and CMS, at a minimum, require that Medical Decisions made by MDs and RNs are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with distribution of affirmative statement about financial incentives to members, practitioners, providers and employees.	Circulate to all MDs and RNs an attestation that states: ▪ Utilization Management decisions are based on medical necessity and medical appropriateness. ▪ Health Net and CalViva do not compensate physicians or nurse reviewers for denials. ▪ Health Net and CalViva do not offer incentives to encourage denials of coverage or service. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or RNs based on any potential to deny care.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

CalViva Health
2017 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Attestations on file for all staff with activities on target for 2017. Attestations circulated on 12/5/2016. Will circulate again in December 2017. .	None	None	December 2017
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	All attestations from staff were signed and filed for 2017. Process to undergo annual process and affirmations signed next December 2018.	None	None	Complete

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turn around time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with HNCS staff on issues revealed during the file review process.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards are identified, CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented PMR meeting. DHCS audit conducted in April 2017. Awaiting final report.	None	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Health Net's fax system, referred to as Right Fax, incurred a system error that significantly impaired our incoming fax volume, which in turn adversely affected TAT and quality audits for Q3 and Q4. Over 4,000 faxes were affected, and caused over 1,000 duplicates to be produced. The time period that was impacted was August 2017 – the close of November 2017, which drove down TAT and audit scores overall.	Right Fax system issue resolved in December 2017, no known issues affecting TAT and quality audits at this time.	None	Ongoing

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS).	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN State Health Programs MDs interact with the MMCD Division of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program ▪ Provides HN with in-depth information regarding contractual programs ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings Ensures participation by RMDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each RMD. HN and CalViva remain a strong voice in this body with participation on key workgroups	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2017. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue, Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None	To review feedback from DHCS	Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue, Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2017. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	State Health Programs Health Services reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs CMD, Regional Medical Directors, Director of Health Services and Health Services Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2017 UMCM Program Description Write and receive CalViva approval of 2016 UMCM Work Plan Year-End Evaluation Write and receive CalViva approval of 2017 UMCM Work Plan. Write and receive CalViva approval of 2017 UMCM Work Plan Mid-Year Evaluation Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2017 Q 1 2017 Q 1 2017 Q 3 2017 Ongoing Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva Policies and Procedures were reviewed during 2017 and submitted to the appropriate regulatory agencies. 2016 UM/CM Annual evaluation completed. 2017 Program Description and Work Plan completed in Q1 2017.	None	Policies updated with Mega Reg requirements including revised definition of medical necessity. Will continue to monitor for any additional changes and update policies as needed.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	CalViva policies reviewed by Training and Auditing department with no known barriers at this time. 2017 UM/CM Annual evaluation completed 2018 Program Description and Work Plan to be completed in Q1 2018	None	Policies updated with Mega Reg requirements including revised definition of medical necessity. Will continue to monitor for any additional changes and update policies as needed.	Completed February 2, 2018. February 2, 2018

2. Monitoring the UM Process

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and Trend authorization requests month to month. Tracking includes number of prior authorization requests submitted, approved, deferred, denied, or modified. Turnaround times (TAT) Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions.	Ongoing

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The Management team reviews monthly reports to ensure expectations are met in 2017, trends and results discussed during Monthly Medical Management Department KPI meeting. Activities are all on target for 2017.	Challenges with recruiting for licensed staff.	Modified recruiting strategies to include broadening positions to include LVN/RN candidates. Mailing campaign conducted and utilizing online recruiting sites to reach a broader candidate pool. All Prior Authorization openings have been filled August 2017	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	All activities on target with exception to Health Net's fax system, referred to as Right Fax, incurred a system error that significantly impaired our incoming fax volume, which in turn adversely affected TAT and quality audits for Q3 and Q4. In Q3 and Q4 the Right Fax issue impacted approximately 4,000 faxes overall.	Barriers caused by the Right Fax issue included, duplicate faxes to be received and driving up the overall volume of faxes by these two quarters by an average of 2,000 in Q3 and 1,000 in Q4. In December the number of authorizations returned to 6,400 requests per month. No known barriers with faxes and TAT following resolution of Right Fax issue in December 2017. Challenges with recruiting for licensed staff remained for the first 6 months of 2017. For the second half of 2017, no recruiting barriers existed for clinical PA.	Right Fax interventions included, staff overtime, in after hours and on weekends, as well as allocation of additional staff to process and review CalViva authorizations. Successful recruitment was performed by a combination of the above campaigns to hire additional staff.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request. (Turn Around Times =TAT)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and Trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of turnaround times (TATs). Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining	Ongoing

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	**CalViva TAT 2017** • January- 99.3% • February 98.5% • March 100% • April 91% • May 100% • June 94% Average = 97.1%	In April 2017, had one provider who submitted 200 requests for benefit exceptions in one day. Requests were subsequently rescinded by provider, but some of the requested cases fell short of TAT. In June 2017, two clinical positions remained open. During the month of June, we experienced average volume of authorizations with this staff shortage which contributed to decreased production	Modified recruiting strategies to include broadening positions to include LVN/RN candidates. Mailing campaign conducted and utilizing online recruiting sites to reach a broader candidate pool. Staff offered OT to continue to maintain production To place into formal CAP following review of historical TAT data.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	**CalViva TAT 2017** • July = 97.1% • August = 90.6% • September = 97.8% • October = 98% • November = 99.3% • December = 98.5% Average = 96.88%	UM TAT CAP was formulated in Q3 2017 due to TAT for PA and CCR falling under 100% over the first 6 months of 2017. A Right Fax issue at Health Net occurred in August and September 2017 negatively impacting 4,000 faxes and was ultimately resolved in November 2017. TAT times were impacted negatively on this and noted on the CAP and reported in the executive review summary. Approximately 13.8% of CalViva's work was negatively impacted during this time	All licensed staff for clinical PA recruited and filled. Streamlined workflows to identify CalViva cases put in place during Q3. Bolstered Nursing staff dedicated to CaViva.	UM TAT CAP still open at close of 2017.

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals (AxisPoint Health) involved in UM decision-making	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	HN administers AxisPoint Health InterQual® IRR Tool to physician and non-physician UM reviewers annually Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool for physicians and 90% for non-physician staff.	<u>Physician IRR</u> Administer Physician IRR test using case review method and AxisPoint Health's InterQual® IRR tool in Q3-4 2017 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using AxisPoint Health's InterQual® IRR tool in Q3-4 2017	Q4 2017 Q4 2017

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Annual Interqual updates to be scheduled November/December. IRR testing for both non-clinical and MD scheduled for completion in December 2017.	None	None	December 31, 2017
Annual Evaluation ☒ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**	InterQual and IRR Testing completed prior to the close of the 2017 on schedule. All but four associates passed on the first testing period. The four associates were allowed, per policy, to retest and subsequently passed the IRR retest in December 2017. In aggregate we had 96 associates take the 2016 IRR test and 206 associates take the 2017 IRR, for a total of 302 associates. The associates that migrated to the new medical management documentation system took the 2017 IRR, and those that remained on the old documentation system took the 2016 IRR. All remaining associates on the old documentation system, are scheduled to transfer to the new medical management system on July 1, 2018.	None	None	Completed December 2017

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turn Around Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	**Totals:** Overturn 39 Partial Uphold 5 Uphold 52 Withdrawal by Member 2 Grand Total 98 **Appeal Percentages** Overturn: 39.80% Uphold: 53.06% Partial Uphold: 5.10% Withdrawal by Member: 2.04% **Turn Around Time Compliance: 97.6%**	Turn-around time compliance for Appeals below goal of 100% (2 cases) related to staffing variations.	A & G leadership initiated immediate and long-term interventions to correct staffing issues. Continue to monitor.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	**Totals:** • Overturn 84 • Partial Uphold 8 • Uphold 131 • Withdrawal by Member 4 • Grand Total 227 **Appeal Percentages** • Overturn: 37.00% • Uphold: 57.71% • Partial Uphold: 3.52% • Withdrawal by Member: 1.76% **Turn Around Time Compliance: 98.24%**	Increase of 22% year over year (227 cases in 2017 vs 184 cases in 2016).	A & G leadership initiated immediate and long-term interventions to correct staffing issues.	Ongoing

3. Monitoring Utilization Metrics

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Health Net Central Medical Directors and Health Care Services manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting <u>2017 Goals</u>: TANF: 216.6 SPD: 1129.7 Key Metrics (SPD, Non-SPD, MCE) • Bed Days/K • ER visits/K • All Cause Readmits within 30 days • % 0-2 day admits • C-Section Rates	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services and community resource needs and Transition Care Management and Discharge Programs. Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Complex Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development. All internal thresholds will be reviewed and possibly revised for 2017.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	**Bed Day Goal** TANF=216.6 SPD= 1128 MCE= TBD **Bed Days Actual** TANF=105.0 SPD=967 MCE=357 Use data to identify high cost/high utilizing members to target for care management. Track effectiveness of various case management programs on readmissions, hospital utilization, including case management, Complex Case Management, Pharmacy interventions, ESRD program, Disease Management, concurrent review rounds process. These benchmarks are currently under development.		None	None	Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	<table><tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr><tr><td>Fresno</td><td>1086.4</td><td>1129.7</td></tr><tr><td>Kings</td><td>305.9</td><td>1129.7</td></tr><tr><td>Madera</td><td>743.6</td><td>1129.7</td></tr></table> SPD Days/1000 July – December 2017		Challenging access to primary, lower level and ancillary healthcare services may have impacted admit and readmit rates. Low member engagement with care management requires additional education to help member understanding of benefits of CM involvement and follow up care, consistent appointment keeping.	The Concurrent review team is expanding and enhancing three areas of focus. We are expanding our real-time medical necessity review with onsite teams at our most frequently used facilities. We are working directly with hospital care teams to proactively create effective discharge planning through better understanding of member concerns and the identification of cause for readmission using onsite engagement with members and care givers through face to face interviews. We are providing authorization for skilled level care and ancillary services as needed for discharge when creating the discharge plan.	December 31, 2017 Continue in 2018

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	HN ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS PPG profile reports are made available quarterly and one metric for over utilization (ER/K), and two metrics for underutilization, (All Cause Readmits w/in 30 days) and Specialty referrals are assessed on a biannual basis	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. Identify possible fraud, waste and abuse issues. Report any issues to the Compliance Department Thresholds for 2017 are under evaluation. <u>Referral Rates: Specialist</u> HN average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non SPD and MCE members by PPG. HN average referral rates are determined and the bottom10% are identified as outliers. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the RMD to determine if a CAP is indicated. CAPS are monitored by delegation oversight then to document implementation and need for follow up.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Development of PPG specific data Dashboard Reports. These reports are produced quarterly and presented at the CalViva Management Oversight meeting. The reports are derived from claim data and accordingly are produced after the claim time lag is no longer an issue. (approximately 4 -5 months).	None	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. Identify possible fraud, waste and abuse issues. Report any issues to the Compliance Department Thresholds for 2017 are under evaluation	Ongoing Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	All delegates were reported through the Delegation Oversight Workgroup (DOW) in 2017 and per policy; those entities requiring further discussion were sent to the Delegation Oversight Committee (DOC) for ongoing action. Delegation Oversight did recommend the termination of a medical group contract that did occur in 2017	None identified outside of normal business practices	Ongoing monitoring per regulatory requirements and adapt tools to meet any additional regulatory requirements	Completed for 2017

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
3.3 HN SHP Medical Director MRU and Provider Dispute Unit review of ER, ambulance high dollar, Cotiviti and potential CCS claims	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Emergency Room visits often are not for valid emergency conditions and do not meet Title 22, Section 53855 parameters Inpatient LOC may be inappropriate Hospital charges may include unbundling and non-benefit items Claims for both inpatient and ER visits may be CCS carve-out program responsibility Codes not allowed by Medi-Cal may be submitted, as well as unbundling of codes in excess of CMS and CCI rules.	Medi-Cal claims units are sending high-cost and questionably inappropriate claims to respective State Health Programs Medical Directors for timely line-item review to monitor quality of care provided, to identify inappropriate utilization patterns and to ensure that members are connected to other public programs such as CCS. Claim review remains an important activity for HN medical directors to control cost, prevent fraud, and direct provider to the correct payer for the carve out programs. MRU areas of importance are: CCS identification. Trauma reviews. ER visits for ambulatory care sensitive conditions.	Review potential CCS responsibility Review of non-approved inpatient care for medical necessity. Review claims denied for bundling edits, other inconsistent billing patterns according to Claims policy, Cotiviti policy, and industry standard payment rules Cotiviti denials will be reviewed in 2017 Review for quality of care issues and inappropriate utilization Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations	Ongoing

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Health Net

CalViva HEALTH

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2017 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Medical necessity and appropriateness of billings continue to be appropriately monitored and adjudicated. Review potential CCS responsibility Review of non-approved inpatient care for medical necessity. Review claims denied for bundling edits, other inconsistent billing patterns according to Claims policy, Cotiviti policy, and industry standard payment rules Cotiviti denials will be reviewed in 2017 Review for quality of care issues and inappropriate utilization Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations	None	Monthly cross collaborative meetings with clinical MRU, non-clinical MRU, and Claims to identify process improvement opportunities in operational process.	Ongoing Ongoing Ongoing Ongoing December 31, 2017 Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Cotivti denials under review. Continued training and monthly communication meetings between MRU clinical and Ops staff and SHP medical management to ensure smooth operations CAP for PDRs was developed by claims and MRU.	Untimely claims still be sent to MRU, have outlined corrective action plan to have fixes in place to allow adequate time for timely review.	Monthly cross collaborative meetings with clinical MRU, non-clinical MRU, and Claims to identify process improvement opportunities in operational process. Additional nursing staff allocations and resolution of the CAP due before March 1, 2018	Ongoing

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
3.4 PPG Profile	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____ She o	Profiles provide PPGs threshold data based on Health Net CalViva data and comparative performance data to help them measure and improve their UM and QI performance.	Medi-Cal PPGs with greater than 1,000 non-SPD, 1000 MCE or 500 SPD Medi-Cal members are produced quarterly and evaluated .bi-annually for possible over/under utilization. Metrics include: 1. Acute bed days per thousand 2. Average length of acute care stays 3. ER visits/K 4. All Cause Readmits within 30 days 5. Aggregate Specialty Referrals using NPI #'s compared to NPAS 6. % of 0-2 day admissions 7. C-section rates	CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2017. PPG's are identified as potential outliers for the metrics measured undergo further analysis by the RMD to determine if a CAP is indicated. CAPS are monitored by delegation oversight then to document implementation and need for follow up <u>Referral Rates: Specialist</u> HN average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non SPD and MCE members by PPG. HN average referral rates are determined and the bottom10% are identified as outliers.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

CalViva Health
2017 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Dashboard reports are in place. Narrative report for Q2 reviewed at MOM meeting on 9/5/17. CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2017. Further analysis will be initiated by the RMD for PPG's identified to be potential outliers and a Corrective Action Plan (CAP) will be requested when indicated. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	Membership growth and changing regulations	Internal thresholds under re-evaluation.	Ongoing Ongoing Ongoing Ongoing Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Dashboard reports are in place. Narrative report for Q4 reviewed at MOM meetings. CalViva PPG profile reports are made available quarterly and at least one metric for over utilization (ER/K), and at least two metrics for underutilization, (All Cause Readmits w/in 30 days) and specialty referral are assessed on a biannual basis Results will be compared to HN internal thresholds which are under re-evaluation for 2017. Further analysis will be initiated by the RMD for PPG's identified to be potential outliers and a Corrective Action Plan (CAP) will be requested when indicated. CAPS are monitored by the Delegation Oversight team to insure actions are implemented and documentation and follow up are completed.	Membership growth and changing regulations	Internal thresholds under re-evaluation.	Ongoing

4. Monitoring Coordination with Other Programs and Vendor Oversight

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
4.1 Integrated Case Management Program (ICM)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner optimizes physical and emotional health and well-being and improves quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Report referrals to appropriate internal and external programs. Enhance Key Indicator reporting to report, track and trend Integrated Case Management Activities monthly Track and Trend Case Management activities and acuity levels (including complex) monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs	Dedicated staff of RNs, CM Assistants, and LCSWs to perform ICM Further reinforcement of predictive modeling to increase engagement of members.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

CalViva Health
2017 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Dedicated staff in place to support CalViva members. Continue monitoring staff and referral volume to adjust staffing resources to support the population as needed. Modified the Key Indicator Report to align with standardized CM reporting. CalViva members managed in the Top One Percent (TOP) Program have also been transitioned to the dedicated CalViva team. TOP members were previously managed by a different designated team. The unable to reach volume is one aspect of the Key Indicator Report which is monitored monthly. The overall percentage of referrals to Integrated Case Management where the member was unable to be reached was 65% (594/906) from January through June. The overall percentage of members who declined to enroll in Integrated Case Management was 24% (218/906) for that same time period. Support processes have been modified to promote successful outreach. The engagement rate has improved significantly starting in June. Total managed members in this program January through June was 263.	Primary reason for decline into our Integrated Case Management Program case volumes is due to members who are screened and decline services and those we are unable to reach.	Processes were modified to ensure all available contact information is available to the CM making outreach. To support identification and referral of members with complex and serious medical conditions in September we will begin to implement use of the information in the new Health Information Form to identify members who may benefit from CM.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	The volume of referrals through Q4 was 1,346, referrals increased from 156 in Q3 to 301 in Q4. The quarterly average engagement rate increased from 18% Q1 to 36% in Q4. The percentage of complex cases managed increased from 30% in Q1 to 40% in Q4. Total volume of members managed in 2017 was 461. Use of the information in the new Health Information Form to identify members who may benefit from CM has been delayed due to a distribution issue.	Primary barriers to enrollment into Integrated Case Management: -Unable to reach members -Members declined -Decreased volume of referrals in previous quarters Due to distribution issue there is a delay in data being available in TruCare and available for screening/referrals to CM.	Beginning in Q4 conducted monthly Motivational Interviewing classes to increase member engagement and retention in CM. Reviewed outreach process with staff phone numbers to facilitate successful member outreach Constraints for referral criteria put in place in Q2 were lifted in Q4. HIF to be distributed by Marketing end of January 2018. Begin utilizing HIF data to support CM referrals in Q1 2018.	

Created: January 14th, 2017
Updated: February 8th, 2018

CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program Monitor inpatient and NICU utilization for this population, to tailor interventions going forward.	Assess member's level of Social Support and refer to appropriate community resources, as needed. PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Support provider completion of PNIP forms and complete outreach to members identified as "high risk"	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

CalViva Health
2017 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The average number of referrals per month, January through July, was 15. The average engagement rate for that period was 31% and the total number of members managed was 68. Staff will be attending Motivational Interviewing classes to facilitate greater engagement. The CM and the Quality teams have partnered to evaluate the adoption of the StartSmart for Baby Program to support early identification of pregnant members and increase the number of referrals to Perinatal CM. In the interim we recently started utilizing other sources to identify members for the program including pre-delivery admissions on the inpatient daily census.	None	We are collaborating with our Perinatal Initiative Committee to assist our QI department with outreach to high risk members identified from the PNIP forms received. Our HROB CM's outreach members identified by their providers as having a high risk pregnancy, and to those who's risk status is unknown due to incomplete forms.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	There were 231 referrals to the Prenatal CM Program in 2017. Volume of referrals increased in Q4 (86/231).The Engagement Rate stayed relatively consistent 31-34%. Total cases managed in 2017 was 99.	-Timely receipt of PNIP referrals -Low volume of PNIP referrals – dependent of provider indicating high risk pregnancy -Primary source for identifying members for SSFB is through submission of the Notification of Pregnancy Form which has not yet been implemented. -Unable to reach members -Members declined	CM and the Quality team collaborating to evaluate the adoption of the StartSmart for Baby Program to support early identification of pregnant members and increase the number of referrals to Perinatal CM. In the interim CM started utilizing the No NOP report to outreach to members identified through claims as pregnant to complete a Notification of Pregnancy assessment. Results of the assessment are screened and high risk members are referred to CM. Conducted monthly Motivational Interviewing classes to increase member engagement and retention in CM.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
4.3 Disease Management	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program ☐ Other _____	The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy/ encounter claims, health appraisal results, data collected through the UM or case management process, and member or provider referrals. Evaluation of outcome data from HEDIS®-like measures. Review/analyze DM partner annual report	Transitioning vendors and expanding the program from three to five conditions: asthma, diabetes, cardiovascular artery disease, chronic obstructive pulmonary disease, and heart failure. Notify PCPs of their patients identified or enrolled in the disease management program. Focus on streamlining hand-off between Disease Management and the Integrated Case Management programs. (Modification of the referral form and member referral process is in process.) Review of member materials and scripts by the Compliance and Cultural & Linguistics departments and DHCS before going to press. Ongoing program monitoring to assure that reporting needs are met. Monitor the monthly reports and enrollment statistics.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	1. Continued work on the transition of the Disease Management program to another vendor. 2. Bi-Annual mailings are sent to the Providers to notify them of their patients who are enrolled in Disease Management program. 3. Annual Vendor Delegation Oversight Audit of the current vendor to be started in September, 2017. 4. Ongoing program monitoring to ensure appropriate enrollment and the reporting needs are met. .	None	1. Disease Management transition from the current vendor to Envolve PeopleCare (EPC). Collaborating with the stakeholders to ensure a smooth and seamless transition. 2. Review of the current vendors collaterals by appropriate departments (Clinical team, Compliance and Cultural and Linguistics) before mailing. 3. Completion of the Delegation Oversight Audit and appropriate follow up as needed. 4. Continued weekly Issues and Oversight meetings	1. Transition Date: 2018 2. July, 2017 and ongoing 3. October, 2017 4. Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	**Medi-Cal:** Interventions within the Disease Management programs continue to include the following: Eligible Members receive an initial enrollment mailing; outbound calls from an RN following an individualized call schedule; biannual and annual assessments, with mailed letter, individualized action plan and appropriate educational materials. Assessments include: symptom management, depression screening, referrals to Behavioral Health as needed, coordination of care with the physician and education. Providers receive letters with a roster of their patients who are enrolled in the program, a program overview brochure and provider feedback information. Health Net performs an Annual Vendor Delegation Oversight Audit In 2017 reporting year, the Medi-Cal disease management program self reported HEDIS like measures met goal.	None	1. Disease Management transition from the current vendor to Envolve PeopleCare (EPC). Collaborating with the stakeholders to ensure a smooth and seamless transition. 2. Review of the current vendors collaterals by appropriate departments (Clinical team, Compliance and Cultural and Linguistics) before mailing. 3. Completion of the Delegation Oversight Audit and appropriate follow up as needed. 4. Continued weekly Issues and Oversight meetings	1. Transition Date: 2018 2. Completed and ongoing 3. Completed and ongoing 4. Ongoing

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2017 Planned Interventions	Target Completion Date
4.4 MD interactions with Envolve Pharmacy Solutions (EPS)	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. SHP MDs and the CalViva Health Chief Medical Officer work with EPS to refine RDL/Formulary and injectable guidelines to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with EPS to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with EPS to improve CCS ID using pharmacy data SHP MD's and EPS continue with interventions, to adopt DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the HN Medi-Cal plan.	Monthly check write review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Continue active engagement with pharmacy, Medical Directors meet with pharmacy on a quarterly basis to review reports, discuss utilization of medications and discuss proposed formulary and pre-authorization guideline changes. Continued narcotic prior authorization requirements with review of prior authorizations is reviewed at the quarterly Medical Director/pharmacy meeting for changes in trends.	None	Continue with regular meetings.	Ongoing Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Continue active engagement with pharmacy, Medical Directors meet with pharmacy on a quarterly basis to review reports, discuss utilization of medications and discuss proposed formulary and pre-authorization guideline changes. Continued narcotic prior authorization requirements with review of prior authorizations is reviewed at the quarterly Medical Director/pharmacy meeting for changes in trends.	None	Continue with regular meetings.	Ongoing Ongoing

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2017 Planned Interventions	Target Completion Date
4.5 Manage care of CalViva members for Behavioral Health	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to monitor and improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Participate in cross functional team to improve coordination of care. Review data that indicates when a member was referred to the County for services. Review data that indicates when a PCP has referred a member to a BH provider.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	876 calls from members 1/1/17-6/30/17. 210 of 876 calls were sent to clinical care managers for assessment. Of these, 8 of 210 were referred to the County for SMHS services. MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions.	Unable to determine at this time how many were from PCP/PPG because of reporting system issues.	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care MHN Provider Relations is actively pursuing to initiate new contracts with psychiatrists in the three CV counties. They are offering higher rates to incent them to join the MHN network. MHN has also contracted with one telehealth provider who can provide psychiatric services, and is in the process of contracting with more.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**	2052 calls from members 7/1/17-12/31/17. 266 of 1020 calls were sent to clinical care managers for assessment. Of these, 6 of 266 were referred to the County for SMHS services. MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions.	Unable to determine at this time how many were from PCP/PPG because of reporting system issues.	Continue monitoring, tracking, and revising metrics. as needed, to ensure coordination, continuity and integration of care MHN Provider Relations is actively pursuing to initiate new contracts with psychiatrists in the three CV counties. They are offering higher rates to incent them to join the MHN network. MHN Provider Relations continues work to increase MHN's network of telemedicine providers. We have one provider contracted, and a second in the process. This will increase the availability of psychiatry appointments significantly.	Ongoing

UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2017 Planned Interventions	Target Completion Date
4.6 Behavioral Health Performance Measures	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CalViva collaborates with Behavioral Health practitioners to monitor and improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	18 PQIs were submitted for CalViva members to date. **Summary Narrative for Membership & Appointment Accessibility** Q1 2017 CalViva membership was 354,904 (a 0.05% increase over Q4 2016). - There were 0 Life-Threatening Emergent cases. - There were 0 Non Life-Threatening Emergent cases. - There was 1 Urgent case and the timeliness standard was met. Q2 2017 CalViva membership was 355,348 (a 0.1% increase over Q1 2017). - There was 1 Life-Threatening Emergent case and the timeliness standard was met. - There were 0 Non Life-Threatening Emergent cases. - There were 0 Urgent cases.	None	None	Ongoing

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Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2018**	Appointment Accessibility by Risk Rating: all cases risk rated other than routine met DMHC/DHCS TAT standards for Q1, Q2 and Q3 2017. Q4 results not available at the time of this report. Authorization Decision Timelines: Adverse determinations for non-ABA outpatient cases met a 5 business day TAT standard for the Q2 and Q3 of 2017. In Q1 2017 the standard was missed by 1 percentage point at 89%. For ABA outpatient cases, Q1 and Q2 missed the 90% standard at 88% and 89% respectively. Q3 met the standard. Q4 data not yet available. Potential Quality Issues: One PQI was filed for the CalViva account during calendar year 2017. This case was resolved within PQI timeliness standards. Provider Disputes: 17 provider disputes were filed for CalViva in 2017.100% of those were resolved within timeliness standards. MHN determines provider availability (timeliness) through the standard measures below: Network availability was 100% for first three quarters 2017. Fourth quarter information not yet available. Network Adequacy Member Ratios: All Behavioral Health Providers met the target of 1: 5000 for the first three quarters 2017. 1 BCBA per 5,000 covered enrollees missed in Q1 and Q2 at 1:6,013 and 1:5722, respectively. 2 BCaBA/Paraprofessional per 5,000 covered enrollees met target for all 3 quarters. Fourth quarter data is not yet available. .	Q4 Data is not available for distribution	None	Ongoing

5. Monitoring Activities for Special Populations

CalViva Health
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
5.1 Monitor of CCS identification rate.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	CASHP will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Coordinators and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Medi-Cal utilizes a 70% factor to account for CCS age band.	CCS identification and reporting continues to be a major area of focus for SHP. Continue current CCS policies and procedures. Identification through claims review, concurrent review, prior authorization, case management, pharmacy, and member services (welcome calls and CAMHI screening tool) Improve coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans.	Ongoing

Created: January 14th, 2017
Updated: February 8th, 2018

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<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr><td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>Continue to monitor the rate of CCS identification and follow the current planned interventions.

The CCR team screens every inpatient admission, under their review, for CCS eligibility. Any person under the age of 21 with a complex medical condition is screened for potential CCS eligibility. Cases identified as potentially eligible or confirmed eligible for CCS services are referred to the local CCS office.

The CCRNs collaborate directly with the local CCS office to ensure coordinated services and expedited access to care through CCS paneled providers and/or Specialty Care Centers.</td><td>None</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2018</td><td>Current rate of CCS is 7.49% for the Medicaid population. Continue to monitor the rate of CCS identification and follow the current planned interventions.

<table><tr><th></th><th>Fresno</th><th>Kings</th><th>Madera</th></tr><tr><td>Jan 17</td><td>7.19%</td><td>7.19%</td><td>7.19%</td></tr><tr><td>Feb 17</td><td>7.48%</td><td>7.48%</td><td>7.48%</td></tr><tr><td>Mar 17</td><td>7.48%</td><td>7.48%</td><td>7.48%</td></tr><tr><td>Apr 17</td><td>7.58%</td><td>7.58%</td><td>7.58%</td></tr><tr><td>May 17</td><td>7.58%</td><td>7.58%</td><td>7.58%</td></tr><tr><td>June 17</td><td>7.61%</td><td>7.61%</td><td>7.61%</td></tr><tr><td>Jul 17</td><td>7.62%</td><td>7.62%</td><td>7.62%</td></tr><tr><td>Aug 17</td><td>7.59%</td><td>7.59%</td><td>7.59%</td></tr><tr><td>Sept 17</td><td>7.64%</td><td>7.64%</td><td>7.64%</td></tr><tr><td>Oct 17</td><td>7.73%</td><td>7.73%</td><td>7.73%</td></tr><tr><td>Nov 17</td><td>7.71%</td><td>7.71%</td><td>7.71%</td></tr><tr><td>Dec 17</td><td>7.76%</td><td>7.76%</td><td>7.76%</td></tr></table></td><td>None</td><td>None</td><td>Ongoing</td></tr>
</table>

Created: January 14th, 2017
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CalViva Health
2017 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objectives	2017 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements.	☐ Commercial HMO/POS *(Ex. Adults 18-65)* ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO ☒ Medi-Cal ☐ Other _____	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UMCM program. Monitor HRA completions	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into multiple programs, including Complex Case Management, Pharmacy program to prevent hospital readmission, Ambulatory Case Management, and 5 Disease Management gateway conditions. Continue to meet all requirements for SPDs and utilize all programs to support them, including Integrated Case Management.	Ongoing

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<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The identification, risk stratification, and assessment performed during member enrollment into the DM, or Integrated Case Management Program addresses the HRA reassessment requirement. Health Net Monitors this activity through reporting by Axis Point formerly known McKesson.

SPD Days/1000 January – June 2017

<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>1079.2</td><td>1129.7</td></tr>
<tr><td>Kings</td><td>243.7</td><td>1129.7</td></tr>
<tr><td>Madera</td><td>852.6</td><td>1129.7</td></tr>
</table>
</td>
<td>None</td>
<td>TCM efforts are ongoing and continue.

CalViva high risk members are identified via predictive modeling and through referrals from CCR to support TCM post-acute outreach to CalViva’s highest risk members.

Continue on-site concurrent review at the Central Valley's highest volume hospitals.

Continue to track the effectiveness of various case management initiatives on readmissions, hospital utilization, pharmacy and disease management</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2018</td>
<td>SPD Days/1000 July – December 2017

<table>
<tr><th>Counties</th><th>Days/1000</th><th>Goal</th></tr>
<tr><td>Fresno</td><td>1086.4</td><td>1129.7</td></tr>
<tr><td>Kings</td><td>305.9</td><td>1129.7</td></tr>
<tr><td>Madera</td><td>743.6</td><td>1129.7</td></tr>
</table>
</td>
<td>None</td>
<td>Continue with increase of on-site CCR presence in targeted facilities with focus on proactive and collaborative discharge planning in collaboration with hospital care and Health Net care teams.</td>
<td>Completed December 2017.</td>
</tr>
</table>

Created: January 14th, 2017
Updated: February 8th, 2018

Item #9

Attachment 9.A

2017 Annual Compliance Evaluation

CALVIVA HEALTH
2017 ANNUAL COMPLIANCE EVALUATION

The Fresno-Kings-Madera Regional Health Authority ("RHA") dba CalViva Health ("CalViva" or the "Plan") operates as a public agency, Local Initiative Medi-Cal managed care plan covering the counties of Fresno, Kings and Madera. The Plan does not offer any commercial or other product lines. CalViva Health is committed to establishing and maintaining its business operations in compliance with ethical standards, Department of Health Care Services ("DHCS") Medi-Cal contractual obligations, Department of Managed Health Care ("DMHC") requirements, and all-applicable state and federal statutes, regulations and rules. CalViva Health's compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners.

CalViva Health has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative and operational services on the Plan's behalf. CalViva Health also has a Capitated Provider Services Agreement with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers and subcontracted health plans. CalViva Health also has direct contracts with three (3) Federally Qualified Health Centers. CalViva Health also held a direct contract with Kaiser Foundation Health Plan ("Kaiser") to provide services to CalViva Health members. Effective September 1, 2017, CalViva Health terminated its contract with Kaiser. The Plan's primary responsibility is to ensure Health Net, Kaiser and other subcontractors perform delegated services and activities in accordance with CalViva Health standards, contractual requirements and state and federal regulatory requirements.

This Annual Compliance Evaluation describes operational compliance information and major activities completed during 2017.

Compliance Programs

CalViva Health continued to operate a comprehensive Compliance Program in 2017. The Plan's Compliance Program includes written program descriptions, work plans and supporting policies and procedures documenting the Program requirements. Compliance Program documents created/reviewed and updated in 2017 included:

- Compliance Program Description
- Compliance Policies and procedures
- Code of Conduct
- Compliance Committee Charter
- Anti-Fraud Plan
- Privacy and Security Plan
- Compliance work plan tracking ongoing activities

During 2018, these Compliance Programs will continue to be updated as needed to comply with any new regulatory or contractual requirements or changed business practices. Furthermore, the Plan will continue its ongoing efforts to ensure Commissioners, officers and employees complete

a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable on an annual basis and that the Office of Inspector General ("OIG") exclusion list, Medi-Cal suspended/ineligible provider lists and licensing board sites are checked for all employees, contracted consultants, committee and Commission members as applicable.

Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2017 the Plan conducted trainings for one new hire as well as the following mandatory annual staff trainings:

Compliance Program and Code of Conduct	Anti-Fraud and Abuse Program
Privacy and Security Program	Confidentiality and Conflict of Interest
Drug Free Awareness Program	Cultural Competency

During 2017, all employees successfully completed all required trainings and passed any required quizzes with an 80% or above.

Oversight and Monitoring of Delegated Activities

During 2017, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Kaiser, Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf. These activities included:

- Monthly management oversight meetings with Health Net key management staff to review reports, discuss issues and any improvement actions needed, and to discuss key transitions in Health Net as a result of the Centene acquisition.
- Quarterly Joint Operations Meetings ("JOM") with Kaiser key management staff to review reports, discuss implementation issues and any improvement actions needed (ended in April 2017). The JOMs were replaced by weekly and ad-hoc transition meetings until the September 2017 contract termination date.
- Bi-weekly calls with Kaiser to address any issues (ended in May 2017).
- Monthly and Quarterly monitoring and analysis of key performance measures and reports from delegated entities for timeliness, accuracy and identification of issues.
- Ongoing workgroup collaborations with Health Net to ensure process integrity and contract deliverables in the following areas:
  - Grievance System
  - Quality Improvement, Utilization Management and Credentialing
  - Encounter Data Integrity
  - Access and Availability

Oversight Audits

Delegation Oversight Audit – Health Net

In 2017, CalViva Health continued efforts to streamline the audit process and increase staff efficiency in audit activities. The Plan developed an audit schedule that allows for functional areas to be reviewed throughout the course of the year.

During 2017, the Plan completed audits of the following Health Net functions:

Access and Availability	Emergency Services	Utilization Management
Credentialing	Provider Disputes	Provider Relations/Network
Claims	Privacy and Security	Health Education
Cultural and Linguistics		

Audits include desk reviews of policies and procedures used by Health Net to conduct Plan business, reports, and evidence submitted to meet the required audit elements. An onsite audit was conducted for the delegated activity of Claims.

Member Communications

CalViva Health maintains a process for the review and approval of communications with members.

Approximately 200 (+) communications were reviewed by CalViva Health in 2017. The amount includes a retrospective review of all health education materials as a result of the Health Education Oversight Audit. The additional increase is also attributed to the review of the translated Spanish documents which will be utilized by the EnvolvePeopleCare Disease Management program.

The number also includes the review and approval of four (4) Printed Provider Directories and four (4) Member Newsletters. CalViva Health did not review and approve a new EOC due to the delay in receiving a Model Handbook for use from Regulatory Agencies.

Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area.

In 2017, contracted providers were sent approximately 110 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 41 informational letter templates for contracted providers and 29 forms intended for provider use.

Provider Network

CalViva Health continued to maintain a large, diverse provider network in 2017. The following table provides the approximate number of network providers in the counties of Fresno, King and Madera as of Q4 2017.

Hospitals	11
Clinics	96
Primary Care Physicians	320
Mid-Level Practitioners	106
Specialists	1130
Ancillary Providers	96
Pharmacies	163
Vision Providers	83
Acupuncture Providers	8
Behavioral Health Providers	173

Provider Relations

In 2017, CalViva Health continued productive relationships with participating providers by completing 2,786 provider visits throughout Fresno, Kings, and Madera Counties. Plan staff conducted routine face-to-face visits, trainings and assisted providers with Medi-Cal guidelines and CalViva Health requirements in their day to day operations. Major activities in 2017 include:

- Educating the network about the transition of Members from Kaiser to CalViva Health
- Educating the network regarding changes to the Medi-Cal newborn enrollment process
- Educating the network regarding the timely update of provider demographic data
- Assisting with projects such as the HEDIS Incentive Program, Perinatal Incentive Program, and Office Wait Times
- Ensuring newly contracted providers receive training in a timely manner
- Supporting provider workshops, conferences and seminars to provide knowledge and strategies for successful implementation of health care initiatives.

2017 Reports of Suspected Fraud Waste & Abuse Cases

CalViva Health has an established Anti-Fraud Plan to identify, investigate, and if appropriate, prosecute instances of fraud by providers, members, contractors, or company employees.

The Plan is required to complete a preliminary investigation and report all suspected fraud, waste and/or abuse cases to the DHCS within ten (10) working days following identification of a potential incident. Once the investigation has risen to the suspicion of fraud is the point at which the Plan refers the case to the DHCS.

3 cases rose to the suspicion of fraud in 2017. These 3 cases were referred to the DHCS. 42 cases remain open for investigation heading into 2018.

There were no cases identified that involved potential fraud, waste or abuse by a CalViva Health employee.

There were no cases reported that involved potential provider or member fraud from the Plan's sub-contracted health plan Kaiser in 2017.

Privacy and Security Oversight

Regulatory and Contractual Obligations

CalViva Health continued to review and refine their practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), Department of Health Care Services ("DHCS") contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2017:

- Breach Notifications and Assessments – Risk assessments were conducted on cases to determine the probability of compromise of protected health information in the event of a breach of unsecured protected health information.
- Notice of Privacy Practices ("NPP") – The NPP was successfully distributed to new members upon enrollment and annually.
- Risk Management Team – A team with knowledge about the organization's privacy and security policies and procedures, training program, computer system setup and technical security controls met as needed to identify threats and vulnerabilities and manage risk.
- External scanning for threats and vulnerabilities were continued
- Policy scanning for privacy and security related technical controls were continued

CalViva Health also continued their efforts in the oversight and monitoring of Business Associates ("BA") who create, maintain and/or transmit protected health information (PHI). In addition, CalViva Health maintained a contract with a company to conduct security and vulnerability scans and another company for use of their software to assess CalViva Health's compliance with the HIPAA privacy and security regulations.

In 2018, CalViva Health will continue assessing their practices and processes to ensure compliance with HIPAA. These assessments could include but is not limited to reviewing operational business practices, finalizing new risk analysis which was started in 2016, engaging in ongoing risk management activities and/or reviewing program documents related to HIPAA.

Reports of Possible Privacy and Security Incidents/Breaches

As described in the Plan's privacy and security policies and procedures, upon discovery of an incident/breach, CalViva Health must notify state and federal agencies of the incident/breach in accordance with regulatory requirements. In addition, the Plan must take prompt corrective action to mitigate any risks or damages involved.

In 2017, 29 privacy and security incidents were reported to the DHCS and the Health and Human Services ("HHS") agency if applicable. There were no incidents which occurred within CalViva Health. Two (2) incidents involved the Plan's sub-contracted health plan Kaiser. The remaining 27 incidents involved the Plan's Administrator Health Net. 25 cases were deemed low risk or no risk after the completion of a risk assessment. One case was deemed high risk, which required notifications to affected individuals and to HHS. There are three cases which are still under investigation and waiting to be determined as a high-risk or low-risk case.

CalViva Health Internal Audits

CalViva Health conducts monthly workstation audits to enforce standards for protecting the privacy of Personal Health Information ("PHI"). Compliance staff conduct an after-business hours audit of internal workstations/offices and communal workspaces (e.g. document storage, fax machines, printers, and copy machines) to see if PHI is exposed and to determine if computers have been logged off. Spot check audits are also conducted during work hours to see if PHI is being exposed inappropriately or left unattended.

In 2017, there was one incident where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

Regulatory Filings and Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and materials (e.g. marketing and member materials, new benefits information, changes in Commission and committee members, key policies and procedures, etc.) to the DMHC and DHCS for review and approval. In 2017, CalViva Health made over 100 regulatory filings to DMHC and/or DHCS.

In July 2017, the DHCS discontinued the following Special Populations Reports:

- Detailed Provider Report (Phased out as part of the SB 274 Monthly Provider File Implementation)
- Universal Report
- SPD Report
- OTLIC Report
- Grievance Log (only submitted upon DHCS request)

As of July 2017, the following existing and new DHCS and DMHC reports are required for submission:

Monthly Reports:

Comprehensive Diagnostic Exam (CDE)	New template
Non-Medical Transportation/Non-Emergency Transportation (NMT/NEMT)	New template
Medical Exemption Denial Report	New template

Quarterly Reports:

DMHC Grievance Report	
Provider Network /Subcontractor Reports	
Call Center Report	
Behavioral health Treatment (BHT) Report	New template
Community Based Adult Services (CBAS) Report	
Dental Anesthesia	
DHCS Grievance Report	
Mental Health Report	

Regulatory Audits and Monitoring

In 2017, CalViva Health underwent various regulatory audits and/or monitoring activities from regulatory agencies.

The DHCS continued their process to conduct quarterly reviews of the Plan's provider network. The quarterly reviews evaluated the Plan's provider network against network requirements set forth under the DHCS contract and under the Knox Keene Act, as applicable. These quarterly reviews required a Plan response to the DHCS inquires.

Along with the quarterly reviews of the Plan's provider network, the DHCS also continued their process to evaluate the quality of the Plan's encounter data. During 2017, DHCS issued Q2, 2016 through Q2, 2017 data quality quarterly reports that indicated the Plan was in the "Low Performing" category. This rating is due mainly to the lack of timeliness in encounter data submissions as the Plan spent much of 2017 submitting older catch-up data from 2015 and 2016 service dates. On December 26, 2017, DHCS requested a Corrective Action Plan ("CAP") from CalViva regarding the persistent encounter data delays and deficiencies similar to those identified by DHCS in December 2016. CalViva is expected to achieve 100% compliance by April 1, 2018.

CalViva Health also received the following regulatory audits and performance reports in 2017:

- HEDIS® Compliance Audit for 2017
- DMHC Routine Full-Service Survey – 18-Month Follow-Up Desk Audit Request
- DHCS Medical Audit (Preliminary Report pending)
- DHCS State Supported Services (Preliminary Report pending)
- Final DHCS 2015-2016 Performance Evaluation report
- 2016-2017 HSAG Quality Focus Study

The Plan performed well in meeting regulatory requirements and for many of the above assessments required little or no corrective action. Where required, improvement plans were successfully implemented and/or ongoing implementation is occurring.

In 2018 CalViva Health will be involved in the following regulatory audits and monitoring processes:

- DHCS Medical Audit and State Supported Services
- DMHC Routine Full-Service Survey – 18-Month Follow-Up Desk Audit Request
- HEDIS® Compliance Audit for 2017
- DHCS 2016-2017 Performance Evaluation of CalViva Health
- Encounter Data Validation (EDV) Study

Programs and Operational Accomplishments

In 2017, CalViva Health participated in numerous activities to address the implementation of programs and operational processes to ensure compliance issues are addressed and oversight and workflow processes are established as needed.

Operational Processes

- Implementation of the "Final Rule" commenced with the Plan revising and submitting several P&PS to DHCS for approval. Areas covered included provider directories, appeals and grievances, payment recoveries, monthly data certification, etc.

- Quality Measures For Encounter Data ("QMED") – CalViva Health continued to work with Health Net to improve the quality of the Plan's encounter data and address the DHCS CAP.

- Oversight of Centene – Health Net merger activities impacting CalViva Health processes, members and providers. The Plan participates in monthly status meetings regarding any changes or transitions affecting CalViva Health, has focused meetings with staff from specific operational areas of Centene and Health Net as needed to address implementation issues, is revising/creating Plan policies and procedures to reflect changes, reviewing and approving member and provider communications, and making regulatory filings as appropriate.

- Kaiser contract termination and membership transition – Completed regulatory filings, established transition activities with Kaiser, implemented continuity of care processes, transitioned approximately 9,000 members, and provided regular reports to regulators of transition activity. Reporting on required DMHC Undertakings related to the Kaiser termination will continue into 2018.

- EHS termination and member transition - As a result of a December 2017 DMHC Cease and Desist Order and a DHCS CAP directive, Health Net and other managed care plans

were required to terminate their provider group contract with EHS. Approximately 110,000 CalViva Health members are assigned to EHS and will have to be transitioned to new provider groups or the Health Net direct provider network effective February 1, 2018. The majority of members will still keep their current primary care provider. Plan staff have completed regulatory filings, established transition activities with several other impacted managed care plans, implemented continuity of care processes, and provided regular reports to regulators of transition activity. Transition and post termination activities will continue into 2018.

- CalViva Health Operations – A Chief Operating Officer position was appointed in October 2017. Re-organization and re-alignment of responsibilities and activities started in 2017 and will continue in 2018 as the Operations Department is established.

Benefit Expansions

- Effective July 1, 2017, Non-Medical Transportation (NMT) became a benefit for all members (not just EPSD-related services) to obtain medically necessary Medi-Cal Managed Care covered services. Effective October 1, 2017, Plans must also provide for services not covered by the DHCS contract (e.g., specialty mental health, substance use disorder, and any other benefit delivered through the Medi-Cal FFS delivery system.

- Effective October 1, 2017, Plans had to be in compliance with the Federal Mental Health Parity regulations outlined in the "Final Rule". The general parity requirement stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominate treatment limitations applied to medical and surgical benefits. Additionally, Plans may not require a referral from a PCP or prior authorization for an initial mental health assessment.

Summary of Plan Operational Compliance

In 2017, CalViva Health compliance staff also monitored various Plan operational activities. The following sections summarize performance in several key areas.

CalViva Health Member Service Call Center

Performance Indicators	**Member Service Calls**	**Member Service (Mental Health) Calls)**
Calls Received (includes calls that were not handled by Member Services and routed out to another department and abandoned calls)	133,891	4,738
Calls Handled	130,766	4,689
Abandonment Rate % (Goal 5% or less)	2.3%	1.0%
Average Speed of Answer (Goal 30secs) or less)	27	9
Service Level (Goal 80%)	86	92

Member Services met and exceeded several call performance standards in 2017.

Appeal and Grievance Resolution Activity Summary

CalViva monitors all appeal and grievance activity on an ongoing basis. Cases are reviewed for compliance with regulatory resolution timeframes, accuracy of language used in resolution letters, correct use of approved letter templates and completeness of case records. Expedited grievances and appeals must be resolved within 72 hours and standard appeals and grievances must be resolved within 30 calendar days. Exempt grievances are grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved by the close of the next business day.

The following table summarizes the number and type of A&G cases received in 2017, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented in order to ensure there would not be future similar occurrences.

	No. of Cases Received	**No. of Cases Resolved †**	**% of Cases Resolved within TAT (No.)**
Standard Appeals	174	160	98.1 % (157)
Expedited Appeals	66	67	98.5% (66)
Standard Grievances	804	813	98.4% (800)
Expedited Grievances	174	172	98.8% (170)
Total:	**1,218**	**1,212**	**98.4% (1,193)**
SPD Appeals & Grievances *	318	260	99.6% (259)
Exempt Grievances	2862		

† Total will not match as some cases received in December 2017 may remain open at the start of 2018 and the resolved case number may include some cases received in December 2016 and resolved in 2017.

* The number of total A&G cases which were attributed to seniors and persons with disabilities (SPD).

Provider Dispute Resolution Compliance

A total of 35,519 Provider Disputes were received in the regulatory reporting period of October 1, 2016 - September 30, 2017. 29,536 of the Provider Dispute cases met the resolution turnaround time of 45 working days. The majority of cases involved claims/billing disputes.

Claims Processing Compliance

The Plan received 6,595,046 medical and institutional claims and 6,365,837 claims were processed (paid, denied, adjusted or contested) in the regulatory reporting period of October 1, 2016 - September 30, 2017. A total of 6,001,659 claims were paid or had adjustment payments and 364,178 claims were denied or contested during the reporting period. The turn-around for

processing claims within the required timeframe (30 calendar/45 working days) met the required goal approximately 98% of the time. There were no compliance concerns to note.

Conclusion

CalViva Health continues to maintain the Plan's operational foundation while developing new or updated key activities to operate a successful and compliant health plan. Compliance efforts continue to focus on Plan staff and provider training; improving critical work flow processes between CalViva Health and Health Net or CalViva Health and other delegated organizations; conducting oversight audits, reviewing reports and data needed for oversight and monitoring of delegated organizations.

CalViva Health's staff succeeded in meeting the 2017 challenges of multiple regulatory audits/reviews, new regulation implementation, increased regulatory reporting and new program implementations (e.g. Mega-Reg implementation, benefit expansions, member transitions due to provider contract terminations, etc.).

In 2018, the Plan expects to undergo additional audits and reviews from regulatory agencies and will continue to address new regulation implementation. In 2018, the Plan will be focusing on ongoing implementation of federal regulatory changes passed as the part of the Medicaid Managed Care regulation (aka Mega-Reg) and the associated Medi-Cal contract changes mandating the Plan's implementation of the changes. CalViva Health also expects the reporting requirements to continue and intensify. DMHC and DHCS have significantly increased their oversight and monitoring of health plan activities particularly in the area of member access to providers. The Plan will be implementing new DHCS required geographic access standards and timely appointment access standards and a new annual provider network certification filing requirement. Compliance efforts will focus on preparing for and successfully performing these activities.

The 2018 Compliance Programs and work plans will focus on strengthening oversight activities, improving workflows, enhancing the effectiveness and efficiency of monitoring delegated activities, and identifying new areas of opportunity for collaboration with Health Net and subcontractors. The 2018 Compliance Program will continue its oversight of Health Net and the contract termination activities with Kaiser which includes complying with the associated DMHC Undertakings through September 1, 2018. Compliance oversight of the transition activity related to the EHS termination will also continue and enhanced oversight activities will be implemented. Complete the transition of designated activities and responsibilities to CalViva Health's Operations Department in 2018.

APPROVAL:

		Date:	**February 15, 2018**
Name:	Mary Beth Corrado		
Title:	Chief Compliance Officer		
		Date:	**February 15, 2018**
Name:	Gregory Hund		
Title:	Chief Executive Officer		
		Date:	**February 15, 2018**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Item #10

Attachment 10.A

2018 Compliance Program Description

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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CALVIVA HEALTH COMPLIANCE PROGRAM

I. CalViva Health Overview

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors, and their downstream contracted entities, are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

In serving its membership, CalViva Health ("CalViva" or the "Plan") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, especially those pertaining to the Medi-Cal program. To that end, CalViva established a Compliance Program as described below.

II. Compliance Program Purpose and Objectives

The Compliance Program exists to ensure that all CalViva members have access to quality health care services that are in compliance with all applicable state and federal statutes and regulations, and CalViva's contractual requirements to DHCS.

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

Ensure the integrity of CalViva's Health Plan by upholding the ethical standards stated in the Code of Conduct, and complying with the policies and procedures that reflect our commitment to compliance.
Develop and maintain effective communication and collaboration with CalViva employees, subcontractors and regulators in order to maintain operational and regulatory integrity.
Provide oversight of subcontractors, including auditing of delegated functions.
Detect noncompliance as soon as possible, and in cooperation with CalViva subcontractors and stakeholders, make all reasonable efforts to correct or remedy the operational factors/circumstances under which the noncompliance occurred.
Report promptly to the appropriate state and federal agencies all required or contracted operational data, and also any suspected criminal and civil violations of statutes governing the provision of health care and health care plans.
Comply with the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) in their audits of CalViva and its providers.

Additionally, CalViva's Compliance Program is based on seven key elements stated in the Federal Sentencing Guidelines Manual as necessary for an effective compliance program:

1. Written standards of compliance
2. Designation of a Chief Compliance Officer
3. Effective education and training
4. Audits and evaluation techniques to monitor compliance
5. Reporting processes and procedures for complaints
6. Appropriate disciplinary mechanisms
7. Investigation and remediation of systemic problems

III. SCOPE

CalViva's Compliance Program oversight extends to the members of the Commission and the Commission's subcommittees, CalViva's employees and CalViva's delegated subcontractors, including contracted Knox-Keene licensed health plans, participating providers, and suppliers.

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

The following are some of the state and federal agencies that have legal authority to regulate various aspects of health care and health care plans.

- Centers for Medicare and Medicaid (CMS)
- Office of Civil Rights (OCR)
- Department of Managed Health Care (DMHC)
- Department of Health Care Services (DHCS)

By extension, CalViva assumes contractual responsibility from DHCS for assuring compliance with the regulations promulgated by these agencies and has developed various operational policies and procedures for that purpose. Section VIII of this Program Description lists the statutes and regulations that specifically relate to CalViva's Compliance Program. Moreover, these agencies have the right to access premises to determine/investigate compliance with the applicable regulations, executed contracts, and for any other reasonable purpose with or without notice to CalViva or its subcontractors and delegates.

Corporate oversight of CalViva's Compliance Program is shared by the RHA Commission, CalViva's Compliance Committee, and CalViva's Chief Compliance Officer ("CCO"). Their respective roles are briefly outlined below:

B. RHA COMMISSION

1. Bears ultimate responsibility for overseeing and supporting CalViva's operations, including the Compliance Program.
2. Reviews and approves the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct.
3. Reviews periodic reports of Compliance Program activities

C. THE COMPLIANCE COMMITTEE

1. Oversees CalViva's Compliance Program and advises the CCO on Program adequacy.
2. Reviews the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct and recommends revisions as needed.
3. Analyzes CalViva's contractual, legal, and regulatory requirements and risk areas and consults with advisors and legal counsel as necessary.
4. Monitors reports of fraud, waste and abuse, and unauthorized use and/or disclosures of personal information ("PI"), including protected health information ("PHI").
5. Reviews and approves recommendations to modify or establish internal systems

and controls necessary to carry out the Compliance Program.

6. Supports investigational activities performed by the CCO, and or state and federal officials, as they relate to violations of the federal False Claims Act, Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act (HIPAA).
7. Reviews and approves disciplinary and corrective actions related to non-compliance with the Compliance Program.

D. CHIEF COMPLIANCE OFFICER (CCO)

1. Has operational accountability for the entire Compliance Program as detailed in this document.
2. Oversees the development, operation, evaluation and improvement of the Compliance Program, including corrective actions.
3. Develops the annual Compliance Program Work Plan.
4. Reports to CalViva's Chief Executive Officer and the Commission.
5. Chairs the CalViva Compliance Committee.
6. Serves as CalViva's ~~"Privacy and Security Officer" and~~ "Anti-Fraud Officer".
7. Is the primary CalViva liaison with DHCS and DMHC.

V. COMPLIANCE RISK AREAS

The following presents just some of the potential risks associated with the delivery of health care and health plan administration. These, and many others, are the focus of the Compliance Program's due diligence in monitoring, reporting, taking corrective action and improving.

A. Access & Availability, and Quality of Care:

- Unavailable or inaccessible covered services to members;
- Inappropriate withholding or delay of covered services;
- Improper interference with health care professionals' advice to members regarding member's health status, medical care and treatment;
- Non-credentialed physicians or unlicensed/certified practitioners and providers;
- Discrimination on the basis of race, color, national origin, sex, age or disability.

B. Data Collection and Submission:

- Noncompliance with contractual and regulatory requirements related to the accurate, complete, timely and truthful submission of data (e.g., encounters data, claims data, financial reports and other required operational reports).

C. Member Grievance and Appeal Procedures:

- Failure to ensure that members are properly notified of their grievance and appeal rights;
- Failure to respond and resolve member grievances and appeals within the required timeframes.

D. Emergency Services:

- Improper use of prior authorization for emergency services;
- Denial of payment for emergency services based on contractual standards, including the "prudent layperson" standard;
- Unavailable or inaccessible emergency services within the Plan's service area.

E. Kickbacks and Other Inducements:

- Willful offer, payment, solicitation or receipt of remuneration to induce the referral of business reimbursable under the Medi-Cal program;
- Inappropriate incentives or remuneration to enrollees to induce them to use a particular practitioner, provider, or supplier.

F. False Claims:

- False or fraudulent claims knowingly presented for payment or approval;
- False records or statements material to a false or fraudulent claim knowingly made, used, or caused to be made or used.

G. Confidentiality:

- Unauthorized use and or disclosure of a member's or an employee's personal information (PI) or protected health information (PHI);
- Improper disclosure of protected peer review information.

H. Excluded Providers:

- Contractual or employment relationships with persons or entities which are suspended, excluded or otherwise not eligible to participate in federal or state health care programs;
- Improper reimbursement for items or services furnished, ordered, prescribed, or supplied by an excluded person or entity;
- Failure to take appropriate corrective action upon subsequently learning of a person's or entity's excluded status.

I. Member Dis-Enrollment:

- Improper action to request or encourage an individual to dis-enroll from any health plan.

J. Marketing

- Improper or misleading marketing materials

VI. COMPLIANCE PROGRAM ELEMENTS

A. POLICIES AND PROCEDURES

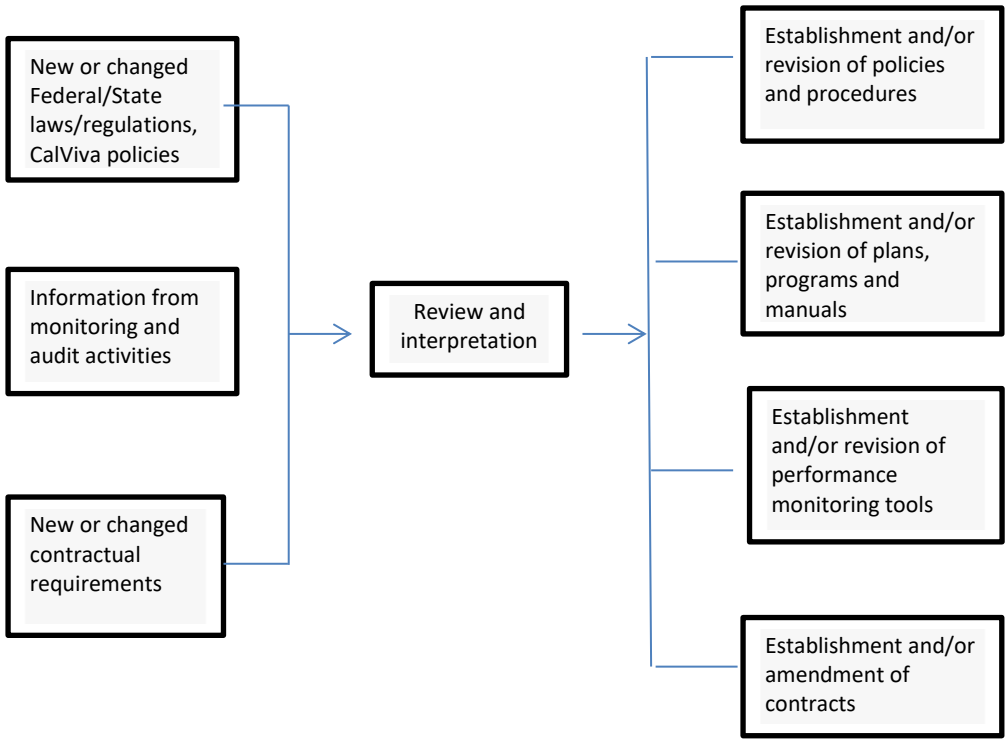
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from the Medical Management and Finance Departments. CalViva's Compliance Committee or other Plan Committees, as applicable, meet regularly to review and approve proposed changes to CalViva's Policies and Procedures. CalViva maintains an on-line library of policies and procedures. Although it contains many policies, Table 2 lists those key policy topics that underpin the majority of CalViva's risk management approach and compliance methodologies. Two fundamental Compliance Program plans, the "Privacy and Security Plan" and the "Anti-Fraud Plan", are reviewed annually by the Commission and provide detailed plan requirements and activities.

Table 2. Key Compliance-Related Policy Topics

Code of Conduct	**Quality Improvement**
Conflict of Interest	**Utilization Management**
Privacy and Security	**Credentialing**
Anti-Fraud	**Peer Review**
Appeals and Grievances	**Delegation Oversight**
Claims	**Provider Disputes**

Figure 1 shows the factors that may precipitate changes in various policies, procedures, and ancillary documents.

Figure 1.



B. MONITORING

The Compliance Program incorporates periodic monitoring and auditing of its subcontractors. Mechanisms such as delegation oversight audits, case file audits, and periodic review of operational metrics are employed. Additionally, CalViva conducts joint operational and management meetings with subcontractors. Table 3 presents some of the key activities that are monitored and reported on a periodic basis (e.g., monthly, quarterly, annually).

Table 3. Activities Monitored by CalViva

Provider Network Contracting and Updating	**Member Appeals and Grievances**	**Practitioner and Provider Credentialing**
Provider Access	**Facility Site Reviews & Medical Record Reviews**	**Encounter Data**

Member Rights and Services	Cultural and Linguistic services	Claims Payment
Marketing	Provider Grievances and Disputes	Utilization Management & Case Management
Health Education	Mental Health & Behavioral Health Services	Quality Improvement
Pharmaceutical Services	Provider Training	Continuity of Care

When monitoring indicates problems, an appropriate Corrective Action Plan (CAP) is implemented to ensure issues are communicated and resolved.

C. EDUCATION AND TRAINING

The Compliance Department provides continuous training and education of its employees on their legal and ethical obligations under applicable laws, regulations and organizational policies. For example, upon completion of new hire training and annually thereafter, all employees must sign a certification statement acknowledging that they have read and understood the documents listed in Table 4.

Table 4. Program Documents

Compliance Program Description	Code of Conduct	Conflict of Interest	Anti-Fraud Plan
Privacy and Security Plan	Confidentiality Agreement	Drug ~~Free Workplace~~ and Alcohol Policy	

Contracted consultants also receive copies of the Compliance Program, Anti-Fraud Plan, Privacy and Security Plan, and Code of Conduct. They must sign a certification statement acknowledging that they have read and understand the documents.

Employees also receive training on the proper execution of key work processes. CalViva regularly reviews and updates its training programs as well as identifies additional areas of training as needed based on new developments. Information regarding these developments and their implications are also communicated to and from CalViva's contractors as applicable.

Additionally, CalViva's CCO, Management and staff receive additional education and training through professional associations, webinars and regulatory agency meetings related to federal and state requirements and compliance.

D. REPORTING NONCOMPLIANCE

Fundamental to the effectiveness of CalViva's Compliance Program is the concept of nonretaliation. All persons associated with CalViva, including its Commission members, Committees, employees, subcontractors, consultants, and vendors are free to come forward and report suspected noncompliance with the Code of Conduct, Program Documents, CalViva policy and procedures, and state and federal regulations without fear of retaliation or retribution. The following types of noncompliance are of particular concern for expeditious reporting and corrective action:

1. **Criminal and Civil Violations of Law**: CalViva conducts fact-finding activities, and reports to the proper authorities for further investigation and action, all credible, suspected occurrences of fraud, waste, abuse, kickbacks, and unauthorized uses and disclosures of protected information, including PHI.

2. **Contractual Violations**: As outlined in the "Scope of Work" section of CalViva's contract with DHCS (and occasionally as issued in DHCS "All Plan Letters"), CalViva must submit a broad range of Plan data and information to DHCS and DMHC (e.g., encounter data, grievances /appeals, provider network, timely access, etc.). Many of these reports are submitted in agency-specified formats by each Department's stated due date. Additionally, CalViva must also respond to DMHC and DHCS as it relates to members' requests for Independent Medical Reviews (IMRs) and State Hearings (SHs) by each Department's due date. Failure to comply in a timely manner to these agency's requests may result in CalViva receiving an Enforcement Action.

3. **Other Misconduct**: Those behaviors that do not comport with the general principles outlined in the Code of Conduct of treating other employees, subcontractors, providers, and Plan members with honesty, dignity, respect and courtesy.

E. RESPONSE AND CORRECTIVE ACTION

Noncompliance with, and violation of, state and federal regulations can threaten CalViva's status as a reliable and trustworthy provider capable of participating in federal health care programs. Accordingly, CalViva in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violations occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If any consultant or subcontractor is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination of CalViva's contract with the consultant or subcontractor.

VII. SUMMARY

CalViva's Compliance Program employs a comprehensive approach to ensuring its business operations are in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, including those specifically related to the Medi-Cal program. Moreover, CalViva maintains an on-going commitment to ensure that the Compliance Program remains relevant and vigilant to the requirements of a constantly evolving and regulated managed health care system.

VIII. AUTHORITY

1. Knox-Keene Health Care Service Plan Act of 1975 and its amendments (California Health and Safety Code)
2. Title 28 of the California Code of Regulations
3. Title 22 of the California Code of Regulations
4. California Welfare and Institutions Codes
5. 42 CFR 438 (Managed Care)
6. 45 CFR 160, 162, and 164 (HIPAA Privacy & Security Rules)
7. 45 CFR 92 (Anti-Discrimination)
8. California Information Practices Act of 1977 (IPA)
9. The California Confidentiality of Medical Information Act (CMIA)
10. CalViva-DHCS Medi-Cal Contract (Including all amendments)
11. Federal Sentencing Guidelines Manual: Chapter 8, §8B2.1. Effective Compliance and Ethics Program

IX. Program Documents

1. Code of Conduct
2. Anti-Fraud Plan
3. Privacy and Security Plan
4. CalViva Policies & Procedures

X. APPROVAL

February ~~16~~15, 201~~7~~8

	_____	_____
Name:	Mary Beth Corrado	Date
Title:	Chief Compliance Officer	

February 1~~6~~5, 201~~7~~8

	_____	_____
Name:	Gregory Hund	Date
Title:	Chief Executive Officer	

February 1~~6~~5, 201~~7~~8

	_____	_____
Name:	David S. Hodge, M.D.	Date
Title:	Chair, RHA Commission	

DOCUMENT HISTORY	
Date	**Comments**
03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
02/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.

Item #11

Attachment 11.A

2018 Code of Conduct

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

Table of Contents

I. CalViva Health Overview:

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

II. Purpose:

All employees and all persons associated with CalViva Health, including its Commission members, delegated organizations, consultants, contracted providers and vendors, are responsible for acting in a manner consistent with the code of conduct summarized in the following general principles:

1. We will treat all members with dignity, respect and courtesy.
2. We will consistently & accurately represent ourselves & our capabilities to members the public and the Medi-Cal program.
3. We expect all employees to perform their jobs with honesty and integrity.
4. We will strive to ensure that our providers render services that meet the identified needs of our members and avoid the provision of services which are not medically necessary, effective or efficient.
5. We will strive to respond in a meaningful way to the concerns of our stakeholders, Members, Providers, Counties of Fresno, Kings, and Madera.
6. We will strive to achieve an excellent standard of performance throughout the organization.

III. Elements:

The following provisions of the CalViva Health Code of Conduct are intended to guide

employees and all persons associated with CalViva Health in their day-to-day activities. The above general principles are applied in the following:

1. Member Services and Rights:

A. CalViva Health requires its providers to adopt a standard of care that reflects federal and state laws and regulations, clinical practice guidelines, and the standards of each professional discipline.

B. CalViva Health employees and providers will treat members in a manner that reflects the following rights:

1. To be treated with respect, dignity and courtesy from health plan providers and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.

2. To be provided with free aids and services to communicate effectively with CalViva Health employees and providers and not be discriminated against on the basis of race, color, national origin, age, disability or sex.

3. To have a private relationship with their provider and to have their medical record kept confidential. To be noticed if there is a breach of their protected health information. Members also have the right to receive a copy of, amend and request corrections to their medical record. Minors have the right to certain services that do not need a parent's okay.

4. To receive information about CalViva Health, its services, its doctors and other providers. Members have the right to choose their Primary Care Physician from the doctors and clinics listed in CalViva Health's provider directory. They also have the right to get appointments within a reasonable amount of time.

5. To talk with their doctor about any care the doctor provides or recommends, discuss all treatment options, and participate in making decisions about their care. Members have the right to talk candidly to their doctor about appropriate or medically necessary treatment options for their condition, regardless of the cost or what their benefits are.

6. To receive information about treatment regardless of the cost or what their benefits are. Members have the right to say "no" to treatment. Members have a right to decide in advance how they want to be cared for in cases of a life-threatening disease, illness, or injury.

7. To complain about CalViva Health, the health plans and providers we work with, or the care provided without fear of losing their benefits. CalViva Health

will help the member with the process. If a member doesn't agree with a decision, they have the right to appeal. Members have the right to disenroll from CalViva Health whenever they want.

8. To request a State Hearing.

9. To receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of CalViva Health's network. No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

10. To request an interpreter at no charge and not use a family member or a friend to interpret. Members have the right to get the Member Handbook and other information in another language or format.

11. To receive information about member rights and responsibilities. Members have the right to make recommendations about these rights and responsibilities.

2. Provider/Vendor Relations and Contracts:

A. CalViva Health does not enter into contracts or other arrangements with providers which, directly or indirectly, pay or offer to pay anything of value, be it money, gifts, space, equipment or services, in return for the referral of members to or by CalViva Health for services paid by the Medicaid program or by any other federal health care program.

B. CalViva Health does not enter into financial arrangements with providers that base compensation on the volume of Medicaid services provided.

C. CalViva Health does not approve nor cause claims to be submitted to the Medicaid program or any other federal health care program:

1. For services provided as a result of payments made in violation of (1) above.

2. For services not rendered by the provider identified on the claim form.

3. For services rendered by a person who is not properly licensed or is known to have falsely claimed to be a specialist.

4. For services that are not reasonable and necessary.

5. For services, which cannot be supported by the documentation in the medical record.

D. CalViva Health does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with the Medicaid program or any other federal health care benefit program.

E. CalViva Health does not provide improper or inappropriate incentives to providers to reduce or limit services to Medicaid beneficiaries or recipients of other federal health care programs.

F. CalViva Health conducts all business with provider and vendors at arm's length and pursuant to written contract.

G. All contracts with providers are for no less than a one year term, clearly state the responsibilities of the provider and clearly delineate compensation or fee schedules that meet regulatory guidelines and are not based on the volume of Medicaid services to be provided.

H. All provider contracts meet Medicaid program subcontracting requirements, including, but not limited to, a "hold harmless" provision.

I. Contracts with providers and vendors contain a provision that requires the vendor or provider to abide by all applicable provisions of the Plan.

3. Business Operations and Accounting:

A. CalViva Health does not retain Medicaid funds that are not properly owed to CalViva Health or one of its contracted providers.

B. CalViva Health does not engage in transactions that provide excessive economic benefit to persons with a vested interest in CalViva Health (e.g. members, directors, officers).

C. All financial reports, accounting records, research reports; expense accounts, time sheets and other financial documents shall accurately represent performance of operations.

D. CalViva Health strives to preserve and protect its assets and to direct such assets to its appropriate purposes.

E. CalViva Health has established procedures to ensure a system of internal controls that provide reasonable assurance that financial records are executed consistent with local, state and federal regulatory requirements and accounting industry guidelines.

F. CalViva Health trains and/or educates accounting staff regarding asset accountability and the need to account for all financial transactions.

G. CalViva Health has an audit performed annually by an independent certified public accountant or independent accountant.

H. The accounting staff maintains documents and other records of original entry to support asset acquisitions and dispositions. Books and records shall fairly and accurately reflect, in reasonable detail, CalViva Health's business transactions, assets acquisitions, sales and deposits, as well as other activity.

I. CalViva Health regularly maintains assets and other such records in accordance with CalViva Health's policy, but no less frequent than monthly, to include, but not be limited to, Cash, Accounts Receivable, Fixed Assets, etc.

J. CalViva Health management regularly provides financial statements to the RHA Commission.

K. CalViva Health protects and secures its financial data. Record destruction is conducted in accordance with approved document destruction policies and procedures.

L. CalViva Health recognizes the potential for conflicts of interest in business activities. To achieve our goals and to maintain integrity, any employee or other persons associated with CalViva Health who could potentially benefit from a contract shall not participate in CalViva Health's decision-making process relative to that business entity.

M. To guard against any conflicts of interest, CalViva Health requests all RHA Commissioners, officers and employees to complete a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable on an annual basis.

N. In compliance with Article 2.4 of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code, on a biannual basis RHA Commissioners and CalViva Health officers will take the two-hour public service ethics law and principles AB 1234 course approved by the Attorney General and Fair Political Practices Commission.

O. CalViva Health prohibits the solicitation or acceptance of gifts, gratuities, favors or other benefits from persons or entities that do business with CalViva Health. Notwithstanding the foregoing, acceptance of common business hospitality, such as occasional meals, entertainment or nominal gifts with a value of $50.00 or less, are not considered a violation of this paragraph.

P. CalViva Health is a not-for-profit public entity, and CalViva Health requires all employees to comply with campaign finance and ethics laws. No employee may use CalViva Health's funds to make any contribution to any political candidate, or political organization except as allowed under federal law. Individual employees may personally participate in and contribute to political organizations or campaigns with their own funds, but must do so as individuals and not as representatives of CalViva Health. CalViva Health may publicly offer recommendations concerning legislation or regulations being proposed which pertain to managed health care. However, neither CalViva Health nor a CalViva Health employee may attempt to influence the decision-making process of any governmental body or official by an improper offer.

Q. CalViva Health avoids any activities that unfairly or illegally reduce or eliminate competition, control prices, allocate markets or exclude competitors. To this end, CalViva Health:

1. Does not enter into agreements to unduly influence prices, charges, profits and service or supplier selection;

2. Negotiates contracts with contractors or suppliers on a competitive basis based upon such factors as price, quality and service; and,

3. Employees who attend association or professional association meetings, or who otherwise come in contact with competitors, avoid discussions at those meetings regarding pricing or any other topic which could be interpreted as collusion between competitors.

R. CalViva Health prepares Medicaid Capitation Program reports as necessary. The reports are prepared based upon the Accounting and Auditing Guidelines issued by the California Department of Managed Health Care and California Department of Health Care Services, which administer the various State Regulations as they relate to CalViva Health and its contractors.

S. No employee or person associated with CalViva Health prevents or delays the communication of information or records related to violation of the Plan's Compliance Program to the Chief Compliance Officer (CCO).

T. CalViva Health shall respond appropriately to government subpoenas. If CalViva Health has reason to believe that there is an impending government investigation, it retains all documents that may pertain to that investigation.

U. CalViva Health, in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violation occurs. Depending on

the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If a subcontractor fails to remedy the circumstance, corrective action may include a range of disciplinary and corrective actions up to and including termination of the contract.

4. Medical Records:

A. Contractually, CalViva Health providers are required to maintain member medical records in accordance with Federal and State laws and regulations. Such records may be forwarded for review by CalViva Health (or CalViva Health is given access to such records) in a confidential manner, with access to medical records limited to those CalViva Health employees involved in claims adjudication, grievance/appeal review, quality improvement or medical/utilization review management.

B. CalViva Health handles and transmits electronic or paper medical record information in accordance with the HIPAA privacy and security regulations. CalViva Health will timely implement HIPAA-compliant systems. As part of its Compliance Program, CalViva Health will:

1. Enter into written contracts with all business associates (as that term is defined in the HIPAA privacy regulations) to ensure that all entities performing services on behalf of CalViva Health comply with the HIPAA privacy and security regulations.

2. Maintain a member specific log of all requests for access to the medical information of a member by third parties and all releases of medical record information to third parties.

3. Report in a timely manner any suspected privacy and security incidents and/or breaches to the required regulatory agencies.

4. Conduct ongoing training of employees to ensure awareness and adherence with the HIPAA privacy and security regulations.

C. CalViva Health retains records in accordance with a written policy which incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

A. CalViva Health monitors the claims submitted by providers to ensure honest, fair and accurate claim practices. All entities providing claims functions on behalf of CalViva Health are required to demonstrate experience and knowledge in performing such functions in accordance with federal, state and local law.

B. CalViva Health monitors and periodically audits (part of delegation audits) the claims process of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure honest, fair and accurate claims processes.

C. CalViva Health reviews the written claims policies and procedures of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure that the policies properly reflect CalViva Health's policies and the requirements of the Medicaid program.

D. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, properly coordinate benefits with any applicable third-party payor.

E. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, have prior authorization policies, as applicable, for all inpatient admissions, partial hospitalizations and therapies requiring prior authorization and that prior authorization numbers accompany all claims from providers. CalViva Health and its contracted administrative organization maintain records to support decisions regarding prior authorization.

F. CalViva Health, its' contracted administrative organization and when applicable, other contracted delegated organizations, send denial letters and provide reconsideration and appeal of denials in accordance with applicable federal or state law.

G. CalViva Health does not compensate its contracted administrative organization and when applicable, other contracted delegated organizations, or contracted providers/vendors in such a manner as to induce improper or up-coded claims.

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and cultural differences of other individuals.

B. CalViva Health does not discriminate on the basis of age, religion, color, race, sex, sexual preference or national origin in personnel policies and procedures.

C. CalViva Health strives to provide equal employment opportunities and a working environment free from harassment.

7. Avoiding Potential Conflict of Interest or Retribution

It is the policy of CalViva Health to promote a working environment free from conflict of interest or retribution against individuals who report suspected fraud. In training sessions with employees regarding fraud prevention, employees are informed that there is no retribution against employees for reporting fraud. Employees and members are notified in writing of the procedures for reporting fraud and that there is no retribution against individuals reporting suspected fraud. If anyone has concerns about retribution, he or she may elect to remain anonymous in reporting suspected fraud.

If the Chief Compliance Officer or any member of the Executive Management Staff has a conflict of interest in an incident of suspected fraud, the person must report the conflict of interest to the Chief Executive Officer or Chairman of the RHA Commission and be disassociated from the investigation. If necessary and appropriate, the report will be referred to outside counsel for investigation.

APPROVAL:

		Date:	**February 165, 20178**
Name:	Mary Beth Corrado		
Title:	Chief Compliance Officer		
		Date:	**February 156, 20178**
Name:	Gregory Hund		
Title:	Chief Executive Officer		
		Date:	**February 165, 20178**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Item #12

Attachment 12.A

2018 Anti-Fraud Plan

ANTI-FRAUD PLAN

For inquiries regarding this Anti-Fraud Plan, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

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CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") Anti-Fraud Plan is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and abusive activities, and to protect members and the public in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Through the Anti-~~fraud~~Fraud Plan, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's Anti-Fraud Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the Department of Health Care Services Medi-Cal Contract requirements in Exhibit E, Attachment 2, Provision 26.

2. Definitions:

A. **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Health care fraud is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud could be committed by dishonest

health care providers such as doctors, laboratories, medical equipment suppliers, by health plan members, Plan staff, and Plan subcontractors.

Some examples of fraud include:

1. Billing for services or supplies not provided
2. Altering or falsifying claims
3. Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
4. Using another person's Medi-Cal card to obtain medical care

See Appendix A for a more extensive set of examples*.*

B. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Some examples of abuse include**:**

1. Excessive charges for services or supplies
2. Overutilization/underutilization of medical or health care services

C. **Waste** means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit (42 CFR 455.2).

II. Scope of Anti-Fraud Plan:

In an effort to assure public accountability, conduct proper business practices, and operate within the limited resources of the Medi-Cal program, CalViva/delegated organizations will investigate and pursue prosecution of fraudulent activity by providers, enrollees, employees, and other individuals or entities. CalViva/delegated organizations also cooperate with local, state and federal authorities whenever appropriate.

The Anti-Fraud Plan is part of CalViva's comprehensive Compliance program and includes the following:

A. the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations;
B. training of plan personnel and contractors concerning the detection of health care fraud;

C. the plan's procedure for managing incidents of suspected fraud; and
D. the internal procedure for referring suspected fraud to the appropriate government agency.

1. Responsibilities for Anti-Fraud Plan:

The RHA Commission has ultimate responsibility for this Anti-Fraud Plan. The Anti-Fraud Plan will be submitted to the Commission for annual approval. An annual report will be made to the Commission regarding the Plan's Anti-Fraud activities, subject to any confidentiality protections which may be required.

The implementation of the Anti-Fraud Plan will be the responsibility of the Chief Compliance Officer ("CCO"), under the supervision of the Chief Executive Officer ("CEO"). The CEO will make certain that sufficient resources are in place to properly implement the Anti-Fraud Plan. The CCO will be responsible for overseeing any investigation or necessary corrective action, except as otherwise provided in this Plan.

The CCO will serve as the Anti-Fraud Officer and have the following duties:

1. Receive information (formal and informal) on cases of suspected fraud
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities.
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU.
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva
5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required
6. Maintain logs to assure timely investigations and reporting
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf.
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies

2. General Anti-Fraud Oversight Mechanisms:

The general oversight mechanisms of the Plan's Anti-Fraud program include the following:

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements.

2. Policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate.
4. Ongoing monitoring and oversight by the CalViva Compliance Committee.
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents.
6. Provide members with information on how to report suspected fraud incidents.
7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem.
8. Assure that conflicts of interest are not present in the investigation of suspected fraud cases.
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends.
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary.
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities.
12. Monitor and review fraud cases/issues reported by delegated organizations.
13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities, through the review of performance reports and annual audits; and developing corrective action plans, when appropriate.
14. Review the Anti-Fraud Plan annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC).
15. Review Health Net's annual anti-fraud report to the DMHC.
16. Assure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds.

3. Procedures for Investigating Suspected Fraud:

Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures.

1. The procedure for undertaking an investigation includes:
    A. A review of all identified related documents;
    B. Consultation, if necessary, with internal or external resources with knowledge of applicable law, regulations or policies, procedures or standards; and
    C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.
3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.
4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
    A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies.
    B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members.
    C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.
6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. CalViva Employee, Consultant and Contractor Investigations - CalViva has retained Prentice, Long & Epperson, LLP to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Prentice, Long & Epperson, LLP for investigation as needed.
2. CalViva Member and Provider Investigations - As described in Section 3, in accordance with the ASA and CPSA between CalViva and Health Net, Health Net Special Investigations Unit (SIU) performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), and Certified Fraud Examiners ("CFE").
3. Member and Provider Investigations – Delegated Organizations -Organizations with delegated responsibilities (e.g. sub-contracted health plans, participating provider groups, etc.) that the Plan may contract with to provide services to CalViva Health members are required to comply with Plan requirements and all applicable state and federal regulations. Delegated organizations must participate with CalViva's Anti-Fraud Program and/or have policies, processes, experienced investigative staff/contractor in place for the detection, identification, and investigation of suspected fraud incidents.

5. Additional Internal and External Resources:

Other internal and external investigative resources available to the Plan include the following:

1. The Plan's Chief Medical Officer, Chief Financial Officer, Chief Operating officer ("COO") other Compliance and Operations Department staff.
2. The Plan's independent financial audit firm
3. DHCS audits and surveys
4. DMHC audits and surveys

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

CalViva will promote an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. The Plan will comply with Section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the False Claims Act. In training sessions with employees regarding the Plan's anti-fraud efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting fraudulent activities, including that there is no retaliation against individuals for reporting potential fraudulent activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

If the CEO, CCO, or member of the RHA Commission has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Chairperson of the RHA Commission, and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

7. Referrals to or from Appropriate Outside Agencies:

Depending on the nature of fraud cases, CalViva may receive notices directly from the DHCS or will refer cases to the appropriate regulatory authority.

1. Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements to report to DHCS any potential fraud, waste, or abuse that the Plan identifies to DHCS' Medi-Cal Managed Care Program Integrity Unit or any potential fraud directly to DHCS' Medicaid Fraud Control Unit. The Plan will provide DHCS with the results of a preliminary investigation of the suspected fraud, waste and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity

   The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

   a) Email at PIUCases@DHCS.ca.gov;
   b) E-fax at (916) 440-5287; or
   c) U.S. Mail at:
   Department of Health Care Services
   Audits & Investigations Division
   Attention: Chief, Intake Unit
   MS 2500
   Sacramento, CA 95814

2. Receipts of a Credible Allegation from DHCS - CalViva may be notified by DHCS when there has been a credible allegation of fraud against a provider that is part of the Plan's provider network. In these cases, CalViva must take one or more of the following four actions and submit all supporting documentation to the MCQMD@dhcs.ca.gov inbox:

    1. Terminate the provider from its network
    2. Temporarily suspend the provider from its network pending resolution of the fraud allegation
    3. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
    4. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

3. Removed, Suspended, Excluded, or Terminated Provider Report - CalViva/delegated organizations are prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. CalViva/delegated organizations will check the list of suspended and ineligible providers maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). CalViva/delegated organizations are deemed to have knowledge of any providers on these lists. CalViva will notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

    1. Email at PIUCases@DHCS.ca.gov;
    2. E-fax at (916) 440-5287; or
    3. U.S. Mail at:

    Department of Health Care Services
    Medi-Cal Managed Care Division
    Attention: Chief, Program Integrity Unit
    MS 4417
    P.O. Box 997413
    Sacramento, CA 95899-7413

4. Referrals to Other Regulatory Authorities - If the occurrence of fraudulent activity is confirmed, CalViva may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud committed by enrollees, providers, agents, company employees and other individuals. Such referrals include but are not limited to:
    1. Local police departments,
    2. U.S. Postal Inspector,
    3. Federal Bureau of Investigation,
    4. Office of the Inspector General of the U.S. Department of Health and Human Services,
    5. Internal Revenue Service
    6. Local departments of Public Health in Fresno, Kings, or Madera counties,
    7. DMHC,
    8. Centers for Medicare and Medicaid Services,
    9. State medical licensing and disciplinary boards or
    10. Any other appropriate authorities or agencies.

5. Prosecution - In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section 8.A.

8. Staff Training and Education:

CalViva recognizes that the most effective way to combat fraud is to increase staff awareness through education. The Plan is therefore committed to assuring the education and training of its staff, the staff of its administrative contractor, and providers on fraud and fraud prevention.

The CEO and CCO, in consultation with the RHA Commission, and other executive staff as applicable, will develop a strategic approach to educating CalViva and its community about fraudulent activities that occur in health care environments. CalViva will work closely with Health Net to assure that appropriate fraud prevention strategies are in place and that staff are trained and educated to detect, deter, and refer instances of suspected fraud to the appropriate levels of the organization.

1. CalViva will provide information regarding the detection, prevention and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.

2. An annual training session will be required for all CalViva staff. External experts for training will be consulted, as necessary, to augment and implement the training program.

9. Public Awareness:

CalViva members and their families are the ultimate victims of any fraud activity occurring within the Plan. It is therefore essential for them to be aware of activities that may constitute fraud and to have avenues to report suspected fraudulent activities in order to assist with the prevention and cessation of such activities. Information is included in the Member Handbook/Evidence of Coverage and articles regarding health care fraud and CalViva's efforts to prevent fraud will be sent out in periodic newsletters to members.

The Plan will publicize a fraud reporting telephone number. Potential fraud, waste and abuse incidents may be reported directly to CalViva via one of the following methods:

Toll-free Phone: 1-866-863-2465
Fax: 559-446-1998
Mail: Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
Email: fraudtips@calvivahealth.org

CalViva is sensitive to providing a quick response to any member service concerns that may arise for health plan members. Plan employees will convey any complaints, grievances and/or customer service concerns to the CCO, its administrative subcontractor, Health Net, or, if necessary, to the appropriate regulatory or law enforcement agency.

Concerns expressed are documented and investigation is initiated immediately. If appropriate, within 30 days, a letter is sent out to the originator to acknowledge receipt of the concern and to provide a brief status update.

Medi-Cal anti-fraud information resources are also available through the Department of Health Care Services through the following:

Websites:

- www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx
- www.stopmedi-calfraud.dhs.ca.gov

The Medi-Cal Program has a hotline maintained by the Department of Health Care Services: Medi-Cal Fraud Hotline: 1-800-822-6222

10. Participating Health Care Providers:

The Plan contracts with health care provider organizations, Health Net and other delegated organizations to provide services to CalViva members through their network of health care providers. These provider networks include but are not limited to: primary care providers, medical specialists, mental health specialists, acute care hospitals, skilled nursing facilities, clinical laboratories, pharmacies and other ancillary providers. Providers are given information about fraud prevention, how to report suspected fraud or abuse incidents, and how the Plan and/or contracted organizations respond to fraudulent activity.

11. Location:

The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

12. Annual Report to the Department of Managed Health Care:

In compliance with California Health & Safety Code Section 1348, CalViva will file with the Department of Managed Health Care a written annual report regarding the Plan's anti-fraud activities, including, but not limited to:

1. CalViva's efforts to deter, detect and investigate fraud, and report cases of fraud to law enforcement agencies.
2. Of the cases reported to law enforcement agencies, a listing of the number of cases prosecuted and the status of prosecution if known.
3. Recommendations to further improve and refine the Plan's Anti-Fraud Plan.

Authority

DHCS Contract, Exhibit E, Attachment 2, Provision 26
Health & Safety Code Section 1348
Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75

DHCS All Plan Letter 08-007, 15-026, 16-001

References
CalViva Health Compliance Plan
CalViva Health Policies and Procedures

APPENDIX A

Types of Fraudulent Acts and Examples/Indicators of Potential Fraud (Adapted from National Health Care Anti-Fraud Association publications)

I. Types of Fraudulent Acts

It is virtually impossible to itemize every conceivable health care fraud; any opportunity to bill for services is an opportunity to commit health care fraud and every fraud scheme has its own unique characteristics. Most health care frauds, however, fall into one or more broad categories of activity, including the outright fabrication of claims and the falsification of claims.

A. Fabrication of Claims

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or adds to otherwise legitimate claims fictitious charges for treatments or services that were never provided. Some examples of such fabrication are:

1. An individual provider who, using existing information on his/her patients creates claims for office visits or treatments that never took place.
2. A provider who, in the case of billing for patient treatments, adds charges for x-rays or lab tests that were never performed.
3. A contracted service provider/institution bills for services that were ordered but did not occur due to unforeseen circumstances (patient refused or was unable to make the appointment).

B. Falsification of Claims

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more element(s) of information in a claim for the purpose of obtaining, a payment (or a higher payment) to which he/she is not entitled. Examples of outright falsifications include:

1. Falsifying patients' symptoms or diagnosis and/or the procedures performed as a pretext for obtaining payment for otherwise non-covered services (i.e.: alternative therapies; elective cosmetic surgeries etc.) and/or performing medically unnecessary services solely in order to submit claims and be paid.
2. Falsifying the dates on which service was provided so as to fall within a given coverage period.

3. Falsifying the identity of the provider of the service in an attempt to obtain payment for services rendered by a non-covered and/or non-licensed provider (i.e.: billing for massages as licensed physical therapy or counseling by a Social Worker as psychiatric treatment).
4. "Upcoding" or falsifying the nature of services provided to obtain a higher rate on payment (i.e.: filling a prescription with the generic equivalent but billing for the higher-priced brand-name drug).
5. "Unbundling" or deliberately billing separately for the various elements of a given medical procedure to which one all-encompassing billing code applies, so as to obtain a higher aggregate payment.

II. Examples of Indicators of Potential Fraud

Indicators of potential claims fraud are as varied as they are numerous, ranging from the obvious to more subtle signs. Visibly discernible alterations or handwriting anomalies on a given claim are examples of an obvious indicator. A subtler indicator would be an inconsistency of diagnosis and treatment or an unusually high incidence of a given condition among a provider's patients.

Deciding what factors represent indicators of potential fraud is a subjective matter that varies widely. There is no formulaic or universal set of such indicators. The presence of one or more indicators in and of itself does not necessarily signify fraud, it merely serves to call attention to a claim or situation that is out of the ordinary and therefore requires further review.

The following examples illustrate some of the signs that might represent indicators of potential fraud on the part of a dishonest provider, a provider employee and/or a dishonest claimant:

1. Misspelled medical terminology on claim.
2. Similarity of patient/provider handwriting.
3. Apparent alteration of dates, amounts and/or other claim information.
4. Claims for non-emergency services dated Sundays or holidays.
5. Inconsistency between treatment billed and patient's diagnosis, age, gender etc.
6. Inconsistency between provider type and treatment billed.
7. Inconsistency between patient diagnosis and prescription billed.
8. Inconsistency between patient's medical history and treatment billed.
9. Consistent submission of photocopied claims.
10. Provider's lack of support documentation for claim selected for audit.
11. High-dollar claim for service dated either soon after effective date of coverage or just before the termination of coverage.
12. Unusual time lapse between date of service and date claim submitted.
13. Anonymous and/or persistent telephone inquiries re: status of claims.
14. Undue pressure to pay claims quickly.
15. Payments to P.O. Box not under provider or claimant name.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

Please Note: CalViva Health will not discriminate against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal or California False Claims Act, including an investigation for, initiation of, testimony for, or assistance in such an action.

Name: _____ Contact Phone: _____

Department: _____

Please indicate here if you wish to remain anonymous: _ Yes, I wish to remain anonymous

Case Type: __ Provider __ Member __ Employee ___ Subcontractor ____Other ____

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

Other Identifying Information (Member ID Number, Date of Service, etc.) _____

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

_____

_____

Signed: _____ Date: _____

The completed form should be put in an envelope marked "Confidential, for CalViva Health Chief Compliance Officer and submitted to CalViva Health, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

APPROVAL:

Name: Mary Beth Corrado
Title: Chief Compliance Officer
Date: February 15, 2018~~February 17, 2017~~

Name: Gregory Hund
Title: Chief Executive Officer
Date: February 15, 2018~~February 17, 2017~~

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson
Date: February 15, 2018~~February 17, 2017~~

Program Description History		
Date	**Section #**	**Comment(s)**
3/1/2011		New Program Description
4/30/2012	Replaces former version	Annual review; changes to clarify and reflect current activity
1/7/2013	various	Annual review, clarified descriptions of activities
6/7/13	Cover page, sections 8 & 9	Changes to address DMHC requirements
2/6/14	Various	Annual review, changes to clarify current contractual relationships and activities
1-26-15	Sections 5, 6, 7, 8, 11, 13 and 15	Annual review, changes to update General Counsel information, clarify several sections to better reflect current activities and correct typographical errors
2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026

2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	**Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.**

Item #13

Attachment 13.A

2018 Privacy and Security Plan

PRIVACY AND SECURITY PLAN

For inquiries regarding this Privacy and Security Plan, please contact:

~~Mary Beth Corrado~~Jeffrey Nkansah
Chief ~~Compliance~~ Operating Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
~~mbcorrado@calvivahealth.org~~jnkansah@calvivahealth.org
Phone: 559-540-7850~~47~~

Table of Contents

I. CalViva Health Overview

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS~~") to~~") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

All of the processes and activities performed by contracted or delegated entities on CalViva Health's behalf are performed in compliance with CalViva Health's Privacy and Security Plan described in the following pages. These entities agree to the same restrictions and conditions that apply to CalViva Health with respect to protected health information (PHI) and applicable provisions governing the use of PHI are incorporated into CalViva Health's service and/or business associate agreements with contracted or delegated entities.

1. **Statement of Purpose**:

The purpose of CalViva Health's Privacy and Security Plan is to safeguard the confidentiality of personal information (PI) and protected health information (PHI) while not impeding the exchange of information needed to provide quality health care treatment, payment and operations. To that end, CalViva Health develops and implements policies and procedures designed to enable compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the American Recovery and Reinvestment Act (ARRA) California's Information Practices Act of 1977 (IPA) and Confidentiality of Medical Information Act (CMIA). CalViva Health is committed to creating a culture that effectively encourages its employees and associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy rights of its members.

CalViva Health ensures that member health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

Everyone has a responsibility for monitoring and reporting any activity that appears toviolate this program or the supporting policies and procedures. Failure to follow the Privacy and Security Plan and related policies and procedures are grounds for appropriate discipline, which may include immediate termination.

2. **Confidentiality Guideline:**

CalViva Health and its business associates have adopted a strict guideline regarding the confidentiality of certain information provided to CalViva Health employees and business associates. This guideline applies to all CalViva Health employees/business associates:

All employees/associates are prohibited from any unauthorized access to, use or disclosure of patient ("Member") protected health information (PHI), health care provider confidential information, or CalViva Health proprietary information. This includes, but is not limited to: medical records, claims, benefits or other administrative data that is personally identifiable, CalViva Health compliance program cases, peer review cases, quality improvement and utilization management programs, reports and disease management information containing PHI (hereinafter, collectively referred to as "Confidential Information").

Employees/associates must hold in strict confidence, and not copy, disclose or permit the disclosure to any person of any PHI or Confidential Information disclosed or delivered to him/her by CalViva Health or any provider except that which is allowable based on employee job role, by regulation, or by contractual and business associate agreements.
Employees/associates must comply with all CalViva Health policies and procedures concerning the maintenance of all Confidential Information made known to him/her as a CalViva Health employee/associate.

Employees must comply with all applicable state and federal laws and regulations regarding the Confidential Information. CalViva Health limits access to CalViva Health employee data to a subset of employees who are permitted the use and disclosure of other employee confidential information as required in the scope of their duties.

Any violation of statutes, regulations, policies and/or procedures designed to safeguard the confidentiality of the Confidential Information may include a range of disciplinary and corrective actions up to and including immediate discharge from CalViva Health. Failure to comply with this guideline and all applicable policies, laws, and regulations may result in legal action brought against the violating employee/associate.

II. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Operating Officer ("COO") to serve as the focal point for privacy and security activities and report directly to the Chief Executive Officer and to the RHA Commission. The COO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The COO works with a Compliance Committee to assist in implementation of the Privacy and Security Plan.

The COO responsibilities include:

A. Serving as the Privacy and Security Officer

B. Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;

C. Ensuring Risk Analyses and Risk Mitigation plans are implemented;

D. Ongoing oversight and monitoring of Privacy and Security activities;

E. Preparing and overseeing distribution of the Notice of Privacy Practices;

F. Reporting on a regular basis to the RHA Commission on implementation and compliance;

G. Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;

H. Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;

I. Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;

J. Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;

K. Coordinating mitigation efforts in the event of a disclosure that violates the privacy

laws; and

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has a Compliance Committee to advise the Privacy and Security Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The Chief Compliance Officer ("CCO") serves as chairperson of the meeting. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

B. Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

C. Developing a system to solicit, evaluate and respond to complaints and problems;

D. Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

E. Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, reports from CalViva Health's COO, reports from contractors, appeals and grievances, etc.;

F. Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a breach;

G. Creating or revising policies to better prevent or address privacy and security breaches; and

H. Overseeing development of resolutions to breach issues.

When a potential problem is identified, the COO may also select various individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a

recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

B. The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable

C. That adherence to the Plan and Policies and Procedures is a condition of employment

D. That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations

The Chief Operating Officer will include any significant privacy and security issues as part of the operations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The COO along with Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the deficiency will be corrected and set a time frame for implementing the corrective actions.

~~II.~~III. DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES

1. Definitions:

A. **Abuse** - incidents or practices of a provider, which although are not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary cost to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.

B. **Access and Uses** - allows employee access to PHI subject to qualifying job requirements. Each employee is provided appropriate levels of security to perform their job duties.

C. **Authorization** - written authorization for any use or disclosure of PHI that is not for treatment, payment, health care operations or otherwise permitted or required by regulations and/or statutes.

D. **Breach** - the acquisition, access, use, or disclosure of protected health information, where the security or privacy of an individual's information is compromised; the compromise shall be presumed to be a breach unless CalViva Health or one of its Business Associates as applicable demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment. See 45 C.F.R. § 164.402.

a. "Breach" excludes three scenarios:

- Any unintentional acquisition, access, or use of protected health information by a CalViva Health employee or person acting under the authority of CalViva Health or one of its business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure.

- Any inadvertent disclosure between employees of CalViva Health or of a CalViva Health business associate, where both employees are authorized to access such protected health information, and where the information received as a result of such disclosure is not further used or disclosed.

- A disclosure of protected health information where CalViva Health or one of its business associates has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

E. **Confidentiality** - the obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws and regulations.

F. **Data Aggregation –**the combining of PHI created or received by the Plan on behalf of DHCS with PHI received by CalViva Health in its capacity as the contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

G. **Disclosure** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

H. **Protected health information (PHI)** - Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to: 1) the individual's past, present or future physical or mental health or condition, 2) the provision of health care to the individual, or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

I. **Risk Assessment/Analysis** – the process of identifying, prioritizing, and estimating risks of organizational operations (including mission, functions, image, and reputation), organizational assets, individuals, other organizations, and the Nation, resulting from the operation of an information system.

J. **Risk Management** – The program and supporting processes to manage information security risk to organizational operations (including mission, functions, image, reputation), organizational assets, individuals, other organizations, and the Nation, and includes: (i) establishing the context for risk-related activities; (ii) assessing risk; (iii) responding to risk once determined; and (iv) monitoring the risk over time.

K. **Risk Mitigation** – Prioritizing, evaluating, and implementing the appropriate risk-reducing controls/countermeasures recommended from the risk management process.

L. **Security** - security or security measures encompassing all of the administrative, physical and technical safeguards in an information system. It relates to the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".

M. **Threat** – Any circumstance or event with the potential to adversely impact organizational operations (including mission, functions, image or reputation), organizational assets, individuals, other organizations, or the Nation through an information system via unauthorized access, destruction, disclosure, or modification of information, and/or denial of service.

N. **Vulnerability** – Weakness in an information system, system security procedures, internal controls, or implementation that could be exploited by a threat source.

2. **Mission:**

CalViva Health has incorporated the HIPAA General Administrative Privacy Rule Requirements, the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the HITECH Act and the National Institute of Standards and Technology (NIST) Risk Management Guide for Information Technology systems into its Privacy and Security Plan. CalViva Health has administrative and management arrangements or procedures, including a Privacy and Security Plan, which is designed to guard against the unauthorized access and/or use of PHI. This document provides a description of these requirements, which are as follows:

A. Written standards of conduct, policies, and procedures, which promote CalViva Health's commitment to comply with all applicable Federal and State standards.
B. The designation of a ~~Chief Compliance Operating~~ Privacy and Security Officer and compliance committee responsible for implementing and monitoring privacy and security activities.
C. Effective lines of communication with the organization's employees
D. Conducting ongoing education and training programs
E. Conducting ongoing Risk Analyses to identify threats and vulnerabilities within the organization.
F. Conducting ongoing Risk Mitigation efforts to protect PHI from threats and vulnerabilities.
G. Monitoring and auditing processes to assess the effectiveness of the Privacy and Security Plan.
H. An internal reporting system for receiving complaints and for prompt response to detected offenses.
I. Mechanisms for enforcing compliance standards through well-publicized disciplinary guidelines.
J. The implementation of appropriate measures to prevent future offenses.

The elements of the mission allow CalViva Health to:

A. Ensure that Member's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.
B. Comply with the requirements of ARRA including, but not limited to, Member

requests for restrictions and accounting of disclosures.

C. Protect the public's health and well-being.

D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).

E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160, 162 and 164.

F. Adhere to the HIPAA Omnibus Rule as published on January 17, 2013.

G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b)~~)~~() (15) requirements and the California information Practices Act of 1977.

I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act breach reporting requirements.

J. Ensure privacy and security training is provided to CalViva Health employees, management and business associates.

K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

The goal is to assure that a CalViva Health member's personal health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

CalViva Health's Privacy and Security Plan incorporates the following objectives:

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.

B. Implement corrective action plans to address deficiencies in the safeguard or use of protected health information.

C. Conducting ongoing Risk Analyses to identify threats and vulnerabilities within the organization.

D. Conducting ongoing Risk Mitigation efforts to protect PHI from threats and vulnerabilities.

E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.

F. Identify and investigate potential privacy and security breaches. Take appropriate

action(s) to resolve and report breaches.

G. Provide education and other available resources to assist contracted providers and sub- contractors in becoming compliant with privacy and information security requirements.

H. Educate staff and enforce adherence to CalViva Health's Code of Conduct standards, privacy and security policies and procedures and mission.

I. Provide new legislation updates to providers and contractors that specify required actions to ensure contractual compliance and makes available additional information about privacy and security activities and requirements on an ongoing basis as needed.

Anyone with questions or concerns about the Privacy and Security Plan or a particular policy or procedure should seek the guidance of the ~~Chief Compliance~~Privacy and ~~Officer~~Security Officer ~~(CCO)~~. The Privacy and Security~~Chief Compliance~~ Officer provides support in CalViva Health's ongoing commitment to provide quality services in compliance with the health information privacy and security laws.

~~III.~~IV. SCOPE OF PLAN

1. Policy and Procedures:

CalViva Health has adopted a set of policies and procedures. The policies and procedures are available to employees and business associates. Employees and business associates are able to access the policies in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Privacy and Security Plan and outline areas such as:

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy breaches
E. CalViva Health's training programs
F. CalViva Health's risk analyses and risk mitigation measures
G. CalViva Health's contingency plans

2. Permitted Uses and Disclosures:

CalViva Health's Privacy and Security Plan covers the permitted uses and disclosures pertaining to protected health information. This includes sending a Notice of Privacy Practice to members upon enrollment and annually thereafter explaining how CalViva Health uses and discloses protected health information. CalViva Health is permitted to use and disclose protected health information for activities that are directly connected with the administration of the Plan's healthcare program, which includes but is not limited to establishing eligibility and methods of reimbursement, and providing services for members. CalViva Health extends this commitment to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners. CalViva Health provides DHCS with a list of external entities, including persons, organizations, and agencies to which it discloses PHI annually. The guiding principles of CalViva Health's Permitted Uses and Disclosures of PHI include:

A. Use/disclosure of PHI for CalViva Health management and administration
B. Use/disclosure of PHI by CalViva Health for data aggregation services to DHCS
C. Use/disclosure of PHI by CalViva Health for conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan's healthcare program
D. Use/disclosure of PHI by CalViva Health for legislative investigations/audits related to the administration of the Plan's healthcare program

3. CalViva Health Responsibilities:

CalViva Health has made several commitments in its Privacy and Security Plan, policies and

procedures and business operations. CalViva Health takes steps to ensure a member's Medi-Cal status is not divulged without prior approval except for treatment, payment and operations, or as required by law. CalViva Health's commitment to privacy and security of PHI also includes:

A. **Implementing Safeguards –** CalViva Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in both electronic and hard-copy form. CalViva Health employees are trained in methods to assure that they use all reasonable measures to safeguard protected health information from any use or disclosure that would violate the HIPAA or state regulations or CalViva Health's privacy and security policies. CalViva Health's employees have limited access to protected health information through role-based access and password protections. CalViva Health also has firewalls to protect information from those who do not need to access the protected health information to perform their job functions.

B. **Implementing Security Measures –** CalViva Health employees working with PHI sign a confidentiality agreement; undergo a background check and use workstations and laptops with encryption mechanisms. CalViva Health enforces the "minimum necessary" principle in regards to PHI and ensures employees send secure emails or utilize another appropriate secure method (i.e. secure file transfer protocol ("FTP") when PHI is involved. CalViva Health uses the latest antivirus software and security patches on their workstation and/or laptops. Any uses of removable media devices or remote access used by CalViva Health associates for PHI are encrypted. CalViva Health incorporates a data destruction method consistent with the Department of Defense standard methods and assigns unique usernames and passwords to users accessing PHI. CalViva Health enforces security measures in several ways:

1. **Use of System Security Controls –** CalViva Health will ensure computer systems automatically timeout after no more than 20 minutes of inactivity. CalViva Health will make sure all systems containing PHI display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. CalViva Health's systems will include system-logging functions, access controls, transmission encryption and host based intrusion detection. Logs and user activities are maintained by CalViva Health in accordance with the Plan's document and data retention policy and procedures.

2. **Use of Audit Controls –** CalViva Health will conduct system security reviews of all systems processing and/or storing PHI. The audit controls in place include reviewing systems logs for unauthorized access and ensuring there is a documented change control procedure in place.

3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file

cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

4. **Use of a Contingency Plan –** CalViva Health's contingency plan includes an ability to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency. CalViva Health makes sure all sensitive data including PHI is backed up regularly. Data backups are stored offsite, which allows for restoration of data in the event of an outage.

C. **Notification and Investigation of Incidents and/or Breaches -** CalViva Health is committed to compliance with HIPAA and state health information compliance laws and to correcting violations. Upon discovery of a suspected security incident and/or breach, CalViva Health notifies the applicable state and federal agencies without unreasonable delay. CalViva Health takes prompt corrective action to mitigate any risks or damages involved with the breach. Refer to the Plan's Privacy and Security policies and procedures for detailed descriptions of the breach investigation and notification processes.

1. **Investigation and Corrective Action -** If there is a report of noncompliance, or the Privacy and Security~~Chief Compliance~~ Officer, a member of the Compliance Committee or a Plan employee/associate discovers credible evidence of a violation, an investigation will immediately ensue. When CalViva Health substantiates a reported violation, it is the policy to institute corrective action.

2. **Initiating Systemic Changes to Correct Problems** - After a problem has been identified and corrected, the Privacy and Security~~Chief Compliance~~ Officer and Compliance Committee will review the circumstances to determine 1) whether similar problems have been uncovered elsewhere and 2) whether modifications of the policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy and Security~~Chief Compliance~~ Officer will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All employees with access to protected health information are required to attend and participate in privacy and security training sessions. Adherence to the provisions of this Plan, such as attending

training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

CalViva Health understands a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security rule. CalViva Health works to ensure an accurate and through assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of PHI held by the Plan.

CalViva Health implements these steps when conducting a risk analysis:

a. Step 1: System Characterization
b. Step 2: Threat Identification
c. Step 3: Vulnerability Identification
d. Step 4: Control Analysis
e. Step 5: Likelihood Determination
f. Step 6: Impact Analysis
g. Step 7: Risk Determination
h. Step 8: Control Recommendations
i. Step 9: Results Documentation

The steps referenced above are consistent with the methodologies described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Risk Management Guide for Information Technology Systems and NIST SP 800-66 An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security rule.

Along with risk analyses, CalViva Health maintains a risk management protocol which provides a structure for the evaluation, prioritization, and implementation of risk-reducing security measures. CalViva Health has a team of individuals in place who are knowledgeable about the organization's Privacy and Security policies, procedures, training program, computer system set up, and technical security controls~~, and who are responsible for the risk management process and procedures~~.

IV. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Compliance Officer ("CCO") to serve as the focal point for privacy and security activities and report directly to the Chief Executive Officer and to the RHA Commission. The CCO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The CCO works with a Compliance Committee to assist in implementation of the Privacy and Security Plan.

The CCO responsibilities include:

A. Serving as the Privacy and Security Officer

B. Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;

C. Ensuring Risk Analyses and Risk Mitigation plans are implemented;

D. Ongoing oversight and monitoring of Privacy and Security activities;

E. Preparing and overseeing distribution of the Notice of Privacy Practices;

F. Reporting on a regular basis to the RHA Commission on implementation and compliance;

G. Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;

H. Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;

I. Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;

J. Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;

K. Coordinating mitigation efforts in the event of a disclosure that violates the privacy laws; and

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has established a Compliance Committee to advise the Chief Compliance Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The Chief Compliance Officer ("CCO")CCO serves as chairperson of the meeting. Compliance staff and other key staff are responsible to report on their respective monitoring activities and key performance indicators. The CCO provides summary reports of the Committee's activities, findings and any identified risk issues to the RHA Commission. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

B. Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

C. Developing a system to solicit, evaluate and respond to complaints and problems;

D. Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

E. Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, reports from CalViva Health's CCO, reports from contractors, appeals and grievances, etc.;

F. Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a breach;

G. Creating or revising policies to better prevent or address privacy and security breaches; and

H. Overseeing development of resolutions to breach issues.

When a potential problem is identified, the CCO may also select various individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

B. The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable

C. That adherence to the Plan and Policies and Procedures is a condition of employment

D. That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations

The Chief Compliance Officer will include any significant privacy and security issues as part of the complianceoperations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The CCO along with the OperationsCompliance Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the

~~deficiency will be corrected and set a time frame for implementing the corrective actions.~~

APPROVAL:

		Date:	**February 15, 2018~~February 16, 2017~~**
Name:	~~Mary Beth Corrado~~Jeffrey Nkansah		
Title:	Chief ~~Compliance~~ Operating Officer		
		Date:	**February 1~~5~~6, 201~~8~~7**
Name:	Gregory Hund		
Title:	Chief Executive Officer		
		Date:	**February 1~~5~~6, 201~~8~~7**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Program Description History		
Date	**Section #**	**Comment(s)**
1/1/2012		New Program Description
3/1/2013		Updated entire document to properly reflect Privacy and Security Measures
2/6/2014		Changes to the Breach and Protected Health Information definition to align with the HIPAA FINAL Rule published on January 17, 2013; added language pertaining to the Risk Management Team; clarification to identify the Chief Compliance Officer is also the Privacy and Security Officer and other minor changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
1/5/2015		Annual Review; No Changes Needed
2/18/2016		Annual Review; Updated the contact information for the Compliance Officer. Minor edits to clarify current practices.

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.