Gregory Hund
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

Phone: 559-540-7840
Fax: 559-446-1990
www.calvivahealth.org

DATE: March 10, 2017

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

Please find the agenda and supporting documents enclosed for the upcoming Commission meeting on:

Thursday, March 16, 2017
1:30 pm to 3:30 pm

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

Teleconference Locations:

Kings County Government Center
Administration Building
1400 W. Lacey Boulevard
Hanford, CA 93230

Fresno County Administrative Office
Third Floor, Room 304
2281 Tulare Street
Fresno, CA 93721

Meeting materials have been emailed to you.

Currently, there are 13 Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum is maintained

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
March 16, 2017
1:30pm - 3:30pm
Meeting Location: CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Teleconference Locations: Kings County Government Center
Administration Conference Room
1400 W. Lacey Blvd.
Hanford, CA 93230

Fresno County Administrative Office
Third Floor, Room 304
2281 Tulare Street
Fresno, CA 93721

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD; Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment A Attachment B Attachment C Attachment D	**Consent Agenda** • Commission Minutes dated 2/16/2017 • Finance Committee Minutes dated 11/17/2016 • QI/UM Committee Minutes dated 11/17/2016 • Public Policy Committee Minutes dates 12/7/2016 *Recommended Action: Approve Consent Agenda*	D. Hodge, MD; Chair
4 Information	Attachment A	**Kings County At-Large Reappointment** • Harold Nikoghosian	D. Hodge, MD; Chair
5		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** **A.** Government Code section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation	
6 Action	No Attachment	**CEO Annual Review** • Select ad-hoc Committee *Recommended Action: Selection of Ad-Hoc Committee*	D. Hodge, MD; Chair
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 7 and 8*	
7 Action	Attachment A Attachment B	**2017 Quality Improvement** • Program Description • Work Plan	P. Marabella, MD, CMO

8 Action	Attachment A	**2017 Utilization Management** • Work Plan *Recommended Action: Approve 2016 Quality Improvement Program Description and Work Plan; and 2017 Utilization Management Work Plan*	P. Marabella, MD, CMO
9 Action	Attachment A	**Valley Health Team Residency Program Sponsorship** *Recommended Action: Approve Program Sponsorship*	Nikki Nocella, Consultant
10 Action		**Standing Reports**	
	Attachment A	**Finance Report** • Financials as of January 31, 2017	W. Gregor, CFO
	Attachment B *No attachment*	**Compliance** • Compliance Report • Public Policy	M.B. Corrado, CCO
	Attachment C Attachment D Attachment E Attachment F Attachment G	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • QIUM Quarterly Summary Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment H No attachment	**Executive Report** • Executive Dashboard • ACA Update *Recommended Action: Accept Standing Reports*	G. Hund, CEO
11		**Final Comments from Commission Members and Staff**	
12		**Announcements**	
13		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
14		**Adjourn**	D Hodge, Chair

Supporting documents will not be posted. If you would like a copy please email the Clerk to the Commission at: Churley@calvivahealth.org

If special accommodations are needed to participate in this meeting, please contact Cheryl Hurley at 559-540-7840 during regular business hours (M-F 8:00 a.m. – 5:00 p.m.)

Next Meeting scheduled for May 18, 2017 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

"To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners."

Item #3

Attachment 3.A

Commission Minutes
Dated 2/16/17

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 16, 2017

Meeting Location:
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

	Commission Members		
✓	**David Cardona**, M.D., Fresno County At-large Appointee	✓	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
	Aldo De La Torre, Community Medical Center Representative	✓●	**Harold Nikoghosian**, Kings County At-large Appointee
✓	**Van Do-Reynoso**, Director, Madera Co. Dept. of Social Services	✓	**David Pomaville**, Director, Fresno County Dept. of Public Health
✓	**John Frye**, Commission At-large Appointee, Fresno	✓*	**Sal Quintero**, Fresno County Board of Supervisor
	Soyla Griffin, Fresno County At-large Appointee	✓	**Stephen Ramirez,** Fresno County At-large Appointee
✓	**Derrick Gruen**, Commission At-large Appointee, Kings County	✓	**David Rogers**, Madera County Board of Supervisors
✓	**David Hodge**, M.D., Chair, Fresno County At-large Appointee		**David Singh**, Valley Children's Hospital Appointee
✓	**Aftab Naz**, Madera County At-large Appointee	✓	**Paulo Soares**, Commission At-large Appointee, Madera County
		✓●	**Keith Winkler**, Director, Kings County Dept. of Public Health
	Commission Staff		
✓	**Gregory Hund**, Chief Executive Officer (CEO)	✓	**Amy Schneider**, R.N., Director of Medical Management
✓	**William Gregor**, Chief Financial Officer (CFO)	✓	**Jeff Nkansah**, Director, Compliance and Privacy/Security
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Cheryl Hurley**, Commission Clerk
✓	**Mary Beth Corrado**, Chief Compliance Officer (CCO)	✓	**Daniel Maychen**, Director of Finance & MIS
	General Counsel and Consultants		
✓	**Jason Epperson**, General Counsel		
✓= Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
● = Attended via Teleconference			

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order	The meeting was called to order at 1:34 pm. A quorum was present.	
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.	*A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 Appointment/Reappointment of Board of Supervisors Commissioners Information David Hodge, MD, Chairman	Fresno County has appointed Supervisor Sal Quintero as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Doug Verboon as alternate. Madera County has re-appointed Supervisor David Rogers as Commissioner and Supervisor Brett Frazier as alternate.	
#4 Fresno County At-Large Reappointments • Dr. Hodge • Dr. Cardona Information David Hodge, MD, Chairman	Fresno County Board of Supervisors have reappointed Dr. Hodge and Dr. Cardona for the Fresno County At-Large positons for a three-year term for the period of May 2016 through May 2019.	
#5 Consent Agenda a) Commission Minutes 11/17/16 b) Finance Committee Minutes 10/20/16 c) QI/UM Committee Minutes 10/20/16 d) Public Policy Committee Minutes 9/7/16 e) Compliance Report Action David Hodge, MD, Chairman	All consent items were presented and accepted as read.	**Motion:** *Approve Consent Agenda* *13–0–0–4* (Neves / Rogers)
#6 Closed Session	The report out of Closed Session is that the Commission discussed item #6. A motion was made to proceed with negotiations of a contract with Kaiser.	**Motion:** *Approve* *14–0–0–3* (Rogers / Naz)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
A. Government Code section 54954.5 – Report Involving Trade Secret – Discussion of service, program, or facility. Action David Hodge, MD, Chairman	*Supervisor Quintero arrived during closed session @ 1:36 pm and participated in discussion and vote.*	
#7 Annual Administration Information David Hodge, MD, Chairman	Dr. Hodge reminded the Commission the Form 700 is due on an annual basis and all Commissioners will receive a notification from the Commission Clerk via email. In addition, if anyone is due for an updated Ethics Certification, they will be notified as well.	
#8 Annual Utilization Management Program Review Action David Hodge, MD, Chairman	Dr. Marabella presented the Annual Utilization Management Program Review. The Utilization Management & Case Management focus for 2016 consisted of the following: • Compliance with Regulatory & Accreditation Requirements: o Licensing and credentialing requirements maintained. o Documents and policies incorporate new regulatory requirements into practice. o DHCS Medi-Cal Managed Care Division Medical Director meetings attended by CMO. • Monitoring the UM Process: o Turn-around times with prior authorizations are monitored with a goal of 100%; currently averaging approximately 95%.	*See #9 for Action Taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Appeal rates are reviewed including: Overturns, Partial Upholds, Upholds, and Withdrawals. In addition, the turn-around-time compliance rate is also monitored. Rates have been consistent year to year. • Monitoring Utilization Metrics: ○ The Key Indicator Report is presented at each Commission meeting. ○ The Transition Care Management (TCM) program continues. ○ PPG Profiles are reviewed to monitor how they are performing. • Monitoring Coordination with Other Programs and Vendor Oversight: ○ Case Management moved to an Integrated Case Management (ICM) model eliminating vendor relationship for Complex Case Management (CCM), and is now conducted in-house. ○ Perinatal Case Management saw increased participation in 2016. ○ MHN participates in weekly rounds with HN case managers and MD to integrate and coordinate care. ○ MHN continues to track metrics associated with Autism Spectrum Disorder (ASD). • Monitoring Activities for Special Populations: ○ Continued monitoring for CCS Identification. ○ SPD, CBAS, and Mental Health tracking is ongoing. The Utilization Management & Case Management Program Description changes for 2017 include the following:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Inpatient Facility Concurrent Review – summary of program's goals and responsibilities have been added. • Removed Complex Case Management and added Integrated Case Management. • Updates to the Population Based Programs have been made and are more comprehensive. This portion has not officially launched due to filing with State agencies. Anticipated date of launch is Q2 2017. • Updated Medical Management titles have been made in the Organizational Structure and Resources section. • Additional edits throughout the document have also been made. *Supervisor Rogers stepped out at 1:57 pm*	
#9 2016 Annual Quality Improvement Work Plan Evaluation Action David Hodge, MD, Chairman	Dr. Marabella presented the 2016 Annual Quality Improvement Work Plan Evaluation. The planned activities and Evaluation for 2016 included the following: • Access, Availability and Service: o Data validation for the 2016 Provider Appointment Availability Survey is currently pending. The Provider Office Wait Time met overall goal for 30 minutes or less for all three counties in Q4. o 90% standard was met in MY2015 for emergency instructions however, the call-back within 30 minutes for urgent issues after hours, was not. Corrective Action Plans were required from all 255 non-compliant providers. Resurvey results from Q4 2016 After Hours Survey are pending.	**Motion:** Approve 2016 Utilization Management Work Plan Evaluation, 2017 UM Program Description, and the 2016 Annual Quality Improvement Work Plan Evaluation. *14-0-0-3 (Frye / Gruen)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Summary of results for the full CAHPS Survey conducted in 2016 is pending. • Quality and Safety of Care: The External Accountability Set includes 16 measures that must be evaluated for Full Scope Medi-Cal Plans in California; within those 16 there are six that are selected as Default Enrollment Measures: ○ Childhood Immunization Combo 3: Fresno and Madera Counties exceeded DHCS MPL. Kings County fell below the MPL. ○ Well Child Visits 3-6 years: All three counties exceeded the MPL. ○ Prenatal Care: All three counties exceeded the MPL. ○ HbA1c Testing: Madera county exceeded the MPL. Fresno and Kings counties fell below the MPL. ○ Controlling High Blood Pressure: Kings and Madera Counties exceeded the MPL. Fresno County fell below. ○ Cervical Cancer Screening: Fresno and Kings Counties are above the MPL. Madera County fell below the MPL. • Performance Improvement Projects (PIPs): The two PIPs for 2016 were: ○ Comprehensive Diabetes Care - HbA1c Testing: CVH has been working with a targeted provider group in Kings County to improve testing rates. ○ Timeliness of Postpartum Care: The goal for this project was to improve the health of new mothers by encouraging them to attend their postpartum visit at targeted providers in Kings County. Visit completion rates are trending upward and final results will be reported in June 2017. • Ongoing Workplan Activities.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Supervisor Rogers returned at 2:00 pm	
#10 - #14 • 2016 Annual Compliance Evaluation • 2017 Compliance Program Description • 2017 Code of Conduct • 2017 Anti-Fraud Plan • 2017 Privacy and Security Plan Action David Hodge, MD, Chairman	MB Corrado reported on the Compliance Program Annual Review. **<u>2016 Annual Compliance Evaluation</u>** CalViva had three new hires for 2016, in which all completed the new hire training required. All existing employees participated in and passed annual mandatory trainings as well. Feedback obtained in reference to the mandatory trainings was positive. Oversight Audits of delegated functions to Health Net were conducted in 2016 and returned favorable results with minor corrective actions. The 2016-2017 Member Handbook/EOC mailing was delayed as a result of regulatory guidance. DHCS is in the process of issuing a model template requiring all health plans to use for the Medi-Cal EOC. A letter was mailed to all membership informing them to continue to use the 2015-2016 handbook. A quarterly printed directory is beginning in 2017 as a result of SB 137 with production beginning soon. The online provider search function on the CalViva website significantly expanded in 2016 to include additional types of providers. 90 Provider Updates were sent to contracted providers; 7 Provider Toolkits were reviewed and approved for use with providers; and 2,604 provider visits and events occurred throughout the Fresno, Kings, and Madera Counties. There were 41 potential Fraud and/or Abuse leads identified and investigated. Of those, 38 involved potential incidents involving	**Motion:** Approve 2016 Compliance Evaluation, 2017 Compliance Program Description, Code of Conduct, Anti-Fraud Plan, and Privacy & Security Plan. *14-0-0-3 (Rogers / Naz)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	provider billing practices and 3 cases involved member incidents. One case was reported to the DHCS. The Risk Management Team continues to meet regularly and monitor CalViva's practices and processes. Enhancements were made with the IT vendor and activities were implemented related to scanning for threats and vulnerabilities. There were 41 Privacy & Security incidents reported to DHCS in 2016, 35 of which were no risk or low risk, and 5 of which were high risk requiring notification to member(s) of the issues. 2016 Regulatory Audits & Performance Evaluations included: DMHC Routine Full Service Survey, DMHC SPD Survey, DHCS Medical Audit, DHCS State Supported Services, HEDIS® Compliance Audit, DMHC Financial & Administrative Affairs Examination, Final DHCS 2014-2015 Performance Evaluation report, and Final DHCS 2014-2015 Encounter Data Validation Study results. Overall, the Plan performed well. Most of the audits and performance evaluations indicated very few deficiencies, of which most were very minor. Highlights of Operational activities included the following: • The Member Services Call Center received upwards of 147,000 calls, of which approximately 144,000 were handled. Mental Health calls are handled separately and there were 1,845 calls, of which 1,811 were handled. Overall, the performance standards for the Call Center were either met or exceeded.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• There were 3,596 Appeals and Grievances cases received, of which 99.71% of cases were resolved with the turnaround times. • There were 28,634 Provider Disputes received from 10/1/15 through 9/30/16. 98% of those cases met the resolution turnaround time of 45 working days. Looking ahead into 2017, it is anticipated that there will be increased regulatory audit and performance monitoring activity. DHCS will be on-site in April 2017 to conduct an annual Medical Audit. In addition, there will be a HEDIS Compliance Audit, a DHCS 2015-2016 Performance Evaluation of CVH, and 2016-2017 HSAG Quality Focus Study. Additional oversight responsibilities resulting from Centene's acquisition of Health Net is expected, as well as Plan responsibility of oversight with Kaiser as a result of DHCS 's decision to withdraw from the three-way agreement. **2017 Compliance Program Description** The new Compliance Program document replaces the previous document in its entirety. The name was changed to imply a comprehensive, rather than specific, plan. Contents were reorganized to better reflect the overall robust structure and elements of the Compliance Program, and editorial changes to enhance the narrative. The new document adds more detail to program elements, and has removed duplicate detailed information found in other Compliance documents. **2017 Code of Conduct** There were very minor changes to the Code of Conduct. The changes consist of: adding a Table of Contents for ease of readability; update	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	of the CalViva Health overview; a statement relating to Section 1557 Non-Discrimination provision was added; and a statement clarifying actions which can be taken with an employee and/or sub-contractor when non-compliance or violation occurs was also added. **2017 Privacy and Security** Jeff Nkansah reported on the 2017 Privacy and Security Plan. The document was renamed from a Program to a Plan. In addition, the Overview section was reviewed to make sure it was consistent and in line with the Compliance Program. In addition, edits were made to remove duplicate information. **2017 Anti-Fraud Plan** Jeff Nkansah reported on the 2017 Anti-Fraud Plan. Updates were made to the Anti-Fraud Plan to include: a Table of Contents and updated CalViva Health Overview section; added a definition for "Waste" and incorporated "Waste" globally into the document; added a statement clarifying all employees receive background checks; clarified the new current operational practices for member and provider investigations; and global edits to remove duplicate information.	
#15 Standing Reports • **Finance Report** William Gregor, CFO	**Finance** **Financial Statements as of December 31, 2016:** Tangible net equity is $45M which is slightly over 338% of the minimum required TNE by DMHC and on goal to achieve 400% of the	**Motion:** Approve Standing Reports *14-0-0-3 (Rogers / Frye)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	minimum TNE which DHCS would like to see. Current ratio is 1.16 as of the end of December which is a good liquidity measurement. Revenues through December are $643M which is ahead of budget because of increased premium tax add-on and enrollment, which also gives rise to increased Medical Costs and Administrative Services Fees. DHCS has finalized the premium tax amounts and calculations for the current fiscal year. Premium tax has gone from approximately 4% of revenue in FY2016 to 10% in the current fiscal year. Both Total Revenue and Premium tax expense are impacted by the same amount. Other expenses overall are in line with budget for the current fiscal year. Net income through the end of December stands at $6.6M which is $1M greater than what was budgeted so far this year. **<u>Medical Management</u>** **Appeals and Grievances Report** Dr. Marabella presented the Appeals and Grievances Dashboard through December 31, 2016. • The total number of grievances received for 2016 decreased from 2015. • Compliance rates were comparable. • Total grievances resolved for 2016 was lower than in 2015. • Exempt Grievance categories were modified in 2016 to be consistent with the categories used for standard grievances. • Year-to-date numbers for Appeals have remained comparable.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Preservice Appeals decreased in 2016; the highest volume being Pharmacy related; most commonly associated with Hepatitis C drugs. • Uphold/denial rates are similar at about 70%. • Appeals PTMPM remained the same. • Grievances PTMPM for 2016 decreased even though membership has grown. **Key Indicator Report** Dr. Marabella presented the Key Indicator report. • Membership increased in 2016 over 2015. • ER visits on average for 2016 were comparable to the previous year; however, SPD volume is noted to have decreased since 2015. • Bed Days Acute - PTMPY decreased from 2015 to 2016. SPD's in this category have also decreased from previous year. • Turnaround times have improved in recent months. **QI/UM** Dr. Marabella provided the QI/UM Quarter 4 update. Two QI/UM meetings were held during this reporting period, October 20, 2016 and November 17, 2016. The guiding document, Preventive Screening Guidelines, was approved at the November meeting. The reports reviewed included the following Quality Improvement Reports: Appeals and Grievances Dashboard, Potential Quality Issues Report, The Initial Health Assessment Comprehensive Report, and the Facility Site Review Report.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** G. Hund, CEO	The Utilization Management reports covered included the Key Indicator Report and the Concurrent Review Report. In addition, HEDIS® Activity was reviewed and there are seven projects underway: • Childhood Immunizations • Monitoring Persistent Meds • Cervical Cancer Screening • Avoiding Antibiotics for Bronchitis • Controlling High Blood Pressure • Postpartum Visits • Diabetes HbA1c Testing Also reviewed was Access & Availability, and Kaiser Reports. **<u>Executive Report</u>** Membership decreased December 2016 through January 2017. All other local initiatives, with the exception of two, have also had a decrease in membership during the same time period. Speculation is due to the changes in Washington, DC; fewer people are applying or going to the exchanges to see if they qualify. The Annual Report was provided to all Commission members via electronic copy and hard copy. In addition, hard copies were mailed to provider partners, hospitals, and FQHC's.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	A meeting with Congressman Valadao, Congressman Nunes' staff, and Assemblyman Juan Arambula was held to share what the impact would be if the expansion population under the ACA was eliminated. Legislators were very receptive to this information. Commission members were shown a video, One Pair of Glasses Can Change a Child's Life, related to the Vision Program coordinated by CalViva staff and funded by CalViva Health, St. Agnes, Kaiser, and EyeQ.	
#16 Final Comments from Commission Members and Staff	None.	
#17 Announcements	None.	
#18 Public Comment	None.	
#19 Adjourn	The meeting was adjourned at 3:09 pm The next Commission meeting is scheduled for March 16, 2017 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #3

Attachment 3.B

Finance Committee Minutes
Dated 11/17/16

CalViva Health
Finance
Committee Meeting Minutes

November 17, 2016

Meeting Location
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	William Gregor, Chair	✓	Daniel Maychen, Director of Finance
✓	Gregory Hund, CEO	✓	Cheryl Hurley, Office Manager
✓	Paulo Soares		
✓•	Joe Neves		
✓•	Harold Nikoghosian		
	David Rogers		
	David Singh		
		✓	Present
		*	Arrived late
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order	The meeting was called to order at 11:00 am a quorum was present.	*A roll call was taken*
#2 Finance Committee Minutes dated October 20, 2016 Attachment 2.A Action W Gregor, Chair	The minutes from October 20, 2016 Finance meeting were approved as read.	Motion: *Minutes were approved* *5 – 0 – 0 – 2* *(Neves / Hund)* *A roll call was taken*
#3 Financial Statements as of	Current assets are $172M and current liabilities are	Motion: *Approve Financial Statements*

October 31, 2016 Attachment 3.A Action Daniel Maychen, Director of Finance & MIS	$140.7M, with a current ratio of 1.22. TNE at the end of October was $42.7M. Premium capitation income was $417.4M. Total cost of medical care expense, administrative service agreement fees expense and taxes are above budgeted amount. Premium taxes have been finalized and accrued amount for FY17 has been booked. The new tax amount is approximately 10% of gross revenues. Any tax amounts assessed to CVH are matched with increase in revenues. The net income impact is minimal. All other expense line items are in line with budget. Net income ending October 2016 is $4.3M which is $1 million ahead of budget.	*5 – 0 – 0 – 2* *(Soares / Nikoghosian)* *A roll call was taken*
#4 MCO Tax Update	W. Gregor reported the MCO Tax Update. The MCO tax has been finalized. Last fiscal year $45M in premium tax was paid, this fiscal year the tax liability will be $112M. The premium rates are to be adjusted accordingly which should have a negligible impact on CVH. The State has granted CVH a waiver to pay the tax until March 2017, as CVH does not have the funds to pay the tax until the premium rates have increased and paid to CalViva.	
#5 Announcements	None.	
#6 Adjourn	Meeting was adjourned at 11:10 am	

Submitted by: Cheryl Hurley, Clerk to the Commission

Dated: Feb. 16, 2017

Approved by Committee: William Gregor, Committee Chairperson

Dated: Feb 16, 2017

Item #3

Attachment 3.C

QI/UM Committee Minutes
Dated 11/17/16

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
November 17, 2016

CalViva Health
7625 North Palm Avenue; Suite #109
Fresno, CA 93711
Attachment A

	Committee Members in Attendance		CalViva Health Staff in Attendance
✓	**Patrick Marabella, M.D.**, CalViva Chief Medical Officer, Chair	✓	**Mary Beth Corrado**, Chief Compliance Officer (CCO)
✓	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Amy Schneider, RN,** Director of Medical Management Services
	Brandon Foster, PhD. Family Health Care Network	✓	**Brandi Ferris**, Medical Management Administrative Coordinator
✓	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Mary Lourdes Leone**, Compliance Project Manager
✓	**John Zweifler, MD.,** At-large Appointee, Kings County	✓	**Melissa Mello**, Medical Management Specialist
✓	**Nicholas Nomicos, M.D.,** Camarena Health		
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
	Guests/Speakers		
	Lali Witrago, Cultural & Linguistics Department		

✓ = in attendance

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D, Chair	The meeting was called to order at 10:36am.	
#2 **Approve Consent Agenda** - Committee Minutes: October 20, 2016 - Preventative Screening Guidelines - CCS Report - Standing Referrals Report - Pharmacy Recommended Drug List (Attachments A-E) Action Patrick Marabella, M.D, Chair	The August minutes were reviewed and highlights from the consent agenda items were discussed.	Motion: Approve Consent Agenda (Nomicos/Cardona) 4-0-0-2
#3 **QI Business** Appeals & Grievances: - Dashboard	The A & G reports provide monthly and quarterly data to facilitate monitoring for trends in the number and types of cases over time. In the third quarter report the following items were noted:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Executive Summary - Quarterly Member Report - Clinical Audit Summary (Attachment F-I) Informational Patrick Marabella, M.D, Chair	Member Appeals and Grievances – ➢ There were a total of 58 appeals. 54 cases were pre-service appeals, and 4 cases were post-service appeals. ➢ There were 181 grievances. ➢ New members are being educated about standards and expected timelines. Access Grievances – ➢ There were 8 Access to Care – Availability of Appointment with PCP. Exempt Grievances – the categories have been expanded for better trending of exempt grievances. Inter-rater Reliability – ➢ This report evaluates clinical and non-clinical A&G staff adherence to regulatory requirements and internal policies and procedures established for handling appeals and grievances. The third quarter overall score averaged 99%. The audit score threshold is 95%. No action required at this time.	
	Dr. Lee arrived at 11:29am.	
#3 **QI Business** Potential Quality Issues Report Q3 (Attachment J) Informational Patrick Marabella, M.D, Chair	This report provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member, PQI reviews may be initiated by a member, non-member or peer review activities. Data was reviewed including the follow up actions taken when indicated.	
#3 **QI Business** MHN Performance Indicator Report (Attachment K) Informational Patrick Marabella, M.D, Chair	The MHN Performance Indicator Report was presented. For Q3 2016, out of the 17 metrics with targets, all met or exceeded their targets.	
#3 **QI Business** Facility Site Review Report Q1-Q2 (Attachment L) Informational Patrick Marabella, M.D, Chair	This report displays completed activity and results of the DHCS required Facility Site Review (FSR) and Medical Records Review (MRR) for the tri-county area. ➢ There were 27 FSR's completed in the first and second quarters 2016. ➢ There were 28 MRR's completed in the first and second quarters 2016. ➢ 10 FSR's and 3 MRR's required CAP's to verify correction during this time period. All CAPs completed timely. ➢ 33 Physical Accessibility Review Survey (PARS) have been completed since 2011, of which 37% have Basic Level access.	
#3 **QI Business** Initial Health Assessment Audit Comprehensive	The Department of Health Care Services (DHCS) requires completion of the Initial Health Assessment (IHA) for new Medi-Cal members within 120 days of enrollment. In follow up to our 2016 DHCS Audit CalViva has initiated a more comprehensive and in-depth assessment of our IHA completion rates. This new multi-pronged approach includes	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Report (Attachment M) Informational Patrick Marabella, M.D, Chair	the following: ➢ Medical Record Review (MRR) via onsite provider audits ➢ Monitoring of claims and encounters ➢ Member outreach This new expanded report covers Quarter 3, 2016 for MRR with 25 records of new members audited. Semi-annual results for Q1 and Q2 2016 Member Outreach were reviewed. The initial analysis of claims and encounters data for 2016 revealed a higher completion rate for adult members when compared to pediatric members. An initial PPG report has been created to be used to provide feedback to providers on their completion rates. Quarterly reporting will continue as we refine our new reporting processes.	
#4 **UM Business** Key Indicator Report (Attachment N) Informational Patrick Marabella, M.D, Chair	The Key Indicator Report reflects data as of September 2016. This report includes key metrics for tracking utilization and case management activities. ➢ Membership continues to increase. ➢ ER visits have started to trend down. ➢ Bed days per thousand for SPD's have decreased. ➢ Turn-around times are acceptable.	
#4 **UM Business** Turnaround Time Report (Attachment O) Informational Patrick Marabella, M.D, Chair	The UM Turn-around Time Report was reviewed which provides an analysis of and actions taken to address timeliness metrics that do not meet standards. This report provides ongoing analysis of monthly audit scores.	
#4 **UM Business** Utilization Management Concurrent Review Report (Attachment P) Informational Patrick Marabella, M.D, Chair	The 2016 Utilization Management/Medical Management Concurrent Review Report presents inpatient utilization data and clinical concurrent review activities for Q3 2016. Focus is on improving member health care outcomes, minimizing readmission risk and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services. ➢ The increase in membership has impacted inpatient utilization. Increased enrollment of the MCE population which is new to managed care and may have had limited access to primary healthcare services previously, has contributed to higher acute admission rates and bed days. ➢ Medical Management system enhancements have been implemented to support identification of acute care discharge barriers.	
#4 **UM Business** Case Management Report (Attachment Q) Informational Patrick Marabella, M.D, Chair	The Case Management program provides an evidence based process for the medical management of members, including assessment, care plans and evaluation of care effectiveness. This report covers three case management programs: Integrated (ICM), Complex (CCM), and Perinatal (PCM). Beginning September 1st, 2016, a new case management model was implemented for CalViva members and our team transitioned to a new case management documentation system. ICM is a Case Management Society of America (CMSA) endorsed, complexity based case management model addressing the member's biological, psychological, social and health system needs through a primary care manager who is responsible for coordinating all the aspects of member's care.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#4 **UM Business** Specialty Referrals Report – HN Q3 (Attachment R) Informational Patrick Marabella, M.D, Chair	This report provides a summary of Specialty Referral Services that require prior authorization in the tri-county area for HN. This report provides evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members. Results will continue to be monitored over time.	
#5 **Pharmacy Business** - Executive Summary - Operations Metrics Report - Top 30 Prior Authorizations (Attachment T-V) Informational Patrick Marabella, M.D, Chair	Pharmacy quarterly reports include Operation Metrics, Top Medication Prior Authorization Requests, and quarterly Recommended Drug List changes to assess for emerging patterns in authorization requests and compliance around prior authorization and Call Center metrics, and to formulate potential process improvements. Operations Metrics: ➢ All third quarter 2016 pharmacy prior authorization metrics were within 5% of standard; reporting currently unavailable for August and September. Top 30 Prior Authorizations: ➢ Third quarter 2016 top medication prior authorization requests varied minimally from last quarter.	
#6 **Credentialing and Peer Review Subcommittee Business** - Credentialing Subcommittee Report - Peer Review Subcommittee Report (Attachment W, X) Action Patrick Marabella, M.D, Chair	**Credentialing Subcommittee Report.** This report provides the QI/UM Committee with a summary of the CVH Credentialing Subcommittee activities. 1. The Credentialing Sub-committee met on October 20th, 2016. At the October meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services. Reports covering the first and second quarter for 2016 were reviewed for delegated entities, second quarter for MHN and second and third quarter for Health Net. 2. County specific Credentialing Sub-Committee reports were reviewed for the second and third quarters of 2016. No significant cases were identified on these reports. **Peer Review Subcommittee Report.** This report provides the QI/UM Committee with a summary of the CVH Peer Review Subcommittee activities. All Peer Review information is confidential and protected under law. 1. The Peer Review sub-committee met on October 20th, 2016. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 & 3 2016 were reviewed. There were no significant cases identified on the reports. 2. The Quarter 2 & 3 Peer Count Reports were presented at the meeting. For Q2, there were 3 cases closed and cleared to track and trend. Four were tabled pending further information. For Q3, there were 4 cases closed and cleared to track and trend. Seven were tabled pending further information.	Motion: Approve the Credentialing Subcommittee Report (Nomicos/Lee) 5-0-0-1 Motion: Approve the Peer Review Subcommittee Report (Nomicos/Lee) 5-0-0-1
#7 **Compliance Update**	Mary Beth Corrado presented the Compliance Update: ➢ Health Net Oversight Audits: The Credentialing, Continuity of Care, and Provider Network audits are currently in	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	progress. The Access and Availability audit is complete and there was a CAP required. The Utilization Management audit has been completed, but an acceptable CAP is still in progress. ➢ Provider Dispute Resolution (PDR) Case Audits: The Q4 2015 audit is currently in progress. ➢ The DMHC completed a routine examination of the Plan as required by Section 1382 (a) of the Knox-Keene Health Care Service Plan Act. The examination reviewed the Plan's fiscal and administrative affairs. ➢ The DMHC/DHCS conducted their annual audit of the health plan in April 2016. ➢ Behavioral Health Treatment (BHT) Coverage for Children Diagnosed with Autism Spectrum Disorder (ASD): The DHCS transitioned the responsibility for the provision of BHT services from Regional Centers to DHCS Medi-Cal managed care health plans. The transition has been completed. Based on the information provided by the DHCS, 376 CalViva Health members had their services transitioned to the Plan. ➢ The next Public Policy Committee meeting is scheduled for December 7, 2016.	
#8 **Old Business**	None.	
#9 **Announcements**	None.	
#10 **Public Comment**	None.	
#11 **Adjourn** Patrick Marabella, M.D, Chair	Meeting was adjourned at 12:29pm.	

NEXT MEETING: February 16th, 2017

Submitted this Day: February 16, 2017

Submitted by: Amy B Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #3

Attachment 3.D

Public Policy Committee Minutes
Dated 12/7/16

Public Policy Committee
Meeting Minutes
December 7, 2016

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

Committee Members			Community Base Organizations (Alternates)
✓	Joe Neves, Chairman		Jeff Garner, KCAO
✓	David Phillips, Provider Representative	✓	Roberto Garcia, Self Help
	Beatrice Avila, Fresno County Representative		**Staff Members**
✓	Gabriela Chavez, Madera County Representative	✓	Mary Beth Corrado, CCO
✓	Seng Moua, Fresno County Representative	✓	Mary Lourdes Leone, Compliance Project Manager
✓	Tanya Klapps-Doan, At-Large	✓	Cheryl Hurley, Commission Clerk
	Magdalena Nino, Kings County Representative	✓	Courtney Shapiro, Community Relations Coordinator

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:34 am. A quorum was present.	
#2 Meeting Minutes from September 7, 2016 **Action** Joe Neves, Chair	The September 7, 2016 meeting minutes were reviewed. There were no discrepancies.	**Motion:** Approve September 7, 2016 Minutes 6-0-0-3 (R.Garcia / D.Phillips)
#3 2017 PPC Meeting Calendar **Information** Joe Neves, Chair	The 2017 PPC meeting calendar was provided to the committee members.	
#4 Enrollment Dashboard **Information** Mary Lourdes Leone, Compliance Project Manager	Mary Lourdes Leone presented the enrollment dashboard. As of November 2016, membership enrollment is currently 358,722, which is an increase of 23,000 members compared to the same time last year.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#5 Health Education **Information** Tony Gonzalez	Tony Gonzalez presented an update on Health Education's Work Plan mid-year evaluation. Twelve initiatives are on track in meeting year-end goals. The remaining two initiatives, Obesity Prevention and Perinatal initiatives experienced challenges in having updated promotional materials to support member enrollment. Plans to meet all work plan goals by end of Q4 2016 are in place. In comparing mid-year utilization outcomes of key health education programs and services to 2016 year-end goals, 7 out of 12 programs and services have met or are close to meeting 50% of the year end goal.	
#6 Cultural and Linguistics **Information** Lali Witrago	Lali Witrago presented the Cultural and Linguistics 2016 Work Plan Mid-Year evaluation. Activities complete during the first six months of 2016 included: • Language Assistance Services • Compliance Monitoring • Communication Training and Education • Health Literacy, Cultural Competency and Health Equity All activities were completed or are on target to be completed by the end of 2016. Continuing efforts to implement, monitor and track C&L related services and activities are ongoing. Lali Witrago additionally reported on the Cultural and Linguistics Language Assistance Program Mid-Year Report. As of June 30, 2016, CalViva Health has 355,480 members with 58% being Latino/Hispanic followed by 14% White/Caucasian, 12% Asian/Pacific Islander, and 6%	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	African American/Black. During the first six months of 2016 the total number of calls handled by Member Services Department representatives was 77,154 for all languages. 15,345 (20%) of the 77,154 calls handled by call center service representatives were handled in Spanish and Hmong languages. Additionally, 675 interpreter requests were fulfilled for CalViva Health members. Of these requests, 503 (74%) were fulfilled utilizing telephonic interpreter services followed by 141 (21%) for in-person (face-to-face) and 31 (5%) for sign language interpretation. The number of interpreter request for telephone interpretation was lower during this reporting period compared to previous.	
#7 Medical Management **Information** Patrick Marabella, M.D.	Dr. Marabella reported on the HEDIS® results for reporting year 2016. Each measure was explained in relation to the minimum performance level required. Each HEDIS® measure scoring below the minimum performance level is required to complete a performance improvement plan in order to get the score up to meet the minimum performance levels. CalViva Health projects for 2016-2017 include the following: • Immunization Project • Monitoring Persistent Meds (MPM) • Cervical Cancer Screening (CCS) • Avoid antibiotics for Bronchitis • Control Blood Pressure • Postpartum Performance Improvement Project (PIP) • Comprehensive Diabetic Care – HbA1c (PIP)	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#8 Group Needs Assessment **Information** Tony Gonzalez	Tony Gonzalez presented the results from the Group Needs Assessment. This is CalViva Health's first full scope GNA and will be completed every five years. 421 members completed the GNA Survey. The majority of members indicated their doctor or office staff speaks the language they prefer. 83% of members responding indicated they were aware of the health plan having medical interpreters available at no cost. 52% of members responding indicated they need information on who to call when they or a family member are sick when the doctor's office is closed.	
#9 Appeals, Grievances, and Complaints **Information** Mary Lourdes Leone, Compliance Project Manager	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q3 of 2016. Total appeals and grievances for Q3 2016 were 259, for a total of 791 for the year to date. Total of appeals only for Q3 is 67, for a total of 154 for the year to date. Total grievances for Q3 is 192, with a total of 637 for the year to date. Total exempt grievances received were 466. The majority of appeals and grievances are from Fresno county.	
#10 New Federal Affordable Care Act Non-Discrimination Requirements **Information** Mary Lourdes Leone, Compliance Project Manager	Mary Lourdes provided an overview of the new Federal requirements related to non-discrimination in healthcare. The law broadly prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health related coverage programs and activities. This law applies to any health program or activity that receives federal funding.	
#11 2016 DHCS/DMHC Audit **Information**	Mary Beth Corrado reported on the audits, and also the results, from the 2016 DHCS and DMHC audits. Taking into consideration the number of audits performed, CalViva Health did very well with only a few minor deficiencies	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Mary Beth Corrado, Chief Compliance Officer	noted. Responses to all audit findings have been sent to DHCS and DMHC, with the exception of the Finance audit. DHCS and DMHC's responses regarding the corrective action plans are pending. Once the corrective action plans have been accepted, a final report will be issued and made available to the public via their websites.	
#12 2016 DMHC Routine Examination of Fiscal and Administrative Affairs **Information** Mary Beth Corrado, Chief Compliance Officer	Mary Beth Corrado reported on the 2016 DMHC Routine Examination of Fiscal and Administrative Affairs. There were no findings related to financial matters. There were minor findings related to administrative processes. A response to the findings is in preparation.	
#13 Final Comments from Committee Members and Staff	Mary Beth Corrado thanked the PPC members for their participation in 2016.	
#14 Announcements	Lali Witrago handed out the most current CVH Newsletter.	
#15 Public Comment	None.	
#16 Adjourn	Meeting adjourned at 1:40 pm.	

NEXT MEETING **March 1, 2017 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: March 1, 2017

Submitted By: C. Shapiro
Courtney Shapiro, Community Relations Coordinator

Approval Date: March 1, 2017

Approved By: Joe Neves
Joe Neves, Chairman

Item #4

Attachment 4.A

Kings County At-Large

Reappointment: Harold Nikoghosian

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

RICHARD VALLE – DISTRICT 2
AVENAL, CORCORAN, HOME GARDEN & KETTLEMAN CITY

DOUG VERBOON – DISTRICT 3
NORTH HANFORD, ISLAND DISTRICT & NORTH LEMOOORE

CRAIG PEDERSEN – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

COUNTY OF KINGS
BOARD OF SUPERVISORS

MAILING ADDRESS: KINGS COUNTY GOVERNMENT CENTER, HANFORD, CA 93230
OFFICES AT: 1400 W. LACEY BLVD., ADMINISTRATION BUILDING # 1, HANFORD
(559) 582-3211, EXT. 2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

February 23, 2017

Harold Nikoghosian

Subject: **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission**

Dear Harold:

It is a pleasure to inform you that on February 7, 2017 at the regular meeting of the Kings County Board of Supervisors they took action to re-appoint you to serve as the Kings County community at large member on the **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission.**

Congratulations on your re-appointment and thank you for your continued interest to serve Kings County in this capacity. A copy of this letter is being sent to the Committee Coordinator to inform them of your appointment. Please call if you have any questions concerning the above.

Sincerely,

Catherine Venturella
Clerk of the Board of Supervisors

Enclosure

cc: Committee Coordinator

Item #7

Attachment 7.A

2017 Quality Improvement Program Description

CalViva Health
Quality Improvement (QI) Program Description

~~2016~~2017

Table of Contents

I.

Introduction and Background

A. Health Plan Products and Membership

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera. Under California's Medi-Cal managed care program, the RHA dba CalViva Health ("CalViva") is designated as the Local Initiative. CalViva is contracting with Health Net Community Solutions (HNCS or Health Net), a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for the majority of CalViva's membership.

CalViva recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Fresno-Kings-Madera Region. CalViva in conjunction with HNCS has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Fresno-Kings-Madera Region and meet those challenges. CalViva's collaborative health plan partner, HNCS, has over 15 years' experience in Fresno County since 1997 when the Two-Plan model was implemented. As such, CalViva is well prepared to serve Medi-Cal beneficiaries in Fresno, Kings and Madera Counties with quality care through evidence-based practices that emphasizes preventative care and encourages self-management for healthy behaviors.

The RHA may also contract with other entities or health plans to provide or arrange services for CalViva members enrolled with CalViva in the Service Area.

The CalViva Quality Improvement Program (QI Program) provides members with access to network-wide safe clinical practices and services and assures they are given the information they need to make better decisions about their healthcare choices. The QI Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QI Program employs an organizational structure that reports to the RHA Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CalViva also collaborates externally with network physicians, other provider types and community partners for effective QI integration process.

CalViva works with stakeholders in each county to develop unique programs tailored to the county's needs and continues to interact with the families, health care providers and county administrators to assure the programs achieve their goal of providing access to needed health care services.

B. Provider Network

In the Fresno-Kings-Madera Region, CalViva partners with HNCS and other entities to maintain contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, laboratory services, outpatient pharmacies, and hospices. HNCS and other entities also arrange health care through direct contracts with certain health care providers. In Fresno, Kings and Madera counties, all of the provider contracts are a mix of fee-for-service (FFS) capitated delegated and capitated non-delegated models.

C. Information Systems and Analysis

HNCS Information Systems consist of various integrated sub-data systems that support the QI Program. The major sources of data utilized for QI activities are obtained from the following subsystems:

• Accounts Receivable	• Membership
• Encounters	• Credentialing
• Benefits	• Provider Network Management
• Grievance and Appeals	• Member Complaints
• Billing	• Remittance
• Medical Management	• Customer Call Centers
• Claims	•

Analytical resources are available within the HNCS QI Department and will be made available to CalViva. The manager of the QI Research and Analysis Department has Masters Degrees with SAS and programming skills. Additional resources are available from regional and corporate departments: Information Systems, Health Care Services, Pharmacy Operations, Medical Informatics, Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement and Reporting, Actuary, Finance, Strategic Planning, and Marketing. Additional sources of information also come from the HEDIS®, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), appointment access and provider availability surveys, practitioner after-hours telephone access surveys.

II.

Purpose and Goals

A. Mission

CalViva mission is:

"To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners."

The mission of the CalViva QI Program is:

To help CalViva members stay healthy, secure and comfortable by providing access to quality care and services and information to make better decisions about their healthcare choices.

The vision of CalViva QI Program is to:

- Provide access to quality health care that helps CalViva members achieve improved health outcomes.
- Provide understandable, reliable and affordable products and services that exceed expectations.
- Monitor and promote the delivery of accessible, appropriate, compassionate and comprehensive health care and service.
- Offer wellness services that minimize adverse outcomes or improve health care status.
- Foster member-focused partnerships with physician groups and other health care practitioners and providers.

B. Purpose

The CalViva QI Program (QI Program) is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve clinical health outcomes, safety, and access, services and member and provider satisfaction.

The purpose and goals of the CalViva QI Program are to:

- Support CalViva's strategic business plan to promote safe, quality care and services.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve quality and safety of clinical care and quality of services for members.
- Implement and continually evaluate the effectiveness of the CalViva QI program. Ensure data collection and reporting systems to provide reliable and timely information. Analyze internal organizational performance measures and compare to professionally recognized standards of practice; recommend action to maintain and/or improve performance and conduct routine follow up when necessary.

- Support a partnership among members, practitioners, providers, regulators, employers, and the community to promote effective health management, health education, and disease prevention and to facilitate appropriate use of health care resources and services.

C. Goals

- Implement organization-wide programs that continually measure and improve member, practitioner and provider satisfaction with services and clinical delivery systems.

- Develop and implement population-based, ongoing clinical studies focused on high risk and high frequency criteria that incorporate current public health goals.

- Design, implement and measure the effectiveness of clinical practice guidelines, preventive health guidelines and health management programs that meet professionally recognized standards of practice for the high volume/high risk population ~~isues~~issues.

- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner, and provider information in accordance with state and federal requirements and accreditation guidelines.

- Maintain full compliance with the requirements of federal, California regulatory and Medi-Cal contractual requirements. These include, but are not limited to, the Centers for Medicare and Medicaid Services (CMS), California Department of Health Services (DHCS), and the California Department of Managed Health Care (DMHC).

- Promote safe clinical practices through member, practitioner and provider education, including the Initial Health Assessment (IHA), and preventive services in accordance with national and specialty society standards.

- Promote safe clinical practices and better outcomes for members through improved practitioner relationships and promotion of evidence-based health care.

- Provide efficient, simple and high quality administrative services that minimize duplication and errors and produces effective outcomes that result in improved member and practitioner satisfaction.

- Anticipate, understand and respond to customer and community needs, be customer- and community-driven and dedicated to a standard of excellence in all customer and community relationships.

III.

Scope

A. Scope of QI Program

The CalViva QI Program includes the development and implementation of standards for clinical care and service. CalViva ensures that there are no financial incentives or gain, including financial gain to providers, vendors, or facilities, to delay or withhold appropriate care. The QI Program provides oversight to ensure that RHA Commission and CalViva providers exert no economic pressure on facilities to grant privileges to providers. Facilities have in place Policies and Procedures for credentialing and re-credentialing. These processes are not subject to CalViva intervention.

A systematic methodology for ongoing monitoring and evaluation is performed to assess conformance to the standards. Corrective actions are recommended to improve performance, and follow up is planned when actions are taken to evaluate effectiveness. These efforts maintain compliance with federal and state regulations and contractual requirements as appropriate. The scope of these activities is determined in an annual assessment of the enrolled populations' demographics and health risk characteristics, as well as current national, state and local public health goals. The scope of the program includes:

- Health promotion, wellness and preventive care including the Initial Health Assessment
- Chronic care improvement/disease management
- Monitoring and evaluating access, availability, satisfaction and service
- Complex Case Management (CCM)
- Quality and safety of care
- Monitoring and evaluating care coordination for medical and behavioral conditions, ensuring coordination of care with other county and state programs
- Practitioner satisfaction
- Practitioner site and facility inspection including physical accessibility reviews of PCP and high volume specialist provider sites.
- Medical record and documentation standards
- Practitioner and provider qualifications and selection through a careful credentialing and peer review process
- Utilization Management
- Credentialing & recredentialing
- Delegation Oversight
- Health Plan Clinical and Service Performance
- Member Rights & Responsibilities
- Communication to meet cultural and linguistic needs ~~Cultural & Linguistic Needs~~ of all members
- Ensure SPD members undergo annual risk stratification, Health Risk Assessment (HRA), care plan preparation and distribution to the PCP

CalViva's QI Program has mechanisms to monitor the quality of care provided in an inpatient setting to ensure that providers utilize equipment and facilities appropriate to the care through the concurrent review process. Health Net Provider Network Management ensures hospital and outpatient facilities are certified by appropriate oversight agencies. Physician reviewers during the Provider Dispute Resolution process additionally review for appropriate standards of care, including but not limited to, ensuring appropriate specialty care referrals are made, ensuring surgical care is not delayed, ensuring usual standards of care are met, and ensuring physicians in training have oversight of clinical decision making, exams and orders. The QI Program also has mechanisms to monitor the quality of care provided in an inpatient setting to ensure that appropriate referral procedures are in place and utilized for services not customarily provided by a hospital.

The QI Program is prepared annually by the CalViva Chief Medical Officer for presentation to the CalViva QI/UM Committee during the first quarter of each year. The QI/UM Committee, which includes primary care and specialist providers engaged in clinical practice, approve or modify the QI Program annually, based on goals and initiatives for the year, taking into consideration new legislation, regulation and needs of the membership and provider community. Once approved, the CalViva Chief Medical Officer presents the finalized QI Program to the RHA Commission for its approval at its next scheduled RHA Commission meeting. After the RHA Commission has approved the QI Program, the CalViva Chief Medical Officer, as a licensed physician and the QI/UM Committee Chair collaborates with the QI/UM Committee to monitor the full scope of clinical services rendered on a scheduled basis, including a full review at mid-year. During the first quarter of the next year, an annual review of the QI and UM Work plan progress and completion is conducted by the CalViva Chief Medical Officer and QI/UM Committee following the completion of a calendar year.

Each CalViva delegate has established and implemented policies and procedures regarding approval, modification, delay or denial of services as well as the timeliness of those decisions (within the requirements outlined in UM-002 Precertification and Prior Authorization Requests). As part of the pre-delegation audit and annual audit, CalViva verifies that each delegate has policies and procedures regarding authorization, modification, denial or delay of services, as well as policies regarding the timelines of those decisions.

B. Preventative Health Screening Guidelines(PSGs)

CalViva adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease. The guidelines are reviewed, adopted and updated on an annual ~~bienni~~al basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review. CalViva along with HNCS medical directors with various medical specialties are involved in the adoption of the guidelines through the Medical Advisory Council (MAC). New members receive the Preventive H~~h~~ealth Screening guidelines in new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see CalViva members. It is also available to all ~~are communicated annually to~~ members and existing practitioners and providers online and by calling the Health Education Department at 1-800-804-6074.~~, and new providers receive this information with orientation materials within 10 days of becoming authorized to see CalViva members.~~ Updates, when applicable, are distributed to all practitioners via Provider Updates.

Preventive services that are relevant to CalViva's membership are monitored through participation in HEDIS® and other programs as specified in the QI Work Plan. In collaboration with HNCS, physicians and providers, CalViva encourages members to utilize health promotion and preventive care services.

C. Health Promotion Programs

CalViva Health provides ~~the *Be In Charge!*℠ Programs for the State Health Plan~~health education programs, services and resources to Medi-Cal members to help manage their health and reach their goals. ~~These programs provide specific interventions to facilitate the member's individual goals.~~ A whole person approach

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

CalViva offers a variety of health education programs, services and resources that are free to CalViva members. Examples include:

- The Health Education Information Line – The Health Education Information Line (1-800-804-6074) allows members to request health education materials and find out about health education programs available.
- Weight Management Programs – Members have access to a comprehensive Fit Families for Life-*Be In Charge!*℠ suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Overweight children and adult can also access telephonic coaching through Raising Well and Adult Weight Management programs respectively.
- Disease Management Program – Members with asthma, diabetes, and chronic heart failure are enrolled into *Be In Charge!*℠ Disease Management program to help them control their condition. Members receive educational resources and have unlimited 24 hour access to a nurse to address their medical concerns
- Pregnancy Matters® – Pregnant members receive educational resources which include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting.
- California Smokers' Helpline – The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego Moore's Cancer Center. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking.
- Nurse Advice Line – Members may speak to a nurse 24 hours a day, 7 days a week in the member's preferred language about any health related concerns. Pre-recorded information about a variety of diseases and health issues is also available via the Nurse Advice Line as part of the Audio Health Library.
- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Electronic Health Education – Teens from 13 years old and adults may participate in electronic health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide participants in learning how to access credible health education information and seek preventive health care services.
- Community Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Member Newsletters – Newsletters are mailed to members on a quarterly basis and covers various health topics and the most up-to-date information on health education programs and services.

~~The goal of the *Be In Charge!*℠ Programs is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventative wellness, and chronic care management evaluations and treatments performed in accordance with national peer-reviewed published guidelines. Preventative medicine, achieved through proactive education and active engagement of the members, promotes optimal health.~~

~~The *Be In Charge!*℠ Programs include:~~

~~• Disease Management~~
~~• Nurse Advice Line~~
~~• Adult Weight Management~~
~~• Raising Well Pediatric Weight Management• Audio Library~~
~~•Health Education classes and programs are offered in specific counties to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health, hypertension and healthy pregnancy.~~
~~CalViva monitors HEDIS® rates and outreaches directly to members encouraging regular preventive screening using education and incentives. For practitioners, CalViva emphasizes the importance of registries to track and remind patients about regular health screenings. Activities are reviewed annually and prioritized based upon the prior year's HEDIS® results.~~

~~CalViva offers a variety of health education programs, services and resources that are free to CalViva members. Examples include:~~
~~The Health Education Information Line (1-800-804-6074) allows members to request health education materials and find out about health education programs available.~~
~~California Smokers' Helpline is a one-on-one telephone-based program personalized to fit the individual member's needs.~~
~~Pregnancy Information Packets containing information about what to expect during pregnancy, optimizing health, prevention of premature births and prenatal oral health are provided to CalViva members.~~
~~Member Newsletters are mailed to all members and include health articles, plus up-to-date information on health education programs and services.~~
~~The Breastfeeding and NutritionSupport Line affords members the opportunity to call any time of the day or night to receive information about healthy eating, appropriate diets for specific diseases, and breastfeeding advice.~~
~~Audio Health Library is available to members who call the Nurse Advice Line to receive pre-recorded information, via the telephone, about a variety of diseases and health issues.~~

~~Health Education materials are provided to CalViva's members upon request and are available in English, Spanish, and Hmong. Preventive Health mailings are distributed by QI and the Pharmacy departments.~~
~~Educational materials and instructions are also provided to members in other languages through the use of interpreter services.~~

D. Clinical Practice Guidelines

Clinical practice guidelines (CPG) are developed and/or adopted to reduce variation in practice and improve the health status of members. CalViva adopts nationally recognized, evidence-based clinical practice guidelines. CalViva, Medical Directors, and network practitioners are involved in the review and update process for clinical practice guidelines. Specialty input on guidelines is obtained, when indicated. Guidelines are evaluated for consistency with CalViva's benefits, utilization management criteria, and member education materials.

E. Disease Management

The Disease Management – *Be In Charge!* SM Program provides disease specific management for members with asthma, diabetes, and heart failure (HF). In 2017, the program will expand to incorporate members with Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD). The goal of the *Be In Charge!* SM Program is to improve member knowledge and self-

management of these diseases leading to improved quality of life, better functional status and decreased absenteeism. Additionally, the program aim is to empower members to manage their diseases in accordance with national peer-reviewed published guidelines and to ensure that members receive necessary screenings and monitoring services.
Enrolled members in the program are mailed educational materials with action plans, information about the program, and contact numbers for the Nurse Advice Line. Program members receive outbound telephonic interventions and referrals are made to the complex case management program if the member is identified as being at high risk for hospitalizations or poor outcomes.

Nurse Advice Line

The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines high-tech, patented, algorithm based tools with high-touch call center services. The NAL provides immediate symptom assessment, and member education services. In addition to educating members how to better manage their own health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is offered 24 hours a day, seven days a week, all year long, in English and Spanish with translation services available for other languages.

Using clinical decision algorithms, the NAL registered nurse listens to each member's chief complaint, identifies member symptoms, and selects the most appropriate algorithm to be used for a thorough assessment. A combination of member input and clinical judgement allow the nurses to answer clinical questions and determine timeliness of care. The Nurse Advice Program have physicians there to provide support to the nurses as they interact directly with the member. The NAL is URAQ accredited.

- **Adult Weight Management**

Members' ages 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered dietitians and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, tips for eating out, and more. Members are offered unlimited inbound calls and appropriate educational resources.

Raising Well-Pediatric Weight Management

Raising Well is a new telephonic weight management program for children and adolescents. Members ages 2–17 with a body mass index (BMI) at or above the 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight management. Coaches include registered dietitians, exercise physiologists and nutritionists.

Developed from nationally recognized, evidence-based practices, program components include:

- Behavioral counseling and coping skills.
- Dietary counseling and physical activity education.
- Parent training and modeling.
- Physician visit promotion and tracking.
- Printed educational materials.
- Private social media/Facebook peer support group.
- Readiness to change assessment.
- Unlimited inbound calls.

Audio Library

Members can choose from over 1000 health-related topics in the Audio Health Library for a concise overview of any subject of interest. Topics are available in English and Spanish.

~~**Health Education**~~

~~Health Net State Health Programs provides health education programs, materials, and services to Medi-Cal members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. Health education services may include individual, group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors. Health Education programs, services and materials vary by membership type but generally include:~~

~~Weight Management Programs – Members have access to adult and pediatric weight management programs and suite of Fit Families for Life community classes and print educational resources to help members achieve healthy eating and active living.~~

~~Pregnancy Matters® – Pregnancy members receive educational resources including Text4baby text messaging program to help them achieve a successful pregnancy and healthy baby.~~

~~California Smokers' Helpline – The service provides personalized telephonic counseling and educational resources.~~

~~Healthy Hearts Healthy Lives Program – Members can access preventive and disease management resources to maintain a healthy heart.~~

~~myStrength™, an online wellness program that addresses depression, anxiety, and substance abuse. This program is available at www.mystrength.com or through the myStrength mobile app.~~

~~Community Health Education Classes – Members can participate in health promotion classes covering topics such as diabetes, nutrition, exercise, asthma, hypertension, dental, pregnancy, parenting and more.~~

~~T2X – Members can participate in electronic health education campaigns and programs through the web, mobile applications, and text messaging. Current campaigns and programs include asthma, immunizations, nutrition, smoking cessation, anti-bullying, sexually transmitted diseases (STDs), adolescent well care visits, talking to their doctor, teen pregnancy, and depression. More topics will be added in the future.~~

~~Health Education incentive programs- Members may participate in various incentive programs to encourage them to receive prenatal and postpartum visits, get certain preventive health screenings, and attend community health education classes.~~

~~Lifeline Program and Health Promotion Text Messaging Programs-Medi-Cal members can enroll in a federal Lifeline Program to receive a free cell phone with unlimited minutes and text, and a data plan. These members may also participate in various health promotion text messaging program to get educational messages and health reminders to stay healthy.~~

~~Health Education Materials - Members have access to culturally appropriate health education brochures, flyers, newsletter, and screening guidelines on 25 health topics and up to 3 threshold languages~~
~~To serve members with chronic conditions, CalViva partners with HNCS for disease management programs. . These programs are focused on the total health status of the member and take into account how comorbidities, medications and treatments impact one another. Interventions specifically tailored to the diverse clinical, cultural and linguistic needs of this population. HNCS contracts with an NCQA-accredited disease management vendor to deliver population-based interventions to CalViva members.~~

~~Evidence-based programs are implemented based on the principles of shared decision-making. HNCS systematically identifies and stratifies members at least quarterly using a predictive modeling algorithm that is produced from medical claims, encounter data, and pharmacy claims. Member interventions are stratified by clinical need and include educational materials that promote self-care skills, problem solving and adherence to prescribed treatment plans developed by their providers. Working with the member, goals are established and an action plan is developed.~~
~~These programs are designed and implemented using a consistent clinical framework that includes:~~

- ~~Population-based identification~~
- ~~Risk stratification~~
- ~~Member interventions based on clinical need and severity~~
- ~~Patient self-management and disease education~~
- ~~Practitioner education about the program and services~~
- ~~Process and outcomes measurement~~

~~Member participation is voluntary and active involvement in the programs is highly encouraged. Once a member is engaged his/her primary care or treating physician is notified. CalViva partners with the network of participating physicians/groups to identify opportunities to coordinate program services with any and all medical management programs initiated by the provider~~

~~The Disease Management program referral and participation rates are regularly tracked. Measurement of program outcomes is monitored though annual HEDIS® scores, trended ED and inpatient utilization rates, self-reported satisfaction and self-reported changes in health risk behaviors such as smoking cessation, physician visits, and adherence to medication.~~

F. ~~Complex Case Management~~ Integrated Care Management (ICM) Program

CalViva partners with HNCS to provide the ~~complex~~ Integrated ~~case~~ care management (I~~C~~CM) services. The program targets members identified as being at high risk for hospitalizations or poor outcomes and who

have barriers to their care. The program utilizes an evidence-based approach, which is member focused and goal directed in developing, implementing and monitoring an individualized care plan. Trained nurse care managers, in collaboration with a multiple disciplinary team, provide coordination, education and support to the member (family and caregiver) in achieving optimal health, enhancing quality of life and accessing appropriate services. HNCS contracts with a NCQA – accredited case management vendor to deliver these services to the CalViva members.

Members for the ~~complex~~ Integrated ~~case~~Care M~~m~~anagement program are identified using utilization, claims, pharmacy and encounter data sources and may be directly referred by Providers, the Medical Review Unit, internal case management, or by self-referral. The risk stratification process incorporates data gathered during the nurse assessments and screenings with daily and monthly electronic filtering to identify members that qualify for the CCM program. It is a telephonic based program which can provide face-to-face contacts, as needed. Outcomes of this program include:

The goals of the ICM program are:

- Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.
- Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.
- Accomplish the goals in the individual member's care plan.
- Provide members and their families with the information and education that promotes self-care management.
- Assist in optimizing use of available benefits.
- Improve member and provider satisfaction.
- Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the member.
- Provide member with tools to empower member to achieve optimal health, independence and functioning in the most proactive and effective way.

- Ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services.

This program seeks to identify and intervene with members:

- 1 - Who are at risk of re-admission to hospitals
- 2 - With declining health status
- 3 - Whose profiles resemble other members with prior poor outcomes
- 4 - Who are most likely to engage with case manager (demographics)
- 5 – With extensive coordination of care needs, such as members receiving transgender services.

Members are initially identified for participation in the program using data stratification that includes:

- Claims and encounter data
- Hospital discharge data
- Pharmacy data
- Information gathered as part of the concurrent review process, as applicable.

Members may also be identified for case management programs by direct referral from sources, which may include:

- Health information lines
- Any of the Disease management programs
- The concurrent review and discharge planning process
- A member/caregiver request for case management
- A practitioner request for case management

Once members are identified for potential inclusion in the case management program, outreach to the member is completed to assess the care need and the member is invited to participate in case management if they meet established screening criteria. If the member agrees, the member is assigned to the appropriate program and acuity level to address their care needs. Acuity levels vary from complex to low. Members are also afforded the opportunity to decline participation in the program.
The Case Management Program includes an initial assessment, the use of evidence based care plans and algorithms, documentation of member preferences, resources, barriers, goals, progress and ongoing evaluation of members needs with adjustments of interventions as needed. In addition, an in home assessment is preferred for the highest risk complex members.
Each year the program is evaluated for its effectiveness using both established metrics and documented measures of member satisfaction.

- ~~Completion of a comprehensive health assessment that identifies medical needs (including primary and specialty care), medication management, durable medical equipment (DME) needs, and other psychological and social needs.~~
- ~~Collaboration between the case manager, member (family and caregiver), multidisciplinary team, primary care physician (PCP), and other clinical providers to develop an individual written plan of care that is communicated to the provider and medical home.~~
- ~~Coordination of care, including provision of emotional and social support, for acute and chronic illness.~~
- ~~Improved member knowledge of their illnesses, self-management skills, health care options and available services.~~
- ~~Appropriate emergency visits and hospitalizations, seamless transitions between levels of care and the appropriate use of resources.~~

~~The Plan is committed to serving members with complex health needs through coordinating services and assisting them in accessing needed resources. Seniors and Persons with Disabilities (SPD) population are included in this service. The focus of the case manager is to manage patients with significant life limiting primary diagnosis with multiple co-morbidities.. Members are identified using member health data sources and may also be referred into the following programs:~~

- ~~Disease Management (not available concurrently with CCM)~~
- ~~Ambulatory Case Management(Not available concurrently with CCM)~~
- ~~Decision Support~~
- ~~SPD Health Assessment Program~~
- ~~Fit Families for Life~~
- ~~Nutrition Counseling~~
- ~~Lactation Support~~
- ~~Smoking Cessation~~
- ~~Primary Care, Urgent Care, Hospital or Ancillary referral~~

~~The program is evaluated for care outcomes, effectiveness and satisfaction and provides an annual summary is provided to CalViva for review at the QI/UM committee.~~

G. Behavioral Health Services

CalViva's provider network arrangements to deliver covered mental health services to the majority of members are administered through a contract Health Net holds with its affiliate MHN Services ("MHN"). MHN contracts directly with psychiatrists and other behavioral health specialists and is delegated to perform certain functions (e.g. credentialing, claims, utilization management, etc.).

CalViva Health, HNCS and MHN are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans
- Diagnosis, treatment, and referrals of members with mental health and substance use disorders to network specialists, county mental health plans, -County Drug and Alcohol Programs and other resources as appropriate
- Appropriate uses of psychopharmacologic medications and treatment adherence
- Managing coexisting conditions and behavioral health preventive programs

These areas are measured through the following sources to identify new initiatives or opportunities to enhance existing interventions.

- Member survey to assess satisfaction with and access to covered mental health services
- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners
- Network availability and adequacy of behavioral health providers
- Member quality of care and service complaints investigation
- Evaluation of behavioral health QI initiatives such as the Screening for Clinical Depression and follow up plan (CDF) HEDIS initiative.

H. Credentialing / Recredentialing

CalViva has established policies and standards to ensure the selection of qualified and credentialed practitioners and providers.

Compliance issues are reported to CalViva's Chief Medical Officer. The Chief Medical Officer will work with CalViva Chief Compliance Officer and CalViva's QI/UM Committee to address such compliance issues.

I. Continuity and Coordination of Care

A major aspect of CalViva's QI program is continuity and coordination of care, including coordination activities:

- Across medical care settings that include (but are not limited to) inpatient, residential, ambulatory and other locations where care may be rendered
- Between medical care locations and public health agencies
- Between medical care providers, behavioral health care providers and county mental health plans
- Transition of care when benefits end or practitioners leave the network, between practitioners or changes in setting

CalViva, in conjunction with HNCS, identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals & Grievance data analysis
- Provider satisfaction surveys
- HEDIS® measures
- Medical record review

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Complex case management
- Pharmacy programs
- Utilization and Case Management Programs
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations
- Information will be posted on the Plan website for advising providers, contractors, members, and the public how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CalViva.

J. Delegation

CalViva has delegated certain functions (e.g. credentialing and recredentialing, utilization management, and claims administration, etc.) to HNCS and other entities as specified in written agreements between CalViva and the entities. CalViva will institute corrective action and/or may revoke delegation when it determines that HNCS or other entities are unable or unwilling to carry out the delegated responsibilities.

CalViva has established delegation policies and processes to address oversight. HNCS and other entities must demonstrate the capability, proficiency and experience to manage the delegated responsibilities. An annual evaluation of the delegates programs may include as appropriate for the function under review: an analysis of the program documents, reports, audit of related files, and periodic on-site review of their operations. HNCS and other entities are required to report activities and key performance data to CalViva in accordance with agreement requirements, CalViva policies and regulatory requirements . CalViva is responsible for oversight of delegated functions, final approval and monitoring of such delegated activities.

The CalViva QI Program incorporates input from appropriate professionals into the designs of its corrective action plans or QI Programs. Should Corrective Action Plans (CAP) be required and implemented, CalViva utilizes physicians and registered nurse's input and other Plan compliance staff, as applicable to the delegated function, to define the CAP, approve the CAP, and monitor progress and resolution of the CAP. Such CAP is reviewed by CalViva's Chief Medical Officer and/or Chief Compliance Officer as applicable with summary reports of actions taken and progress toward resolution reported to the QI/UM Committee or other appropriate Plan Committees.

CalViva requires that each delegate have a written description of the UM program that includes structure, scope, criteria, processes, and policies and have a designated medical director who is responsible for UM program oversight and holds an unrestricted license to practice medicine in California. As part of the annual delegation audit and pre-delegation audit by CalViva, CalViva verifies the status of the Medical Directors and Registered Nurses for the delegate and verifies that the delegate's UM program has oversight by medical directors licensed in California.

CalViva assesses the capability of each delegated entity by performing a capability assessment prior to delegation specifically with regard to technical expertise and review of budgetary resources. As part of the

delegation audit, HNCS and other delegated entities must demonstrate they have adequate clinical staffing to provide timely determinations.

Each CalViva delegate will ensure that emergency health care services are available and accessible, that providers are reimbursed for care necessary to stabilize an emergency condition, and that denials of payment for emergency care meets requirements. As part of the pre-delegation audit, and annual audits CalViva ensures that each subcontracted delegate, including HNCS, has policies and procedures that ensure access to emergency services, and that emergency services are not subject to prior authorization or denial. The delegates may review for medical necessity and appropriateness of care following the triage exam when there is no emergency condition, or following stabilization of an emergency condition. Additionally, claims payment policies are reviewed to ensure that delegates are providing payment for emergency services. Delegates may review records and any other clinical information to determine emergency versus non-emergency condition as a condition of determining payment. These standards are audited during claims audits. The QI/UM Committee monitors appeal and grievance data to ensure issues involving inappropriate denial of emergency claims or inappropriate billing of members are addressed in a timely and complete manner to prevent future similar occurrences.

K. Safety

CalViva is committed to ongoing collaboration with network practitioners, providers and external agencies to build a safer health system. This is accomplished through quality initiatives that promote best practices, track outcomes, educate members, educate practitioners and providers, and ensure coordination of care. Measures to ensure that the goals of the member safety and quality data collection program are met include but are not limited to:

- Informing and educating health care professionals on safety issues
- Identifying and evaluating strategies for reducing errors and improving member safety
- Promoting the dissemination of effective strategies and best practices throughout the health care industry
- Making performance data publicly available for members and practitioners
- Current member safety activities include, but are not limited to: Conducting PCP facility site reviews and physical accessibility reviews of PCP and other high volume provider sites.
- Conducting a rigorous credentialing and recredentialing process to ensure only qualified practitioners and organizational providers provide care in the network.
- Monitoring quality of care indicators on a quarterly basis to identify patterns and/or trends
- Conducting pharmacy system edits to assist in avoiding medication errors.
- Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet CalViva's severity threshold.
- Monitoring narcotic prescribing carefully and ensuring a narcotic contract is in place for any member on narcotic medication in excess of DHCS determined or nationally recommended quantity limits
- Analysis of member quality of care complaints, potential quality of care, and provider preventable conditions cases to identify patterns and trends
- Care coordination for high risk patients
- Member education
- Assuring that affected members and providers are notified of FDA and voluntary drug safety alerts and recalls

- Nurse Advice and Triage Line available 24 hours a day, 7 days a week, every day of the year

Mechanisms for communication include:

- CalViva website
- Provider Updates
- Drug safety, refill history and dosage alerts
- Letters to individual practitioners, providers, or members
- Member and Provider Newsletters
- Regular provider and member communications
- Automated reminder calls to members
- Prior Authorization process for Pharmacy and Medical Services

L. Health Plan Performance

CalViva conducts ongoing monitoring of health plan performance by participating in annual HEDIS® measurement, member and practitioner satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services. CalViva's QI Program also has established metrics for key operational processes, such as Claims and Customer Service, and monitoring for service improvement opportunities.

CalViva adopts and maintains a broad range of key performance metrics to monitor clinical and service quality in Medical Management, Appeals & Grievances, Disease Management, Case Management, Concurrent Review and the Medical Review Unit. CalViva's QI Program also monitors key performance metrics for Pharmacy.

M. Satisfaction

QI activities focusing on access, availability, satisfaction, and service rely on multi-departmental involvement. Service activities involve CalViva and HNCS staff in the Health Care Services, Customer Contact Center, QI, Appeals & Grievances, Pharmacy, Claims, Credentialing, Provider Network Management, Delegation Oversight, and Marketing departments.

An important aspect of satisfaction and service to members is providing details of the benefit plan to prospective members and enrollees. Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, how to obtain primary, specialty, and behavioral health care, how to voice complaints and appeals, and how to obtain information on translation and interpretative services. In addition, members receive various communications that highlight general medical information and other focused activities.

Information used to assess and monitor member satisfaction with service and clinical care include the following: CAHPS®, SWBHC (Satisfaction With Behavioral Health Care), grievance and appeal data, member call data, including reasons for transfers between practitioners or member disenrollment. Practitioners and providers are informed of the results of member satisfaction analyses and any opportunities for improvement that have been identified through Provider Updates and Committees with external participants. Opportunities for improvement are shared internally through quality committees.

N. Access and Availability

To ensure CalViva has a network that is sufficient and adequate to provide its members appropriate access to, and availability of, practitioners, providers, and health care services and to ensure CalViva's members have appropriate access to health care services within a reasonable period of time, CalViva has established access to care standards for medical services including primary, specialty, and behavioral health care appointment access, after-hours access and instruction, emergency care and telephone access; and standards for availability of practitioners, providers and health care facilities including primary care physicians, specialty care physicians, high volume specialty care physicians, hospitals, ERs, pharmacies, laboratory/radiology facilities, skilled nursing facilities, home health agencies and ambulatory clinics.

CalViva does not pressure providers or facilities to render care beyond the scope of their training or experience.

Access standards are communicated to network practitioners and providers via the online Provider Operations Manual, and Provider Updates.

CalViva measures, evaluates, and reports compliance with access and availability standards using the following methods:

- Member Satisfaction Surveys: HEDIS® CAHPS® and SWBHC (Satisfaction With Behavioral Health Care) Surveys.
- Provider After-Hours Access Survey (PAHAS) ~~After Hours Access Surveys~~: Annual ~~Provider After-Hours Access Survey and CalViva conducts~~ provider telephone survey assessing after- hours ER information~~,~~ and physician afterhours access.
- Provider~~Practitioner~~ Appointment Availability ~~ccess~~ Survey~~s~~(PAAS): Annual provider appointment survey to assess member access to care and service. Specific elements include preventive care, routine care, and urgent care for medical and behavioral care.
- Member Grievances: Grievance data related to access is tracked and trended to identify issues with access.
- Geo Access Analysis: Geographic distribution of PCPs, SCPs, high volume SCPs, hospitals, emergency services, ambulatory clinics and ancillary (laboratory, radiology, and pharmacy) providers.
- Hospital ~~bed~~ Bed ~~capacity~~Capacity: Ratio of members per hospital beds in the contracted hospital network.
- Ratio of Members to Practitioner/Provider: Assessment of the ratio of members to PCPs, SCPs, and high volume SCPs.
- Network ~~Percentage~~ Open Access Report: Presents the percentage of PCPs accepting new members by line of business.

Results are analyzed to identify opportunities for improvement through corrective actions. Plan-level results and applicable actions for improvement are communicated to the CalViva QI/UM Committee, Access Workgroup or appropriate CalViva or HNCS staff for review, recommendations and approval, and to practitioners and/or providers through the CalViva QI/UM Committee.

O. Member Rights and Responsibilities

CalViva has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are

reviewed and approved annually by the appropriate CalViva staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include, the right to:

- be treated with respect, dignity, and courtesy;
- privacy and confidentiality;
- receive information about your health plan, its services, its doctors and other providers;
- choose a Primary Care Physician and get an appointment within a reasonable time;
- participate in making decisions and have a candid discussion with practitioners regarding appropriate or medically necessary treatment options;
- decide in advance how you want to be cared for in case you have a life-threatening illness or injury;
- voice complaints or other feedback about the Plan or the care provided without fear of losing your benefits;
- appeal if you don't agree with a decision;
- request a State Fair Hearing;
- receive emergency or urgent services whenever and wherever you need it;
- services and information in your language;
- receive information about your rights and responsibilities; and
- make recommendations regarding the organization's members' rights and responsibilities policies.

Member responsibilities include:

- acting courteously and respectfully toward doctors and staff and being on time for visits;
- providing up-to-date, accurate and complete information;
- following the doctor's advice and participating in the treatment plan;
- using the Emergency Room only in an emergency; and
- reporting health care fraud or wrong doing.

CalViva has established policies that address member grievances and appeals. Grievances and appeals are resolved in a timely manner. Trends are monitored on a regular basis to assess opportunities to improve health plan processes.

P. Medical Records

CalViva requires its practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

CalViva's documentation standards address format, documentation, coordination of care and preventive care and includes, but is not limited to, the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers.

Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record keeping practices.

CalViva monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits as part of the Medi-Cal Managed Care Division Department of Healthcare Services PCP Full Scope Facility Site and Medical Record Review process.

At least annually, the PCP Facility Site and Medical Record Review results are analyzed and reported to the QI/UM Committee to identify opportunities for improvement and action is taken when compliance issues are identified. Appropriate interventions are implemented based on compliance rates established for each standard. Interventions may include Corrective Action Plan, sending Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, and creating template medical record forms. Follow up is conducted to evaluate the effectiveness of the corrective actions.

Q. Cultural and Linguistic Needs

CalViva Health is contracted with Health Net Community Solutions (HNCS) to provide cultural and linguistic services and programs for the majority of CalViva Health's membership. CalViva Health ("CalViva" or "Plan") may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva Health. CalViva Health, in collaboration with Health Net Community Solutions (HNCS), is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, provider networks, and CalViva Health and HNCS.

The C&L Services Department, on behalf of CalViva Health, provides resources, materials, trainings, and in-services on a wide range of C&L topics that impact health and health care. Cultural competency training addresses members with limited English proficiency, diverse cultural and ethnic backgrounds and disabilities, including topics on gender, sexual orientation and gender identity. Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and cultural responsiveness education. C&L also analyses the needs of its membership by reviewing various sources of date which may include membership demographic data, call center data, appeals and grievance information, and geo-access analysis of provider network language capabilities.

To ensure compliance with applicable Medi-Cal contractual requirements, state and federal rules and regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), the C&L Services Department:

a) Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services
b) Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities
c) Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities
d) Collects, analyzes and reports membership language, race and ethnicity data in reports such as the annual Group Needs Assessment (GNA) and annual GNA updates
e) Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually
f) Maintains information links with the community through Public Policy Committee (PPC) meetings, Group Needs Assessment (GNA) and annual GNA updates, and other methods
g) Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources

h) Engage community-based organizations, coalitions, and collaborative in counties where CalViva Health members reside and be a resource for them on C&L issues
i) Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (ICE), Office of Patient Advocate (OPA), America's Health Insurance Plans (AHIP), California Association of Health Plans (CAHP), and National Health Plan Collaborative (NHPC)
j) Provide C&L services that support member satisfaction, retention, and growth
~~g)~~k)

Additionally, C&L performs the following activities to ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members:

a) Provide C&L information and support for HNCS and CalViva Health staff in their efforts to provide excellent customer relations and services
b) Collaborate with other departments, where appropriate, to further the mutual attainment of culturally and linguistically appropriate healthcare services received by members, e.g. work with the Appeals and Grievance department on culture and language related grievances
c) Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services
d) Promote effective communication by staff and contracted providers with LEP members by providing them with easy access to culturally and linguistically appropriate materials, high quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers
e) Deliberately address health equity through collaborating to develop and implement an organizational and member level strategic plan to improve health disparities
f) Sustain efforts to address health literacy in support of CalViva Health members
g) Assess bilingual capabilities of bilingual staff and provide ongoing education and support
h) Increase cultural awareness of Plan staff through trainings, newsletter articles, annual "Heritage" day, and other venues.

IV.

QI Process

A. Confidentiality / Conflict of Interest

CalViva Health's Compliance Department is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. CalViva Health's contracts require that providers and practitioners maintain the confidentiality of member's information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

As a public entity, the Plan's QI/UM Committee is subject to the "open meeting" rules of the California Brown Act. Confidential matters presented to the Committee are discussed in a closed session, otherwise all other matters discussed at Committee meetings are open to the public and materials presented in the public portion of meetings are available to the public. Within CalViva's internal operations, QI activities that will not be presented in the public Committee meetings are conducted and discussed under a code of confidentiality. All document created as part of the QI Program are maintained in accordance with federal and state law. Materials pertaining to confidential QI Review will be marked "confidential" and kept in a locked area. CalViva Health, its providers, vendors and contracted or delegated entities are responsible for safeguarding all confidential materials.

CalViva fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). CalViva strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

CalViva has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. CalViva and HNCS contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law. Prior to participation in the QI Program or its non-public committees (Credentialing and Peer Review Sub-Committees), participants are educated regarding confidentiality requirements. The CalViva Chief Compliance Officer is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Conflict of Interest
No person(s) will be assigned or selected for a QI Committee where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other practitioners they are in direct competition with or are associated with through financial arrangements. All Peer Review case presentations are blinded as to member and practitioner identification prior to committee review.

B. QI Process

CalViva's quality and performance improvement activities are implemented and documented in accordance with applicable state, federal, and accreditation regulations and standards. CalViva, in conjunction with HNCS, identifies opportunities for improvement through continuous monitoring of important aspects of care and service. CalViva's QI process includes the following:

- Establishment of quantitative and qualitative measures to assess performance and identify and prioritize areas for improvement
- Establishment of goals or benchmarks for each measure using nationally recognized, evidence-based standards of practice if applicable
- Identification of appropriate methodology to identify the targeted population or sample and ensure the validity and reliability of the collected data
- Performance of a quantitative and qualitative (identification of barriers) analysis of the data collected for each measure
- Identification of opportunities for improvement
- Implementation of appropriate interventions to improve practitioner, provider, and plan performance
- Measurement of the effectiveness of the interventions and corrective actions
- Quality of care problems or grievances are identified and can be submitted by the member, member's family, or provider on behalf of the member and can include problems or grievances about any type of medical or behavioral health service including, without limitation, care in a physician's office, clinic, hospital, ER, outpatient facility, home health agency, rehabilitation office, retail pharmacy, dialysis center, laboratory facility, hospice, imaging center. The full range of medical providers and their facilities under contract or providing medical care to CalViva members are included in and covered by the Appeal and Grievance process.

Areas for focused performance improvement are identified based on but not limited to the following:

- HEDIS®, CAHPS®, and SWBHC, rates, national and regional benchmarks and goals
- Local and state required improvement projects
- Concordance with plan initiatives (e.g., disease management programs)
- QI programs identified through community collaborative activities
- Patterns of inappropriate utilization
- Cultural or linguistic makeup of membership causing gaps in care
- Health Outcome disparities
- Appeals and grievance / customer service rates
- Member and provider survey results regarding satisfaction, access and availability, and coordination of care

Selection of topics takes into account:

- Relevance to the health plan population
- Prevalence of a condition among, or need for a specific service, by plan membership
- Demographic characteristics and health risks

Data collected to support the CalViva QI process include:

- Claims and encounter data
- Membership and Pharmacy data
- Reports of key indicators and sentinel events
- Demographic factors generally associated with risk such as age and sex or special health care needs status
- Cultural and linguistic makeup of membership
- Federal and state-reported quality and administrative data
- Clinical quality data collected by the plan, including recognized quality indicators such as HEDIS® and HEDIS®-like measures

- CAHPS® Survey
- SWBHC
- Medical Record Review
- Member & Practitioner Complaint & Inquiry Reports
- Appeals Reports

Information about CalViva's QI Program, including program description, activities and projects, and progress toward goals is available, upon request, to members and practitioners. CalViva notifies members of the availability of information about the QI program through regular member communications, committee meetings, and CalViva's website. Practitioners and providers are notified of the availability of information about the QI program via Provider Updates, committee meetings, new practitioner welcome letters, the Provider Operations Manual and CalViva's website.

V.

Program Structure and Resources

A. QI Committees

Governing Body/RHA Commission

The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of the CalViva QI Program. The RHA Commission has delegated the authority and responsibility for development and implementation of the QI Program to the CalViva QI/UM Committee.
RHA Commission functions:

- Establish strategic direction for the QI/Utilization Management/Credentialing/ Peer Review Program
- Annually review and approve the QI Program Description, QI Workplan and QI Workplan Evaluation
- Review quarterly reports regarding the QI program, delineating actions taken and improvements made
- Ensure the QI Program and Work Plan are implemented effectively to provide improvements in care and service
- Provide feedback to the CalViva QI/UM Committee, as appropriate following each review
- Assess and recommend resources, as needed, to implement QI activities

CalViva Quality Committees: CalViva Quality Improvement/Utilization Management (QI/UM) Committee and its Peer Review and Credentialing Sub-Committees

The CalViva QI/UM Committee meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its quality improvement activities. Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends policy decisions, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate. The Committee also ensures practitioners participate in the planning, design, implementation and review of the CalViva QI Program. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis. Membership of the CalViva QI/UM Committees includes practicing practitioners.

CalViva QI/UM Committee has the following subcommittees:

- Credentialing and Peer Review Sub-Committees

Credentialing and Peer Review Sub-Committees

The RHA Commission has final authority for the Credentialing and Peer Review Programs. The CMO receives recommendations regarding policies, processes and standards from the Credentialing and Peer Review Sub-Committees. The Chairperson of the Credentialing and Peer Review Sub-Committees is responsible for the Credentialing and Peer Review Sub-Committees operations, including, but not limited to, communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting credentialing and peer review policies. The CalViva QI/UM Committee, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees, provides program oversight.

The RHA Commission provides oversight of the QI/UM Committee and Credentialing and Peer Review Subcommittees, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees. The RHA Commission has final decision-making responsibility and authority to monitor, suspend, terminate or deny practitioners or organizational providers who have a direct contract with CalViva Health. CalViva retains the right to request in writing any modifications to a Health Net contracted participating providers' status in the CalViva network, including, without limitation, a request to terminate a participating provider's contract.

Furthermore, in the interest of protecting the safety and welfare of CalViva members, the Credentialing and Peer Review Sub-Committees also review summary reports of member Quality of Care (QOC) grievances and Potential Quality Issues (PQIs) cases that may be initiated by members, providers, CalViva or HNCS staff, or other sources. The Peer Review Sub-Committee may conduct an assessment of a practitioner's professional competence and conduct. If the Credentialing and Peer Review Sub-Committees decide to take disciplinary action against a practitioner that would be reportable to any outside agency, as a result of a practitioner's professional competence and/or conduct not meeting participation criteria or community care standards, all case materials are handled in accordance with CalViva Credentialing/Peer Review policies and procedures.

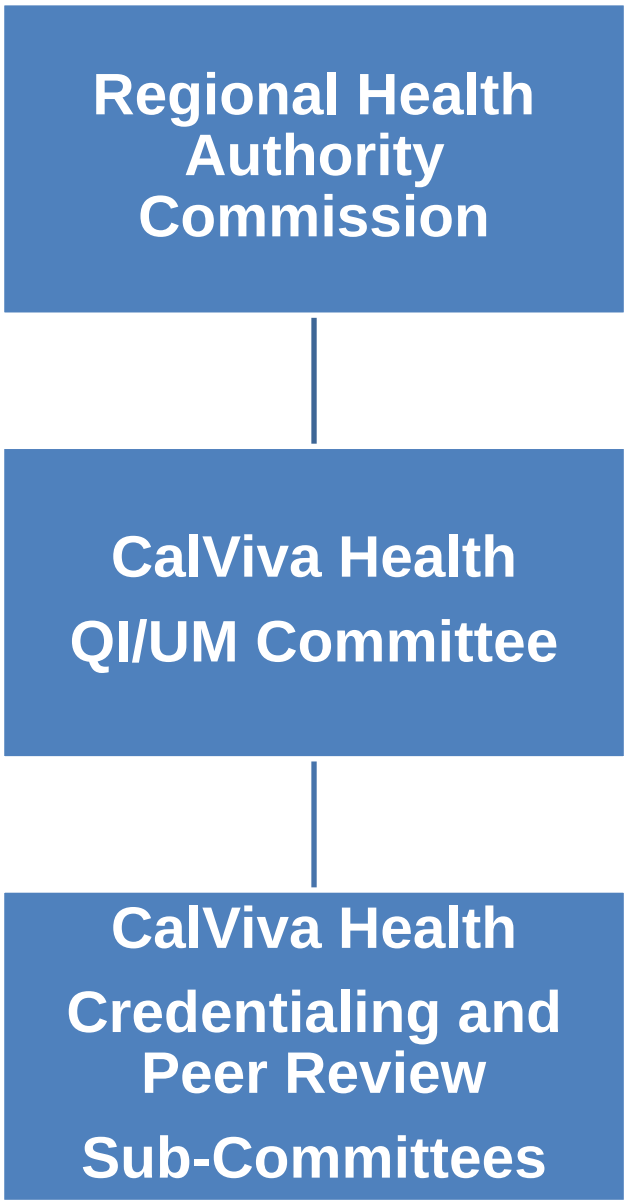
B. QI Workgroups

QI/UM Operational Workgroup

The QI/UM Operational Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and QI/UM related services on a continuous and systematic basis. The Workgroup supports the identification and pursuit of opportunities to improve health outcomes, safety, access, services and member and provider satisfaction. The Workgroup consists of CalViva Health and Health Net Community Solutions core staff including CalViva Health's Chief Medical Officer, Director of Medical Management, Chief Compliance Officer, and QI Analyst. Health Net Community Solutions staff includes designated Medical Directors, Quality Improvement staff, Utilization Management staff, Appeals and Grievance staff, Credentialing, Provider Network, and ad-hoc members pertinent to the report or discussion topic. The Workgroup process includes performance improvement review and discussion of monitoring activities, findings, barriers, and interventions to develop and implement actions. The QI Operational Workgroup meets weekly and reports significant findings and ensures follow up to the QI/UM Committee.

Access Workgroup

The CalViva Access Workgroup brings together representatives from CalViva and HNCS multiple departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services. The Access Workgroup will report recommendations and findings to the QI/UM Workgroup.


Regional Health Authority Commission
CalViva Health QI/UM Committee
CalViva Health Credentialing and Peer Review Sub-Committees

C. Staff Resources and Accountability

CalViva Chief Medical Officer

- The CalViva Chief Medical Officer's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations. This position makes recommendations to the RHA Commission to initiate major program revisions and communicates the RHA Commission's directives to both internal and external stakeholders.

Regional Medical Director

- The Regional Medical Directors (RMDs), who are provided through HNCS, assist in the clinical focus of the QI, utilization and case management programs for CalViva's Medi-Cal members. The RMDs communicate with providers on a day-to-day basis to ensure the provider performance meets established CalViva, DHCS, DMHC, and NCQA standards. The RMDs will participate in DHCS clinical improvement workgroups and other CalViva QI activities, such as provider training, grievance and appeals review, and collaboration with network physicians and other providers to facilitate improved health outcomes for Medi-Cal members.

Department Resources

CalViva staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CalViva QI Program. These administrative and clinical staff works with CalViva's Chief Medical Officer to carry out QI activities for CalViva's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the QI process are described below.

QI Team

- The QI team will include a Chief Medical Officer, Director of Medical Management Services, who is a Registered Nurse, and a Medical Management Specialist to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Quality Program are appropriately trained and experienced in Quality Improvement and Safety, Public Health, Health Administration, and Case Management.

Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)

- CalViva delegates DHCS required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per Medi-Cal Managed Care Division (MMCD) Policy Letters 02-02 and 12-006, HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high volume specialists, ancillary providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

- The FSR team will include a registered nurse who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting initial evaluation, conducting annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CalViva Chief Medical Officer and the CalViva QI/UM Committee.

Health Education

- CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support community needs assessments and work plans based on the results of the assessments. Based on cultural and linguistic needs of the membership, CalViva, with HNCS's assistance, implements preventive care programs, such as weight management, tobacco cessation and prenatal/postpartum education, at varying intervention levels such as individual, group and community-level.

Pharmacy Services

- CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the CalViva drug formularies, the education and communication of formularies and non-formulary issues throughout the CalViva practitioners and pharmacy network. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and non-formulary drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

Grievances and Appeals

- CalViva will process, track and trend member grievances and appeals at the practitioner and plan level. CalViva identifies patterns and/or trends of potential risk exposures via the Potential Quality Incident Referral Form. CalViva staff will report to the CalViva QI/UM Committee and as indicated its Credentialing and Peer Review Sub-Committees to ensure and allow CalViva the ability to review, act, and follow-up on identified clinical and/or service events or trends that are significant at the practitioner or plan level.

Credentialing/Recredentialing

- CalViva delegates credentialing/recredentialing of practitioners and organizational providers to HNCS but retains oversight and ultimate authority for such function.

Utilization Management/Medical Management

- CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and medical management programs. A systematic approach is used by CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Healthcare Services Department and medical management team partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among

CalViva's members. Utilization/Medical Management staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CalViva members. HNCS UM Department prepares and presents reports to the CalViva QI/UM committee at each meeting, and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CalViva QI/UM committee and RHA Commission prior to preparing the annual Workplan.

Customer Contact Centers

- The Customer Contact Centers, operated by HNCS on CalViva's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CalViva and HNCS staff for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports of trended member/practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CalViva's Chief Medical Officer to directly identify and/or confirm opportunities for improvement.

Provider Network Management

- CalViva delegates provider network management to HNCS. HNCS Provider Network management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network Management staff liaison also collaborates with the hospitals, practitioners and other providers for the resolution of contractual, operational, service and medical issues and conducts training sessions to provide contracted practitioners and providers with current CalViva policies and operational and product changes.

Delegation Oversight

- CalViva staff is responsible for the development, implementation and monitoring of the delegation program for functions (e.g. utilization management, credentialing, claims and claims administration, etc.) delegated to HNCS and other entities as specified in written agreements between CalViva and the entities. CalViva staff maintains responsibility for the implementation and monitoring of corrective action plans resulting from oversight recommendations.

HEDIS® Management and Clinical Reporting

- HNCS provides CalViva with the HEDIS® Management and Clinical Reporting Team which is responsible for HEDIS® and CAHPS® data collection and reporting. This team works collaboratively with CalViva staff to collect and report data.

VI.

Program Evaluation and Work Plan

A. Review and Oversight

The RHA Commission is responsible for QI and annually receives reviews and approves the CalViva QI Program Description, QI Work Plan and QI Program Evaluation. The CalViva QI/UM Committee submits regular reports to the Commission on quality findings related to monitoring and quality issues identified and activities initiated.

B. Annual QI Evaluation

The evaluation of the QI Program and Work Plan is based on the results of a systematic monitoring and assessment of QI efforts. It includes a summary of completed and ongoing QI activities, trending of measures to assess performance, analysis of the results of QI initiatives (including barriers), and evaluation of the overall effectiveness of the QI program, which is conducted during the year. The process identifies program strengths and limitations, improvement opportunities and unfinished business. The QI Evaluation assesses the adequacy of resource allocations needed to plan and implement the QI activities and programs for the upcoming year. The annual QI Program Evaluation and Work plan are reviewed and approved by CalViva QI/UM Committee during the first quarter each year.

C. Annual QI Work Plan

The work plan documents the annual QI initiatives and defines goals, objectives, specific actions, responsible parties and time frames targeted for completion or resolution of activities that address quality and safety of clinical care and quality of service. The work plan builds on the recommendations and findings of the previous year's program evaluation. The work plan allows integration of QI reporting and studies from various CalViva and HNCS departments, and includes the requirements for both internal and external reporting. The CalViva and HNCS staff, CalViva QI/UM Committee, and RHA Commission utilize the work plan as a tool for monitoring the effectiveness of the CalViva QI Program. The structure of the work plan outlines the steps necessary to complete the QI cycle: monitoring, planning, implementation, action, assessment and evaluation of outcomes. Each individual department or functional unit retains the responsibility for the implementation and evaluation of their specific activities. It is a dynamic document that CalViva with HNCS assistance updates regularly to reflect progress on QI activities throughout the year. The following CalViva and/or HNCS departments/functional units or staff contributes to the annual QI Program Work Plan:

- QI
- Credentialing/ Peer Review
- Delegation Oversight
- Health Education
- Cultural and Linguistics Department
- Grievances and Appeals
- Healthcare Services
- Pharmacy Services
- Customer Contact Center (Member Services)
- Provider Network Management
- Medical Management
- Case Management
- Disease Management
- Compliance Staff
- Public Programs Department

VII. Approval

A. Fresno-Kings-Madera Regional Health Authority Commission Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description

_____ _____

David Hodge, MD, Fresno County Regional Health Authority Commission Chairperson — Date

_____ _____

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee — Date

Item #7

Attachment 7.B

2017 Quality Improvement
Work Plan

CalViva Health
2017
Quality Improvement
Work Plan

TABLE OF CONTENTS

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.

Glossary of Abbreviations/Acronyms

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

Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan Evaluation.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)

1-1: Improve Access to Care

☐ New Initiative ☒ Ongoing Initiative from prior year

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

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

Aim and Goals 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.

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 QI-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 Availability Survey 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	Q3	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q1 - Q3	CVH/HN
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
Communicate monitoring requirements through Provider Update, revise the Guidelines and Monitoring sheet as needed and distribute to providers	P	Ongoing	CVH/HN
Complete all Provider Updates informing CalViva Health providers of AH Survey results, with educational information for improvement (no later than 3 months after survey is conducted).	P	Q1-Q2 (for 2016 results)	CVH/HN
Annual review, update and distribution of After-Hours Scripts to providers to improve after-hours results	P	Q1-Q2	CVH/HN
Send Provider Update informing providers of upcoming After Hours survey	P	Q3	CVH/HN
Process and conduct the CalViva Health AH Survey	P	Q3-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	Q2-Q3	CVH/HN
Annually review, update and distribution and of the Patient Experience Toolkit and appointment Access Tip sheet	P	Q1-Q2	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered			
Section C: Measures & Goals			
Specific Measure(s)	**Goal (Source of Goal)**	**Prior Reporting Year Rate 2016**	**Current Reporting Year Rate (populate mid-year)**
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	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= 76.1% Fresno=87.6% Kings=80.9% Madera=60%	
Access to Urgent Care Services that do not require prior authorization – Appointment within 48 hours of request	80%	Overall= 72.5% Fresno=71.3% Kings=67.7% Madera=81.6%	
Access to Urgent Care Services that require prior authorization – Appointment within 96 hours of request	80%	Overall= 55.5% Fresno=50% Kings=44.4% Madera=73%	
Access to First Prenatal Visit – Within 10 business days of request	80%	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= 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= 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= 90.9% Fresno=90.9% Kings=N/A Madera=N/A	
Appropriate After-Hours (AH) emergency instructions	90%	Overall= 92.3% Fresno=94.6% Kings=79.4% Madera=83.3%	
Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P)	90%	Overall= 86.5% Fresno=87.1% Kings=90.9% Madera=80%	

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐ **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**	☐ **Member Experience**
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**	

Aim and Goals of Initiative

Member Satisfaction by DHCS was last evaluated in RY 2016 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.

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	P/M	Q1-Q2	CVH/HN

Line to encourage use of this service by members			
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
CAHPS metric: Getting Needed Care	Exceed RY2017 All Plans Medicaid Average	78%	
CAHPS metric: Getting Care Quickly	Exceed RY2017 All Plans Medicaid Average	74%	
CAHPS metric: Rating of All Health Care	Exceed RY2017 All Plans Medicaid Average	69%	
CAHPS metric: Rating of Personal Doctor	Exceed RY2017 All Plans Medicaid Average	77%	
CAHPS metric: How well doctors communicate	Exceed RY2017 All Plans Medicaid Average	90%	

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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	☐ Member Experience

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

Aim and Goals 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.

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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
Cervical Cancer Screening (CCS)	Meet or Exceed DHCS MPL 48.18% (2017)	Fresno: 61.05% Kings: 54.99% Madera: 52.87%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ 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	☐ Member Experience

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

Aim and Goals 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.

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 targeted clinics to facilitate scheduling appointments for immunizations for children turning 2 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 imiprove 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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
Childhood Immunizations - Combo 3 (CIS-3)	Meet or Exceed DHCS MPL 64.30% (2017)	Fresno: 68.19% Kings: 63.03% Madera: 71.19%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered			
Initiative Continuation Status (Populate at year end)	☐ **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	☐ Member Experience

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

Aim and Goals of Initiative

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

Rationale: Adverse drug events cause more than 700,000 visits to the ER each year. The more medications people take, the higher their risk of having an adverse drug event.[1] Patient safety is paramount especially for risk from long-term use of drugs. Continual use of medication requires monitoring by the prescribing doctor to assess the dosage requirement for therapy and side effects (8). Annual monitoring of medications can reduce the cost associated with the misuse of drugs in the ambulatory setting [2].

- Approximately 1.5 million preventable adverse drug events occur in the United States each year, resulting in $3.5 billion in medical costs. [1]
- Severe adverse drug events can result in hospitalization. From 2007–2009, there were an estimated 99,628 emergency hospitalizations for adverse drug events in adults 65 years of age or older.[3]

In addition, a study showed nearly one-third of patients dispensed an ACEI/ARB, did not have an annual laboratory monitoring event. Though patients are at increased risk of hyperkalemia were more likely to be monitored, many remained unmonitored. [4]

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for member on diuretics

_____

[1]Centers for Disease Control and Prevention. 2012. "Adults and Older Adult Adverse Drug Events." http://www.cdc.gov/MedicationSafety/Adult_AdverseDrugEvents.html (June 19, 2014)
[2] Johnson JA, Bootman JL. Drug-related morbidity and mortality. A cost-of-illness model. Arch Intern Med. 1995 Oct 9;155(18):1949-56.
[3] Institute of Medicine. 2007. "Preventing Medication Errors: Quality Chasm Series." Washington, DC: The National Academies Press.
[4] Raebel, M. A., Lyons, E. E., Andrade, S. E., Chan, K. A., Chester, E. A., Davis, R. L., Ellis, J. L., Feldstein, A., Gunter, M. J., Lafata, J. E., Long, C. L., Magid, D. J., Selby, J. V., Simon, S. R. and Platt, R. (2005), Laboratory Monitoring of Drugs at Initiation of Therapy in Ambulatory Care. Journal of General Internal Medicine, 20: 1120–1126. doi: 10.1111/j.1525-1497.2005.0257.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions.

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
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

Section B: Mid-Year Update of Intervention Implementation (due Q3) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL 85.63% (2017)	Fresno: 84.94% Kings: 83.07% Madera: 83.98%	TBD
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL 85.18% (2017)	Fresno: 85.07% Kings: 84.26% Madera: 83.57%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ 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	☐ Member Experience

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

Aim and Goals 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.

_____

[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.

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 memberswhich 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 withHealthy 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	Q2	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	Q2	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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
HEDIS® Controlling High Blood Pressure	Meet or Exceed DHCS MPL 46.87% (2017)	Fresno: 47.96% Kings: 58.77% Madera: 57.99%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **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**	☐ **Member Experience**

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

Aim and Goals 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.

_____

[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.

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	P		CMAF/CVH/HN

member educational resources on appropriate antibiotic use. (sent to select antibiotic high prescribers)		Q1	
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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
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)	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)	19.69%	

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**

Quality Of 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	☐ Member Experience

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

Aim and Goals of Initiative

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

Rationale:The incidence of diabetes in the United States has increased fourfold since 1980, with 5.5 million people diagnosed with diabetes in 1980, and 22 million in 2014.[1] One in five health care dollars is spent caring for people with diabetes.[2] For individuals with diabetes, it's important to minimize the risk of adverse diabetic outcomes through accurate and consistent medical self-management, and maintaining steady blood glucose levels. This includes taking medications as directed (medication adherence), eating a proper diet, and getting regular physical activity.

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 fingerstick 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] CDC National Surveillance Statistics. http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm
[2] J. O. Hill, J.M. Galloway, A. Goley, D.G. Marrero, B. Montgomery, G.E. Petterson, R.E. Ratner, E. Sanchez and V.R. Aroda, "Scientific Statement: Socioecological Determinants of Prediabetes and Type 2 Diabetes," Diabetes Care, pp. Published online June 20, 2013, 2013.
[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.

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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
HEDIS® Comprehensive Diabetes Care – HbA1c Testing	Meet or Exceed DHCS MPL 82.98%	Fresno: 80.29% Kings:76.64% Madera:87.10%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered

Initiative Continuation Status (Populate at year end)	☐ 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	☐ Member Experience

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

Aim and Goals 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 August 2017.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions.

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) If Activities Not Met: Include Barriers Encountered

Section C: Measures & Goals

Specific Measure(s)	Goal (Source of Goal)	Prior Reporting Year Rate 2016	Current Reporting Year Rate (populate mid-year)
Postpartum Care Visits	Meet or Exceed DHCS MPL 55.47%	Fresno: 67.59% Kings: 50.24% Madera: 58.76%	TBD

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered			
Initiative Continuation Status (Populate at year end)	☐ **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		☐		
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN		☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for Asthma, Diabetes, Coronary Artery Disease (CAD), Congestive Health Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD) and ensure vendor conducts member and provider enrollment mailers and outbound calls.	CVH/HN		☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN		☐		
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN		☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/ HN		☐		
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN		☐		
5. 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		☐		
6. 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		☐		
7. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN		☐		
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	Axis Point Health/CVH/HN		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
members enrolled in Complex Case Management					
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN		☐		
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		☐		
QUALITY IMPROVEMENT					
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 02-02 and Physical Accessibility Review Survey per MMCD Policy Letter 11-013	CVH/HN	,	☐		
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	.	☐		
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		☐		

Item #8

Attachment 8.A

2017 Utilization Management Work Plan

CalViva Health

2017

Utilization Management/ Case Management Annual Work Plan

Created: January 14, 2017
Updated: March 6, 2017

TABLE OF CONTENTS

Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date

Created: January 14, 2017
Updated: March 6, 2017

1. Compliance with Regulatory & Accreditation Requirements

Created: January 14, 2017
Updated: March 6, 2017

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 14, 2017
Updated: March 6, 2017

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 Consideratio ns	☐ 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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: turnaround 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 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 MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

2. Monitoring the UM Process

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 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 McKesson 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	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2017 <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2017	Q3-4 2017 Q3-4 2017

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

3. Monitoring Utilization Metrics

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 2017 Goals: 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, Integrated 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
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2017 are under evaluation. <u>Referral Rates: Specialist</u> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom10% are identified as outliers. (*pending approval from DHCS/DHMC.) PPG's are identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2017 Planned Interventions	Target Completion Date
3.3 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 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 MD 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> Average PM/PY referral rates are calculated from claims and set as internal thresholds for SPD, Non-SPD and MCE members by PPG. Average referral rates are determined and the bottom10% are identified as outliers (*pending approval from DHCS/DHMC.)	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

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 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2017 Planned Interventions	Target Completion Date
4.4 MD interactions with Pharmacy	☐ 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 Pharmacy to refine the 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 Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data SHP MD's and Pharmacy continue to mirror the DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the CalViva	Monthly checkwrite review Monthly report of PA requests	Continued active engagement with pharmacy Continue narcotic prior authorization requirements Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2017 Planned Interventions	Target Completion Date
		Medi-Cal plan.			

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 improve coordination between medical and behavioral health care members.	Total number of registrations and referrals	Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

5. Monitoring Activities for Special Populations

Created: January 14, 2017
Updated: March 6, 2017

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 %. Goal: HN identifies 5% of total population for CCS eligibility.	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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

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 Integrated 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 ACM, CCM, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2018**				

Item #9

Attachment 9.A

Valley Health Team Residency
Program Sponsorship

VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

VALLEY HEALTH TEAM
FAMILY MEDICINE RESIDENCY PROGRAM
FUNDING REQUEST

Purpose:

The nation's leading health care agencies recognize that increasing access to health services is critical for the health of vulnerable populations. One of the goals in *Healthy People 2020* is to "improve access to comprehensive, quality health care services."[1]

The lack of access to primary health care for vulnerable populations continues to grow as the population increases. The limited availability of primary care physicians in the service area exacerbates the target population's poor health access and health status.

In areas, such as Fresno County, where there are a high number of medically underserved minority populations, it is imperative that there is access to a sufficient physician workforce that is highly skilled clinically and culturally and are dedicated to serving the underserved.

To relieve the shortage of primary care physicians in the underserved communities, Valley Health Team is developing a Teaching Health Center (THC) and establishing a Family Medicine Residency Program. Recruiting, training, and retaining Family Medicine physicians that are dedicated to serving the underserved in the Central Valley while adding to the fund of knowledge on models of community based medical education via a Teaching Health Center is the primary purpose of this funding request.

Background:

The Fresno Healthy Communities Access Program (HCAP) established a Family Medicine Residency Program in 2013 as a 4-4-4 program. Its initial Major Participating Institution was Clinica Sierra Vista which played an integral role as the Family Medicine Practice site and as the employer of the Program Director, faculty, and residents. HCAP applied and received HRSA Teaching Health Center funding, which funded all twelve residents. HCAP also was awarded Song-Brown Capitation and Special Program cycles.

[1] *Healthy People 2020*, Access to Health Services, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid.

During late 2015, HCAP and Clinica Sierra Vista decided to part ways effective June 30, 2016. Valley Health Team, a Federally Qualified Health Center also located in Fresno County, decided to step forward and provide the services, patients, and venues necessary to maintain and enhance the teaching experience for the residents and faculty. However, in the Spring of 2016, HCAP was notified that the residency program would lose accreditation as of June 30, 2017.

Since that time, the following actions have occurred:

- HCAP PGY-3 residents graduated, with a 100% Board pass rate
- HCAP PGY-2 residents are now PGY-3s and will complete the HCAP program
- HCAP PGY-1 residents have transferred to other residency programs. Two transferred to Valley Consortium for Medical Education (VCME) in Modesto. HRSA has agreed to temporarily assign the THC funds to Valley Consortium until those residents graduate, at which time the funding will come back to Valley Health Team, should Valley Health Team meet all HRSA requirements and THC funding continues.
- HCAP Incoming PGY-1 residents are currently training in the HCAP program and will need to find a new program before July 1, 2017.
- Valley Health Team has submitted and received accreditation as an ACGME Sponsoring Institution.
- Valley Health Team has submitted and had a site visit on January 31, 2017 for a new Family Medicine Residency Program.
- Valley Health Team will not officially know until late April, 2017 of ACGME's decision regarding the accreditation of its Family Medicine Program. However, accreditation appears likely.
- Until accredited, Valley Health Team is unable to make any offers, suggestions, or engage in other recruitment efforts to the current PGY-1s in the HCAP program. Therefore, it is unknown as to what decisions the PGY-1s are making about their future residency programs.

The table below details descriptions of how the HCAP and VHT models are structured, and notation of their similarities or differences.

Characteristic	HCAP (as of 7/1/16)	VHT New Program	Similar or Different?
Entity that employs residents	Valley Health Team employs the residents via contract. HCAP reimburses VHT for the costs of the residents' compensation.	Valley Health Team employs the residents via contract.	Same
Entity that employs program director	Valley Health Team employs the Program Director. VHT is reimbursed for this cost via HCAP.	Valley Health Team employs the Program Director.	Same
Locations of resident training	Inpatient at Community Regional Medical Center. Pediatrics at Valley Children's. Family Medicine Practice with Valley Health Team.	Inpatient at Community Regional Medical Center. Pediatrics at Valley Children's. Family Medicine Practice with Valley Health Team.	Same

Funding Needs:

Valley Health Team projects direct expense at $196,379 per FTE resident for Academic year 2017-2018. Based on our projected eight (8) THC FTE's for 2017-2018 (four PGY-1s and 4 PGY-2s), VHT projects total direct costs at $1,571,032. Total indirect costs are projected at $22,557 per FTE for a total of $180,456 for 8 residents. Total THC costs for 8 FTE residents is $1,751,488 for the 2017-18 academic year

Health Resources Services Administration (HRSA) has provisionally committed to reassigning the HCAP (and transferred funding to VCME) to Valley Health Team upon HCAP's relinquishing of the grant and Valley Health Team's completion of HRSA requirements, on or before June 30, 2017 However, 100% of the current THC funding is set to end on September 30, 2017 and it is not certain if the funding for Teaching Health Centers will be approved as part of the reconciliation for 2017-2018 and beyond as a result of the current political climate surrounding the Affordable Care Act (ACA). Teaching Health Centers, both in concept and in funding, were created as part of the ACA.

Currently, Valley Health Team is requesting that the Song-Brown Commission reassign HCAP's capitation and Special Program slots to Valley Health Team as of July 1, 2017 for the existing PGY-1 residents capitation cycle for 2017-2018. HCAP did not apply for a 2018-2019 capitation cycle for the current PGY-1 residents leaving a gap in funding for the third year of their graduate medical education. In January, the Governor's 2017-2018 state budget proposal eliminated the $100 million workforce commitment that included $33 million for Teaching Health Centers over a period of three years beginning 2017-18.

Valley Health Team has stepped forward to maintain community based Family Medicine training in the Central Valley. However, at this point the funding to support the residency is unknown. Valley Health Team has achieved what others viewed as impossible in obtaining the accreditations from ACGME that it has in such a short period of time. And, Valley Health Team has invested significantly in doing this, solely because of its commitment to the patients in the Central Valley.

Funding Request:

Valley Health Team respectfully requests a two-year commitment, consisting of $1,751,488 each year, to sponsor 8 residents in this program. Such funding will allow Valley Health Team to graduate the PGY-2 residents while waiting for the Federal situation to stabilize and funding scenarios to be clarified.

Submitted by: Soyla A. Reyna-Griffin, CEO
Valley Health Team

Date: March 8, 2017

Item #10

Attachment 10.A

Financial Statements as of
January 31, 2017

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Balance Sheet
As of January 31, 2017

	Total
ASSETS	
Current Assets	
Bank Accounts	
Cash	30,251,550.00
Savings CD	0.00
ST Investments	0.00
Wells Fargo Money Market Mutual Funds	6,202.55
Total Bank Accounts	**$ 30,257,752.55**
Accounts Receivable	
Accounts Receivable	191,399,839.83
Total Accounts Receivable	**$ 191,399,839.83**
Other Current Assets	
Interest Receivable	10,719.22
Investments - CDs	5,000,733.40
Prepaid Expenses	477,691.94
Security Deposit	0.00
Total Other Current Assets	**$ 5,489,144.56**
Total Current Assets	**$ 227,146,736.94**
Fixed Assets	
Buildings	7,560,850.62
Computers & Software	12,661.55
Land	3,161,419.10
Office Furniture & Equipment	179,093.69
Total Fixed Assets	**$ 10,914,024.96**
Other Assets	
Investment -Restricted	308,963.27
Total Other Assets	**$ 308,963.27**
TOTAL ASSETS	**$ 238,369,725.17**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	486,566.17
Accrued Admin Service Fee	3,983,441.00
Capitation Payable	119,702,998.49
Claims Payable	18,055.35
Total Accounts Payable	**$ 124,191,061.01**
Other Current Liabilities	
Accrued Expenses	30,333.31
Accrued Payroll	113,113.19
Accrued Vacation Pay	184,550.85
Amt Due to DHCS	0.00
IBNR	177,685.81
Loan Payable-Current	0.00
Premium Tax Payable	208,137.41
Premium Tax Payable to BOE	1,551,651.32
Premium Tax Payable to DHCS	65,599,139.10
Total Other Current Liabilities	**$ 67,864,610.99**
Total Current Liabilities	**$ 192,055,672.00**
Long-Term Liabilities	
Renters' Security Deposit	36,500.00
Subordinated Loan Payable	0.00
Total Long-Term Liabilities	**$ 36,500.00**
Total Liabilities	**$ 192,092,172.00**
Equity	
Retained Earnings	38,352,168.72
Net Income	7,925,384.45
Total Equity	**$ 46,277,553.17**
TOTAL LIABILITIES AND EQUITY	**$ 238,369,725.17**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Income Statement
July 2016 - January 2017

		Total
Income		
Interest Earned		65,335.71
Premium/Capitation Income		772,298,444.75
Total Income	**$**	**772,363,780.46**
Cost of Medical Care		
Capitation - Medical Costs		661,204,000.93
Medical Claim Costs		1,154,433.62
Total Cost of Medical Care	**$**	**662,358,434.55**
Gross Margin	**$**	**110,005,345.91**
Expenses		
Admin Service Agreement Fees		27,743,441.00
Bank Charges		2,906.28
Computer/IT Services		70,421.92
Depreciation Expense		169,362.94
Dues & Subscriptions		77,666.57
Insurance		108,397.81
Labor		1,491,230.25
Legal & Professional Fees		65,572.56
License Expense		349,134.34
Marketing		396,216.13
Meals and Entertainment		7,583.92
Office Expenses		35,600.96
Parking		750.24
Postage & Delivery		1,242.79
Printing & Reproduction		1,894.88
Recruitment Expense		35,730.40
Rent		3,076.87
Seminars and Training		5,424.79
Supplies		6,215.03
Taxes		71,760,179.69
Telephone		10,671.54
Travel		10,829.49
Total Expenses	**$**	**102,353,550.40**
Net Operating Income	**$**	**7,651,795.51**
Other Income		
Other Income		273,588.94
Total Other Income	**$**	**273,588.94**
Net Other Income	**$**	**273,588.94**
Net Income	**$**	**7,925,384.45**

Item #10

Attachment 10.B

Compliance Report

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2016 Total
# of DHCS Filings													
Administrative/ Operational	4	3	2										9
Member & Provider Materials	0	1	1										2
# of DMHC Filings	4	5	1										10
# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No/Low Risk	2	1	0										3
High Risk	0	0	0										0
# of Potential Fraud, Waste, & Abuse Cases Received													
# of Leads Investigated	4	0	0										4
# of MC 609 Submissions to DHCS	0	0	0										0
Summary of Filings	**DHCS Administrative/Operational** filings include ad-hoc reports, policies & procedures, Commission changes, and other Plan and Program documents. **DHCS Member & Provider materials** include advertising, health education materials, flyers, promotional items, etc. **DMHC Filings** include ad-hoc reports, Plan and Program documents, policies & procedures, advertising, flyers, promotional items, bylaw changes, Commission changes, undertakings, etc. **Potential Privacy and Security Breach Cases** - CalViva Health is required to provide notification and respond to a potential breach of the security of protected health information upon discovery, but no later than 24 hours after discovery. No/Low risk - Official letter not required to be sent to affected individuals. High risk - Official notice required to be sent to affected individuals. **Potential Fraud, Waste & Abuse cases** - CalViva Health is required to investigate leads of potential fraud, waste and abuse. If the lead rises to the level suspicion of fraud, CalViva Health reports those cases to DHCS within 10 working days from the date of identification.												

Report Date 3-16-17

Compliance Oversight & Monitoring Activities	Description
CalViva Health Oversight Meetings	**Health Net** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to the Centene-Health Net merger that may affect CalViva Health. The Plan recently requested Health Net to provide corrective action plans (CAPs) for the following areas: encounter data submissions, third party liability information submissions, and specialty provider access. These CAPs will be monitored at the monthly oversight meetings until complete. Health Net submitted CAP responses for the respective areas and these CAP responses are currently under review by CalViva Health. **Kaiser** CalViva Health and Kaiser management continue to hold quarterly Joint Operations Meetings (JOM). The last meeting was February 23, 2017. The next meeting is scheduled for May 16, 2017. Kaiser has received a CAP and financial sanction from the Department of Health Care Services for failure to meet its regulatory and contractual obligations for reporting encounter data. This encounter data issue also affects the encounter data Kaiser submits to CalViva Health. The Plan is monitoring the Kaiser CAP as it relates to CalViva Health data at monthly encounter data oversight meetings with Kaiser as well as the quarterly JOMs.
Oversight Audits	Health Net Oversight Audits: Audits for 2017 have been scheduled and several are in progress. The following 2017 audits are in progress: Claims, Health Education, and Utilization Management. A detailed summary of the audits which were scheduled in 2016 will be provided to the Commission on May 18, 2017. Provider Dispute Resolution (PDR) Case Audits: In 2017, the Plan is currently working on the Q1, Q2, and Q3 2016 PDR audits. The Q1 2016 audit was completed. There was a CAP required for timely resolution of PDRs. The Plan is currently reviewing the Health Net CAP response for the Q1 2016 audit. The Q2 and Q3 2016 audits are in progress.
Regulatory Reviews/Audits	**Status**
Department of Health Care Services ("DHCS") and Department of Managed Health Care ("DMHC") Medical Audits	The February 2017 Compliance Report to the Commission provided information about the medical audits conducted by DHCS and DMHC in April, 2016. The following are updates since the last report: • DMHC Routine Full Service Medical Audit Survey – A 60-day status response related to implementation of the online grievance submission process was provided to the Department on February 17, 2017. The Plan also filed their proposal to implement an online grievance submission process for enrollees with DMHC. The Department is currently reviewing the Plan's proposal. • DHCS Medical Survey Audit Plan - The Plan submitted a CAP response to the DHCS and the DHCS approved the Plan's CAP response on March 1, 2017.

Department of Health Care Services ("DHCS") Medical Audit	On February 10, 2017, the Plan received notification from the DHCS of their intention to conduct an audit of the Plan from April 17, 2017 – April 28, 2017. The audit review period will cover April 1, 2016 – March 31, 2017. The Plan submitted a majority of the requested pre-audit documents to the DHCS by March 6, 2017. The audit will consist of an evaluation of CalViva Health's compliance with its contract and regulations in the following areas: • Utilization Management • Case Management and Coordination of Care • Access and Availability of Care • Member Rights • Quality Management • Administrative and Organizational Capacity
Department of Health Care Services ("DHCS") Encounter Data Validation ("EDV") Study	On February 28, 2017, DHCS notified Plans of their intent to cancel the EDV study for 2017. DHCS intends to move forward with the EDV study in 2018 and will initiate efforts related to this study in late 2017.
Department of Managed Health Care ("DMHC") Timely Access Report Measurement Year ("MY") 2015 Report and Findings	On February 2, 2017, DMHC released a public Timely Access Report (TAR) for MY 2015. The report was a compilation and summary of results from all health plans that submitted a TAR for MY 2015. The report identified DMHC concerns with the data submitted by plans. Plans were compared for data errors in 9 categories in the public report and CalViva Health performed comparatively well when compared to other plans listed in the report. DMHC also issued individual plan specific reports to each plan. The CalViva Health MY 2015 findings from DMHC noted concern with geographic access to hospitals for some zip codes and questioned the availability of some ancillary and specialty services. The Plan must provide a response to the DMHC addressing the MY 2015 findings by April 15, 2017.
Committee Report	
Public Policy Committee	The Public Policy Committee had a meeting on March 1, 2017. The Public Policy Committee was provided information on committee membership, the enrollment, annual report, health education, appeals, grievances and complaints, operational compliance report, and updates on the DMHC and DHCS audits which occurred in 2016 of the Plan. The Committee also received an update on the Member Handbook and Provider Directory. There were no items requiring action by the Commission. The next Public Policy Committee meeting is scheduled for June 7, 2017, 11:30 a.m. at 1400 W. Lacey Boulevard, Hanford, CA 93230.

NEW REGULATIONS

Law Number	Name	Description	Effective Date	Notes
AB 796	Autism and Pervasive Developmental Disorders	Removes the January 1, 2017 sunset date in Health and Safety Code Section 1374.73 related to Pervasive Developmental Disorder, Autism and Behavioral Health Treatment.	7/1/2017	No requirements for health plans
AB 1696	Tobacco Cessation Services	AB 1696 adds Section 14134.25 to the Welfare and Institutions Code relating to Medi-Cal: 14134.25 (a) Requires that tobacco cessation services are covered benefits under the Medi-Cal program, subject to utilization controls. Requires tobacco cessation services to include all intervention recommendations assigned a grade A or B by the Unites States Preventive Services Task Force (USPSTF), as periodically updated. 14134.25 (b) (1)Requires tobacco cessation services to include at least four tobacco cessation counseling sessions per quit attempt that may be conducted in person or by telephone and individually or as part of a group, at the beneficiary's option. 14134.25 (c) Prohibits Medi-Cal beneficiaries from being required to receive a particular form of tobacco cessation service as a condition of receiving any other form of tobacco cessation service. 14134.25 (d) Beginning January 1, 2017, requires DHCS, to seek any federal approvals necessary to implement this bill that the department determines are necessary. 14134.25 (e) Requires this bill to be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any federal approvals have been obtained.	1/1/2017	DHCS released an All Plan Letter (APL) 16-014 addressing these requirements. Plan Action: The Plan is reviewing the contents of the APL and is making the appropriate updates to policies and reports to ensure these requirements are tracked within the health plan.
AB 1709	Deaf or Hard-of-Hearing Individuals	Updates various California codes to reflect the terms "deaf or hard-of-hearing" instead of "hearing impaired". It modifies existing language required to be included in written notices that health plans currently send to enrollees affected by contract terminations with a provider group or general acute hospitals or block transfers.	1/1/2017	Plan Action: The Plan will need to review their member-related communications as well as the website to ensure updates are made and the new reference is implemented.

AB 2394	Nonmedical Transportation	Makes nonmedical transportation (NMT) a covered benefit for all Medi-Cal beneficiaries. Defines "NMT" to include, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.	7/1/2017	Provide coverage for nonmedical transportation (NMT) for a beneficiary to obtain covered Medi-Cal services, subject to utilization controls and permissible time and distance standards. Plan action: Policies, procedures and member handbook information will need to be updated to ensure the benefit is being covered and communicated in accordance with the new requirements.
SB 1135	Notice of Timely Access	Requires health plans to provide information to enrollees regarding the standards for timely access to care which includes information regarding appointment wait times for urgent care, primary care, specialty care, and telephone screening. It also includes information related to receipt of interpreter services in a timely manner annually. This bill also requires this information to be provided to consumers upon initial enrollment, annually upon renewal, and to contracting providers no less than on an annual basis.	7/1/2017 - 1/1/2018	Plan Action: The Plan will need to implement a process to ensure members receive this information initially and annually and providers receive the information on an annual basis.
SB 999	Contraceptives: Annual Supply	Requires every health plan contract, to allow for a 12-month supply of FDA-approved, self-administered hormonal contraceptives be dispensed at one time for an enrollee.	1/1/2017	DHCS released APL 16-003 addressing these requirements. Plan Action: The Plan will need to update policies and procedures as well as oversight audit tools to ensure this requirement is met consistently.

Item #10

Attachment 10.C

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2017

Current as of End of the Month: January

Revised Date: 2/17/2017

CalViva - 2016																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2017 YTD**	**2016 YTD**
Expedited Grievances Received	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	0	17	131
Standard Grievances Received	77	0	0	77	0	0	0	0	0	0	0	0	0	0	0	0	77	709
Total Grievances Received	**94**	**0**	**0**	**94**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**94**	**840**
Grievance Ack Letters Sent Noncompliant	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	10
Grievance Ack Letter Compliance Rate	**97.4%**	**0.0%**	**0.0%**	**97.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**97.40%**	**98.6%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Expedited Grievances Resolved Compliant	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	0	17	128
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**97.7%**
Standard Grievances Resolved Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	59	0	0	59	0	0	0	0	0	0	0	0	0	0	0	0	59	698
Standard Grievance Compliance rate	**98.3%**	**0.0%**	**0.0%**	**98.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.33%**	**100.0%**
Total Grievances Resolved	**77**	**0**	**0**	**77**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**77**	**829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**52**	**0**	**0**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**567**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	25
Access - PCP - DHCS	19	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	19	127
Access - Physical/OON - DHCS	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Access - Spec - DHCS	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	34
Administrative	9	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14	129
Interpersonal	14	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	145
Mental Health	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Other	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	86
Pharmacy	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
Quality Of Care Grievances	**25**	**0**	**0**	**25**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**262**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	8
Access - PCP - DHCS	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	56
Access - Physical/OON - DHCS	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Access - Spec - DHCS	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	20
PCP Care	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100
PCP Delay	5	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	36
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	1	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	29
Specialist Delay	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	3
Exempt Grievances Received - New Classifications	279	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2153**	2153
Authorization	11	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	106
Avail of Appt w/ Other Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Avail of Appt w/ PCP	9	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	186
Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Claims Complaint	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Eligibility Issue	13	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	46
Health Care Benefits	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
ID Card - Not Received	30	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	113
Information Discrepancy	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	7	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	85
Interpersonal - Behavior of Clinic/Staff - Provider	79	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	589
Interpersonal - Behavior of Clinic/Staff - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	14
Other	13	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	51
PCP Assignment	98	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	777
Pharmacy	12	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	114
Wait Time - In Office for Scheduled Appt	4	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	33
Wait Time - Too Long on Telephone	3	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	33

CalViva Health Appeals and Grievances Dashboard 2016

Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**June**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**YTD**
Expedited Appeals Received	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	57
Standard Appeals Received	22	0	0	22	0	0	0	0	0	0	0	0	0	0	0	0	22	140
Total Appeals Received	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	28	**197**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.3%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	7	0	0	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	7	56
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Appeals Resolved Noncompliant	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	132
Standard Appeals Compliance Rate	**88.9%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Total Appeals Resolved	**17**	**0**	**0**	**17**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**188**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	17	0	0	**17**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**17**	184
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18
DME	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	35
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	23
Pharmacy	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	90
Surgery	3	0	0	3	0	0	0	0	0	0	2	2	0	0	0	0	5	18
Post Service Appeals	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	0	0	**5**	0	0	0	0	0	0	0	0	0	0	0	0	5	133
Uphold Rate	**29.4%**	**0.0%**	**0.0%**	**29.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**29.41%**	**70.7%**
Overturns - Full	9	0	0	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	9	47
Overturn Rate - Full	**52.9%**	**0.0%**	**0.0%**	**52.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**52.94%**	**25.0%**
Overturns - Partials	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	4
Overturn Rate - Partial	**17.6%**	**0.0%**	**0.0%**	**17.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**17.65%**	**2.1%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	4
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0%**	**0.0%**	**0.0%**	**0.0%**	**#DIV/0!**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**0.00%**	**2.1%**
Membership	350,692	-	-		-	-	-		-	-	-		-	-	-			
Appeals - PTMPM	0.05	-	-	0.05	-	-	-	-	-	-	-	-	-	-	-	-	0.05	0.05
Grievances - PTMPM	0.22	-	-	0.22	-	-	-	-	-	-	-	-	-	-	-	-	0.22	0.20

CalViva SPD only

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2017 YTD	2016 YTD
Expedited Grievances Received	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	34
Standard Grievances Received	21	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	21	205
Total Grievances Received	**27**	**0**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27**	**239**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	34
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	21	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	21	202
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**27**	**0**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	27	**236**
Grievance Descriptions - Resolved Cases	**27**	**0**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	27	**236**
Access to primary care	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	54
Access to specialists	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	13
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	11
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
QOC Non Access	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	51
QOS Non Access	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	106
Exempt Grievances Received - New Classifications	29	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0	0	**0**	**0**	241
Authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**29**
Avail of Appt w/ Other Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	0
Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	18
Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	0
Claims Complaint	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**0**
Eligibility Issue	2	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**3**
Health Care Benefits	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	0
ID Card - Not Received	2	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**10**
Information Discrepancy	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**0**
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	1	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	14
Interpersonal - Behavior of Clinic/Staff - Provider	10	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	78
Interpersonal - Behavior of Clinic/Staff - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	10
Other	1	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**4**
PCP Assignment	10	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	49
Pharmacy	2	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	**21**
Wait Time - In Office for Scheduled Appt	1	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	1
Wait Time - Too Long on Telephone	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	4

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	14
Standard Appeals Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	41
Total Appeals Received	**11**	**0**	**0**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	11	**55**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	15
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	1	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	4	0	0	4	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	4	39
Standard Appeals Compliance Rate	**75.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Appeals Resolved	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**54**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**51**
Consultation	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	4
DME	4	0	0	**4**	0	0	0	0	0	0	0	0	0	0	0	0	4	23
Experimental/Investigational	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	4
Pharmacy	4	0	0	**4**	0	0	0	0	0	0	0	0	0	0	0	0	4	18
Surgery	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Pharmacy	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	36
Uphold Rate	**12.5%**	**0.0%**	**0.0%**	**12.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**12.5%**	**66.7%**
Overturns - Full	5	0	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	16
Overturn Rate - Full	**62.5%**	**0.0%**	**0.0%**	**62.50%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**62.50%**	**29.63%**
Overturns - Partials	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	1
Overturn Rate - Partial	**25.0%**	**0.0%**	**0.0%**	**25.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**25.0%**	**1.9%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Membership	21,458																	
Appeals - PTMPM	0.37	-	-	0.37	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.09	0.21
Grievances - PTMPM	1.26	-	-	1.26	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.31	0.93

Item #10

Attachment 10.D

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 01/01/2016 to 1/31/2017

Report created 3/1/2017

Purpose of Report:

Summary report on Inpatient and Outpatient Utilization Metrics by Region, County, PPG entity
Reports show inpatient Rates with and without maternity, readmission, TAT Compliance, Care Management Programs

Exhibits:

Regional Team Lead Contact Information

Region	Contact Person
Region 3:	Jim Adlhoch

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 01/01/2016 to 1/31/2017
Report created 3/1/2017

ER utilization based on Claims data	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2016-Trend	2017-01	2017-Trend	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Qtr Trend	CY- 2016	CY-2017	CY-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	77,833	78,360	79,317	81,004	82,068	83,089	83,826	84,569	85,456	86,376	86,898	87,400		86,840		78,503	82,054	84,617	86,891		83,016	86,840	
Family/Adult/Other Mbr Mos	237,009	239,281	241,591	242,621	243,194	243,880	244,220	244,228	245,133	245,786	245,513	246,380		246,475		239,294	243,232	244,527	245,893		243,236	246,475	
SPD Mbr Months	27,679	27,852	28,001	28,191	28,232	28,446	28,633	28,801	28,940	29,113	29,248	29,400		29,564		27,844	28,290	28,791	29,254		28,545	29,564	
Admits - Count	2,178	2,192	2,270	2,055	2,289	2,048	2,147	2,265	2,187	2,128	2,095	2,266		2,212		2,213	2,131	2,200	2,163		2,177	2,212	
Expansion	531	549	554	511	614	524	543	609	582	552	555	633		588		545	550	578	580		563	588	
Family/Adult/Other	1,096	1,142	1,131	1,039	1,156	1,066	1,086	1,150	1,182	1,100	1,073	1,177		1,134		1,123	1,087	1,139	1,117		1,117	1,134	
SPD	546	500	582	502	518	457	514	506	423	476	465	454		488		543	492	481	465		495	488	
Admits Acute - Count	1,459	1,426	1,515	1,342	1,509	1,306	1,329	1,416	1,334	1,378	1,396	1,500		1,455		1,467	1,386	1,360	1,425		1,409	1,455	
Expansion	416	420	439	383	491	412	399	456	442	423	429	485		426		425	429	432	446		433	426	
Family/Adult/Other	531	541	549	491	548	471	457	489	497	520	533	593		573		540	503	481	549		518	573	
SPD	508	464	524	465	469	422	470	471	395	435	433	421		455		499	452	445	430		456	455	
Readmit 30 Day - Count	268	267	271	221	243	237	234	250	266	262	269	298		283		269	234	250	276		257	283	
Expansion	87	64	76	59	73	62	55	76	69	71	70	94		83		76	65	67	78		71	83	
Family/Adult/Other	73	91	72	54	66	74	75	68	94	85	93	100		97		79	65	79	93		79	97	
SPD	107	112	122	107	104	101	104	106	103	106	106	104		103		114	104	104	105		107	103	
Readmit 14 Day - Count	25	23	24	23	19	18	18	27	24	29	22	24		21		24	20	23	25		23	21	
Expansion	10	4	9	6	5	6	9	6	4	6	6	6		4		8	6	6	6		6	4	
Family/Adult/Other	6	8	6	8	6	3	2	10	11	11	8	5		9		7	6	8	8		7	9	
SPD	9	11	9	9	7	9	7	11	9	12	8	13		8		10	8	9	11		10	8	
**ER Visits - Count	15,341	16,373	17,110	14,859	17,471	15,492	16,313	16,776	17,260	17,101	15,670	15,389		5,876		16,275	15,941	16,783	16,053		16,263	5,876	
Expansion	2,840	2,544	2,972	3,031	3,198	3,137	4,236	4,092	3,899	3,728	3,488	3,394		1,338		2,785	3,122	4,076	3,537		3,380	1,338	
Family/Adult/Other	10,653	12,130	12,175	9,983	12,367	10,606	10,335	10,874	11,623	11,695	10,631	10,612		3,993		11,653	10,985	10,944	10,979		11,140	3,993	
SPD	1,848	1,699	1,963	1,845	1,906	1,749	1,715	1,796	1,734	1,671	1,545	1,375		538		1,837	1,833	1,748	1,530		1,737	538	
Admits Acute - PTMPY	50.7	49.3	52.0	45.8	51.2	44.1	44.7	47.5	44.5	45.8	46.3	49.6		48.1		50.7	47.0	45.6	47.2		47.6	48.1	
Expansion	64.1	64.3	66.4	56.7	71.8	59.5	57.1	64.7	62.1	58.8	59.2	66.6		58.9		65.0	62.7	61.3	61.5		62.6	58.9	
Family/Adult/Other	26.9	27.1	27.3	24.3	27.0	23.2	22.5	24.0	24.3	25.4	26.1	28.9		27.9		27.1	24.8	23.6	26.8		25.6	27.9	
SPD	220.2	199.9	224.6	197.9	199.3	178.0	197.0	196.2	163.8	179.3	177.7	171.8		184.7		214.9	191.7	185.6	176.3		191.9	184.7	
Bed Days Acute - PTMPY	240.4	213.4	243.3	203.7	227.7	196.1	196.4	205.4	201.7	211.8	215.4	238.9		216.7		232.3	209.2	201.2	222.1		216.1	216.7	
Expansion	325.3	320.5	334.2	270.9	326.7	272.5	263.5	322.2	310.8	305.4	304.1	358.1		297.7		326.7	290.1	299.0	322.6		309.5	297.7	
Family/Adult/Other	90.8	86.8	86.8	74.3	82.0	82.5	76.2	85.9	92.7	89.9	92.5	106.2		101.1		88.1	79.6	84.9	96.2		87.2	101.1	
SPD	1,294.6	1,010.8	1,336.2	1,116.5	1,194.4	944.1	1,016.7	875.8	802.8	963.7	982.6	995.5		942.5		1,213.9	1,084.6	898.0	980.7		1,042.5	942.5	
ALOS Acute	4.7	4.3	4.7	4.5	4.4	4.4	4.4	4.3	4.5	4.6	4.7	4.8		4.5		4.6	4.4	4.4	4.7		4.5	4.5	
Expansion	5.1	5.0	5.0	4.8	4.5	4.6	4.6	5.0	5.0	5.2	5.1	5.4		5.1		5.0	4.6	4.9	5.2		4.9	5.1	
Family/Adult/Other	3.4	3.2	3.2	3.1	3.0	3.6	3.4	3.6	3.8	3.5	3.5	3.7		3.6		3.3	3.2	3.6	3.6		3.4	3.6	
SPD	5.9	5.1	6.0	5.6	6.0	5.3	5.2	4.5	4.9	5.4	5.5	5.8		5.1		5.6	5.7	4.8	5.6		5.4	5.1	
Readmit % 30 Day - PTMPY	12.3%	12.2%	11.9%	10.8%	10.6%	11.6%	10.9%	11.0%	12.2%	12.3%	12.8%	13.2%		12.8%		12.1%	11.0%	11.4%	12.8%		11.8%	12.8%	
Expansion	16.4%	11.7%	13.7%	11.5%	11.9%	11.8%	10.1%	12.5%	11.9%	12.9%	12.6%	14.8%		14.1%		13.9%	11.8%	11.5%	13.5%		12.7%	14.1%	
Family/Adult/Other	6.7%	8.0%	6.4%	5.2%	5.7%	6.9%	6.9%	5.9%	8.0%	7.7%	8.7%	8.5%		8.6%		7.0%	5.9%	6.9%	8.3%		7.1%	8.6%	
SPD	19.6%	22.4%	21.0%	21.3%	20.1%	22.1%	20.2%	20.9%	24.3%	22.3%	22.8%	22.9%		21.1%		20.9%	21.1%	21.7%	22.7%		21.6%	21.1%	
Readmit % 14 Day - PTMPY	1.7%	1.6%	1.6%	1.7%	1.3%	1.4%	1.4%	1.9%	1.8%	2.1%	1.6%	1.6%		1.4%		1.6%	1.4%	1.7%	1.8%		1.6%	1.4%	
Expansion	2.4%	1.0%	2.1%	1.6%	1.0%	1.5%	2.3%	1.3%	0.9%	1.4%	1.4%	1.2%		0.9%		1.8%	1.3%	1.5%	1.3%		1.5%	0.9%	
Family/Adult/Other	1.1%	1.5%	1.1%	1.6%	1.1%	0.6%	0.4%	2.0%	2.2%	2.1%	1.5%	0.8%		1.6%		1.2%	1.1%	1.6%	1.5%		1.4%	1.6%	
SPD	1.8%	2.4%	1.7%	1.9%	1.5%	2.1%	1.5%	2.3%	2.3%	2.8%	1.8%	3.1%		1.8%		1.9%	1.8%	2.0%	2.6%		2.1%	1.8%	
**ER Visits - PTMPY	598.8	638.7	663.0	569.0	662.3	582.2	548.8	563.0	576.1	568.0	519.9	508.5		194.3		562.3	540.9	562.7	532.1		549.4	194.3	
Expansion	437.9	389.6	449.6	449.0	467.6	453.1	606.4	580.6	547.5	517.9	481.7	466.0		184.9		425.8	456.6	578.0	488.4		488.6	184.9	
Family/Adult/Other	539.4	608.3	604.7	493.8	610.2	521.9	507.8	534.3	569.0	571.0	519.6	516.9		194.4		584.4	542.0	537.1	535.8		549.6	194.4	
SPD	801.2	732.0	841.3	785.4	810.1	737.8	718.8	748.3	719.0	688.8	633.9	561.2		218.4		791.6	777.7	728.7	627.8		730.3	218.4	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 01/01/2016 to 1/31/2017
Report created 3/1/2017

ER utilization based on Claims data	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2016-Trend	2017-01	2017-Trend	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Qtr Trend	CY- 2016	CY-2017	CY-Trend
Services	**TAT Compliance Goal: 100%**													**Compliance Goal:**		**TAT Compliance Goal: 100%**					**TAT Compliance Goal: 100%**		
Preservice Routine	96.7%	86.7%	100.0%	100.0%	100.0%	73.3%	73.3%	93.3%	100.0%	96.7%	93.3%	100.0%		100.0%		94.5%	91.1%	88.9%	96.7%		88%		
Preservice Urgent	90.0%	93.3%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		94.4%	97.8%	100.0%	100.0%		92%		
Postservice	80.0%	93.6%	100.0%	100.0%	96.7%	100.0%	100.0%	90.0%	100.0%	96.7%	96.7%	96.7%		96.7%		91.2%	98.9%	96.7%	96.7%		87%		
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	90.0%	96.7%	93.3%	90.0%	93.3%	100.0%		100.0%		100.0%	100.0%	93.3%	94.4%		100%		
Deferrals - Routine	80.0%	73.3%	100.0%	100.0%	96.7%	73.3%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%		100.0%		84.4%	90.0%	98.9%	100.0%		77%		
Deferrals - Urgent	50.0%	61.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		70.5%	100.0%	100.0%	100.0%		56%		
Deferrals - Post Service	null	null	null	null	null	null	null	null	null	null	null	null		null		null	null	null	null		null		
	CCS ID RATE													**CS ID RAT**		**CCS ID RATE**					**CCS ID RATE**		
CCS %	7.61%	7.17%	7.25%	7.20%	7.30%	7.35%	7.43%	7.36%	7.23%	7.25%	7.25%	7.28%		7.19%		7.34%	7.28%	7.34%	7.26%		7.45%	7.19%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand													**ternity Utilizatin A Rate Per Thousanc**		**Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand**							
Births	20.9	21.5	20.8	19.6	21.6	20.6	23.1	23.9	24.0	20.3	18.7	21.0		20.7		21.1	20.6	23.7	20.0		21.3		
OB % Days	14.2%	16.7%	14.7%	15.7%	15.2%	17.0%	18.4%	18.4%	18.1%	15.2%	15.8%	15.2%		16.4%		15.2%	16.0%	18.3%	15.4%		17.0%		
OB % Admits	27.6%	28.4%	26.7%	28.0%	27.8%	29.8%	32.0%	31.5%	32.8%	28.7%	27.0%	28.0%		28.3%		27.6%	28.5%	32.1%	27.9%		30.0%		
	Complex Cases													**Complex Cases**		**Complex Cases**					**Complex Cases**		
Total Members Outreached	97	163	63	132	79	83	177	147	0	0	0	0				323	294	324	0				
Total New Cases Open	31	37.0	9	32	37	30	46	73	2	0	0	0				77	99	121	0				
Total Cases Closed	83	173	95	88	138	107	102	147	105	29	27	25				351	328	354	81				
Total Cases Open During Montl	162	180	132	137	135	106	118	151	126	81	52	25				222	205	183	81				
	Ambulatory Case Management													**atory Case Manag**		**Ambulatory Case Management**					**Ambulatory Case Manageme**		
Total Outreached	112	138	138	133	113	68	67	61								0	314	0	0		830		
Accepted	58	77	62	68	48	23	27	25								0	139	0	0		388		
Acceptance Rate	52%	56%	45%	51%	42%	34%	40%	41%								-	44%	41%	-		47%		
New Cases Opened	60	74	63	68	45	20	27	31								0	133	0	0		388		
Total Cases Open During Perioc	235	258	222	299	294	251	210	197								NA	NA	NA	NA		N/A		
Total Cases Closed	51	33	54	50	63	66	46	61								0	179	0	0		424		
Cases Ending Open	184	225	168	249	231	185	164	136								NA	NA	NA	NA		N/A		
	Perinatal Case Management													**atal Case Manage**		**Perinatal Case Management**					**Perinatal Case Management**		
Total Outreached	15	15	12	41	77	61	80	20	45	53	35	15		27		103	179	0	103		469	27	
Accepted	6	7	1	8	12	9	9	3	33	17	9	2		8		28	29	0	28		116	8	
Acceptance Rate	40%	47%	8%	20%	16%	15%	11%	15%	73%	32%	26%	13%		30%		24%	16%	31%	27%		25%	30%	
New Cases Opened	7	8	5	7	13	10	9	2	29	17	9	2		8		28	30	0	28		118	8	
Total Cases Open During Perioc	33	35	31	44	44	50	55	45	53	50	52	49		50		NA	NA	NA	61		N/A	50	
Total Cases Closed	6	4	6	13	5	4	10	13	24	7	5	5		10		17	22	0	17		102	10	
Cases Ending Open	27	31	25	31	39	46	45	32		43	47	44		40		NA	NA	NA	N/A		N/A	40	
	Integrated Case Management													**ated Case Manage**		**Integrated Case Management**					**Integrated Case Management**		
Total Outreached									133	116	71	78		220				0	265		398	220	
Accepted									118	44	19	22		43				0	85		203	43	
Acceptance Rate									89%	38%	27%	28%		20%				-	32%		51%	20%	
Total Screened and Refused/Decline									5	23	15	17		35				0	55		60	35	
Unable to Reach									10	19	33	35		50				0	87		97	50	
New Cases Opened									65	44	19	22		43				0	85		150	43	
Total Cases Closed									32	180	175	174		179				0	220		N/A	179	
Cases Ending Open									65	24	23	39		37				0	86		79	37	
Total Cases Open During Period									97	156	152	135		142				NA	N/A		N/A	142	
Critical-Complex Acuity									1	16	23	30		42				0	30		N/A	42	
High/Moderate/Low Acuity									142	164	152	144		137				NA	190		N/A	137	
	Record Processing													**Record Processing**		**Record Processing**					**Record Processing**		
Total Records	4,849	4,817	5,388	4,685	4,978	4,872	4,572	5,182	5,054	4,976	4,902	5,089		5,013		15,054	14,535	14,808	14,967		59,364	5,013	
Total Admissions	2,181	2,132	2,200	1,999	2,232	2,003	2,080	2,189	2,142	2,068	2,048	2,866		2,230		6,513	6,234	6,411	6,982		26,140	2,230	
Total Precerts	-	-	-	-	-	-	-	-	-	-	-	-											

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 01/01/2016 to 1/31/2017
Report created 3/1/2017
Fresno County

ER utilization based on Claims data	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2016-Trend	2017-01	2017-Trend	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Qtr Trend	CY- 2016	CY-2017	CY-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	64,423	64,812	65,633	67,185	68,181	69,083	69,746	70,416	71,268	72,073	72,563	72,942		72,320		64,956	68,150	70,477	72,526		69,027	72,320	
Family/Adult/Other Mbr M	195,605	197,363	199,333	199,989	200,523	201,091	201,399	201,470	202,483	202,973	202,711	203,363		203,103		197,434	200,534	201,784	203,016		200,692	203,103	
SPD Mbr Months	23,369	23,542	23,669	23,850	23,890	24,080	24,251	24,403	24,520	24,690	24,786	24,902		25,030		23,527	23,940	24,391	24,793		24,163	25,030	
Admits - Count	1,877	1,950	2,011	1,786	2,012	1,821	1,870	1,973	1,867	1,855	1,873	2,016		1,939		1,946	1,873	1,903	1,915		1,909	1,939	
Expansion	457	485	500	437	540	457	478	540	488	484	499	568		517		481	478	502	517		494	517	
Family/Adult/Other	926	1,014	974	885	999	950	917	983	1,004	953	947	1,026		976		971	945	968	975		965	976	
SPD	490	450	534	461	472	413	471	450	375	418	426	420		444		491	449	432	421		448	444	
Admits Acute - Count	1,262	1,260	1,347	1,178	1,346	1,145	1,168	1,245	1,154	1,201	1,242	1,348		1,292		1,290	1,223	1,189	1,264		1,241	1,292	
Expansion	355	367	392	324	440	357	351	408	377	377	390	440		376		371	374	379	402		382	376	
Family/Adult/Other	448	475	470	426	477	407	381	417	426	442	454	518		498		464	437	408	471		445	498	
SPD	456	417	482	425	428	380	433	420	351	382	397	389		417		452	411	401	389		413	417	
Readmit 30 Day - Count	238	237	243	194	217	213	210	226	232	233	238	277		263		239	208	223	249		230	263	
Expansion	74	59	66	48	63	53	49	69	61	63	66	90		78		66	55	60	73		63	78	
Family/Adult/Other	65	75	61	47	57	66	61	58	75	73	78	89		86		67	57	65	80		67	86	
SPD	98	103	115	98	97	94	100	99	96	97	94	98		99		105	96	98	96		99	99	
Readmit 14 Day - Count	19	20	23	21	18	18	16	25	23	24	18	23		21		21	19	21	22		21	21	
Expansion	5	3	9	4	4	6	7	6	4	6	5	6		4		6	5	6	6		5	4	
Family/Adult/Other	6	7	5	8	6	3	2	8	11	7	6	5		9		6	6	7	6		6	9	
SPD	8	10	9	9	7	9	7	11	8	11	7	12		8		9	8	9	10		9	8	
**ER Visits - Count	15,341	16,373	17,110	14,859	17,471	15,492	13,484	13,839	14,226	14,156	13,063	13,415		5,232		16,275	15,941	13,850	13,545		14,902	5,232	
Expansion	2,840	2,544	2,972	3,031	3,198	3,137	3,448	3,356	3,252	3,082	2,946	2,990		1,205		2,785	3,122	3,352	3,006		3,066	1,205	
Family/Adult/Other	10,653	12,130	12,175	9,983	12,367	10,606	8,568	8,961	9,530	9,671	8,758	9,211		3,529		11,653	10,985	9,020	9,213		10,218	3,529	
SPD	1,848	1,699	1,963	1,845	1,906	1,749	1,449	1,511	1,440	1,397	1,354	1,207		491		1,837	1,833	1,467	1,319		1,614	491	
Admits Acute - PTMPY	53.1	52.7	55.9	48.6	55.2	46.7	47.4	50.4	46.4	48.1	49.7	53.7		51.6		53.9	50.1	48.1	50.5		50.6	51.6	
Expansion	66.1	68.0	71.7	57.9	77.4	62.0	60.4	69.5	63.5	62.8	64.5	72.4		62.4		68.6	65.8	64.5	66.6		66.3	62.4	
Family/Adult/Other	27.5	28.9	28.3	25.6	28.5	24.3	22.7	24.8	25.2	26.1	26.9	30.6		29.4		28.2	26.1	24.3	27.9		26.6	29.4	
SPD	234.2	212.6	244.4	213.8	215.0	189.4	214.3	206.5	171.8	185.7	192.2	187.5		199.9		230.4	206.0	197.4	188.4		205.3	199.9	
Bed Days Acute - PTMPY	254.5	228.8	256.0	218.7	243.6	208.6	207.0	224.5	207.2	225.1	235.6	261.8		237.6		246.5	223.6	212.9	240.9		230.9	237.6	
Expansion	338.5	341.8	330.9	269.5	354.6	290.3	277.0	354.5	317.6	317.0	343.5	400.6		321.4		337.0	304.9	316.5	353.9		328.3	321.4	
Family/Adult/Other	93.2	89.8	90.4	78.8	81.8	81.9	71.3	90.7	87.7	92.8	93.4	107.6		109.1		91.1	80.8	83.3	97.9		88.3	109.1	
SPD	1,381.8	1,092.9	1,442.9	1,239.2	1,282.4	1,029.1	1,122.8	954.5	873.1	1,045.0	1,082.1	1,113.2		1,038.0		1,305.9	1,183.1	983.0	1,080.2		1,136.1	1,038.0	
ALOS Acute	4.8	4.3	4.6	4.5	4.4	4.5	4.4	4.5	4.5	4.7	4.7	4.9		4.6		4.6	4.5	4.4	4.8		4.6	4.6	
Expansion	5.1	5.0	4.6	4.7	4.6	4.7	4.6	5.1	5.0	5.1	5.3	5.5		5.2		4.9	4.6	4.9	5.3		4.9	5.2	
Family/Adult/Other	3.4	3.1	3.2	3.1	2.9	3.4	3.1	3.7	3.5	3.5	3.5	3.5		3.7		3.2	3.1	3.4	3.5		3.3	3.7	
SPD	5.9	5.1	5.9	5.8	6.0	5.4	5.2	4.6	5.1	5.6	5.6	5.9		5.2		5.7	5.7	5.0	5.7		5.5	5.2	
Readmit % 30 Day - PTMPY	12.7%	12.2%	12.1%	10.9%	10.8%	11.7%	11.2%	11.5%	12.4%	12.6%	12.7%	13.7%		13.6%		12.3%	11.1%	11.7%	13.0%		12.0%	13.6%	
Expansion	16.2%	12.2%	13.2%	11.0%	11.7%	11.6%	10.3%	12.8%	12.5%	13.0%	13.2%	15.8%		15.1%		13.8%	11.4%	11.9%	14.1%		12.8%	15.1%	
Family/Adult/Other	7.0%	7.4%	6.3%	5.3%	5.7%	6.9%	6.7%	5.9%	7.5%	7.7%	8.2%	8.7%		8.8%		6.9%	6.0%	6.7%	8.2%		7.0%	8.8%	
SPD	20.0%	22.9%	21.5%	21.3%	20.6%	22.8%	21.2%	22.0%	25.6%	23.2%	22.1%	23.3%		22.3%		21.4%	21.5%	22.8%	22.9%		22.1%	22.3%	
Readmit % 14 Day - PTMPY	1.5%	1.6%	1.7%	1.8%	1.3%	1.6%	1.4%	2.0%	2.0%	2.0%	1.4%	1.7%		1.6%		1.6%	1.6%	1.8%	1.7%		1.7%	1.6%	
Expansion	1.4%	0.8%	2.3%	1.2%	0.9%	1.7%	2.0%	1.5%	1.1%	1.6%	1.3%	1.4%		1.1%		1.5%	1.2%	1.5%	1.4%		1.4%	1.1%	
Family/Adult/Other	1.3%	1.5%	1.1%	1.9%	1.3%	0.7%	0.5%	1.9%	2.6%	1.6%	1.3%	1.0%		1.8%		1.3%	1.3%	1.7%	1.3%		1.4%	1.8%	
SPD	1.8%	2.4%	1.9%	2.1%	1.6%	2.4%	1.6%	2.6%	2.3%	2.9%	1.8%	3.1%		1.9%		2.0%	2.0%	2.2%	2.6%		2.2%	1.9%	
**ER Visits - PTMPY	598.8	638.7	663.0	569.0	662.3	582.2	547.8	560.5	572.3	566.7	522.4	534.4		209.0		680.2	653.6	560.2	541.2		607.9	209.0	
Expansion	529.0	471.0	543.4	541.4	562.9	544.9	593.2	571.9	547.6	513.1	487.2	491.9		199.9		514.6	549.7	570.7	497.4		533.1	199.9	
Family/Adult/Other	653.5	737.5	732.9	599.0	740.1	632.9	510.5	533.7	564.8	571.8	518.5	543.5		208.5		708.2	657.4	536.4	544.6		611.0	208.5	
SPD	948.9	866.0	995.2	928.3	957.4	871.6	717.0	743.0	704.7	679.0	655.5	581.6		235.4		936.8	919.0	721.6	638.6		801.6	235.4	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 01/01/2016 to 1/31/2017
Report created 3/1/2017
Kings County

ER utilization based on Claims data	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2016-Trend	2017-01	2017-Trend	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Qtr Trend	CY- 2016	CY-2017	CY-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	6,125	6,261	6,327	6,394	6,415	6,433	6,420	6,420	6,380	6,455	6,461	6,498		6,571		6,238	6,414	6,407	6,471		6,382	6,571	
Family/Adult/Other Mbr M	16,958	17,262	17,435	17,528	17,493	17,550	17,585	17,567	17,353	17,438	17,416	17,572		17,756		17,218	17,524	17,502	17,475		17,430	17,756	
SPD Mbr Months	2,087	2,092	2,101	2,104	2,109	2,115	2,124	2,136	2,152	2,153	2,168	2,188		2,208		2,093	2,109	2,137	2,170		2,127	2,208	
Admits - Count	103	52	72	63	79	53	81	73	85	76	50	71		71		76	65	80	66		72	71	
Expansion	21	16	12	14	22	13	21	15	29	15	11	20		25		16	16	22	15		17	25	
Family/Adult/Other	59	25	46	33	49	27	50	45	43	41	29	40		36		43	36	46	37		41	36	
SPD	23	11	14	16	8	13	10	13	13	20	10	11		10		16	12	12	14		14	10	
Admits Acute - Count	63	38	45	40	42	36	48	42	46	52	34	38		29		49	39	45	41		44	29	
Expansion	19	14	12	8	13	9	15	11	16	11	6	13		14		15	10	14	10		12	14	
Family/Adult/Other	23	13	22	16	22	14	25	20	17	23	19	16		9		19	17	21	19		19	9	
SPD	21	11	11	16	7	13	8	11	13	18	9	9		6		14	12	11	12		12	6	
Readmit 30 Day - Count	9	5	5	6	5	4	7	5	7	9	5	6		3		6	5	6	7		6	3	
Expansion	3	2	2	1	1	0	1	1	1	0	0	0		3		2	1	1	0		1	3	
Family/Adult/Other	2	2	1	1	4	2	4	4	3	7	4	3		0		2	2	4	5		3	0	
SPD	4	1	2	4	0	2	2	0	3	2	1	3		0		2	2	2	2		2	0	
Readmit 14 Day - Count	0	0	0	0	0	0	1	1	0	5	1	1		0		0	0	1	2		1	0	
Expansion	0	0	0	0	0	0	1	0	0	0	0	0		0		0	0	0	0		0	0	
Family/Adult/Other	0	0	0	0	0	0	0	1	0	4	1	0		0		0	0	0	2		1	0	
SPD	0	0	0	0	0	0	0	0	0	1	0	1		0		0	0	0	1		0	0	
**ER Visits - Count	15,341	16,373	17,110	14,859	17,471	15,492	1,420	1,445	1,492	1,433	1,095	602		270		16,275	15,941	1,452	1,043		8,678	270	
Expansion	2,840	2,544	2,972	3,031	3,198	3,137	458	412	355	370	262	146		71		2,785	3,122	408	259		1,644	71	
Family/Adult/Other	10,653	12,130	12,175	9,983	12,367	10,606	793	855	946	892	711	388		175		11,653	10,985	865	664		6,042	175	
SPD	1,848	1,699	1,963	1,845	1,906	1,749	163	175	191	170	121	67		24		1,837	1,833	176	119		991	24	
Admits Acute - PTMPY	29.6	17.6	20.8	18.4	19.4	16.6	22.0	19.3	21.3	24.0	15.7	17.4		13.1		22.7	18.1	20.9	19.0		20.2	13.1	
Expansion	37.2	26.8	22.8	15.0	24.3	16.8	28.0	20.6	30.1	20.4	11.1	24.0		25.6		28.9	18.7	26.2	18.5		23.0	25.6	
Family/Adult/Other	16.3	9.0	15.1	11.0	15.1	9.6	17.1	13.7	11.8	15.8	13.1	10.9		6.1		13.5	11.9	14.2	13.3		13.2	6.1	
SPD	120.7	63.1	62.8	91.3	39.8	73.8	45.2	61.8	72.5	100.3	49.8	49.4		32.6		82.2	68.3	59.9	66.4		69.1	32.6	
Bed Days Acute - PTMPY	119.2	74.8	66.6	75.6	68.7	86.9	69.8	59.3	84.4	96.8	59.9	65.8		41.6		86.7	77.1	71.1	74.1		77.2	41.6	
Expansion	201.8	145.7	58.8	82.6	93.5	78.3	121.5	76.6	139.2	156.2	42.7	134.8		62.1		134.7	84.8	112.4	111.3		110.6	62.1	
Family/Adult/Other	47.4	25.0	42.0	21.9	43.2	42.4	45.0	41.7	44.9	36.5	47.5	28.0		19.6		38.1	35.8	43.9	37.3		38.8	19.6	
SPD	483.0	281.1	297.0	501.9	204.8	482.3	118.6	151.7	239.8	406.9	210.3	164.5		157.6		353.5	396.3	170.3	259.9		294.3	157.6	
ALOS Acute	4.0	4.2	3.2	4.1	3.5	5.3	3.2	3.1	4.0	4.0	3.8	3.8		3.2		3.8	4.3	3.4	3.9		3.8	3.2	
Expansion	5.4	5.4	2.6	5.5	3.8	4.7	4.3	3.7	4.6	7.6	3.8	5.6		2.4		4.7	4.5	4.3	6.0		4.8	2.4	
Family/Adult/Other	2.9	2.8	2.8	2.0	2.9	4.4	2.6	3.1	3.8	2.3	3.6	2.6		3.2		2.8	3.0	3.1	2.8		2.9	3.2	
SPD	4.0	4.5	4.7	5.5	5.1	6.5	2.6	2.5	3.3	4.1	4.2	3.3		4.8		4.3	5.8	2.8	3.9		4.3	4.8	
Readmit % 30 Day - PTMPY	8.7%	9.6%	6.9%	9.5%	6.3%	7.5%	8.6%	6.8%	8.2%	11.8%	10.0%	8.5%		4.2%		8.4%	7.7%	7.9%	10.2%		8.5%	4.2%	
Expansion	14.3%	12.5%	16.7%	7.1%	4.5%	0.0%	4.8%	6.7%	3.4%	0.0%	0.0%	0.0%		12.0%		14.3%	4.1%	4.6%	0.0%		5.7%	12.0%	
Family/Adult/Other	3.4%	8.0%	2.2%	3.0%	8.2%	7.4%	8.0%	8.9%	7.0%	17.1%	13.8%	7.5%		0.0%		3.8%	6.4%	8.0%	12.7%		7.6%	0.0%	
SPD	17.4%	9.1%	14.3%	25.0%	0.0%	15.4%	20.0%	0.0%	23.1%	10.0%	10.0%	27.3%		0.0%		14.6%	16.2%	13.9%	14.6%		14.8%	0.0%	
Readmit % 14 Day - PTMPY	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%	2.4%	0.0%	9.6%	2.9%	2.6%		0.0%		0.0%	0.0%	1.5%	5.6%		1.7%	0.0%	
Expansion	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%		0.0%	0.0%	2.4%	0.0%		0.7%	0.0%	
Family/Adult/Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	17.4%	5.3%	0.0%		0.0%		0.0%	0.0%	1.6%	8.6%		2.6%	0.0%	
SPD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.0%	11.1%		0.0%		0.0%	0.0%	0.0%	5.6%		1.4%	0.0%	
**ER Visits - PTMPY	598.8	638.7	663.0	569.0	662.3	582.2	652.1	663.8	691.7	660.2	504.5	275.1		122.1		7,574.9	7,342.6	669.1	479.4		4,005.3	122.1	
Expansion	5,564.1	4,875.9	5,636.8	5,688.5	5,982.2	5,851.7	856.1	770.1	667.7	687.8	486.6	269.6		129.7		5,358.4	5,841.0	764.8	480.9		3,090.5	129.7	
Family/Adult/Other	7,538.4	8,432.4	8,379.7	6,834.6	8,483.6	7,252.0	541.1	584.0	654.2	613.8	489.9	265.0		118.3		8,121.1	7,522.6	592.9	455.7		4,159.5	118.3	
SPD	10,625.8	9,745.7	11,211.8	10,522.8	10,845.0	9,923.4	920.9	983.1	1,065.1	947.5	669.7	367.5		130.4		10,528.7	10,429.8	990.0	660.0		5,592.2	130.4	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 01/01/2016 to 1/31/2017
Report created 3/1/2017
Madera County

ER utilization based on Claims data	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2016-Trend	2017-01	2017-Trend	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Qtr Trend	CY- 2016	CY-2017	CY-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	7,285	7,287	7,357	7,425	7,472	7,573	7,660	7,733	7,808	7,848	7,874	7,960		7,949		7,310	7,490	7,734	7,894		7,607	7,949	
Family/Adult/Other Mbr M	24,446	24,656	24,823	25,104	25,178	25,239	25,236	25,191	25,297	25,375	25,386	25,445		25,616		24,642	25,174	25,241	25,402		25,115	25,616	
SPD Mbr Months	2,223	2,218	2,231	2,237	2,233	2,251	2,258	2,262	2,268	2,270	2,294	2,310		2,326		2,224	2,240	2,263	2,291		2,255	2,326	
Admits - Count	198	190	187	206	198	174	196	219	235	197	172	179		202		192	193	217	183		196	202	
Expansion	53	48	42	60	52	54	44	54	65	53	45	45		46		48	55	54	48		51	46	
Family/Adult/Other	111	103	111	121	108	89	119	122	135	106	97	111		122		108	106	125	105		111	122	
SPD	33	39	34	25	38	31	33	43	35	38	29	23		34		35	31	37	30		33	34	
Admits Acute - Count	134	128	123	124	121	125	113	129	134	125	120	114		134		128	123	125	120		124	134	
Expansion	42	39	35	51	38	46	33	37	49	35	33	32		36		39	45	40	33		39	36	
Family/Adult/Other	60	53	57	49	49	50	51	52	54	55	60	59		66		57	49	52	58		54	66	
SPD	31	36	31	24	34	29	29	40	31	35	27	23		32		33	29	33	28		31	32	
Readmit 30 Day - Count	21	25	23	21	21	20	17	19	27	20	26	15		17		23	21	21	20		21	17	
Expansion	10	3	8	10	9	9	5	6	7	8	4	4		2		7	9	6	5		7	2	
Family/Adult/Other	6	14	10	6	5	6	10	6	16	5	11	8		11		10	6	11	8		9	11	
SPD	5	8	5	5	7	5	2	7	4	7	11	3		4		6	6	4	7		6	4	
Readmit 14 Day - Count	6	3	1	2	1	0	1	1	1	0	3	0		0		3	1	1	1		2	0	
Expansion	5	1	0	2	1	0	1	0	0	0	1	0		0		2	1	0	0		1	0	
Family/Adult/Other	0	1	1	0	0	0	0	1	0	0	1	0		0		1	0	0	0		0	0	
SPD	1	1	0	0	0	0	0	0	1	0	1	0		0		1	0	0	0		0	0	
**ER Visits - Count	15,341	16,373	17,110	14,859	17,471	15,492	1,409	1,492	1,542	1,512	1,512	1,372		374		16,275	15,941	1,481	1,465		8,790	374	
Expansion	2,840	2,544	2,972	3,031	3,198	3,137	330	324	292	276	280	258		62		2,785	3,122	315	271		1,624	62	
Family/Adult/Other	10,653	12,130	12,175	9,983	12,367	10,606	974	1,058	1,147	1,132	1,162	1,013		289		11,653	10,985	1,060	1,102		6,200	289	
SPD	1,848	1,699	1,963	1,845	1,906	1,749	103	110	103	104	70	101		23		1,837	1,833	105	92		967	23	
Admits Acute - PTMPY	46.8	44.7	42.8	42.8	41.6	42.8	38.6	44.0	45.5	42.3	40.5	38.3		44.8		44.8	42.4	42.7	40.4		42.5	44.8	
Expansion	69.2	64.2	57.1	82.4	61.0	72.9	51.7	57.4	75.3	53.5	50.3	48.2		54.3		63.5	72.1	61.5	50.7		61.8	54.3	
Family/Adult/Other	29.5	25.8	27.6	23.4	23.4	23.8	24.3	24.8	25.6	26.0	28.4	27.8		30.9		27.6	23.5	24.9	27.4		25.8	30.9	
SPD	167.3	194.8	166.7	128.7	182.7	154.6	154.1	212.2	164.0	185.0	141.2	119.5		165.1		176.3	155.3	176.8	148.4		164.1	165.1	
Bed Days Acute - PTMPY	213.1	188.8	269.2	174.2	213.6	172.5	201.1	153.1	241.2	183.9	158.6	172.7		170.9		223.8	186.8	198.5	171.7		195.0	170.9	
Expansion	313.0	281.6	600.2	446.1	271.4	275.7	260.1	232.8	388.8	321.1	155.4	150.8		276.3		398.9	330.6	294.3	208.8		306.2	276.3	
Family/Adult/Other	101.6	105.6	89.9	75.0	110.1	115.1	136.5	78.6	165.6	103.6	116.3	148.6		93.7		99.0	100.1	126.9	122.8		112.3	93.7	
SPD	1,139.0	827.8	1,183.3	386.2	1,187.6	469.1	722.8	710.9	576.7	607.9	638.2	514.3		660.4		1,050.4	680.3	670.0	586.6		745.1	660.4	
ALOS Acute	4.6	4.2	6.3	4.1	5.1	4.0	5.2	3.5	5.3	4.4	3.9	4.5		3.8		5.0	4.4	4.7	4.3		4.6	3.8	
Expansion	4.5	4.4	10.5	5.4	4.4	3.8	5.0	4.1	5.2	6.0	3.1	3.1		5.1		6.3	4.6	4.8	4.1		5.0	5.1	
Family/Adult/Other	3.5	4.1	3.3	3.2	4.7	4.8	5.6	3.2	6.5	4.0	4.1	5.3		3.0		3.6	4.3	5.1	4.5		4.3	3.0	
SPD	6.8	4.3	7.1	3.0	6.5	3.0	4.7	3.4	3.5	3.3	4.5	4.3		4.0		6.0	4.4	3.8	4.0		4.5	4.0	
Readmit % 30 Day - PTMPY	10.6%	13.2%	12.3%	10.2%	10.6%	11.5%	8.7%	8.7%	11.5%	10.2%	15.1%	8.4%		8.4%		12.0%	10.7%	9.7%	11.1%		10.8%	8.4%	
Expansion	18.9%	6.3%	19.0%	16.7%	17.3%	16.7%	11.4%	11.1%	10.8%	15.1%	8.9%	8.9%		4.3%		14.7%	16.9%	11.0%	11.2%		13.5%	4.3%	
Family/Adult/Other	5.4%	13.6%	9.0%	5.0%	4.6%	6.7%	8.4%	4.9%	11.9%	4.7%	11.3%	7.2%		9.0%		9.2%	5.3%	8.5%	7.6%		7.7%	9.0%	
SPD	15.2%	20.5%	14.7%	20.0%	18.4%	16.1%	6.1%	16.3%	11.4%	18.4%	37.9%	13.0%		11.8%		17.0%	18.1%	11.7%	23.3%		17.2%	11.8%	
Readmit % 14 Day - PTMPY	4.5%	2.3%	0.8%	1.6%	0.8%	0.0%	0.9%	0.8%	0.7%	0.0%	2.5%	0.0%		0.0%		2.6%	0.8%	0.8%	0.8%		1.3%	0.0%	
Expansion	11.9%	2.6%	0.0%	3.9%	2.6%	0.0%	3.0%	0.0%	0.0%	0.0%	3.0%	0.0%		0.0%		5.2%	2.2%	0.8%	1.0%		2.3%	0.0%	
Family/Adult/Other	0.0%	1.9%	1.8%	0.0%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%	1.7%	0.0%		0.0%		1.2%	0.0%	0.6%	0.6%		0.6%	0.0%	
SPD	3.2%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	0.0%	3.7%	0.0%		0.0%		2.0%	0.0%	1.0%	1.2%		1.1%	0.0%	
**ER Visits - PTMPY	598.8	638.7	663.0	569.0	662.3	582.2	481.0	508.8	523.1	511.2	510.3	461.0		125.0		5,675.1	5,479.6	504.3	494.1		3,010.7	125.0	
Expansion	4,678.1	4,189.4	4,847.6	4,898.6	5,136.0	4,970.8	517.0	502.8	448.8	422.0	426.7	388.9		93.6		4,572.6	5,001.9	489.3	412.5		2,561.1	93.6	
Family/Adult/Other	5,229.3	5,903.6	5,885.7	4,772.0	5,894.2	5,042.7	463.1	504.0	544.1	535.3	549.3	477.7		135.4		5,674.6	5,236.6	503.8	520.7		2,962.4	135.4	
SPD	9,975.7	9,192.1	10,558.5	9,897.2	10,242.7	9,323.9	547.4	583.6	545.0	549.8	366.2	524.7		118.7		9,910.1	9,820.0	558.6	480.1		5,145.5	118.7	

Item #10

Attachment 10.E

QIUM Quarterly Summary Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick C. Marabella, MD
Amy Schneider, RN

COMMITTEE DATE: March 16th, 2017

SUBJECT: CalViva Health QI/UM Update of Activities in Quarter 1 2017 (February)

Purpose of Activity:

This report is to provide the RHA Commission with an update on the CalViva Health QI/UM performance, program and regulatory activities in Quarter 1 of 2017.

I. Meetings

One QI/UM Committee meeting has been held to date in Quarter 1, on February 16th, 2017. The following guiding documents were approved at the February meeting:

1. 2016 QI Annual Evaluation
2. 2016 UMCM Annual Evaluation
3. 2017 UMCM Program Description

Additionally, the following general documents were reviewed and approved at this meeting:

1. Medical Policies Qtr 3
2. Medication Provider Update Qtr 4

The following is a summary of some, but not all, of the reports and topics reviewed:

- **Quality Improvement Reports -** The quality and safety of many of the health plan functions are assessed and monitored through quality improvement reports. These reports cover health plan performance, programmatic documents and regulatory reports. During this reporting period the QI/UM Committee's review included, but was not limited to:
  1. The **Appeal and Grievance Dashboard & Quarterly Reports** which track volumes, turn-around times, case classifications, and access related issues. Data through the end of December 2016 were reviewed. Year-end results were evaluated and compliance rates were noted to be comparable. Overall the total number of grievances decreased in 2016 compared to 2015. Pharmacy appeals continue to be related primarily to Hepatitis C drugs.
  2. **The semi-annual Emergency Drug Report** This report provides a summary of monitoring activities associated with the provision of prescription medications to members post Emergency Room visit as required by state regulations. Ninety-five (95) members were included in this study of ER visits at hospitals in all 3 counties to validate that medications were provided and the 90% goal was met.
  4. **The Potential Quality Issues Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review activities. Data was reviewed including the follow up actions taken when indicated. The total number of PQIs reported in Q4 was similar to previous quarters in 2016 with 2 non-member source, 65 member source and 8 Peer Review.
- **UMCM Reports -** Utilization and Case Management activities are monitored in an ongoing manner through a variety of performance, programmatic and regulatory reports. At the February meeting the UMCM related reports included but were not limited to the following:
  1. The **Key Indicator Report (KIR)** reflects data as of December 31st,2016. This report includes key metrics for tracking utilization and case management activities.

- Membership increased in 2016 compared to 2015.
- ER visits were comparable to the prior year, except for SPDs which did demonstrate a decrease.
- Bed days per thousand also decreased in general and for the SPD population.

2. The **Utilization Management Concurrent Review Report**. The 2016 Utilization Management/Medical Management Concurrent Review Report presents inpatient utilization data and clinical concurrent review activities for Q4 2016. Focus is on improving member health care outcomes, minimizing readmission risk and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services.
   - The Transitional Care Management (TCM) program continues to demonstrate positive results focusing on members at high risk for readmission. TCM staff initiate proactive TCM referrals within 1 day of inpatient review to facilitate proactive and successful engagement at the time of acute hospitalization.

- **Credentialing and Peer Review Sub-Committee Reports** were reviewed and submitted to RHA Commission for review.

II. HEDIS® Activity

HEDIS performance measures are used to assess the quality of care provided to health plan members. Managed Care Plans are required by contract to annually report performance measurement results to DHCS/HSAG. CalViva Medical Management staff continue efforts associated with two formal Performance Improvement Projects (PIPs) required by DHCS and five other Rapid-cycle improvement projects identified through HEDIS measurements.

Key Activities in Quarter 1:

- Annual evaluations were completed for all current improvement projects to identify successful strategies and new opportunities for improvement.
- The 2017 CalViva HEDIS Roadmap was submitted by January 31st as required by state regulations.
- MY2016 HEDIS data is being gathered from clinics and providers throughout the three-county area and will be available in Quarter 2 to provide direction for future quality activities.

III. Access & Availability

Effective and efficient access to providers and services is critical to the provision of safe, high quality care. CalViva has established an Access Workgroup to ensure this high-risk function receives adequate monitoring and oversight.

The Access Workgroup met on November 14th 2016 and January 9th ,2017. Along with routine monitoring reports the Access Workgroup continues efforts on:

- Establishing a plan to address the Specialist Shortage finding from CVH 2016 DHCS Audit
- Evaluating the effectiveness of the 2016 CVH After Hours Corrective Action Plan
- Requesting approval from DHCS for Alternative Access standards in specific CVH zip-codes

The annual Timely Access Report is due to DMHC in March each year and an initial workplan has been developed to ensure timely completion and submission.

Kaiser Report

Quarter 4 2016 reports were received in January and February with the following findings:

1. Grievance Reports 4th Quarter- All member, SPD, CBAS and Targeted Low Income Child members
2. Utilization Management & DME 4th Quarter – Summary - no significant findings
3. Mental Health Services 4th Quarter –Mental Health COC Report, Mental Health Referral, Grievance, BHT Report no significant issues.
4. CBAS Services and Assessment – 4th Quarter - no significant issues
5. Overall Volumes and Call Center Report – 4th Quarter – no significant issues

IV. Findings/Outcomes

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of the quality and safety of care provided to CalViva members. No significant compliance issues have been identified. Oversight and monitoring processes will continue.

Item #10

Attachment 10.F

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: QI/UM Committee Members
Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick C. Marabella, MD
Amy R. Schneider, RN

COMMITTEE DATE: March 16th, 2017

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2017

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2017 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 16th, 2017. At the February meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services. Reports covering the third quarter for 2016 were reviewed for delegated entities, third and fourth quarters for MHN and fourth quarter for Health Net. A summary of the third quarter data is included in the table below.

II. Table 1. Third Quarter 2016 Credentialing/Recredentialing

	EHS	Sante	ChildNet	MHN	HealthNet	La Salle	VSP	IMG	Adventist	**Totals**
Initial credentialing	46	2	15	0	9	10	8	9	1	**100**
Recredentialing	14	98	26	0	5	18	301	0	10	**472**
Suspensions	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	**0**
Totals	**60**	**100**	**41**	**0**	**14**	**28**	**309**	**9**	**11**	**572**

Note: Administrative Terminations have been removed from this table. This category is considered non-significant since they are related to physician retirement, relocation, etc and are voluntary. This category is no longer tracked on the ICE Credentialing Template.

III. A standardized template for submitting credentialing data has been distributed to both delegated and non-delegated entities. The updated template includes the required data elements per the Industry Collaboration Effort (ICE) recommendations. These new forms are now consistently used by those submitting reports.

IV. Additionally, these reporting forms include a section for providing organizational updates and improvements when applicable.

V. County specific Credentialing Sub-Committee reports were reviewed for the fourth quarter of 2016. No significant cases were identified on these reports.

VI. CalViva Medical Management Team is currently finalizing the Credentialing Oversight Audit.

.

Item #10

Attachment 10.G

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	March 16th, 2017
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2017

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the CalViva Health Peer Review Sub-Committee activities. All Peer Review information is confidential and protected by law under the Knox Keene Health Care Services Plan Act of 1975, Section 1370 which prohibits disclosure to any parties outside the peer review process.

I. The Peer Review Sub-Committee met on February 16th, 2017. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2016 were reviewed for approval. There are no significant cases identified on the reports.

II. The Quarter 4 Peer Count Report was presented at the meeting with the following outcomes:
    a. Quarter 4 - two cases were closed and cleared to track and trend, six were tabled pending further information.

III. No significant quality of care issues noted. Follow up will be initiated to obtain additional information for tabled cases and ongoing monitoring and reporting will continue.

Item #10

Attachment 10.H

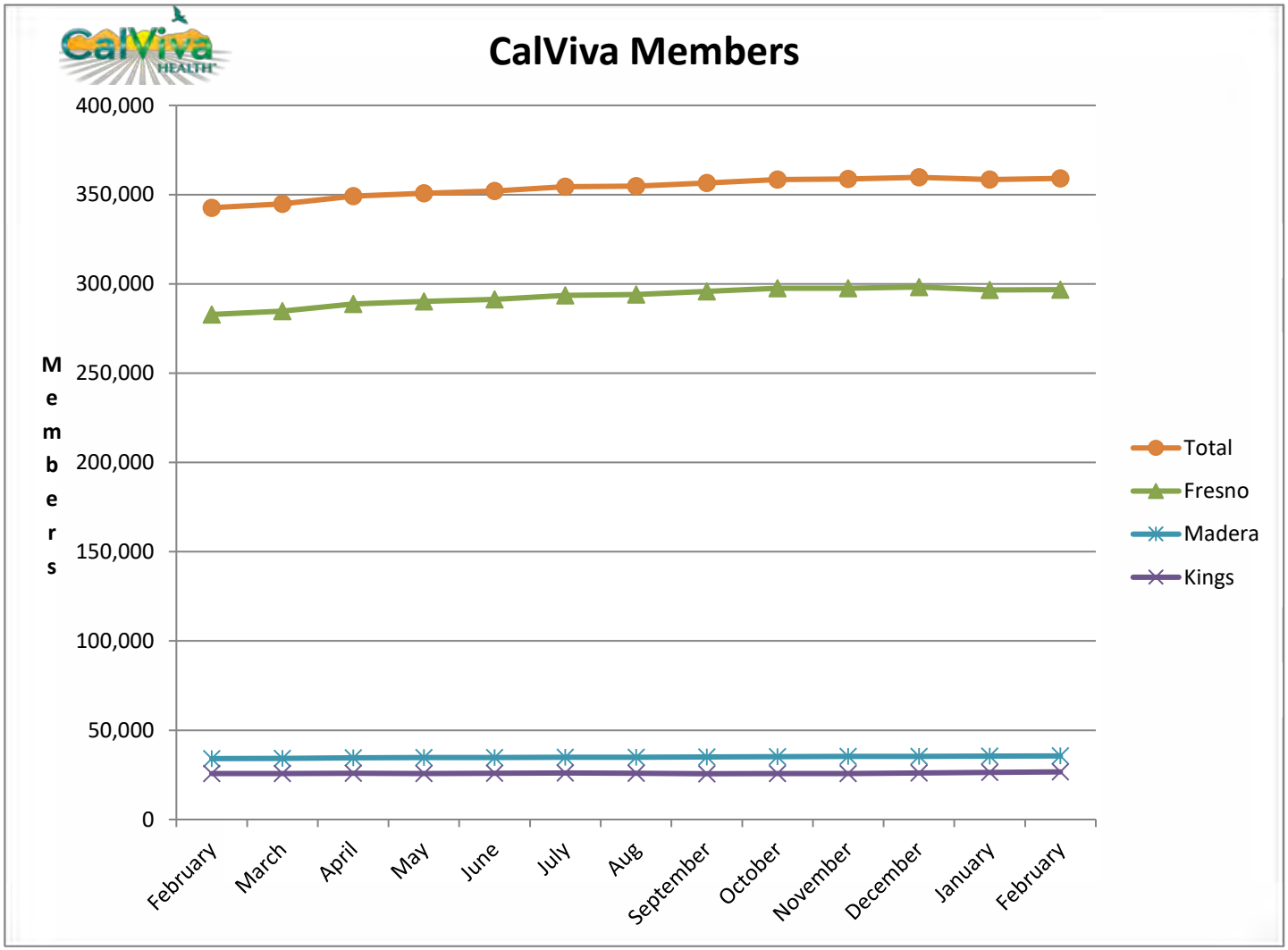
Executive Dashboard

Month	2016 February	2016 March	2016 April	2016 May	2016 June	2016 July	2016 Aug	2016 September	2016 October	2016 November	2016 December	2017 January	2017 February
CVH Members													
Fresno	282,892	284,722	288,696	290,219	291,380	293,530	293,999	295,801	297,534	297,649	298,282	296,674	296,787
Kings	25,670	25,820	25,873	25,791	25,924	26,021	25,934	25,635	25,758	25,762	26,036	26,310	26,680
Madera	34,108	34,234	34,515	34,703	34,778	34,953	34,899	35,106	35,211	35,311	35,379	35,504	35,612
Total	342,670	344,776	349,084	350,713	352,082	354,504	354,832	356,542	358,503	358,722	359,697	358,488	359,079
SPD	27,794	27,891	27,891	28,156	28,286	28,459	28,617	28,839	28,886	29,072	29,239	29,349	n/a
CVH Mrkt Share	70.00%	70.09%	70.15%	70.25%	70.30%	70.34%	70.41%	70.46%	70.46%	70.45%	70.45%	70.40%	70.40%
ABC Members													
Fresno	108,500	108,568	109,947	110,063	110,194	110,775	110,405	110,949	111,686	111,882	112,033	111,653	111,865
Kings	19,155	19,361	19,366	19,266	19,367	19,490	19,557	19,333	19,385	19,366	19,586	19,885	20,023
Madera	19,201	19,193	19,253	19,201	19,177	19,249	19,144	19,210	19,224	19,248	19,225	19,167	19,061
Total	146,856	147,122	148,566	148,530	148,738	149,514	149,106	149,492	150,295	150,496	150,844	150,705	150,949
Default													
Fresno	963	892	1,367	1,151	1,002	1,070	878	945	1,003	886	873	1,071	n/a
Kings	125	93	186	118	108	116	89	104	125	118	126	158	n/a
Madera	161	152	201	153	141	163	114	170	153	140	167	191	n/a
County Share of Choice as %													
Fresno	70.20%	69.70%	70.20%	71.70%	69.10%	70.40%	70.20%	68.70%	67.90%	68.30%	66.50%	61.30%	n/a
Kings	58.00%	56.40%	55.40%	57.60%	53.10%	49.20%	54.10%	53.30%	57.10%	52.50%	57.20%	54.90%	n/a
Madera	58.80%	61.20%	64.70%	67.40%	67.10%	62.90%	66.00%	60.30%	60.60%	61.10%	60.00%	57.40%	n/a
Voluntary Disenrollments													
Fresno	418	551	585	1,057	569	505	584	666	636	1,153	540	1,064	n/a
Kings	76	65	76	132	53	55	72	69	64	138	53	66	n/a
Madera	115	66	115	175	86	80	109	119	82	161	62	83	n/a
No. Claims Processed	180,921	188,366	201,115	179,781	203,583	175,777	183,750	180,762	160,087	184,227	196,360	176,008	n/a
Claims Turn-around	99.12%	99.48%	99.78%	99.87%	99.90%	99.30%	99.86%	99.90%	99.80%	99.86%	99.91%	99.76%	n/a
Weekly Average	36,184	37,673	40,223	44,945	50,896	43,944	45,938	45,191	40,022	46,057	49,090	44,002	n/a

Note: Most data is preliminary and may have retroactive adjustments as new or updated information becomes available..

Data Current as of February 27, 2017

Note: Claims Turn-around = 30 Calendar/45 Work Days - Updates will be available on quarterly basis based on calendar year.


CalViva Members
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
Members
February
March
April
May
June
July
Aug
September
October
November
December
January
February
Total
Fresno
Madera
Kings